

Simple Facts

About Medicare

What is Medicare?

Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

There are two types of Medicare:

1. Original Medicare (usually referred to as Part A and Part B), and
2. Medicare Advantage (also called Part C).

Each covers the same basic services, but they work differently. You'll need to choose the method that best meets your needs.

Original Medicare (parts A and B) is operated by the government and government subcontractors. When you visit a doctor or hospital to receive care, Medicare pays these providers directly for covered services. This is often called, "fee for service."

Medicare Advantage (Part C) is operated by private companies approved by Medicare, such as Health Net. Medicare pays a fixed fee to the plan for your care. The plan then handles its own payments to doctors and hospitals.

A more detailed overview of the different parts of Medicare is outlined in the next few pages. You'll need to determine your personal situation and the type of plan that will work best for you. This overview will provide some basic information that can help you make the right decision.

Medicare eligibility

It's important to make sure you are eligible for Medicare before you begin shopping for a plan. Below are two criteria to help determine your eligibility. You are eligible if:

- You are 65 years old, or are under 65 and qualify on the basis of disability or another special situation, and
- You are a U.S. citizen or a legal resident who has lived in the United States for at least five consecutive years.

The Social Security Administration handles the majority of the paperwork for joining Medicare. You will likely receive a letter from the Social Security Administration about Medicare as you approach age 65. If you're drawing Social Security benefits when you turn 65, Social Security will automatically

enroll you in Medicare Part A and Part B.

If you have questions about Medicare eligibility, you can visit www.medicare.gov, or call your local Social Security Administration office for more information.

The Different Parts of Medicare



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Medicare Part A

Medicare Part A insurance helps pay for “medically necessary” care that involves an inpatient stay in the hospital. Part A also helps pay for a stay in a skilled nursing facility (SNF) as a follow-up to a hospital stay, hospice care for the terminally ill, and some skilled home health care. Additionally, Part A also helps pay for some blood transfusions.

What costs do I pay with Part A?

With Part A, you must cover all personal costs in the hospital, like charges for a television or telephone calls, or the cost of “custodial care,” such as eating, bathing or dressing.

How much does it cost?

There is no premium for Part A if you have made payroll contributions to Social Security for at least 10 years. However, if you qualify for Medicare

but have not contributed to Social Security for at least 10 years, you'll have to pay a monthly premium that can vary from year to year.

If you must pay a premium for Part A, it can be higher if you don't enroll in Part A when you become eligible for Medicare. Part A also has deductibles, copays and coinsurance that you will pay when you receive certain types of care.

When can I join Part A?

You can join Part A as soon as you become eligible for Medicare. You'll need to sign up in your “initial enrollment period.” You can also join at a later date, but only at certain times of the year, unless you qualify for an exception.

If you are receiving Social Security benefits when you become eligible, you'll automatically be enrolled in

parts A and B. If you're not receiving Social Security benefits, you can sign up for Part A at your local Social Security office. Once you've enrolled, your Part A coverage renews automatically from year to year.

Medicare Part B

Medicare Part B helps pay for a variety of "medically necessary" care for an illness or medical condition even when there is no inpatient hospital stay. This includes services like doctor's office visits, care in hospitals and clinics when you are not admitted for an inpatient stay, laboratory tests, some diagnostic screenings, annual physical exams, preventive screenings and some skilled nursing care at home. After you pay your deductible, Part B generally pays 80 percent and you pay 20 percent of the cost of services.

What costs do I pay with Part B?

Part B primarily helps you pay the costs of medically necessary care when you're sick. Only in very limited situations does it cover any care for your eyes, teeth or hearing. Except in a few very limited situations, Part B does not cover medical care you receive outside the United States.

How much does it cost?

The premium amount you pay for Part B depends on your annual income and can be automatically deducted from your Social Security benefits. Part B also has deductibles, copays and coinsurance that you will pay when you receive certain types of care.

You may pay a penalty if you don't sign up for Part B when you are first eligible. Your cost for Part B may go up 10 percent for each full 12-month period that you could have had Part B but didn't sign up for it. You'll pay that penalty for as long as you're enrolled in Part B.

When can I join Part B?

If you are receiving Social Security benefits when you turn 65, or otherwise become eligible for Medicare, you will automatically be enrolled in parts A and B. If you don't want to join Part B, you can refuse Part B coverage by going to your local Social Security office.

If you're not receiving Social Security benefits, you can sign up for Part B at your local Social Security office when you turn 65 or otherwise become eligible for Medicare.

