



Medicare

Making the choice
that's right for you

Humana®



You have many options when choosing your Medicare coverage

The right one for your friends — or even your spouse — may not be the right one for you. Humana developed this booklet to help you decide which option is best for you.

Whether that's Original Medicare, Original Medicare with a supplement or a Medicare Advantage plan, Humana offers this guide to help you feel comfortable in making your selection.

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Medicare – the basics



- Medicare is the U.S. government’s largest health insurance program. It serves more than 55 million people,¹ covering U.S. citizens and legal residents 65 and older, and people who qualify on the basis of disability or end-stage renal failure (ESRF).
- The Centers for Medicare & Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, runs Medicare.



¹Centers for Medicare & Medicaid Services (Ed.). (2015, July 28). On its 50th anniversary, more than 55 million Americans covered by Medicare. Retrieved from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html>

Medicare – the parts

Medicare is divided into parts.

A

B



Parts A and **B** are Original Medicare and are offered by the **federal government**.

Parts A and **B** cover much of your medical care but not all of it, and you pay a deductible and coinsurance when you use it. That's why many people buy coverage with benefits beyond those included in Original Medicare.

C



Part C is Medicare Advantage, offered through **insurance companies**.

D



Part D is a Medicare prescription drug plan, offered by **insurance companies and other private companies**.

Medicare – coverage

Most people get Medicare coverage in one of these two ways:

1. Original Medicare plus a prescription drug plan and a Medicare supplement plan.
2. Medicare Advantage, which includes parts A and B from Original Medicare. It often includes extra services at no additional cost and prescription drug coverage.



Medicare **Part A** is hospital insurance. It helps cover hospital, skilled nursing, home health and hospice care.



Medicare **Part B** is medical insurance. It helps cover doctor visits, outpatient care and preventive services. It also helps pay for services Part A does not cover, like occupational and physical therapies.



Medicare **Part C** is Medicare Advantage (MA). It covers everything parts A and B cover. It often covers other services, such as dental, vision and wellness programs.



Medicare **Part D** is a Medicare prescription drug plan. This is optional prescription drug coverage for people with Medicare. Part D coverage is only available from private companies contracted by the federal government. By law, all Part D plans must offer at least the basic benefits required by Medicare.



Things to consider

Now that you know more about how Medicare works, consider the following:

Cost: How much will you pay for premiums, deductibles, coinsurance and copayments?

Benefits: Does the plan include prescription drug coverage or other additional benefits?

Doctor and hospital choice: Do the doctors, hospitals, pharmacies and other providers you prefer accept the plan?

Convenience: Does the plan require you to complete claim forms? Are providers who accept the plan nearby? Can you get prescription or specialty drugs through the mail?

Your healthcare history: How often have you needed care over the past few years? Are you fairly healthy, or do you have a chronic condition that requires ongoing care?

Your healthcare future: Even if you don't spend much on prescription drugs now, you may in the future. That's when Medicare Part D can help cover the cost of prescription drugs.

Are you comfortable with the coverage provided by Medicare Part A and Part B? Are you able to pay a separate premium for added benefits? A Medicare supplement plan may help cover some unexpected healthcare costs, like a long-term hospital stay.



Figuring your coverage costs

Medicare Part D prescription drug coverage, Medicare Advantage plans, and Medicare supplemental insurance have additional and separate premiums from Original Medicare. Your costs will differ depending on the coverage you choose. The cost for a Medicare Advantage plan depends on whether the plan charges a monthly premium and pays any of your monthly Part B premium.

Original Medicare and Medicare Advantage plans both cover routine services. Medicare Advantage plans are required to cover everything covered by Original Medicare, including coverage for services that Medicare considers medically necessary.

If you choose a Medicare Advantage plan, you never “lose” your Medicare coverage. You remain a member of the Medicare program. You simply choose to receive your inpatient and outpatient Medicare benefits through a private insurance company and have the option to pay an additional plan premium for managed care and additional coverage. Costs and coverage can change each year.

Note: You must have both Medicare parts A and B to join a Medicare Advantage plan.



About Medicare Advantage

Medicare Advantage plans usually include extra benefits and services and can reduce out-of-pocket costs. Some Medicare Advantage plans include:



- **Fitness programs**
- **Gym membership**
- **Mail-delivery pharmacy access**
- **Health education programs**
- **A 24-hour nurse advice line**

In addition, many Medicare Advantage plans have optional supplemental benefits. These let you customize your insurance to meet your needs. For example, you could add dental or vision coverage. There's an added cost for optional supplemental benefits.

Types of Medicare Advantage plans include:

- **Health maintenance organization (HMO):**
A primary care physician arranges your healthcare in the plan's network
- **Preferred provider organization (PPO):**
Choose any provider, although you'll probably pay less for in-network services
- **Private-fee-for-service (PFFS):** More freedom to choose providers may be available, however a network arrangement may still apply



Understanding the Part D coverage gap

The **coverage gap**, also known as the donut hole, happens when you have to pay a higher percentage of your drug costs. The figures are adjusted each year.

