Toolkit for Medicare Beneficiaries

Pennsylvania
Medicare Education and Decision Insight

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Contents

Welcome to your Toolkit for Medicare Beneficiaries. Inside this toolkit you will find a variety of information regarding Medicare including a brief history of Medicare, information about programs that help with Medicare costs, a Preventive Benefit checklist to discuss with your doctor, some fun puzzles to complete, and a listing of the local PA MEDI office phone numbers in each county.

Pennsylvania Medicare Education and Decision Insight, PA MEDI, is Pennsylvania's State Health Insurance Assistance Program (SHIP). PA MEDI counselors provide free, unbiased help to Medicare beneficiaries of any age, their families and caregivers, as well as people who will soon be eligible for Medicare. PA MEDI can answer questions about Medicare coverage, counsel people about Medicare health and drug coverage options, help people enroll in Medicare Cost Savings Programs they may be eligible for, and troubleshoot problems people may experience getting coverage or services.

If you have any questions about the information included in this toolkit, or if you are interested in learning more about the programs that help with Medicare costs or applying for them, please call your local PA MEDI office. The listing of contact numbers is at the end of this toolkit. You may also contact the PA MEDI Statewide Helpline at 1-800-783-7067, Monday thru Friday from 8am – 5pm.

PA MEDI relies on a network of knowledgeable and trained volunteers to do this important work. If you are interested in becoming a volunteer, please contact your local PA MEDI office or visit Volunteer with Aging Services | Department of Aging | Commonwealth of Pennsylvania to submit a volunteer interest form.

Pennsylvania Department of Aging

SHIP State Health Insurance Assistance Program

Navigating Medicare

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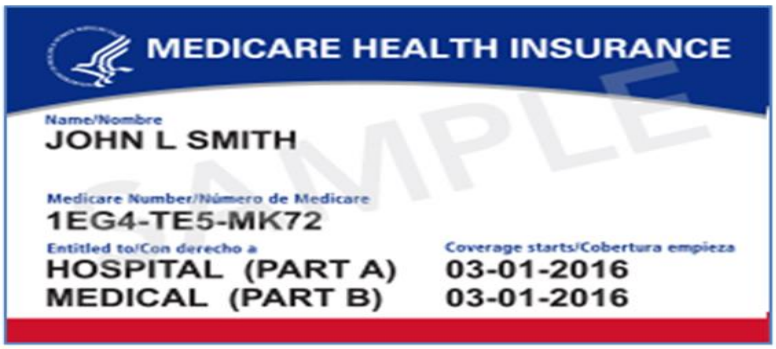


Glossary of Terms

Appeal
A process to request your Medicare health plan to reconsider or perhaps change the decision of denying your request for coverage for the medical care coverage that you want.

Assignment
Your doctor, provider, or supplier agrees (or is required to by law) to accept the Medicare approved amount as full payment for covered services.

Catastrophic coverage
The part of the prescription drug benefit that kicks in after you have paid a certain amount in a calendar year.

Centers for Medicare & Medicaid Services (CMS)
The branch of the Department of Health and Human Services that administers Medicare.

Co-Insurance
The percentage of costs you are responsible for paying after you meet your deductible.

Co-Pay
A fixed payment amount you pay for a health care visit or prescription at the time of service.

Deductible
The amount of money you must pay for a health care service before an insurance plan starts to pay.

Durable medical equipment (DME)
Certain medical equipment that is ordered by your doctor for use in your home. Some examples are walkers, wheelchairs, and hospital beds.

End-Stage Renal Disease (ESRD)
Permanent kidney failure that requires a transplant or dialysis.

Extra Help
Financial assistance from Medicare to help cover Part D drug plan costs. Also known as the low-income subsidy (LIS).

Formulary
A plan's list of covered prescription drugs.

Grievance
Any expression of dissatisfaction (complaint).

Guaranteed Issue
Rights you have in certain situations when insurance companies must offer you certain Medigap policies without any medical underwriting. Also known as Medigap Protections.

Glossary of Terms

Maximum Out of Pocket (MOOP) Costs
The most a beneficiary, enrolled in a Medicare Advantage plan, has to pay for covered services in a plan year. After you spend the set MOOP on deductibles, co-payments, and co-insurances for in-network care, your health plan will pay 100% of the costs of covered benefits. The MOOP does not include your monthly premium or payment regarding prescription drugs.

Medicaid
A joint federal and state program, separate from Medicare, that helps pay medical costs for people with low incomes, limited assets, and disabilities.

Medicare
The federal health insurance program for people age 65 and older. It is also available to some people under 65 who have certain disabilities, and to people with end-stage renal disease.

Medicare Part A
Coverage that helps pay for hospital stays, skilled nursing care, some home health services, and hospice care.

Medicare Part B
Coverage that helps pay for physicians' services, outpatient care, and other medical services not covered by Part A. Parts A and B together are known as Original Medicare.

Medicare Part C (Medicare Advantage)
A plan offered by a private organization as an alternative to Parts A and B only. Part C plans may offer more benefits than Original Medicare and may include Part D coverage.

Medicare Part D
Prescription drug coverage available as a stand-alone plan (PDP) or as part of a Medicare Advantage plan (MA-PD).

Medigap
Medicare supplement insurance that helps fill the "gaps" in Original Medicare and is sold by private insurance companies.

Original Medicare (also known as **Traditional Medicare** or **fee-for-service Medicare**)
Collective term for Medicare Parts A and B.

Skilled nursing care
Treatment that must be given or supervised by a registered nurse (RN), such as intravenous injections or tube feedings.

Special Needs Plan (SNP)
A Medicare Advantage plan for people who are institutionalized, or entitled to both Medicare and state Medicaid benefits, or have certain chronic conditions.

A Brief History of Medicare

[1]1960's

- On July 30, 1965, Lyndon B. Johnson signed Medicare into law. President Harry S. Truman had called for the creation of a national health insurance fund twenty (20) year earlier.
- Medicare was only available for Americans who were aged 65 and older.

1970's

- In 1972, President Richard M. Nixon signed the first bill to expand Medicare. This expansion would make people who were under 65 years of age with long-term disabilities or people with end stage renal disease (ESRD) eligible for Medicare.
    - People with long-term disabilities have a 24-month waiting period to be eligible for Medicare.
    - People with ESRD were now eligible for Medicare as early as three months after they began regular hospital dialysis treatments or immediately if they went through a home-dialysis training program and began doing in-home dialysis.

1980's

- In 1980, Medicare Supplemental Insurance (Medigaps) was put under federal oversight and home health services were expanded.
- In 1982, hospice care coverage was added for terminally ill beneficiaries.
- A law requiring states to use Medicaid funds to cover Medicare premiums and cost-sharing for a qualifying group of impoverished Medicare beneficiaries was also passed.