Medicare Part C

Medicare Part C plans, typically referred to as "Medicare Advantage" plans, combine coverage for doctor visits and for hospital stays,

These plans are run by private companies, such as Health Net, and let you choose plans that include prescription drug coverage (often at no additional premium), as well as plans without prescription drug coverage.

Medicare Advantage plans are required to cover the same services as Medicare parts A and B, and often include medical coverage above and beyond that of parts A and B. In some

cases, Medicare Advantage plans include coverage for vision, dental and hearing, as well as added tools that can help you proactively manage your health and wellness. Plans that include drug coverage may have restrictions related to that coverage.

How much does it cost?



Premiums, deductibles and copays for Medicare Advantage plans can vary widely from year to year. If you join a Medicare Advantage plan, such as Health Net, you will continue to pay your Part B premium and your Part A premium, if you have one. While some Medicare Advantage plans do not have premiums, depending on the plan you choose, you may have to pay an additional premium for Medicare Advantage. Part C also has deductibles, copays and coinsurance you will pay when you receive certain types of care, depending on the type of plan you choose.

Medicare Advantage plans differ further from Part A and Part B regarding limits on your cost-sharing.

With Part A and Part B plans, there are no limits on your out-of-pocket spending for cost-sharing. And, in some situations, like extremely long hospital stays, your coverage under Part A ends entirely and you become responsible for paying all of your own costs.

In contrast, Medicare Advantage plans, as offered by Health Net, can protect you from high cost-sharing with a feature that caps your out-of-pocket spending for cost-sharing like copays and deductibles in any given year.

For more details about the Medicare Advantage plans offered by Health Net and their costs, feel free to contact Health Net at the phone number on the back of your enrollment kit.

When can I join a Medicare Advantage plan?

You can join a Medicare Advantage plan as soon as you become eligible for Medicare, during your initial enrollment period. You can join at a later date, but some plans restrict your enrollment to your Annual Election Period unless you qualify for an exception. Once you enroll, you have the chance to change your coverage each year during the Annual Election Period. If you don't want to make any changes, you continue to pay the premium every month, and, provided the plan is still available in your service area, your plan will renew automatically from year to year.

Types of Medicare Advantage Plans

Medicare Advantage includes several kinds of coordinated care plans. They're called coordinated care plans because they are built on the idea of a network of doctors and hospitals working together to provide care.

Health Net offers several of these options including HMO, PPO and Special Needs Plans. Coordinated care plans offer one-stop shopping for all of your health care needs. They combine hospital care and doctor's visits and other outpatient care in a single plan. Many plans offer prescription drug coverage as well.

In an HMO-type plan, you must use doctors and hospitals that are part of the plan's preferred network. If you go outside the network for care, other than for emergency care, urgent care or out-of-area renal dialysis, you must pay for your own care. These plans may require you to choose a primary care physician. This doctor coordinates your specialist care and provides the required referral when a specialist visit is needed.

In a PPO-type plan, you have more freedom to choose your doctor. These plans typically don't require you to select a primary care physician or have a referral to see a specialist.

You can see doctors outside the network without having to pay the entire cost yourself. However, if you do visit a doctor or hospital outside the network, you'll usually pay a larger share of the cost of your care.

A Special Needs Plan is a care management plan, a special type of coordinated care plan designed for people with special needs. Special Needs Plans may serve people in any of these groups:

- People who are institutionalized in a nursing home or other long-term-care facility because they are unable to care for themselves
- People who are eligible for both Medicare and the Medicaid assistance program
- People with certain chronic diseases, such as diabetes or heart disease

Like an HMO or PPO plan, a Special Needs Plan uses a network of doctors and hospitals working together to provide care.



Low income subsidy (Extra Help)



If you have limited income and resources, you may qualify for a low-income subsidy from Medicare to pay for prescription drug costs. If you are eligible, you will get help paying for your monthly premium, yearly deductible, prescription coinsurance and copays and will not fall into the coverage gap.

You may be automatically eligible for this low-income subsidy. To qualify, you must be a(an):

- Full benefit dual eligible (see Common Terms and Definitions on the next page).
- SSI recipient with Medicare or Medicare Savings Programs participant.

You may be required to apply through the Social Security Administration (SSA), particularly if your income is below 150 percent of the Federal Poverty Level. More information about low-income subsidies and the Federal Poverty Level can be found at www.cms.gov.

