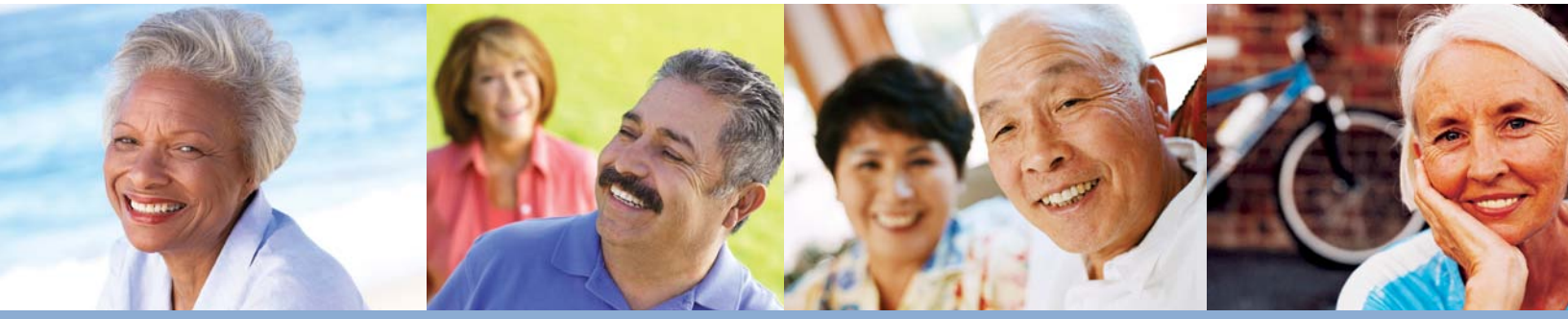
Medicare Resource Guide

What you need to know — and do — to get the most out of the Medicare benefits you've earned.

Independence Blue Cross







About this booklet

If you or someone you care for currently has Medicare — or are about to join Medicare — it's important to know how Medicare works, what it covers, and what it doesn't cover. The more you know, the better equipped you'll be to make important health care coverage decisions.

That's why we put this booklet together for you. Think of it as a roadmap to Medicare, with everything you need to know all in one place, in plain English. There's a lot of good information in here designed to take the guesswork out of Medicare for you. And while Medicare may seem overly complicated at first — especially if you're new to it — our goal is to help you see that it's really just health insurance for the next stage of your life.

This booklet is your guide to understanding Medicare, Part D prescription drug coverage, and your health plan options. You'll learn more about Original Medicare (Part A and Part B), Medicare Advantage plans, Medicare Supplement (Medigap) plans, and Medicare prescription drug plans.

In this Resource Guide, you'll learn more about:

- Original Medicare
- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Medicare Advantage Plans
- Part D: Prescription Drug Insurance
- Medicare Supplement Plans (Medigap)
- Eligibility
- When to Enroll
- Glossary of Medicare Terms
- Frequently Asked Questions

Original Medicare *(Here's how it all starts)*

The Medicare program began in 1965 to provide health insurance for older Americans. The program has changed quite a bit over the years. Today, Medicare is the nation's largest health insurance program, covering more than 42 million people over age 65 and those with certain disabilities. Medicare has traditionally provided coverage for health care services such as hospital stays, skilled nursing facilities, and doctor visits. As a result of the Medicare Modernization Act of 2003, Medicare also provides prescription drug coverage and additional health plan options.

Original Medicare is administrated by the Centers for Medicare & Medicaid Services (CMS).

Part A: Hospital Insurance

Part A covers you whether you're a patient in a hospital or in a skilled nursing facility. You're eligible for Part A coverage if you or your spouse paid into Social Security for at least 10 years through your employment, and you are a citizen or permanent resident of the United States. Part A coverage is free for most people since it is funded by Social Security payroll taxes. However, Part A does have a deductible and copays.



Hospital Services

Part A provides coverage for a semi-private room, meals, and certain other services for up to 90 days per benefit period.

- You pay a deductible of $1,100* for each benefit period.
- For the first 60 days, eligible care is covered in full after you pay the deductible.
- For days 61 through 90, you pay a copay of $275* per day.
- For your additional 60 lifetime reserve days, you pay a copay of $550* per day.
- You pay any charges not covered by Medicare.

Skilled Nursing Facility Care

Part A provides coverage for up to 100 days for eligible services in a Medicare-certified facility after a hospital stay of at least three covered days.

- For the first 20 days, care is covered in full.
- For days 21 through 100, you pay $137.50* per day.

Hospice Care

Terminally ill patients may receive up to 210 days of care (two 90-day periods and one 30-day period) plus a benefit period of unlimited days during a hospice patient's lifetime. Care must be provided by a Medicare-certified hospice program. Hospice care benefits are in place of regular Medicare benefits.