1990's

- More laws were passed to help cover Medicare premiums and cost-sharing for qualifying groups of impoverished Medicare beneficiaries.
- Medicare Part C or Medicare Advantage (MA) offered "add on" benefits provided by private insurance companies. (see pages 9 – 11)

2000's

- Americans 64 and younger, who have been diagnosed with amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and are receiving Social Security Disability, are now eligible for Medicare without the 24-month waiting period.
- The Medicare Prescription Drug Improvement and Modernization Act of 2003, signed by President George H. Bush, added Part D to Medicare. As of 2006, Medicare beneficiaries can buy prescription drug coverage through stand-alone plans or as part of a Medicare Advantage plan.
- The Medicare Improvements for Patients and Providers Act (MIPPA) was passed in 2008. It included several provisions related to various parts of Medicare and aimed to help more people with limited incomes and resources qualify for programs to help with certain Medicare costs.

[1]https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/

A Brief History of Medicare

2010's

- Provisions in the Patient Protection and Affordable Care Act of 2010 are intended to contain Medicare costs while increasing revenue and increasing services to the program.

2015 – 2022

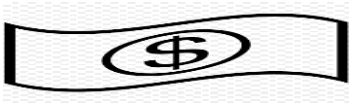
- As of August 2022, there were nearly 65 million people enrolled in Medicare. Enrollment had stood at fewer than 50 million people as of 2014. The rapid increase is due to Baby Boomers turning 65.
- The donut hole has closed, as a result of the ACA. Enrollees with standard Part D plans now pay 25% of the cost of their drugs until they reach the catastrophic coverage limit (as opposed to paying the full cost of the drugs while in the donut hole, which had been the case before the ACA started to close the donut hole in 2010/2011).
- The COVID pandemic, which began in 2020, resulted in numerous regulatory changes for the Medicare program. Between January 1 and July 24, more than 200 Medicare legislative and regulatory changes were made in response to the pandemic. Most were introduced on a temporary and emergency basis, avoiding the lengthy notice-and-comment process that new rulemaking normally must follow. But some, including increased access to telehealth, are likely to remain in place after the pandemic is over.
- In August 2022, the Inflation Reduction Act (IRA) was signed into law. This legislation includes significant improvements in drug coverage for Medicare beneficiaries.

2023 – 2029

- In 2023, under the Inflation Reduction Act (IRA), recommended vaccines will be free under Medicare Part D (vaccines covered by Part B are already free).
- In 2023, under the IRA, Part D plans will have to offer all of their covered insulin products with cost-sharing of no more than $35/month.
- In 2024, under the IRA, the Part D full Extra Help benefit will be available to more people, and there will no longer be cost-sharing once Part D beneficiaries reach the catastrophic coverage phase. From 2024 through 2030, growth of the Part D national base beneficiary premium will be capped at 6% per year.
- In 2025, there will be an out-of-pocket cap of $2,000 for Part D coverage, including stand-alone Part D plans and Part D coverage that's integrated with Medicare Advantage. (The cap will then be indexed in future years.)
- In 2025, the donut hole was eliminated.
- Starting in 2026, Medicare will begin to negotiate with drug manufacturers over the price of certain high-cost drugs. This will be phased in from 2026 through 2029, with additional drugs added each year.

[1]https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/

“No Longer will Illness Crush and Destroy Savings”
President Lyndon B. Johnson



$$ - Medicare and Medicaid cover nearly 1 out of every 3 Americans – that’s more than 100 million Americans

$$ - Medicare Enrollment – 19 million in 1966; 45 million in 2014; 61.2 million in 2024

$$ - President and First Lady Truman were the first Medicare beneficiaries

$$ - Medicaid provided coverage to over 72 million people in 2024. This includes working men and women, pregnant women, children, people with disabilities, and older adults.

$$ - Medicare was responsible for helping to desegregate hospitals after the Civil Rights Act went into effect. If hospitals wanted to receive federal funding, they had to comply with the Civil Rights Act and desegregate.

$$ - Original Medicare includes Part A which covers inpatient hospital, skilled nursing facility, some home health visits, and hospice care; and Part B which helps pay for physician, hospital, outpatient, some home health, and preventive services.

$$ - In 2024, 53 million people with Medicare had a Medicare Part D plan through a stand-alone prescription drug plan or a Medicare Advantage Plan to help cover the cost of prescription drugs.

$$ - More than two-thirds or 40.8 million Medicare beneficiaries live with two or more chronic conditions. Chronic conditions include Alzheimer’s Disease, Asthma, Depression, Diabetes, Heart Failure, HIV/AIDS, High Blood Pressure, and Stroke. (This is not a complete list.)

$$ - Fewer “Medicare and You” handbooks are printed on paper each year because more people are viewing it online.

$$ - 11,000 Americans will be eligible for Medicare every day until the year 2030.

$$ - Between 77 million and 80 million Americans will be enrolled in Medicare by 2030.
67 million of these beneficiaries will be between age 65 – 75.

Programs that Help with Medicare Costs

The Medicare Improvement for Patients and Providers Act (MIPPA) made important changes to help Medicare beneficiaries with limited incomes and resources qualify for cost saving programs. MIPPA grants are administered by the U.S. Administration for Community Living (ACL). Help is available if you cannot afford your Medicare Part B premium or your Medicare Part D plan premium, deductible, and drug copays.

The Medicare Savings Programs (MSP) help pay the Medicare Part B premium and may also help with Medicare deductibles and coinsurance and copays. The program is administered by the Pennsylvania Department of Human Services (DHS). Individuals or married couples must meet certain income and resource guidelines to qualify. Eligible individuals/married couples no longer pay the Part B premium from their social security check!

The Extra Help Program helps to pay for prescription drug costs through Medicare Part D, including the monthly premium, deductible, and co-pay amounts. The program is administered by the Social Security Administration (SSA). Individuals or married couples must meet certain income and resource guidelines to qualify.

You may reapply for these programs any time during the year even if you have been denied in the past.

For more information on the Medicare Savings Programs or the Extra Help Program contact your local PA MEDI Program or call the statewide PA MEDI Helpline at 1-800-783-7067.

IMPORTANT INFORMATION ABOUT ENROLLING IN MEDICARE OR CHANGING MEDICARE COVERAGE

Medicare has strict rules about when you can enroll and when you can change your Medicare health and/or drug plan. If you do not enroll in Medicare when you are first eligible for it, you may not be able to enroll when you need the coverage and you may have to pay a late enrollment penalty. PA MEDI counselors can help you understand the enrollment rules and help you explore coverage options. Contact your local PA MEDI office to discuss your specific situation.

Initial Enrollment Period (IEP)

The 7-month period when you first become eligible for Medicare. Since most people become eligible for Medicare when they turn 65, you can enroll in Medicare starting 3 months before you turn 65, the month of your birthday, and the 3 months after you turn 65.

Special Enrollment Period (SEP)

These are special opportunities based on your specific situation to join, change, or drop Medicare coverage. The SEP rules are different for Medicare Part B coverage than they are for Medicare Part C (Medicare Advantage) and Medicare Part D (drug) coverage.

General Enrollment Period (GEP)

Between **January 1st and March 31st**, you can sign up for Medicare Part B and for Medicare Part A when you must pay a premium. Coverage begins the first day of the following month. You may use this period to sign up for premium Medicare Part A or Medicare Part B if both of the following apply:

- You did not sign up when you were first eligible.
- You are not eligible for a Special Enrollment Period

Annual Open Enrollment Period (AOEP)

The period from **October 15th to December 7th** when you can enroll in a Medicare Advantage plan or a stand-alone Prescription Drug Plan, or switch Medicare health and drug plans. New coverage begins January 1st.

