Medicare: The Basics

Medicare is a federal health insurance program for:

- People over age 65.
- Certain disabled people under 65.
- People of any age with permanent kidney failure or ALS.

Medicare is divided into parts: Medicare Part A which provides hospital insurance benefits, Medicare Part B which covers supplemental medical insurance benefits, and Medicare Part D which covers prescription drugs. The Social Security Administration processes applications for Medicare and provides information about the program.

Eligibility and Enrollment for Medicare

If you are enrolled in Social Security or in the Railroad Retirement Board's retirement or disability benefits, you are eligible for Medicare and are enrolled automatically: your application for retirement benefits is also your application for Medicare. If you started to receive retirement benefits through these programs prior to age 65, Medicare enrollment occurs automatically at age 65, or your 30th month of disability.

An application for enrollment is required for:

- Persons age 65 or over, eligible for retirement benefits, but not receiving them.
- Persons with end-stage renal disease.
- Enrollment based on Medicare-qualified government employment.

If you do not enroll when you are first eligible, there is a general enrollment period each year. This period is from January 1 through March 31. If you enroll during this period, your coverage begins on July 1 of that calendar year. Medicare Part D has an annual enrollment from November 15 to December 31, for coverage beginning January 1.

Medicare Part A: Hospital Insurance Benefits

Medicare Part A pays for qualified medically necessary inpatient care in a hospital, skilled nursing facility, or hospice. The full cost of qualified medically necessary home health care is also covered. There is a yearly deductible for Part A and a co-payment for most services.

Hospital care: Medicare covers the first 90 days of hospital care in the benefit period plus an additional 60 exhaustible lifetime reserve days. The first 60 days are covered 100% after you have met the deductible. Days 61 through 90 require a co-payment. Note: Medicare will not pay for certain complications that occur after a hospital admission.

When you are admitted to a hospital for covered care, the hospital is required to give you a document called, "An Important Message from Medicare." This message explains your rights as a Medicare patient, including what you can do if you think you are being discharged too early or are notified that Medicare will no longer pay for your care.

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Skilled Nursing Facility (SNF): Medicare provides limited coverage for care in a skilled nursing facility. Coverage is available for up to 100 days during a benefit period subject to the following conditions:

- Admission to a Medicare-certified SNF must occur within 30 days of a covered hospital stay of three days or more.
- A physician must certify the need for skilled or rehabilitation services.

If these conditions are met, Medicare will pay 100% for the first 20 days only. Days 21 through 100 require a daily co-payment.

Home Health Care: Medicare pays the full cost of qualified medically necessary home health visits by a Medicare-approved home health agency. Neither the deductible nor co- payment applies. To qualify, you must:

- Require intermittent skilled nursing care, physical therapy, or speech therapy.
- Be confined to your home.
- Be under the care of a doctor who prescribes the services.

Once you qualify, you are entitled to these home health services:

- Skilled nursing.
- Limited physical, speech and occupational therapy.
- Medical social services, including medical social workers.
- Home health aides, including assistance with care such as bathing, grooming, feeding, dressing and walking.

Hospice care: Hospice benefits are available to Medicare beneficiaries who:

- Are certified by their doctor and the hospice medical director as terminally ill with a life expectancy of 6 months or less.
- Sign a statement choosing hospice care using the Medicare Hospice Benefit.
- Enroll in a Medicare-approved hospice program.

Covered services from a Medicare-approved hospice program include the following as long as the service relates to the terminal diagnosis and is contained in the patient's care plan:

- Physician services.
- Nursing care.
- Home health aide and Homemaker services.
- Physical, speech and occupational therapy.
- Social work, counseling and bereavement counseling.
- Medical equipment and supplies.

Medicare Part B: Supplemental Medical Insurance Benefits

Medicare Part B pays for qualified doctor visits, medical test, durable medical equipment, and outpatient services. There is a yearly deductible and a co-payment for most services.

