M E D I C A R E - 2022

A Summary of Parts A, B, C, & D

Notice: This document explains Medicare, Medicare Supplements, Medicare Advantage, Prescription Drug Plans

Medicare was signed into law by President Lyndon B. Johnson in 1965 and the law was effective on January 1, 1966. It provided a national health plan for senior citizens over the age of 65 and under age 65 with certain disabilities. It was called Medicare. Original Medicare had two distinct parts:

Part A – Hospital Expense Coverage

I MEDICARE: PART A (Hospital Coverage)

A WHAT DOES "PART A" COVER:

1 Covers Inpatient Hospital Care:

a Generally Includes:
- 1 Hospital Meals
- 2 General Nursing
- 3 Medically Necessary Prescriptions & Supplies
- 4 Equipment

b Semi-Private hospital room
c Skilled Nursing Facility Care
d Home Health Care
e Hospice Care

B WHAT IS NOT COVERED BY PART A:

1 Non - Covered Inpatient Hospital Care

a Custodial care in Nursing Homes
b Private Duty Nursing
c Care Outside the United States
d Hospital Stays for Cosmetic Surgery
e Hospital Stays Not Medically Necessary
f Outpatient Prescription Drugs

C COST:

1 **No Premiums**: Many people get "Medicare A" without paying premiums. If they worked and paid Medicare taxes for 40 quarters (10 years). However, there is a charge for Medicare Part A if you have not worked and paid Medicare deductions for the required 40 quarters.

Part A Enrollees age 65 or older who have fewer than 40 quarters of (employee payments to Medicare) and certain person with disabilities must pay a monthly premium to voluntarily enroll in Medicare Part A. Individuals who had at least 30 quarters paid / or were married to someone with at least 30 quarters paid, may buy into Medicare A at a reduced monthly premium, which will be $274 in 2022, a $15 increase from 2021. Certain uninsured aged individuals who have less than 30 quarters of coverage and certain individuals with disabilities who have exhausted other entitlements will pay the full premium, which will be $499 per month for 2022.

2 **Other Costs**: Medicare A has other costs, as well: Similar to an employer sponsored health plan, Medicare A contains deductibles, copayments, and coinsurance. A person's overall cost will depend on the types of services and length of time treatment is rendered.

D MEDICARE A COVERAGE:

1 **Coverage Details:**

a	2022 Deductible	$1,556
b	1st 60 days of each benefit period:	No Cost
c	61st to 90th day of each benefit period	$ 389 / day
d	60 Lifetime Reserve Days (following 90the day)	$ 778 / day

2 **Reserve Hospital Days**: Each covered person is allowed 60 life-time reserve hospital days following the 90th day of a hospital period, after the Reserve Days are exhausted, the patient pays full cost.

3 **Skilled Nursing Home Care**:

a	1st day to 20th day	No Cost
b	21st day thru 100th day	$194.50 / day
c	No Coverage after 100th day	

E ENROLLMENT:

1 **Eligibility**: If you have paid FICA (Social Security and Medicare) Taxes for 10 years (40 Quarters) you will be eligible for Medicare Parts A and B, beginning on the first day of the month in which you turn age 65.

2 **Automatic**: If you are already drawing Social Security benefits when you are first eligible for Medicare; your enrollment will be automatic.

3 **Self-Enroll**: If you are not enrolled in Social Security when first eligible for Medicare, you will need to Self-enroll in Medicare. Since Medicare is effective on the first day of the month in which you turn age 65, you will need to enroll in Medicare 3 months in advance of your 65th birthday. Below is the current contact information:

a On-Line: Govssa.gov

b Call: Social Security at 1-800-772-1213,
TTY – 1-800-325-0778

c In Person: Visit a Social Security Office.

4 **Additional Circumstances**: There are additional circumstances that will require manual enrollment in Medicare:

a If you have not worked long enough to get Medicare without premium.

b If you have not paid Medicare taxes through your employer.

c If you have end-stage renal disease before age 65, you may apply for Social Security disability regardless of age.