Here's how it works:

- Phase 1** Your plan pays a higher percentage of your prescription drug costs, until you reach a specified amount
- Phase 2** When you reach that amount, you enter the coverage gap, where your plan pays a lower percentage of your drug costs
- Phase 3** When you reach the specified total annual out-of-pocket amount, your plan returns to paying a higher percentage of your drug costs

People usually choose Part D in one of two ways

1. A **“stand-alone” insurance plan** to cover medicines when you have Original Medicare or when you pair Medicare supplement insurance with your Original Medicare
2. As part of a **Medicare Advantage plan**; if you enroll in a Medicare Advantage plan with prescription drug coverage, you don't need to sign up for a stand-alone prescription drug plan

The list of medicines Part D covers is called a **formulary**. The **formulary** must include some of the most prescribed medicines for people with Medicare.

Each private plan covers a specific formulary, or list of medicines. Choose your plan carefully to make sure it covers medicines you use regularly.

Medicare eligibility

Medicare is available to those considered eligible. The Centers for Medicare & Medicaid Services has rules on when you become eligible for Medicare Initial Enrollment Period (IEP) and can enroll:



- **Three months before you turn 65**
- **The month you turn 65**
- **Three months after you turn 65**
- **If you retire after you're 65, enrollment depends on when your employer-sponsored coverage ends**

At age 65, you're eligible for parts A and B even if you still work. You may be eligible for Medicare because your spouse is a “qualified wage earner” — someone who worked for 10 years and had Social Security taxes withheld. You may also qualify for Medicare parts A and B if you're under 65 and have a disability.

You've probably already paid for Part A through paycheck deductions during your working years. Some people have to sign up for Part A and may have to pay a premium. Most Medicare recipients have to sign up and pay a monthly premium for Part B when they turn 65. If you have health coverage through your employer, you should check to find out if that coverage works with Medicare.

You can verify your Medicare-eligibility status by visiting www.medicare.gov or calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. If you use **TTY**, call **1-877-486-2048**.



What happens if you don't sign up for Part B or Part D when you become eligible?

If you don't sign up when you're first eligible, you may have to pay a penalty for parts B or D. If you're still working, talk with the person in charge of benefits.

If you plan to work after age 65, your benefits administrator can help you decide whether to keep your current health plan or switch to a Medicare plan. Medicare parts B and D are optional, but waiting to sign up can affect your costs in the future.

	NO PENALTY: qualified reasons for delaying your enrollment	PENALTY: if you delay and aren't qualified to delay
Part B	If you have group health insurance	You may have to pay a higher monthly premium for the life of your Part B coverage
Part D	If you have "creditable coverage" (see glossary) for prescription drugs If you qualify for a low-income subsidy	You may have a late enrollment penalty added to your premium each month as long as you have Part D coverage



If you qualify, you can delay signing up for Medicare without a penalty.



Every year after you become eligible for Medicare

Oct. 1 – Oct. 14 Pre-enrollment Period: During this period, you can find out which products will be offered during the Annual Election Period.

Oct. 15 – Dec. 7 Annual Election Period (AEP): You can enroll in a Medicare Advantage or prescription drug plan for the next calendar year.

Jan. 1 – Feb. 14 Annual Disenrollment Period (ADP) for Medicare Advantage plans and prescription drug plans: During this time, you can disenroll from a Medicare Advantage plan and return to Original Medicare. You can then also enroll in a stand-alone prescription drug plan if you choose. But you can't select another Medicare Advantage plan at this time.

Feb. 15 – Oct. 14 Generally, you can only make changes if you qualify for a special exception. You can purchase a Medicare supplement plan any time during the year, although restrictions may apply outside of the Medicare supplement Open Enrollment Period or if you don't qualify for guaranteed acceptance.



Special Election Period (SEP) is a special enrollment period based on certain conditions or exceptions. Some exceptions include moving from your plan's service area and needing to select a new plan or qualifying for Medicaid coverage. If you are eligible for a special election, you can enroll in a Medicare Advantage plan outside of the Annual Election Period. If you qualify for a special election, you can enroll in a Medicare Advantage plan even between Feb. 15 and Oct. 14.



Medicare supplement plans

Your Medicare supplement Open Enrollment Period starts on the first day of the month you turn age 65 or with your Part B effective date. You must be enrolled in both Medicare parts A and B to be eligible.

The Medicare supplement OEP lasts six months. The best time to purchase a Medicare supplement plan is during the OEP because you're guaranteed a plan and the insurance company can't use medical underwriting. Some states have additional OEPs.

There are several situations that may guarantee a Medicare supplement plan is available to you if you meet certain criteria.

Medicare supplement plans — a valuable option to consider

Medicare supplement plans — sometimes called “Medigap plans” — are health insurance policies provided by private insurance companies. You can purchase them to go with Original Medicare to help with some costs parts A and B don't cover. Their costs can be more predictable and there isn't a specific network of healthcare providers.