Medicare Advantage Open Enrollment Period (MA OEP)

If you have a Medicare Advantage plan, you can make a one-time change to your coverage between **January 1st and March 31st.** Changes begin the first of the month after you make the change. Here are the changes that can be made during this period:

- You can switch to a different Medicare Advantage Plan.
- You can disenroll from your Medicare Advantage plan and return to Original Medicare. You can enroll in a stand-alone prescription drug plan.

IMPORTANT INFORMATION ABOUT ENROLLING IN MEDICARE OR CHANGING MEDICARE COVERAGE

Medicare Health or Drug Coverage (Part C and Part D) SEP: There are a number of different SEPs that allow you to change your Medicare Advantage Plan or your Medicare Prescription Drug plan during the year. This SEP can be triggered when certain life events happen such as you move or you lose other insurance coverage like Medicaid or job-based insurance. People with Medicaid/Extra Help also have access to SEPs that allow them to make changes during the year. The rules about what changes you can make or when you can make changes differ depending on your situation. PA MEDI can help you figure out if you qualify for an available SEP.

Medicare Part B SEP: This should be used when you stop working and you had healthcare coverage through your job. This SEP allows you to enroll in Medicare Part B within **8 months after your employment ends or your employer healthcare coverage ends, whichever happens first.** You should not have a late enrollment penalty if you use this SEP for any of the following circumstances to enroll in Medicare Part B:

You were impacted by an emergency or disaster		
You have an SEP if…	**Your SEP lasts…**	**To use this SEP…**
You missed an enrollment opportunity because you live in an area where the Federal, state, or local government declared an emergency. You can also use this SEP if the person who makes health care decisions on your behalf lives in an area where there was a declared emergency. Example: Your Social Security office was closed and you could not enroll in Medicare.	For six months. Your SEP begins the date the emergency or disaster is declared (as long as it is after January 1, 2023). Your SEP ends six months after the end date in the emergency declaration. If the emergency declaration is extended, then the six months start with the end date of the extension. Your coverage begins on the first of the month following the month you enroll.	Contact Social Security. You must include proof to show that you live or did live in the area when it was affected by the disaster or emergency.

IMPORTANT INFORMATION ABOUT ENROLLING IN MEDICARE OR CHANGING MEDICARE COVERAGE

You got certain types of misinformation from your employer		
You have an SEP if...	**Your SEP lasts...**	**To use this SEP...**
Your employer, employer health insurance plan, or someone acting on behalf of your employer gave you incorrect information that caused you to delay Medicare enrollment. You must have received this misinformation on or after January 1, 2023. Your decision to not enroll in Medicare must have been a mistake. Note that not receiving any Medicare enrollment information from your employer does not count as misinformation. If you received misinformation before January 1, 2023 you cannot use this SEP to enroll in Part B for the first time.	For six months. Your SEP begins the day you notify Social Security of the misinformation (as long as you received the misinformation on or after January 1, 2023). Your SEP ends six months after you notify Social Security. Your coverage begins on the first of the month following the month you enroll.	Contact Social Security. You must provide documentation that shows you were misinformed by your employer or their representative. An example of proof is a letter from your employer that provides incorrect information about Medicare enrollment. Another example is a letter from your employer that acknowledges that they gave you misinformation. You can also submit your own written statement describing the misinformation if you do not have written proof from the employer or representative.
You were released from incarceration		
You have an SEP if...	**Your SEP lasts...**	**To use this SEP...**
You are released from incarceration on or after January 1, 2023. If you were released from incarceration before January 1, 2023 you cannot use this SEP to enroll in Part B for the first time.	For twelve months. Your SEP begins the day you are released from incarceration. Your SEP ends the last day of the twelfth month after you are released. You have two choices for when coverage will begin: • You can choose to have your coverage begin on the first of the following month • You can choose to have your coverage begin up to six months retroactively (but coverage cannot begin before January 1, 2023 or before you were released from incarceration)	Contact Social Security.

IMPORTANT INFORMATION ABOUT ENROLLING IN MEDICARE OR CHANGING MEDICARE COVERAGE

Your Medicaid coverage is ending		
You have an SEP if…	**Your SEP lasts…**	**To use this SEP…**
You lose Medicaid eligibility on or after January 1, 2023. (**Note:** If you lost Medicaid and enrolled in Medicare before January 1, 2023 and you now have a late enrollment penalty, contact Social Security to get the penalty removed and to be reimbursed for the penalties you already paid.)	For six months. If your Medicaid eligibility ends on or after January 1, 2023, your SEP begins when you receive notice of upcoming termination of Medicaid eligibility. Your SEP ends six months after the termination of eligibility. You have two choices for when coverage will begin: • You can choose to have your coverage begin on the first of the month following the month you enroll • You can choose to have your coverage begin retroactively back to when your Medicaid ended (but no earlier than January 1, 2023)	Contact Social Security. You must prove that you are eligible for Medicare and that your Medicaid eligibility ended on or after January 1, 2023.
You experience other exceptional circumstances		
You have an SEP if…	**Your SEP lasts…**	**To use this SEP…**
Social Security decides that you have experienced an exceptional circumstance. You can request to enroll through this SEP if you missed other enrollment periods because of situations you could not control. Forgetting to enroll or not knowing that you were supposed to enroll do not count as exceptional circumstances.	Depends on the circumstances.	Contact Social Security. You may be asked to provide proof of your exceptional circumstance.

[2]Part B Special Enrollment Periods for exceptional circumstances - Medicare Interactive

Programs that Help with Prescription Drug Costs

PACE - Pharmaceutical Assistance Contract for the Elderly

PACE is Pennsylvania's prescription assistance program for older adults, providing affordable prescription medications to eligible residents.

- Must be 65 years of age or older
- Pennsylvania resident for at least 90 consecutive days
- Cannot be receiving Medicaid prescription benefits
- Meet income requirements based on previous year's gross income (income exclusions apply)

PACE		PACENET	
Single	$14,500 year	Single	$33,500 year
Married	$17,700 year	Married	$41,500 year

Based on a 30-day supply:
PACE: $6 for generic/ $9 for brand name medications
PACENET: $8 for generic/$15 for brand name medications.
Apply online or by phone 1-800-225-7223

The Clearinghouse

The Clearinghouse researches local, state, and national programs to identify resources tailored to individual needs and offers application assistance as needed. This free service is available to Pennsylvania residents aged 18 and older.

The Clearinghouse connects Pennsylvania residents with programs for the following services:

Medications	Medical Expenses	Food	Housing
Utilities	Employment	Transportation	Furniture
Clothing	Legal Aid	Family Resources	Social Services

Apply online or by phone 1-800-955-0989

The Chronic Renal Disease Program

The Chronic Renal Disease Program (CRDP) provides care and treatment for adults with End-Stage Renal Disease.