* These are the 2010 deductibles and copays, and may change on January 1, 2011.

Part B: Medical Insurance

Medicare Part B covers doctors' services, outpatient hospital care, durable medical equipment, and some medical services and supplies not covered by Medicare Part A. It is optional coverage. There is a monthly premium which most people have deducted right from their monthly Social Security checks. If you use Part B services, you have to pay an annual deductible and coinsurance.

For Part B, you pay:

- A monthly Part B premium that increases annually and varies based on your income.
- An annual Part B deductible of $155.*
- After your annual deductible, 20% (Medicare pays 80%) of Medicare-approved charges for eligible services considered medically necessary.

Part B Eligible Services:

- Doctor services, including hospital, clinic, office, or home visits; surgery; osteopathy; and radiology.
- Diagnostic X-rays, laboratory tests, radiation therapy, and certain other procedures that are part of your treatment but are not covered under Part A.
- Medical supplies and services, including surgical dressings; splints, casts, and other devices; oxygen, ventilator-assist devices, and durable medical equipment used in your home; prosthetic devices; and portable X-ray services.
- Outpatient diagnostic or treatment services provided by certified hospitals, skilled nursing facilities, home health care facilities or rehabilitation facilities, and ambulance transportation.
- Ambulatory surgical center services, including coverage for services furnished in connection with certain procedures performed at a Medicare-certified ambulatory surgical center.
- Comprehensive outpatient rehabilitation facility services, including coverage of certain services furnished by a certified comprehensive outpatient rehabilitation facility.
- Unlimited visits for home health care are paid at 100% when ordered by a doctor and provided by a nurse and/or therapist from a Medicare-certified home health agency.

Most preventive services are not covered by Medicare Parts A or B, except for a one-time "Welcome to Medicare" physical exam, cardiovascular screening, and diabetes screening.

* These are the 2010 deductibles and copays, and may change on January 1, 2011.

Another way to look at what Medicare pays ... and what you pay

MEDICARE PART A (Hospital)

Service	You Pay
Hospital First 60 days of an admission	You pay $1,100* each benefit period. Medicare covers the rest.
61st to 90th day	You pay $275* per day. Medicare covers the rest.
91st to 150th day**	You pay $550* per day. Medicare covers the rest.
Beyond 150 days	You pay 100% of expenses.
Skilled Nursing Facility care First 20 days	You pay nothing. Medicare covers 100%.
21st to 100th day	You pay $137.50* per day. Medicare covers the rest.
Beyond 100 days	You pay 100% of expenses.

MEDICARE PART B (Medical and Doctor Charges)

Service	You Pay
Medical expenses In or out of the hospital and outpatient treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	You pay a $155† annual deductible, then 20% of Medicare-approved charges.
Clinical laboratory services Blood tests for diagnostic services	You pay nothing. Medicare covers 100%.

Other Benefits Under Medicare

Service	You Pay
Benefits for medically necessary emergency care received in a foreign country (except in some parts of Canada and Mexico)	You pay 100% of expenses.
Preventive services	Costs will vary. In 2011, the health reform legislation eliminates out-of-pocket cost-sharing for most Medicare-covered preventive and screening services. You will also be covered for an Annual Wellness Visit.
Outpatient prescription drugs	Costs will vary based on the Part D plan and benefit level you select.

* These are the 2010 deductible and copays for Medicare Part A (Hospital and Skilled Nursing Facility care) and may change on January 1, 2011.

** After 90 consecutive days of hospitalization, Medicare benefits are paid from a one-time lifetime reserve of 60 additional days that are not renewable each benefit period.

† This is the 2010 deductible for Medicare Part B and may change on January 1, 2011.

Covering Medicare's Gaps *(Here's where it starts to get interesting)*

Original Medicare covers many of your health care needs — but not all. Your out-of-pocket expenses for these "gaps" can add up quickly. Years ago, the only way to protect yourself against the bills *not* paid by Medicare was to buy a Medicare supplement policy. While still a popular choice for many people, today's Medicare is working with private companies to bring you new options to meet both your health care and prescription drug needs.

As a person eligible for Medicare, you have many health care coverage options — perhaps even more than when you selected benefits through an employer. There are many different types of plans to consider, including:

- Medicare Advantage plans (Part C)
- Medicare Advantage plans with prescription drugs (Part C and Part D)
- Medicare prescription drug plans (Part D)
- Medicare supplement plans (Medigap)

Part C: Medicare Advantage Plans and Medicare Advantage Plans with Prescription Drugs

These are managed care plans that generally give you more health care coverage and benefits than Original Medicare. They cover a full range of medical care and replace the need for standard Medicare benefits. The government pays the Medicare Advantage plan a certain amount each month for each enrolled member. That money is then used to pay the doctors, specialists, and hospitals you use. You share the cost, usually with a low, fixed copay for covered services.