5 **Late Enrollment Penalty**:

a If you are eligible for premium free Medicare Part A, you may enroll in Medicare any time after initial eligibility, without a penalty.

b If you are not eligible for premium-free Part A, and you do not enroll in Medicare Part A during the initial 7-month enrollment period (3 months before your birthday month, your birthday month, and 3 months after your birthday month) **you will need to wait until the next "Open Enrollment Period" which is January 1st to March 31st . Your Medicare effective date will be the following July 1st.**

II MEDICARE PART B (Medical Coverage)

A WHAT IS COVERED BY PART B, MEDICARE:

1 **Outpatient Services**:

a Doctor's Visits (Office, Hospital, or Clinic)

b Outpatient Medical Care

b Laboratory Tests

c Diagnostic Tests

d Emergency Ambulance Service

e Surgery

f Mental Health Services

g Durable Medical Equipment

h Preventive Services; Pap smears, flu shots, exams, & screenings

i Rehabilitative Services: Speech, physical, & occupational therapy

j Preventive services to prevent or detect blindness at an early age.

B WHAT IS NOT COVERED BY PART B, MEDICARE:

1 **Non-Covered Outpatient Services:**

a Prescription Drugs (Except in limited circumstances)
b Routine Foot care & Podiatry services
c Routine Beauty care and aids
d Routine eye exams and prescription eye wear
e Routine dental care: exams, fillings, extractions, & dentures
f Fitness and Wellness Programs.

C PART B COSTS:

1 **PART B Deductible: There is an annual deductible of $233 that Medicare recipients must pay before Medicare Part B coverage begins.**

2 **Monthly Premium:** You will pay a monthly premium of $170.10, however, some people who were enrolled in Medicare in 2020 or earlier will pay slightly less because of a hold-harmless provision that does not allow Social Security payments to be reduced from year to year for Medicare premiums.

3 **Income Adjusted Premium:** If you first enroll in Medicare Part B during 2022, or you are now collecting Social Security benefits, your premium will be $170.10 / month. Also, if your adjusted gross income is over $91,000 (or $182,000 for a couple), the monthly premium is higher. These monthly surcharges have increased for 2022, as indicated on the below chart:

Yearly Income in 2020 will determine what your Medicare Part B Premium is for 2022:

File Individual Tax Return	File Joint Tax Return	File Married and Separate Tax Return	You Pay Each Month (in 2022)
$ 91,000 or less	$182,000 or less	$ 91,000 or less	$ 170.10
$91,000 up to $114,000	$182,000 up to $228,000	Not Applicable	$ 238.10
$114,000 up to $142,000	$228,000 up to $284,000	Not Applicable	$ 340.20
$142,000 up to $170,000	$284,000 up to $340,000	Not Applicable	$ 442.30
$170,000 up to $500,000	$340,000 up to $750,000	$91,000 up to $409,000	$ 544.30
$500,000 & above	$759,000 & above	$409,000 & above	$ 578.30

III MEDICARE PART D

A HISTORY:

1 **Background:** The Part D (drug) plan was signed into law by President, George W. Bush in 2003. and was effective January 1, 2006. It was specifically designed to be an add-on to Medicare Parts A and B. The legislation put forth a specific benefit plan to create a minimum level of coverage. Drug companies were encouraged to offer several plans, however, every plan offered must, as a minimum, equal or exceed the base plan outlined in the legislation. Insurance companies and drug companies were encouraged to design their own offerings which would create competition to help hold down costs

2 **Formularies:** Each Medicare drug plan has its own list of covered drugs, known as their drug formulary. Most Part D drug plans categorize drugs into different groupings by type and cost – called "Tiers" on their drug formularies. Drugs are assigned to these "Tiers" with the lower cost drugs (usually generic drugs) being assigned to "Tier 1. The higher cost generics and lower cost "brand name" drugs are assigned to Tier 2. The higher cost brand name drugs are assigned to Tier 3, and the more expensive brand name and the specialty drugs are assigned to Tiers 4 and 5 (based on cost). Therefore, the drugs will tend to increase in cost from Tier 1 drugs, on a step-rate bases up to the Specialty drugs in Tier 5:

Tier 1	Lowest cost generic drugs:	= Usually No Copay
Tier 2	Generic & lower cost brand drugs	= Lowest Copays
Tier 3	Brand Name drugs	= Slightly Higher Copays
Tier 4	More Expensive Brand Name drugs	= Higher Cost Copays
Tier 5	Highest Cost: Specialty Drugs	= Highest Copays

NOTE: a) Some drug plans may have more than one Tier.
b) Others may require "prior approval" to cover brand name drugs
c) Drug "Formularies" usually cover most drugs but not all. You will need to check your Rx drugs against the Formulary to be certain they are covered and to know what your copay will be.