You are eligible to enroll in the CRDP if:

- You have end-stage renal disease;
- You have lived in Pennsylvania for at least 90 days before the date on your application or you have shown that you plan to live permanently in PA;
- You are a U.S. citizen or legal alien; and

- Your income is within the guidelines (at or below 325% FPL)

The CRDP assists with costs related to:

Dialysis and Renal Transplantation	Medications	Medical Management
Inpatient/outpatient services	Home dialysis supplies/equipment	Limited patient transportation

Download an enrollment application or call 1-800-225-7223 for information

Special Pharmaceutical Benefits Programs (SPBP)

SPBP HIV/AIDS assists individuals with HIV to obtain medications, pay for some laboratory services and provides premium assistance with select Medicare Advantage and Part D Plans.

To be eligible for SPBP HIV/AIDS, a person must:

- Live in Pennsylvania;
- Have a gross annual (household or individual) income of less than or equal to 500% of FPL;
- Have a diagnosis of HIV, and
- Not eligible for pharmacy services under the Medical Assistance Program.

Enroll online or call 1-800-922-9384 for more information

SPBP Mental Health provides payment for specific atypical antipsychotic medications for eligible participants. The SPBP-MH formulary is Abilify, Clozaril, Clozapine, Geodon, Invega, Risperdal, Risperidone, Seroquel or Zyprexa.

- Live in Pennsylvania;
- Cannot be institutionalized;
- Meet income guidelines:
  - $35,000 gross income per year
  - Families - $35,000 gross income per year, plus an allowance of $2,893 for each additional family member.
- Must have a medical need with an ICD-10-CM diagnosis of schizophrenia.

Download an enrollment application or call 1-877-356-5355

Medicare Appeals

What to Do If Coverage or Payment Is Denied

If Medicare or your Medicare plan denies coverage or payment for something you and your health care provider think should be covered, you have the right to appeal. This means you can ask Medicare to take another look at their decision.

You can file an appeal if:

- Medicare, your Medicare Advantage plan, or your Medicare Part D Prescription Drug plan won't cover a health service, supply, item, or drug you believe you need.
- You already received a service, supply, item, or drug, but Medicare or your plan refuses to pay for it.
- You think you're being charged too much for a health service, supply, item, or drug.
- Medicare or your plan stops paying for a service, supply, item, or drug you still need.

How the Appeals Process Works

The steps to appeal depend on the type of Medicare coverage you have. In most cases, there are five levels of appeal. If you do not agree with a decision at one level, you can usually move to the next. After each level of appeal, you will get a decision letter explaining what to do if you do not agree.

Standard Appeals

- **Original Medicare**: Check your Medicare Summary Notice (MSN) to see what Medicare paid and what you owe. If Medicare denies coverage for your care, talk with your doctor's office to see if additional information is required to process the claim before submitting an appeal. A simple billing error may be the cause of the denial.
- **Medicare Advantage Plans**: If your plan denies coverage for a service or item before you get it, you can appeal and ask them to reconsider. Follow the steps in your plan's Evidence of Coverage. The Evidence of Coverage is available online or by request from the plan. If your Medicare Advantage Plan denied coverage for a service or item that you have already received, you can appeal the decision. You should receive a letter from the plan called "Notice of Denial of Payment." This notice will outline the steps you need to follow to start an appeal.
- **Medicare Part D Plans**: If your prescription drug is denied, you can appeal to challenge the decision. Follow the steps provided by your Medicare Part D Plan in your Evidence of Coverage that is available online or by request from the plan.

Medicare Appeals

Fast Appeals

If you think your Medicare-covered services are ending too soon, you have the right to a fast appeal. This applies if you're receiving care from a:

- Hospital
- Skilled nursing facility
- Home health agency
- Comprehensive outpatient rehab facility
- Hospice care

Before your services end, you'll get a written notice explaining how to request a fast-track appeal. An independent reviewer, called a Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO), will decide if your coverage should continue. In Pennsylvania, the BFCC-QIO is **Livanta**. If you disagree with the BFCC-QIO decision, you can continue to appeal through the Medicare appeals process.

Tips for a Successful Appeal

- **Understand the denial** – Contact Medicare or your plan to clarify the reason for the denial.
- **Gather supporting documents** – Collect medical records, doctor's notes, test results, and treatment plans.
- **Keep detailed records** – Save copies of bills, notices, and any correspondence with Medicare or your plan. Keep detailed records about any phone calls including date, time and who you talked to.
- **Obtain a doctor's letter** – Ask your doctor to provide a letter explaining the medical necessity of the requested services or coverage.
- **Meet the deadline** – Submit your appeal within the required timeframe.

Need Help with an Appeal?

- **PA MEDI**: PA MEDI offers free, one-on-one Medicare counseling and education to those with Medicare, their families and caregivers. Check this toolkit for your local PA MEDI contact information.
- **Appoint a Representative**: If a family member or friend is helping with your appeal, you can officially name them as your representative. Click here to get the Appointment of Representative form.

Adding on to Medicare

Medicare covers a lot, but not everything. For example, Medicare doesn't cover most dental, vision, and hearing care, including hearing aids. It also doesn't cover most non-emergency transportation or care outside of the United States. Even when Medicare does cover your care, there may be out-of-pocket costs left to you, like copays and coinsurances, that can really add up. Today we'll discuss ways to add on to your Medicare to help you access these types of care.

Medigaps: Covering out-of-pocket costs

Medigaps are health insurance policies that work with Original Medicare—not with Medicare Advantage. They are sold by private insurance companies.

- If you have a Medigap, it pays part or all of certain remaining costs after Original Medicare pays first. Medigaps may cover outstanding deductibles, coinsurance, and copayments.
- Medigaps may also cover health care costs that Medicare does not cover at all, like emergency care received when travelling abroad.

If you want to purchase a Medigap policy, you need to find out the best time to buy one in your state.

- In most states, insurance companies must only sell you a policy at certain times and if you meet certain requirements.
- If you miss your window of opportunity to buy a Medigap, your costs may go up, your options may be limited, or you may not be able to buy a Medigap at all.
- Even if you do not have the right to buy a Medigap in your state, you may still be able to buy a policy if a company agrees to sell you one. However, know that companies can charge you a higher price because of your health status or other reasons.

When you're ready to buy a Medigap, you should compare your options and decide which plan you want. You can compare Medigaps on Medicare.gov. After choosing a Medigap, you should contact the insurance company directly to enroll.

Medicare Advantage Plans: Supplemental benefits

Medicare Advantage Plans may cover things that Medicare can't cover. These are called supplemental benefits. Examples of common supplemental benefits are:

 Dental care

 Vision care

 Hearing aids

 Gym memberships.

Medicare Advantage Plans can also offer benefits that are not primarily health-related for beneficiaries who have chronic illnesses, like meal delivery, transportation for non-medical needs, and home air cleaners.

It's very important to read a plan's coverage rules around its supplemental benefits. These benefits may not be as comprehensive as you assume.

Medicaid: For limited income and assets

- Medicaid in your state may cover dental, vision, hearing, long-term care, or transportation services. You may qualify for Medicaid if you have a low income and minimal assets. Contact your local Medicaid office to learn if you qualify.

Stand-alone plans: Covering what Medicare doesn't

- You can purchase stand-alone dental, vision, or hearing plans through private insurance companies.