Members generally pay a monthly plan premium (in addition to the Part B premium). Some plans provide medical-only coverage, while others combine medical coverage with Medicare Part D prescription drug benefits.

IMPORTANT: Some Medicare Advantage plans (like HMOs and PPOs) require you to receive your Medicare Part D prescription drug coverage through the plan. That means if you select a plan's medical-only coverage option (when combined medical and drug option(s) are also available), you won't be able to sign up for drug coverage through another plan. If you join a Private Fee-for-Service (PFFS) plan without prescription drug coverage (even if combined medical and drug option(s) are also available), you can sign up for drug coverage through another plan.

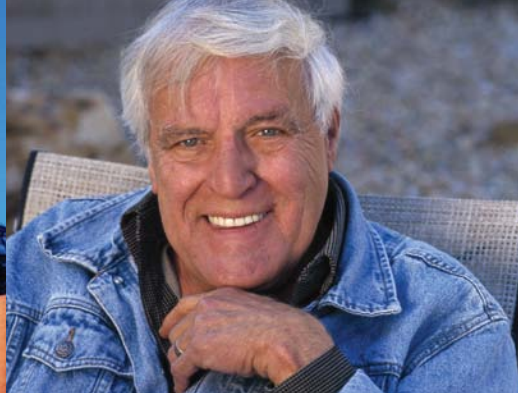
Types of Medicare Advantage plans:

Medicare Health Maintenance Organization (HMO) plans manage your care through a network of doctors and hospitals. You get broad coverage — more benefits than Original Medicare and a typical Medicare supplement combined. Costs are generally low and predictable. You choose a primary care physician who coordinates all your health care — including referrals for specialists and hospitalization. With an HMO, you are required to use network providers except in emergency situations.

Medicare Preferred Provider Organization (PPO) plans generally provide the same kind of broad coverage as an HMO, without in-network referrals. With a PPO, you're also able to use any doctor or hospital outside of the network for a higher copay or coinsurance.

Medicare Private Fee-for-Service (PFFS) plans work like Original Medicare, except that a private company (not Medicare) decides how much it will pay and how much you will pay for the services you receive. There is no provider network with these plans. You can use any doctor or hospital that is a Medicare participating provider, but they must accept the plan's terms and conditions before you can receive any services.





Part D: Medicare Prescription Drug Coverage

Starting in 2006, Medicare Part D made prescription drug coverage available to all people with Medicare. Anyone who is entitled to Medicare Part A or enrolled in Part B is eligible to join a plan that offers substantial federal help in paying for prescription drugs.

Under Part D, Medicare beneficiaries who want prescription drug coverage are required to join a private plan. Medicare works with insurance companies and other private companies to offer prescription drug plans. These Medicare-approved drug plans are also known as stand-alone "Part D" plans. They cover prescription drugs only. You can also get Part D prescription drug benefits through a Medicare Advantage plan with prescription drugs.

Medicare prescription drug plans and Medicare Advantage plans with prescription drugs provide insurance coverage for generic and brand-name prescription drugs. If you join a plan, you will likely pay a monthly premium, plus a share of the cost of your prescriptions. There are different drug plans available that vary by types of drugs covered, how much you have to pay, and the pharmacies you can use. All drug plans must provide at least a standard level of coverage.

Medicare standard Part D drug benefits at a glance (2011 calendar year)

	Total Drug Costs	Medicare-Approved Plan Pays	You Pay
Deductible	$0 – $310	$0	100% — up to $310
Cost-sharing	$311 – $2,840	75%	25% — up to $632.50
Coverage Gap*	$2,841 – $6,447.50	0%	100% — up to $3,607.50
Catastrophic coverage begins when you reach $4,550 in out-of-pocket drug costs			
Castastrophic Coverage	Over $6,447.50	95%	5%, or $2.50 copay/generic $6.30 copay/brand-name

Note: Your monthly premium is *not* included in what you pay as shown in the chart above.

* In 2011, Medicare beneficiaries will receive a 7% subsidy from Medicare to help pay for generic prescriptions in the coverage gap (you pay 93% of the cost). In addition, you will receive a 50% discount on the cost of covered brand-name prescription drugs.

Many private Medicare prescription drug plans do not look like this standard design. Many plans offer enhanced prescription drug coverage. For a higher monthly premium, these enhanced plans provide more coverage than the standard level of coverage.