Contact Jim Benge CHC (RIPEA Insurance Consultant) at 1-833-351-0073 to receive the "Drug Form" to have your drugs checked against the "Formulary".

3 **Changes in Formularies:** Drug Formularies change almost every year, due to manufacturing price changes or new, more effective drugs coming into the market. If the Formulary change involves a drug you use, your Part D Carrier must either:

a Provide to you written notification of the changes at least 60 days prior to the date the changes become effective, or

b When you request a refill, your insurance provider must provide written notification of the changes and a 60 – day supply of the drug under the rules of the prior plan.

4 **Special Drug Rules:**

a PRIOR AUTHORIZATION: You or your drug prescriber must contact the drug plan before filling certain prescriptions. The prescriber may need to provide information certifying that the drug is "medically necessary" before the prescription can be approved.

b QUANITY LIMITS: In some cases, there are limits on how much of a medication can be issued with a prescription. Amounts above this level must be approved and will require information from the prescriber.

c STEP THERAPY: A patient is required to try, or to have tried one or more similar drugs before the drug plan will approve the prescription. In some cases, a letter from your physician certifying that you have already tried the required drugs will suffice to get the requested drug or drugs approved.

d PART D VACCINE COVERAGE: Except for vaccines covered under Medicare Part B, Medicare Drug Formularies must include all commercially available medically necessary vaccines to prevent illness.

5 **Drug Plan Deductibles**: In drug plans, a **deductible** is defined as the amount you must pay, each year, before your Part D Drug Plan benefits begin. Deductibles vary between drug plans. They are generally lower in Medicare Advantage plans; however, for "stand alone drug plans" (usually purchased with a Medicare Supplement coverage), the maximum allowable deductible for 2022 is $480.

6 **Copayments & Coinsurance:** Some "generic drugs" on Tier 1 are not applied toward the deductible and therefore are available at no cost. Other drugs would apply to the deductible (until met) and then to the copays. If drug expenditures are high enough, they may reach to the "Donut Hole" or even to the "Catastrophic Level"

7 Drug Coverage Varies by "Coverage Phase": The coverage offered by your Prescription Drug Carrier will vary according to your "coverage phase". Prescription Drug coverage is paid in 4 distinct phases:

- Deductible Phase
- Initial Coverage Phase
- Coverage Gap
- Catastrophic Coverage
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a **Deductible Phase:** For most stand-alone Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans you will pay 100% of the cost for medications until you have met the annual deductible (but not more than the deductible $480 (2022). After the deductible, the prescription drug coverage moves ahead to the **"Initial coverage phase."**

b **Initial Coverage Phase:** After meeting the deductible ($480), your drug coverage begins. You will be assessed a copay or coinsurance based on the drug and the cost factor determined by the drug tier to which it is assigned. For most drugs, you will be assessed a small to moderate copay for the drug. Coverage for some drugs is determined on the percentage of a discounted cost basis. However, once you and your plan, including the deductible have spent $4,130 during a calendar year for covered drugs, you have reached the initial coverage limit and will then move into the **"Coverage Gap"** phase.

c **"Coverage Gap Phase":** Many people do not spend enough on prescription drugs annually, however, when you do, you may enter the "Coverage Gap" (better known as the "Donut Hole"). This phase begins when you have spent $4,130 and was initially designed for the insured to pay 100% of the cost of the prescription drugs, until the total retail cost of drugs reached $7,050. However, this was quite expensive for folks on Social Security; therefore, the Federal Government has negotiated with the drug companies to reduce the cost of the drugs when purchased in the "Coverage Gap". Now folks purchasing prescription drugs while in the "Coverage Gap (Donut Hole), are afforded significant reductions to the extent that brand name drugs costs about 25% of the retail price and generic drugs are reduced to about 44% of the actual retail price. Once your overall annual out-of-pocket expenses reach $7,050, you move to the "**Catastrophic Coverage Phase".**