Strategies for low-cost care outside of Medicare

- You can find low-cost care for services not covered by Medicare, in places like Federally Qualified Health Centers or Community Health Centers. Schools and facilities that train dentists, optometrists, and audiologists may also offer low-cost care. Students work with patients under the supervision of experienced, licensed providers.

Look out for over-the-counter (OTC) hearing aid scams

Medicare does not cover most hearing care, including hearing aids. Because OTC hearing aids are a new product, older adults may not realize that they can buy one without a prescription from a doctor. Fraudsters may take advantage of this, stealing a person's Medicare number when selling the devices. Also, some companies selling OTC hearing aids may make false claims, have unclear or misleading labels, and fail to offer the guarantees and customer support they promise.

Below are red flags that may point to hearing aid scams, identified by the National Council on Aging (NCOA):

- **Unknown brand names:** Instead, look for well-known and reputable brands with reviews on hearing and retail websites. You can learn about a company's reputation online at the Better Business Bureau or TrustPilot.

- **Misleading labels:** Make sure your device is clearly labeled as a hearing aid (rather than, for example, a "hearing enhancement") to avoid buying a different kind of product.

- **Fake FDA registration certificates:** The FDA does not issue registration certificates, so this could be a scam or misleading marketing.

- **Extremely low prices:** Companies selling hearing aids far below the price of other companies may be trying to sell you a hearing product other than a hearing aid or trying to sell you a very poor-quality device. Consider your budget but remember that a deal that seems too good to be true, may be just that.

- **No trial period or warranty:** Most companies offer at least a 30-day trial period to test new devices, and some offer even more. Be cautious of companies that don't offer these trial periods or warranties.

- **Lack of customer support:** Avoid companies that don't clearly have contact information on their website. Reputable companies should be easy to contact with issues you're experiencing.

- **Unsupported claims:** There is currently no cure for hearing loss, so be wary of companies that claim their products can cure hearing loss or offer immediate relief from symptoms.

Hearing aid scams can range from dishonest companies misleading you to someone calling to tell you Medicare will cover a hearing aid in an attempt to get your Medicare number or promise you other unneeded medical supplies.

Preventive Benefits

The following two pages contain a check list of Medicare Preventive Benefits. You should take this list along to your next doctor's appointment and discuss which services may be right for you. Preventive services are a great way to keep you healthy and protect you by detecting problems early. Many of Medicare's Preventive Services have no co-insurance or deductible if you have Original Medicare. If you have a Medicare Advantage Plan, please contact your plan to find out if there is co-insurance or a co-pay and/or any deductible you must pay when you get Preventive Services.

Date Discussed	Date Completed	Medicare Preventive Service
		One time "Welcome to Medicare" Preventive Visit—within the first 12 months you have Medicare Part B (Medical Insurance)
		Yearly "Wellness" Visit—get this visit 12 months after your "Welcome to Medicare" preventive visit or 12 months after your Part B effective date
		Abdominal Aortic Aneurysm Screening
		Alcohol Misuse Screening and Counseling
		Bone Mass Measurement (Bone Density Test)
		Cardiovascular Disease (Behavioral Therapy)
		Cardiovascular Screenings (cholesterol, lipids, triglycerides)
		Colorectal Cancer Screenings
		Depression Screening
		Diabetes Screening
		Diabetes Self-management Training

Preventive Benefits

Date Discussed	Date Complete	Medicare Preventive Service
		Flu/COVID Shot
		Glaucoma Test
		Hepatitis B Screening
		Hepatitis C Screening
		HIV Screening
		Lung Cancer Screening
		Mammogram (screening for breast cancer)
		Medical Nutrition Therapy Services
		Medicare Diabetes Prevention Program
		Obesity Screening and Counseling
		Pap Test and Pelvic Exam (includes a breast exam)
		Pneumococcal Shots
		Prostate Cancer Screening
		Sexually Transmitted Infection Screening and Counseling
		Counseling to Prevent Tobacco Use and Tobacco-Caused Disease

PA MEDI Office Phone Number by County

County	PA MEDI Phone Number
Adams	717-334-9296
Allegheny	412-661-1438
Armstrong	724-548-3290
Beaver	724-847-2262
Bedford	814-623-8148
Berks	610-374-3195
Blair	814-946-1235
Bradford	800-982-4346 or 570-265-6121
Bucks	267-880-5700
Butler	724-282-3008
Cambria	814-539-5595
Cameron	814-776-0428
Carbon	610-824-7830 or 800-441-1315
Centre	814-355-6716
Chester	610-344-5004 option 2
Clarion	814-226-4640
Clearfield	814-765-2696
Clinton	570-601-9569
Columbia	570-784-9272 ext. 3110
Crawford	814-336-1792

County	PA MEDI Phone Number
Cumberland	717-240-6110
Dauphin	717-780-6130
Delaware	484-494-3769
Elk	814-776-0428
Erie	814-459-4581
Fayette	724-489-8080
Forest	814-723-3763
Franklin	717-263-2153
Fulton	717-485-5151
Greene	724-489-8080
Huntington	814-643-5115
Indiana	724-349-4500
Jefferson	814-849-3096
Juniata	800-348-2277
Lackawanna	570-343-1267 ext.239
Lancaster	717-299-7979
Lawrence	724-658-3729
Lebanon	717-273-9262
Lehigh	610-782-3200
Luzerne	570-624-3027
Lycoming	570-601-9569

PA MEDI Office Phone Number by County

County	PA MEDI Phone Number
McKean	814-776-0428
Mercer	724-662-6222
Mifflin	800-348-2277
Monroe	570-420-3735
Montgomery	610-834-1040
Montour	570-784-9272 ext. 3110
Northampton	610-829-4540
Northumberland	570-495-2395
Perry	717-582-5128
Philadelphia	Zip codes: 19102, 19103, 19104, 19105, 19106, 19107, 19112, 19121, 19122, 19123, 19125, 19127, 19130, 19131, 19132, 19133, 19134, 19137, 19138, 19139, 19142, 19143, 19144, 19145, 19146, 19147, 19148, 19151, 19153, 19175, 19182 Please call: 215-545-5728 Zip codes: 19111, 19114, 19115, 19116, 19118, 19119, 19120, 19124, 19126, 19128, 19129, 19135, 19136, 19138, 19140, 19141, 19144, 19149, 19150, 19152, 19154 Please call: 215-456-7600

County	PA MEDI Phone Number
Pike	570-775-5550
Potter	1-800-800-2560 or 814-544-7315
Schuylkill	570-624-3026
Snyder	570-524-2100
Somerset	814-443-2681
Sullivan	800-982-4346 or 570-265-6121
Susquehanna	800-982-4346 or 570-265-6121
Tioga	800-982-4346 or 570-265-6121
Union	570-524-2100
Venango	814-432-9723
Warren	814-723-3763
Washington	724-489-8080
Wayne	570-253-4262
Westmoreland	724-925-4213
Wyoming	570-822-1158
York	717-852-4902 ext.1041

Pennsylvania
Medicare Education and Decision Insight

Medicare Help

P	A	D	E	L	B	I	T	C	U	D	E	D	E
I	A	L	A	E	M	E	D	I	C	A	R	E	C
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MIPPA
MEDICARE
EXTRA HELP
PREMIUMS
PART A
PART B