Even if you don't take many prescriptions now …

You should consider joining a plan that covers prescription drugs anyway to avoid paying a penalty later. In most cases, if you don't join when you are first eligible — and you don't already have a drug plan that is as good as the Medicare prescription drug coverage — you will pay a penalty that increases every month you wait.

Keep in mind that this is insurance coverage. Should your health decline, you'll want prescription drug coverage in place to help limit your out-of-pocket expenses.

Extra help is available

People with limited income and resources (including savings and stocks and bonds from the government, but not your home and car) may be able to get extra help paying for prescription drug plan premiums and costs. To see if you qualify for extra help, call:

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

MA | MA–PD | PDP

MA =
Medicare Advantage Plans

These plans cover the same benefits as Original Medicare and more: usually vision, hearing, preventive care, and other wellness benefits. They do not cover your prescription drug costs.

MA–PD =
Medicare Advantage Plans with Prescription Drug Coverage

These plans offer the most complete coverage available, because you get medical and prescription drug coverage combined in one plan, plus you may get extra benefits that Original Medicare doesn't cover.

PDP =
Medicare Prescription Drug Plans

These plans help cover prescription drugs only.

Medicare Supplement Plans (Medigap)

Medicare supplement plans are sold by private insurance companies and help pay for some of the health care costs or "gaps" that Medicare doesn't cover. In most cases, you must have both Medicare Parts A and B to buy a Medigap policy.

As of January 1, 2006, Medigap policies covering prescription drugs were no longer available. People with Medicare who want drug coverage in addition to their Medigap plan need to purchase a separate stand-alone prescription drug plan.

While people with Medicare aren't required to buy Medigap policies, many people choose to enroll in a plan to help pay for some of the health care costs not covered by Medicare. The best time to buy a Medigap policy is during your Medicare Open Enrollment Period. The open enrollment period is six months, starting on the first day of the month in which your Medicare Part B coverage becomes effective.

Unlike most Medicare Advantage plans, there are no networks when you join a Medicare supplement plan. You can use any doctors and hospitals that accept Medicare.

Eligibility

Original Medicare
You are eligible for Medicare if you are a U.S. citizen or have been a permanent legal resident for five continuous years, and:

- You are age 65 or older and eligible to receive Social Security; or
- You are under age 65, are permanently disabled, and have received Social Security disability insurance payments for at least two years; or
- You require continuing dialysis for permanent kidney failure or need a kidney transplant.

Medicare Advantage Plans
To enroll in a Medicare Advantage plan, you must:

- Be entitled to Medicare Part A, and
- Be enrolled in Medicare Part B, and
- Live in the plan's service area.

Members must continue to pay Medicare Part A, if applicable, and Part B premiums if not otherwise paid for under Medicaid or by another third party.

Most plans will not accept you if you have End-Stage Renal Disease (ESRD) but cannot disenroll you if you develop ESRD while a member.

Medicare Prescription Drug Plans
To enroll in a Medicare prescription drug plan, you must:

- Be entitled to Medicare Part A, or
- Be enrolled in Medicare Part B, and
- Live within the plan's service area.

Members must continue to pay the Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

You can join a stand-alone prescription drug plan if you have traditional Fee-for-Service Medicare (Original Medicare) only, or Original Medicare and a Medigap or other supplemental insurance plan.

Medigap or Medicare Supplement Plans
To enroll in a Medigap plan, you must:

- Be entitled to Medicare Part A, and
- Be enrolled in Medicare Part B.

How to Enroll in Medicare

- Call or visit your local Social Security office. You'll need an original or certified copy of your birth certificate, W-2 forms for the past two years, and your Social Security card.

- The Social Security Administration enrolls most people in Original Medicare. You do not have to be retired to enroll in Original Medicare. You can enroll in Original Medicare up to three months before age 65. If you are already receiving Social Security benefits, you will be automatically enrolled. You can contact the Social Security Administration for questions about enrolling. Call **1-800-772-1213 (TTY/TDD 1-800-325-0778)** from 7 a.m. to 7 p.m., Monday through Friday, or go online to www.ssa.gov.

When to Enroll

Part A

Most people receive Medicare Part A (hospital insurance) automatically — and for free — starting the first day of the month you turn 65. If you don't receive an enrollment notice, call Social Security at 1-800-772-1213 (railroad retirees should call 1-800-808-0772).

If you are disabled, there is a 24-month waiting period for Medicare after you become disabled; after that, you are automatically on Medicare Part A and must decline Part B if it is not wanted. In the meantime, you may qualify for Medicaid/Medical Assistance, or use COBRA coverage or services from state-specific programs.

