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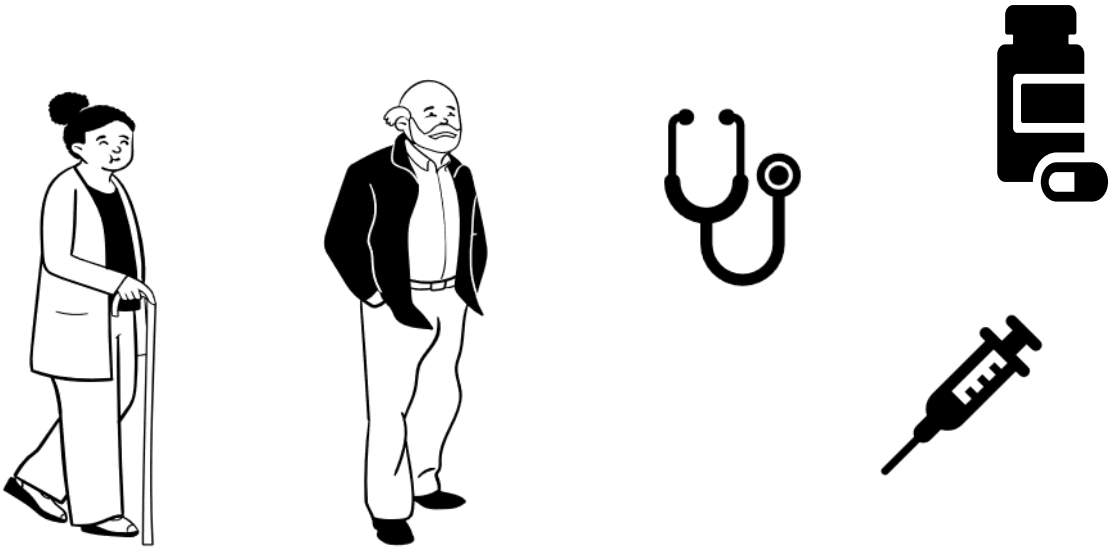

PUBLISHER'S NOTE

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I. PART I: MEDICARE

A. CHAPTER 1:MEDICARE BASICS

MEDICARE IS A HEALTH INSURANCE PROGRAM FOR

- Individuals age 65 or older,
- Individuals under age 65 with certain disabilities, and
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

1. THE DIFFERENT PARTS OF MEDICARE

The different parts of Medicare help cover specific services. Medicare has the following parts:

a) Part A: Hospital Insurance

- Helps cover inpatient care in hospitals
- Helps Cover skilled nursing facility, hospice, and home health care

b) Part B: Medical Insurance

- Helps cover doctor's services, outpatient care, and home health care
- Helps cover some preventive services to help maintain an individual's health and keep certain illnesses from getting worse.

c) Part C: Medicare Advantage Plans (HMO or PPO)

A health coverage option run by private insurance companies approved by and under contract with Medicare. Includes Part A, Part B, and usually other coverage like prescription drugs

d) Part D: Medicare Prescription Drug coverage

- A prescription drug option run by private insurance companies approved by and under contract with Medicare.
    - Helps cover the cost of prescription drugs.
    - May help lower prescription drug costs and help protect against higher costs in the future.

2. SUMMARY OF COVERAGE CHOICES

a) ORIGINAL MEDICARE

- Run by the Federal government.
- Provides Part A and/or B coverage.
- Individuals can go to any doctor or hospital that accepts Medicare.
- Individuals can join a Medicare Prescription Drug Plan to add drug coverage.
- Individuals can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill the gaps in Part A and Part B.

b) Medicare Advantage Plans (like an HMO or PPO) Advantage Plans are run by private insurance companies approved by and under contract with Medicare.

Provides Part A and Part B coverage but can charge different amounts for certain services. It may offer extra coverage and prescription drug coverage, sometimes for extra cost. Costs vary by plan.

If an individual wants drug coverage, they usually get it through their plan.

An individual does not need and cannot use a Medigap policy with a Medicare Advantage Plan.

c) Other Medicare health plans

Plans that are not Medicare Advantage Plans but are still part of Medicare include Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Most plans provide Part A and Part B coverage, and some also provide prescription drug coverage (Part D).

3. MEDICARE PART A

Medicare Part A: (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals (not custodial or long-term care). It also helps cover hospice care and some home health care. For inpatient care in a Religious Nonmedical Health Care Institution, individuals must meet certain conditions to get these benefits.

a) Cost

Most people don't have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while working. For those who don't get premium-free Part A, they may be able to buy it.

Individuals who must pay a premium for Part A include:

- Individual (or their spouse) who aren't entitled to Social Security, because they didn't work or didn't pay enough Medicare taxes while they worked and are age 65 or older, or
- Individuals who are disabled but no longer get free part because they have returned to work.

b) Some people Need to sign up for Part A

In most cases, if an individual chooses to **buy** Part A, they must also have Part B and pay monthly premiums for both. **If an individual has limited income and resources, their state may help them pay for Part A and/or Part B.**

If an individual gets benefits from Social Security or the Railroad Retirement Board (RRB), they automatically get Part A starting the first day of the month they turn age 65. If they are under age 65 and disabled, they automatically get Part A after they get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. They will get their Medicare card in the mail 3 months before their 65th birthday or their 25th month of disability.

If an individual has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), they automatically get Part A the month their disability benefits begin.

If an individual needs to sign up for Part A, they can sign up during the following times:

Initial Enrollment Period—When they are first eligible for Medicare. (This is a 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65.)

General Enrollment Period—Between January 1–March 31 each year. The coverage will begin July 1. Individuals may have to pay a higher premium for late enrollment. See below.

Special Enrollment Period—If the individual or their spouse (or family member if they are disabled) is currently working, and they are covered by a group health plan through the employer or union. Enrollment process is discussed under Part B.

Special Enrollment Period for International Volunteers—If you are serving as a volunteer in a foreign country. Enrollment process is discussed under Part B.

If an individual is not eligible for premium-free Part A, they may be able to buy it. However, if they don't buy Part A when they are first eligible, their monthly premium may go up 10%. They will have to pay the higher premium for twice the number of years they could have had Part A, but didn't join. For example, if they were eligible for Part A, but didn't join for 2 years, they will have to pay the higher premium for 4 years. They don't have to pay a penalty if they are eligible for a special enrollment period.

For more information on Part A, call Social Security, or visit www.socialsecurity.gov. If an individual gets benefits from the RRB, call 1-877-772-5772.

If an individual has End-Stage Renal Disease (ESRD), different rules apply. For more information, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

4. MEDICARE PART-A COVERED SERVICES:

a) Blood:

In most cases, the hospital gets blood from a blood bank at no charge, and the insured won't have to pay for it or replace it. If the hospital has to buy blood, the insured must either pay the hospital costs for the first 3 units of blood the insured gets in a calendar year or have the blood donated by someone.

b) Home Health Services

Limited to medically-necessary, part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment , and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.

c) Hospice Care

Hospice is for people with a terminal illness. The doctor must certify that the insured is expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; and other covered services as well as services Medicare usually doesn't cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in the home or other facility like a nursing home. Hospice care doesn't include room and board unless the hospice medical team determines that the insured needs short-term inpatient stays for pain and symptom management that can't be addressed in the home.

These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care which is care given in a Medicare-approved facility so that the usual caregiver can rest. An individual can stay up to 5 days each time they get respite care. Medicare will pay for covered services for health problems that aren't related to the terminal illness. An individual can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that the individual is terminally ill.

d) Hospital Stays (inpatient)

Hospital stays include semi-private rooms, meals, general nursing, and drugs as part of the inpatient treatment, and other hospital services and supplies. Examples include inpatient care an individual gets in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or telephone in the room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If the individual has Part B, it covers the doctor's services they get while they are in a hospital.

e) Skilled Nursing Facility Care

Medicare covers skilled nursing facility care after a 3-day minimum medically necessary inpatient hospital stay (not including the day you leave the hospital) for an illness or injury related to the hospital stay. Medicare covers semi-private rooms, meals, skilled nursing and therapy services, and other medically necessary services and supplies in a skilled nursing facility.

To qualify for skilled nursing facility care, your doctor must certify that you need daily skilled care (like intravenous fluids/medications or physical therapy) which, as a practical matter, you can only get as a skilled nursing facility inpatient. Medicare doesn't cover non-medical long-term care.

You may get skilled nursing care or therapy if it's necessary to improve or maintain your current condition. If you disagree with your discharge, you can appeal. For example, if you're discharged only because you aren't improving, but still need skilled nursing care or therapy to keep your condition from getting worse, you can appeal.

In each benefit period (2024), you pay:

- Days 1–20: Nothing. Note: If you're in a Medicare Advantage Plan, you may be charged copayments during the first 20 days.
- Days 21–100: $204 each day.
- Days 101 and beyond: All costs.

Note: You may not need a 3-day minimum inpatient hospital stay if your doctor participates in an Accountable Care Organization (ACO), or your provider is approved for a Skilled Nursing Facility 3-Day Rule Waiver. If your provider participates in an ACO , ask about benefits that may be available. Medicare Advantage Plans may also waive the 3-day minimum. Contact your plan for more information

5. MEDICARE PART B

Medicare Part B (Medical Insurance) helps cover medically necessary doctors' services, outpatient care, home health services, durable medical equipment, mental health services, limited outpatient prescription drugs, and other medical services. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.

Part B helps pay for these covered services and supplies when they are medically necessary.

Cost: Most recipients pay the standard Medicare Part B premium each month. However, if an individual's modified adjusted gross income as reported on their IRS tax return from 2 years ago is above a certain amount may have to pay more. Social Security notifies any individual who may have to pay more than the standard premium. In some cases, this amount may be higher if the individual didn't sign up for Part B when they first became eligible.

a) How to Get Part B

If an individual gets benefits from Social Security or the Railroad Retirement Board (RRB), in most cases, they will automatically get Part B starting the first day of the month they turn age 65. If their birthday is on the first day of the month, their Part B will start the first day of the prior month. If they are under age 65 and disabled, they will automatically get Part B after they get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. They will get your Medicare card in the mail about 3 months before their 65th birthday or their 25th month of disability. If they don't want Part B, they follow the instructions that come with the card, and send the card back. If they keep the card, they keep Part B and will pay Part B premiums.

If they have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), they automatically get Part B the month their disability benefits begin.

b) When Can You Sign Up for Part B?

If an individual didn't sign up for Part B when they first became eligible, they may be able to sign up during one of these times:

General Enrollment Period —Between January 1–March 31 each year. Their coverage will begin on July 1. They may have to pay a late enrollment penalty.

Special Enrollment Period —If they wait to sign up for Part B because they or their spouse is currently working, and they are covered by a group health plan based on that work, or if they are disabled and they or a family member is working, and they are covered by a group health plan based on that work. They can sign up for Part B anytime while they have group health plan coverage based on current employment or during the 8-month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first. If they have COBRA coverage, they

must enroll during the 8-month period that begins the month after the employment ends. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD).

Special Enrollment Period for International Volunteers —If the individual waited to sign up for Part B because they had health insurance while volunteering outside of the U.S. for a tax exempt organization for at least a year. They can sign up during the 6-month period that begins the first month that any one of the following happens:

- They are no longer volunteering outside the U.S.
- The sponsoring organization is no longer tax exempt.
- They no longer have health insurance coverage outside the U.S.

If an individual has Medicare because of End-Stage Renal Disease (ESRD), they can sign up for Part B when they sign up for Part A. If they delay signing up for Part B, they can only get it during the general enrollment period, and they may have to pay a late enrollment penalty.

If they live in Puerto Rico, and they want Part B, they will need to sign up for it. Contacting their local Social Security office for more information is the best process to follow..

If an individual is not getting Social Security or RRB benefits, and they want to get Part B, they will need to sign up for Part B during their initial enrollment period (the 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).

If an individual doesn't sign up for Part B when they are first eligible, they may have to pay a late enrollment penalty for as long as they have Medicare. Their monthly premium for Part B may go up 10% for each full 12-month period that they could have had Part B, but didn't sign up for it. Usually, they don't pay a late enrollment penalty if they sign up for Part B during a special enrollment period.

NOTE: If they are age 65 or older, after they sign up for Part B, they have a 6-month Medigap open enrollment period which gives them a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or replaced.

c) Medicare and TRICARE Coverage

If an individual has Medicare Part A and TRICARE (coverage for active-duty military or retirees and their families), they must have Part B to keep their TRICARE coverage.

However, if they are an active-duty service member, or the spouse or dependent child of an active-duty service member, the following applies:

They don't have to enroll in Part B to keep their TRICARE coverage while the service member is on active duty.

When the active-duty service member retires, they must enroll in Part B to keep their TRICARE coverage. They can get Part B during a special enrollment period if they have Medicare because they are age 65 or older, or they are disabled.

6. MEDICARE PART B AND EMPLOYER OR UNION COVERAGE

It's important that an individual understands how their Part B enrollment rights can be affected if they or their spouses are still working, and they have coverage through an employer or union, or under COBRA.

When the employment ends, three things happen:

1. An individual's health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
2. They may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after their employment ends. This period will run whether or not they elect COBRA. If they elect COBRA, they should not wait until their COBRA ends to enroll in Part B. If they enroll in Part B after the 8-month special enrollment period, they may have to pay a late enrollment penalty. When you sign up for Part B,
3. An individual has a 6-month Medigap open enrollment period which gives them a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated.

7. MEDICARE PART B SERVICES

There are two kinds of Part B-covered services:

- ✓ **Medically-necessary services**—Services or supplies that are needed to diagnose or treat a medical condition and that meet accepted standards of medical practice.
- ✓ **Preventive services**—Health care to prevent illness or detect it at an early stage, when treatment is most likely to work best (for example, Pap tests, flu shots, and colorectal cancer screenings).

a) Acupuncture Medicare only covers acupuncture (including dry needling) for chronic low back pain. Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain defined as:

- Lasting 12 weeks or longer
- Not having an identifiable cause (for example, not an identifiable disease like cancer that has spread, or an infectious or inflammatory disease)
- Pain that isn't associated with surgery or pregnancy

Medicare covers an additional 8 sessions if you show improvement. You can get a maximum of 20 acupuncture treatments in a 12-month period. The Part B deductible and coinsurance apply. If you aren't showing improvement, Medicare won't cover the 8 additional treatments.

Not all providers can give acupuncture, and Medicare can't pay licensed acupuncturists directly for their services.

b) Advance care planning Medicare covers voluntary advance care planning as part of your yearly "Wellness" visit. This is planning for care you would get when you need help making decisions for yourself. As part of advance care planning, you may choose to complete an advance directive. This important legal document records your wishes about medical treatment in the future, if you aren't able to make decisions about your care. You can talk about an advance directive with your health care provider, and they can help you fill out the forms, if you prefer.

Consider carefully who you want to speak for you and what directions you want to give. You have the right to carry out your plans as you choose without discrimination based on your age or disability.

You can update your advance directive at any time. You pay nothing if it's given as part of the yearly "Wellness" visit, and your doctor or other qualified health care provider accepts assignment.

Medicare may also cover this service as part of your medical treatment. When advance care planning isn't part of your yearly "Wellness" visit, the Part B deductible and coinsurance apply.

c) Alcohol misuse screenings & counseling Medicare covers an alcohol misuse screening for adults (including pregnant individuals) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your primary care doctor or other health care provider determines you're misusing alcohol, you can get up to 4 brief, face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting, like a doctor's office. You pay nothing if your primary care doctor or other health care provider accepts assignment.

d) Ambulance services Medicare covers ground ambulance transportation to a hospital, critical access hospital, rural emergency hospital, or skilled nursing facility for medically necessary services when traveling in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter if you need immediate and rapid ambulance transport that ground transportation can't provide.

In some cases, Medicare may pay for medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. For example, a patient discharged from the hospital may need a medically necessary ambulance transport to a skilled nursing facility.

Medicare will only cover ambulance transportation to the nearest appropriate medical facility that's able to give you the care you need.

You pay 20% of the Medicare-approved amount. The Part B deductible applies.

e) Ambulatory surgical centers Medicare covers the facility service fees related to approved surgical procedures done in an ambulatory surgical center (outpatient facility that performs surgical procedures), and the patient is expected to be released within 24 hours. Except for certain preventive services (for which you pay

nothing if your doctor or other health care provider accepts assignment), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you. The Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

f) Bariatric surgery Medicare covers some bariatric surgical procedures, like gastric bypass surgery and laparoscopic banding surgery, when you meet certain conditions related to morbid obesity.

g) Behavioral health integration services If you have a behavioral health condition (like depression, anxiety, or another mental health condition), Medicare may pay your provider to help manage that condition. Some providers that manage behavioral health conditions may offer integrated care services, like the Psychiatric Collaborative Care Model. This model is a set of integrated behavioral health services, including care management support that may include:

- Care planning for behavioral health condition(s)
- Ongoing assessment of your condition
- Medication support
- Counseling
- Other treatment your provider recommends

Your health care provider will ask you to sign an agreement for you to get these services on a monthly basis. Your Part B deductible and coinsurance will apply to the monthly service fee.

h) Blood If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a copayment for the blood processing and handling services for each unit of blood you get. The Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or you or someone else can donate the blood.

i) Bone mass measurements This test helps to see if you're at risk for broken bones. Medicare covers it once every 24 months (more often if medically necessary) for people who have certain medical conditions (like possible osteoporosis) or meet certain criteria. You pay nothing for this test if your doctor or other qualified health care provider accepts assignment.

j) Cardiac rehabilitation Medicare covers comprehensive programs that include exercise, education, and counseling if you've had at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable chronic heart failure

Medicare covers regular and intensive cardiac rehabilitation programs. Medicare covers services in a doctor's office or hospital outpatient setting. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office, and a copayment in a hospital outpatient setting. The Part B deductible applies.

k) Cardiovascular behavioral therapy Medicare covers a cardiovascular behavioral therapy visit one time each year with your primary care doctor or other qualified primary care provider in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips on eating well. You pay nothing if your primary care doctor or other health care provider accepts assignment.

l) Cardiovascular disease screenings These screenings include blood tests for cholesterol, lipid, and triglyceride levels that help detect conditions that may lead to a heart attack or stroke. Medicare covers these

screening blood tests once every 5 years. You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment.

m) Caregiver training resources Medicare now covers **training** that helps your caregiver learn and develop skills to care for you (like giving medications, personalized care, and more) as part of your treatment plan. If your health care provider determines that caregiver training is appropriate for your treatment plan, your caregiver can get individual or group training sessions from your provider without requiring you to be present. Training must focus on your health goals, and your treatment must require a caregiver's help to succeed. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

n) Cervical & vaginal cancer screenings Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months in most cases. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Medicare also covers Human Papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you're 30–65 without HPV symptoms. You pay nothing for the lab Pap test, the lab HPV with the Pap test, the Pap test specimen collection, and pelvic and breast exams if your doctor or other qualified health care provider accepts assignment.

o) Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting if you have cancer. You pay a copayment for chemotherapy in a hospital outpatient setting.

You pay 20% of the Medicare-approved amount for chemotherapy in a doctor's office or freestanding clinic. The Part B deductible applies.

For Part A-covered chemotherapy in an inpatient hospital setting.

p) Chiropractic services

Medicare only covers manipulation of the spine to correct a subluxation (when the spinal joints fail to move properly but the contact between the joints remains intact). You pay 20% of the Medicare-approved amount. The Part B deductible applies.

q) Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other health information. It also explains the care you need and how it will be coordinated.

If you agree to get this service, your provider will prepare the care plan for you or your caregiver, help you with medication management, provide 24/7 access for urgent care management needs, give you support when you go from one health care setting to another, and help you with other chronic care needs.

You pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance, including Medicaid, it may help cover the monthly fee.

r) Chronic pain management and treatment services

Medicare covers monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. The Part B deductible and coinsurance apply.

s) Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe, like how well a cancer drug works. For certain clinical research studies, Medicare covers some costs, like office visits and tests. You may pay 20% of the Medicare-approved amount, depending on the treatment you get. The Part B deductible may apply.

Note: If you're in a Medicare Advantage Plan, Original Medicare may cover some costs along with your Medicare Advantage Plan. Contact your plan for details about coverage for clinical research studies.

t) Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting if you have cancer. You pay a copayment for chemotherapy in a hospital outpatient setting.

You pay 20% of the Medicare-approved amount for chemotherapy in a doctor's office or freestanding clinic. The Part B deductible applies.

For Part A-covered chemotherapy in an inpatient hospital setting.

u) Chiropractic services

Medicare only covers manipulation of the spine to correct a subluxation (when the spinal joints fail to move properly but the contact between the joints remains intact). You pay 20% of the Medicare-approved amount. The Part B deductible applies.

v) Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other health information. It also explains the care you need and how it will be coordinated.

If you agree to get this service, your provider will prepare the care plan for you or your caregiver, help you with medication management, provide 24/7 access for urgent care management needs, give you support when you go from one health care setting to another, and help you with other chronic care needs.

You pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance, including Medicaid, it may help cover the monthly fee.

w) Chronic pain management and treatment services

Medicare covers monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. The Part B deductible and coinsurance apply.

x) Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe, like how well a cancer drug works. For certain clinical research studies, Medicare covers some costs, like office visits and tests. You may pay 20% of the Medicare-approved amount, depending on the treatment you get. The Part B deductible may apply.

Note: If you're in a Medicare Advantage Plan, Original Medicare may cover some costs along with your Medicare Advantage Plan. Contact your plan for details about coverage for clinical research studies.

y) Cognitive assessment & care plan services

When you visit your provider (including your yearly "Wellness" visit), they may perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, or making decisions. Conditions like depression, anxiety, and delirium can also cause confusion, so it is important to understand why you may be having symptoms.

Medicare covers a separate visit with a doctor or health care provider to do a review of your cognitive function, establish or confirm a diagnosis like dementia or Alzheimer's disease, and develop a care plan. You can bring someone with you, like a spouse, friend, or caregiver, to help provide information and answer questions.

During this visit, the doctor or health care provider may:

• Perform an exam, talk with you about your medical history, and review your medications.

• Identify your social supports including care that your usual caregiver can provide.

• Create a care plan to help address and manage your symptoms.

• Help you develop or update your advance care plan.

• Refer you to a specialist, if needed.

• Help you understand more about community resources, like rehabilitation services, adult day health programs, and support groups.

The Part B deductible and coinsurance apply.

Some people living with dementia and their family and unpaid caregivers may be able to get additional support through the Guiding an Improved Dementia Experience Model pilot program. Talk to your provider for more information and to find out if they're participating.

z) Colorectal cancer screenings

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. Medicare may cover one or more of these screening tests:

• **Barium enema:** Medicare covers this test once every 48 months if you're 45 or older (or every 24 months if you're high risk) when your doctor uses it instead of a flexible sigmoidoscopy or screening colonoscopy. You pay 20% of the Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible doesn't apply. Visit Medicare.gov/coverage/barium-enemas for more information.

• **Screening Colonoscopies:** Medicare covers this screening test once every 120 months (or every 24 months if you're high risk) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age requirement. If you initially have a non-invasive stool-based screening test (fecal occult blood tests or multi-target stool DNA test) and receive a positive result, Medicare also covers a follow-up colonoscopy as a screening test. You pay nothing for the screening test(s) if your doctor or other qualified health care provider accepts assignment.

• **Flexible sigmoidoscopies:** Medicare covers this test once every 48 months if you're 45 or older, or 120 months after a previous screening colonoscopy if you aren't at high risk. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, you pay 15% of the

Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a 15% coinsurance. The Part B

deductible doesn't apply.

• **Fecal occult blood tests:** Medicare covers this screening test once every 12 months if you're 45 or older. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

• **Multi-target stool DNA & blood-based biomarker tests:** Medicare covers these screening tests once every 3 years if you meet all of these conditions:

• You're between 45–85.

• You show no symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, a positive guaiac fecal occult blood test or fecal immunochemical test.

• You're at average risk for developing colorectal cancer, meaning:

• You have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative ccolitis.

• You have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer. Multi-target stool DNA tests are at-home lab tests. Blood-based biomarker tests are

conducted in a lab. You pay nothing for these tests if your doctor or other qualified health care provider accepts assignment.

aa) Continuous Positive Airway Pressure (CPAP) devices & accessories

Medicare may cover a 3-month trial of CPAP devices and accessories if you've been diagnosed with obstructive sleep apnea. After the trial period, Medicare may continue to cover CPAP devices and accessories if you meet with your doctor in person, and your doctor documents in your medical record that you meet certain conditions and the CPAP is helping you.

You pay 20% of the Medicare-approved amount for the machine rental and purchase of related supplies (like masks and tubing). The Part B deductible applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you'll own it.

Note: Medicare may cover a rental or replacement CPAP machine and/or CPAP accessories if you had a CPAP machine before you got Medicare, and you meet certain requirements.

Preventive service Counseling to prevent tobacco use & tobacco-caused disease

Medicare covers up to 8 face-to-face visits in a 12-month period if you use tobacco. You pay nothing for the counseling sessions if your doctor or other qualified health provider accepts assignment.

bb) COVID-19 (Coronavirus disease 2019)

Many people with Medicare are at higher risk for serious COVID-19 illness, so it's important to take the necessary steps to keep yourself and others safe.

Medicare covers several tests, items, and services related to COVID-19. Talk with your doctor or health care provider to find out which are right for you.

COVID-19 Vaccines:

• FDA-approved and FDA-authorized vaccines help reduce the risk of illness from COVID-19 by working with the body's natural defenses to safely develop immunity (protection) against the virus.

• You pay nothing for the COVID-19 vaccine if your doctor or other qualified health care provider accepts assignment for giving you the shot.

• Be sure to bring your red, white, and blue Medicare card with you when you get the vaccine so your health care provider or pharmacy can bill Medicare. If you're in a Medicare Advantage Plan, you must use the card from your plan to get your Medicare-covered services. You pay nothing when you get the vaccine from an in-network provider. Check with your plan for more information.

Diagnostic laboratory tests:

• These tests check to see if you have COVID-19.

• You pay nothing when a health care provider orders this test and you get it from a laboratory, pharmacy, doctor, or hospital that takes Medicare.

• If you're in a Medicare Advantage Plan, check with your plan to find out if you have any out-of-pocket costs.

Monoclonal antibody treatments and products:

• These FDA-authorized or approved treatments can help fight the disease and keep you out of the hospital. You must test positive for COVID-19, have mild to moderate symptoms, and be at high risk for progressing to severe COVID-19, and/or needing hospitalization.

• Original Medicare will cover monoclonal antibody treatments if you have COVID-19 symptoms.

• You pay nothing for these treatments when you get them from a Medicare provider or supplier. You must meet certain conditions to qualify. If you're in a Medicare Advantage Plan, check with your plan about your coverage and costs. **Note:** Certain FDA authorized or approved monoclonal antibody products can protect you before you're exposed to COVID-19. If you have Part B and your doctor decides this type of product could work for you (like if you have a weakened immune system), you pay nothing for the product when you get it from a Medicare provider or supplier.

cc) Defibrillators

Medicare may cover an implantable cardioverter defibrillator if you've been diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for your doctors' services. You also pay a copayment. In most cases, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies. Part A covers surgeries to implant defibrillators in an inpatient hospital setting.

dd) Depression screening

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and/or referrals. You pay nothing for this screening if your doctor accepts assignment.

If you or someone you know is struggling or in crisis and would like to talk to a trained crisis counselor, **call or text 988,** the free and confidential Suicide & Crisis Lifeline. You can also connect with a counselor through web chat at 988lifeline.org.

ee) Diabetes equipment, supplies, & therapeutic shoes

Medicare covers meters and continuous glucose monitors used to estimate your blood glucose (blood sugar level) and related supplies, including test strips, lancets, lancet holders, sensors, and control solutions. Medicare also covers tubing, insertion sets, and insulin for patients using insulin pumps, and sensors, transmitters, and receivers for patients using continuous glucose monitors. In addition, Medicare covers one pair of extra-depth or custom shoes and inserts per year for people with specific diabetes-related foot problems.

You pay 20% of the Medicare-approved amount if your supplier accepts assignment. The Part B deductible applies.

Important! Medicare drug coverage (Part D) may cover insulin you inject yourself, certain medical supplies used to inject insulin (like syringes), disposable pumps, and some oral diabetes drugs. Check with your plan for more information. The cost of a one-month supply of each covered insulin product is capped at $35. Similar caps on costs apply for traditional insulin used in Part B-covered insulin pumps.

ff) Diabetes screenings

Medicare covers up to 2 blood glucose (blood sugar) laboratory test screenings (fasting or non-fasting) each year if your doctor determines you're at risk for developing diabetes. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

Preventive service

Diabetes self-management training

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood glucose (blood sugar), taking prescription drugs, and reducing risks. You must have been diagnosed with diabetes and have a written order from your doctor or other health care provider. Some patients may also be eligible for medical nutrition therapy services . You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Note: You may be able to get diabetes self-management training from a doctor or other health care provider who's located elsewhere using audio and video communication technology, like your phone or a computer. Visit adces.org/program-finder to find certified programs near you.

gg) Doctor & other health care provider services

Medicare covers medically necessary doctor services (including outpatient services and some inpatient hospital doctor services) and most

preventive services. Medicare also covers services you get from other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, physical therapists, occupational therapists, speech-language pathologists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing if your doctor

or other provider accepts assignment), you pay 20% of the Medicare-approved amount for most services. The Part B deductible applies.

Important! If you haven't received services from your doctor or group practice in the last 3 years, they may consider you a new patient. Check with the doctor or group practice to find out if they're accepting new patients.

hh) Drugs

Part B covers a limited number of outpatient prescription drugs, like:

- Most injectable and infused drugs when a licensed medical provider gives them
- Certain oral anti-cancer drugs
- Drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump)
- Intravenous Immune Globulin for use in the home
- Certain drugs you get in a hospital outpatient setting (under very limited circumstances)
- Most renal dialysis drugs and biological products

Note: Other than the examples above, you pay 100% for most drugs, unless you have Medicare drug coverage (Part D) or other drug coverage.

For some drugs used with an external infusion pump, and for Intravenous Immune Globulin for use in the home, Medicare may also cover services (like nursing visits) under the home infusion therapy benefit and the Intravenous Immune Globulin benefit . Part B also covers some injectable or implantable drugs to treat substance use disorder when a provider administers them in a doctor's office or in an outpatient hospital setting. You pay 20% of the Medicare-approved amount for these drugs. The Part B deductible applies. You won't have to pay any copayments for these services if you get them from a Medicare-enrolled Opioid Treatment Program.

Doctors and pharmacies must accept assignment for Part B-covered drugs, so you should never be asked to pay more than the coinsurance or copayment for the Part B drug itself.

Important! Your coinsurance can change depending on your prescription drug's price. You might pay a lower coinsurance for certain Part B-covered drugs and biologicals when you get them in a doctor's office or pharmacy, or in a hospital outpatient setting if their prices have increased higher than the rate of inflation. The specific drugs and potential savings change every quarter.

If the Part B-covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. Part B doesn't cover "self-administered drugs" in a hospital outpatient setting. "Self-administered drugs" are drugs you'd normally take on your own.

What you pay for self-administered drugs in a hospital outpatient setting depends on whether you have Medicare drug coverage (Part D) or other drug coverage, and if the hospital's pharmacy is in your drug plan's network. If you have other drug coverage, your drug plan may cover drugs that Part B may not cover. Contact your drug plan to find out what you pay when Part B doesn't cover the drugs you get in a hospital outpatient setting.

ii) Durable medical equipment (DME)

Medicare covers medically necessary items like oxygen and oxygen equipment, walkers, and hospital beds when a Medicare-enrolled doctor or other health care provider orders them for use in the home. You must rent most items, but you can also buy them. Some items become your property after you've made a number of rental payments. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. It's important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment (which means they can charge you only the coinsurance and Part B deductible for the Medicare-approved amount). If DME suppliers aren't participating and don't accept assignment, you may have to pay for the full cost of the DME.

jj) Electrocardiogram (EKG or ECG) screenings

Medicare covers a routine EKG/ECG screening if you get a referral from your doctor or other health care provider during your one-time "Welcome to Medicare".. After you meet the Part B deductible, you pay 20% of the Medicare-approved

amount. Medicare also covers EKGs or ECGs as diagnostic tests . You also pay a copayment if you have the test at a hospital or a hospital-owned clinic.

kk) Emergency department services

Medicare covers these services when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a copayment for each emergency department visit and 20% of the Medicare-approved amount for doctors' services. The Part B deductible applies. If your doctor admits you to the same hospital as an inpatient, your costs may be different.

ll) E-visits

Medicare covers E-visits to allow you to talk with your provider using an online patient portal without going to the provider's office. Providers who can give these services include doctors, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, occupational therapists, speech-language pathologists, and when they are for mental health care, licensed clinical social workers, clinical psychologists, marriage and family therapists, and mental health counselors.

To get an E-visit, you must request one with your doctor or other provider. You pay 20% of the Medicare-approved amount for your doctor's or other provider's services. The Part B deductible applies.

mm) Eyeglasses

Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants an intraocular lens. Medicare will only pay for contact lenses or eyeglasses from a supplier enrolled in Medicare, whether you or your provider submits the claim. After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for corrective lenses after cataract surgery with an intraocular lens.

nn) Federally Qualified Health Center services

Federally Qualified Health Centers provide many outpatient primary care and preventive health services. There's no deductible, and you usually pay 20% of the charges or the Medicare-approved amount. You pay nothing for most

preventive services. Federally Qualified Health Centers may offer discounts if your income is limited. Visit findahealthcenter.hrsa.gov to find a health center near you.

oo) Flu shots

Medicare covers the seasonal flu shot (or vaccine). You pay nothing for the flu shot if your doctor or other health care provider accepts assignment for giving you the shot.

pp) What You Pay

Costs for Part B services depend on whether the individual has Original Medicare or are in a Medicare health plan.

The following pages give general information about what an individual must pay if they have Original Medicare. For some services, there are no costs, but the individual may have to pay for the visit to the doctor. If the Part B deductible applies, an individual must pay all costs until they meet the yearly Part B deductible before Medicare begins to pay its share. After the deductible is met, an individual typically pay 20% of the Medicare-approved amount of the service.

qq) Foot care

Medicare covers yearly foot exams or treatment if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss, or if you need medically necessary treatment for foot injuries or diseases, like hammer toe, bunion deformities, and heel spurs. You pay 20% of the

Medicare-approved amount for medically necessary treatment your doctor approves. The Part B deductible applies. You also pay a copayment for medically necessary treatment in a hospital outpatient setting.

rr) Glaucoma screenings

Medicare covers this screening once every 12 months if you're at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed to do glaucoma screenings in your state must do or supervise the screening. You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

ss) Hearing & balance exams

Medicare covers these diagnostic exams if your doctor or health care provider orders them to see if you need medical treatment.

You can visit an audiologist once every 12 months without an order from a doctor or other health care provider, but only for non-acute hearing conditions (like hearing loss that occurs over many years) and for diagnostic services related to hearing loss that's treated with surgically implanted hearing devices.