NOTE: If your drug plan requires that you purchase all your drugs at a particular drug company, be certain that you continue to honor that requirement because drugs purchased at other pharmaceutical companies may not count toward the various phases outlined above.

d **Catastrophic Coverage Phase** : Again, not everyone will reach this phase: It begins when your out-of-pocket costs exceed $7,050 (2022). During this **"Catastrophic Phase",** you will only pay a small coinsurance for covered prescription drugs, for the remainder of the calendar year.

e **Cost Sharing:** In summary, the above-described drug phases are specifically designed to cost share with you on the following basis:

	Phase	Insured Pays	2022
1	**Deductible**	**100% up to-**	**$ 480**
2	**Initial Coverage**	**Copays, up to**	**$4,430**
3	**Coverage Gap**	**25% up to**	**$7,050**
4	**Catastrophic Cap**	**Higher of 5%**	**Beyond $7050**

Or small copay

8 **How & When Do You Enroll In Part D Coverage:** Medicare drug coverage is available to anyone age 65 or older who is enrolled in Part A and Part B of Medicare. You may contact the individual drug plans directly or you can shop drug plans on **Medicare.gov.** This website is easy to use and provides the information that you need to determine which drug plan is the best fit for you.

9 **Late Enrollment Penalty:** You may be penalized if you fail to enroll in a drug plan when you are **first eligible**, unless you:

1 have other creditable drug coverage, like an employer plan or
2 qualify for "Extra Help" (financially) to afford the cost of drugs.

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The penalty for late enrollment in a drug plan is a 1% surcharge for each month you were eligible for Part D coverage but were not covered. This amount is added to your regular monthly Part D premium when you do enroll and will continue for as long as you remain on prescription drug coverage.

There are 3 ways to avoid paying a prescription drug penalty:

1) Enroll in Medicare drug coverage (Part D) when first eligible.
2) Enroll in Medicare drug coverage (Part D) if you lose other creditable coverage.
3) Keep records showing when you had other creditable drug coverage and tell your plan when (if) they ask about it.

However, if you do incur a prescription drug coverage penalty, here is how the penalty is determined:

For example, if you were without coverage for 15 months after you were first eligible, the penalty would be (1% x 15 months) a 15% penalty is added to your monthly prescription drug premium. The increase amount is not calculated as an increase of 15% of your current premium, but rather 15% of an average prescription drug Premium; would be permanently added to your monthly premium. For example: The average premium for 2022 is $33.37; therefore, your penalty would be (15% x $33.37 = $5.01). This amount would be added to your monthly premium. It would be recalculated each year as an add-on to your monthly prescription drug premiums.

10 **IRMAA (Income Related Monthly Adjustment Amount):** Part D enrollees with income levels above $91,000 (individually), or $182,000 (married filing jointly), will be assessed larger costs for Part D (drug coverage). Just as the premiums for Part B of Medicare are adjustable by income, the monthly premium for Part D drug coverage is also adjusted by income. This is called the **"Income Related Monthly Adjustment Amount"**, and is assessed according to the below income chart, and added to your normal monthly Part D premiums:

Yearly Income	Monthly Surcharge
Single - Equal to or Below $ 91,000	$ 0
Married- Equal to or Below $182,000	$ 0
Single - $ 91,001 - $114,000	$ 12.40
Married- $182,001 - $228,000	$ 12.40
Single - $114,001 - $142,000	$ 32.10
Married- $228,001 - $284,000	$ 32.10
Single - $142,001 - $170,000	$ 51.70
Married- $284,001 - $340,000	$ 51.70
Single - $170,001 - $499,999	$ 71.30
Married- $340,001 - $749,999	$ 71.30
Single - $500,000 & Above	$ 77.90
Married- $750,000 & Above	$ 77.90

IV MEDICARE SUPPLEMENT COVERAGE:

Although many think that Medicare will provide sufficient coverage as they accrue medical expenses past the age of 65; the truth is Medicare often leaves gaps of coverage that can cause large out-of-pocket costs. A Medicare Supplement insurance policy, also know as a Medigap policy, can help pay some of the health care cost that Original Medicare does not cover, like copayments, coinsurance, and deductibles.