Part B

There are three opportunities to sign up for Part B (medical insurance): the Initial Enrollment Period, the Special Enrollment Period, and the General Enrollment Period.

Part B Initial Enrollment Period
During the Part B Initial Enrollment Period, you can enroll three months prior to, the month of, or three months after your 65th birthday; or after your 24th month of receiving cash disability benefits. If you want to decline Part B enrollment during the Initial Enrollment Period, you must return your Part B notice to Social Security.

If you do not sign up, a 10% penalty may be added to the Part B premium for each 12-month period you could have had Part B but didn't sign up for it when first eligible, unless you qualify for the Part B Special Enrollment Period. The penalty continues for as long as you have Part B.

Part B Special Enrollment Period

If you or your spouse has medical coverage through a union or an employer with more than 20 employees, or you had Part B coverage and dropped it because you went back to work and had group medical coverage, you can use the Part B Special Enrollment Period to enroll. The Special Enrollment Period lasts for eight months and begins when your employer or union coverage ends, or when employment ends, whichever is first.

To use the Part B Special Enrollment Period, contact Social Security four months before you retire or when your employer or union coverage ends, and request a form that your employer will need to complete to activate your Special Enrollment. Then send the employer paperwork along with your Part B enrollment form to Social Security.

If you are 65 and have COBRA coverage on an employer's policy, you should enroll in Part B. *You will not get a Special Enrollment Period when COBRA ends.* You must sign up for Part B during the first eight months you have COBRA coverage to avoid the late-enrollment penalty in the General Enrollment Period.

Part B General Enrollment Period

If you do not enroll in Part B during the Initial or Special Enrollment Periods, you can enroll during the General Enrollment Period from January 1 through March 31 of each year, with coverage not starting until July 1. For each year you are late in enrolling, you can be charged a 10% Part B penalty. This charge increases annually as Medicare premiums increase and will continue for your lifetime or as long you are on Part B.

- Be sure to sign up for Medicare at age 65 even if you decide to delay your retirement (in order to get full Social Security benefits). At age 65, you are eligible for full Medicare benefits.

- If you currently receive Social Security or Railroad Retirement benefits, contact your Social Security office or Railroad Retirement Board three months before you turn 65 to verify your eligibility for Medicare Parts A and B.

Parts C and D

Medicare Advantage Plans, Medicare Advantage Plans with Prescription Drugs, and Medicare Prescription Drug Plans

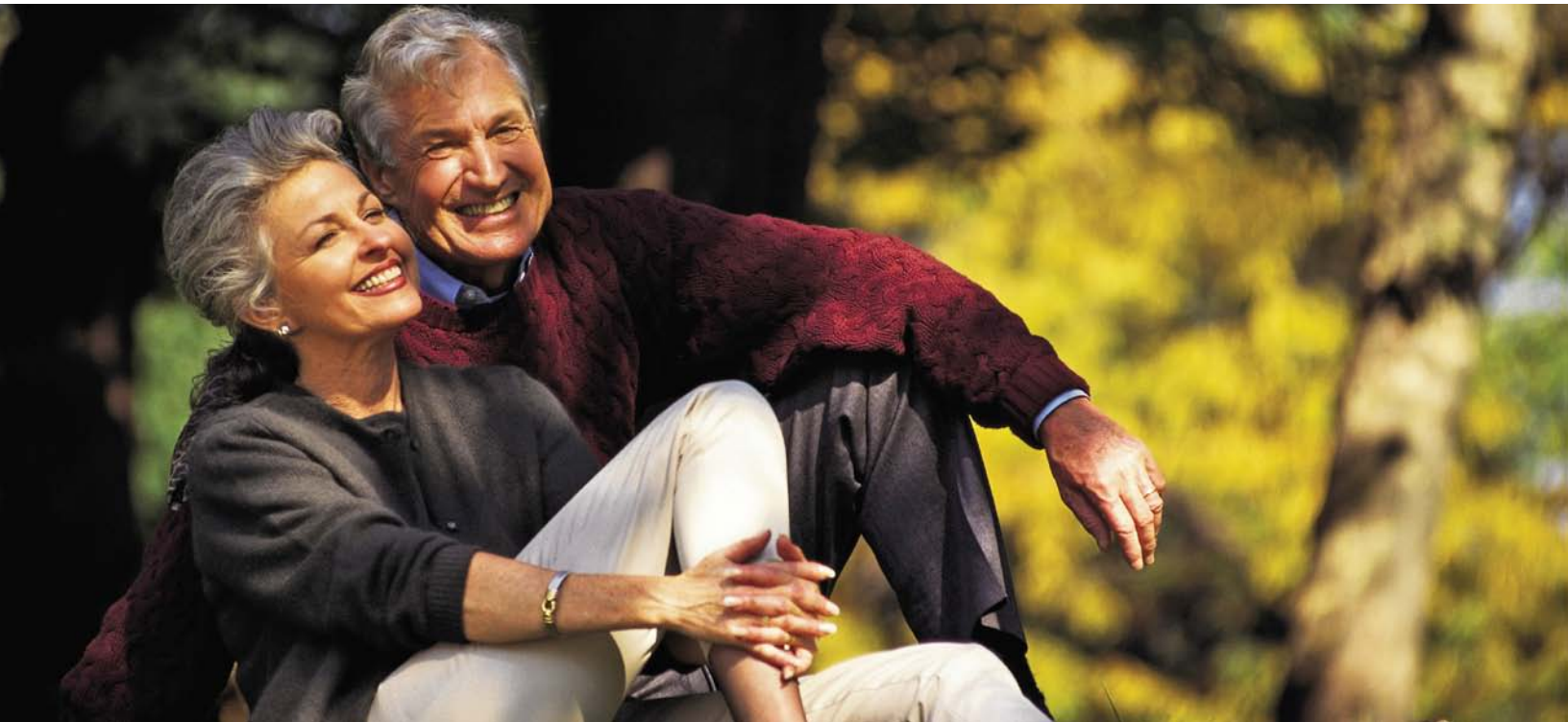
Initial Election Period
If you are newly eligible for Medicare, you most likely qualify for an Initial Election Period. During the Initial Election Period you can enroll in a Medicare Advantage plan, a Medicare Advantage plan with prescription drugs, or a prescription drug plan, three months prior to, the month of, to three months after your 65th birthday; or after your 24th month of receiving cash disability benefits.