You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

Note: Medicare doesn't cover hearing aids or exams for fitting hearing aids.

tt) Preventive service Hepatitis B shots

Medicare covers these shots (or vaccines) if you're at medium or high risk for Hepatitis B Virus. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, living with someone who has Hepatitis B, or employment as a health care worker who has frequent contact with blood or body fluids. Check with your doctor to find out if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if your doctor or other health care provider accepts assignment for giving you the shots.

uu) Preventive service Hepatitis B Virus infection screenings

Medicare covers Hepatitis B Virus infection screening tests if your doctor orders it. Medicare also covers the screening tests:

• Yearly, only if you're at continued high risk and don't get a Hepatitis B shot.

Foot care

Medicare covers yearly foot exams or treatment if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss, or if you need medically necessary treatment for foot injuries or diseases, like hammer toe, bunion deformities, and heel spurs. You pay 20% of the

Medicare-approved amount for medically necessary treatment your doctor approves. The Part B deductible applies. You also pay a copayment for medically necessary treatment in a hospital outpatient setting.

Preventive service

Glaucoma screenings

Medicare covers this screening once every 12 months if you're at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed to do glaucoma screenings in your state must do or supervise the screening. You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

vv) Hearing & balance exams

Medicare covers these diagnostic exams if your doctor or health care provider orders them to see if you need medical treatment.

You can visit an audiologist once every 12 months without an order from a doctor or other health care provider, but only for non-acute hearing conditions (like hearing loss that occurs over many years) and for diagnostic services related to hearing loss that's treated with surgically implanted hearing devices.

You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

Note: Medicare doesn't cover hearing aids or exams for fitting hearing aids.

ww) Preventive service Hepatitis B shots

Medicare covers these shots (or vaccines) if you're at medium or high risk for Hepatitis B Virus. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, living with someone who has Hepatitis B, or employment as a health care worker who has frequent contact with blood or body fluids. Check with your doctor to find out if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if your doctor or other health care provider accepts assignment for giving you the shots.

xx) Preventive service Hepatitis B Virus infection screenings

Medicare covers Hepatitis B Virus infection screening tests if your doctor orders it. Medicare also covers the screening tests:

• Yearly, only if you're at continued high risk and don't get a Hepatitis B shot.

Foot care

Medicare covers yearly foot exams or treatment if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss, or if you need medically necessary treatment for foot injuries or diseases, like hammer toe, bunion deformities, and heel spurs. You pay 20% of the

Medicare-approved amount for medically necessary treatment your doctor approves. The Part B deductible applies. You also pay a copayment for medically necessary treatment in a hospital outpatient setting.

yy) Glaucoma screenings

Medicare covers this screening once every 12 months if you're at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed to do glaucoma screenings in your state must do or supervise the screening. You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

zz) Hearing & balance exams

Medicare covers these diagnostic exams if your doctor or health care provider orders them to see if you need medical treatment.

You can visit an audiologist once every 12 months without an order from a doctor or other health care provider, but only for non-acute hearing conditions (like hearing loss that occurs over many years) and for diagnostic services related to hearing loss that's treated with surgically implanted hearing devices.

You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

Note: Medicare doesn't cover hearing aids or exams for fitting hearing aids.

aaa) Hepatitis B shots

Medicare covers these shots (or vaccines) if you're at medium or high risk for Hepatitis B Virus. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, living with someone who has Hepatitis B, or employment as a health care worker who has frequent contact with blood or body fluids. Check with your doctor to find out if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if your doctor or other health care provider accepts assignment for giving you the shots.

bbb) Hepatitis B Virus infection screenings

Medicare covers Hepatitis B Virus infection screening tests if your doctor orders it. Medicare also covers the screening tests:

• Yearly, only if you're at continued high risk and don't get a Hepatitis B shot.

- If you're pregnant:
- At the first prenatal visit for each pregnancy
- At the time of delivery for those with new or continued risk factors
- At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative Hepatitis B screening results

You pay nothing for the screening test if the doctor or health care provider accepts assignment.

ccc) Preventive service Hepatitis C Virus infection screenings

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you use or have used illicit injection drugs.
- You had a blood transfusion before 1992.
- You were born between 1945–1965.

Medicare also covers yearly repeat screening tests if you're at high risk.

Medicare will only cover a Hepatitis C screening test if your health care provider orders one. You pay nothing for the screening test if your primary care doctor or other qualified health care provider accepts assignment.

ddd) Preventive service HIV (Human Immunodeficiency Virus) screenings

Medicare covers HIV screening tests once per year if you're:

• Between 15–65.

• Younger than 15 or older than 65, and at increased risk.

Medicare also covers this screening test up to 3 times during a pregnancy. You pay nothing for the HIV screening test if your doctor or other qualified health care provider accepts assignment.

eee) Home health services

Medicare covers home health services under Part A and/or Part B. Medicare covers medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy services. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. "Part-time or intermittent" means you may be able to get skilled nursing care and home health aide services if they're provided less than 8 hours each day or less than 28 hours each week (or up to 35 hours a week in some limited situations). A doctor or other health care provider (like a nurse practitioner) must assess you face-to-face before certifying that you need home health services. A doctor or other health care provider must order your care, and a Medicare-certified home health agency must provide it.

Medicare covers home health services as long as you need part-time or intermittent skilled services and as long as you're "homebound," which means:

• You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.

• Leaving your home isn't recommended because of your condition.

• You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. However, for Medicare-covered durable medical equipment, you pay 20% of the

Medicare-approved amount. The Part B deductible applies.

fff) Home infusion therapy services, equipment & supplies

Medicare covers equipment and supplies (like pumps, IV poles, tubing, and catheters) for home infusion therapy to administer certain IV infusion drugs, like Intravenous Immune Globulin, at home. Medicare covers certain equipment and

supplies (like the infusion pump) and the infusion drug under durable medical equipment . Medicare also covers services (like nursing visits), training for caregivers, and patient monitoring. You pay 20% of the Medicare-approved amount for these services and for the equipment and supplies you use in your home.

ggg) Kidney (renal) dialysis services & supplies

Generally, Medicare covers 3 dialysis treatments (or equivalent continuous ambulatory peritoneal dialysis) per week if you have End-Stage Renal Disease (ESRD). This includes renal dialysis drugs and biological products, laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount. The Part B deductible applies.

hhh) Kidney disease education

Medicare covers up to 6 sessions of kidney disease education services if you have Stage 4 chronic kidney disease that will usually require dialysis or a kidney transplant, and your doctor or other qualified health care provider refers you for the service. You pay 20% of the Medicare-approved amount per session if you get the service from a doctor or provider. The Part B deductible applies.

iii) Laboratory tests

Medicare covers medically necessary clinical diagnostic laboratory tests when your doctor or provider orders them. These tests may include certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these tests.

jjj) Lung cancer screenings

Medicare covers lung cancer screening tests with low dose computed tomography once per year if you meet these conditions:

- You're 50–77.
- You don't have signs or symptoms of lung cancer (you're asymptomatic).
- You're either a current smoker or you quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 20 "pack years" (an average of one pack—20 cigarettes—per day for 20 years).
- You get an order from your doctor.

You pay nothing for this screening test if your doctor accepts assignment.

Before your first lung cancer screening, you'll need to schedule an appointment with a health care provider to discuss the benefits and risks of lung cancer screening to decide if the screening is right for you.

kkk) Lymphedema compression treatment items

If you've been diagnosed with lymphedema, Medicare may cover your prescribed gradient compression garments (standard and custom fitted). You pay 20% of the Medicare-approved amount. The Part B deductible applies.

lll) Mammograms

Medicare covers a mammogram screening to check for breast cancer once every 12 months if you're a woman 40 or older. Medicare covers one baseline mammogram if you're a woman between 35–39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the Medicare-approved amount for diagnostic mammograms. The Part B deductible applies.

Note: Medicare covers medically necessary breast ultrasounds only when your doctor or provider orders them.

mmm) Medical nutrition therapy services

Medicare covers medical nutrition therapy services if you have diabetes or kidney disease, or if you've had a kidney transplant in the last 36 months and a doctor refers you for services. Only a Registered Dietitian or nutrition professional who meets certain requirements can provide medical nutrition therapy services. If you have diabetes, you may also be eligible for diabetes self-management training. You pay nothing for medical nutrition therapy preventive services because the deductible and coinsurance don't apply.

nnn) Medicare Diabetes Prevention Program

If you have prediabetes and meet other eligibility requirements, Medicare covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with 16 weekly core sessions led by coaches in a group setting over a 6-month period. Once you complete the core sessions, you'll get 6 monthly follow-up sessions to help you maintain healthy habits. You can attend sessions in-person, virtually, or both.

You can get these services from an approved Medicare Diabetes Prevention Program supplier. These suppliers may be traditional health care providers or organizations like community centers or faith-based organizations. To find a supplier or learn more about the program, visit Medicare.gov/coverage/medicare-diabetes-prevention-program.

If you're in a Medicare Advantage Plan, contact your plan to find out where to get these services.

ooo) Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression and anxiety. These visits are often called counseling or psychotherapy, and can be done individually, in group psychotherapy or family settings, and in crisis situations. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, hospital outpatient department, or by telehealth), including visits with a psychiatrist or other doctor, clinical psychologist, clinical nurse specialist, clinical social worker, nurse practitioner, or physician assistant.

Medicare-covered mental health care includes:

- Services provided by marriage & family therapists and mental health counselors.
- **Partial hospitalization** services that are given by a Community Mental Health Center or by a hospital to outpatients. This structured day program offers outpatient psychiatric services as an alternative to inpatient psychiatric care.
- **Intensive outpatient program** services that include intensive psychiatric care, counseling, and therapy. These services may be given in hospitals, Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, and Opioid Treatment Programs (when services are for the treatment of Opioid Use Disorder).

Partial hospitalization and intensive outpatient services are for more hours a day than care you'd get in a doctor's or therapist's office. To learn more, visit Medicare.gov/coverage/mental-health-care-partial-hospitalization.

Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies for mental health care services. Part A covers inpatient mental health care services you get in a hospital

ppp) Preventive service Obesity behavioral therapy

If you have a body mass index (BMI) of 30 or more, Medicare covers obesity screenings and behavioral counseling to help you lose weight by focusing on diet and exercise. Medicare covers this counseling if your primary care doctor or other primary care provider gives the counseling in a primary care setting (like a doctor's office), where they can coordinate your personalized plan with your other care. You pay nothing for this service if your primary care doctor or other provider accepts assignment.

qqq) Occupational therapy services

Medicare covers medically necessary therapy to help you perform activities of daily living (like dressing or bathing). This therapy helps to improve or maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

rrr) Opioid Use Disorder treatment services

Medicare covers Opioid Use Disorder treatment services in Opioid Treatment Programs. The services include medication (like methadone, buprenorphine, naltrexone, and naloxone), dispensing and administration of such medications, substance use counseling, drug testing, individual and group therapy, intake activities, periodic assessments, and intensive outpatient services. Medicare covers counseling, therapy services, and periodic assessments both in-person and, in certain circumstances, virtually (using audio and video communication technology like your phone or a computer). Medicare also covers services given through Opioid Treatment Program mobile units.

Medicare pays doctors and other providers for office-based Opioid Use Disorder treatment, including management, care coordination, psychotherapy, counseling activities, and allotment and distribution of medications.

Under Original Medicare, you won't have to pay any copayments for these services if you get them from an Opioid Treatment Program provider that's enrolled in Medicare and meets other requirements. However, the Part B deductible still applies. Talk to your doctor or other health care provider to find out where to go for these services. You can also visit Medicare.gov/coverage/opioid-use-disorder-treatment-services to find a program near you.

Medicare Advantage Plans must also cover Opioid Treatment Program services, but may require you see an in-network Opioid Treatment Program. Since Medicare Advantage Plans can apply copayments to Opioid Treatment Program services, check with your plan to find out if you have to pay a copayment.

sss) Outpatient hospital services

Medicare covers many diagnostic and treatment services you get as an outpatient from a Medicare-participating hospital. Generally, you pay 20% of the Medicare-approved amount for your doctors' or other health care providers' services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll also usually pay the hospital a copayment for each service you get in a hospital outpatient setting (except for certain preventive services that don't have a copayment). In most cases, the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay deductible.

Cost & coverage: Get cost estimates for hospital outpatient procedures done in hospital outpatient departments:

Medicare.gov/procedure-price-lookup

ttt) Outpatient medical & surgical services and supplies

Medicare covers approved procedures, like X-rays, casts, stitches, and outpatient surgeries. You pay 20% of the Medicare-approved amount for doctor or other health care provider services. You generally pay a copayment for each service you get in a hospital outpatient setting. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service you get. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

uuu) Physical therapy services

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to improve or maintain current function or slow decline, **when your doctor or other health care provider, including a nurse practitioner, clinical nurse specialist or physician assistant certifies you need it.** You pay 20% of the Medicare-approved amount. The Part B deductible applies.

vvv) Pneumococcal shots

Medicare covers pneumococcal shots (or vaccines) to help prevent pneumococcal infections (like certain types of pneumonia). Talk with your doctor or other health care provider about this vaccine. You pay nothing for these shots if your doctor or other health care provider accepts assignment for giving you the shots.

www) Principal care management services

Medicare covers disease-specific services to help you manage a single, complex chronic condition that puts you at risk of hospitalization, physical or cognitive decline, or death. If you have one chronic high-risk condition that you expect to last at least 3 months (like cancer and you aren't being treated for any other complex conditions), Medicare may pay for a health care provider to help manage it. Your provider will create a disease-specific care plan and continuously monitor and adjust it, including the medicines you take. The Part B deductible and coinsurance apply.

Note: Medicare may also cover principal illness navigation services for your chronic high-risk condition. These services can help you understand your medical condition(s) or diagnosis and navigate the health care system to find the care and providers you need. Visit Medicare.gov/coverage/principal-illness-navigation-services to learn more.

xxx) Preventive service Prostate cancer screenings

Medicare covers digital rectal exams and prostate specific antigen (PSA) tests once every 12 months for men over 50 (starting the day after your 50th birthday). For the digital rectal exam, you pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting. You pay nothing for the PSA test.

yyy) Prosthetic/orthotic items

Medicare covers these prosthetics/orthotics when a Medicare-enrolled doctor or other health care provider orders them: arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); and prosthetic devices needed to replace an internal body organ or function of the organ (including ostomy supplies, parenteral and enteral nutrition therapy, and some types of breast prostheses after a mastectomy).

For Medicare to cover your prosthetic or orthotic, you must get it from a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

zzz) Pulmonary rehabilitation programs

Medicare covers a comprehensive pulmonary rehabilitation program if you have:

- Moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor who's treating it, or
- Had confirmed or suspected COVID-19 and experience persistent symptoms including respiratory dysfunction for at least 4 weeks

You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

aaaa) Rural Health Clinic services

Rural Health Clinics provide many outpatient primary care and preventive services in rural and underserved areas. Generally, you pay 20% of the charges. The Part B deductible applies. You pay nothing for most preventive services.

bbbb) Second surgical opinions

Medicare covers a second surgical opinion in some cases for medically necessary surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

cccc) Sexually transmitted infection (STI) screenings & counseling

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B. Medicare covers these screenings if you're pregnant or at increased risk for an STI when your primary care doctor or other health care provider orders the tests. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual, 20–30 minute, face-to-face, high-intensity behavioral counseling sessions each year if you're a sexually active adult at increased risk for STIs. Medicare will only cover these counseling sessions with a primary care doctor or health care provider in a primary care setting (like a doctor's office). Medicare won't cover counseling as a preventive service in an inpatient setting, like a skilled nursing facility.

You pay nothing for these services if your primary care doctor or provider accepts assignment.

dddd) Shots (or vaccines)

Part B covers:

- Flu shots.
- Hepatitis B shots.
- Pneumococcal shots.
- Coronavirus disease 2019 (COVID-19) vaccines. G

Important! Medicare drug coverage (Part D) generally covers all other recommended adult immunizations to prevent illness (like shingles, tetanus, diphtheria, pertussis, and respiratory syncytial virus (RSV)) at no cost to you. If the shot isn't on your plan's drug list yet, you can ask for a coverage exception or get reimbursed. Contact your plan for details, and talk to your doctor or other health care provider about which vaccines are right for you. To learn more about covered vaccines, visit Medicare.gov/coverage.

eeee) Speech-language pathology services

Medicare covers medically necessary evaluation and treatment to regain and strengthen speech and language skills. This includes cognitive and swallowing skills, or to improve or maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

ffff) Surgical dressing services

Medicare covers medically necessary treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for your doctor or other health care provider services. You pay a set copayment for these services when you get them in a hospital outpatient setting. The Part B deductible applies.

gggg) Telehealth

Medicare covers certain telehealth services you get from a doctor or other health care provider who's located elsewhere using technology to communicate with you in real time. Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and certain other medical or health services.

Through December 31, 2024, you can get telehealth services at any location in the U.S., including your home. After this period, you must be in an office or medical facility located in a rural area to get most telehealth services. However, you'll still be able to get certain telehealth services **without** being in a rural area. They include:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit
- Services to treat a substance use disorder or a co-occurring mental health disorder or for the diagnosis, evaluation, or treatment of a mental health disorder, including in your home
- Behavioral health services (also called mental health services), including in your home
- Diabetes self-management training
- Medical nutrition therapy

You pay 20% of the Medicare-approved amount for your doctor or other health care provider or practitioner's services. The Part B deductible applies. For most of these services, you'll pay the same amount you would if you got the services in person.

Compare: Medicare Advantage Plans and some providers in Original

Medicare may offer more telehealth benefits than the basic coverage in Original Medicare. For example, you may be able to get some services from home, no matter where you live. If your provider in Original Medicare participates in an Accountable Care Organization (ACO), check with them to find out what telehealth benefits may be available.

hhhh) Tests (Non-laboratory)

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount. In most cases, this amount can't be more than the Part A hospital stay deductible. sts.

iiii) Transitional care management services

Medicare may cover this service if you're returning to your community after an inpatient stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work with you and your caregiver to coordinate and manage your care for the first 30 days after you return home. The Part B deductible and coinsurance apply. Visit Medicare.gov/coverage/transitional-care-management-services to learn more.

jjjj) Transplants & immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions, but only in Medicare-certified facilities. Medicare also covers bone marrow and cornea transplants under certain conditions.

Medicare covers immunosuppressive drugs if Medicare paid for the organ transplant. You must have Part A at the time of the covered organ transplant, and you must have Part B at the time you get immunosuppressive drugs (or qualify for the immunosuppressive drug benefit described on this page). You pay 20% of the Medicare-approved amount for the drugs. The Part B deductible applies. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them.

If you're thinking about joining a Medicare Advantage Plan and are on a transplant waiting list or think you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Ask for information about covered drugs and their costs. Also, check the plan's coverage rules for prior authorization and coverage for your living donors.

Medicare may cover transplant surgery as a hospital inpatient service under Part A.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

kkkk) Immunosuppressive drug benefit

If you only have Medicare because of End-Stage Renal Disease (ESRD), your Medicare coverage (including immunosuppressive drug coverage) ends 36 months after a successful kidney transplant. Medicare offers a benefit to help you pay for your immunosuppressive drugs beyond 36 months **if you don't have certain types of other health coverage** (like a group health plan, TRICARE, or Medicaid that covers immunosuppressive drugs). **This benefit only covers your immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage. You can sign up for this benefit any time after your Medicare Part A coverage ends, as long as you had Medicare because of ESRD at the time of your kidney transplant.** To sign up, call Social Security at 1-877-465-0355. TTY users can call 1-800-325-0788.

You'll pay a monthly premium of $103 (or higher based on your income) and $240 deductible for this immunosuppressive drug benefit in 2024. Once you've met the deductible, you'll pay 20% of the Medicare-approved amount for immunosuppressive drugs. If you have limited income and resources, you may be able to get help from your state to pay for this benefit. Travel

Medicare generally doesn't cover health care while you're traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some limited exceptions. Visit Medicare.gov/coverage/travel-outside-the-u.s. to learn more.

Medicare may cover medically necessary ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

llll) Urgently needed care

Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for your doctor or other health care provider services, and a copayment in a hospital outpatient setting. The Part B deductible applies.

mmmm) Virtual check-ins

Medicare covers virtual check-ins with your doctor or certain other providers. Virtual check-ins allow you to briefly communicate with your health care providers using audio or video communication technology like your phone or a computer, without going to the doctor's office. Your doctor can also conduct remote assessments using photo or video images you send for review to determine whether you need to go to the doctor's office. Your doctor or other provider can respond to you by phone, virtual delivery, secure text message, email, or patient portal.

Virtual check-ins are different from a telehealth visit because they're usually 10 minutes or less and aren't done in real time.

You can have a virtual check-in if you meet these conditions:

• You talked to your health care provider about starting these types of visits.

• You verbally consent to the virtual check-in, and your doctor documents your consent in your medical record. Your doctor may get one consent for a year's worth of these services.

• The virtual check-in doesn't relate to a medical visit you've had within the past 7 days and doesn't lead to the medical visit within the next 24 hours (or the soonest appointment available).

Compare: You pay 20% of the Medicare-approved amount for your doctor or other health care provider services. The Part B deductible applies. Medicare Advantage Plans may offer more virtual check-in services than Original Medicare. Check with your plan to find out what they offer.

nnnn) "Welcome to Medicare" preventive visit

During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. The visit includes a review of your medical and social history related to your health. It also includes education and counseling about preventive services, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and referrals for other care, if needed.

When you make your appointment, let your doctor's office know you'd like to schedule your "Welcome to Medicare" preventive visit. You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.

If you have a current prescription for opioids, your provider will review your potential risk factors for Opioid Use Disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate. Your provider will also review your potential risk factors for substance use disorder and alcohol and tobacco use and refer you for treatment, if needed.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that Medicare doesn't cover under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply. If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

oooo) Yearly "Wellness" visit

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit. **The yearly "Wellness" visit isn't a physical exam—**it's a visit to develop or update your personalized plan to prevent disease or disability based on your current health and risk factors. Medicare covers this visit once every 12 months.

Your doctor or health care provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Your visit may also include routine measurements, health advice, a review of your medical and family history, a review of your current prescriptions, advance care planning, and more.

Your doctor or health care provider may also use a questionnaire to better understand your social needs and refer you for appropriate services and support. This is called a "social determinants of health risk assessment," and it's free when you get it as part of your yearly "Wellness" visit. For more information, visit Medicare.gov/coverage.

Your doctor or health care provider will also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, and making decisions about your everyday life. If your doctor or health care provider thinks you may have cognitive impairment, Medicare covers a separate visit to do a more thorough review of your cognitive function and check for conditions like dementia, depression, anxiety, or delirium, and design a care plan.

Your doctor or health care provider will also evaluate your potential risk factors for a substance use disorder and refer you for treatment, if needed. If you use opioid medication, your provider will review your pain treatment plan, share information about non-opioid treatment options, and refer you to a specialist, as appropriate.

Note: Your first yearly "Wellness" visit can't take place within 12 months of your Part B enrollment or your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to qualify for a yearly "Wellness" visit.

You pay nothing for the yearly "Wellness" visit if the doctor or health care provider accepts assignment.

Important! If your doctor or health care provider performs additional tests or services during your "Wellness" visit that Medicare doesn't cover under this preventive benefit, you may have to pay a coinsurance, and the Part B deductible may apply. If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

pppp) What is not covered by Medicare Part A & B

Medicare doesn't cover everything. If you need certain services Part A or Part B doesn't cover, you'll have to pay for them yourself unless:

• You have other coverage (including Medicaid) to cover the costs.

• You're in a Medicare Advantage Plan or Medicare Cost Plan that covers these services. Medicare Advantage Plans and Medicare Cost Plans may cover some extra benefits, like fitness programs and vision, hearing, and dental services.

Some of the items and services that Original Medicare doesn't cover include:

✕ Eye exams (for prescription eyeglasses).

✕ Long-term care.

✕ Cosmetic surgery.

✕ Massage therapy.

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B. CHAPTER 2: MEDICARE CHOICES

Individuals can choose different ways to get their Medicare coverage. If they choose Original Medicare and they want drug coverage, they must join a Medicare Prescription Drug Plan (Part D).

If they choose to join a Medicare Advantage Plan, the plan may include Medicare prescription drug coverage. In most cases, if they don't make a choice, they will have Original Medicare. .

Each year individuals should review their health and prescription needs because their health, finances, or plan's coverage may have changed.

If an individual decides other coverage will better meet their needs, they can switch plans during certain times

There are Two Main Choices for How You Get Your Medicare

1. Choice One: Original Medicare

Part A (Hospital Insurance) and Part B (Medical Insurance)

Medicare provides this coverage.

Individuals have their choice of doctors, hospitals, and other providers.

Generally, the individual or their supplemental coverage pays deductibles and coinsurance.

Individuals usually pay a monthly premium for Part B.

Individuals must decide if they want Prescription Drug Coverage (Part D)

An individual must also decide they want Supplemental Coverage. If they want to get coverage that fills gaps in Original Medicare coverage: They can choose to buy a Medigap (Medicare Supplement Insurance) policy from a private company.

Costs vary by policy and company. Employers/unions may offer similar coverage.

2. Choice Two: Medicare Advantage Plan (like an HMO or PPO)

Part C—Includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)

Private insurance companies approved by Medicare provide this coverage. In most plans, individuals need to use plan doctors, hospitals, and other providers, or they pay more or all of the costs. The individual usually pays a small monthly premium (in addition to their Part B premium) and a copayment or coinsurance for covered services.

Costs, extra coverage, and rules vary by plan.

If an individual wants prescription drug coverage, and it's offered by their plan, in most cases they must get it through their plan.

If an individual's plan doesn't offer drug coverage, the individual can choose to join a Medicare Prescription Drug Plan.

3. Things to Consider When Choosing or Changing Coverage

Coverage—Are the services needed covered?

Individual's other coverage—Does the individual have, or are they eligible for, other types of health or prescription drug coverage?

If so, the individual should read the materials they get from their insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare. If an individual has coverage through a former or current employer or union, or get their health care from an Indian Health or Tribal Health Program, they should talk to their benefits administrator, insurer, or plan before making any changes to their coverage.

Cost—How much are the premiums, deductibles, and other costs? How much does an individual have to pay for services like hospital stays or doctor visits? Is there a yearly limit on what the individual could pay out-of-pocket for medical services? An individual's costs may vary and may be different if they don't follow the coverage rules.

Doctor and hospital choice—Does the individual's doctors accept the coverage? Are the doctors they want to see accepting new patients? Do they have to choose their hospital and health care providers from a network? Do they need to get referrals?

Prescription drugs—What are the individual's drug needs? Do they need to join a Medicare drug plan? Do they already have creditable prescription drug coverage? Will they pay a penalty if they join a drug plan later? What will their prescription drugs cost under each plan? Are their drugs covered under the plan's formulary (drug list)?

Quality of care—The quality of care and services given by plans and other health care providers can vary. Medicare has information to help individuals compare plans and providers.

Convenience—Where are the doctors' offices? What are their hours? Which pharmacies can the individual use? Can they get their prescriptions by mail? Do the doctors use electronic health records or prescribe electronically?

Travel—Will the plan cover the individual while in another state? If an individual is in a Medicare plan, they should review the Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) the plan sends individuals each year. The EOC gives details about what the plan covers, how much an individual pays, and more. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.

C. THE ORIGINAL MEDICARE

The Original Medicare Plan is one of the health plan choices as part of the Medicare Program. Individuals stay in the Original Medicare Plan unless they choose to join a Medicare Advantage Plan or other Medicare Health Plan.

How does the Original Medicare Plan work?

The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. Based on a traditional major medical plan, there is a premium, co-pay or co-insurance. There is NO STOP LOSS, a.k.a. out of pocket limit. The rules for how the Original Medicare Plan works are below.

Individuals use their red, white, and blue Medicare card when they get health care.

Individuals that have Medicare Part A, get all the Part A-covered services.

Individuals that have Medicare Part B, get all the Part B-covered services. They usually pay a monthly premium for Part B.

Individuals can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility.

Individuals pay a set amount for their health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and the individual pays their share (coinsurance or co-payment) for covered services and supplies (unless they have a Medigap policy).

Monthly, after getting a health care service, the individual gets a Medicare Summary Notice (MSN) in the mail.

The notices are sent by companies that handle bills for Medicare.

The notice lists the details of the services received and the amount that an individual may be billed.

For more information about the Medicare Summary Notice, visit www.medicare.gov on the web and select "Medicare Billing".

1. COSTS IN THE ORIGINAL MEDICARE PLAN

What an individual pays out-of-pocket depends on:

- Whether an individual has Part A and/or Part B (most people have both).
- Whether the doctor or supplier accepts "assignment."
- Whether the individual and their the doctor sign a private contract
- How often an individual needs health care.
- What type of health care is needed.
- Whether an individual chooses to get services or supplies not covered by Medicare. In this case, an individual would pay all the costs for these services them self.
- Whether an individual has other health insurance coverage that works with Medicare.
- Whether an individual has Medicaid or get state help paying their Medicare costs.
- Whether an individual has a Medigap (Medicare Supplement Insurance) policy.

If an individual has Medicare Part A and/or Part B, they will have to pay a part of the services they get. These costs can change each year. If an individual wants to know the costs for a specific service, they should visit www.medicare.gov on the web for this information.

2. WHAT IS "ASSIGNMENT" IN THE ORIGINAL MEDICARE PLAN

Assignment is a waiver of some of the owner's rights in a policy. Traditional Major Medical policies have the insured pay the doctor, fill out and send in claim forms, and wait for reimbursement. Traditional or Original Medicare is the same. The insured, a.k.a. the Beneficiary has the option to pay the provider and do all the claim paperwork. They can also assign this to the provider. Assignment with Medicare also limits what the provider can charge.

Assignment is an agreement between people with Medicare, their doctors and other providers, and Medicare.

The person with Medicare agrees to let the doctor or other provider request direct payment from Medicare for covered Part B services, items, and supplies. Doctors or providers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, their other insurance, or anyone else.

If assignment isn't accepted, doctors and providers may charge individuals more than the Medicare-approved amount. For most services, there is a limit on the amount over the Medicare-approved amount the doctors and providers can bill the patient.

The highest amount of money a patient can be charged for a Medicare covered service by doctors and other providers who don't accept assignment is called the limiting charge.

The limiting charge is 15% over Medicare's approved amount. The limiting charge applies only to certain services and doesn't apply to supplies and items.

In addition, a patient may have to pay the entire charge at the time of service.

Medicare will send the patient its share of the charge when the claim is processed.

In some cases, the health care providers and suppliers must accept assignment.

3. WHAT IS A PRIVATE CONTRACT?

A "private contract" is a written agreement between the patient and a doctor or other health care provider who has decided not to provide services to anyone through Medicare. The private contract only applies to the services provided by the doctor or other provider who asked an individual to sign it. Individuals don't have to sign a private contract. They can always go to another doctor who does provide services through Medicare. If an individual signs a private contract with your doctor or other provider, the following rules apply:

Medicare won't pay any amount for the services that an individual gets from this doctor or other provider.

The individual will have to pay the full amount of whatever this doctor charges.

If an individual has a Medigap (Medicare Supplement Insurance) policy, it won't pay anything for the services they get.

The doctor must tell the individual if the service is one that Medicare would pay for if the individual got it from another doctor who accepts Medicare.

A doctor must tell you if he or she has been excluded from Medicare.

Individuals cannot be asked to sign a private contract for emergency or urgent care.

4. ADDING MEDICARE DRUG COVERAGE PART D

In Original Medicare, if an individual doesn't already have creditable prescription drug coverage and they would like prescription drug coverage, they must join a Medicare Prescription Drug Plan.

These plans are available through private companies approved by and under contract with Medicare. If an individual currently does not a creditable prescription drug coverage, they should think about joining a Medicare Prescription Drug Plan as soon as they are eligible. If an individual doesn't join a Medicare Prescription Drug Plan when they are first eligible and they decide to join later, they may have to pay a late enrollment penalty.

If an individual has a creditable prescription drug coverage, they should call their employer or union's benefits administrator before they make any changes to their coverage. If an individual drops their employer or union coverage, they may not be able to get it back.

a) Extra Help Paying for Drug Coverage

People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs.

D. MEDICARE ADVANTAGE- PART C

1. MEDICARE ADVANTAGE PLANS

A Medicare Advantage Plan (like an HMO or PPO) is another health coverage choice individual may have as part of Medicare.

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare.

If an individual joins a Medicare Advantage Plan, the plan will provide all of Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all plan types, an individual is 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 the individual is in a Medicare Advantage Plan. Medicare Advantage Plans aren't considered supplemental coverage.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage. In addition to Part B premium, an individual usually pays a small monthly premium for the services provided.

Medicare pays a fixed amount for their care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how to get services (like whether an individual needs a referral to see a specialist or if they have to go to only doctors, facilities, or suppliers that belong to the plan).

2. MEDICARE ADVANTAGE PLANS

Medicare Advantage Plans include the following:

a) Medicare Health Maintenance Organization (HMOs)Plans

Individuals generally must get their care from primary care doctors, specialists, or hospitals on the plan's list (network) except in an emergency.

b) Medicare Preferred Provider Organization (PPOs) Plans

In most of these plans, individuals pay less if they use primary care doctors, specialists, and hospitals on the plan's list (network). Individuals can go to any doctor, specialist, or hospital not on the plan's list, but it will usually cost extra,

c) Medicare Special Needs Plans

These plans provide health care coverage designed for specific groups of people.

d) Medicare Private Fee-for-Service (PFFS) Plans

If individuals join one of these plans, they can go to any primary care doctor, specialist, or hospital that accepts the terms of the plan's payment.

The private company, rather than the Medicare Program, decides how much it will pay and how much the individual pays for the services they get.

There are other less common types of Medicare Advantage Plans that may be available:

Point of Service (POS) Plans—Similar to HMOs, but an individual may be able to get some services out-of-network for a higher cost.

Provider Sponsored Organizations (PSOs)—Plans run by a provider or group of providers. In a PSO, individuals usually get their health care from the providers who are part of the plan.

Not all Medicare Advantage Plans work the same way.

e) More about Medicare Advantage Plans

As with Original Medicare, individuals still have Medicare rights and protections, including the right to appeal. Individuals should check with the plan before they get a service to find out whether they will cover the service and what your costs may be.

- Individuals must follow plan rules, like getting a referral to see a specialist or getting prior approval for certain procedures to avoid higher costs. Check with the plan.
- Individuals can join a Medicare Advantage Plan even if they have a pre¯existing condition.
- Individuals can only join a plan at certain times during the year. In most cases, individuals are enrolled in a plan for a year.
- If an individual goes to a doctor, facility, or supplier that doesn't belong to the plan, their services may not be covered, or their costs could be higher, depending on the type of Medicare Advantage Plan.
- If the plan decides to stop participating in Medicare, the individual will have to join another Medicare health plan or return to Original Medicare.
- Individuals usually get prescription drug coverage (Part D) through the plan. If they are in a Medicare Advantage Plan that includes prescription drug coverage and they join a Medicare Prescription Drug Plan, the individual will be disenrolled from their Medicare Advantage Plan and returned to Original Medicare.
- Individuals don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance) policy while they are in a Medicare Advantage Plan. It won't cover their Medicare Advantage Plan deductibles, copayment, or coinsurance.

f) Who Can Join a Medicare Advantage Plan?

