2012 How Medicare Works

Helping you make the most of Medicare

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About Medicare

Whether you're new to Medicare or want a refresher, this brochure will help you understand the costs, benefits and choices offered by the country's largest health insurance program.

Medicare covers more than 46 million people today who are age 65 and older or have disabilities. Medicare started in 1965 with basic coverage for hospital and medical services. Since then it has grown to offer other health plan options and prescription drug coverage from private insurers.

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Original Medicare

Original Medicare has two parts — Part A and Part B. Medicare Part A is offered at no cost to nearly everyone eligible for Medicare. Medicare Part B is available for a monthly premium to most people eligible for Medicare. Medicare premiums, deductibles and cost-sharing amounts are set by the federal government each fall for the next year.

The Centers for Medicare & Medicaid Services (CMS) administers Medicare Part A and Part B. The Social Security Administration automatically enrolls most people in Medicare at age 65 if they already receive Social Security benefits. You can enroll in Medicare up to three months before your 65th birthday and up to three months after your 65th birthday. You don't have to be retired or collecting Social Security benefits to enroll. For more detailed information on what Medicare Part A and Medicare Part B cover, visit **www.medicare.gov**.

Part A: Hospital coverage

Medicare Part A pays for inpatient hospital stays, care in a skilled nursing facility, home health care and hospice care after you pay your deductible and coinsurance.

Hospital services

Part A covers a semiprivate room, meals and eligible services for up to 90 days per benefit period. A benefit period begins on the first day of a hospital stay and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. In 2011:

- You pay a deductible of $1,132 for each benefit period. See the Glossary for the definition of a benefit period.
- For the first 60 days, eligible care is covered in full after you pay the deductible
- For days 61 through 90, you pay $283 per day for each benefit period
- You pay $566 per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime)
- You pay expenses not covered by Medicare

These costs will change in 2012.

Skilled nursing facility care

Part A covers up to 100 days for eligible services in a Medicare-certified skilled nursing facility after at least a three-day covered hospital stay. In 2011:

- Care is covered in full for the first 20 days
- For days 21 through 100, you pay $141.50 per day
- You pay all costs for each day after day 100 in a benefit period

These costs will change in 2012.

Home health care

Home health care services are paid in full when ordered by a doctor and provided by a nurse and/or therapist from a Medicare-certified home health agency.

Hospice care

Hospice services are paid by Medicare and may include drugs to control symptoms and relieve pain, short-term respite care and home health services. Care must be provided by a Medicare-certified hospice program. You pay part of the cost for outpatient drugs and inpatient respite care.

Part B: Medical coverage

Medicare Part B covers doctors' services and tests, outpatient care, durable medical equipment and some medical services and supplies not covered by Medicare Part A. Part B also covers some preventive services.

For Medicare Part B in 2011 you pay:

- A monthly premium of $115.40*
- A yearly deductible of $162
- After your yearly deductible, you pay 20 percent (Medicare pays 80 percent) of Medicare-approved expenses for eligible services and supplies that are medically necessary

These costs will change in 2012.

*Your Part B premium will be higher if an individual's income is more than $85,000 (or a married couple's income is more than $170,000)

Part B eligible services

- Doctors' services, including hospital, clinic, office and home visits; surgery; osteopathy and radiology
- X-rays, lab tests, radiation therapy and some other procedures that are part of your treatment but not covered by Part A
- Medical supplies and services, including surgical dressings; splints, casts and other devices; oxygen, ventilator-assist devices and durable medical equipment used at home; prosthetic devices and portable X-ray services
- Diabetes self-monitoring training, nutrition therapy and supplies including glucose monitors, test strips and lancets; screening tests, self-management training, retinal exam/glaucoma test and foot exam/therapeutic soft shoes
- Outpatient diagnostic and treatment services received from certified hospitals, skilled nursing facilities, home health care facilities, rehabilitation facilities and ambulance services
- Some services performed at a Medicare-certified ambulatory surgical center
- Outpatient rehabilitation services provided by a certified outpatient rehabilitation facility
- A one-time "Welcome to Medicare" physical exam within the first 12 months of enrolling for Part B coverage
- Annual wellness visits. A wellness visit will be covered at no cost every 12 months. You must be enrolled in Medicare for more than 12 months to receive this benefit. If you had a "Welcome to Medicare" physical exam when you first enrolled in Medicare, the wellness visit has to come at least 12 months after that exam.
- Cancer screenings, such as mammograms, prostate exams, colorectal screenings, Pap tests and pelvic exams
- Bone mass measurements
- Flu shots and pneumonia and hepatitis B vaccines
- Diabetes and HIV screenings
- Stop-smoking counseling

What Part A and Part B do not cover

Part A and Part B don't cover all of your medical costs. Exams for fitting hearing aids, routine eye exams and most outpatient prescription drugs are not covered. Plus, you must pay deductibles and coinsurance when you receive eligible health care services.