Annual Election Period
If you are currently a Medicare beneficiary, you can make one "election" during the Annual Coordinated Election Period between November 15 and December 31 of each year. This includes enrolling in or changing to a Medicare Advantage plan, a Medicare Advantage plan with prescription drugs, a prescription drug plan, or other Medicare health plan for an effective date of January 1 of the following year.

Open Enrollment Period
For many years, beneficiaries enrolled in Medicare health plans were able to switch from one plan to another during the months of January, February, and March. This Open Enrollment Period has been eliminated. In its place, starting in 2011 there will be an Annual Disenrollment Period.

Annual Disenrollment Period
From January 1 – February 14, beneficiaries enrolled in a Medicare Advantage health plan may disenroll from their plan and return to Original Medicare. The Annual Disenrollment Period does not allow beneficiaries in a Medicare Advantage plan to switch to another Medicare Advantage plan or people in Original Medicare to join a Medicare Advantage plan.

Beneficiaries who want to disenroll from a Medicare Advantage-Prescription Drug Plan and return to Original Medicare during the Annual Disenrollment Period will qualify for a Special Election Period to join a stand-alone Part D plan.



Special Election Period

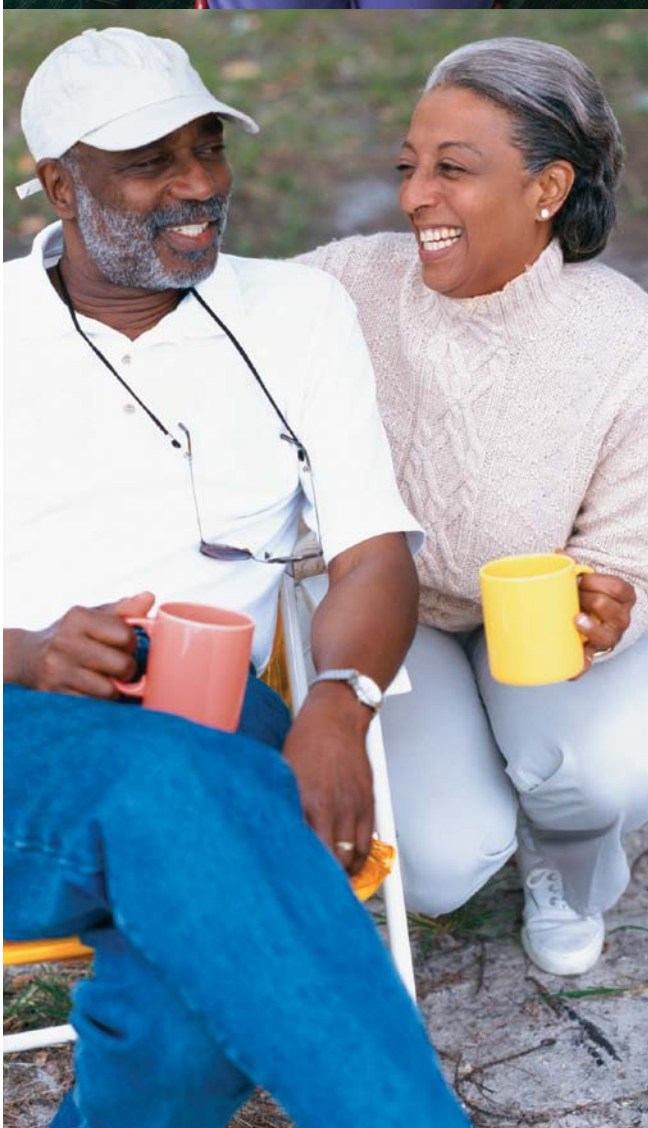
A Special Election Period allows you to enroll in a prescription drug plan or Medicare Advantage plan after an Initial or Annual Enrollment Period has ended. Reasons you might qualify for a Special Election Period are:

- You are eligible for additional financial help from Social Security.
- You permanently move outside your plan's service area.
- Your plan's contract is terminated, or the plan goes out of business.
- You lose your prescription coverage from an employer or union, or your coverage changes so that it is no longer as good ("creditable") as the standard Medicare benefit.

Medicare Supplement (Medigap) Plans

If you are newly eligible for Medicare and want to enroll in a Medicare supplement (Medigap) plan, the Open Enrollment Period lasts for six months, starting on the first day of the month in which your Medicare Part B coverage becomes effective. If you enroll during this time, you won't need to provide a health history to your insurance company. If you delay buying Medigap coverage during this time frame, you may need to complete a health history application when you do decide to enroll.

Note: If you want to enroll in a Medigap plan and in a prescription drug plan, be sure to do so within the different enrollment time frames outlined here.





A Glossary of Medicare-Related Terms

Benefit Period
The way that Medicare measures your use of hospitals and skilled nursing facilities. A benefit period starts on the first day of an inpatient hospital stay and ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days.

Brand-Name Prescription Medication
A prescription medication that has been patented and is produced only by one manufacturer.

Centers for Medicare & Medicaid Services (CMS)
The federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS makes sure that beneficiaries in both programs are able to get access to high-quality health care.

Coinsurance
This is the percentage of the Medicare-approved amount that you have to pay for a medical service. For example, if your coinsurance is 20 percent and Medicare approves a $100 doctor office visit, Medicare will pay $80 and you will pay $20. With some plans, you do not pay coinsurance until you have first paid a deductible.

Copayment or Copay
In some Medicare Advantage plans, this is a flat amount the member pays for a particular service, such as $10 to visit a doctor. Copays are also used for some hospital outpatient services in the Original Medicare plan.

Cost-Sharing
This is the percentage (coinsurance) or flat amount (copay) you must pay, up to a certain amount or limit.

Deductible
A set amount you may be required to pay before you receive coverage for your plan benefits. Generally, deductibles apply to Medicare Parts A, B, and D. Deductibles may also apply to Medicare supplement plans.

Durable Medical Equipment
Equipment needed for medical reasons that is sturdy enough to be used many times without wearing out. Examples of durable medical equipment include wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency
A sudden, serious, and unexpected illness, injury, or condition in which a person believes his or her health is in danger if medical treatment is not received immediately.

Exclusions
Health plans do not cover all health care services. Exclusions are those services not covered by — or excluded from — the plan.

Formulary
A list of selected FDA-approved prescription drugs chosen for their effectiveness and value. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.

Health Maintenance Organization (HMO)
A Medicare Advantage plan in which a group of health care providers agrees to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO plan, all of your care must be provided by or arranged for by a primary care physician in most cases, and referrals are required.

Hospital Insurance (Medicare Part A)
The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

Mail-Order Medications
A program that allows individuals to buy prescription medications for chronic conditions through the mail. Larger supplies are available than are typically dispensed at a local pharmacy.

Medical Insurance (Medicare Part B)
The part of Medicare that covers doctors services, outpatient hospital care, and some other services that Part A doesn't cover, like physical and occupational therapy.

Medicare Advantage
A Medicare managed-care program under which a non-government entity arranges for all Medicare-covered services, including physicians, labs, and hospitals. Some Medicare Advantage plans may offer the Medicare Part D prescription drug benefit to the enrollees.

Medicare Supplement or Medigap
Health insurance policies that typically have standardized benefits and are sold by private insurance companies. Medigap policies work in tandem with your Medicare Part A and B coverage. They allow you to use any doctor or hospital that accepts Medicare.

Member
The person who is the policy holder of the health plan coverage.