An individual can generally join a Medicare Advantage Plan if they meet these conditions:

- They have Part A and Part B.
- They live in the service area of the plan.

If an individual has other coverage the individual should talk to their employer, union, or Indian or Tribal Health Program benefits administrator about their rules before they join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause the individual to lose employer or union coverage. In other cases, if they join a Medicare Advantage Plan, they may still be able to use their employer or union coverage along with the plan they join. Individuals must keep in mind that if they drop their employer or union coverage, they may not be able to get it back.

If an individual has a Medigap (Medicare Supplement Insurance) Policy, he or she cannot use it to pay for any expenses they have under a Medicare Advantage Plan.

If they drop their Medigap policy to join a Medicare Advantage Plan, in most cases, they won't be able to get it back.

g) End-Stage Renal Disease (ESRD)

What if I have End-Stage Renal Disease (ESRD)?

If you have ESRD, you can choose either Original Medicare or a Medicare Advantage Plan when deciding how to get Medicare coverage. If you're only eligible for Medicare because you have ESRD and you get a kidney transplant, your Medicare benefits will end 36 months after the transplant.

If an individual already in a Medicare Advantage Plan when they develop ESRD, they can stay in their plan or join another plan offered by the same company under certain circumstances.

If the individual has an employer or union health plan or other health coverage through a company that offers Medicare Advantage Plans, they may be able to join one of their Medicare Advantage Plans.

If the individual has had a successful kidney transplant, they may be able to join a Medicare Advantage Plan.

If the individual has ESRD and are in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in their area, they have a one-time right to join another Medicare Advantage Plan.

If the individual does not use their one-time right to join a new plan immediately and If they go directly to Original Medicare after their plan leaves or stops providing coverage, they will still have a one-time right to join a Medicare Advantage Plan later.

An individual may also be able to join a Medicare Special Needs Plan (SNP) for people with ESRD if one is available in their area.

For questions or complaints about kidney dialysis services, call the local ESRD Network Organization. An ESRD Network Organization is a group of kidney care experts paid by the Federal government to check and improve the care given to Medicare patients who get dialysis treatments for kidney care. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

For more information about ESRD, visit

www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

h) Costs for Medicare Advantage Plans

- The out-of-pocket costs in a Medicare Advantage Plan depend on the following:
- Whether the plan charges a monthly premium in addition to the Part B premium.
- Whether the plan pays any of the monthly Part B premium. Some plans offer this option, usually for an extra cost.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much an individual pays for each visit or service (copayments).
- The type of health care services an individual needs and how often they get them.
- Whether the individual follows the plan's rules, like using network providers.
- Whether the individual needs extra coverage and what the plan charges for it.
- Whether the plan has a yearly limit on out-of-pocket costs for all medical services.
- To learn more about individual costs in specific Medicare Advantage Plans, the individual should contact the plans they are interested in to get more details.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

i) Medicare Health Maintenance Organization (HMO) Plans

These are the general rules for how Medicare HMOs work.

- For some of these rules, plans may differ slightly, so it's important to read plan materials carefully.
- In most Medicare HMOs, there are doctors and hospitals that join the plan (called the plan's "network"). individuals generally
- must get their care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan's network.
- When individuals join a plan, they may be asked to choose a primary care doctor.

- The primary care doctor is the doctor they see first for most health problems. In many HMOs, an individual must see their primary care doctor before they can see any other health care provider.
- If an individual wants to keep seeing their current doctor, they can call and ask if he or she is in the Medicare HMO and can continue to see the doctor.
- If an individual wants to change their primary care doctor, they can ask their plan coordinator for the names of other plan doctors in the area.
- **Doctors can join or leave Medicare HMOs.**
- If an individual's primary care doctor should leave their plan, the plan will notify the individual in advance and give them a chance to pick a new doctor.
- If an individual gets health care outside of the plan's network, they may have to pay for these services them self. In some cases, neither the Medicare HMO nor the Original Medicare Plan will pay for these services.
- The service area is where the plan accepts members and where plan services are provided. Individuals are covered if they need emergency or urgently needed care and they aren't in their HMO's service area.
- Individuals usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor for the individual to see a specialist or get certain services.
- There are special rules for certain services. If the Medicare HMO includes prescription drug coverage, the individual will pay a copayment or coinsurance for each covered prescription (unless they have Medicare and Medicaid, and are in an institution like a nursing home).

j) Medicare Preferred Provider Organization (PPO) Plans

Medicare PPOs use many of the same rules as Medicare HMOs listed above and elsewhere in this book.

However, generally in a PPO individuals can see any doctor or provider that accepts Medicare.

Individuals don't need a referral to see a specialist or any provider out-of-network.

If they go to doctors, hospitals, or other providers who aren't part of the plan ("out-of-network" or "non-preferred"), they will usually pay more.

Individuals may want to contact the plan before they get services to find out how much they will have to pay and to determine if the service they want is covered.

There are two types of PPOs— Regional PPOs and Local PPOs. Regional PPOs serve one of 26 regions set by Medicare. Local

PPOs serve the counties the PPO Plan chooses to include in its service area.

k) Medicare Private Fee-for-Service (PFFS) Plans

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies. The general rules for how Medicare Private Fee-for-Service Plans work are below:

- Individuals can go to any Medicare-approved doctor or hospital that accepts the terms of the plan's payment.
- Individuals may get extra benefits not covered under the Original Medicare Plan, such as extra days in the hospital.
- The private company, rather than the Medicare Program, decides how much it will pay and what the individual will pay for the services they get.
- Individuals in a Medicare Private Fee-for-Service Plan can get their Medicare prescription drug coverage from the plan if it's offered, or they can join a separate Medicare Prescription Drug Plan to add prescription drug coverage if drug coverage isn't offered by the plan.

PFFS Plans aren't the same as Original Medicare or Medigap. The plan decides how much an individual must pay for services.

Doctors, hospitals, and other providers may decide on a case-by-case basis not to treat an individual even if they've seen them before.

For each service an individual gets they should check to make sure their doctors, hospitals, and other providers will agree to treat them under the plan, and that they will accept the PFFS Plan's payment terms.

In an emergency, doctors, hospitals, and other providers must agree to treat you.

l) Medical savings account

- Individuals can go to any Medicare-approved doctor or hospital that accepts the terms of the plan's payment.
- An individual must join a Medicare Prescription Drug Plan to get drug coverage.
- Medicare MSA Plans have two parts -a high deductible health plan and a bank account.
- Medicare gives the plan an amount each year for an individual's health care, and the plan deposits a portion of this money into their account. The amount deposited is less than their deductible amount, so they will have to pay out-of-pocket before their coverage begins. Money spent for Medicare -covered Part A and Part B services counts toward their plan's deductible. After they reach their out-of-pocket limit, their plan will cover their Medicare-covered services in full. Any money left in their account at the end of the year remains in their account, along with the deposit for next year.
- In 2010 Medicare MSA Plans are only available in Pennsylvania

m) Medicare Special Needs Plans

An individual generally must get their care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis. Plans typically have specialists for the diseases or condition that effect their members.

- Individuals, generally, need to have a primary care doctor.
- Individuals need a referral to see a specialist. Yearly screening mammograms and in-network Pap test and pelvic exam don't require a referral.
- A plan must limit plan membership to people in one of the following groups:
- People who live in certain institutions (like a nursing home) or who require nursing care at home, or
- People who are eligible for both Medicare and Medicaid, or
- People who have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS).
- Plans may further limit membership within these groups.
- Plans should coordinate the services and providers an individual needs to help them stay healthy and follow their doctor's orders.
- If an individual has Medicare and Medicaid, their plan should make sure that all of the plan doctors or other health care providers accept Medicaid.
- If an individual lives in an institution, they need to make sure that plan doctors or other health care providers serve people where they live.

3. WHEN CAN AN INDIVIDUAL JOIN, SWITCH, OR DROP A MEDICARE ADVANTAGE PLAN?

An individual can join, switch, or drop a Medicare Advantage Plan at these times:

- When an individual first become eligible for Medicare (the 7-month period that begins 3 months before the month an individual turns age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).
- If an individual gets Medicare due to a disability, they can join during the 3 months before to 3 months after their 25th month of disability. They will have another chance to join 3 months before the month they turn age 65 to 3 months after the month they turn age 65.
- Between November 15–December 31 each year. Their coverage will begin on January 1 of the following year, as long as the plan gets their enrollment request by December 31.
    - **Change your Medicare health or drug coverage , if you decide to.** You can join, switch, or drop a Medicare Advantage Plan or Medicare drug plan, or switch to Original Medicare during this Open Enrollment Period each year.

- Between January 1–March 31 of each year. Their coverage will begin the first day of the month after the plan gets their enrollment form.

- **If you're in a Medicare Advantage Plan,** you can change to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. Any changes you make will be effective the first day of the month after the plan gets your request.

- During this period, they can't do the following:
- Join or switch to a plan with prescription drug coverage unless they already have Medicare prescription drug coverage (Part D).
- Drop a plan with prescription drug coverage. Join, switch, or drop a Medicare Medical Savings Account Plan.
- In most cases, the individual must stay enrolled for that calendar year starting the date their coverage begins. However, in certain situations, they may be able to join, switch, or drop a Medicare Advantage Plan at other times.
- Some of these situations include the following:
- If the individual moves out of their plan's service area
- If they have both Medicare and Medicaid
- If they qualify for Extra Help to pay for their prescription drug costs
- If they live in an institution (like a nursing home)

Individuals can call their State Health Insurance Assistance Program (SHIP) for more information.

i) How to Join

If an individual chooses to join a Medicare Advantage Plan, they can join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. They can also enroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When an individual joins a Medicare Advantage Plan, they will have to provide their Medicare number and the date their Part A and/or Part B coverage started. This information is on their Medicare card.

ii) How to Switch

If an individual is already in a Medicare Advantage Plan and

wants to switch, this is what they need to do:

To switch to a new Medicare Advantage Plan, simply join the plan they choose. They will be disenrolled automatically from their old plan when their new plan's coverage begins.

To switch to Original Medicare, they can contact their current plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. They will also need to decide about Medicare prescription drug coverage (Part D).

If an individual's Plan Decides Not to Participate in Medicare

The plan will send the individual a letter about their options. Generally, the individual will automatically be returned to Original Medicare if they don't choose to join another Medicare Advantage Plan. The individual will also have the right to buy certain Medigap policies.

If the Plan Stops Providing Service in the Area an individual may be able to keep their coverage with that plan if there are no other Medicare Advantage Plans in their area.

If their plan offers this option, the individual must agree to travel to the plan's service area to get all their services (except for emergency and urgently-needed care). If the individual's plan doesn't have this option, they will automatically return to Original Medicare.

In this case they will have the right to buy a Medigap policy. If the individual decides to return to Original Medicare and they want drug coverage, they will need to join a Medicare Prescription Drug Plan.

b) Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug coverage).

These plans have some of the same rules as Medicare Advantage Plans. Some of these rules are explained briefly below. However, each type of plan has special rules and exceptions, so the individual should contact any plans they're interested in to get more details.

c) Medicare Cost Plans

- These are the general rules for how Medicare Cost Plans work. For some of these rules, plans may differ slightly, so it's important to read plan materials carefully.
- Medicare Cost Plans are available in limited areas of the country.
- Medicare Cost Plans use many of the same rules as Medicare HMOs . However, in a Medicare Cost Plan – if an individual goes to a non-network provider, the services are covered under the Original Medicare Plan. Individuals would pay the Medicare Part A and Part B coinsurance and deductibles.
- Individuals can join a Medicare Cost Plan anytime it is accepting new members.
- Individuals can leave a Medicare Cost Plan at any time and return to the Original Medicare Plan.
- Individuals can either get their Medicare prescription drug coverage from the plan if it's offered, or they can buy a separate Medicare Prescription Drug Plan to add prescription drug coverage.
- There is another type of Medicare Cost Plan that only provides coverage for Part B services. These plans never include Part D. Part A services are covered through Original Medicare. These plans are either sponsored by employer or union group health plans or offered by companies that don't provide Part A services.

d) Demonstrations/Pilot Programs

Demonstrations and pilot programs, sometimes called "research studies," are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas. Check with the demonstration or pilot program for more information about how it works.

For more information about current Medicare demonstrations and pilot programs, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048.

Programs of All-Inclusive Care for the Elderly (PACE) PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people. This program provides community-based care and services to people who otherwise need a nursing home-level of care.

To qualify for PACE, an individual must meet the following conditions:

Be age 55 or older.

Live in the service area of a PACE organization.

Be certified by their state as meeting the need for a nursing home-level of care.

At the time they join, to be able to live safely in the community with the help of PACE services.

PACE uses Medicare and Medicaid funds to cover all of their medically necessary care and services.

The individual can have either Medicare or Medicaid or both to join PACE.

Individuals should call their State Medical Assistance (Medicaid) office to find out if they are eligible and if there is a PACE site near them.

4. MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

Medicare offers prescription drug coverage (Part D) to everyone with Medicare. To get Medicare drug coverage, the individual must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

There are two ways to get Medicare prescription drug coverage:

Medicare Prescription Drug Plans.

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

Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage.

Individuals get all of their Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Both types of plans are called "Medicare drug plans" in this section.

a) Why Join a Medicare Drug Plan?

Even if an individual doesn't take a lot of prescription drugs now, they should still consider joining a Medicare drug plan. If an individual decides not to join a Medicare drug plan when they are first eligible, and they don't have other creditable prescription drug coverage (also called creditable coverage), they will likely pay a late enrollment penalty (higher premiums) if they join later..

NOTE: Discount cards, doctor samples, free clinics, drug discount Web sites, and manufacturer's pharmacy assistance programs aren't considered prescription drug coverage and aren't creditable coverage.

b) Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, an individual must have Medicare Part A and/or Part B. If an individual would like to get prescription drug coverage through a Medicare Advantage Plan, they must have Part A and Part B. An individual must also live in the service area of the Medicare drug plan they want to join.

If an individual has employer or union coverage, they need to call their benefits administrator before they make any changes, or before they sign up for any other coverage. If an individual drops their employer or union coverage, they may not be able to get it back. They also may not be able to drop their employer or union drug coverage without also dropping their employer or union health (doctor and hospital) coverage. If an individual drops their coverage, they may also have to drop coverage for their spouse and dependents.

c) When Can an individual Join, Switch, or Drop a Medicare Drug Plan?

An individual can join, switch, or drop a Medicare drug plan at these times:

When they are first eligible for Medicare (the 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).

If an individual gets Medicare due to a disability, they can join during the 3 months before to 3 months after their 25th month of disability. They will have another chance to join 3 months before the month they turn age 65 to 3 months after the month they turn age 65.

Between November 15 – December 31 each year. Their coverage will begin on January 1 of the following year, as long as the plan gets their enrollment request by December 31.

Anytime, if an individual qualifies for Extra Help or if they have both Medicare and Medicaid.

In most cases, they must stay enrolled for that calendar year starting the date their coverage begins. However, in certain situations, they may be able to join, switch, or drop Medicare drug plans during a special enrollment period (like if they move out of the service area, lose other creditable prescription drug coverage, or live in an institution).

d) How Do You Join?

Once an individual chooses a Medicare drug plan, they may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. They can also enroll by calling 1-800-MEDICARE. Medicare drug plans aren't allowed to call an individual to enroll them in a plan.

When an individual joins a Medicare drug plan, they will have to provide their Medicare number and the date their Part A or Part B coverage started.

e) How to Switch?

Depending on the circumstances, an individual can switch to a new Medicare drug plan simply by joining another drug plan during one the enrollment periods. An individual does not need to cancel their old Medicare drug plan or send them

anything. Their old Medicare drug plan coverage will end when their new drug plan begins. They should get a letter from their new Medicare drug plan telling them when their coverage begins. After they join a Medicare drug plan, the plan will mail them membership materials, including a card to use when they get their prescriptions filled.

f) What You Pay

Exact coverage and costs are different for each Medicare drug plan, but all plans must provide at least a standard level of coverage set by Medicare. Actual drug plan costs will vary depending on the prescriptions used, the plan an individual chooses, whether an individual goes to a pharmacy in their plan's network, whether their drugs are on their plan's formulary, and whether an individual qualifies for Extra Help paying for their Part D costs.

Monthly premium—Most drug plans charge a monthly fee that varies by plan. An individual pays this in addition to the Part B premium. If they belong to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.

Yearly deductible—Amount an individual pays for their prescriptions before their plan begins to pay. Some drug plans don't have a deductible.

Copayments or coinsurance—Amounts an individual pays at the pharmacy for their covered prescriptions after the deductible. The individual pays their share, and their drug plan pays its share for covered drugs.

Coverage gap—Most Medicare drug plans have a coverage gap. This means that after the individual and their drug plan have spent a certain amount of money for covered drugs, the individual has to pay all costs out-of-pocket for their prescriptions up to a yearly limit. Their yearly deductible, their coinsurance or copayments, and what qn individual pays in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium or what an individual pays for drugs that aren't on their plan's formulary.

There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. An individual needs to check with the drug plan first to see if their drugs would be covered during the gap.

Catastrophic coverage—Once an individual reaches their plan's out-of-pocket limit during the coverage gap, they automatically get "catastrophic coverage." Catastrophic coverage assures that once an individual has spent up to their plan's out-of-pocket limit for covered drugs, they only pay a small coinsurance amount or copayment for the drug for the rest of the year.

g) What is the Part D Late Enrollment Penalty?

The late enrollment penalty is an amount that is added to an individual's Part D premium. An individual may owe a late enrollment penalty if one of the following is true:

The individual didn't join a Medicare drug plan when they were first eligible for Medicare, and they didn't have other creditable prescription drug coverage.

The individual had a break in their Medicare prescription drug coverage or other creditable coverage of at least 63 days in a row.

NOTE: If an individual gets Extra Help, they don't pay a late enrollment penalty.

Here are a few ways to avoid paying a penalty:

Join a Medicare drug plan when you're first eligible.

Don't go for more than 63 days in a row without a Medicare drug plan or other creditable coverage. Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, or the Department of Veterans Affairs. An individual's plan will tell them each year if their drug coverage is creditable coverage. An individual should keep this information, because they may need it if they join a Medicare drug plan later.

Don't go 63 days or more in a row without letting your Medicare drug plan know if you had other creditable coverage. When an individual joins a plan, they may get a letter asking if they have creditable coverage. They should complete the form. If an individual doesn't tell the plan about their creditable coverage, they may have to pay a penalty.

h) How much more will an individual pay?

When an individual joins a Medicare drug plan, the plan will tell them if they owe a penalty, and what their premium will be. To estimate the penalty amount, an individual can count the number of full months that they didn't have creditable coverage after they were eligible to join a Medicare drug plan.

If the number of months is multiplied by the "1% penalty calculation" which is $.32 in 2010, an individual can estimate the amount that will be added each month to their Medicare drug plan's premium for the current year. This penalty amount may increase every year.

If an individual doesn't agree with their late enrollment penalty, they may be able to ask Medicare for a review or reconsideration. They will need to fill out a reconsideration request form, and the individual will have the chance to provide proof that supports their case such as information about previous prescription drug coverage.

i) Important Drug Coverage Rules

The following information can help answer common questions as an individual begins to use your coverage.

To Fill a Prescription Prior to the Membership Card is Received Within 2 weeks after the plan gets the completed application, the individual will get a letter from the plan letting them know they got their information. The individual should get a welcome package with their membership card within 5 weeks or sooner. If an individual needs to go to the pharmacy before their membership card arrives, they can use any of the following as proof of membership to the Medicare drug plan:

A letter from the plan

An enrollment confirmation number that the individual got from the plan,

The plan name, and telephone number

The individual should also bring their Medicare and/or Medicaid card, proof of any other prescription drug coverage, and a photo ID.

Once the individual has considered their options and chosen a plan, they should join early to give the plan time to mail their membership card, acknowledgement letter, and welcome package before their coverage becomes effective.

Plans may have the following coverage rules:

Prior authorization—The individual and/or their prescriber (their doctor or other health care provider who is legally allowed to write prescriptions) must contact the drug plan before they can fill certain prescriptions. Their prescriber may need to show that the drug is medically necessary for the plan to cover it.

Quantity limits—Limits on how much medication an individual can get at a time.

Step therapy—The individual must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

What Are "Tiers"?

Many Medicare drug plans place drugs into different "tiers."

Drugs in each tier have a different cost. For example, a drug in a lower tier will cost less than a drug in a higher tier. In some cases, if the drug is on a higher tier and the prescriber thinks the individual needs that drug instead of a similar drug on a lower tier, they can file an exception and ask their plan for a lower copayment.

NOTE: Medicare drug plans must cover all commercially-available vaccines (like the shingles vaccine) when medically necessary to prevent illness except for vaccines covered under Part B. Information about a plan's list of covered drugs (called a formulary) isn't included in this book because each plan has its own formulary. Formularies can change.

In most cases the prescription drugs an individual gets in an outpatient setting like an emergency department (sometimes called "self-administered drugs") aren't covered by Part B.

The individual's Medicare drug plan may cover these drugs under certain circumstances. They will likely need to pay out-of-pocket for these drugs and submit a claim to their drug plan for a refund.

j) Ways to Pay the Premium

Depending on their plan and their situation, an individual may be able to pay their Medicare drug plan premium in one of four ways:

- Deducted from their checking or savings account.

- Charged to a credit or debit card.
- Billed to you each month directly by the plan. Some plans bill in advance for coverage the next month. Payment should be paid directly to the plan (not Medicare).
- Deducted from an individual's monthly Social Security payment.

The individual should contact their drug plan (not Social Security) to ask for this payment option. With this option, the first deductions usually take 3 months to start, and 3 months of premiums will likely be collected at one time. Individuals may also see a delay in premiums being withheld if they switch or leave plans.

For more information about a specific Medicare drug plan premium or ways to pay for it, an individual should contact their drug plan.

k) Other Private Insurance

i) Employer or Union Health Coverage—Health coverage from the spouse or other family member's current or former employer or union. If an individual has prescription drug coverage based on their current or previous employment, their employer or union will notify the individual each year to let them know

ii) Employer or Union Health Coverage—Health coverage from your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. Keep the information you get. Call your benefits administrator for more information before making any changes to your coverage.

iii) COBRA—A Federal law that may allow an individual to temporarily keep employer or union health coverage after the employment ends or after the individual loses coverage as a dependent of the covered employee. There may be reasons why an individual should take Part B instead of COBRA. However, if they take COBRA and it includes creditable prescription drug coverage, they will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends.

iv) Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage—Medigap policies can no longer be sold with prescription drug coverage, but if an individual has drug coverage under a current Medigap policy, they can keep it.

However, it may be to their advantage to join a Medicare drug plan because most Medigap drug coverage isn't creditable. If an individual join a Medicare drug plan, their Medigap insurance company must remove the prescription drug coverage under their Medigap policy and adjust their premiums.

v) Federal Employee Health Benefits Program (FEHBP)—Health coverage for current and retired Federal employees and covered family members. If an individual joins a Medicare drug plan, they can keep their FEHBP plan, and their plan will let hem know who pays first.

vi) Veterans' Benefits—Health coverage for veterans and people who have served in the U.S. military. The individual may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if they do, they can't use both types of coverage for the same prescription.

vii) TRICARE (Military Health Benefits)—Health care plan for active-duty service members, retirees, and their families. Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits. If an individual has TRICARE, they aren't required to join a Medicare Prescription Drug Plan. If they do, their Medicare drug plan pays first, and TRICARE pays second. If they join a Medicare Advantage Plan with prescription drug coverage, TRICARE won't pay for their prescription drugs.

viii) Indian Health Services—Health care for people who are American Indian/Alaska Native through an Indian health care provider. If an individual gets prescription drugs through an Indian health pharmacy, they

pay nothing and their coverage won't be interrupted. Joining a Medicare drug plan may help their Indian health provider with costs, because the drug plan pays part of the cost of their prescriptions.

l) Who Pays First When You Have Other Insurance?

When an individual has other insurance (like employer group health coverage), there are rules that decide whether Medicare or their other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage.

If your other coverage is from an employer or union group health plan, these rules apply:

- If an individual is retired, Medicare pays first.
- If the individual's group health plan coverage is based on their or a family member's current employment, who pays first depends on the individual's age, the size of the employer, and whether the individual has Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
- If the individual is under age 65 and disabled, their plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
- If the individual is over age 65 and still working, their plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If the individual has Medicare because they have ESRD, their plan pays first for the first 30 months they have Medicare.

The following types of coverage usually pay first:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

5. MEDIGAP (MEDICARE SUPPLEMENT INSURANCE) POLICIES

Original Medicare pays for many, but not all, healthcare services and supplies. A Medigap policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

Medigap policies are standardized

Medigap must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only "standardized" plans, which are named in most states by letters A–D, F, G, and K–N. All plans with the same letter offer the same basic benefits, no matter where you live or which insurance company you buy the policy from. Some offer additional benefits. Compare the benefits of each lettered plan to find one that meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. Get information and find Medigap policies in your area: Medicare.gov/medigap-supplemental-insurance-plans

You can also visit Medicare.gov/publications to review the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Important! Medigap plans sold to people who are new to Medicare on or after January 1, 2020 aren't allowed to cover the Part B deductible. Because of this, Plans C and F are no longer available to people new to Medicare on or after January

1, 2020. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. While people new to Medicare on or after January 1, 2020, can't buy Plans C and F, they have the right to buy Plans D and G (instead of Plans C and F), which provide the same benefits with the exception of coverage for the Part B deductible.

How do I compare Medigap plans?

The chart below shows basic information about the different benefits covered by Medicare Supplement Insurance (Medigap) in 2024. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

A Yes in the box indicates 100%

Medigap plans

Medigap Benefits	**Plan A**	**Plan B**	**Plan C**	**Plan D**	**Plan F***	**Plan G***	**Plan K**	**Plan L**	**Plan M**	**Plan N**
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$7,060 in 2024	$3,530 in 2024	N/A	N/A

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount *($2,800 in 2024)* before your policy pays anything. (Plans C and F aren't available to people who were newly eligible for Medicare on or after January 1, 2020.)

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.

If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

a) Buying a Medigap Policy

- Generally, an individual must have Part A and Part B to buy a Medigap policy.
- A Medigap policy only covers one person. If an individual and their spouse both want Medigap coverage, they must each buy separate policies.
- It's important to compare Medigap policies since the costs can vary and may go up as an individual gets older. Some states limit Medigap costs.
- The best time to buy a Medigap policy is during the 6-month period that begins on the first day of the month in which the individual is both age 65 or older and enrolled in Part B. (Some states have additional open enrollment periods.) After this initial enrollment period, an individual's option to buy a Medigap policy may be limited.
- If an individual is under age 65, they may have additional rights to buy a Medigap policy, depending on the laws in their state.
- If an individual has a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO),they may want to consider dropping their Medigap policy. They can continue to pay their Medigap premium, but their policy can't be used to pay their Medicare Advantage Plan copayments and deductibles.
- If an individual wants to drop their Medigap policy, they must contact their insurance company to cancel the policy.
- If an individual already has a Medicare Advantage Plan, it's illegal for anyone to sell them a Medigap policy unless they are switching back to Original Medicare.
- If an individual joins a Medicare health plan for the first time, and they aren't happy with the plan, they will have special rights to buy a Medigap policy if they return to Original Medicare within 12 months of joining.
- If an individual had a Medigap policy before they joined, they may be able to get the same plan back if the company still sells it.
- The Medigap policy can no longer have prescription drug coverage even if the individual had it before, but they may be able to join a Medicare Prescription Drug Plan.
- If an individual joined a Medicare health plan when they were first eligible for Medicare, they can choose from any policy.
- If an individual buys a Medicare SELECT policy they also have rights to change their mind within 12 months and switch to a standard Medigap policy.
- An individual can't have drug coverage in both their Medigap policy and a Medicare drug plan.
- To find and compare Medigap policies:
    - Visit www.medicare.gov, and select "Compare Medicare Health Plans and Medigap Policies in Your Area."
    - Call 1-800-MEDICARE.
    - Call the individual State Health Insurance Assistance Program Individuals pay a monthly premium for their Medigap policy to the private insurer, and they pay their monthly Part B premium.

E. Chapter 5: Medicare drug coverage (Part D)

1. How does Medicare drug coverage work?

Medicare drug coverage (Part D) helps pay for your prescription drugs. It's optional and offered to everyone with Medicare. Even if you don't take prescription drugs now, consider getting Medicare drug coverage. If you decide not to get it when you're first eligible, and you don't have other creditable prescription drug coverage (like drug coverage from an employer or union) or get Extra Help, **you'll likely pay a late enrollment penalty if you join a plan later.** Generally, you'll pay this penalty for as long as you have Medicare drug coverage . To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered. Visit Medicare.gov/plan-compare to find and compare plans in your area. You can also call your State Health Insurance Assistance Program (SHIP) for help comparing plans.

There are 2 ways to get Medicare drug coverage (Part D):

a) Medicare drug plans.

These plans add Medicare drug coverage (Part D) to Original Medicare, some Medicare Cost Plans, some Medicare Advantage Private Fee-for-Service Plans, and Medical Savings Account (MSA) Plans. You must have Part A and/or Part B to join a separate Medicare drug plan.

b) Medicare Advantage Plans or other Medicare health plans with drug coverage.

You get your Part A, Part B, and Medicare drug coverage (Part D) through these plans. Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all Medicare Advantage Plans offer drug coverage.

In either case, you must live in the service area of the plan you want to join and be lawfully present in the U.S.

Medicare drug plans and Medicare health plans with drug coverage are called "Medicare drug coverage" in this handbook.

Important! If you have employer or union coverage

Call your benefits administrator before you make any changes, or sign up for any other coverage. If you sign up for other coverage, you could lose your employer or union health and drug coverage for you and your dependents. If this happens, you may not be able to get your employer or union coverage back.

2. When can I join, switch, or drop a plan?

You can join, switch, or drop a Medicare drug plan or a Medicare Advantage Plan with drug coverage during these times:

a) • Initial Enrollment Period.

When you first become eligible for Medicare, you can join a plan.

b) • Open Enrollment Period.

From October 15 – December 7 each year, you can join, switch, or drop a plan. Your coverage will begin on January 1 (as long as the plan gets your request by December 7).

c) • Medicare Advantage Open Enrollment Period

(only if you're already in a Medicare Advantage Plan). From January 1 – March 31 each year, you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time.

If you have to pay for Part A, and you sign up for Part B during the General Enrollment Period (January 1 – March 31), you can also join a Medicare drug plan when you sign up for Part B. You'll have 2 months after signing up for Part B to join a drug plan. Your drug coverage will start the month after the plan gets your request to join.

d) Special Enrollment Periods

Generally, you must stay in your plan for the entire year. But when certain events happen in your life, like if you move or lose other insurance coverage, you may qualify for a Special Enrollment Period. You may be able make changes to your plan mid-year if you qualify. Check with your plan for more information.

Important! If you sign up for Part A or Part B during a Special Enrollment Period because of an exceptional circumstance , you'll have 2 months to join a Medicare Advantage Plan (with or without drug coverage) or a Medicare drug plan. Your coverage will start the first day of the month after the plan gets your request to join.

e) How do I switch plans?

You can switch Medicare drug coverage simply by joining another plan during one of the enrollment times. Your old drug coverage will end when your new drug coverage begins. You should get a letter from your new plan telling you when your coverage begins, so **you don't need to cancel your old plan.** You can also switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

f) How do I drop my plan?

If you want to drop your plan and don't want to join a new plan, you can only do so during certain times. You can disenroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan or Medicare health plan with drug coverage later, you have to wait for an enrollment period. You may also have to pay a late enrollment penalty if you don't have creditable prescription drug coverage.

g) Read the information you get from your plan

Review the "Evidence of Coverage" and "Annual Notice of Change" your plan sends you each year. The Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. If you don't get these important documents in early fall, contact your plan.

3. How much do I pay?

Your drug costs will vary based on the plan you choose. Remember, plan coverage and costs can change each year. You may have to pay a premium,

deductible, copayments, or coinsurance throughout the year. Learn more about these costs on the next page.

Starting in 2025, your out-of-pocket drug costs will be capped at $2,000. .

a) Your actual drug coverage costs will vary depending on:

• Your prescriptions and whether they're on your plan's list of covered drugs

(formulary).

• What "tier" a drug is in.

• Which drug benefit phase you're in (like whether you've met your deductible, or reached your out-of-pocket limit).

• Which pharmacy you use (whether it offers preferred or standard cost sharing, is out of network, or is mail order). Your out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.

• Whether you get Extra Help paying your Medicare drug costs.

b) Cost & coverage:

Some ways you may be able to lower the cost of your drugs include choosing generics over brand name prescriptions or biosimilars over original biological products. You might also pay for a drug without insurance (like using pharmacy savings programs or manufacturer discounts). Ask your pharmacist—they can tell you if there's a less expensive option available. Check with your doctor to make sure the generic or biosimilar option is best for you.

c) Monthly premium

Most drug plans charge a monthly fee that varies by plan. If you have Part B, you pay this in addition to the Part B premium. If you're in a Medicare

Advantage Plan or a Medicare Cost Plan with drug coverage, the monthly premium may include an amount for drug coverage.

Note: Contact your plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your drug premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your plan.

Important! If you have a higher income, you might pay more for your Medicare drug coverage (Part D). If your income is above a certain limit (in 2024 $103,000 if you file individually or $206,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D IRMAA"). You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage. This doesn't affect everyone, so most people won't pay an extra amount.

Visit Medicare.gov for 2025 limits.

Usually, Medicare or the RRB will deduct the extra amount from your Social Security or RRB payment. If Medicare or the RRB bills you for the extra amount instead of deducting it from your Social Security or RRB payment, then you must pay the extra amount to Medicare or the RRB, not your plan. If you don't pay the extra amount, you could lose your Medicare drug coverage (Part D). You may not be able to join another plan right away, and you may have to pay a late enrollment penalty for as long as you have drug coverage.

You'll pay Part D IRMAA payments separately, even if your employer or another third party (like a retirement system) pays your plan premiums.

If you have to pay the Part D IRMAA and you disagree (for example, you have one or more life-changing events that lower your income), visit SSA.gov/medicare/lower-irmaa.

d) Yearly deductible

This is the amount you must pay before your plan begins to pay its share of your covered drugs. Some plans don't have a deductible. In some plans that do have a deductible, drugs on some tiers are covered before the deductible.

e) Copayments or coinsurance

These are the amounts you pay for your covered drugs after the deductible (if the plan has one). You pay your share and your plan pays its share for covered drugs. If you pay coinsurance, these amounts may vary because drug plans and manufacturers can change what they charge at any time throughout the year. The amount you pay will also depend on the tier level assigned to your drug.

Once you and your plan spend $5,030 combined on drugs (including the deductible) in 2024, you'll generally pay no more than 25% of the cost for prescription drugs until your out-of-pocket spending is $8,000.

f) Out-of-pocket limit on drug costs

In 2025, your yearly out-of-pocket drug costs will be capped at $2,000. Once you reach this limit in 2025 (from your out-of-pocket spending plus certain payments other people or entities make, including Medicare's Extra Help program) you won't have to pay a copayment or coinsurance for covered Part D drugs for the rest of the calendar year.