Your out-of-pocket expenses for these gaps in coverage can add up quickly. Fortunately, you can enroll in one of several private health plan options to help pay for costs and services that Medicare Part A and Part B don't cover.

These plans include:

- Medigap (Medicare supplement) health plans
- Medicare Advantage plans
- Medicare Cost plans
- Prescription drug plans

Medigap (Medicare supplement) plans

Medigap plans are sold by private health coverage companies like Blue Cross and Blue Shield. They help pay for some of the health care costs or "gaps" that Medicare Part A and Part B don't cover. In most cases, you must have both Medicare Part A and Part B to purchase a Medigap policy.

Blue Cross Blue Shield of Arizona offers Senior Security and Senior Preferred Medicare Select. Senior Security offers the most flexibility and choice among Supplement Plans A, C, F and N. There are no "service area" restrictions and your coverage is available when you travel throughout the United States. Senior Preferred Medicare Select includes Supplement Plans C and N. This plan has a network of more than 15,000 providers and requires members to use network providers, except in emergencies. You do not need a referral from your primary care physician to see a specialist. Senior

Preferred is available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal and Santa Cruz counties.

Each plan has different premiums. If you choose a Medigap plan and want prescription drug coverage, you must purchase a stand-alone Medicare Part D prescription drug plan, like Blue MedicareRx.

When to buy a Medigap plan

Medigap health plans are optional. You don't have to purchase one. Your Medigap initial enrollment period starts on the first day of the month in which you are 65 or older and enrolled in Part B. If you don't enroll in a Medigap plan during this time, it might cost you more to enroll later. Many Medigap plans may require a health history after the six month Medigap initial enrollment period.

For more information about Blue Cross Blue Shield of Arizona Medicare supplement plans, call Customer Service at the number listed on page 13 or visit **azblue.com/Ready.**

Medicare Advantage plans

Medicare Advantage plans offer more health plan choices than Original Medicare. With these plans you get Medicare Part A and Part B benefits and some plans may offer extra benefits. Some Medicare Advantage plans also include prescription drug coverage in one plan. Like all Medicare plans, benefits, premiums and copayments may change from year to year. The different types of Medicare Advantage plans include:

Preferred Provider Organization (PPO) plans have a network of doctors and hospitals you can go to. Referrals are not needed to see a doctor, specialist or out-of-network provider. However, you will likely pay more if you go to doctors, hospitals or other providers not in the PPO network.

Health Maintenance Organization (HMO) plans also have a network of doctors and hospitals. You will get most of your care and services from this network of providers. You may need a referral for some services and to see providers not in the plan's network. Services from providers outside the network may not be covered or you may pay more for them.

Private-fee-for-service (PFFS) plans are a type of Medicare Advantage plan that let you get care from any provider that agrees to accept the plan's terms and conditions of payment. The provider must also be eligible to provide services under Original Medicare. Most PFFS plans have a network of contracted providers for some or all of the services. However, network providers also have the option of deciding each time whether to accept the plan's terms and conditions of payment. If the provider does not accept the plan's payment terms, members need to find another provider that will accept the plan's terms and conditions of payment.

Medicare Advantage prescription drug (MA-PD) plans also include Part D prescription drug coverage (see Part D: Prescription drug plans on the next page). If you choose this type of plan, you'll get all of your hospital, medical and prescription drug benefits from one plan. If you join a Medicare Advantage plan that offers prescription drug coverage, you must get your drug coverage from that plan.

Medicare Cost plans

Medicare Cost plans combine features of both Medigap and Medicare Advantage plans. They offer added benefits to help you pay for expenses that Original Medicare doesn't cover. Plan benefits, coverage levels and provider networks may differ from Medigap plans. Cost plans are regulated by federal and state governments and may or may not include Part D prescription drug coverage.

Part D: Prescription drug plans

Medicare works with health plans and other private companies to offer prescription drug coverage. These Medicare-approved plans are called stand-alone Part D plans.