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Medicare - MIPPA Preventive Benefits

I	Y	I	U	A	A	H	E	A	A	D	M	V	I
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C	C	A	E	S	N	T	S	S	E	I	I	E	N
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AWARENESS
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PREVENTIVE
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PA MEDI

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Volunteers Needed

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CARING
LISTENER
SMILE
COMPANION
EASY GOING
DONATION
TIME
SENIOR CENTER
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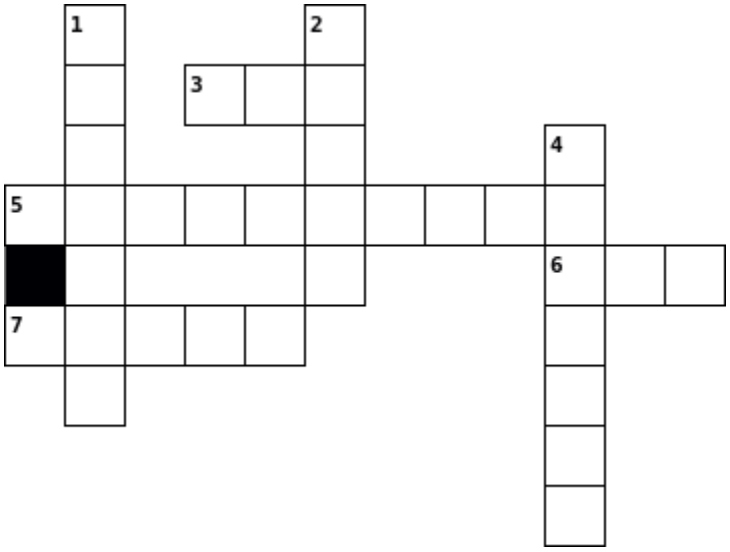
Medicare



Across

3. Does the SSA or DHS handle enrollment & eligibility for Medicare?

5. An initial amount of medical expense for which the beneficiary is responsible before Medicare or an insurance policy will pay

6. A person with ___ Gehrig's disease is eligible for Medicare at any age.

7. Which part cover hospice

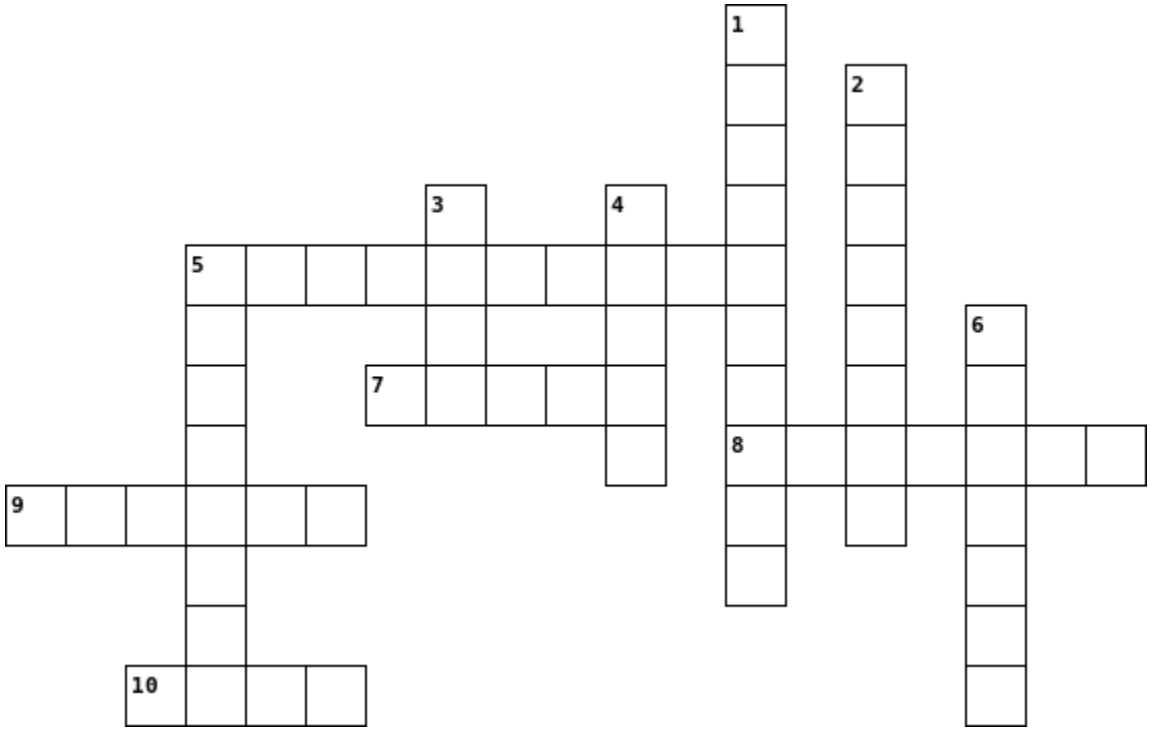
Down

1. Is Medicare a state or federal insurance program?

2. Which part covers Doctor's visits?

4. One-time free exam within the first 12 months of having Part B is called the ____ to Medicare Exam

Medicare Preventive Services



Across

5. Medicare covers screening _____ to check for breast cancer.

7. High levels of cholesterol can increase your risk for _____ disease and stroke.

8. Diabetes causes your blood sugar to be too high because your body needs _____ to use sugar regularly.

9. Medicare covers colorectal _____ screening tests to help find pre-cancerous polyps.

10. Medicare covers one depression screening per _____.

Down

1. Medicare covers alcohol misuse screening and _____.

2. The Yearly _____ Visit is used to develop or update a personalized prevention plan based on your current health and risk factors.

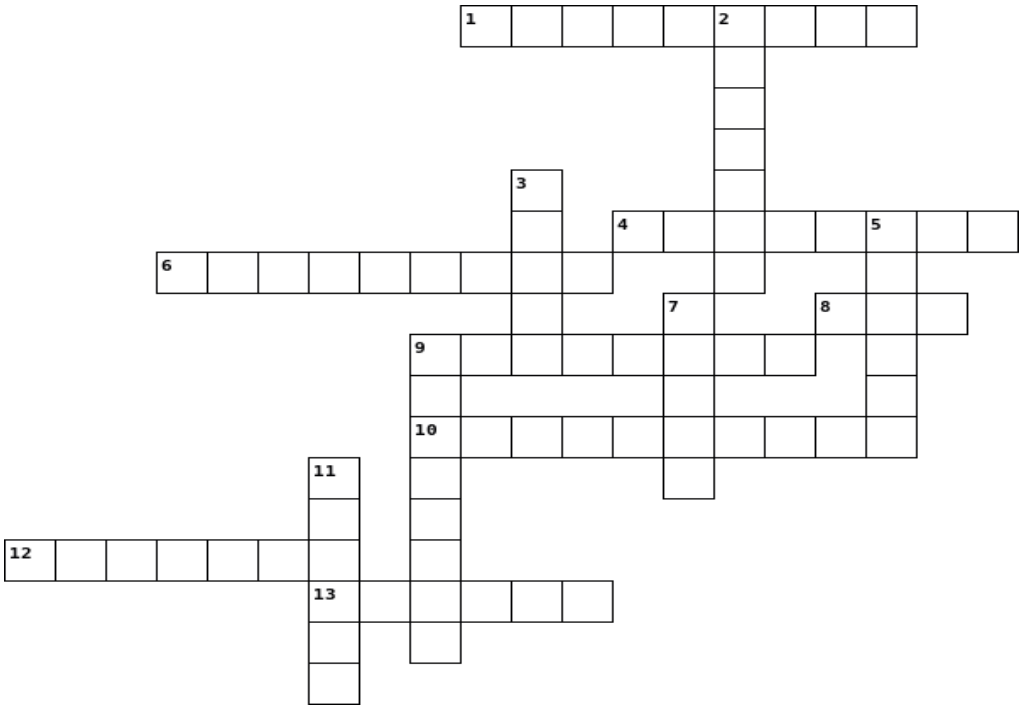
3. Medicare covers _____ mass measurements to see if you're at risk for broken bones due to osteoporosis.