Note: If you get Extra Help, you won't have some of these Part D costs.

Important! Visit Medicare.gov/plan-compare to get specific Medicare drug plan and Medicare Advantage Plan costs, and call the plans you're interested in to get more details. For help comparing plan costs, call your State Health Insurance Assistance Program (SHIP). for the phone number of your local SHIP. A trusted agent or broker may also be able to help.

g) Medicare Prescription Payment Plan

Starting in 2025, this new payment option works with your current drug coverage to help you manage your out-of-pocket drug costs, by spreading them across the calendar year (January–December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), **and** you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). All plans offer this payment option, and **participation is voluntary.** It doesn't cost anything to participate in the Medicare Prescription Payment Plan. Contact your plan or visit Medicare.gov/prescription-payment-plan for more information and to find out if this payment option is right for you.

h) What's the Medicare drug coverage (Part D) late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Medicare drug coverage (Part D) premium. You may have to pay a late enrollment penalty if you enroll at any time after your Initial Enrollment Period is over and there's a period of 63 or more days in a row when you don't have Medicare drug coverage or other creditable prescription drug coverage. You'll generally have to pay the penalty for as long as you have Medicare drug coverage.

4. If you get Extra Help, you don't pay a late enrollment penalty.

There are 3 ways to avoid paying a penalty:

a) Get Medicare drug coverage (Part D) when you're first eligible for it.

Even if you don't take drugs now, you should consider joining a separate Medicare drug plan or a Medicare Advantage Plan with drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums.

b) Add Medicare drug coverage (Part D) if you lose other creditable coverage.

Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage. Your plan must tell you each year if your non-Medicare drug coverage is creditable coverage. If you go 63 days or more in a row without Medicare drug coverage or other creditable prescription drug coverage, you may have to pay a penalty if you sign up for Medicare drug coverage later.

c) Keep records

showing when you had other creditable prescription drug coverage, and tell your plan when they ask about it. If you don't tell your plan about your previous creditable prescription drug coverage, you may have to pay a penalty for as long as you have Medicare drug coverage.

d) How much more will I pay for a late enrollment penalty?

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" ($34.70 in 2024) by the number of full, uncovered months that you were eligible but didn't have Medicare drug coverage (Part D) and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. The "national base beneficiary premium" may increase or decrease each year. If that happens, the penalty amount you pay may increase or decrease. After you get Medicare drug coverage, the plan will tell you if you owe a penalty and what your premium will be.

5. Which drugs are covered?

All plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain "protected classes," like drugs to treat cancer, HIV/AIDS, or depression. Information about a plan's list of covered drugs (called a "formulary") isn't included in this handbook because each plan has its own formulary. **Before joining a plan, be sure to review its formulary.** A plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. For example, your plan may change its drug list during the year because drug therapies change, new drugs are released, or new medical information becomes available. Your plan coinsurance may increase for a particular brand name drug or generic drug when the manufacturer raises the price. Your copayment or coinsurance may increase when a plan starts to offer a generic version of a brand name drug or biosimilar version of an original biological product, but you continue to take the brand name drug or original biological product. In some cases, the plan may cover a drug for one health condition but not another.

Note: Medicare Part B covers a limited number of outpatient prescription drugs. Medicare drug coverage (Part D) includes drugs, like buprenorphine, to treat Opioid Use Disorders. It also covers drugs, like methadone, when prescribed for pain (but not covered under Part D to treat Opioid Use Disorders).

Part D typically places drugs into different levels called "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier.

a) What happens if my drug is in a higher tier?

In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower coinsurance or copayment for the drug in the higher tier.

Plans can change their formularies at any time. Your plan may notify you of any formulary changes that affect drugs you're taking.

Contact your plan for its current formulary, or visit the plan's website.

Important! Each month you fill a prescription, your plan sends you an "Explanation of Benefits" notice. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379).

b) Plans may have coverage rules for certain drugs

i) • Prior authorization:

Limits coverage of a drug to patients who meet certain requirements. Before you can fill the prescription, your prescriber must contact your plan to show the drug is medically necessary and that you meet certain requirements. Plans may also use prior authorization when they cover a drug for only certain medical conditions it's approved for, but not others. When this occurs, plans will likely have alternative drugs on their list of covered drugs (formulary) for the other medical conditions the drug is approved to treat. Contact your plan or visit their website to find out about prior authorization requirements.

ii) • Quantity limits:

Limits how much of a drug you can get at a time.

iii) • Step therapy:

You may need to try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.

iv) • Opioid pain medication safety checks at the pharmacy:

Before the pharmacy fills your prescriptions, your plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages. The opioid safety checks also include checking for possible unsafe amounts of opioid pain medications, limiting the day's supply of a first prescription for opioids, and limiting the use of opioids at the same time as benzodiazepines (commonly used for anxiety and sleep). Opioid pain medicine (like oxycodone and hydrocodone) can help with certain types of pain, but have risks and side effects (like dependence, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.

v) • Drug Management Programs:

Medicare drug coverage (Part D) has programs in place to help you use opioids and benzodiazepines safely. If your opioid use could be unsafe (for example, due to getting opioid prescriptions from multiple doctors or pharmacies, or if you had a recent overdose from opioids), your plan will contact the doctors who prescribed them for you to make sure they're medically necessary and you're using them appropriately.

c) Can I get automatic prescription refills in the mail?

Medicare drug plans may offer a voluntary auto-ship program which allows some people with Medicare to get their prescription drugs delivered automatically before they run out. Contact your plan for more information.

d) Medication Therapy Management services

Plans with Medicare drug coverage (Part D) must offer Medication Therapy Management services to help members if they meet certain requirements or are in a Drug Management Program . If you qualify, you can get these services at no cost to help you understand how to manage your medications and take them safely. Medication Therapy Management services usually include a discussion with a pharmacist or health care provider to review your medications. These services may vary by plan. Contact your plan for specific details and to find out if you're eligible.

e) Part D coverage for insulin

Part D covers insulin, including insulin used with either a disposable or non-traditional insulin pump. It also covers certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs. Covered insulin products are included on your plan's formulary.

Important! Plans can't charge you more than $35 for a one-month supply of each Part D-covered insulin you take, and you don't have to pay a deductible for insulin.

6. How do other insurance and programs work with Medicare drug coverage (Part D)?

a) Medicaid

If you have Medicare and full Medicaid coverage, Medicare covers your prescription drugs. However, Medicaid may still cover some drugs that Medicare doesn't cover.

Note: You qualify automatically for Extra Help if you have Medicare and Medicaid.

b) Employer or union coverage

This is health coverage from your, your spouse's, or other family member's current or former employer or union. When you have employer or union coverage or other health insurance (like a retiree health plan) and Medicare, there are rules for whether Medicare or your other coverage pays first. If you have drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

Important! If you get Medicare drug coverage, you, your spouse, or your dependents may lose your employer or union health coverage.

c) COBRA (Consolidated Omnibus Budget Reconciliation Act)

This federal law may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of, or in addition to, COBRA coverage . However, if you take COBRA and you're eligible for Medicare, **COBRA may only pay a small portion of your medical costs,** and you may have to pay most of the costs yourself. Contact your COBRA plan and ask what percent they pay. To avoid unexpected medical bills, you may need to sign up for Medicare right away. Talk with your State Health Insurance Assistance Program (SHIP) for free, personalized help with this decision.

If you have COBRA that includes creditable prescription drug coverage, you'll have a Special Enrollment Period to get Medicare drug coverage (Part D) without paying a penalty when the COBRA coverage ends. If you have questions about Medicare and COBRA, call the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627. A trusted agent or broker may also be able to help.

d) Medicare Supplement Insurance (Medigap) with drug coverage

Medigap policies can no longer be sold with drug coverage, but if you have an older Medigap policy that was sold with drug coverage, you can keep it. You may choose to join a separate Medicare drug plan because most Medigap drug coverage isn't creditable, and you may pay more if you join a drug plan later.

You can't have drug coverage in both Medigap and your Medicare drug plan. If you decide to join a separate Medicare drug plan, tell your Medigap insurance company so they can remove the drug coverage and adjust your premiums. Call your Medigap insurance company for more information.

7. How does other government insurance work with Medicare drug coverage (Part D)?

The types of insurance listed below are all considered creditable prescription drug coverage. In most cases, it's to your advantage to keep this coverage if you have it.

a) Federal Employee Health Benefits Program (FEHB)

This is health coverage for current and retired federal employees and covered family members. These plans usually include creditable prescription drug coverage, so you don't need to get Medicare drug coverage (Part D). However, if you decide to get Medicare drug coverage, you can keep your FEHB plan, and in most cases, Medicare will pay first. For more information, visit

OPM.gov/healthcare-insurance/healthcare, or call the Office of Personnel Management at 1-888-767-6738. TTY users can call 711. If you're an active federal employee, contact your Benefits Officer. Visit apps.opm.gov/abo for a list of Benefits Officers. You can also call your plan if you have questions.

Starting January 1, 2025, eligible U.S. Postal Service employees, retirees, and their families will get coverage through the Postal Service Health Benefits Program (PSHB) instead of FEHB. Visit OPM.gov/healthcare-insurance/pshb to learn more.

b) Veterans' benefits

This is health coverage for veterans and people who have served in the U.S. military. You may be able to get drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a separate Medicare drug plan, but if you do, you can't use both types of coverage for the same drug at the same time. For more information, visit VA.gov or call the VA at 1-800-827-1000. TTY users can call 711.

c) CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)

This is a comprehensive health care program in which the Department of Veterans Affairs (VA) shares the cost of covered health care services and supplies with eligible people with Medicare. You may join a separate Medicare drug plan, but if you do, you won't be able to use the Meds by Mail program which can provide your maintenance drugs at no charge (no premiums, deductibles, and copayments). For more information, visit

VA.gov/communitycare/programs/dependents/champva or call CHAMPVA at 1-800-733-8387.

d) TRICARE (military health benefits)

This is a health care program for active-duty service members, military retirees, and their families. **Most people with TRICARE who are entitled to Part A must also have Part B to keep their TRICARE drug benefits.** If you have TRICARE, you don't need to join a separate Medicare drug plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a Medicare Advantage Plan with drug coverage, your Medicare Advantage Plan and TRICARE may coordinate benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket costs. For more information, visit tricare.mil, or call the TRICARE Pharmacy Program at 1-877-363-1303. TTY users can call 1-877-540-6261.

e) Indian Health Service (IHS)

The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers several clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in Medicare drug coverage (Part D). If you get prescription drugs through an Indian health facility, you'll continue to get them at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan or Medicare Advantage Plan with drug coverage may help your Indian health facility because the plan pays the Indian health facility for the cost of your prescription drugs. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

F. PROGRAMS FOR PEOPLE WITH LIMITED INCOME

There are Federal and state programs available for people with limited income and resources. These programs may help an individual save on their health care and prescription drug costs or provide extra income.

1. Medicare Savings Programs (MSPs)

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

a) There are 4 kinds of Medicare Savings Programs:

i) Qualified Medicare Beneficiary (QMB):

The QMB program covers Part A and/or Part B premiums. In addition, Medicare providers aren't allowed to bill you for services and items Medicare covers, including deductibles, coinsurance, and copayments. If you get a bill for these charges, tell your provider or the debt collector that you're in the QMB Program and can't be charged for Medicare deductibles, coinsurance, and copayments. If you've already made payments on a bill for services and items Medicare covers, you have the right to a refund. If you're in a Medicare Advantage Plan, you should also contact the plan to ask them to stop the charges. To make sure your provider knows you're in the QMB Program, show both your Medicare and Medicaid or QMB card each time you get care. If you have Original Medicare, you can also give your provider a copy of your "Medicare Summary Notice" (MSN). Your MSN will show you're in the QMB Program and shouldn't be billed. Log into (or create) your secure Medicare account at Medicare.gov to sign up to get your MSNs electronically. If your provider won't stop billing you, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. We can also confirm that you're in the QMB Program.

ii) Specified Low-Income Medicare Beneficiary (SLMB):

Covers Part B premium only.

iii) Qualifying Individual (QI):

Covers Part B premium only. QI is only available for people who don't qualify for any other Medicaid coverage or benefits.

iv) Qualified Disabled and Working Individuals (QDWI):

Covers Part A premium only. You may qualify for this program if you have a disability, you're working, and you lost your Social Security disability benefits and premium-free Part A because you returned to work.

If you qualify for a QMB, SLMB, or QI Program, you qualify automatically forExtra Help, a separate program that helps pay for Medicare drug coverage (Part D).

Important! Medicare Savings Programs are available through your state. The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico or the U.S. Virgin Islands.

b) How do I qualify?

• In most cases, to qualify for a Medicare Savings Program, you must have income and resources below a certain limit. Income and resource limits vary by state.

• Even if you don't think you qualify, you should still apply. Contact your State Medical Assistance (Medicaid) office to get started.

• To get the phone number for your state's Medicaid office, visit Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu

or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

c) Get Extra Help paying your Medicare drug costs

If you have limited income and resources, you may qualify for Extra Help, a program to help pay some Medicare drug costs, like premiums, deductibles, and coinsurance.

You may qualify for Extra Help if your yearly income and resources are below these limits in 2024:

Yearly income Resources

Single person less than $22,590 less than $17,220

Married person living with a spouse and no other dependents

less than $30,660 less than $34,360

Important! Extra Help has expanded to cover more drug costs for certain people with limited income and resources.

In some situations, you may qualify even if you have a higher income. For example, if you still work, live in Alaska or Hawaii, or have dependents living with you, the income limits are higher.

Resources

• **Include** money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs).

• **Don't include** your home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

You can find 2025 income and resource limits on Medicare.gov.

If you qualify for Extra Help and join a separate Medicare drug plan or Medicare Advantage Plan with Medicare drug coverage (Part D):

- You'll get help paying your drug coverage costs.
- You won't pay a Part D late enrollment penalty.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. But there are other programs available in these areas to help people with limited income and resources. Cost & coverage:

Most people with Medicare can only switch plans at certain times of the year. Starting in 2025, if you have Medicaid or get Extra Help, you may be able to change your drug coverage once per month. If you make a change, it will begin the first day of the following month.

d) You qualify automatically for Extra Help if you have Medicare and meet any of these conditions:

• You have full Medicaid coverage.

• You get help from your state Medicaid program to pay your Part B

premiums and other Medicare costs.

• You get Supplemental Security Income (SSI) benefits.

e) Medicare will mail you a purple letter to let you know you qualify automatically for Extra Help. Keep this for your records. You don't need to apply for Extra Help if you get this letter.

• If you don't already have Medicare drug coverage (Part D), you must get it to use Extra Help.

• If you don't have drug coverage, Medicare may enroll you in a separate Medicare drug plan so you'll be able to use the Extra Help. If Medicare enrolls you in a plan, you'll get a yellow letter letting you know when your coverage begins, and you'll have a Special Enrollment Period to change plans if you want to join a different plan than the one Medicare enrolled you in.

• Different plans cover different drugs. Check to find out if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit Medicare.gov/plan-compare or call 1-800-MEDICARE (1-800-633-4227) to compare your plan with other plans in your area. TTY users can call 1-877-486-2048.

• If you have Medicaid and live in certain institutions (like a nursing home) or get certain home and community-based services, you pay nothing for your covered drugs.

• Drug costs for people who qualify will generally be no more than $4.50 for each generic drug and $11.20 for each brand-name drug you fill at one of your plan's participating pharmacies. Look at the Extra Help letters you get, or contact your plan if you have questions about costs.

If you don't want to join a separate Medicare drug plan (for example, because you want only your employer or union coverage), call the plan listed in your letter, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Tell them you don't want to be in a Medicare drug plan (you want to "opt out"). If you continue to qualify for Extra

Help or if your employer or union coverage is creditable prescription drug coverage, you won't have to pay a penalty if you join later.

Important! If you have employer or union coverage and you get Medicare drug coverage (Part D), you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your benefits administrator before you get Medicare drug coverage.

If you didn't qualify automatically for Extra Help, you can apply any time at SSA.gov/extrahelp.

When you apply for Extra Help, you can also begin the application process for a Medicare Savings Program (MSP). These state programs help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

To get help choosing drug coverage and answers to your questions about Extra Help, call your State Health Insurance Assistance Program (SHIP).

f) Other ways to save on Medicare health care costs

i) Medicaid

Medicaid is a joint federal and state program that helps pay health care costs if you have limited income and (in some cases) resources and meet other requirements. Some people qualify for both Medicare and Medicaid.

ii) What does Medicaid cover?

• If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through

Original Medicare or a Medicare Advantage Plan, like a Special Needs Plan.

• If you have Medicare and full Medicaid coverage, Medicare covers your prescription drugs. You qualify automatically for Extra Help paying your Medicare drug costs . Medicaid may still cover some drugs that Medicare doesn't cover.

• People with full Medicaid coverage may get coverage for services that Medicare doesn't cover or only partially covers, like nursing home care, personal care, transportation to medical services, home and community-based services, home-delivered meals, and dental, vision, and hearing services.

iii) How do I qualify?

• Medicaid programs vary from state to state. They may also have different names, like "Medical Assistance" or "Medi-Cal."

• Each state has different income and resource requirements.

• Call your State Medical Assistance (Medicaid) office to find out if you qualify. Visit Medicaid.gov/about-us/beneficiary-resources/

index.html#statemenu or call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your state's Medicaid office. TTY users can call 1-877-486-2048.

Note: If you're eligible for both Medicare and Medicaid, contact your local State Health Insurance Assistance Program (SHIP) for help with your options.

g) Medicare-Medicaid Plans

Medicare works with some states and health plans to offer demonstration plans for certain people who have both Medicare and Medicaid to make it easier for them to get the services they need. They're called Medicare-Medicaid Plans. These plans include drug coverage and are only available in certain states. To find out if a Medicare-Medicaid plan is available in your area, visit Medicare.gov/plan-compare, enter your zip code and select Medicare Advantage Plan (Part C). When asked if you get help with your costs, select Medicaid. A list of all available plans will appear and the demonstration plans will have (Medicare-Medicaid Plan) next to their name.

h) State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help certain people pay for prescription drugs based on financial need, age, or medical condition. To find out if there's a State Pharmaceutical Assistance Program in your state and how it works, call your State Health Insurance Assistance Program (SHIP).

. You can also visit Medicare.gov/pharmaceutical-assistance-program/#state-programs.

i) Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage (Part D) who meet certain requirements. Visit

Medicare.gov/pharmaceutical-assistance-program to learn more about Pharmaceutical Assistance Programs.

j) Program of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community.

k) Supplemental Security Income (SSI) payments

SSI provides monthly payments to adults and children who are blind or have a disability and have limited income and resources. SSI payments are also provided to people 65 and older without disabilities who meet the financial qualifications. These payments aren't the same as Social Security retirement benefits. You may be able to get both SSI and Social Security benefits at the same time if your Social Security benefit is less than the SSI federal benefit rate. If you're eligible for SSI, you qualify automatically for Extra Help and are usually eligible for Medicaid.

You can visit SSA.gov/apply/ssi to find out if you're eligible for SSI or other benefits.

Note: People who live in Puerto Rico, the U.S. Virgin Islands, Guam, or American Samoa can't get SSI.

l) Programs for people who live in the U.S. territories

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your State Medical Assistance (Medicaid) office to learn more. Visit Medicaid.gov/about-us/beneficiary-resources/

index.html#statemenu or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.

G. MEDICARE RIGHTS

1. What are my Medicare rights?

All people with Medicare have certain rights and protections. You have the right to:

- Be treated with courtesy, dignity, and respect at all times.
- Be protected from unlawful discrimination.
- Have your personal and health information kept private.
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors.
- Learn about your treatment choices in clear language you can understand, and participate in treatment decisions.
- Get Medicare information and health care services in a language you understand.
- Get your Medicare information in an accessible format, like braille or large print.. **Note:** If you need plan information in a language other than English or in an accessible format, contact your plan.

• Get answers to your Medicare questions.

• Have access to doctors, specialists, and hospitals for medically necessary services.

• Get Medicare-covered services in an emergency.

• Get a decision about health care payment, coverage of items and services, or drug coverage. When you or your provider files a claim, you'll get a notice letting you know what will and won't be covered. This notice comes from one of these:

- Medicare
- Your Medicare Advantage Plan (Part C) or other Medicare health plan
- Your Medicare drug plan

If you disagree with the decision on your claim, you have the right to file an appeal. You can request a review (appeal) of certain decisions about health care payment, coverage of items and services, or drug coverage.

If you have concerns about the quality of care and other services you get from a Medicare provider, you can:

- File a complaint (sometimes called a "grievance").
- Get help from End-Stage Renal Disease (ESRD) Networks and State Survey Agencies if you have complaints (grievances) about your dialysis or kidney transplant care.

Visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to learn more about filing a complaint. TTY users can call 1-877-486-2048.

2. What are my rights if my plan stops participating in Medicare?

Medicare health and drug plans can decide not to participate in Medicare for the coming year. In these cases, your coverage under the plan will end after December 31. Your plan will send you a letter explaining your options. If this happens:

• You can choose another plan from October 15 – December 7. Your coverage will begin January 1.

• **You also have a special right to join another Medicare plan until the last day in February.**

• You may have the right to buy certain Medigap policies within 63 days after your plan coverage ends.

3. What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

• A request for a health care service, supply, item, or drug you think Medicare should cover.

• A request for payment of a health care service, supply, item, or drug you already got.

• A request to change the amount you must pay for a health care service, supply, item, or drug.

You can also appeal:

• If Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or drug you think you still need.

• An at-risk determination made under a Drug Management Program that limits access to coverage for frequently abused drugs, like opioids and benzodiazepines.

• If your claim is denied because of an open accident record, and the claim isn't related to the accident.

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information to make your appeal stronger. **Keep a copy of everything related to your appeal,** including what you send to Medicare or your plan.

4. How do I file an appeal?

How you file an appeal depends on the type of Medicare coverage you have.

a) If you have Original Medicare

• Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing.

• Circle the item(s) on the MSN you disagree with. Write an explanation of why you disagree with the decision. You can write on the MSN or on a separate piece of paper and attach it to the MSN.

• Include your name, phone number, and Medicare Number on the MSN. Keep a copy for your records.

• Send the MSN, or a copy, to the company that handles bills for Medicare (Medicare Administrative Contractor) listed on the MSN. You can include any information you have about your appeal, like information from your health care provider. Or, you can use Form CMS-20027. To get this form in English and Spanish, visit Medicare.gov/basics/forms-publications-mailings/forms/appeals, or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users can call 1-877-486-2048.

• You must file your appeal by the date in the MSN. If you missed the deadline for appealing, you may still file an appeal and get a decision if you can show good cause for missing the deadline (for example, if you have a disability, illness, or accident that delayed you from sending it by the deadline).

• You'll generally get a decision from the Medicare Administrative Contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.

• You may have the right to a fast appeal if you think your Medicare services from a hospital or other facility are ending too soon.

b) If you're in a Medicare Advantage or other Medicare health plan

The timeframe for filing an appeal may be different than Original Medicare. In some cases, you can file a fast appeal. To learn more, look at the materials your plan sends you, call your plan, or visit Medicare.gov/claims-appeals/how-do-i-file-an-appeal.

c) If you have a separate Medicare drug plan

Even before you buy a certain drug, you have the right to:

• Get a written explanation for drug coverage decisions (called a "coverage determination") from your Medicare drug plan. A coverage determination is the first decision your Medicare drug plan (not the pharmacy) makes about your benefits. This can be a decision about if the plan covers your drug, if you met the plan's requirements to cover the drug, or how much you pay for the drug. You'll also get a coverage determination decision if you ask your plan to make an exception to its rules to cover your drug.

• Ask for an exception if you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believe you need a drug that isn't on your plan's list of covered drugs (formulary).

• Ask for an exception if you or your prescriber believe that your plan should waive a coverage rule (like prior authorization).

• Ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believe you can't take any of the lower tier drugs for the same condition.

d) How can I get help filing an appeal?

You can appoint a representative. They can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else to act on your behalf. For more information, visit Medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me. You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP).

e) How can I get help filing an appeal?

You can appoint a representative. They can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else to act on your behalf. For more information, visit Medicare.gov/claims-appeals/file-an-

appeal/can-someone-file-an-appeal-for-me. You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP).

f) How do I ask for a coverage determination or exception?

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription, the pharmacist will give you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't give you this notice, ask for a copy.

If you're asking for a prescription you haven't gotten yet, you or your prescriber may make a standard request or an expedited (fast) request by phone or in writing. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

Important! If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why your plan should approve the exception.

g) What are my rights if I think my services are ending too soon?

If you're getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon (or you're being discharged too soon), you can ask for a fast appeal (also known as an "immediate appeal" or an "expedited appeal"). Your provider will give you a notice before your services end telling you how to ask for a fast appeal. Read this notice carefully. If you don't get this notice, ask for it. With a fast appeal, an independent reviewer, called a Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO), will decide if your covered services should continue. You can contact your BFCC-QIO for help with filing an appeal.

A fast appeal only covers the decision to end services or discharge you from the hospital. You may need to start a separate appeal for any items or services you may have gotten after the decision to end services. Visit Medicare.gov/appeals or Medicare.gov/publications to review the booklet, "Medicare Appeals."

5. Your right to access your personal health information

By law, you or your legal representative generally have the right to review and/or get copies of your personal health information from health care providers who treat you and bill Medicare for your care. If you want Medicare to give your personal information to someone else, like a caregiver.

You also generally have a right to get this information from health plans that pay for your care, including Medicare.

These types of personal health information include:

- Claims and billing records
- Information related to your enrollment in health plans, including Medicare
- Medical and case management records
- Other records that doctors or health plans use to make decisions about you

Generally, you can get your information on paper or electronically. If your providers or plans store your information electronically, they generally must give you electronic copies if you ask for them. You have the right to get your information in a timely manner, but it may take up to 30 days to get a response. If your information is electronic, you also may request to have it sent to a third party of your choosing, like a health care provider who treats you, a family member, or a researcher.

You may have to fill out a form to request copies of your information and pay a fee. This fee typically can't be more than the total cost of:

- Labor for copying the information requested
- Supplies for creating the copy
- Postage (if you ask your health care provider to mail you a copy)

In most cases, you won't be charged for reviewing, searching, downloading, or sending your information through an electronic portal.

For more information, visit HHS.gov/hipaa/for-individuals/guidance-materials-for-consumers.

If you need help getting and using your health records, the Office of the National Coordinator for Health Information Technology (ONC) in the U.S. Department of Health and Human Services (HHS) created "The Guide to Getting & Using Your Health Records." It shows you how to get your health records and make sure they're accurate and complete, so you can get the most out of your health care. Visit healthit.gov/how-to-get-your-health-record to review the guide.

a) How does Medicare use my personal information?

Medicare protects the privacy of your health information.

6. Notice of Privacy Practices for Original Medicare

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The law requires Medicare to protect the privacy of your personal medical information. It also requires us to give you this notice so you know how we may use and share ("disclose") the personal medical information we have about you.

We must provide your information to:

- You, to someone you name ("designate"), or someone who has the legal right to act for you (your personal representative)
- The Secretary of the Department of Health and Human Services, if necessary
- Anyone else that the law requires to have it

We have the right to use and provide your information to pay for your health care and to operate Medicare. For example:

- Medicare Administrative Contractors use your information to pay or deny your claims, collect your premiums, share your benefit payment with your other insurer(s), or prepare your "Medicare Summary Notice."
- We may use your information to provide you with customer services, resolve complaints you have, contact you about research studies, and make sure you get quality care.

We may use or share your information under these limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to help federal/state Medicaid programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like investigating fraud and abuse)
- For judicial and administrative proceedings (like responding to a court order)
- For law enforcement purposes (like providing limited information to find a missing person)

- For research studies that meet all privacy law requirements (like research to prevent a disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you about new or changed Medicare benefits
- To create a collection of information that no one can trace to you
- To health care providers and their business associates for care coordination and quality improvement purposes, like participation in an Accountable Care Organization (ACO)

We don't sell or use and share your information to tell you about health products or services ("marketing"). We must have your written permission (an "authorization") to use or share your information for any purpose that isn't described in this notice.

You may take back ("revoke") your written permission at any time, unless we've already shared information because you gave us permission.

You have the right to:

- Review and get a copy of the information we have about you.
- Have us change your information if you think it's wrong or incomplete, and we agree. If we disagree, you may have a statement of your disagreement added to your information.
- Get a list of people who get your information from us. The listing won't cover information that we gave to you, your personal representative, or law enforcement, or information that we used to pay for your care or for our operations.
- Ask us to communicate with you in a different manner or at a different place (for example, by sending materials to a PO Box instead of your home address).
- Ask us to limit how we use your information and how we give it out to pay claims and run Medicare. We may not be able to agree to your request.
- Get a letter that tells you about the likely risk to the privacy of your information ("breach notification").
- Get a separate paper copy of this notice.
- Speak to a Customer Service Representative about our privacy notice. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you believe your privacy rights have been violated, you may file a privacy complaint with:

- The Centers for Medicare & Medicaid Services (CMS). Visit Medicare.gov or call 1-800-MEDICARE.
- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Visit HHS.gov/hipaa/filing-a-complaint.

Filing a complaint won't affect your coverage under Medicare.

The law requires us to follow the terms in this notice. We have the right to change the way we use or share your information. If we make a change, we'll mail you a notice within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective September 23, 2013.

7. How can I protect myself from fraud and medical identity theft?

Medical identity theft is when someone steals or uses your personal information (like your name, Social Security Number, or Medicare Number) to submit fraudulent claims to Medicare and other health insurance companies without your permission. When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think there's an error or a provider bills you for services you didn't get, take these steps to find out what was billed:

- Check your "Medicare Summary Notice" (MSN) if you have Original Medicare to find out if the service was billed to Medicare. If you're in a Medicare health plan, check the statements you get from your plan.
- Log into (or create) your secure Medicare account at Medicare.gov to review your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also download your claims data from your Medicare.gov account by going to 'Download my claims & personal data' under 'My account.' You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.

If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1-800-MEDICARE.

You can also call 1-800-MEDICARE if you believe your Medicare Number has been used fraudulently.

Only give personal information, like your Medicare Number, to doctors, insurance companies (and their licensed agents or brokers), or plans acting on your behalf; or trusted people in the community who work with Medicare like your State Health Insurance Assistance Program (SHIP). Don't share your Medicare Number or other personal information with any unsolicited person who contacts you by phone, email, or in person. Medicare, or your Medicare plan representative, will only call you in limited situations:

- A Medicare plan can call you if you're already a member of the plan. The agent who helped you join can also call you.
- A customer service representative from 1-800-MEDICARE can call you if you've left a message, or a representative said that someone would call you back.
- If you filed a report of suspected fraud, you may get a call from someone representing Medicare to follow up on the status of your suspected fraud report.

For more information about Medicare fraud, visit Medicare.gov/fraud or contact your local Senior Medicare Patrol. Learn more about the Senior Medicare Patrol and find help in your state by going to smpresource.org or call 1-877-808-2468.

a) Plans must follow marketing rules

Medicare plans and agents must follow certain rules when marketing their plans and getting your enrollment information. Plans don't need your personal information to provide a quote. Medicare plans can't sign you up for a plan over the phone unless you call them and ask to sign up, or you've given them permission to contact you.

Important! Call 1-800-MEDICARE to report any plans or agents that:

- Ask for your personal information over the phone or email
- Call to enroll you in a plan
- Visit you unexpectedly
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC fights fraud, waste, and abuse in

Medicare Advantage Plans and Medicare drug plans.

b) Investigating suspected fraud takes time

Every tip counts. Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case, but rest assured that your information is helping us protect Medicare.

c) How the Medicare Beneficiary Ombudsman can help you

The Medicare Beneficiary Ombudsman helps you with Medicare-related complaints, grievances, and information requests. They make sure you have Medicare rights and protections information and understand how to get your concerns resolved. If you have a concern that hasn't been resolved by Medicare or your plan, ask 1-800-MEDICARE (1-800-633-4227) to submit your inquiry to the Medicare Beneficiary Ombudsman. TTY users can call 1-877-486-2048. Visit Medicare.gov to learn more.

H. PLANNING AHEAD: LONG TERM CARE INSURANCE

Long-term care, simply put, is care for a long time. It is generally used by the elderly but can be used by anyone of any age. It does not mean someone is terminal, a person with a broken hip needs care. They do not need to be in a hospital but they cannot be at home, a rehab facility will take care of them until they can return home. It includes a variety of services including medical and non¯medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care, also called "custodial care." Medicare only pays for medically necessary skilled nursing facilities or home health care if the individual meets certain conditions. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home.

1. Paying for Long-Term Care

Long-term Care Insurance—This type of private insurance policy can help pay for many types of long-term care, including both skilled and non-skilled (custodial) care. Long-term care insurance can vary widely. Some policies may cover only nursing home care. Others may include coverage for a range of services.

a) Paying for long-term care

Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for non-medical long-term care services. This includes personal care assistance, like help with everyday activities, including dressing, bathing and using the bathroom. Non-medical long-term care services may also include home-delivered meals, adult day health care, home and community-based services and others. You may be eligible for some of this care through Medicaid, or you can choose to buy private long-term care insurance.

You can get non-medical long-term care services at home, in the community, in an assisted living facility, or in a nursing home. **It's important to start planning for non-medical long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, now and in the future.**

Policies will have an elimination or waiting period – a deductible measured in days rather than dollars, and can pay out several ways once this timeframe has passed.

b) Long-term care resources

Use these resources to get more information about long-term care:

• Visit longtermcare.acl.gov to learn more about planning for long-term care.

• Visit the Eldercare Locator at eldercare.acl.gov, or call 1-800-677-1116 to find help in your community.

• Call your Long-Term Care Ombudsman, or visit ltcombudsman.org for help with services you need and to be advised of your rights, and to find an Ombudsman program near you.

• Call your State Medical Assistance (Medicaid) office or visit Medicaid.gov and ask for information about long-term care coverage.

• Call your State Health Insurance Assistance Program (SHIP).

• Call your State Insurance Department for information on long-term care insurance.

• Get a copy of "A Shopper's Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners at content.naic.org/sites/default/files/publication-ltc-lp-shoppers-guide-long-term.pdf.

c) Long-term care resources

Use these resources to get more information about long-term care:

• Visit longtermcare.acl.gov to learn more about planning for long-term care.

• Visit the Eldercare Locator at eldercare.acl.gov, or call 1-800-677-1116 to find help in your community.

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• Get a copy of "A Shopper's Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners at content.naic.org/sites/default/files/publication-ltc-lp-shoppers-guide-long-term.pdf.

LTC covers many different forms of care including adult day care, assisted living, medical equipment, and informal home care.

Long-term care insurance doesn't replace Medicare coverage.

An individual's current or former employer or union may offer long-term care insurance. Current and retired Federal employees, active and retired members of the uniformed services, and their qualified relatives can apply for coverage under the Federal Long-term Care Insurance Program. Information is available at www.opm.gov/insure/ltc, or by calling the Office of Personnel Management at 1-800-582-3337.

Personal Resources—An individual can use their savings to pay for long-term care or perhaps their life insurance policy.