Medicare prescription drug plans provide coverage for generic and brand-name drugs. If you join a Part D plan, you will likely pay a monthly premium, plus a share of the cost of your prescriptions. Drug plans vary by types of drugs covered, how much you pay and the pharmacy network you can use.

All Part D prescription drug plans must provide at least a standard Medicare-approved level of coverage. The standard Part D prescription drug plan has four stages of coverage. In each stage, you and the plan pay a different share of your prescription drug costs.

Blue Cross Blue Shield of Arizona offers Blue MedicareRx (PDP), a stand-alone prescription drug plan. To learn more go to **www.YourAZMedicareSolutions.com** or call Customer Service at the number listed on page 13.

How standard Part D drug coverage works (2012 deductibles and cost sharing)

Stage	You pay	Plan pays
Deductible stage. You pay the first $320 of your prescription drug costs. This amount is your plan's annual deductible.	**You pay $320**	
Initial coverage stage. When you reach your deductible, your plan pays 75 percent of your prescription drug costs. You pay the remaining 25 percent. This is called cost sharing.	**You pay 25%**	**Plan pays 75%**
Coverage gap stage. Once you and your plan (together) have paid $2,930 (total drug cost) in cost sharing, you pay 86 percent for all generic drugs and receive up to a 50 percent discount on brand-name drugs. This coverage gap is sometimes called the "donut hole." The coverage gap ends when your total yearly out-of-pocket costs reach $4,700.	**You pay 86% for generic drugs** **You pay up to 50% for brand-name drugs**	**Plan pays 14% for generic drugs** **Drug companies discount brand-name drugs up to 50%**
Plan pays nearly all stage (Catastrophic coverage). When the coverage gap ends, for the remainder of the year you only pay a $2.60/$6.50 copay or 5 percent of your drug costs, whichever is greater. The plan pays the rest.	**You pay 5%***	**Plan pays 95%**

*Cost-sharing amounts are for a 31-day drug supply.

Not all Part D prescription drug plans follow this standard design. Deductibles and other cost-sharing rules may differ by plan. Some plans offer added drug coverage for a higher premium. There are also plans with no deductible and/or coverage gap.

Eligibility

Original Medicare

You can enroll in Medicare if you are a U.S. citizen or have been a legal resident for five straight years and:

- Are 65 years or older and eligible to receive Social Security, or
- Are under age 65, are permanently disabled and have received Social Security disability payments for at least twenty-four (24) months, or
- Require ongoing dialysis for end-stage renal disease (ESRD) or need a kidney transplant

Medigap (Medicare supplement) plans

To enroll in a Medigap plan you must:

- Be eligible for Medicare Part A and enrolled in Part B, and
- Live in the plan's service area, and
- Continue to pay your Part B premium (and Part A if applicable, if not paid by Medicaid or another third party)

Medicare Advantage plans

To enroll in a Medicare Advantage plan, you must:

- Be eligible for Medicare Part A and enrolled in Part B, and
- Live in the plan's service area, and
- Continue to pay your Part B premium (and Part A if applicable, if not paid by Medicaid or another third party)

Note: If you have ESRD, you may not be eligible.

Medicare Prescription Drug Plans

To enroll in a Medicare Prescription Drug Plan, you must:

- Be eligible for Medicare Part A and/or enrolled in Medicare Part B, and
- Live in the plan's service area, and
- Continue to pay your Part B premium (and Part A if applicable, if not paid by Medicaid or another third party)

When to enroll

Original Medicare: Part A

Most people are enrolled automatically in Medicare Part A and Part B on the first day of the month they turn 65. If you don't receive an enrollment notice from Social Security three months before your 65th birthday, call them at **1-800-772-1213** (Railroad Retirees call **1-800-808-0772**). If you are disabled, there is a 24-month waiting period for Medicare after you become disabled. During this time, you may qualify for Medicaid/Medical Assistance, COBRA coverage or services from state programs.

Original Medicare: Part B

There are three main times when you can sign up for Part B.

Part B Initial Enrollment Period

You can enroll in Part B during the three months before the month of your 65th birthday, the month you turn 65 and the three months after the month you turn 65. If you are disabled, you can enroll after receiving disability benefits for 24 months.

If you don't want to enroll in Part B during your seven-month Initial Enrollment Period, you must return your Part B notice to Social Security to decline coverage. Be aware that a 10 percent penalty will typically be added to your Part B premium for each year you delay enrolling in Part B (unless you qualify for a Special Enrollment Period such as leaving an employer plan). You will pay the penalty for as long as you have Medicare Part B.