4. Medicare _____ covers preventive services.

5. Your _____ & You handbook has information about preventive services, including costs and conditions that may apply.

6. The _____ to Medicare preventive visit covers a one-time preventive visit within the first 12 months that you have Medicare Part B.

Medicare Basics



Across

1. Financial assistance from Medicare to help cover Part D drug plan costs

4. The Social _____ Administration completes Medicare enrollments.

6. A list of prescription drugs that an insurance company will cover?

8. A physician who provides initial care and coordinates additional care as needed.

9. A joint federal and state program, separate from Medicare, that helps pay medical costs for people with low incomes, limited assets, and disabilities.

10. Medicare Part B has a yearly _____.

12. Medicare supplemental insurance is also known as a _____ policy.

13. You can compare and _____ in a Part D plan on the Medicare.gov Plan Finder

Down

2. Healthcare for terminally ill patients

3. Part of Medicare that covers outpatient prescription drugs.

5. To qualify for the Medicare Savings Programs you must meet the _____ and resource guidelines.

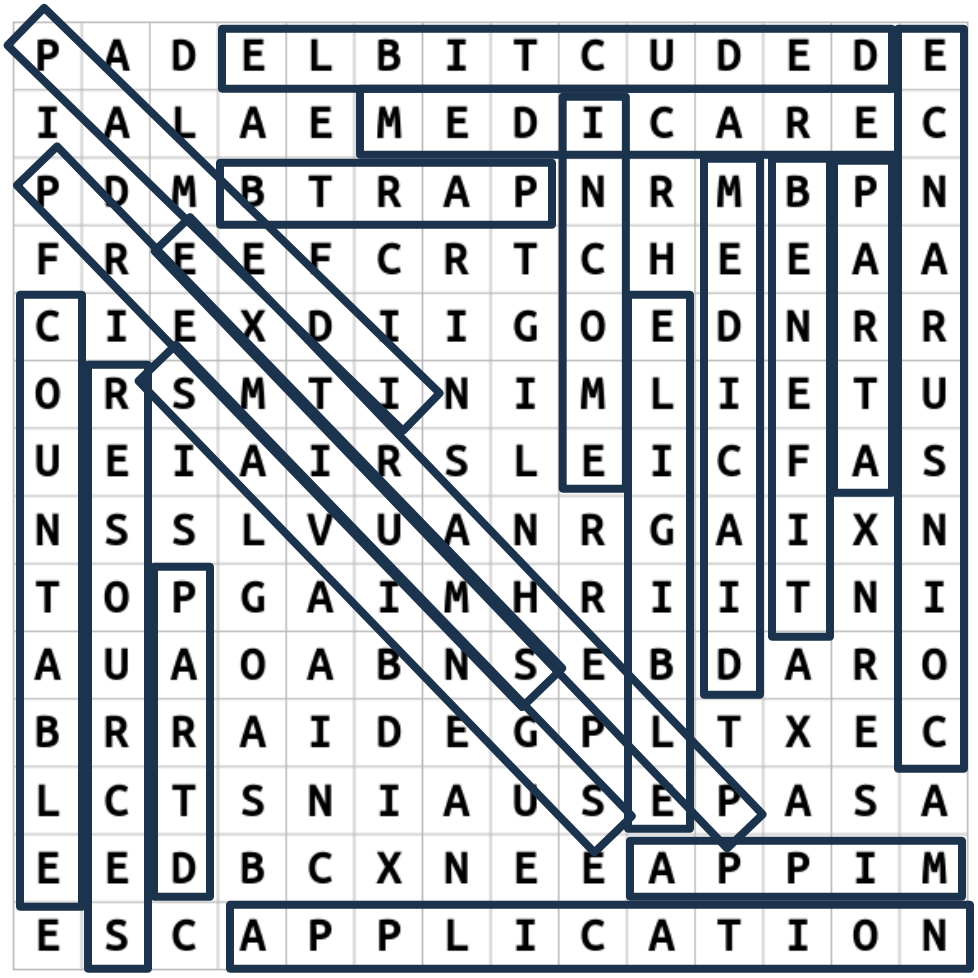
7. Which part of Medicare covers doctor's visits?

9. Insurance provided by the Federal government for people over the age of 65, those with disabilities, or End Stage Renal Disease

11. A process to request your Medicare health plan to reconsider or perhaps change the decision of denying your request for coverage for the medical care coverage that you want

Puzzle Answer Key

Medicare Help



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PART B

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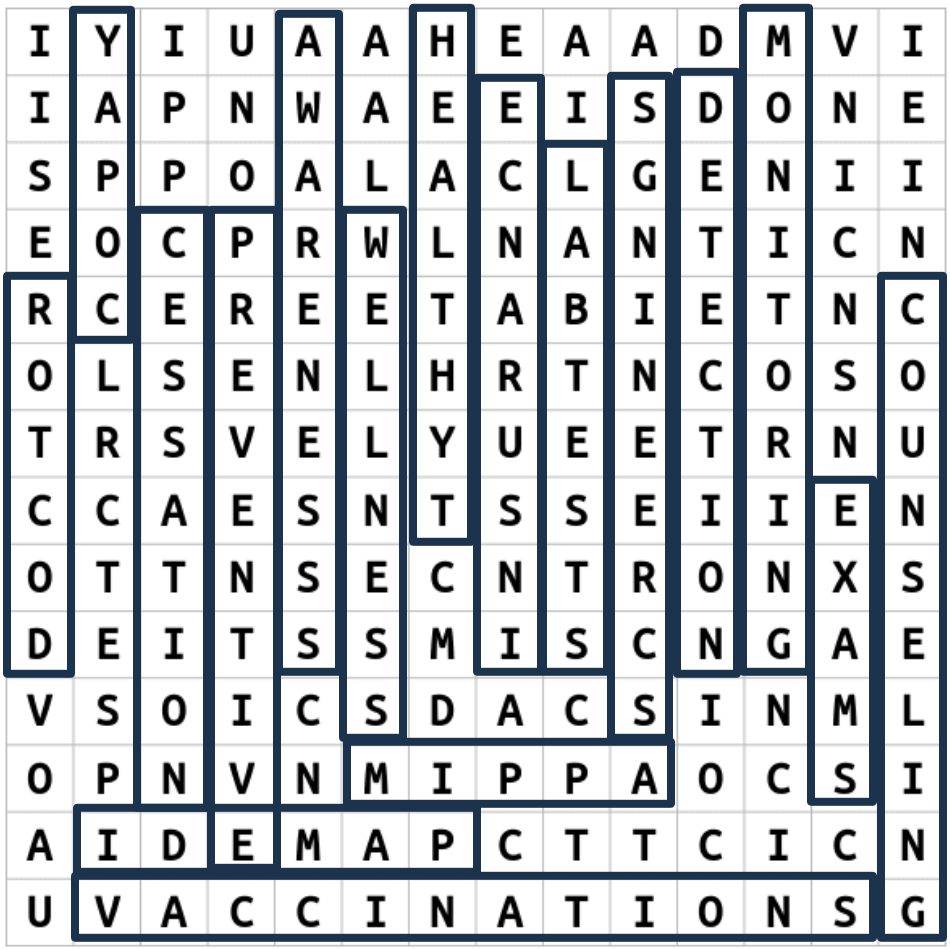
Puzzle Answer Key