In the event that one needs urgent medical care or an emergency operation, Medicare coverage can still Leave you with bills mounting to tens of thousands of dollars, representing the need for supplemental coverage. It is obvious that supplemental Medicare coverage is necessary to provide a low, predictable cost of medical expenses, but when's the right time to buy? The answer lies in the fact that not only do we all need supplemental coverage, but we need it BEFORE something happens to us. Luckily, the Medicare Supplement "Open Enrollment Period" provides the perfect time for those turning age 65 to obtain coverage.

The "Open Enrollment Period" lasts 7 months (3 months before your birth month and 3 months after your birth month) and begins at the time the enrollee turns age 65 (and is covered by Medicare Part B). During this period, insurance companies providing Medicare Supplement insurance cannot deny selling you the supplemental plans they offer. Also, they cannot charge more premium, due to any health-related problems you may have.

It is important to keep in mind that although you cannot receive coverage until the age of 65, it is never too early to begin conducting research on the benefits you have and the additional coverage you may need.

MEDICARE SUPPLEMENT COVERAGE: The RETIRED INDIANA PUBLIC EMPLOYEES ASSOCIATION has two Medicare Supplement plans; however, they are the two very best Medicare Supplement Plans. A summary of the two plans is listed below:

RIPEA MEDICARE SUPPLEMENT COVERAGE PLANS:

COVERAGE PLAN:	PLAN F+2	PALN G+2
Medicare Part A coinsurance and Hospital Expense (up to an additional 365 days after Medicare Benefits are exhausted	100%	100%
Medicare B Coinsurance	100%	100%
Blood (First 3 Pints	100%	100%
Part A Hospice Care Coinsurance 100%	100%	100%
Skilled Nursing Facility Care	100%	100%
Part A Deductible	100%	100%
Part B Deductible (Medical Only)	100%	$233
Part B Excess Charges 1	100%	100%
Foreign Travel Emergency	80% 5	80% 5

1 **Part B Excess Charges:** Physician charges that are over the Medicare Allowed Amounts are also paid.

2 **Plus Added after Plan letter:** indicates that an unlimited Anthem Major Medical Plan has been added to the plan to cover services that are not covered by Medicare

3 **Rates for the above Plans will vary by age.**

4 **A Part D prescription drug plan** will need to be acquired with either of the above Supplements

5 **Foreign Travel Coverage**: Is paid up to 80% of the emergency cost after a $250 deductible and has a lifetime coverage maximum of $250,000

NOTE: Medicare requires that you purchase a separate "prescription drug plan" with either of these Medicare Supplements. There is a "lifetime penalty" for not purchasing the drug plan when first eligible. If you purchase a Medicare Advantage Plan, the drug plan is already included.

V MEDICARE C (ADVANTAGE PLANS):

A DIFFERENT PLAN DESIGN:

We have already presented: Medicare Part A (Hospital coverage), Part B (Medical coverage), and Part D (Drug coverage); but now it is time to introduce the least known

Medicare alternative – Medicare Advantage Plans. These plans are sometimes referred to as Medicare Part C since they were initially called "Choice Plans". These plans were designed to provide original Medicare in a different format. Original Medicare did not include prescription drug coverage. However, Medicare Advantage plans can include three coverage areas:

Medicare Part A – Hospitalization
Medicare Part B - Physician Coverage
Medicare Part D - Prescription Drug Coverage

B **PRESCRIPTION DRUG PLANS:**

Previously mentioned drug plans were separate policies that could be purchased to add Part D drug coverage to a separate Medicare Supplement plan. However, with some Medicare Advantage Plans the "prescription drug coverage" is already included.

Since the "prescription drug coverage" is an integral part of a Medicare Advantage Plan, and cannot be changed during the year, it is extremely important that you take "special interest" to determine if your prescription drugs are covered. The "prescription drug formulary" is the master list of the drugs that are included in the drug formulary. It is imperative that you check your prescriptions against the prescription drug formulary so that you know for certain your prescription drugs are covered.