Part B General Enrollment Period

If you don't enroll in Part B during your Initial Enrollment Period, you can enroll during the General Enrollment Period from January 1 through March 31 each year. Coverage begins on July 1 of the year you enroll. You will be charged a 10 percent penalty for each year you delay enrolling in Part B. This charge may increase as Medicare premiums increase and will continue for as long as you are enrolled in Part B.

Part B Special Enrollment Period

A Special Enrollment Period allows you to avoid the penalty for late enrollment. You may qualify for a Special Enrollment Period if:

- You or your spouse has medical coverage through a union or employer with more than 20 employees, or
- You cancelled Part B coverage because you went back to work and have group medical coverage

The Special Enrollment Period lasts eight months. It begins when your employer or union coverage ends or when your employment ends, whichever is first. Contact Social Security four months before you retire or when your employer or union coverage ends. Request a form that your employer will complete to begin your Special Enrollment Period and send the form with your Part B enrollment form to Social Security.

If you are age 65 and continue your employer coverage through COBRA, you should enroll in Medicare Part B. You will not get a Special Enrollment Period when COBRA ends. You must sign up for Part B during the first eight months of your COBRA coverage to avoid the late enrollment penalty.

Medigap (Medicare supplement) plans

You have a six-month Open Enrollment Period to enroll in a Medigap plan. It begins on the first day of the month you are both 65 and enrolled in Part B. If you enroll during this period, you don't need to provide a health history to your health plan. If you delay Medigap coverage, you may need to provide your health history and could be denied coverage.

Note: If you want to enroll in a Medigap plan and a stand-alone prescription drug plan, you must enroll in each plan separately.

Medicare Advantage plans with and without prescription drug coverage, prescription drug plans

Initial Enrollment Period

If you are newly eligible for Medicare, you likely qualify for the Initial Enrollment Period. During this seven-month period you can enroll in a stand-alone prescription drug plan, a Medicare Advantage plan or a Medicare Advantage plan with prescription drug coverage. Your Initial Enrollment Period begins three months before the month of your 65th birthday, includes the month you turn 65, and ends three months after the month of your 65th birthday. If you are under age 65 with a disability, your Initial Enrollment Period is the three months before to the three months after your 24th month of disability.

When you can switch

Annual Enrollment Period

People with Medicare can make plan changes between October 15 and December 7 each year. During this time you can enroll in or change stand-alone prescription drug plans and Medicare Advantage plans with and without prescription drug coverage. Plan changes begin on January 1 of the next year.

Medicare Advantage Disenrollment Period

The Medicare Advantage Disenrollment Period runs from January 1 through February 14. During this time you can disenroll from a Medicare Advantage plan (with or without drug coverage) and return to Original Medicare and a stand-alone prescription drug plan.

Special Enrollment Period

There are circumstances that may allow you to enroll in a prescription drug plan or Medicare Advantage plan after an Initial or Annual Enrollment Period has ended. You might qualify for a Special Enrollment Period if:

- You are eligible for financial help from Social Security or your state
- You move outside your plan's service area
- Your plan's government contract ends, or the plan goes out of business
- You lose prescription drug coverage from an employer or union, or your drug coverage is no longer as good as the standard Part D benefit

You may also qualify due to other conditions.

Frequently asked questions

Q: Do I need a physical exam to qualify for Medicare?

A: No. You must be 65 or older, under age 65 with a disability, or meet other requirements as explained on page 7 of this booklet.

Q. Can I get Medicare even if I have a pre-existing condition?

A. Yes, you can enroll in Medicare no matter what your health status is or what pre-existing conditions you may have. If you qualify for Medicare (see page 7), you will receive the benefits. You also won't be charged higher premiums because of past or current health conditions.

Q: Which Medicare health plan is right for me?

A: It depends on what you need from a health plan and how much you can afford to pay. Ask yourself these questions:

- If you travel often or for several months each year, will your health plan cover you in other parts of the country?
- Can you afford the plan's monthly premium? What are the plan's cost-sharing and out-of-pocket maximum?
- What medical services will you likely use? Will you use your health plan often, such as for frequent checkups or treatments for an ongoing condition? Or will you seldom use it, such as for an annual physical or flu shot?
- Do you want a plan with drug coverage or do you prefer a stand-alone drug plan?
- Are you OK with benefits and/or cost-sharing that may change each year? Or do you want a plan with benefits that do not change from year to year?