Medicare - MIPPA Preventive Benefits



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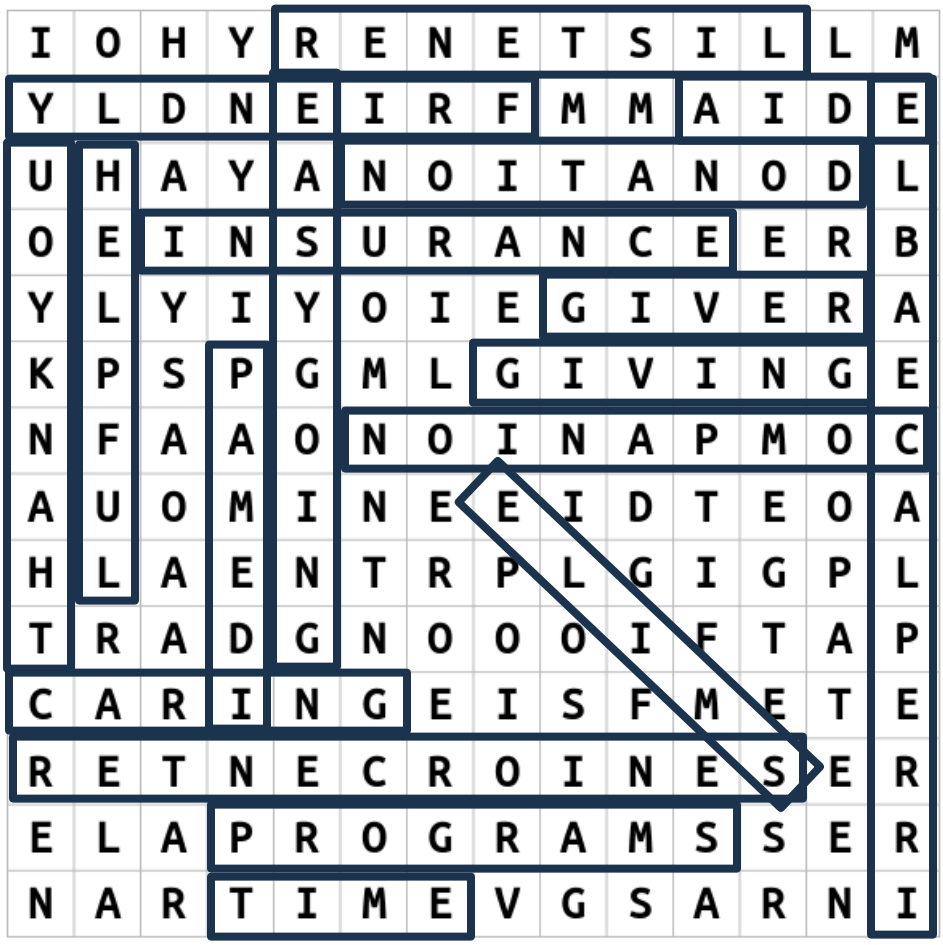
Puzzle Answer Key

Volunteers Needed



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CARING
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SMILE
COMPANION
EASY GOING
DONATION
TIME
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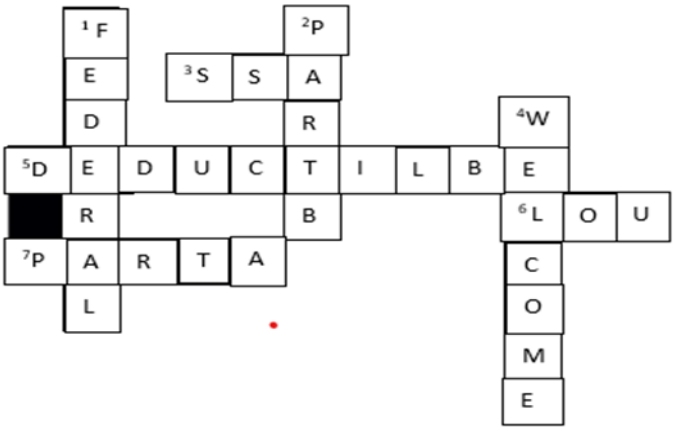

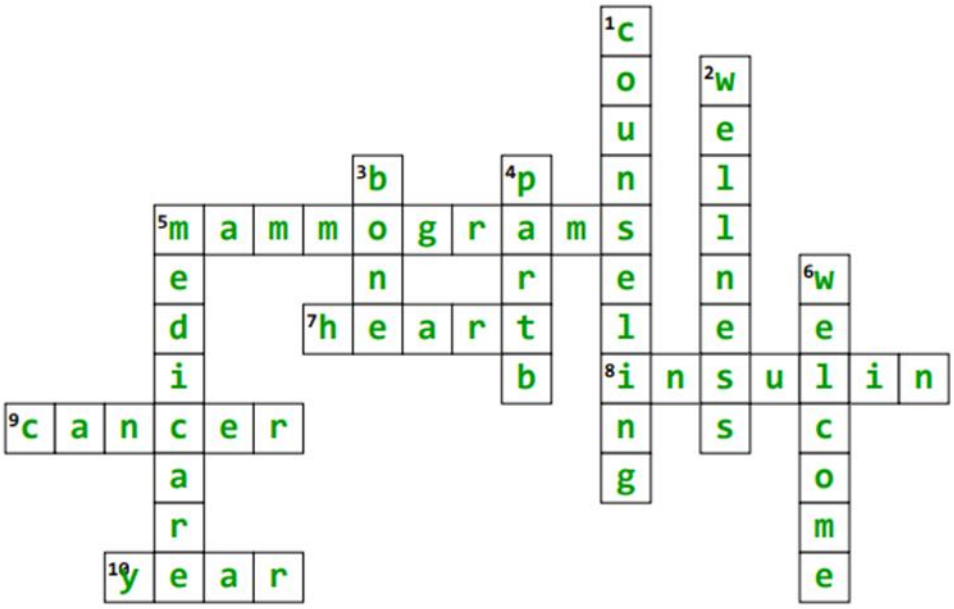

Puzzle Answer Key