RIPEA does offer Medicare Advantage Plan 10-PE, which includes a more comprehensive prescription drug formulary for RIPEA members who may take rare or more expensive drugs. However, since the implementation of this more comprehensive drug coverage very few RIPEA members have needed it, which is an indication of how comprehensive our Rx plans are. However, it is prudent for you to know for sure that your prescription drugs are covered.

B **PROVIDER NETWORKS**: Original Medicare did not limit access to medical providers, so, you were able to go to any medical provider that accepts Medicare assignment (this means they accept the lower Medicare pricing). However, most Medicare Advantage Plans have some type of "**defined medical provider network"**, such as Health Maintenance Organizations (HMO), Preferred Provider Organization (PPO), or a Private Fee for Service Plans. These plans mandate that you must use only their **network medical providers**. Of course, the medical providers in these networks are quality well-trained doctors and hospitals, but you must choose from a listing of unfamiliar providers. In some Medicare Advantage Plans, you are allowed to select providers outside their approved network, however, you must pay more of the cost. Defined "provider networks" are considered a normal aspect of Medicare Advantage Plans and is the primary reason that many folks shy away from Medicare Advantage Plans. People prefer to make their own decisions and thereby choose the provider they know and trust; after all some of these decisions are matters of life and death. Of course, these mandated provider networks have continued to be a negative to Medicare Advantage Plans.

RIPEA HAS SOLVED THIS PROBLEM FOR OUR MEMBERS. The RIPEA Advantage Plans do include a PPO provider network, however, **RIPEA members are free to keep their current providers, or go to any other provider that accepts Medicare Assignment. Your coverage is the same whether your provider is in or out of the Anthem PPO network**.

RIPEA has eliminated the one big negative of Medicare Advantage Plans and provided a choice of very comprehensive plans that allow you to choose your provider and limit your out of pocket "medical liability" to as little as $500 per year.

These plans are attracting a lot of attention from existing RIPEA members, and many new members are joining RIPEA just to get access to these new, more comprehensive Medicare Advantage plans.

C **MEDICARE ADVANTAGE PLAN FUNDING**: Medicare Advantage Plans are funded primarily from Medicare dollars. The Medicare funding is provided to the various insurance carriers based on the average amount Medicare is paying in claims per Medicare recipient in that geographical area. The insurance carrier may add a small premium to the plan to cover the cost of the additional coverages (not covered by Medicare) – like dental, vision, hearing, prescription drug, and even fitness-center memberships, and more.

The insurance carrier (subject to Medicare's approval) determines the coverage and drug formulary that can be provided by this funding. The insurance company then takes the entire risk as to whether this insurance plan is properly funded to meet claims. Medicare is happy to let the insurance companies take the risk as it gets Medicare out of the insurance business – since with this arrangement Medicare takes no risk. The insurance companies appreciate this financial arrangement as it allows them the creative opportunity to "dress up" the coverage to make it more attractive and make a small profit from their expertise in claims management.

D **$ 0 PREMIUM ADVANTAGE PLANS**: Since participating insurance carriers receive Federal Funding as outlined above, many of them can design benefit plans with higher deductibles, coinsurance, copays and out of pocket maximums that reduce their claims liability. They, in fact, can finance the entire benefit plan with just the funds provided by Medicare; and therefore, they are able to offer Medicare Advantage Plans with no monthly premium cost to the insured. Although the "zero premium" aspect of this coverage does require the insured to pay higher levels of out-of-pocket claims costs; however, these plans are extremely popular: especially for folks with limited income, but they are not happy with increases in the amount they pay when they incur medical claims.

A new concept that has just been implemented in the last few years is to return cash back to the insured using the same (above) principle. However to afford this refund the insurance carrier must decrease coverage through increased deductibles, coinsurance, copays, and out of pocket maximums, so the insurance carrier can afford to fund the return of premium. The refund may be nice, but increased cost to the insured at the time of claim can be significantly higher than the "refunded Medicare dollars" to insured. Of

course, this can reduce the overall level of coverage provided, which negatively impacts the primary reason to have the coverage.