Special Needs Plans

In some areas, you may be able to get a Medicare Advantage Special Needs Plan (SNP). These plans generally offer benefits, providers and drug lists designed to meet the specific needs of the members they serve.

To join a Medicare-approved Special Needs Plan, you must have Medicare parts A and B.



Also, **at least ONE of the following must apply** to you:

- You have a chronic illness, like diabetes or a heart condition, that's diagnosed and verified by a physician
- You're eligible for Medicare, and you receive Medicaid assistance from the state
- You reside within a long-term care facility



Medicare Advantage **Special Needs Plans include all Medicare Part A, Part B and Part D benefits**, and may also include:

- Access to proactive programs focused on supporting your specific condition.
- Additional benefits and services targeted to members with special healthcare needs.
- Additional support through increased care coordination. The goal is to help you receive the medical care and support you need.

Additional Medicare guidance



Medicare has resources to help you choose the Medicare coverage that's right for you. The “Medicare & You” handbook contains detailed information. To get a copy, visit www.medicare.gov.

Medicare supplement plans

See the publication “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” To view a copy, visit www.medicare.gov.

State Health Insurance Assistance Programs

Each state has a State Health Insurance Assistance Program (SHIP). Visit www.shiptalk.org for details.



Financial assistance

If you have limited income, you may be able to get assistance. To find out if you qualify, contact your state Medicaid office or call the Social Security Administration at **1-800-772-1213 (TTY: 1-800-325-0778)**. Hours are **7 a.m. – 7 p.m., Monday – Friday**.





Glossary

Annual Election Period (AEP): From Oct. 15 through Dec. 7, people who are Medicare eligible can enroll in, disenroll from or change to the Medicare Advantage or Medicare prescription drug plan of their choice for the following year.

Coinsurance: A percentage of your medical and drug costs that you pay out of pocket.

Copayment: The fixed dollar amount you pay when you receive medical services or have a prescription filled.

Creditable coverage: Health coverage you had in the past that gives you certain rights when you apply for new coverage.

Deductible: The amount you pay for medical services or prescriptions before your plan pays for your benefits.

Formulary: Also called a drug list, the formulary lists the drugs your plan covers. It's often divided into sections, or tiers, based on the amount your plan will pay for the drugs in that group.

Glossary (continued)

Health maintenance organization (HMO):

Generally, a primary care physician arranges your healthcare in the plan's network.

Initial Enrollment Period (IEP): When you're eligible to sign up for Part A and/or Part B for the first time.

Mail-delivery pharmacy: These pharmacies allow you to order your medicines and often supplies (like diabetes test strips) and have them mailed to you. Many mail-delivery pharmacies will allow you to fill many maintenance medications for up to a 90-day supply and provide regular refill reminders. Some medications may only be filled for a 30-day supply.

Medically necessary: Medicare defines this as services or supplies needed for the diagnosis or treatment of a medical condition. These services and supplies must meet the standards of good medical practice in the local area and cannot be mainly for the convenience of you or your doctor.

Network: A group of healthcare providers who have agreed to provide care based on a plan's terms and conditions. These providers include doctors, hospitals and other healthcare professionals and facilities.

Out-of-pocket costs: Anything you are required to pay for medical care, prescriptions and other healthcare services. These include coinsurance, copayments and deductibles.

Original Medicare: Original Medicare is the traditional fee-for-service program offered directly by the federal government, which pays directly for your healthcare. You can see any doctor who takes Medicare anywhere in the country.

Preferred provider organization (PPO):

This type of health plan gives you freedom to choose your own doctors and hospitals. Your out-of-pocket costs are usually lower if you choose healthcare providers in the plan's network.



Premium: What you pay Medicare or a health plan for healthcare coverage.

Private-fee-for-service (PFFS): Plan requires the member to find doctors, hospitals and other types of providers that accept the plan's payment terms. Some PFFS plans have a network of providers. You can still see out-of-network providers that accept the plan's payment terms, although you may pay more. A private-fee-for-service plan is not Medicare supplement insurance. Providers who do not contract with the PFFS plan are not required to see plan members except in an emergency.

Special Needs Plan (SNP): Plans that may offer benefits, providers and drug lists designed to meet the specific needs of the groups they serve. People with chronic conditions, like diabetes or heart conditions, or who are dually eligible for Medicare and Medicaid, may benefit from this type of plan.



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Humana is a Medicare Advantage Plan and a stand alone prescription drug plan organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. This information is available for free in other languages. Please call our Customer Care number at 1-800-457-4708 (TTY: 711). Hours are 8 a.m. – 8 p.m., seven days a week through Feb. 15, 2017, and 8 a.m. – 8 p.m., Monday – Friday, the rest of the year.

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con el Departamento de Servicio al Cliente llamando al 1-800-457-4708 (TTY: 711)

本資訊也有其他語言的免費版本可供選擇。請於 期間致電 1-800-457-4708 (聽障專線：711) 與客戶服務部聯絡。

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