Medicaid—Medicaid is a joint Federal and state program that pays for certain health services for people with limited income and resources. If an individual qualifies, they may be able to get help to pay for nursing home care or other health care costs.

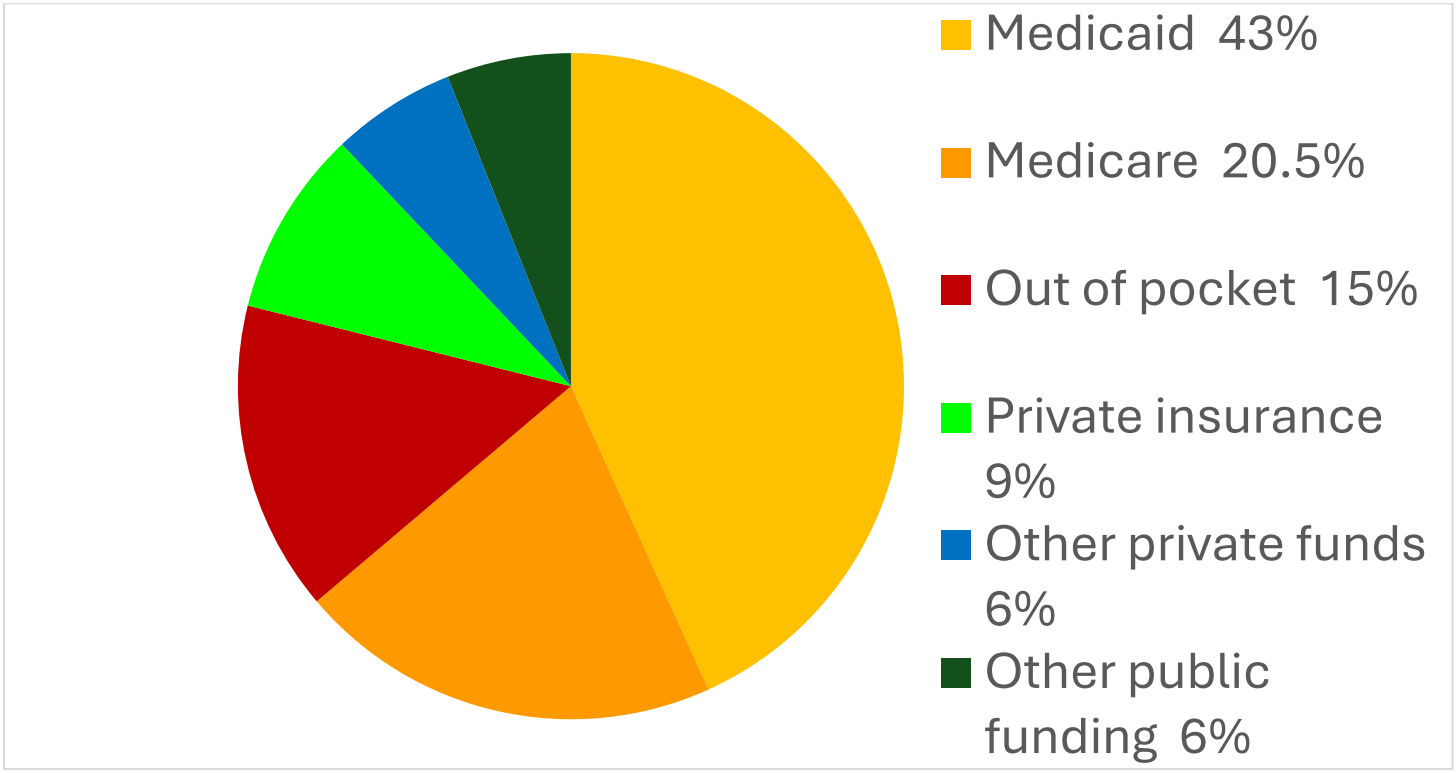
Home and Community-based Services Programs—If an individual is already eligible for Medicaid (or, in some states, would be eligible for Medicaid coverage in a nursing home), an individual may be able to get help with the costs of services that help them stay in their home instead of moving to a nursing home. Examples include homemaker services, personal care, and respite care. For more information, contact your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1800-633-4227), and say "Medicaid" to get the telephone number, or visit www.medicare.gov. TTY users should call 1-877-4862048.

Programs of All-inclusive Care for the Elderly (PACE)— PACE is a Medicare and Medicaid program that allows people who otherwise need a nursing home-level of care to remain in the community.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by a team of health professionals, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary.

Who Pays for Long-Term Care? FYI

(Source: Congressional Research Service, updated 8/5/2021)



Note: The portion paid for by Medicare is 100% for 20 days only and that is only AFTER being ADMITTED to the hospital for 3 days. You can be in the hospital for observation and not be admitted (part B medical pays and you pay the difference). If that is the case none of the Skilled Nursing Facility payments are covered. If you were admitted, what happens after 20 days? A healthy copayment ($204 per day) through day 100, then you pay the full amount.

d) ADVANCE DIRECTIVES

- Advance directives are legal documents that allow an individual to put in writing what kind of health care they would want if they were too ill to speak for themselves. Advance directives most often include the following:
  - A health care proxy (durable power of attorney)
  - A living will
  - After-death wishes
- A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person an individual wishes to make health care decisions for them if they aren't able to make them for themselves. Having a health care proxy is important because if an individual suddenly isn't able to make their own health care decisions, someone they trust will be able to make these decisions for them.
- A living will is another way to make sure their voice is heard. It states which medical treatment they would accept or refuse if their life is threatened.
- Dialysis for kidney failure, a breathing machine if they can't breathe on their own, CPR (cardiopulmonary resuscitation) if their heart and breathing stop, or tube feeding if they can no longer eat are examples of medical treatment they can choose to accept or refuse.
- In some states, advance directives can also include after-death wishes. This may include choices such as organ and tissue donation.
- Each state has its own laws for creating advance directives. For more information, contact your health care provider, an attorney, your local Area Agency on Aging, or your state health department.

i) Tips

- Keep the original copies of your advance directives where they are easily found.
- Give the person named as the health care proxy, and other concerned family members or friends, a copy of the advance directives.
- Give the doctor a copy of the advance directives for the medical record.
- Provide a copy to any hospital or nursing home providing care.
- Carry a card in their wallet that states they have advance directives-

I. SOURCES FOR INFORMATION

My.Medicare.gov provides individuals with direct Internet access to their Medicare benefits, eligibility, and preventive health information---24 hours a day, 7 days a week.

Individuals can visit the site, sign up, and Medicare will mail them a password to allow them access to their personal Medicare information.

1. Get personalized help

1. Call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call

1-877-486-2048.

2. Live chat with us at Medicare.gov/talk-to-someone.

3. Write us at PO Box 1270, Lawrence, KS 66044.

Get information 24 hours a day, including weekends

• Speak clearly and follow the voice prompts to pick the category that best meets your needs.

• Have your Medicare card in front of you, and be ready to give your Medicare Number.

• When asked for your Medicare Number, say the numbers and letters clearly one at a time.

• For help in a language other than English or Spanish, or to get a Medicare publication in an accessible format (like large print or braille), ask the customer service representative.

Important! If you need someone (like a caregiver) to access your personal health information when they call 1-800-MEDICARE You can complete an "Authorization to Disclose Personal Health Information" form that lets Medicare give your personal health information to someone other than you. To get this form in English and Spanish, visit Medicare.gov/basics/forms-publications-mailings/forms/other or call 1-800-MEDICARE. You can also submit this form at Medicare.gov in your Medicare account. Medicare must process the form before the authorization becomes effective.

2. State Health Insurance Assistance Programs (SHIPs)

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare. You can get this counseling at no cost to you. SHIPs aren't connected to any insurance company or health plan. They provide free, personalized counseling to you and your family to help with Medicare topics like these:

• Your Medicare rights

• Billing problems

• Complaints about your medical care or treatment

• Plan comparison and enrollment

• How Medicare works with other insurance

• Finding help paying for health care costs

Call a SHIP in your state to get free, personalized, and unbiased help with your Medicare questions, or learn how to become a volunteer SHIP counselor.

3. Get personal Medicare information online

a) Create your own Medicare account

Visit Medicare.gov to log into (or create) your secure Medicare account. You can also:

• Add your prescriptions and pharmacies to help you better compare Medicare health and drug plans in your area.

• Sign up to get this "Medicare & You" handbook and your official Original

Medicare claims statements, called "Medicare Summary Notices," electronically.

• Review your Original Medicare claims as soon as they're processed.

• Print a copy of your official Medicare card.

• Find a list of preventive services you're eligible to get with Original

Medicare.

• Learn about your Medicare premiums, and pay them online if you get a bill from Medicare.

b) Medicare's Connected Apps Directory

Connected apps are Medicare-approved applications or websites that a third party (not Medicare) creates. When you connect to an app and log in with your Medicare.gov account information, you can use the app's services without manually entering your health information. These third parties can only access your Medicare data if you choose to share it with them. It's always your choice if you want to connect (or stay connected) to a third-party app.

With these apps you can:

• Share your health information with doctors, caregivers, and others.

• View all of your health records in one place (like hospitalizations, lab results, and medications).

• Submit your health information to participate in clinical research studies.

Note: If you're enrolled in a Medicare Advantage Plan, only Part D information is available through Medicare connected apps. For Part A and Part B data, check with your plan.

Remember: Treat your personal and health information the same way you treat other confidential information.

To learn about how to use Medicare-connected apps to save your Medicare claims information, visit:

• Medicare.gov/manage-your-health/share-your-medicare-claims

• Medicare.gov/manage-your-health/medicares-blue-button-blue-

button-20/blue-button-apps

4. Find general Medicare information online

Visit Medicare.gov

• Get information at Medicare.gov/plan-compare about the Medicare health and drug plans in your area, including what they cost and what services they provide.

• Find Medicare-participating doctors or other health care providers and suppliers at Medicare.gov/care-compare. You can also learn about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation

facilities, and long-term care hospitals.

• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits).

• Get Medicare appeals information and forms.

5. Medicare is working to better coordinate your care

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible.

Here are examples of how your health care providers can better coordinate your care:

a) Accountable Care Organizations

An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers who accept Original Medicare and work together to coordinate your health care.

Working as part of an ACO helps your doctors and other health care providers understand your health history and talk to one another about your care and your health care needs. This may save you time, money, and frustration by avoiding repeated tests and appointments. More coordination also helps prevent medical errors and unexpected drug interactions that may happen if one provider isn't aware of what another has prescribed you.

Important! An ACO won't limit your choice of health care providers. If your doctor or other provider is part of an ACO, you still have the right to visit any doctor, hospital, or other provider that takes Medicare at any time.

In addition, if your primary care doctor participates in an ACO, you may be able to get more benefits. For example, in some ACOs, your provider may offer more telehealth services. This means you may be able to get some services from home using technology, like your phone or a computer, to communicate in real time with your health care provider.

In addition, a doctor or other provider who is part of an ACO may be able to send their patients for skilled nursing facility care or rehabilitation services even if they haven't stayed in a hospital for 3 days first, which is usually a requirement in Medicare. For you to qualify for this benefit, your doctor or other provider has to decide that you need skilled nursing facility care and meet certain other eligibility requirements.

If your primary care doctor participates in an ACO and you have Original Medicare, you'll get a written notice and/or find a poster in their office about their ACO participation. There are now hundreds of ACOs across the country. Visit Medicare.gov/care-compare to find a primary care doctor that's part of an ACO.

i) Sharing your health care information with ACOs

One of the most important benefits of an Accountable Care Organization

(ACO) is that your doctors and other providers can communicate and coordinate your care. To help with that, Medicare allows your health care provider's ACO to ask for certain information about your care. Having Medicare share your data in this way helps make sure all the people involved in your care have access to your health information when they need it to help you.

If you don't want Medicare to share your health information with your doctors for care coordination, call 1-800-MEDICARE (1-800-633-4227) and let the representative know. TTY users can call 1-877-486-2048. Medicare may still share general information to measure provider quality.

To learn more about ACOs, visit Medicare.gov/manage-your-health/

coordinating-your-care/accountable-care-organizations or call 1-800-MEDICARE.

ii) Electronic Health Records

Electronic health records are a history of your medical conditions, health care, and treatment that your doctor, other health care provider, medical office staff, or hospital keeps on a computer.

• They can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.

• Your doctor's electronic health records may be able to link to a hospital, lab, pharmacy, other doctors, or immunization information systems (registries), so the people who care for you can have a more complete picture of your health.

iii) Electronic prescribing

This is an electronic way for your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) to send your prescriptions directly to your pharmacy. Electronic prescribing can save you money and time, and help keep you safe.

6. Other ways to get Medicare information

a) Medicare emails

Visit Medicare.gov to create your secure Medicare account. Include your email address to get important reminders and information about Medicare.

b) Publications

Visit Medicare.gov/publications to review, print, or download copies of publications on different Medicare topics. You can also call 1-800-MEDICARE. G The "Medicare & You" handbook is available in other languages, like Spanish, Chinese, Korean, and Vietnamese.

c) Social media

Stay up to date and connect with other people with Medicare by following us on Facebook (facebook.com/Medicare) and X, formerly known as Twitter (twitter.com/MedicareGov).

d) Videos

Find videos about Medicare and other health care topics at YouTube.com/cmshhsgov.

7. Other helpful contacts

a) Social Security

Visit SSA.gov to apply for and sign up for Original Medicare, and find out if you qualify for Extra Help with Medicare drug costs. Also, when you open a personal "my Social Security" account, you can review your Social Security Statement, verify your earnings, change your direct deposit information, request a replacement Medicare card, update your address, and more. Visit

SSA.gov/myaccount to open your personal account.

b) Benefits Coordination & Recovery Center

Contact the Benefits Coordination & Recovery Center at 1-855-798-2627 to report changes in your insurance information or to let Medicare know if you have other insurance. TTY users can call 1-855-797-2627.

c) Beneficiary and Family Centered Care-Quality Improvement Organization and State Survey Agency

Contact your Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if you think Medicare coverage for your service is ending too soon (like if your hospital says that you must be discharged and you disagree). You may have the right to a fast appeal. If you have concerns about the quality of care you or a loved one received in a

state or federally-certified health care facility, or if you aren't satisfied with your provider's response to your concern, you may file a formal complaint directly with your state's survey agency or the BFCC-QIO. Call 1-800-MEDICARE (1-800-633-4227) to get the phone number of your BFCC-QIO or your state's survey agency. TTY users can call 1-877-486-2048. For more information, visit Medicare.gov/claims-appeals/file-a-complaint-grievance/filing-a-complaint-about-your-quality-of-care.

d) Department of Defense

Get information about TRICARE For Life (TFL) and the TRICARE Pharmacy Program.

TFL:

1-866-773-0404, TTY: 1-866-773-0405

tricare.mil/tfl

tricare4u.com

e) TRICARE Pharmacy Program:

1-877-363-1303, TTY: 1-877-540-6261

tricare.mil/pharmacy

militaryrx.express-scripts.com

f) Department of Veterans Affairs (VA)

Contact the VA if you're a veteran or have served in the U.S. military and you have questions about veteran benefits.

1-800-827-1000, TTY: 711

VA.gov

eBenefits.va.gov

g) Office of Personnel Management

Get information about the Federal Employee Health Benefits Program for current and retired federal employees.

Federal retirees:

1-888-767-6738, TTY: 711

OPM.gov/healthcare-insurance/Guide-Me/Retirees-Survivors

Active federal employees:

Contact your Benefits Officer. Visit apps.opm.gov/abo for a list of Benefits Officers.

h) Railroad Retirement Board (RRB)

If you get benefits from the RRB, call them to change your address or name, check eligibility, sign up for Medicare, replace your Medicare card, or report a death.

1-877-772-5772, TTY: 1-312-751-4701

RRB.gov

J. CHAPTER 10:MEDICARE COSTS

Medicare is not free health care. Most people pay in when they pay their taxes so the premium you and I pay today covers the benefit of those currently on the plan.

Part A Hospital coverage has no premium for those who qualify, but there are other costs; copays, coinsurance, and limits.

When a plan has paid out the maximum limit, the insured, a.k.a. beneficiary (for Medicare) is billed the full amount. We will cover those next. Not everyone is eligible for Medicare but they can still buy into the plan at age 65 by paying a monthly premium.

Part B Medical has a premium, coinsurance, and **no stop loss limits**.

If an individual has Medicare Part A and/or Part B, they will have to pay a part of the services they get. Below is a list of some of the costs they may have to pay. These costs are for 2025 and they might change each year. Anyone wanting to know the costs for a specific service should visit www.medicare.gov on the web for this information. They can also call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Your Medicare Benefits" (CMS Pub. No. 10116).

Costs in 2025: What does the beneficiary pay?

Part A: Premium, deductible, copays

a) Part A: Premium

- Most people pay $0 each month for Part A, because they or a spouse paid Medicare taxes long enough – 10 years - while working.
- Those individuals who do not receive premium-free Part A can pay up to $505 each month as a premium.
    - In order to buy into Part A, a person must also buy Part B.
    - If you need to buy Part A and do not do so at the age of 65, you will be charged a 10% late enrollment penalty. This penalty will be charged monthly for twice the number of years you were late buying into the plan.

b) Part A: Deductible

- $1632 for each benefit period.
- There can be more than 1 benefit period in a year. Your first 60 days in the hospital are at no charge. Day 1 is when you are admitted.
- The benefit period ends when you have been out of the hospital for more than 60 consecutive days.

Let's say a person went in for a surgery on Jan 10. They were sent home on Jan 15. Feb 2 they had complications and were readmitted for 3 weeks. They now have used (5 + 21) 26 days of the benefit period and have 34 left. If they are admitted within 60 days of Feb 23, for any reason, it will still be the same benefit period. If they are admitted 3 months later for any reason there will be another deductible of the same amount, with a new benefit period.

c) Part A: Copays

Days 1-60: $0 after the Part A deductible.

Days 61-90 in the hospital, the copay is $408 per day.

Days 91 – 150 in the hospital $816 per day is the cost. These are considered lifetime reserve days and might only be covered one time. These days need not be used up consecutively.

After day 150 the insured bears all the cost.

d) Part A: Skilled nursing facility

This is covered ONLY after being ADMITTED to the hospital for 3 days. A person can be held for observation for a few days and then sent to a SNF. If they were not admitted and charged under Part A, there will be no SNF coverage.

- Days 1-20: $0.
- Days 21-100: $204 each day.
- Days 101 and beyond: You pay all costs.

e) Part A: Home Health Care

- $0 for covered home health care services.
- 20% of the Medicare-approved amount for durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)

f) Part A: Hospice Care

- $0 for covered hospice care services.
- You may also pay:
    - A copayment of up to $5 for each prescription drug and other similar products for pain relief and symptom control while you're at home.
    - 5% of the Medicare-approved amount for inpatient respite care.

2. Part B: Premium, deductible, coinsurance

a) Part B: Premium

- **$174.70 each month** (or higher depending on your income). The amount can change each year. You'll pay the premium each month, even if you don't get any Part B-covered services.
- You might pay a monthly penalty if you don't sign up for Part B when you're first eligible for Medicare (usually when you turn 65). You'll pay the penalty for as long as you have Part B. The penalty goes up the longer you wait to sign up. Find out how the Part B penalty works and how to avoid it. (Link.)

b) Part B: Deductible

- **$240 before Original Medicare starts to pay.** You pay this deductible once each year.

c) Part B: General costs

- Medicare is a Gold plan, meaning 80/20 coinsurance. This means the beneficiary will pay 20% of all approved and medically necessary expenses. This is for providers who accept assignment. This means they will only charge the beneficiary the amount after Medicare has paid, they will submit the paperwork, and they will not charge more than the accepted Medicare rate for the services provided.
- Any services not deemed medically necessary will not be paid by Medicare and may be charged to the patient.

d) Part B: Clinical Lab Services

- $0 for covered clinical laboratory services.

e) Part B: Home Health Care

- $0 for covered home health care services is paid by the beneficiary
- 20% of the Medicare-approved amount for durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment).

f) Part B: Inpatient hospital care

- 20% of the Medicare-approved amount for most doctor services while you're a hospital inpatient.

g) Part B: Outpatient mental health care

- $0 for your yearly depression screening.
- 20% of the Medicare-approved amount for visits to your doctor or other health care provider to diagnose or treat your condition.
- If you get your services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional amount to the hospital.

h) Part B: Partial hospitalization mental health care

- After you meet the Part B deductible:
  - 20% of the Medicare-approved amount for each service you get from a doctor or certain other qualified mental health professional
  - Coinsurance for each day of partial hospitalization services you get in a hospital outpatient setting or community mental health center

i) Part B: Outpatient hospital care

- Usually 20% of the Medicare-approved amount for doctor and other health care providers' services.
- You'll also pay a copayment to the hospital for each service you get in a hospital outpatient setting (except for certain preventive services). In most cases, your copayment won't be more than the Part A hospital stay deductible amount.
  - This additional hospital copayment means you may pay more for an outpatient service you get in a hospital than you'd pay if you got the same service in a doctor's office.
  - Compare outpatient procedure costs under Original Medicare. (Link.)

3. Part C

a) Part C: Premiums & other costs (like deductibles, copayments, & coinsurance)

- **Varies by plan.** These amounts can change each year.
  - You must have Part B and keep paying your Part B premium to stay in your plan.
  - Some plans will help pay all or part of your Part B premium. This is sometimes called a "Medicare Part B premium reduction." Contact your plan for more information.
- Compare costs for specific health care plans. (Link.)

b) Part C: Out-of-pocket limit

- **Varies by plan.** Once you pay the plan's limit, the plan pays 100% of your covered health services for the rest of the calendar year.

4. Part D

a) Part D: Premium

- **Varies by plan.** You may have to pay more, depending on your income.
- Who pays a higher Part D premium because of income?
  - You'll pay the higher premium if your income is above a certain amount. The extra amount added to your Part D premium is called an Income Related Monthly Adjustment Amount (IRMAA).
  - The amount of IRMAA you pay depends on how you file your taxes and your modified adjusted gross income, **as reported on your IRS tax return from 2 years ago.**
  - Social Security will tell you if you have to pay a higher premium because of your income. If you've had a life-changing event that reduced your household income, you can ask Social Security to lower the additional amount you'll pay.
- Avoid paying a penalty:
  - Join a Medicare drug plan when you first get Medicare Part A and/or Part B, **and**
  - Don't go 63 days or more without creditable drug coverage (coverage that's similar in value to Part D).
- Find out more about the Part D penalty. (Link.)

b) Part D: Deductibles, copayments, & coinsurance

- Varies by plan and pharmacy. Find Medicare drug plans in your area (Link), and compare their costs and coverage.

5. Medicare Supplemental Insurance (Medigap)

Thes plans are necessary to cover the costs Medicare approves but does not pay. They are plans sold by insurance companies but are not technically insurance. They can choose to not accept a beneficiary* or exclude a pre-existing condition for a period of time because they are not health care.

*A beneficiary cannot be turned down if they apply for a Medigap plan within 6 months of applying for coverage part B of Medicare.

a) Medicare Supplemental Insurance (Medigap): Premium

- **Varies based on which Medigap policy you buy, where you live, and other factors.** The amount can change each year.
    - You must have Part B and keep paying your Part B premium to keep your Medigap policy.

b) Medicare Supplemental Insurance (Medigap): Other costs

- Medigap usually helps pay your portion of the costs (like deductibles and coinsurance) for services that Part A and Part B cover in Original Medicare. The amount you'll pay for Part A and Part B services if you have a Medigap policy varies depending on the policy you buy.
- Some Medigap policies include extra benefits to lower your costs, like coverage when you travel out of the country.

K. MEDICARE TERMINOLOGY

Active Treatment

Therapy designed specifically for individuals to help resolve or improve their condition.

Appeal

A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare or your health plan. You can appeal if you request a health care service, supply or prescription that you think you should be able to get, or you request payment for health care you already received, and Medicare or a health plan denies the request. You can also appeal if you are already receiving coverage and the plan stops paying. There is a specific process your Medicare Advantage Plan, other Medicare Health Plan, Medicare drug plan, or the Original Medicare plan must use when you ask for an appeal.

Assignment

In the Original Medicare Plan, this means a doctor or supplier agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Benefits

The money or services provide by an insurance policy. In a health plan, benefits take the form of health care.

Benefit Period

The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you haven't received any 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 one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods an individual can have.

Coinsurance

The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Copayment

In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount you pay. For example, this could be $10 or $20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Creditable Prescription Drug Coverage

Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Critical Access Hospital—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial Care—Non-skilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom.

It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible

The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan or other insurance begins to pay. For Example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

End-Stage Renal Diseases (ESRD)

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Extra Help—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Excess Charges

If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Formulary

A list of certain kinds of prescription drugs that a Medicare drug plan will cover subject to limits and conditions.

Guaranteed Issue Rights (also called "Medigap Protections")

Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a policy, or place conditions on a policy, such as exclusions for preexisting conditions and can't charge you more for a policy because of past or present health problems.

Health Maintenance Organization Plan

A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your cost may be lower than in the Original Medicare Plan.

Hospice Care

A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well. Hospice care is covered under the Medicare Part A (Hospital Insurance).

Inpatient Rehabilitation Facility—A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution

A facility that provides short-term or long-term care, such as a nursing home or skilled nursing facility (SNF) or rehabilitation hospital. Private residences. such as assisted or adult living facilities, or group home are considered institutions for this purpose.

Lifetime Reserve Days

In the Original Medicare Plan, a total of 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-Term Care Hospital

Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare-Approved Amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Health Plan—A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term is used throughout this handbook to include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Plan—Refers to any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Medical Underwriting

The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting a period for the pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Penalty

An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan, if you don't join when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions.

Premium

The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Doctor—Your primary care doctor is the doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider. Quality Improvement Organization (QIO)— A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

Referral—A written order from your primary care doctor for you to see a specialist or to get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service Area—A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care

A Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include, physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

State Insurance Department

A State agency that regulates insurance and can provide information about Medigap policies and other private insurance.

State Medical Assistance Office

A State agency that is in charge of the state's Medicaid program and can give information about programs that help pay medical bills for people with low income.

II. PART II: PATIENT PROTECTION AND AFFORDABLE HEALTH CARE ACT 2010

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the new law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

1. OVERALL APPROACH TO EXPANDING ACCESS TO COVERAGE

Requires most U.S. citizens and legal residents to have health insurance. Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.

2. INDIVIDUAL MANDATE-REQUIREMENT TO HAVE COVERAGE

Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule:

$95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

3. EMPLOYER REQUIREMENTS REQUIREMENT TO OFFER COVERAGE

a) Requirement to offer coverage

Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014)

Exempt employers with fewer than 50 employees from any of the above penalties.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees who receive premium credits in the Exchange. (Effective January 1, 2014)

b) Other requirements

Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

4. EXPANSION OF PUBLIC PROGRAMS

a) Treatment of Medicaid

Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate-passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)

b) Treatment of CHIP

Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.

5. PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS

a) Eligibility

Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee shared the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.

b) Premium credits

Provide refundable and advance-able premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:

Up to 133% FPL: 2% of income

133-150% FPL: 3 – 4% of income

150-200% FPL: 4 – 6.3% of income

200-250% FPL: 6.3 – 8.05% of income

250-300% FPL: 8.05 – 9.5% of income

300-400% FPL: 9.5% of income

Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP.

Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.

c) Cost-sharing subsidies

Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level.

This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

d) Verification

Require verification of both income and citizenship status in determining eligibility for the federal premium credits.

e) Subsidies and abortion coverage

Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde Amendment).

If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

6. PREMIUM SUBSIDIES TO EMPLOYERS

a) Small business tax credits

Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit.

Phase I: For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.

Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

b) Reinsurance program

Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program.

(Effective 90 days following enactment through January 1, 2014)

7. TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM

a) Tax changes related to health insurance

Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.

Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011)

Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011)

Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.

(Effective January 1, 2013)

Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.

(Effective January 1, 2013)

Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). (Effective January 1, 2013).

Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020).

The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers.

The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018)

Eliminate the tax deduction for employers who receive

Medicare Part D retiree drug subsidy payments.

Summary of (Effective January 1, 2013)

8. COVERAGE PROVISIONS

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary explains key health coverage provisions in the new law and incorporates changes made to the law by subsequent legislation.

The legislation will do the following:

Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.

Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.

New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.

Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years while reducing the deficit by $124 billion during this time period.

a) Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016.

Congress removed this mandate in 2017

b) Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income.

This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.

Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

c) American Health Benefit Exchanges

States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.

Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity.

In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.

Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges.

These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.

Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

d) Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.

Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.

Increases in health plan premiums will be subject to review.

Young adults will be allowed to remain on their parent's health insurance up to age 26.

States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.

Waiting periods for coverage will be limited to 90 days.

Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

e) Employer Requirements

There is no employer mandate but employers with 50 or more employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees).

Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.

Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

f) Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years.

According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some

who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by $124 billion

over ten years (the total reduction in the deficit including the health care and education components is estimated to be $143 billion over ten years).

g) Tax changes related to financing health reform

Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:

$2.8 billion in 2012-2013;

$3.0 billion in 2014-2016;

$4.0 billion in 2017;

$4.1 billion in 2018; and

$2.8 billion in 2019 and later.

Impose an annual fee on the health insurance sector, according to the following schedule:

$8 billion in 2014;

$11.3 billion in 2015-2016;

$13.9 billion in 2017;

$14.3 billion in 2018

For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee.

Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014)

Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012)

Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009)

Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010)

Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010)

Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)

9. HEALTH INSURANCE EXCHANGES

a) Creation and structure of health insurance exchanges

Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)

b) Eligibility to purchase in the exchanges'

Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.

c) Public plan option

Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the

qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules.

These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

d) Consumer Operated and Oriented Plan (CO-OP)

Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPS by July 1, 2013-

e) Benefit Tiers

Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets:

Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);

Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;

Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;

Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits;

Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HAS current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:

100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);

200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);

300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.

f) Insurance market and rating rules

Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange.

Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)

g) Qualifications of participating health plans

Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment

assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information.

Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

h) Requirement of the exchanges

Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges.

Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.

i) Basic health plan

Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees.

States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

j) Abortion coverage

Permit states to prohibit plans participating in the Exchange from providing coverage for abortions.

Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Effective dates

Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.

10. BENEFIT DESIGN

a) Essential benefits package

Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014)

Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)

b) Abortion coverage

Prohibit abortion coverage from being required as part of the essential health benefits package.(Effective January 1, 2014)

the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)

11. CHANGES TO PRIVATE INSURANCE

a) Temporary high-risk pool

Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010).

Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)

b) Medical loss ratio and premium rate reviews

• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs

and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less

than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)

• Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)

c) Administrative simplification

Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)

d) Dependent coverage

Provide dependent coverage for children up to age 26 for all individual and group policies.

e) Insurance market rules

Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.

Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition

exclusions for children within six months of enactment and by 2014 for adults. (Effective six months following enactment, except where otherwise specified)

Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on preexisting condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014)

Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014)

Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016)

Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)

f) Consumer protections

Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment).

Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)

g) Health care choice compacts and national plans

Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)

h) Health Insurance Administration

Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate $1 billion to implement health reform policies.

12. STATE ROLE

a) State role

Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.

Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the

maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.

Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010)

Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit.

(Effective January 1, 2017)

13. COST CONTAINMENT

a) Administrative simplification

Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; (effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

b) Medicare

Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify the rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years.

- Reduce annual market basket updates for inpatient hospitals, home health, skilled nursing facilities, hospice, and other Medicare providers, and adjust for productivity. (Effective dates vary)
- Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/ couple.(Effective January 1, 2011)
    - Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five-year period ending that year. If so, beginning

January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration.

The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for

one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015.

- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014)
- Eliminate the Medicare Improvement Fund. (Effective upon enactment)
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.

(Effective October 1, 2012)

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

c) Medicaid

Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. (Effective January 1, 2010)

Extend the drug rebate to Medicaid managed care plans. (Effective upon enactment) Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016,$1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011)

Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)

d) Prescription drugs

Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)

e) Waste, fraud, and abuse

Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. (Effective dates vary)

14. IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE

a) Comparative effectiveness research

Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)

b) Medical Malpractice

Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance.

(Funding appropriated for five years beginning in fiscal year 2011)

c) Medicare

Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient

hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016)

Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012)

Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)

d) Dual Eligible

Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)

Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011)

Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease foradult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)

e) Primary care

Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primarycare doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013)

Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)

f) National quality strategy

Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011)

Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)

g) Financial disclosure

Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)

h) Disparities

Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)

15. PREVENTION/WELLNESS

a) National Strategy

Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)

Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign form preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015. (Effective fiscal year 2010)

Establish a grant program to support the delivery of evidence-based and community-based prevention and

wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)

b) Coverage of preventive services

Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the

Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011)

Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services. (Effective January 1, 2013)

Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually.

Require the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011.

Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting.

(Effective January 1, 2011)

Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first)

Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010)

Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)

c) Wellness programs

Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011)Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)

Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014)

Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)

d) Nutritional information

Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)

16. LONG-TERM CARE

a) Class Act

Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase nonmedical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program unless they choose to opt out.

(Effective January 1, 2011)

b) Medicaid

Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).

Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010)

Establish the Community First Choice Option in Medicaid to provide community-based attendant support and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2011)

Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)

c) Skilled nursing facility requirements

Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)

17. OTHER INVESTMENTS

a) Medicare

Make improvements to the Medicare program:

– Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010);

– Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020:

For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)

For generic drugs, provide federal subsidies of

75% of the generic drug cost by 2020 form prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011); Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage;

– Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012);

– Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment);

– Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and

– Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and

– Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)

b) Workforce

Improve workforce training and development:

Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010)

Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011)

Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)

Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)

Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)

c) Community Health Centers and School Based Health Centers

Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).

d) Trauma care

Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)

Public health and disaster preparedness

Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)

e) Requirements for non-profit hospitals

Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs,

adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)

f) American Indians

Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)

g) FINANCING

Coverage and financing The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion.

CBO estimates the cost of the coverage components of the new law to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by $124 billion over ten years.

h) SOURCE NOTE

The information provided in this section is also available as a publication (#8061) on the Kaiser Family Foundation's website at www.kff.org. The Henry J. Kaiser Foundation is a non-profit private operating foundation dedicated to producing and communicating the best possible analysis and information on health issues.

i) SUMMARY OF COVERAGE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary explains key health coverage provisions in the new law and incorporates changes made to the law by subsequent legislation. The legislation will do the following:

Most individuals will be required to have health insurance beginning in 2014.

Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.

Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.

New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.

Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years, while reducing the deficit by $124 billion during this time period.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016.

Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold ($9,350 for an individual and $18,700 for a married couple in 2009).

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income.

This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above

133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.

Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

American Health Benefit Exchanges

States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.

Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multistate plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made

available to establish non-profit, member-run health insurance CO-OPs in each state.

Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges.

These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.

Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.

Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.

Increases in health plan premiums will be subject to review.

Young adults will be allowed to remain on their parent’s health insurance up to age 26.

States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.

Waiting periods for coverage will be limited to 90 days.

Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

Employer Requirements

There is no employer mandate but employers with 50 or more employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees).

Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 89.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.

Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program. The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by $124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be $143 billion over ten years).

III. PART III – C.O.B.R.A.

a) INTRODUCTION

Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by your employer.

There was a time when group health coverage was available only for full-time workers and their families. That changed in 1985 with the passage of health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act. (C.O.B.R.A.).

Now terminated employees or those who lose coverage because of reduced work hours may be able to continue in the group coverage for themselves and their families for limited periods of time, they must pay the full premium.