E **COVERAGE OPTIONS:** The coverage offered by Medicare Advantage Plans varies by insurance carrier; but it can also be very comprehensive. Generally, a Medicare Advantage Plan coverage includes emergency room services, urgent care, hospitalization, surgery, wellness, physician office visits, diagnostic tests, prescription drugs and more. They must cover, at least, all the medical and hospital services included in Original Medicare; and they usually cover more. However, they are not obligated to cover them in the same manner as Original Medicare. Original Medicare is designed to cover most services at an 80% coinsurance; a separate plan (Medicare Supplement) provides the additional coverage.

Most Medicare Advantage Plans include deductibles, copays, and occasionally coinsurance percentages, but most also include an "annual out of pocket maximum", not available with Original Medicare. This "maximum" establishes an overall cap to the patients total annual out of pocket liability. Some Medicare Advantage plans also include additional coverage like dental services, hearing benefits, vision services, and even memberships to health and fitness facilities. **Although it is not mandatory, many Medicare Advantage Plans also include prescription drug coverage, so it is not necessary to purchase a separate Rx coverage, as with Original Medicare and Medicare Supplements**.

F **QUALIFICATIONS:** The general qualifications required to participate in a Medicare Advantage Plan are:

-Must be enrolled in Medicare Part A and B.

-Must live in a Medicare Advantage Plan's service area **(this is not a requirement with the RIPEA plans, since the entire United States is the service area).**

-You cannot have End-Stage Renal disease (Exceptions to this requirement is determined by the insurance carrier, therefore, it may be necessary to contact local carriers for more specific information).

G **GAINING IN POPULARITY**: Although Original Medicare, with a Medicare Supplement and a Prescription Drug Plan, remains the most common method for retirees (65+) to get Medicare health coverage, Medicare Advantage Plans now make up about 35% of the market, and are growing in popularity every year. Although both Original Medicare (with a Supplement and a Prescription Drug Plan) and a Medicare Advantage Plan, can both offer comprehensive coverage, it is the Advantage Plan that is attracting more attention from new age 65 retirees. As new retirees compare the two types of plans, many are determining the Medicare Advantage Plan offers more coverage, convenience, and at a lower overall cost. Therefore, the popularity of the Medicare Advantage Plan is increasing each year.

NOTE: If you have not considered a Medicare Advantage Plan, it may be well worth your time and effort to review the RIPEA Medicare Advantage Plans, since the best RIPEA Advantage Plan is also one of the best Advantage Plans offered anywhere, and it is competitively priced.

VI ENROLLMENT ELIGIBILITY:

When can you initiate your enrollment in these plans?

A THERE ARE SPECIFIC TIME FRAMES TO ENROLL in Medicare, Medicare Supplements or Medicare Advantage Plans:

1 **Initial Coverage Election Period**: A 7-month period beginning three months before and 3 months after the month of your 65th birthday.

2 **If you did not sign up for Original Medicare during the initial Enrollment Period:** (Still covered by an employer or union health plan), your initial Coverage Election Period is the three-month period before your Medicare Part B start date, which would coincide with the date you ceased taking your employer or union coverage.

3 **The Annual Election Period runs from October 15th to December 15th each Year.** You can switch from Original Medicare to a Medicare Advantage Plan at that time and make other changes as well. If you are already enrolled in a Medicare Advantage Plan and want to switch to a different Advantage Plan, or back to a Medicare Supplement, this is the time to make the change. The effective date of your new plan would be the following January 1st.

4 **You may be able to change Medicare Advantage Plans during the Special Election Periods (SEPs).** This election period is available for certain situations:

For example,
- a) losing your current coverage.
- b) Moving to a new address.
- c) Qualifying for other coverage
- d) Changes in your current health plan that negatively impact your coverage.

Or you may want to switch back to Original Medicare, you can do so during the Medicare Advantage Disenrollment Period which runs from January 1st to February 14th, each year.

Please feel free to call us to inquire about your specific situation, we will be happy to let you know how we can help.

IF YOU HAVE ADDITIONAL QUESTIONS, PLEASE CONTACT JIM BENGE CHE

RIPEA Insurance Consultant
2415 Directors Row, Ste "M"
Indpls., IN 46241

Local: 317-734-3839
Toll Free: 1-833-351-0073
EM: jrbenge@ripea.org