How do I apply for a low-income subsidy (Extra Help)?

It is easy to apply for Extra Help. Just complete Social Security's "Application for Extra Help with Medicare Prescription Drug Plan Costs" (SSA-1020). Here's how:

- You can apply online at www.socialsecurity.gov/extrahelp.
- Call Social Security at 1-800-772-1213 (TTY/TDD 1-800-325-0778) to apply over the phone or to request an application.
- Apply at your local Social Security office.

After you apply, Social Security will review your application and send you a letter to let you know if you qualify for Extra Help. Once you qualify, you can choose a Medicare prescription drug plan. If you do not select a plan, the Centers for Medicare & Medicaid Services (CMS) will select one for you. The sooner you join a plan, the sooner you'll begin receiving benefits.



What is a Medigap plan?

A Medigap plan, sometimes called a “Medicare Supplement plan,” helps pay the costs that parts A and B don’t cover. Medicare Supplement policies aren’t a government benefit, like parts A and B. They are insurance policies sold by private companies, like Health Net, and are completely optional to purchase. There are several standard plans you can choose from that range in cost and coverage.

What costs do I pay with a Medicare Supplement plan?

In general, Medicare Supplement policies only help you with your cost-sharing for parts A and B, like deductibles, copays and coinsurance. They don’t cover long-term care, routine vision, dental, hearing care, hearing aids, eye glasses or private nursing.

How much does it cost?

As a general rule, the more generous the coverage, the higher the premium. The premiums can also vary from health plan to health plan. Some Medicare Supplement plans have lower premiums and higher deductibles, while others have high premiums and low deductibles. It is important to decide what coverage works best for you and your budget.

When can I join a Medicare Supplement plan?

You can apply to buy a Medicare Supplement policy at any time after you turn 65 and join Medicare Part B. Medicare guarantees you the right to buy a Medicare Supplement policy where you live during the six months after you turn 65 and enroll in Medicare Part B.

During this time, the insurer can’t consider your medical history or current health in setting the premium. However, when you buy the plan, the insurer may be able to make you wait for six months before coverage begins for a pre-existing condition.



Finding Coverage *that Works for You*

Deciding on a Medicare plan is one of the most important decisions you will make, and the one to make first is whether you want Original Medicare (Part A and Part B) or Medicare Advantage (Part C). Remember, they cover the same basic services – but, as described in the previous pages, they work differently. Your choice depends on what you need, so keep these important factors in mind when making your decision.

- **Coverage** – Think about your health care needs over the past few years. When looking at your plan options, ensure the services you need are covered.
- **Your other coverage** – Do you have, or are you eligible for, other types of coverage (like employer or union)? If so, read the materials from your insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare.
- **Cost** – How much are your current premiums, deductibles and other costs? How do the costs of a new plan fit into your budget? Consider all costs, not just premiums.
- **Doctor and hospital choice** – Do your doctors and other health care providers accept the coverage, or are they part of the network? Are the doctors you want to see accepting new patients? Do you have to choose your hospital and health care providers from a network? Do you need to get referrals?
- **Prescription drugs** – What will your prescription drugs cost under each plan? Are your drugs covered under the plan's formulary? Are there any coverage rules that apply to your prescriptions?
- **Quality of care** – The quality of care and services given by plans and other health care providers can vary. Does the plan offer additional services to help you proactively manage your health?
- **Convenience** – Can you reach your health plan at all hours of the day? Which pharmacies can you use? Can you get your prescriptions by mail? Does the plan offer 24-hour assistance from certified nurses or other health professionals?
- **Travel** – Will the plan cover you in another state or outside the U.S.?

Common Terms *and* Definitions

Annual Election Period (AEP) –

The period from October 15 through December 7 of each year. During the AEP, you may enroll in prescription drug plans and Medicare Advantage plans.

Appeal – A special kind of complaint you submit if you disagree with a decision to deny a request for services, or payment for services you have already received. You may also make a complaint if you disagree with a decision to stop services you are receiving. There is a specific process our Medicare Advantage and Medicare prescription drug plans must use when you ask for an appeal.

Benefit period – In Part A, this period of time begins when you enter a hospital for an overnight stay and ends when you have been out of the hospital for 60 consecutive days.

Catastrophic coverage – In Medicare Part D, this phase of a drug plan allows you to pay only a small coinsurance or small copay for a covered drug, and your plan pays the rest of the cost for the remainder of the year.