If an individual is entitled to COBRA benefits, their health plan must give them a notice stating that they have a right to choose to continue benefits provided by the plan.

They have 60 days to accept coverage or lose all right to benefits. Once COBRA coverage is chosen they are required to pay for the coverage.

b) CONTINUATION HEALTH LAW

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act health benefit provisions in 1985. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances.

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees since usually the employer formerly paid a part of the premium. When using COBRA, the insured pays the full premium. It is ordinarily less expensive, though, than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the Federal Government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards, and enforcement.

ERISA neither establishes minimum standards or benefit eligibility for welfare plans nor mandates the type or level of benefits offered to plan participants. It does, though, require that these plans have rules outlining how workers become entitled to benefits.

For COBRA purposes, a group health plan ordinarily is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or otherwise (such as a trust, health, maintenance organization, self-funded pay-as-you-go basis, reimbursement or combination of these). Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- Inpatient and outpatient hospital care.
- Physician care.
- Surgery and other major medical benefits.
- Prescription Drugs.
- Any other medical benefits, such as dental and vision care.

Life insurance, however, is not a benefit that must be offered to individuals for purposes of health continuation coverage.

2. QUALIFYING FOR COVERAGE

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, beneficiaries, and events, which initiate the coverage.

a) Plan Coverage

Group health plans for employers with 20 or more employees on at least 50 percent of the working days in the previous calendar year are subject to COBRA. "Employees" include full-time and part-time workers, agents, independent contractors and directors, and certain self-employed individuals eligible to participate in a group health care plan.

b) Beneficiary Coverage

A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse, and dependent children, and in certain cases, a retired employee, the retired employee's spouse, and dependent children.

3. QUALIFYING EVENTS

"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, and individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that a plan must offer health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

Types of qualifying events for employees are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct".
- Reduction in the number of hours of employment.

Types of qualifying events for spouses are:

- Termination of the covered employee's employment for any reasons other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Covered employees becoming entitled to Medicare and the spouse does not.
- Divorce or legal separation of the covered employee.

- Death of the covered employee.

Types of qualifying events for dependent children are:

- Termination of the covered employee's employment for any reasons other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Loss of "dependent child" status under the plan rules. (Aging out)
- Covered employees becoming entitled to Medicare and the dependent children are not
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

4. THE RIGHTS OF AN EMPLOYEE

a) Notice and Election Procedures

COBRA outlines procedures for employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The qualifying events contained in the law create rights and obligations of employers and plan administrators.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

5. NOTICE PROCEDURES

a) General Notices

An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of the law.

COBRA information also is required to be contained in the Summary Plan Description (SPD), which participants receive. ERISA requires that SPD's containing certain plan information and summaries of material changes in plan requirements are furnished to participants in modified and updated SPD's.

Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

b) Specific Notices

Specific notice requirements are triggered for employers, qualified beneficiaries, and plan administrators when a qualifying event occurs. Employers must notify plan administrators when a qualifying event occurs.

Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours of employment, entitlement to Medicare or bankruptcy. Multi-employer plans may provide for a longer period of time.

The employee, retiree or family member should notify the plan administrator within 60 days of events consisting of divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of disability determination and prior to the expiration of the 18-month period of COBRA coverage.

These beneficiaries also must notify the plan administrator within 30 days of the final determination that they are no longer disabled.

Plan administrators, upon notification of a qualifying event, must automatically provide notice to employees and family members of their election rights. The notice must be provided in person or by first-class mail within 14 days of receiving information that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multi-employer plans.

First, the time frame for providing notices may be extended beyond the 14 and 30-day requirements if allowed by plan rules.

Second, employers are relieved of the obligation to notify plan administrators when employees terminate or reduce their work hours. Plan administrators are responsible for determining whether these qualifying events have occurred.

c) Election

The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary. A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of any other qualified beneficiary. Each qualified beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a qualified beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

For example, a beneficiary may have had medical, hospitalization, dental, vision, and prescription benefits under single or multiple plans maintained by the employer. Assuming a qualified beneficiary had been covered by three separate health plans of his former employer on the day preceding the qualifying event, that individual has the right to elect to continue coverage in any of the three health plans.

If a plan provides, both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

Beneficiaries may change coverage during periods of open enrollment by the plan.

6. DURATION OF COVERAGE

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA.

COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction in hours of work.

Certain qualifying events (death or divorce), or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage **begins** on the date that coverage would otherwise have been lost by reason of a qualifying event and end when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.

Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.

Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under title II or XVI of the Social Security Act to have been disabled at the time of termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18-month period expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to qualified beneficiaries. COBRA does not prohibit plans from offering continuation health coverage that goes beyond COBRA periods. Some plans allow beneficiaries to convert group health coverage to an individual policy. In this case, you

must be given the option to enroll in a conversion health plan. You usually must enroll in the plan within 180 days before your COBRA coverage ends. The premium is generally not a group rate. The conversion option, however, is not available if you end COBRA coverage before reaching the maximum period of entitlement or it is unavailable under the plan.

7. PAYING FOR COBRA

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 percent of the costs to the plan for similarly situated individuals who have not incurred a qualifying event.

Premiums reflect the **total** cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

For disabled beneficiaries, the premium may be increased after 18 months of 150 percent of the plan's total costs of coverage for the last 11 months of continuation coverage.

Premiums due may be increase if the costs to the plan increase but generally must be fixed in advanced of each 12-month

premium cycle. The plan must allow you to elect to pay
premiums on a monthly basis if requested by you.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment must cover the period of coverage from the date of COBRA election retroactive to the date of the qualifying event.

Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. No payment, however, needs to be paid earlier than 45 days after the date of the election.

The due date may not be prior to the first day of the period coverage. For example, the due date for the month of January could not be prior to January 1st and coverage for January could not be canceled if payment is made by January 31st.

Premiums for the rest of the COBRA period must be made within 30 days of the due date for each such premium of such longer period as provided by the plan.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

8. CLAIMS PROCEDURES

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

The insured should submit a written claim for benefits to whoever is designated to operate the health plan (employer, plan administrator, etc.).

If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, and any additional information needed to support the claim and procedures for appealing the denial.

The insured has 69 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan: Provides a special hearing, or A group, which meets, only on a periodic basis, must make the decision.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices.

9. ROLE OF THE FEDERAL GOVERNMENT

Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private-sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published the Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health plans for Certain State and Local Employees".

A law similar to COBRA covers Federal employees. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

10. CONCLUSIONS

Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. The COBRA law creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in healthcare laws to preserve their benefit rights. A good starting point is reading the plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages the plan.

11. IMPORTANT TERMINOLOGY

63 Day Break in Coverage

A period of 63 consecutive days in which an individual has no Creditable Coverage not counting Waiting Periods or Affiliation Periods.

ADA

Americans with Disabilities Act of 1990

AD&D

Accidental Death and Dismemberment Plan

Affiliation Period

The time an HMO may require an individual to wait after they enroll and before their coverage begins.

HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions under group health plans. Premiums cannot be charged during HMO affiliation periods.

Automatic Certificate of Creditable Coverage

The Certificate of Creditable Coverage is required to be automatically furnished to each individual when normal coverage terminates under the plan, and again when COBRA coverage terminates.

Bundling

Combining two forms of insurance into one policy, for example, vision and dental, or medical and dental. Commonly occurs with non-core benefits. Life/AD&D, LTD, STD, and FSA Dependent Care Reimbursement Accounts are excluded under COBRA unless they are bundled with the group health plan.

Cafeteria Plan

A cafeteria plan is not a typical employee benefit plan. It does not provide benefits directly to employees; rather, it serves as a vehicle for employees to elect benefits under other plans and to finance their elections.

Cafeteria plans must comply with the requirements in Code Section 125. Cafeteria plans give employees an opportunity to choose among a menu of benefits consisting of cash and certain nontaxable benefits (for example, health insurance benefits).

In the simplest form of the cafeteria plan, the employer contributes an amount to the plan that the employee can spend to buy various benefits.

If the employer contribution exceeds the cost of the employee's chosen benefits the employee may take the excess cash as additional taxable wages, assuming the plan allows such a cash-out option.

If the employer contribution is insufficient to pay for the cost of the employee's chosen benefits, the employee can reduce his salary to pay for the excess cost on a pre-tax basis.

CFR

Code of Federal Regulations

Core benefits

Medical and prescription drug only.

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services

(known since March 1995 as TRICARE).

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, which among other things, established the health care continuation requirements that are found in ERISA, the Code and the PHSA.

COBRA requires that if an employee or other "qualified beneficiary" loses employer-provided health coverage due to termination of employment or another specified triggering event, the group health plan must offer continued health care coverage to the qualified beneficiary.

The qualified beneficiary may be required to pay the full cost for the coverage. This 'COBRA Coverage" has limited duration. In most cases, the maximum COBRA period is 18 or 36 months from the date of the qualifying event.

Continuous Coverage

Health insurance coverage that is not interrupted by a significant lapse. When joining a health plan, coverage is considered continuous if there is not a break of 63 or more consecutive days.

Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous.

Conversion Coverage

The insurance laws of most states require health insurers to provide conversion coverage to employees or dependents that lose group insurance coverage that an employer has provided.

Conversion coverage is individual insurance coverage, and typically costs more, and provides fewer benefits than does the group insurance coverage.

COBRA requires a group health plan to provide the option of enrollment under a conversion health plan that is otherwise generally available under the plan during the last 180 days of the COBRA maximum coverage period.

COPCC -Certificate of Prior Creditable Coverage (for HIPAA).

The certificate that must be furnished under HIPAA by Group Health Plans and Health Insurance Issuers to individuals who lose coverage under employer-provided Group Health Plans.

The certificate must be furnished automatically when normal coverage terminates and again when COBRA coverage terminates. The certificate must also be furnished upon written request made within 24 months after plan coverage terminates. The certificate documents the individual's Creditable Coverage.

Covered Employee

An individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan. Covered employee includes retirees, independent contractors, self-employed persons and partners of a partnership.

Creditable Coverage

The period of an individual's coverage under a Group Health Plan, health insurance, Medicare of any one of several other specified health plans or health insurance sources that is not interrupted by a 63 day break in coverage.

Dangerous Activities Exclusion or Limitation

A plan provision that makes individuals who engage in

dangerous activities ineligible for coverage or a plan provision

that excludes coverage for injuries caused by engaging in dangerous activities.

DHHS - Department of Health and Human Services Disclosure

Typically refers to the various disclosure obligations imposed by ERISA on employee welfare benefit plans, including provisions of Summary Plan Descriptions and Summaries of Material Modification.

DOL - Department of Labor

EAP - Employee Assistance Plan

EEOC

The United States Equal Employment Opportunity Commission. This commission is responsible for the investigation of ALL discriminatory matters covered by Title VII of the Civil Rights Act, Age Discrimination Act, Americans With Disabilities Act,

Sexual Harassment Laws and other similar discriminatory matters. It may also bring a case on behalf of a victim of such acts. Election form - Form used to enroll in the COBRA plan, listing things such as qualifying events, contact information, beneficiaries, start date, end date, etc.

Eligible Individual

Relevant for HIPAA's Individual Market Insurance Rules that apply to Health Insurance Issuers, the term generally means an individual with 18 or more months of Creditable Coverage who has exhausted available COBRA (and/or state law) coverage.

Elimination Rider

A feature permitted in individual health plans that excludes coverage for a specific health condition, body part, or body system. Unlike pre-existing condition exclusion periods, which can be no longer than 12 months, elimination riders can last indefinitely. Individual health plans can look back 3 years for evidence of a health problem.

Individuals can apply to have an elimination rider modified or removed, but the health plan is not obligated to do so.

Enrollment Date

With respect to any individual covered under a Group Health Plan, the date of enrollment or, if earlier, the first day of the Waiting Period for such enrollment.

Enrollment Period

The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage.

EOI - Evidence of Insurability

ERISA

ERISA is the Employee Retirement Income Security Act of 1974, as amended. ERISA is a federal law governing the administration, supervision, and management of health and welfare plans, as well as pension plans.

Federally Eligible

Status an individual attains once they have had 18 months of continuous creditable health coverage. To be federally eligible, an individual also must have used up any COBRA or state continuation coverage available to them; an individual must not be eligible for Medicare, Medicaid, or a group health plan; must

not have other health insurance; and must apply for individual health insurance within 63 days of losing their prior creditable coverage.

When someone is buying individual health coverage, federal eligibility confers greater protections on the individual than they would have otherwise have.

Fee-For-Service (FFS) Plan

Health plan that allows the enrollee to choose which doctors and hospitals to use without requiring or providing incentives for the enrollee to use a network of doctors and hospitals. FFS plans are more costly than managed care plans such as HMOs and PPOs.

First Day of Coverage

Term used in interim regulations in place of Date of Enrollment to clarify that the Look Back Rule operates from the date of actual enrollment (or if earlier, the beginning of the waiting period) rather than the date an enrollment application is completed.

Form 5500

The annual information return required to be filed by many ERISA employee benefit plans and by cafeteria plans and educational assistance plans, using the Form 5500 series. Also known as the Annual Report.

FMLA- Family and Medical Leave Act of 1993.

The FMLA generally applies to employers with 50 or more employees. Though it does not amend the COBRA provisions in ERISA, the PHSA or the Code, it requires employers to permit employees to take up to 12 weeks of Family Medical Leave a year and to continue to provide health benefits during the leave.

FSA - Flexible Spending Account.

A health FSA is a “medical reimbursement” plan that is a “flexible spending arrangement.” Example: A cafeteria plan permits participants to elect coverage under a medical reimbursement plan with an annual limit of up to $1,200 and to pay for that coverage with pre-tax salary reduction dollars.

The plan reimburses employees for medical and dental expenses not otherwise reimbursed by the employer’s group health plan (e.g., copays, deductibles, eyeglasses, orthodontia). A participant who elects the maximum of coverage must reduce his/her annual taxable wages by(his/her annual premium) to pay for the coverage.

This medical reimbursement plan is a flexible spending arrangement. The maximum amount of reimbursement available for a plan year is equal to 100% of the annual premium, which is far less than 500% threshold.

Fully Insured Group Health Plan

Health insurance purchased by an employer from an insurance

company.

GTL - Group Term Life Plan

Group Health Plan

A plan sponsored by an employer, union or professional association that covers at least 2 employees and can be insured or self-insured.

Guaranteed Issue

A requirement that health plans must permit an individual to enroll regardless of their health status, age, gender, or other factors that might predict their use of health services.By federal law all health plans, sold to small employers, are guaranteed issue. Plans that are guaranteed issue can turn an individual away for other reasons.

Guaranteed Renewability

A feature in most health plans that means the coverage cannot be canceled because the individual gets sick. HIPAA requires health insurance to be guaranteed renewable.

Coverage can be canceled for other reasons unrelated to their health status.

Health Care Provider

Include providers who render medical care and are recognized by the Federal Employees Health Benefits Program, certified under Federal or State law, recognized as a Native American "traditional healing practitioner," or who practice in a foreign country.

Health Insurance

Benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or HMO contract offered by a health insurance company or a group health plan. Excludes accident or disability income insurance, workers compensation, automobile insurance with medical coverage, coverage for on-site medical clinics or dental or vision benefits.

Health Plan Year

That calendar period during which a health plan coverage is in effect.

Many group health plan years begin on January 1, while others

begin in a different month.

HIPAA - Health Insurance Portability and Accountability Act of 1996.

Generally, HIPAA restricts the use of preexisting condition exclusions, creates special enrollment periods and prohibits discrimination based on health-status related conditions in enrollment and premiums.

HIPAA also creates an obligation for most group health plans or their insurers to provide certificates of creditable coverage to individuals who ceased to be covered by a group health plan.

Administration of the certificate requirements is often coordinated with administration of COBRA.

Because HIPAA requires a certificate to be issued not only when coverage first ceases, but also when COBRA coverage ceases, HIPAA effectively creates a new notice requirement in COBRA administration when COBRA coverage expires or is terminated.

HMO

Health Maintenance Organization. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a co-payment for doctor visits or prescriptions.

If an individual is covered under an HMO, the HMO might require an affiliation period before coverage begins.

Individual Health Plan

Private policies purchased by the self-employed, unemployed or people that have no group health insurance for themselves (or their family members).

IRC - Internal Revenue Code, Title 26

Large Group Health Plan

One with more than 50 eligible employees.

Late Enrollee

An individual who enrolls in a plan after the first available enrollment period but not including an individual who is a Special Enrollee.

Late enrollees may be subject to a longer pre-existing condition exclusion period. Lay-Off - A Lay-Off is an employment decision where the employer makes the decision not to replace a position and the reduction occurs because of financial considerations. A Lay-Off is not a discharge.

Leave Entitlement –

Office of Personnel Management regulations clarify that an employee must invoke his or her entitlement to Family and Medical Leave Act (FMLA) leave, subject to the notification and medical certification requirements.

An employee may not invoke entitlement to FMLA leave retroactively for any previous absence from work.

Look Back Rule

One of the restrictions of Preexisting Condition Exclusions imposed by HIPAA under which such exclusions are limited to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to the Enrollment Date. Also The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions.

LTD - Long Term Disability

Medicaid

A state program providing comprehensive health insurance

coverage where eligibility levels and covered benefits vary.

Medically Necessary

Services or supplies that are proper and needed for the diagnosis, direct care, or treatment of your medical condition, meet standards of good medical practice, and are not mainly for the convenience of you or your doctor.

Medicare

A federal government program that pays for services and supplies it considers "medically necessary".

MEWA - Multiple Employer Welfare Arrangement MHPA - Mental Health Parity Act

NAIC - National Association of Insurance Commissioners

NMHPA-Newborns' and Mothers' Health Protection Act of 1996.

None Core Benefits

Dental, vision, EAP and FSA Medical Reimbursement.

Nondiscrimination

A requirement that group health plans not discriminate against individuals based on their health status. Coverage under a group health plan cannot be denied or restricted, nor can an individual be charged a higher premium, due to their health status. Group health plans can restrict the coverage based on other factors (such as part time employment) that are unrelated to health status.

Nondiscrimination Rules Under HIPAA

Rules added by HIPAA that prohibit a Group Health Plan from discriminating with regard to eligibility or premiums or contributions based on any enumerated "health status-related factor," including medical condition or history, disability or genetic information.

PCE - Preexisting Condition Exclusion

PHSA - Public Health Service Act

The PHSA contains the provisions of COBRA that govern continuation coverage under government-sponsored group health plans.

Plan Administrator

Either the person or entity named as plan administrator in the plan instrument, or, if no one is named, the plan sponsor. (For private sector plans under ERISA, the Department of Labor may designate a plan administrator.)

The employer or the qualified beneficiary or the covered employee, depending on the nature of the qualifying event, must notify the plan administrator when a qualifying event occurs. The plan administrator, in turn, must notify any qualified beneficiary of his or her rights under COBRA.

Plan Sponsor

The plan sponsor of a single-employer plan is the employer. In plans maintained by two or more employers or by one or more employee organizations, the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. Under COBRA, a plan sponsor has the obligation to provide COBRA coverage.

Portability

An employee's ability to carryover plan coverage from one employer to the next. HIPAA does not provide for such portability, but approximates portability by requiring that employees receive credit for prior coverage against any new plan's preexisting condition exclusion.

PPO - Preferred Provider Organization

A type of managed care plan that will cover more of the medical expenses when an individual uses a health care provider such as a doctor or a hospital that is part of the PPO network.

When an individual uses a provider outside the network, the health plan will cover less of the costs.

Pre-existing Condition

Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan.

Group health plans cannot count pregnancy as a pre-existing condition.

Genetic information about the likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition.

Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to preexisting condition exclusions.

Pre-existing Condition Exclusion Period: The time during which a health plan will not pay for covered care related to a pre-existing condition. Note: no longer legal for health care coverage

PWBA - Pension and Welfare Benefits Administration Qualified Beneficiary

Individuals who are allowed to continue coverage based upon certain "qualifying events".

Qualifying event

The loss of coverage under a group health plan on account one of the specific events described in COBRA:

Death of the covered employee;

Voluntary or involuntary termination of the covered employee's employment (other than by reason of gross misconduct), or reduction of hours of the covered employee's employment;

Divorce or legal separation of the covered employee from the employee's spouse;

Covered employee becomes entitled to benefits under Medicare Dependent;

Child ceasing to be a dependent child under the generally applicable requirement of the plan; and

An employer's bankruptcy (but only with respect the health coverage for retirees and their families).

Requested Certificate of Creditable Coverage

The Certificate of Creditable Coverage required to be furnished to each individual upon written request made within 24 months after plan coverage terminates. The certificate documents the individual's Creditable Coverage.

Self-Insured Group Health Plans

Plans set up by employers who set aside funds to pay their

employees' health claims.

Because employers often hire insurance companies to run these plans, they may look to the insured just like fully insured plans.

Employers must disclose in the benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured.

Self-insured plans are regulated by the U.S. Department of Labor.

Serious Health Condition

Via the Department of Labor's (DOL's) regulations, includes chronic conditions, such as asthma, diabetes, and conditions requiring multiple treatments, such as chemotherapy or kidney dialysis.

Small Group Health Plans

Plans with at least 2 but not more than 50 eligible employees.

SPD - Summary Plan Description

A summary plan description is an ERISA-required summary of the terms of an employer sponsored "welfare benefit plan" that must be furnished to all participants and COBRA beneficiaries.

Special Enrollment A time, triggered by certain specific events, during which the employee and their dependents must be permitted to sign up for coverage under a group health plan.

Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days.

HIPAA requires Group Health Plans to offer special enrollment rights to certain un-enrolled employees and dependents when they experience a mid-year loss of other coverage and when there is a mid-year adoption, birth or marriage.

Special Enrollment Period

A time, triggered by certain specific events, during which the employee and his or her dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days.

Enrollment in a health plan during a special enrollment period is not considered late enrollment.

Spouse

Under the Defense of Marriage Act (Public Law 104-199, September 21, 1996). "Spouse" means an individual who is a husband or wife pursuant to a marriage that is a legal union between one man and one woman, including common law marriage between one man and one woman in States where it is recognized.

State Continuation Coverage

A program similar to COBRA for people who used to receive health benefits from a small employer with fewer than 20 employees.

Stop-Loss Insurance

Coverage purchased by self-funded medical plans or plan sponsors to cover claims over a certain amount, on an individual or aggregate basis. The coverage protects the employer in most situations and does not make the medical plan itself insured for purposes of ERISA. Also called "excess insurance" or "reinsurance".

Supplemental Security Income (SSI)

A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI.

Temporary Assistance for Needy Families (TANF) A program that provides cash benefits to low-income families with children. When individuals qualify for TANF, they generally also qualify for Medicaid.

In addition, Medicaid coverage often continues for a limited time or longer if an individual no longer qualify for TANF.

U.S. Department of Labor

A department of the federal government that regulates employer

provided health benefit plans.

Waiting Period

The time an individual may be required to work for an employer before they are eligible for health benefits. Not all employers require waiting periods.

Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous.

If an employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

FREQUENTLY ASKED QUESTIONS ABOUT COBRA

What Is COBRA Continuation Health Coverage? Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The aw amended the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

What Does COBRA Do?

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events.

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire

premium themselves. It is ordinarily less expensive, though, than individual health coverage.

Who is entitled to benefits under COBRA?

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, qualified beneficiaries, and qualifying events:

Plan Coverage - Group health plans for employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA.

Both full and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts, as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualified Beneficiaries - A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is an employee, the employee's spouse, or

an employee's dependent child. In certain cases, a retired
employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries.

In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events - Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are

and the amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

Qualifying Events for Employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in the number of hours of employment
- Qualifying Events for Spouses:
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Qualifying Events for Dependent Children:
- Loss of dependent child status under the plan rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare

- Divorce or legal separation of the covered employee
- Death of the covered employee

How does a person become eligible for COBRA continuation coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees.

COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

What group health plans is subject to COBRA?

The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments.

What process must individuals follow to elect COBRA continuation coverage?

Employers must notify plan administrators of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment or entitlement to Medicare.

A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Plan participants and beneficiaries generally must be sent an election notice not later than 14 days after the plan administrator receives notice that a qualifying event has occurred. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The person has 45 days after electing coverage to pay the initial premium.

How long after a qualifying event does an individual have to elect COBRA coverage?

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA coverage. Each qualified beneficiary may independently elect COBRA coverage. A covered employee or the covered

employee's spouse may elect COBRA coverage on behalf of all other qualified beneficiaries.

A parent or legal guardian may elect on behalf of a minor child. Qualified beneficiaries must be given at least 60 days for the election. This period is measured from the later of the coverage loss date or the employer or plan administrator provides the date the COBRA election notice.

The election notice must be provided in person or by first-class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

How does an individual file a COBRA claim for

benefits?

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures must be described in the Summary Plan Description. An individual should submit a claim for benefits in accordance with the plan's rules for filing claims. If the claim is denied, the individual must be given notice of the denial in writing generally within 90 days after the claim is filed.

The notice should state the reasons for the denial, any additional information needed to support the claim, and procedures for appealing the denial. They will have at least 60 days to appeal a denial and you must receive a decision on the appeal generally within 60 days after that.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices.

Can individuals qualify for longer periods of COBRA continuation coverage?

Yes, disability can extend the 18-month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must: Have a ruling from the Social Security Administration that he or she became disabled within the first 60 days of COBRA continuation coverage. Send the plan a copy of the Social Security ruling letter within 60 days of receipt, but prior to expiration of the 18-month period of coverage. If these requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.

Is a divorced spouse entitled to COBRA coverage from their former spouses' group health plan?

Under COBRA, participants, covered spouses and dependent children may continue their plan coverage for a limited time when they would otherwise lose coverage due to a particular event, such as divorce (or legal separation).

A covered employee's spouse who would lose coverage due to a divorce may elect continuation coverage under the plan for a maximum of 36 months.

A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation. After being notified of a divorce, the plan administrator must give notice, generally within 14 days, to the qualified beneficiary of the right to elect COBRA continuation coverage.

Divorced spouses may call their plan administrator or the EBSA Toll-Free Employee & Employer Hotline number, 1.866.444.EBSA (3272) if they have questions about COBRA continuation coverage or their rights under ERISA.

If an individual waives COBRA coverage during the election period, can they still get coverage at a later date?

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. A beneficiary may then elect COBRA coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Under COBRA, what benefits must be covered?

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage).

A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

When does COBRA coverage begin?

COBRA coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event.

How long does COBRA coverage last?

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA.

COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period.

It may end earlier if:

Premiums are not paid on a timely basis.

The employer ceases to maintain any group health plan.

After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

Although COBRA specifies certain periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period.

The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.

Who pays for COBRA coverage?

Beneficiaries may be required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2 percent for administrative costs.

For qualified beneficiaries receiving the 11-month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

COBRA premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (weekly or quarterly).

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event.

Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. T

The plan is not obligated to send monthly premium notices. COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to co-payments and deductibles, and are subject to catastrophic and other benefit limits.

If an individual elects COBRA, how much do they pay?

Under COBRA, as a former employee no longer receiving benefits, the individual will usually pay the entire premium amount, that is, the portion of the premium that they paid as an active employee and the amount of the contribution made by their employer.

In addition, there may be a 2 percent administrative fee. While COBRA rates may seem high, the insured will be paying group premium rates, which are usually lower than individual rates.

Since it is likely that there will be a lapse of a month or more between the date of layoff and the time they make the COBRA election decision, they may have to pay health premiums retroactively-from the time of separation from the company.

The first premium, for instance, will cover the entire time since their last day of employment with their former employer. Individuals should also be aware that it is their responsibility to pay for COBRA coverage even if they do not receive a monthly statement. Although they are not required to do so, some employers may subsidize COBRA coverage.

Can an individual receive COBRA benefits while on FMLA leave?

The Family and Medical Leave Act, effective August 5, 1993, requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working.

Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, U.S. Department of Labor, Employment Standards Administration.

What is the Federal Government's role in COBRA? COBRA continuation coverage laws are administered by several

agencies. The Departments of Labor and Treasury have jurisdiction over private-sector health group health plans. The Department of Health and Human Services administers the continuation coverage law as it affects public-sector health plans. The Labor Department's interpretive and regulatory responsibility is limited to the disclosure and notification requirements of COBRA.

Can a federal employee receive benefits under COBRA?

A law similar to COBRA covers federal employees. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

Is an individual eligible for COBRA if their company closed or went bankrupt and there is no health plan?

If there is no longer a health plan, there is no COBRA coverage

available. If, however, there is another plan offered by the company, the individual may be covered under that plan.

Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

How does an individual find out about COBRA coverage and how do they elect to take it?

Employers or health plan administrators must provide an initial general notice if individuals are entitled to COBRA benefits. Most individuals probably received the initial notice about COBRA coverage when they were hired.

When an individual is no longer eligible for health coverage, their employer has to provide them with a specific notice regarding their rights to COBRA continuation benefits.

Employers must notify their plan administrators within 30 days after an employee's termination or after a reduction in hours that causes and employee to lose health benefits.

The plan administrator must provide notice to individual employees of their right to elect COBRA coverage within 14 days after the administrator has received notice from the employer.

The employee must respond to this notice and elect COBRA coverage by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later. Otherwise, they will lose all rights to COBRA benefits.

Spouses and dependent children covered under the health plan have an independent right to elect COBRA coverage upon the employee's termination or reduction in hours. If, for instance, the individual has a family member with an illness at the time they are laid off, that person alone can elect coverage.

IV. PART IV– CAFETERIA PLAN

A. A LOOK BACK IN TIME

Cafeteria plans are anything but new. Actually, they were developed during the early 1970s and at that time they were known as ZEBRAS. This stood for Zero Balance Reimbursement Account.

These were accounts set up for key individuals in participating companies and were used to pay for certain benefits not ordinarily available to all employees. Payment was made by payroll deduction or through company contributions to a reimbursement account. Some of these programs were used to finance legitimate benefit programs, some for highly discriminatory plans. Because the programs were virtually unregulated, there was plenty of abuse.

The principal applied in the early plans was that because the individual involved never really received the money; he or she should not have to pay taxes on that money.

This is the same principle used to establish deferred compensation programs, though the circumstances surrounding deferred compensation are entirely different.

There was another problem concerning ZEBRAS, an oversight that spelled their quick exit from the benefits field. The bottom line was ZEBRAS did not live up to their name. They did not reduce to zero at year's end. Monies left in many of the accounts were allowed to re-circulate into the same account the next year.

- The Revenue Act of 1978 was directed at the ZEBRAS. Using the doctrine of constructive receipt, the Act disallowed all plans that involved the contribution of taxable income into accounts that, in essence, paid for personal expenses.
- The IRS contended that it did not matter whether or not an individual saw the money, touched the money, put the money in his or her pocket, the individual had the opportunity to put the money involved to his or her use and benefit.
- The re-circulation of the funds at year's end confirmed the doctrine of constructive receipt. Hence, any money put into a ZEBRA account is considered income and thus taxable to the person for whom the account was established.
- Since 1970, the whole issue of cafeteria plans has centered on constructive receipt. Section 125 of the Code specifically states that failure to meet the standards of the Internal Revenue Code means all participants in the plan in question will be in constructive receipt of the funds.
- The Revenue Act of 1978 blocked future development of ZEBRA plans.

It was not until 1984 when the Tax Reform Act of 1984 specified that money, left in payroll deduction or company contribution accounts, at the end of a taxable year, was forfeited by the individual. **The principle has become known as "use it or lose it".**

Though the 1984 Tax Reform Act clarified the theory of constructive receipt, other guidelines were not issued. Guidelines for nondiscrimination, the type of benefit plans and funding methods, none of these issues were answered by the 1984 Act.

This void of guidelines and regulations served as a block to the development of cafeteria plans. Employers just did not want to take the chance that their plan, if installed before all the guidelines were published, would not meet the federal standards and consequently be disallowed.

The Tax Reform Act of 1986 addressed many of the much needed guidelines, thus paving the way for cafeteria plans; so much so that more than 50 percent of the corporations and businesses in the United States have installed them.

It must be pointed out that the Revenue Act of 1987 targeted cafeteria plans on the amount of cash a plan participant would be eligible to take out of a plan. For a time, it seemed that the whole issue of cafeteria plans would go right back to square one, because the Conference Committee of the House and Senate tabled the idea.

You can see that the history of cafeteria plans has not been a steady one, mainly because of the lack of clear, concise regulations and guidelines. These are now in place and we have a clear path to the future, or, until the next tax reform act comes before congress.

Let's go back to the basics for a few minutes to take a look at the comparisons between a traditional employee benefit plan and a cafeteria plan.

1. ESTABLISHED PLANS

Long and Short Term Disability

Dental Insurance

Term Life Insurance

Medical Coverage

Retirement Income Plans

2. DISABILITY PLANS

Disability plans will pay benefits to a disabled employee based on a stated level of the individual's compensation. The level usually is based on the occupation, salary range and industry rating, or the differences that exist between certain types of nonhazardous, semi-hazardous, and hazardous occupations.

You might find a short-term disability income policy in effect at the company you are calling on. This type pays a benefit for relatively short periods of time and might act as the deductible or gatekeeper to the long-term disability plan. Short-term disability income plans and long-term plans serve the same purpose: To income for the employee while they are disabled.

3. DENTAL INSURANCE PLANS

Dental insurance typically includes deductible amounts and coinsurance elements. The "cap" comes with a maximum amount that would be paid annually. One distinctive feature of dental insurance plans is that routine maintenance, such as cleaning, fluoride treatments, etc., is usually paid for 100 percent by the plan.

4. TERM LIFE INSURANCE

Term life insurance is usually stated in terms of salary (i.e. one times annual salary; two times annual salary). There is a maximum death benefit for employer paid contributions, beyond which the contributions are taxable to the employee. Sometimes family plan coverage is included, which pays a fixed face amount per dependent family member.

5. MEDICAL COVERAGE INSURANCE

There are two types: A basic and a major medical superimposed on the basic plan. It also can be part of the benefit package as one plans a comprehensive policy.

The basic policy usually covers the more standard accidents or illness that call for short-term hospital stays and medical costs that usually are determinable with reasonable accuracy.

In most cases, the basic policy will have a "cap" or maximum that the plan will pay for any one sickness or injury. Once the cap is reached, benefits then are paid for by super-imposed major medical policy. In this case, the basic plan acts as the deductible for the major medical policy. There is usually a stated dollar amount deductible and a coinsurance percent, typically 20 percent, paid for by the employee.

The major medical plan carries the basic medical benefits along with extended maximums to help pay for the more serious illnesses or accidents. The features are similar to the basic plan, a 20 percent coinsurance with a stated dollar deductible and a lifetime maximum benefit

6. RETIREMENT INCOME PLANS

If the retirement program involves what is termed a "tax-qualified" plan this means that the plan has met all the requirements of the tax code and that all contributions to the plan are tax deductible to the employer. The employee's benefits usually are paid at retirement and are based on the amount of contributions made on his or her behalf, the length of time the contributions have been made and the growth of the investment fund over the course of time the employee has been a member of the plan. These six plans constitute a basic employee benefit package.