You must pay a monthly premium for Part B. The premium is usually deducted from your Social Security check. Premiums are based on income for those in higher income brackets. An annual deductible must be met before coverage begins. Medicare will pay 80% of the Medicare-approved amount for covered services. You are responsible for a 20% co-payment.

Medically necessary covered services include:

- Physician services provided in a doctor's office, hospital, nursing home, clinic or your home.
- Outpatient hospital services.
- X-rays and laboratory tests.
- Outpatient mental health services prescribed by a doctor.
- Ambulance transportation.
- Durable medical equipment.

Covered items include:

- Physician services and supplies furnished as part of such services.
- X-ray, radium and radioactive isotope therapy.
- Blood for transfusions after the first three pints per year.
- Surgical dressings, splints, casts and similar medical supplies ordered by a doctor.
- Home health services.
- Artificial replacements for parts of the body (covered by Part A under some circumstances).
- Braces for limb, back or neck.

Medicare Part D Prescription Coverage

Medicare Part D is a prescription drug benefit provided by Medicare through private insurance companies. All plans must include at least one drug from every approved class. Some drugs, such as anxiety drugs, are not included in the program. When selecting a plan, consumers are responsible for verifying that their prescriptions are included in the plan they select.

What services are NOT covered by Medicare?

Although Medicare will pay for most medically necessary health care services, it is important to know there are services that are not covered, including:

- Services performed by a relative or household member.
- Services outside the US (except for qualified Canadian and Mexican facilities if nearest to your home, or for emergency care while traveling to or from Alaska through Canada).
- Routine physical exams, eye exams, glasses, hearing aids and dental care.
- Routine foot care and orthopedic shoes, except for diabetics.
- Most chiropractic services.
- Custodial care.
- Cosmetic surgery (except after an accident).
- Most immunizations (except flu and pneumonia).
- Private nurses.
- Extra charges for telephone, television and other personal comfort items.

Medicare Card

When you enroll in Medicare, you will receive a Medicare Health Insurance Card containing your name, claim number and the effective dates of coverage for Parts A and B. If you are in the original Medicare plan, you will need to present your Medicare card when you receive medical services. If you are in a Medicare Advantage plan, the plan will give you a membership card.

A special note for low-income Medicare beneficiaries

If you have low monthly income and few assets, you may qualify as either a "Qualified Medicare Beneficiary" or "Specified Low- Income Medicare Beneficiary." Both programs provide additional health care coverage through the state Medicaid program. Check with the state office which administers Medicaid.

Special Terms to Know Regarding Medicare

Assignment - An arrangement where a doctor agrees to accept the Medicare-approved amount as full payment for services covered under Part B. The payment is made directly to the doctor. The doctor is called a "participating physician."

Benefit period - A benefit period begins on the day you enter a hospital or SNF and ends when you have been out of the facility for 60 consecutive days. If you are hospitalized again after the 60 days have passed, a new benefit period begins. There is no limit to the number of benefit periods you can use.

Deductible - The amount you personally must pay each year before Medicare begins payment for covered services.

Co-payment - A specified dollar amount or percentage of covered expenses which you are required to pay.

Lifetime reserve days - If you are hospitalized for more than 90 days, you can have up to 60 additional days of coverage. These additional lifetime reserve days can only be used once.

Medically necessary - A service must meet the program definition of medical necessity to be covered under Medicare. Medical necessity is established through diagnostic and/or other information presented on the claim to Medicare.

Medicare-approved amount - The amount that Medicare determines to be reasonable for a service covered under Part B, based upon a national fee schedule. Medicare pays 80% of this set fee for the service you receive.

Skilled nursing facility (SNF) - A specially qualified facility which has staff and equipment to provide skilled nursing care, rehabilitation services, and other related health services.

Where can I learn more?

For more information, call Medicare at 1-800-MEDICARE (1-800-633-4227) or visit the web site at www.medicare.gov.