Q. Do Medicare rates, deductibles and cost sharing change? How will I learn about changes?

A: Medicare rates and deductibles do change. They are announced each fall for the coming year. Medicare members are notified by mail before the Annual Enrollment Period.

Q: What if I don't join a Part D prescription drug plan?

A: Generally, you will pay the lowest monthly premium if you join during your seven-month Initial Enrollment Period. If you don't enroll and don't already have drug coverage that is as good as the standard Part D drug plan, you may have to pay a penalty in the form of a higher monthly premium when you enroll later. The longer you wait to enroll, the greater the penalty. You must pay this higher premium as long as you have Part D drug coverage.

Q: What if I can't afford Medicare?

A: If you have limited income and resources, you may be able to get extra help to pay for your Medicare plan premium and costs. To learn if you qualify for extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week;
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your State Medicaid office.

Q. How do I keep up with changes to Medicare as a result of the Affordable Care Act?

A. For information about Medicare benefits and services:

Call **1-800-MEDICARE (1-800-633-4227)**
TTY users call **1-877-486-2048**
24 hours a day, 7 days a week
www.medicare.gov

Glossary of Medicare terms

Benefit period – Begins on the first day of a hospital or skilled nursing facility stay and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. If you go into the hospital 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 you can have.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs Medicare. CMS also works with each state to run their Medicaid program. CMS makes sure that people in both programs have access to high-quality health care.

Coinsurance – The percentage of the Medicare-approved amount that you pay for a medical service. With some plans, you do not pay coinsurance until you have paid a deductible.

Copayment (copay) – A fixed amount you pay for each medical service, such as a doctor's visit. For example, a copayment might be $20 for a doctor's visit and $7 for a prescription drug you receive.

Cost-sharing – The way Medicare and your health plan share your health care costs with you. Types of cost sharing you may pay include deductibles, coinsurance (percentage) and copayments (a set amount).

Deductible – A set amount of money you must pay before your plan pays. Usually you have a separate deductible for Medicare Part A, Part B and Part D. Deductibles may also come with Medicare Advantage and Medigap plans.

Eligible care – Medical care and services that qualify to be covered by your health plan.

Lifetime reserve days – These are extra days that Original Medicare will pay for when you are in a hospital for more than 90 days. You have 60 lifetime reserve days to use during your lifetime. With Original Medicare, you have a per day copay when you use lifetime reserve days.

Medicare Advantage – A Medicare health plan option in which a private health plan manages Medicare benefits for its members. The most common types of Medicare Advantage plans are HMO, PPO and PFFS plans. Some Medicare Advantage plans may also offer Medicare prescription drug (MA-PD) benefits for their members.

Medicare Cost plan – This type of Medicare plan is available in certain areas of the country. You can join a Cost plan even if you have only Medicare Part B. Generally, a Cost plan pays in-network benefits only; if you go to a non-network provider, Original Medicare benefits and cost-sharing apply. Some Cost plans also include travel benefits.

Medigap (Medicare supplement) plan – Health insurance policies that typically have standardized benefits and are sold by private insurance companies. Medigap policies work together with your Medicare Part A and Part B coverage.

Part D (prescription drug plan) – A Medicare Part D prescription drug plan may be either a stand-alone plan that you can enroll in if you have Original Medicare and/or a Medigap plan, or a Medicare Advantage plan that includes Part D prescription drug coverage.

Premium – A fixed payment usually paid each month to be in a Medicare health plan or prescription drug plan.

Preventive care – Care that is provided to keep you healthy or find an illness or disease early, when it can be better treated. Examples of preventive care are flu shots, mammograms and screening for diabetes.

Learn more

To get plan information or to enroll in Blue MedicareRx, contact:

Customer Service **1-800-422-9990**
daily, 8 a.m. to 8 p.m., local time
TTY hearing impaired users call **711**
www.YourAZMedicareSolutions.com

You have the option to speak with a licensed sales representative when you call.

To get information about Blue Cross Blue Shield of Arizona Medicare supplement plans call the number above or visit **azblue.com/Ready**.

For other help and information contact:

Social Security Administration
1-800-772-1213
TTY **1-800-325-0778**
7 a.m. to 7 p.m., Monday through Friday
www.ssa.gov

Medicare
Toll free **1-800-MEDICARE (1-800-633-4227)**
TTY users call **1-877-486-2048**
24 hours a day, 7 days a week
www.medicare.gov

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