7. MANDATED PROGRAMS (REQUIRED BY LAW)

Now we will concentrate on those plans applicable to all states. Some states will have variations of these plans or will have individually mandated plans. The mandated plans common to all states are:

- Social Security
- Unemployment Compensation
- Workers' Compensation

a) Social Security

Social Security is a federally administered plan that provides benefits for retirees, the permanently and totally disabled, survivors of deceased plan participants and, under the Medicare phase of the program, hospital and medical care benefits for participants aged 65 or older.

Both employees and employers make contributions to the program on a matching basis. A self-employed person also is covered through contributions based on his or her self-employment income. These contributions are paid to a government trust fund, from which benefits are paid.

b) Unemployment Compensation

This is a state-administered program; the federal government acts in the capacity of a supporting player. As the term indicates, benefits are paid to qualified individuals who have lost employment. These benefits are paid up to stated maximums to unemployed individuals while they seek employment elsewhere.

Contributions paid to the State depend on the amount of unemployment claims a particular company has. Should a company terminate 50 out of 100 employees as opposed to 25 out of 100 employees, the former would have a higher unemployment tax rate.

c) Workers' Compensation

This program was designed to cover a worker against sickness or injury on the job. The coverage is normally purchased through a private insurance carrier and the premium is based upon the company's payroll and the type of work involved.

Basically, benefits are paid for medical care, rehabilitation, disability and death. Over the years, workers, compensation has caused much controversy among unions, employees, state governments and others. However, for the most part, it is now well accepted throughout the country.

There are a few states where the Workers Compensation program is run through the State and not insurance companies.

8. THE WORKINGS OF A CAFETERIA PLAN

- Let's look at a basic employee benefit program concept and apply it to the Andex Corporation. Andex currently has these basic benefit plans.
- Group Term insurance equals the employee's annual pay.
- A medical plan with a $250 annual deductible, 20 percent coinsurance after the deductible up to $5,000, then the plan pays 100 percent.
- A long-term disability plan paying up to 55 percent of salary.
- A dental insurance plan that pays 100 percent for preventive services with a $100 annual deductible for basic and major services for individuals; $200 for a family; with an annual maximum of $1,000 per individual.

Andex pays $170 per month for the whole package of benefits per individual. There are 50 employees at the firm and the current annual premium for Andex is $102,000 ($102,00 = $170 x 12 x 50). Andex has just received word that there will be a 30 percent rate increase in both the medical and dental plans, which will raise the total premiums for Andex to well over $132,000 per year.

Andex has decided that $170 per employee per month is as high as it intends to go. The company now wants to create an employee benefit program that will provide employees with the security they want, at an affordable cost, and, at the same time, fit a wide variety of needs. How can a cafeteria plan help Andex?

First, design a "core benefit program" that provides a basic level of protection for each employee and his or her dependents (if applicable). Assume that the basic level of protection is:

Group term life insurance equal to half annual pay.

A $500 deductible medical plan, 80 percent coinsurance up to $3,000 of covered expenses. The plan pays 100 percent of all covered expenses after the coinsurance up to a maximum of $50,000.

50 percent of annual pay long-term disability-plan.

Dental insurance with a $200 annual deductible for individuals, $300 family; up to an annual maximum of $750 per individual.

Let's say the core packages of benefits cost $127 per month per employee, leaving an excess of $40 per employee per month to finance the "optional benefit plans". The employee with the before-tax dollars also can pay for these optional plans. In this case, let's assume that the employee may contribute up to $200 a month in before tax earnings to the optional benefit portion of the program.

Adding the additional benefits area, the employees would find a wide variety of levels from which to choose. Reduced deductibles; higher maximum benefits; coverage for dependents; additional face amounts of group term life insurance – even additional plans for vision care or prescription drugs.

Every cost in the optional benefits area is paid for with the dollars set aside by the company in the form of "credits" and by the employee contributing before-tax dollars, which also can be converted into credits. Each optional benefit carries a price tag stated in terms of credits. Any credits not used could be paid out in cash to the employee, or used to purchase additional personal life insurance, long-term disability or hospital indemnity coverage.

For example here is how the cafeteria plan works on a personal level - Dolores has worked for Andex for five years. She earns a monthly gross salary of $1,600 and is married with children in a daycare center. She pays $200 per month for the daycare and has personal un-reimbursed medical expenses of $60 per month. Under the cafeteria plan, her optional benefit election totals $115 per month.

Gross Monthly Pay	$1,600.00
Federal And State Taxes	-222.00
Social Security Deduction	-120.00
Net Monthly Pay	$1,258.00

If the cafeteria plan were not in place, Dolores, take-home pay would be further reduced by these amounts.

Net Monthly Pay	$1,258.00
Day-Care Expenses	-200.00
Personal Medical	-60.00
Group Medical Premium	-158.00
Net Pay	= $ 883.00

Note that Dolores, second round of reductions to her take home pay comes at a point that is termed "below-the-line" meaning they are paid "after" all taxes have been deducted. A cafeteria plan participant is able to move the second round of reductions "above-the-line".

How does this apply to the employer? Let's assume that Andex has 1,000 employees, all paid the same amount as Dolores and all having the same salary deductions as she has. Let's also assume that total payroll tax, state and federal, is 12 percent.

So far, we have discussed the "core-plus" program, a core of basic protection paid for by the employer with optional benefits selected by the employee. There is a modular program, as well as a cost-shared program, which we will cover later on.

What have we accomplished with the installation of a cafeteria plan at Andex?

All employees can now choose the benefits he or she wants and needs to fit his or her own personal program and budget. They will save money on their federal and state taxes. The owner gains a boost in employee morale, a saving on payroll taxes, and some cost important controls.

	Without Cafeteria Plan	With Cafeteria Plan	
Total Monthly Payroll	$1,600,000	$1,225.000	
12 percent Payroll Taxes	$ -192,000	$ -147,000	
Monthly difference in payroll taxes			$45,000
Annual difference in payroll taxes			$540,000

Look at this example of how the “Below-the-line” and “Above-the-line” reductions compare:

	Without Cafeteria	**With Cafeteria**
Gross Monthly Pay	**$1,600.00**	**$1,600.00**
Nontaxable Benefits:		
• Group Medical	0	0
• Day Care	0	0
• Personal Medical	0	0
Taxable Income	$1,600.00	$1,600.00
• Federal & State Taxes	-222.00	-135.43
• Social Security	-120.16	-91.99
After tax benefits costs	-375.00	0
Spendable Income	$882.84	$997.58

Monthly increases in take-home pay	$114.74
Annual increases in take-home pay	$1376.88

B. TAX CONSIDERATIONS AT THE FEDERAL LEVEL

Except for the sale and exchange of financial securities (stocks, bonds, etc.), perhaps no other financial arena in the United States today is as closely regulated and monitored as that of employee benefits.

Law mandates such close scrutiny and backed by a multiple of regulations, each of which has a direct relationship with the other. The single most important purpose for these regulations is to very carefully define what can, and can't be done concerning cafeteria plans.

You need to be knowledgeable of the Internal Revenue code regulations on cafeteria plans. If a plan fails to meet **any** of the Code Requirements, it will be disallowed.

That means that it will no be regarded as a tax-deductible program for the employer. In addition to that, the employees covered under the plan would be regarded as being in constructive receipt of the benefit dollars being spent on their behalf and would be liable for the taxes on those benefits dollars.

The Internal Revenue Code sections that deal with a cafeteria plan are:

Section 125: Sets forth specific regulations on cafeteria plans.

Section 79: Establishes group term life insurance regulations.

Section 89: Provides nondiscrimination regulations.

Section 105: Defines additional nondiscrimination regulations.

Section 129: Sets forth regulations on dependent childcare.

1. REQUIREMENTS OF SECTION 125

If one were to view a cafeteria plan as a radio or television network, Section 125 would be the headquarters or flagship station. It is through this section of the code that the cafeteria plan draws one of its generic names, **Section 125**.

The IRS definition of a cafeteria plan is quite simple; any employee benefit program that allows a participant to choose among two or more benefits consisting of cash or otherwise nontaxable benefits is a cafeteria plan.

Amounts contributed to the program are excludable from the income of the participant to the extent that they choose "qualified benefits".

In this instance, a "qualified benefit" plan would be the traditional medical expense plans long associated with basic and major medical, group life insurance and both long and short-term disability plans.

The section goes on to include as qualified those amounts that were normally considered to be out of pocket expenses under a traditional group medical plan; Eyeglasses, deductible, dental expense, coinsurance, and so forth. Also included under the qualified banner are expenses incurred for day care centers for dependent children.

As you might notice, the section also tells you what a cafeteria plan isn't. Under the Code, the following are **not** considered to be part of a cafeteria plan.

Deferred compensation plans, if receipt of compensation is deferred beyond two and one half months after the close of the tax year, (December 31st); the plan is a deferred compensation plan.

Scholarship or fellowship programs. Rules for these programs in Section 1941.

Employer provided transportation, which is covered under Section 1987A.

Education assistance programs (as in training courses or night school classes for employees), which are controlled by Section 1989.

a) Who is Eligible to Participate?

There is only one rule for eligibility; No one can be required to complete more than three years of employment in order to be eligible to participate in a cafeteria plan.

Anyone meeting the eligibility rule must be allowed to participate no later than the first day of the first plan year beginning after they have satisfied the employment requirement.

b) Regarding Anti-discrimination

The rule is easy to understand. A cafeteria plan may not discriminate in towards **highly compensated employees** regarding eligibility, contribution to the plan, or benefits.

A highly compensated employee is defined as one whom,

- Is an officer of the sponsoring company with an income of $45,000 or more;
- Is a five percent owner of the sponsoring company;
- Is a member of the top 20 percent of the company earning $50,000 per year or more; or,
- Is an employee of the sponsoring company earning $75,000 or more per year.

c) The Test of Eligibility

All cafeteria plans must establish their eligibility provisions so that 90 percent of the non-highly compensated employees are eligible to participate and would, if they participated, receive a benefit of at least 50 percent of the largest benefit available to a highly compensated employee.

At least 50 percent of those eligible to join the cafeteria plan must be non-highly compensated employees.

To avoid these tax problems, and to assure that the plan is not discriminatory, the key and highly compensated employees must not receive more than 25 percent of the total benefits provided all employees during the plan year. This means that if total benefits for the year came to $100,000, the benefits paid to the key and highly compensated group cannot exceed $25,000 for that plan year.

That no plan provisions discriminate in favor of highly compensated employees.

d) What is a Key Employee by Definition?

An officer of the sponsoring company.

A five-percent or more owner of the sponsoring company.

A one-percent or more owner of the sponsoring company with $150,000 or more of annual compensation. One of the top ten individuals in terms of ownership in the sponsoring company.

As you can see, the definitions of a highly compensated employee and a key employee are much the same. The distinctions can be very subtle and important. This is true if you wish to gain plan approval by the IRS and to continue to have that plan tax approved.

Form 5500 must be filed annually showing the benefits paid to assure that the plan does not discriminate in favor of key and highly compensated employees.

If the plan does discriminate, it will be disqualified and all previous tax benefits received, such the reduction in taxable income and business deduction for premiums and expenses paid for by the employer, will be termed taxable income.

e) The Alternative Test

As the title implies, the alternative test can be used as an alternative to the eligibility test mentioned earlier.

The alternative test requires that at least 80 percent of the non-highly compensated employees must be covered at all times during the plan year. In addition, the plan must not contain any eligibility provision that discriminates in favor of highly compensated employees.

While the alternative test seems to be a more attractive method to meet the requirements of the Code, you should know that an 80 percent participation percentage at all times could be an extremely difficult objective to meet, especially in light of a high turnover industry or company.

A second caution is also in order: The alternative test could be amended in future years as sections of the code are reviewed by the IRS and new sections published.

f) Rules for Participation

If an individual participates in a cafeteria plan, he or she will not be eligible to use the medical insurance premiums, or additional medical expenses incurred during the tax year, as a deduction on Schedule A. The same holds true for the tax credit available for childcare.

Any funds left in a cafeteria plan account at the end of the tax year must be forfeited. (Use it or lose it!).

Profit sharing, 401(k), and stock bonus plans are the only deferred compensation plans allowed.

Amounts from one account cannot be used to pay expenses for another account.

A participant cannot make any changes in his or her account(s) during the year unless the participant terminates employment, gets married, has a child, or has a death in the immediate family.

g) Rules Regarding Reporting Requirements

The employer must report the following information each year:

- The number of employees of the employer;
- The number of employees eligible to participate under the plan;
- The number of employees actually participating in the plan;
- The total cost of the plan during the year;
- The number of highly compensated individuals in the company; and the name, address, and identification number of the employer; along with a description of the type of business in which the employer is engaged.

2. SECTION 125 CAFETERIA PLAN STATUS CHANGES-RULES 2000

In 2000, the IRS released new rules regarding when employees can change their cafeteria plan elections during a plan year. These rules went into effective on the first day of the plan year that started in 2001.

There are 12 events that could support a mid-year election change. Here is the summary of the events.

In general employees who experience any of the 12 events can change their elections for pretax premiums (medical, dental, life, disability, etc.) medical expense reimbursement accounts (medical FSAs) and dependent care reimbursement accounts unless noted otherwise.

The new rules generally allow more flexibility for employees, especially with regard to dependent care accounts. Employees can now change their elections mid-year if their day care costs increase or decrease or they change providers.

A Change in Status. In order for an employee to change his or her cafeteria plan election mid-year, a change in status event must have occurred and the employee's request to change must

be consistent with the event. In other words, the plan administrator should ask himself two questions:

Did the employee incur a change in status?

Does the change in status even affect the coverage eligibility of the employee, spouse, or dependent? The events that can qualify as a change in status event include:

Change in the employee's legal marital status: This includes marriage, divorce, the death of a spouse, legal separation, and annulment.

Change in the number of dependents: This includes, birth, adoption, placement for adoption, and death. Note: a dependent is defined as a tax dependent under Code Section 152.

Change in the employment status: This applies to any employment status change by the employee; his spouse or

dependents that affects benefit eligibility. Such events are termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave, a change in worksite; or a change from salaried to hourly, part-time to full-time. Union to non-union, etc.

Dependent satisfies (or ceases to satisfy) dependent eligibility requirements. A change may be allowed if a dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of age, gain or loss of student status, marriage, or any similar circumstances.

Residence change. If a change in residence affects the employee's eligibility for coverage, an election change may be allowed (e.g. an employee moves outside of an HMO's coverage area.)

Adoption Assistance Commencement or termination of adoption proceedings would allow an election change under an adoption assistance program.

Cost Changes. If the cost of coverage increases(or decreases) during a period of coverage, the employer can automatically increase (or decrease) the affected employee's contributions (not applicable to FSAs).

Election of Alternative Coverage if Significant Cost Increase. If the cost of coverage significantly increases during a period of coverage, employees can either make a corresponding change to their contributions or revoke their elections and choose similar coverage (not applicable to FSAs).

Significant Curtailment in Coverage. If coverage under a plan is significantly curtailed or ceases during a period of coverage, affected employees can revoke their elections and make new elections for similar coverage (not applicable for FSAs).

Addition (or elimination) of a Coverage Option. If a new coverage option is offered, affected employees can elect the newly added option. If an existing coverage option is eliminated, affected employees can elect another option (not applicable to medical FSAs).

Change in Spouse or Dependent Coverage under their Employer's Plan. An employee can change his election due to a change in his spouse or dependent's coverage under their

employer's plan. For example: John has elected family coverage under a calendar plan. His wife's employer's plan runs from July to June and she elects single coverage under her plan beginning July 1. John should be allowed to change his

coverage to single under the plan effective July 1, (not applicable for FSAs).

FMLA Leaves. An employee can (a) pre-pay his or her contributions on a pretax basis, (b) make contributions on a month-by-month basis (pretax if the employee is receiving salary continuation payments) or (c) catch up his or her contributions after returning to work.

401(k) Election Changes. Employees who elect to participate in the 401(k) option under a cafeteria plan can change their 401(k) deferral percentage during the year. (Only applicable to the 401(k) election).

HIPPA Special Enrollment Events. An employee can his cafeteria plan election to correspond with his/her special enrollment rights under HIPPA such as when he or she gains dependents through marriage, birth

or adoption or loss coverage under another group health plan. The special enrollment period that relates to birth of adoption may not be less than 30 days with coverage retroactive to the date of the event. (Applies to medical coverage and some dental, vision, and medical FSAs).

COBRA Events. An employee can increase his contributions during a year to pay for COBRA coverage. (Applies to medical coverage and some dental and vision coverage).

Judgments, Decrees or Orders. An employee can change his election under a cafeteria plan to add or drop medical coverage pursuant to a court order. (Applies only to medical, dental and vision **coverage and medical FSAs).**

Entitlement to Medicare or Medicaid. Entitlement to Medicare may allow an employee to drop or reduce health coverage under his employer's plan. (Applies only to medical coverage and medical FSAs).

3. SECTION 79: GROUP TERM LIFE INSURANCE

Section 79 covers the group term life insurance aspect of a cafeteria plan. Normally, employers paid life insurance premiums are not an excludable amount under a cafeteria plan. However, owing to its presence as a major employee benefit, cafeteria plans are allowed to include group term life coverage up to a maximum of $50,000 of the face amount.

Premiums used to pay in excess of that face amount are taxable income for the employee participant. The language covering eligibility and participation are identical to Section 125.

4. SECTION 89: NON-DISCRIMINATION

Section 89 is the Code section upon which the previous Code sections (especially Section 125) depend for the definitions of highly compensated individuals, the eligibility rules and the nondiscrimination rules.

Under prior law, discriminatory plans were permissible if an employer did not have a cafeteria plan.

As of January 1989, final regulations were effective for all plan years. As Section 89 is now fully effective and synchronized with the other Code sections, the discriminatory plans also must be amended, or face the loss of their tax-qualified status.

5. SECTION 105: MORE NON-DISCRIMINATION

Additional rules are: The cafeteria plan may not discriminate in favor of highly compensated employees regarding eligibility to participate. Additionally, the plan must provide the same benefits to non-highly compensated employees as provided to highly compensated employees

6. SECTION 129: DAY-CARE PROGRAMS

A taxpayer cannot set up a dependent care account within a cafeteria plan, receive the benefits of having his or her taxable income reduced by the amounts spent for dependent care, and then also take the tax credit on his or her form 1040.

a) Day-care assistance within the Cafeteria Plan

There is a $5,000 cap on the amount excludable from the gross income of participating employees. This cap is reduced to $2,500 for a married employee filing a separate return.

Individuals choosing the exclusion from taxable income available under the cafeteria plan are not allowed to claim the credit.

The plan may not discriminate in favor of highly compensated employees regarding eligibility.

Benefits provided to non-highly compensated employees must be at least 55 percent of the benefits provided highly compensated employees. Dependent care benefits under a cafeteria plan are generally taxable employees with non-working spouses.

7. OTHER FEDERAL LEGISLATION

IRS Code Sections regarding the cafeteria plan thus far have been mainly concerned with the dollar aspects of the program. Going beyond the financial areas, there are additional federal laws that affect the general conduct of the plan; its implementation; communication to participants; and its performance in the community. There are also federal laws governing plan participant rights, and the rights of family members. We will discuss these laws in the following section:

a) ERISA

(Employee Retirement Income Security Act of 1974), targeted for pension and profit-sharing plans, this act establishes standards and guarantees for plan benefits and for the security of trust funds set aside for future and present benefits.

Two major provisions of ERISA are that any benefit plan established under the United States Tax Codes must:

Be in writing and, Be communicated to all plan participants. Any plan participant has the right to examine the plan documents that established the plan. The documents may be examined on company property and at a time designated by the company, but they must be made available upon the request of a qualified plan participant.

At the same time, the plan must be communicated to all participants and those eligible to participate through what is called an SPD (Summary Plan Description). An SPD has to be written in plain English, subject to tests that measure the difficulty of the subject matter and the manner in which it is presented.

Other provisions dealing with communication include the requirement that plan participants be furnished a Summary Annual Report showing the financial condition of the plan at the close of the plan year. Lastly, should an event occur that affects the status of a plan, each participant must be notified of that event within a 30-day period.

ERISA established that a plan administrator be appointed with each sponsoring firm for handling communication both within the firm and with those agencies of the federal government charged with supervising benefit plans. These agencies include the Department of Labor, the IRS, and the Pension Benefit Guaranty Corporation. Since the latter deals only with the financial stability of pension and profit sharing plans.

We'll bypass PBGC and concentrate on the communication that must be furnished to the Department of Labor and the IRS.

The following must be filed with the DOL:

- Copies of the plan document establishing the plan.
- Copies of the Summary Plan Description furnished each plan participant.
- Copies of the Summary Annual Report that were furnished each plan participant, and,

- Copies of the summary of material modification, which serves to notify plan participants of plan changes.
- The following must be filed with the IRS:
- Either Form 5500, which is the annual tax return for plans covering 100 or more participants, or Form 5500-C, for plans with less than 100 participants.
- Form 5500-R, which is a tri-annual tax form filed in lieu of 5500 or 5500-C on the scheduled date. As documentation for the above, actuarial evaluations, experience data, and transactional information must be filed with the 5500 series. An optional form is Schedule P, a fiduciary's report, which can be attached to 5500.
- Form SSA, which is a statement of terminated participants with vested benefits.
- In addition to being filed with the IRS, these documents also must be made available to plan participants upon request.

b) TEFRA

This stands for (Tax Equity and Fiscal Responsibility Act of 1982). Again, the primary objective of the act was to focus on pension, profit sharing plans in general, and cafeteria plans specifically. In a general sense, TEFRA acted as an equity-producing device that "smoothed out" the differences in employee benefit plans that had been established over time. Many of these plans favored highly compensated individuals and were, by the language of TEFRA, discriminatory.

TEFRA acknowledged the existence of the plans and, through its provisions, required that the plans be identified to the IRS and DOL through their reporting mechanisms. Once identified, the plans had to be amended according to the legislative language of TEFRA and follow its regulations for continued enjoyment of a tax-favored status.

Most of the details spelled out in TEFRA are not vital to our study of cafeteria plans, however you should be aware of the act's handling of the following:

TEFRA established the definition of what is termed a "top-heavy plan," or a benefit plan that favors the key employees of a company by 60 percent or more in benefits.

TEFRA clarified the definition of a "key employee". This definition was adopted by the 1986 Tax Reform Act and incorporated into Code Language.

TEFRA also redefined certain provisions affecting group term life insurance, notably in the valuation of coverage in excess of $50,000 of face amount. Because of this action, group term life was included as a part of the benefit package of a cafeteria plan (subject to the "key employee" or "highly compensated" employee restrictions we discussed earlier).

c) COBRA

COBRA stands for the (Consolidated Omnibus Budget Reconciliation Act of 1985) and forms the last segment of our legislative cafeteria plans and employee benefit programs. In complying with those sections of the act affecting them, employers must report to the IRS, to the Department of Labor and to the Department of Health and Human Services. Regarding employee benefits, COBRA focuses on continuation of coverage for participants and/or their dependents that, because of one or more of the following qualifying events, are no longer eligible to receive benefits under the employer's group plan:

- Terminations of the participant's employment for any reason other than gross misconduct.
- Death of employee of divorce; and Dependent child reaching maximum age for coverage under the plan.

All employees and their dependents must be notified of their rights under COBRA when they become plan participants and when a qualifying event occurs.

If the participant and/or dependents with to extend their benefits, they must pay the employer the full monthly premium. The employer also may add a two-percent administrative fee. The extension can be for up to 36 months, depending on the qualifying event.

As we said in the beginning, no other financially oriented activity, other than stocks and bonds, is as closely monitored and regulated as that of employee benefits. Because of this, a word of caution is in order; **in case of doubt or confusion, consult with a third-party professiona**l, someone whose judgment and expertise are highly regarded by your client and insurance carrier. With the extreme volume of legislation involved and the interrelationship of all these laws, codes, and regulations, and outside opinion should clarify things significantly.

C. DESIGN OF A CAFETERIA PLAN

1. THE EMPLOYER'S OBJECTIVES

At some point in your initial interview with the decision-maker for your prospective client company, it is critical that you begin the process of identifying the employer's objectives for the company's employee benefit program, both as it stands today and his or her future objectives.

Chances are that the current program has not been reviewed for some time and, even if it has, the offs are that it should be reviewed in light of the trend toward two-income families, the rapid increase in medical care and hospitalization costs and the opportunities offered by the Tax Reform Act of 1986. Goals and objectives of the employer will usually center on the following topics:

a) Improving Current Benefits

All employers wish to improve the benefit package offered by their program. Unfortunately, improvements cost money, dollars that the company usually cannot afford at the present time. Discussion in this area should focus on "Forget the dollars involved right now, what would you want to do to improve the benefit package for your employees assuming you had unlimited funds?"

b) Containing Costs

Raising the issue of inflation should provide you with a great deal of information regarding the specific things an employer would like to do. One of the benefits of a cafeteria plan is that once the employees are involved, they have a direct link with the expense of the plan; they then are motivated to help find ways to contain costs.

c) Helping Employees Save Taxes

The 1986 Tax Reform Act cut back dramatically on many previously available tax deductions; the two-income married couple deduction; the increase to seven and one half percent of adjusted gross income in the threshold before any deduction can be taken for medical expenses; the loss of the state sales tax deduction; and the reduction in the consumer interest deduction.

Also, non-reimbursed employee expenses were moved from that of a direct deduction to where they have to exceed two and one half percent of adjusted gross income before any deduction could be taken. This excellent opportunity for the employer to demonstrate that he is aware of the problems and actually wants to do something to help.

d) Reducing Payroll Taxes

TRA'86 not only reduced the areas of tax relief for individuals, it also reduced many areas of corporate tax relief. Many cash-starved companies are eagerly searching for additional sources of funds, and cost reduction as well. There could easily be a ten-percent decrease in current payroll taxes with the establishment of a cafeteria plan. With a $100,000 monthly payroll, who wouldn't want to save $10,000 in taxes?

e) Employer/Employee Cost Sharing

Used in conjunction with a cost containment objective, a cafeteria plan offers a new opportunity for the employer and the employee to become partners in the operations of the company benefit plan.

Cost containment is part of this objective, but a cafeteria plan goes beyond that to offer new ways to use the benefit dollars wisely and use the savings to provide additional benefits elsewhere. This could be an opportunity for the employer and employee to become partners in cost containment but also provide future openings for improved or new plans.

f) Everyone Wins

The cafeteria plan offers a plan design in which everyone wins; the employees receive an increase in take home pay. They have the opportunity to choose their own benefits. The employer gains increased payroll tax benefits and a chance to control benefit costs. Also, the employer gains the improved morale of the labor focus and new funds for company operations.

2. PROGRAM IMPLEMENTATION

Once you have established the above benefits with the employer, you can now begin to implementation the program in stages. These stages can be established according to this schedule:

STEP 1. Move current contributions from after tax to before tax dollar status. Set up accounts that enable the participants to pay for eligible health care and dependent day care expenses.

STEP 2. Add additional accounts according to fulfillment of initial plan goals and experience. The employer can monitor costs and adjust plan design accordingly; the employee can gain experience in plan budgeting and choice selection.

Moving on Step 1 is of immediate concern if the employer wishes to attack the entire set of six objectives simultaneously. Not only will the savings become evident within short order, but also the current benefit package does not have to be disturbed one bit. What changes is merely the handling of the funds from one mode of operation to another.

Step 2 can be moved on gradually, as experience and familiarity with the program become more settled.

3. BRINGING THE EMPLOYEES INTO THE PROGRAM

a) Employee Surveys

A major part of the design process is gathering the statistics you need for the employee group. Not only is it important from an IRS standpoint regarding plan eligibility and participation, but you also will need information to determine your client's demographics.

How many young, single, people are there?

How many young, married?

How many two-income families?

How many with children, younger or older?

You must also identify the key employees and/or highly compensated employees and develop statistics for them.

You are beginning the **objective** survey and the **subjective** survey process. The employer can assist you with the objective survey giving you the bare bones numbers you need to help develop the plan design. This is essentially completing a census form for an employee group and should be familiar to you.

A subjective survey is used to gain information and statistics to help outline the options on the proposal to be submitted to the employer. This information includes:

Does the company have a 401(k) plan?

What type of retirement income plan does the company have? What type of benefits, such as dental insurance, optical coverage, prescription drugs, etc.

Do the current programs follow the company's fiscal year, taxable year or do they have their own plan year?

What type of communication system does the company employ, employee newspaper, outside consulting firm, etc.?

You must complete the employer's survey with the help of the company's payroll department, human resources department, or

financial accountant. The employee's survey could be conducted through employee meetings. Remember that this is the information-gathering stage, not a sales presentation. You must obtain as much information as you can, analyze it in a clear cut way, and present it to the decision maker in such as way as to allow a decision to be made without any doubts or questions.

4. THE PROPOSAL

All the information you have spent so much time and effort gathering and analyzing will be used to accomplish the following proposals:

The plan option(s) Proposal

The employer Proposal

The employee Proposal

a) The Plan Option(s) Proposal

The proposal to be presented to the employer will depend upon many sources of information; discussions with the employer and his or her representative, the objective survey of individuals, pay levels, marital status and position with the employer, the subjective survey and the employee survey that showed the level of benefits currently in place and those benefits that should be there, but, for one reason or another, haven't been implemented until now. Lastly, do not ignore budget. The spirit of the employer may be willing but the budget is weak.

Your own experience and instincts also have a bearing. You should be in a position to know what comparable companies in the same industry, size and demographic makeup are providing and what other companies have implemented. The actual plan design to be presented has a multitude of variations what will go to shape the plan proposal. No matter what the final plan turns out to be, it will follow one of the following models.

b) The Core Benefits

This was discussed earlier. In review, the method employed is to create a core of basic benefits what will be provided to each employee. Quite often, this core program is provided without cost to the employee. The purpose of the core program is to make sure that each employee has a solid plan of protection in

case of illness, injury, or death. The core could be the present program, or it could be a stripped down version consisting of basic life insurance, medical benefits and disability benefits.

If the present program is stripped down, with quite a bit of cost savings to the employer, consideration should be given to the creation of a credit system that would be the employer's contribution to the optional benefit fund from which employees could draw and help pay for their optional benefits.

c) Elective Benefits

This is the heart of a cafeteria plan for it is here that employees can pick and choose according to their needs. These can include, but are not limited to:

- Decreasing levels of deductible (i.e. $500 base on core, $400, $300, $200, $100, first dollar coverage);
- Decreasing levels of coinsurance (I.e. starting at 20 percent with the core plan, working downwards to fully paid for by the plan coverage);
- Increasing amounts of life insurance.
- The opportunity to purchase other types of benefit plans; dental coverage, eyeglasses, prescription drugs, etc.
- Additional amounts of long-term disability coverage.

Again, the plan design is subject to a wide variety of informational sources and limitations such as budget. However, creativity should be encouraged no matter what limitations exist. A cafeteria plan allows for a wide horizon of options in plan design.

d) The Modular Approach

This method could work with a core quite easily, or, a core could be developed as a stand-alone module. The principle of the modular approach is to design different modules that will fit the needs, pocketbooks, and desires of the company's employee population.

The benefits are pre-designed into packages containing various combinations of medical, dental, vision, dependent coverage, and so on. The individual employee can choose the module that fits his or her needs, desires, and ability to pay the premium. The modules can also be designed to fit specific groups of employees, such as employees with dependents in addition to a spouse, employees with working spouses, single employees, etc.

e) The Cost Sharing Approach

This is more of a method than a package. The point to be made with this approach is that the employer can continue to provide the current employee benefits program with no change. This approach is especially effective where an extensive benefit program has evolved over time. Rather than dismantle it because of future increases in premiums, the employer simply freezes the plan as it is, and continues to pay all the current premiums. Employees will be required to pay for their share of the future benefit costs.

f) The Credit Approach

As mentioned earlier, the credit approach is more of a process than a package or product. In this case, the current monthly expenses being paid by the employer are converted into employee credits. The employee then can add to the credit bank and purchase optional or modular benefit packages. In some IRS-approved plans, the employee could also **convert** credits, such as extra vacation time, into credits to be used for an annual physical exam.

g) Medical Care Reimbursement Accounts

A medical care reimbursement account can be a major supplement to a company's cafeteria plan. An individual who has established a "budget" for the medical expenses not normally covered by an employee benefit plan sets up this type of account. Through payroll deduction the participant according to the "budget" pays the money into the account he or she established.

As the individual incurs the medical expense, he or she obtains a receipt for the payment and submits that receipt to the plan administrator along with a request for reimbursement from the account. At year's end, all the dollars expended go to reduce taxable income dollar for dollar.

The purpose of this account is two-fold:

Most employee benefit medical plans do not pay for the "routine" medical expenses, school physicals, annual checkups, visits to the doctor for a minor complaint, or regular prescriptions such as insulin or high blood pressure medicine. These expenses can add up at the end of the year.

The employee who establishes one of these accounts will certainly be glad if he or she is facing surgery. The account can be budgeted for the out-of-pocket cash deductible and any coinsurance payments that have to be made for the medical plan.

Since most benefit plans do not pay for these types of expenses, the most logical place to obtain some form of relief would be through a deduction on federal income tax. Currently, only those medical expenses that exceed 7.5 percent of adjusted gross income can be deducted.

Being able to use the cafeteria plan as a dollar for dollar reduction in taxable income can be a welcome benefit for the individuals described above.

h) Day Care Expense Account for Dependents

This is a reimbursement account similar in approach to the medical expense account just discussed.

In this case, reimbursement is for expense incurred for dependent care, for the care of a dependent under the age of 15 or a mentally or physically disabled dependent of any age. The following restrictions apply to these accounts.

- The dependent care is necessary for the participant to work.
- Both the employee and spouse must work.
- The expense can't exceed the income of the spouse or employee; whichever is lower.
- The Day Care facility must be state-licensed.
- A dependent care program may not discriminate in favor of highly compensated employees in regard to eligibility, contributions, or benefits.
- There is a $5,000 cap or maximum on the amount that can be excluded from taxable income each year.

5. THE EMPLOYER PROPOSAL

If your cost proposal is going to include your own recommendations for insurance plans that will either replace or supplement the current group insurance plans, you will obviously need the three-year-look back experience records from the employer.

This is an IRS requirement and is used in the identification of highly compensated and key employees. You will also need the employee information you obtained through the objective and subjective surveys.

At this point, and depending on the goals and objectives of your client, you can establish separate cost estimates and tax savings statistics for "core plus" type account levels.

These would be supplemental/additional to the current plans, or those you are going to propose.

They could, for example, provide for lower deductibles; additional life insurance coverage up to a maximum of $50,000; additional long-term disability coverage; or increased levels of benefits for a dental insurance plan.

You can also propose additional plans that could strengthen the current program, such as prescription drugs; eyeglasses; dental insurance, etc.

You might also suggest the placement of a 401(k) plan if one is not in place, which can be included in a cafeteria plan and used as a "more bang for the buck" taxable income reduction.

Again, all of this depends upon the client's goals, the benefit dollars available from both employer and employee, and the status of the employee benefit program currently in place.

Whatever the final selection, if your plan design has included the employer's goals and the employee's needs and desires, everyone's interest will be served. If installed, an add-on account will help diversify and broaden the base of the core benefits, so that the employees will be able to select both the range and the depth of benefit plans that fit their needs. In a sense, this captures the basic concept of a cafeteria plan, because it is in this context that you are in a cafeteria, choosing that which suits you and your family's needs and lifestyle.