Centers for Medicare & Medicaid Services (CMS) –

The federal government agency that runs the Medicare program and works with the states to manage their Medicaid programs.

Coinsurance – The percentage a plan charges for services you may have to pay after you pay any plan deductibles. In a plan, the coinsurance payment is a percentage of the cost of the service.

Copayment (copay) – In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit or prescription. A copay is usually a set amount.

Cost-sharing – A term for the way Medicare shares your health care costs with you. The most common types of cost-sharing are deductibles, copays and coinsurance.

Coverage gap – A name for the phase in a Medicare Part D plan in which you pay most of the plan's discounted cost for your covered medication.

Deductible – The amount you must pay for services before the plan begins to pay. These amounts can change every year.

Dual eligible – A person who is eligible for both Medicare and Medicaid.

Grievance – A complaint about the way your Medicare health plan is providing access to care. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Health Maintenance Organization (HMO) plan – In Part C, a type of Medicare Advantage plan in which you must use doctors and hospitals in the plan's network for your care. If you go outside the network, other than for emergency care, for urgent care, or for out-of-area renal dialysis, you are responsible for paying for your own care.

Home health care – In parts A and B, skilled nursing care and therapy, such as speech therapy or physical therapy, provided to the homebound on a part-time or intermittent basis.

Hospice care – Care for those who are terminally ill. Hospice care typically focuses on controlling symptoms and managing pain. In Part A, hospice care also includes support services for both patients and caregivers. Part A covers both hospice care received at home and care received in a hospice outside the home.

Initial Coverage Limit (ICL) – The maximum limit of drug coverage under the initial coverage period.

Initial coverage – The stage before your total drug expenses have reached the plan's designated dollar amount,

including amounts you've paid and what your plan has paid on your behalf.

Initial enrollment period – A seven-month period when you first become eligible to enroll in Medicare and a Medicare prescription drug plan. It begins three months before your 65th birthday and ends no later than three months after the month of your birthday.

Inpatient care – Care you receive in a hospital when you are admitted for an inpatient stay.

Maximum out-of-pocket limit – A limit that Medicare Advantage plans set on the amount of money you will have to spend out of your own pocket in a plan year. In Medicare Part D, you must reach this maximum before catastrophic coverage begins for the remainder of the year. (See Catastrophic coverage.)

Medically necessary care – Services or supplies that are needed to diagnose or treat a medical condition, according to the accepted standards of medical practice.

Network – In parts C and D, the group of health care providers, such as hospitals, doctors and pharmacies, that agree to provide care to the members of a Medicare Advantage coordinated care plan or prescription drug plan.

Out-of-pocket maximum – A limit that Medicare Advantage plans set on the amount of money you will have to spend out of your own pocket in a plan year. For Medicare Part A and Part B

services, plan premiums do not count toward the out-of-pocket maximum. (See Maximum out-of-pocket limit.)

Outpatient care – Care you receive as a hospital patient if you are not admitted for an inpatient stay, or care you receive in a free-standing surgery center as an outpatient.

Part A – The part of Medicare that provides help with the cost of hospital stays, skilled nursing services following a hospital stay, and some other kinds of skilled care.

Part B – The part of Medicare that provides help with the cost of doctor visits and other medical services that don't involve overnight hospital stays.

Part C – The part of Medicare that allows private insurance companies to offer plans that combine help with hospital costs with help for doctors' visits and other medical services. Part C plans are usually referred to as "Medicare Advantage" plans.

Part D – The part of Medicare that offers help with the cost of prescription drugs.

Preferred Provider Organization (PPO) – In Part C, a type of Medicare Advantage plan in which you can use either doctors and hospitals in the plan's network, or go to doctors and hospitals outside the network.

Premium – A fixed amount you have to pay to participate in a plan or program; in private insurance, the price you pay for a policy, usually as a monthly payment.

Preventive care – Care that is meant to keep you healthy, or to find illness early when treatment is most effective.

Prior authorization – Approval in advance to get services or certain drugs that may or may not be on the plan's formulary. Covered drugs that need prior authorization are marked in the formulary.

Provider – A person or organization that provides medical services and products, such as a doctor, hospital, pharmacy, laboratory or outpatient clinic.

Referral – A written approval from your primary care physician (doctor) for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you can get care from anyone except your primary care physician.

Service area – The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided.

Special Needs Plan (SNP) – A type of Medicare Advantage plan that serves people with special health care needs.

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