Monthly Plan Premium
The payment you make to a health benefits company like Independence Blue Cross for your health plan. Members pay the monthly plan premium in addition to Medicare Part A, if applicable, and Part B premiums.

Network
A group of doctors, hospitals, pharmacies, and other health care providers contracted with a health plan to take care of its members. In an HMO, you must use network providers. With PPO plans, you pay less when you use network providers — or you can use providers outside of the network for a higher copay or coinsurance.

Out-of-Network Provider
A doctor, specialist, hospital, or other health care provider that is not contracted with the network associated with your plan.

Out-of-Pocket Maximum
The total amount a member pays for coinsurance and copays in a calendar year before the plan picks up the full cost of covered expenses.

Part D (Prescription Drug Plan)
A Medicare Part D prescription drug plan may be either a stand-alone prescription drug plan that you can enroll in if you have Original Medicare or a Medigap plan, or a Medicare Advantage plan that offers Medicare Part D prescription drug coverage in addition to health benefits.

Preferred Provider Organization (PPO)
A Medicare Advantage plan in which you use doctors, hospitals, and other health care professionals who have contracted with a health plan to provide care to its members. You can also use health care providers outside the network for an additional cost. Unlike an HMO, you don't need to get referrals to see specialists.

Preventive Care
Health care that emphasizes prevention, early detection, and early treatment of conditions — such as routine women's exams, immunizations, and teeth cleanings.

Primary Care Physician
A doctor who provides basic care. Your primary care physician is the doctor you see for most health problems. In an HMO, you must receive a referral from your primary care physician in order to see a specialist.

Prior Authorization (approval in advance)
Determination that a procedure will meet all the qualifications to be covered by the health plan.

Private Fee-for-Service (PFFS)
A Medicare Advantage plan in which members can use any health care provider that agrees to the terms, conditions, and payment rate of the plan. These plans may offer extra benefits than Original Medicare.

Referral
Approval from your primary care physician to see a specialist or receive certain services. In many Medicare Advantage plans, you need to get a referral to see someone other than your primary care physician.

Specialist
A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, a cardiologist treats only heart problems.

TrOOP
Stands for "true out-of-pocket costs," and is used by Part D plans to differentiate between total drug costs (the amount paid by the plan and the member) and the member's share of costs.

Frequently Asked Questions

Q *Do I have to take a physical to qualify for Medicare?*

A No. You simply must be age 65 or older, be under age 65 with a disability, or meet other requirements mentioned in this booklet.

Q *How do I choose between a Medicare Advantage plan and a Medicare supplement?*

A First you need to carefully examine all the benefits and details of both plan types. Then you will need to select the plan that best meets your current financial and health care requirements. Both plans help fill in the gaps not covered by Original Medicare.

Q *Are there limits to when I can switch Medicare health plans?*

A Yes. In general, you can make one "election" during the Annual Coordinated Election Period between November 15 and December 31 of each year. This includes enrolling in or changing to a prescription drug plan, a Medicare Advantage plan, or a Medicare Advantage plan with prescription drugs or other Medicare health plan for an effective date of January 1 of the following year. See the "How to Enroll in Medicare" section for more information.

Q *What happens if I don't join a Medicare prescription drug plan?*

A For most people, joining during your initial enrollment period means you will pay the lowest monthly premium. If you don't join a plan during your initial enrollment period and you don't currently have a drug plan that covers at least as much as a Medicare prescription drug plan, your monthly premium may increase the longer you wait to enroll. You will have to pay this extra amount for the duration of your Medicare prescription drug coverage.

Q *Do I give up Medicare benefits when I join a Medicare Advantage plan?*

A No. You get the same or better coverage, with additional benefits.

Q *What happens if I join a Medicare Advantage plan but move away?*

A Most Medicare Advantage plans are designed for members who live within the plan's service area. If you move away from the plan's service area, please contact the plan. They may be able to help you explore other options.

Q *Do I have to sign up for Medicare if I'm still working at age 65?*

A If you're still employed and have health coverage through your employer, or coverage with your spouse's employer, you can delay enrolling in Part B. You can sign up anytime while you are still covered by the employer or union group health plan, during the eight months following the month coverage ends, or when the employment ends (whichever is first). To avoid missing the deadline, contact your Social Security office or Railroad Retirement Board before you plan to stop working.

Q *Is my choice of doctors limited with plans that have a network?*

A It depends on the plan and on the size of the network. With some plans, the provider network is very large and is likely to include your current doctors and hospitals.

The Medicare Resource Guide is provided as an educational resource for people interested in Medicare and is published by Independence Blue Cross, an independent licensee of the Blue Cross and Blue Shield Association.

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