6. THE EMPLOYEE PROPOSAL

The objective here is to show the participant what his or her net income will look like once the cafeteria plan is established. This proposal can be used at the enrollment sessions – when you meet with each participant one on one to discuss his or her needs and the needs of the family members.

a) Benefit Enhancement Accounts

In addition to the optional accounts discussed earlier for the supplemental or modular plans, we will now discuss benefit enhancement accounts.

What's the difference? Under benefit enhancement, the plan design encompasses insurance programs to help make up the difference in the monthly retirement income benefits that are lost because the participants will be contributing less to their Social Security. Using a benefit enhancement plan we could replace each dollar of Social Security benefits lost with five dollars.

In addition, the participants should be made aware of the wide range of benefits and options available under a Universal Life plan, a Variable life plan, or a Variable/Universal life plan. These differ quite a bit from the traditional whole life plans and can offer life insurance protection plus and opportunity for investment gain, something no other investment program can provide.

The following plans could be included for benefit enhancement accounts:

- Additional life insurance coverage such as; Universal Life, Variable Life, Variable-Universal Life, Interest-Sensitive Whole Life;
- Retirement/survivor coverage;
- Additional long-term disability income coverage; or,
- A medical reimbursement plan.

These accounts can be funded with the tax saving dollars that result from the application of the core and core-plus accounts. In as much as the disability income and medical reimbursement plans would be able for reducing income, additional tax reductions would result from the purchase of these plans.

7. OTHER CONSIDERATIONS

So far, we have covered the basic objective for a cafeteria plan. Let us now cover some of the benefits to the employer:

- To help the employer attain his of her goals for an employee benefit program;

- To set up the plan so that the employer attains those goals, but so that the employees have the opportunity to pick and choose those benefits that will meet their needs; and
- To provide the benefit of a significant reduction in the employee's taxable income so that equally significant reductions can be made in the amount of federal and state taxes to be paid.

Lastly, the benefit enhancement accounts will provide protection plus investment opportunities not previously available to the employees.

In designing the cafeteria plan and the proposals to be presented to the employer and the employees, there are three other considerations that must be dealt with.

These are:

- Adverse selection,
- Dependent Care, and
- Forfeitures of account balances, at the end of the taxable year.

8. ADVERSE SELECTION

As anyone who has worked in the employee benefit field and individual health insurance market knows, the problem of adverse selection comes with both territories.

Adverse selection can generally be defined as the opportunity to select those benefits that the policyholder or certificate holder will utilize to the maximum, at the lowest possible out of pocket cost to that policyholder or certificate holder.

For example, adverse selection will occur when a benefit program is designed with a low deductible and a very high maximum payout – such as in a dental plan with $100 per family deductible, but with maximum benefits.

Adverse selection also can occur when a person, who is a policyholder or certificate holder, has t he ability to change or add on to his or her coverage once he or she has been accepted into the plan.

For example, someone could get into a plan by selecting a high deductible. Once in, they will then modify their contract to lower the deductible. How do you control adverse selection in a cafeteria plan? Some of these ideas can be included in your cafeteria plan:

- Impose limits and restrictions on any coverage that can be obtained at a later date once the participants have passed initial enrollment. For example, a two-year waiting period can be required before a change to a higher benefit amount or a lower deductible is allowed.
- Use the modular plan approach and price each of the modules accordingly. For example, a dental plan with a high utilization rate can be priced higher at some ages and benefit levels than pricing a disability income plan.
- The modules can also be packages so that high levels of benefits with similar selection patterns are not offered in the same benefit grouping. For example, do not team a $100 basic medical deductible with a $100 dental. Instead, team up a $200 medical plan deductible with a $400 dental plan deductible.
- Use a "carrot" approach. If the plan carries cost containment approaches such as preferred providers; second opinions; and hospital pre-admission testing, offer a bonus of a credit toward the deductible if the participant follows all the cost containment measures.

a) Dependent Care

The 1986 Tax Reform Act has helped individual taxpayers with the increase in the amount allowed for personal exemptions and the standard deduction and the liberalization in the rules for the adjusted gross income needed to qualify for the earned income credit.

These changes have altered the results that can be obtained with a cafeteria plan dependent care account. While taxable income can still be decreased dollar for dollar by the amounts allocated to dependent care expenses, the tax credit available for the same circumstances does result in a higher return for the individual that if he or she elected the cafeteria plan method.

During discussions with the employer and employees, the best course of action is to recommend the tax credit route for the dependent care. Should future tax legislation reverse directions and reduce the credit and increase taxes, we do have an apparatus to reduce taxable income with the cafeteria plan account.

9. ACCOUNT BALANCE FORFEITURES

The ZEBRA plans failed to gain approval from the IRS because the account balances at year's end were re-circulated at the start of the New Year. This gave rise to the question of constructive receipt.

In 1984, the IRS issued regulations on the now famous "use it or lose it" rule. Basically, all account balances must be down to **zero** by the end of the taxable year. If not, the balance is forfeited to the company.

A forfeiture could result because an account is "over-budgeted", hence the need for conservatism. It can also result because the expected expenditure did not materialize.

The company can donate all forfeitures to charity or offset the company's contribution to the traditional benefit costs (medical, major medical, life insurance, etc.), or contribute the money to an employee activity fund.

To make sure that ill feelings or misunderstandings do not occur, this rule must be explained thoroughly to all parties.

D. HOW TO ADMINISTRATE & COMMUNICATE THE PLAN

1. COMMUNICATION

Cafeteria plans are best communicated with a four-stage process that begins during the sale phase and continues well past the implementation of the program. This four-stage process consists of:

a) The Announcement Stage

You must follow the process by creating awareness of the cafeteria plan. You started this process with the decision-maker at your prospective client company allowed you to survey the employees to determine the company's demographics and the current structure of the benefit program.

During the announcement stage, it is best to define the current coverage and give the participants an explanation of the purpose of each plan; what is a medical plan? What would you have to pay for a particular accident or illness if the plan was not available? Follow these steps through all of the plans.

Once the company has approved the proposal you developed for the plan design, the formal process of communication goes into high gear. You now have the responsibility of conducting a series of participant meetings to fully explain the new program and how it affects each member of the company. Once you've established your meeting schedule, you can use the announcement of these meetings to arouse interest in the new program. Two effective tools to meet his objective are the payroll stuffer and the poster.

The payroll stuffer can be inserted in each employee's pay envelope on the payday closest to your scheduled meetings. The poster can be put up in the employer-approved areas where it can be seen and noted. Both poster and stuffer should carry the same message, which is:

"Announcing the Andex Company Cafeteria Plan, Increased benefits with tax savings. Increased Benefits! Tax Savings! More Take Home Pay! A new approach to our Benefits Program!"

The flip side of the poster and the payroll stuffer could read: ***"Every dollar you put into our new Cafeteria Plan Program means tax savings for you. The amount of savings depends upon your individual tax bracket and circumstances, but everyone will benefit!"***

2. ADMINISTRATION AND COMMUNICATION

a) Education

The goal of your employee meetings is to educate the employees regarding the benefit plans being offered and the

choices available to each participant. To achieve this goal, you're going to have to do a lot of preliminary work. You're going to need displays, an audio-visual presentation, and a live presentation.

The displays can be as elaborate or as simple as your budget and judgment allow. One set of displays could feature the company's benefits program as it stood before the introduction of the cafeteria plan; the other set could illustrate the options available under a cafeteria plan. Other displays could feature sample before and after-tax savings. Don't forget to include Social Security as a part of the display.

One topic that is bound to start a good deal of discussion is the increase in mandated social security contributions since 1970. You can show through a display how these contributions have increased in size ten times over this period.

An audio-visual format should form the foundation of your presentation. This is recommended because a professionally prepared script, colorful slides or overhead transparencies and an audiotape will serve to create interest, move things along efficiently and present the most important information in a thorough manner.

Also, you won't risk the chance of omitting something due to lack of time. Audio-visual presentations can be paced precisely, present the information clearly and save your energy for the "live" presentation, which is your responsibility.

During the live presentation, you can use your displays as learning tools. Illustrate the old program as compared to the wide range of options available under the cafeteria plan. Again, show examples of tax savings available with the cafeteria plan and go over the options, making sure everyone understands how the new program operates.

As you reach the close of the presentation, you can distribute a handout that will play an important role in the next communication stage. This tool is the benefits worksheet. The worksheet can be introduced by saying, " I know everyone wants to learn how he or she can earn that $675 per hour for this session.

I have an even better idea. You can nail down that $675 for this hour's session, plus another $100 besides. Your goal is to reduce your taxable income so you won't have to pay as much in taxes as you've been paying. What you have to do is find out just what you've been spending for all the items on this worksheet.

b) Administration and Communication

We'll need to work with some pretty accurate figures, so get your last year's check stubs receipts, and anything that can help you pin down these expenses as accurately as possible.

What you do NOT want to do is overestimate. If you do, and you set up an account that's going to have too much money in it at the end of the year, that money is forfeited. You lose it! It's gone forever! Now, who wants to jut guess on these figures?

3. THE ENROLLMENT PROCESS

Since you have done such a terrific job arousing the interest of all the company employees and educating them in the program. You are now ready to begin enrollment of the participants. If most of your income from this case is coming from the commissions off the sale of individual products available in the benefit enhancement accounts, this is the Super Bowl. Up to now, everything you've done was in anticipation of this event.

Since enrollments will vary from one company to another, from one program to another, etc., these are some general rules to keep in mind:

- The enrollment meeting room should be private and comfortable for your participant.
- Always have a supply of benefit work sheets and a calculator.
- Be informative and professional during each enrollment. DO NOT ASSUME that a participant does not want to enroll in any phase of the plan. Your job is to make sure that each employee clearly understands the benefits of the program.

If you will be enrolling with a software package:

- Make sure you know how to run the software. Hold a practice session well ahead of the enrollment session. Bring along a description of how to run the software with you.
- The participant should sit next to you in the full view of the computer screen.
- Check supply of printer paper before beginning each enrollment.

- Should a computer and software not be available, assemble the completed work sheets and have the tax savings calculated by your home office, or by an accountant.

a) ADMINISTRATION AND COMMUNICATION

And again, should you have a computer and software, be thoroughly familiar with its operation and the mechanics of working with the software. Try some practice sessions with the equipment prior to the enrollments, as you won't have time atenrollment to try to figure out how to do a calculation or work in an option.

4. THE FOLLOW-UP

You know the term "orphan policy owner." You also know the statistics on those individuals and families who, once having purchased a financial product or an insurance product, never see the person from whom they purchased the product again.

This type of situation cannot exist in a cafeteria plan. At a minimum of once a year, essential follow up work must be done. The recommended schedule is twice a year follow up visits to your client.

These follow up visits are not to be confused with the annual re-enrollment session that must be scheduled at the end of the year. Since participants have the right to amend their program once each tax year, a re-enrollment session is required.

The purpose of these follow up visits is to check on the program of the program, see if there are any questions that have come up since your last visit, schedule meetings with participants who have any special requests or problems and especially, show your concern for everyone's welfare and appreciation for the opportunity to be of service.

a) Administration

An effective administration system for a cafeteria plan usually consists of the following:

- An employee statement of account.
- A company statement of account.
- A discrimination report.
- A disbursement record.

- Message file.
- COBRA file.

5. ADMINISTRATION AND COMMUNICATION

a) Statement of Account for the Employee

This is a computerized report showing each employee-participant in the plan the transactions that took place over the

transaction period (I.e. monthly, or quarterly). It shows the activity that occurred in the accounts selected by the participant, the budgeted dollars, and the amounts expended.

Each account is maintained by the administrator for the participant and should be accounted for on the report sent to the participant. Of special importance are contributions that were budgeted to be spent, but, as, yet, have not been spent. (I.e., a budget for eyeglasses at $200 that has not been spent). These should be pointed out to the participant in a footnote to his or her statement.

Account overages of this kind cannot be transferred from one account to another (i.e., medical expenses to dependent care) and if the year ends without the money being spent. It is forfeit.

b) Statement of Account for the Company

The company should receive a regularly scheduled report from the plan administrator showing the volume of transactions occurring within the plan, just the same as the participants. Again, you want the report to show names of persons, amounts involved, budgeted amounts any discrepancies. Amounts owed by the company should be indicated prominently.

c) The Discrimination Report

Of extreme importance to the company is a discrimination report. This will show the benefit amounts involved for all key and highly compensated employees, whose total benefit amounts are not to exceed 25 percent of the overall benefit amounts.

Remember, the IRS requires that the above information has to be filled in and that the final test for discrimination is based on disbursements.

d) The Disbursement Record

This would be the documentation for the reports given the company on a regular basis. It could be reserved as to be provided on a “on demand” basis by the company; if so requested, given to the company on a regular schedule.

6. MESSAGE FILE

This file is self-explanatory; messages exchanges between all parties involved in the plan should be maintained.

7. ADMINISTRATION AND COMMUNICATION

a) C.O.B.R.A. file

Remember the employee/dependent rights to benefits we discussed earlier and how COBRA protected those rights? Remember that this is the principle-monitored program handled by the IRS, the Department of Human Services and the Department of Labor. There are computer software packages available to help you administer a cafeteria plan in accordance with the COBRA regulations.

Your client already may have such a software package since COBRA is an across the board requirement affecting traditional health plans as well as cafeteria plans.

Also tied with an effective administration system are claims handling maintenance of the plan document, reports filed with the monitoring agency or agencies, the Summary Plan description and its amendments, election and amendment election forms, enrollment records and the annual filings for the IRS: 5500-C, or 5500-R.

Effective communication and administration are the foundations upon which a profitable cafeteria plan rests. Without communication, the participants won't have the knowledge upon which to base a decision. Without administration, the program won't be able to function, much less file the necessary reports with the federal government agencies involved. Luckily, a PC and related software can be of tremendous assistance in these areas, as well as the consulting firms that exist to help handle these details.

E. SUMMARIZING CAFETERIA PLANS

1. SECTION 125

Today's record high costs for benefits are making it more expensive than ever for employers to provide quality benefits for their employees. Many company's financial stability is being undermined as a result of this cost.

Section 125 of the Internal Revenue Code, enacted by Congress in 1978, allows companies to give their employees the opportunity to pay for benefits on a pretax basis. Pretax benefits lower payroll related taxes for both the employer and employee.

With Section 125, employers have the power to establish tax-advantageous programs that can significantly enrich their current benefits plans.

Section 125 offers several alternatives; three of the most common are Premium Only Plans, Flexible Spending Accounts & Cafeteria Plans.

a) PREMIUM ONLY PLANS (POP)

This type of plan allows employees to make their contributions to group health and group term life insurance with pre-tax dollars.

A Premium Only Plan creates no new benefits. The employer is simply offering a way to obtain favorable tax treatment on benefits already offered.

Here's how it works:

- Employees' premium contributions are automatically deducted from their salaries before taxes are taken out.
- Taxable income is reduced by the amount contributed, so employees pay less in taxes and have more take-home pay.
- With employee pre-tax income lowered, employers pay less in Social Security (FICA) payroll taxes. (Individuals should consult their tax advisor for applicable state legislation.)

A POP is the simplest type of section 125 plan, and it requires low maintenance once it has been set up.

b) Flexible Spending Account

This plan allows employees to use pre-tax dollars to pay dependent care expenses and medical bills not covered by their insurance.

Usually offered in conjunction with a POP, the FSA is a budgeting tool that can help take care of out-of-pocket expenses such as day care, dental and optical care deductibles, co-pays, and prescription drugs.

Like a POP, an FSA helps pay for itself by increasing employee take-home pay while decreasing employer payroll taxes.

Here's how it works:

An employee decides how much of their salary should be set aside before taxes are calculated.

This amount is automatically deducted from their paycheck every pay period, just like any other payroll deduction, and is deposited into their FSA account.

The employees would pay their out-of-pocket expenses upfront, submit a claim and documentation, and a reimbursement is made from their own account.

Out of Pocket Expenses Include:

- Eyeglasses and contact lenses
- Medical insurance deductibles
- Prescriptions
- Co-payments
- Orthodontia
- Chiropractic services
- Dental treatments
- X-ray and laboratory services

Dependent Care Expenses Include:

- Care for a child under the age of 13
- Care for a disabled spouse or dependent incapable of caring for him/herself
- Household-related services (i.e., visiting nurse)

The flexibility of a FSA plan makes it the best option for small to medium-sized companies.

Full Cafeteria Plan

A full cafeteria plan usually includes POP and FSA features.

Under this plan, employees receive a lump sum of money to spend on their benefits and the employer provides a menu of benefit options for employees to choose from.

If the employee does not use all of the allotted money towards benefit costs, whatever is leftover will be included in the employee's taxable income for the year.

Full cafeteria plans are popular in very large companies. Due to the high level of flexibility offered to the employees.

A Cafeteria Plan is the most complex alternative because it changes the way employees receive benefits.

Instead of providing a determined set of benefits (such as a medical plan and $50,000 of life insurance), each employee is given an amount of "benefit dollars" roughly equal to the employer's expenditure for that person's benefits. The employee then chooses from a menu of benefits and determines those thatbest fit his or her needs. Of course, the employer determines the available options.

Although a Cafeteria Plan is more expensive to implement, employers ultimately save money through the more efficient plan design, as well as the tax-effective and cost effective vehicles of delivery.

Why does the government allow section 125 cafeteria plans?

The pre-tax dollar incentive provided by section 125 helps both employers and employees control escalating health care costs. Regardless of which type of section 125 plan is incorporated in the business, whether a premium only plan, (POP Plan), medical flexible spending accounts, (FSA), or dependent care flexible spending accounts the tax advantages are the same.

c) IMPORTANT DEFINITIONS

Cafeteria Compensation Plan: IRS Code Section 125. A group benefit plan established by an employer for the employees. Cafeteria Compensation Plans are authorized under the U.S. Internal Revenue Code, Section 125. Also referred to as a Section 125 Plan and a Flexible Benefits Plan.

Reimbursement Accounts:

A non-insurance plan established for employees that allows them to set aside certain funds, tax free, to be used to reimburse the employee for expenses authorized under the plan.

Medical Reimbursement accounts can be established to reimburse employees for out-of-pocket expenses not covered under the group health and medical plan such as annual deductibles, employee's co-insurance share, prescriptions, and the like.

Dependent Care accounts can be established to reimburse employees for out-of-pocket expenses relating to dependent care. A Dependent Care Spending Account (DCSA) is used to pay for those costs of dependent care that enable the employee to work. This care may be for a child under the age of 13 or a spouse or other adult dependent who is incapable of self-care.

These accounts may be funded by employee elections through salary reduction or they may be employer funded.

They are also called un-reimbursed medical accounts and flexible spending accounts.

Employees may participate in reimbursements, without regard to participation in other medical plans.

Medical/Dental Reimbursement Account: IRS Code Section 105.

Expenses not covered by the employer plan may qualify as eligible expenses reimbursable under Accident and Health coverage.

If the plan is not totally funded or paid by the employer's medical plan, employees may make annual elections and have these deductions placed in his/her Medical/Dental Reimbursement Account.

Annual elections are most generally payroll deducted from the employee's paycheck on a per pay period basis, and deposited in the employee's Reimbursement Account. These payroll deduction amounts are made on a Pre-Tax basis.

When an eligible expense is incurred, the employee submits these expenses (much like filing an insurance claim form) and completes an expense voucher from which they are reimbursed on a Pre-Tax basis.

Dependent Care Assistance: IRS Code Section 129. Dependent Care Assistance for employees is covered under Code Section 129, and may be provided through use of reimbursement accounts, flexible spending accounts or actual on site facilities.

Elections and benefits are limited to $2,500 or $5,000 annually depending on whether the employee's tax filing status is joint or separate.

Elections are payroll deducted on a Pre-Tax basis and placed in the employee's Dependent Care Assistance Account.

As dependent care expenses are incurred, the employee submits the expense with a completed claim voucher and is reimbursed from his/her account on a Pre-Tax basis.

It is important to note that Dependent Care Reimbursement expenses do not have to be just for children. These expenses may also cover expenses for elder care.

Accident & Health Plans: Excluded for gross income via Code Sections 105 and 106.

Premium costs for these programs are eligible under Section 125. These programs would include employer sponsored Personal Accident plans, Accidental Death & Dismemberment plans, Disability plans and Cancer/Intensive Care plans, etc.

Only plans that have no cash accumulations or return of premium features (even as optional riders) are eligible for inclusion.

Term Life Insurance: IRS Code Section 79.

The expense of the first $50,000 is excluded from gross income under Code Section 79. Amounts above $50,000 may be included on the employee's menu of benefits, but are not payable on a Pre-Tax basis.

In addition, amounts other than "de minimus" amounts are not deductible for the employee spouse and or children.

2. SECTION 125 IRS CODE – CAFETERIA PLANS

a) A. General rule

Except as provided in subsection (b), no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.

b) Exception for highly compensated participants and key employees

Highly compensated participants In the case of a highly compensated participant, subsection (a) shall not apply to any benefit attributable to a plan year for which the plan discriminates in favor of— highly compensated individuals as to eligibility to participate, or highly compensated participants as to contributions and benefits.

c) Key employees

In the case of a key employee (within the meaning of section 416 (i)(1)), subsection (a) shall not apply to any benefit attributable to a plan for which the statutory nontaxable benefits provided to key employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. For purposes of the preceding sentence, statutory nontaxable benefits shall be determined without regard to the last sentence of subsection (f).

Year of inclusion for purposes of determining the taxable year of inclusion, any benefit described in paragraph (1) or (2) shall be treated as received or accrued in the taxable year of the participant or key employee in which the plan year ends.

d) B. Discrimination as to benefits or contributions

For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan does not discriminate where qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants.

e) C. Cafeteria plan defined

For purposes of this section—

1. In general - The term “cafeteria plan” means a written plan under which—
   a. all participants are employees, and
   b. the participants may choose among 2 or more benefits consisting of cash and qualified benefits.
2. Deferred compensation plans excluded
   a. In general - The term “cafeteria plan” does not include any plan which provides for deferred compensation.
   b. Exception for cash and deferred arrangements Subparagraph (A) shall not apply to a profit-sharing or stock bonus plan or rural cooperative plan (within the meaning of section 401 (k)(7)) which includes a qualified cash or deferred arrangement (as defined in section 401 (k)(2)) to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a trust under such plan on behalf of the employee.
   c. Exception for certain plans maintained by educational institutions
   d. Subparagraph (A) shall not apply to a plan maintained by an educational organization described in section 170 (b)(1)(A)(ii) to the extent of amounts which a covered employee may elect to have the employer pay as contributions for post-retirement group life insurance if—
      i. all contributions for such insurance must be made before retirement, and
      ii. such life insurance does not have a cash surrender value at any time.

For purposes of section 79, any life insurance described in the preceding sentence shall be treated as group-term life insurance.

f) D. Exception for health savings accounts

a. Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings account established on behalf of the employee.

E. Highly compensated participant and individual defined For purposes of this section—

1. Highly compensated participant

The term "highly compensated participant" means a participant who is—

a. an officer,
b. a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the employer,
c. highly compensated, or
d. a spouse or dependent (within the meaning of section 152) of anindividual described in subparagraph (A), (B), or (C).

2. Highly compensated individual

The term "highly compensated individual" means an individual who is described in subparagraphs [1] (A), (B), (C), or (D) of paragraph (1).

g) Qualified benefits defined

For purposes of this section, the term "qualified benefit" means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter (other than section 106 (b), 117, 127, or 132). Such term includes any group term life insurance which is includible in gross income only because it exceeds the dollar limitation of section 79 and such term includes any other benefit permitted under regulations. Such term shall not include any product which is advertised, marketed, or offered as long-term care insurance.

h) Special rules

1. Collectively bargained plan not considered discriminatory For purposes of this section, a plan shall not be treated as discriminatory if the plan is maintained under an agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and one or more employers.

2. Health benefits

For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan which provides health benefits shall not be treated as discriminatory if—

a. contributions under the plan on behalf of eachparticipant include an amount which—equals 100 percent of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants similarly situated, or equals or exceeds 75 percent of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan, and contributions or benefits under the plan in excess of those described in subparagraph (A) bear a uniform relationship to compensation.

3. Certain participation eligibility rules not treated as

discriminatory for purposes of subparagraph (A) of subsection (b)(1), a classification shall not be treated as discriminatory if the plan— a. benefits a group of employees described in section 410 (b)(2)(A)(i), and meets the requirements of clauses (i) and (ii):

i. No employee is required to complete more than 3 years of employment with the employer or employers maintaining the plan as a condition of participation in the plan, and theemployment requirement for each employee is the same.

ii. Any employee who has satisfied the

employment requirement of clause (i) and who is otherwise entitled to participate in the plan commences participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year.

4. Certain controlled groups, etc.

All employees who are treated as employed by a single employer under subsection (b), (c), or (m) of section 414 shall be treated as employed by a single employer for purposes of this section.

i) Cross reference

For reporting and record-keeping requirements, see section 6039D.

j) Regulations

The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

3. IRS FREQUENTLY ASKED QUESTIONS REGARDING CAFETERIA PLANS

These frequently asked questions and answers are provided for general information only and should not be cited as any type of legal authority.

How does a cafeteria plan work?

Code section 125 makes it possible for employers to offer their employees a choice between cash salary and a variety of nontaxable benefits (qualified benefits).

A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to the principles of constructive receipt.

Qualified benefits include health care, vision and dental care, group-term life insurance, disability, adoption assistance and certain other benefits. See Sections 125(a), 125(f), 79, 105, 106, 129 and 137 of the Code.

Employers may also offer flexible spending accounts to employees under a cafeteria plan that provides coverage under which specified, incurred expenses may be reimbursed. These include health flexible spending accounts for expenses not reimbursed under any other health plan and dependent care assistance programs.

Employer contributions to the cafeteria plan are usually made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits.

Salary reduction contributions are not actually or constructively received by the participant. Therefore, those contributions are not considered wages for federal income tax purposes. In addition, those sums generally are not subject to FICA and FUTA. See Sections 3121(a)(5)(G) and 3306(b)(5)(G) of the Code.

The above discussion provides only the most basic rules governing a cafeteria plan. For a complete understanding of the rules, see the proposed and final regulations under Code section 125.

What if the employer does not have a section 125 plan, but offers health insurance coverage to a domestic partner and his or her child? Is this a taxable fringe benefit to the employee?

Employer-provided coverage under an accident or health plan for individuals other than the employee, the employee's spouse or dependents is included in the employee's gross income (section 106) the term "dependent" is defined in section 152(a) of the Code. A domestic partner would not qualify unless the dependency tests are met.

Is there a filing requirement for a town that maintains a cafeteria plan?

Generally, NO. If you only have a cafeteria plan, you are not required to file Form 5500 or Schedule F. However, if you have a welfare benefit plan, you may be required under Department of Labor regulations to file a return for that plan.

A town has a cafeteria plan (section 125 plan), which offers dependent care assistance. The benefits received by an employee exceed $5,000. How is this benefit reported on Form W-2?

An employee can generally exclude from gross income up to $5,000 of benefits received under a dependent care assistance program each year. The limit is reduced to $2,500 for married employees filing separate returns.

The exclusion cannot be more than the earned income of either the employee or the employee's spouse. The total dependent care benefits the employer paid to the employee or incurred on the employee's behalf (including amounts from a section 125 plan) should be reported in Box 10 of Form W-2. Any amount over $5,000 should be included in Boxes 1, 3, and 5, as "wages," "social security wages" and "Medicare wages."

What remuneration under a cafeteria plan is not subject to FICA, FUTA, Medicare tax or income tax withholding? Generally, qualified benefits under a cafeteria plan are not subject to FICA, FUTA, Medicare tax, or income tax withholding. However, group-term life insurance that exceeds $50,000 of coverage is subject to social security and Medicare taxes, but not FUTA tax or income tax withholding, even when provided as a qualified benefit in a cafeteria plan.

Adoption assistance benefits provided in a cafeteria plan are subject to social security, Medicare, and FUTA taxes, but not income tax withholding. If an employee elects to receive cash instead of any qualified benefit, it is treated as wages subject to all employment taxes.

A town has a cafeteria plan which offers health care benefits to domestic partners. Does a domestic partner and his or her child qualify to be covered under the health plan?

Cafeteria plans can offer health insurance to employees, their spouses and their dependents. The domestic partner and dependents in this case may not be participants in a cafeteria plan because they are not employees, but the plan may provide benefits to them.

For example, a domestic partner may not be given the opportunity to select or purchase benefits offered by the plan, butthe domestic partner may benefit from the employee's selection of family medical insurance coverage or of coverage under a dependent care assistance program.

If the domestic partner and his or her child do not qualify as the employee's dependents, those individuals may receive coverage under the cafeteria plan on a taxable basis. This means that the fair market value of the coverage for the domestic partner and his or her child must be included in the employee's wages for purposes of income tax withholding, FICA and FUTA taxes.

Child and Dependent Care Credit & Flexible Benefit Plans

I paid into a dependent care benefits plan and the amount is shown in Box 10 of my Form W-2. However, the cost paid to the childcare provider was more.

Can the additional expense not paid into the dependent care benefits plan and not shown in Box 10 of the W-2 be claimed on Form 2441?

That depends on the amount you elected to have contributed to the flexible spending arrangement. The exclusion from income for employer-provided benefits has a maximum dollar amount, while the credit for dependent care expenses has an annual dollar limitation.

You must reduce the dollar limits by the amount of excludible dependent care benefits. If you had expenses that you paid yourself and the employer provided benefits were less than the applicable dollar limit, you can also claim the credit.

Complete Part III of either Form 2441 (PDF), Child and Dependent Care Expenses, or Form 1040A, Schedule 2 (PDF), Child and Dependent Care Expenses for Form 1040A Filers, to determine the excluded benefits and whether you can claim the credit.

The maximum applicable percentage is 35 percent and the allowable employment-related expenses are $3,000 for one qualifying individual and $6,000 for two or more qualifying individuals. Thus, the maximum credit is $1,050 for one qualifying individual and $2,100 for two or more qualifying individuals.

If my employer did not put the amount I paid into a flexible spending account for dependent care in Box 10 on my Form W-2, can I claim the Child and Dependent Care Tax Credit? If the flexible spending account was an eligible plan under Internal Revenue Code Section 125, the amount of the salary reduction that was contributed to your account should appear in box 10 of your Form W-2. Request a corrected Form W-2 from your employer.

You may claim the child care credit if the contribution to your flexible spending account was less than your annual dollar limitation for eligible expenses. Even if you cannot claim the credit, you must complete Part III of either Form 2441 (PDF), Child and Dependent Care Expenses, or Form 1040A, Schedule 2 (PDF), Child and Dependent Care

Expenses for Form 1040A Filers, to exclude your employer provided benefits from your income. If the amount you paid into a flexible spending account reduced your wages in box 1 of Form W-2, it is considered an employer provided benefit.

I was under the impression that a Dependent Care Benefit Plan would benefit me, not penalize me with an increase in taxes. How can my employer say they provided a benefit in

the total amount of $3,000 in W-2, Block 10 when I had $3,000 in wages set aside for dependent care benefits?

The actual mechanism for this type of plan is an agreement to voluntarily reduce your salary in return for an employer-provided fringe benefit. These plans must be set up this way because you have a choice of whether to receive the cash wages or the benefits, which would make the benefit taxable to you. Therefore, the benefits are actually employer provided or funded. You are receiving a tax benefit because you are not paying taxes on the money that is set aside.

I am self-employed, but did not have a net profit last year. Is it correct that we do not qualify for the Child Care Credit on our joint return even though my wife received dependent care benefits on her W-2 box 10?

Generally, yes. When you complete Part III of Form 2441 (PDF), Child and Dependent Care Expenses, which you must do to claim excluded benefits, you will determine the smallest of:

- your dependent care benefits,
- your qualified expenses,
- your earned income, or
- your spouse's earned income.

If you had a loss from self-employment and no other earned income, your earned income would be $0, unless you can use one of the optional methods on Form 1040, Schedule SE (PDF), Self-Employment Tax. That would mean that the amount in box 10 of your wife's Form W-2 would have to be included in income. (For more information on the optional methods of computing self-employment tax, refer to Form 1040, Schedule SE Instructions, Self-Employment Tax.

For a spouse who is a full-time student or incapable of self-care, the spouse's earned income is deemed to a fixed monthly amount base on whether there is one qualifying individual or two or more qualifying individuals in the household. However, this income is deemed to be earned only by one spouse for any given month.

Is a flexible spending account for dependent care a dependent care benefit?

Yes. If the flexible spending account is providing you with a dependent care benefit, then it should be reported in box 10 of your Form W-2. These accounts are funded through salary reduction, so the contribution to the account is considered an employer contribution.

When you receive a dependent care benefit from your employer, you must complete Part III of Form 2441 (PDF), Child and Dependent Care Expenses, (or Form 1040A, Schedule 2 (PDF), Child and Dependent Care Expenses for Form 1040A Filers) to see if the benefits are fully excluded from income.

You may be able to also claim a credit for child and dependent care expenses if the excluded benefits are less than the dollar limit on qualified expenses for the credit.

What publications are available that would explain the taxation policy for Cafeteria Plans and Health Care Flexible Spending Accounts?

Information on Health Care Flexible Spending Accounts and Cafeteria Plans can be found in the following sources listed below:

- Publication 15-B (PDF), Employer's Tax' Guide to Fringe Benefits
- How does a cafeteria plan work?
- Questions & Answers regarding Cafeteria Plans

- Health Care Flexible Spending Accounts
- Questions & Answers on HSA

Is an employer required to provide the IRS with a signed receipt from a dependent care provider in order to release funds that are withheld from an employee's pretax salary and deposited to a dependent care flexible spending account?

The Internal Revenue Service does not specify a method for the documentation of reimbursable expenditures. Good accounting and business practices should dictate the type and sufficiency of documentation provided by employees

who claim reimbursable expenses. Please review the plan document to determine if it specifies the type(s) of documentation acceptable.

Can an employer pay for health care costs of an employee as a fringe benefit?

Yes, generally an employer may pay for health care costs of an employee as a nontaxable fringe benefit. Refer to Publication 535, Business Expenses, for a complete discussion of employee benefit programs.

If our company pays for the employee's health care costs directly to the medical facility, as opposed to a reimbursement, is the employee benefit reported on Form W-2 and subject to social security withholding?

Health care costs paid directly to the medical facility is normally a nontaxable employee benefit provided that it is paid as part of an accident and health plan. Refer to Publication 535, Business Expenses, for more information on employee benefit programs.

If an employer pays health insurance benefits for the employee and dependents, are both the employee's and the dependent's benefits income to the employee?

If an employer provides health insurance for the employees, the benefit provided is generally not taxable to the employee. An employer can generally deduct the cost of a group health plan on the "employee benefit programs" line of their business income tax return.

Group health plan defined:

> This (including a self-insured plan) is a plan that provides medical care to your employees, former employees, and their spouses and dependents. The plan can provide care directly or through insurance, reimbursement, or otherwise. The employer can exclude the cost of providing group health insurance to an employee from his or her wag