The A, B, C, Ds of Medicare

What you need to know for 2009

EMERITI®
RETIREMENT HEALTH SOLUTIONS
TABLE OF CONTENTS

4 Medicare Part A
5 Medicare Part B
6 What Medicare Parts A and B Do Not Cover
7 Medicare Part C, Medicare Advantage Plans
8 Medicare Part D, Prescription Drugs
9 What Medicare Part D Does Not Cover
10 Plans that Build on Medicare
11 Medicare Recap
Now that you are about to retire or are already retired, you need to think about your continuing health care needs in life after work. If you have been paying into Medicare through FICA payroll taxes during your working years and are age 65 and ready to retire, you are probably eligible for Medicare. You may also be eligible if your spouse (or deceased spouse) has (had) Medicare, or if you are permanently disabled and have been receiving Social Security for 25 months. You will be automatically enrolled in Medicare Part A at 65, and also in Part B if you are applying for or receiving Social Security benefits. If not, you will need to enroll in Part B.

Medicare provides an excellent foundation for the health care coverage of retirees, but the program is unlikely to meet all of your medical needs. It is important that you understand how Medicare operates and what choices you have. In order to make the best choices for your needs, you must understand how each part works. Original Medicare (Parts A and B) is administered by the Centers for Medicare and Medicaid Services (CMS). Part C, or Medicare Advantage, which replaces Original Medicare if you choose to go that route, and the relatively new Part D, which covers prescription drugs, are administered by private insurance carriers that receive a subsidy from CMS. If you want to enroll in a Medicare Advantage plan or Part D, you will need to choose an insurer and a plan.

The purpose of this booklet is to help you understand what the different parts of Medicare cover, and what they do not cover. The reality is that although Medicare is a comprehensive framework for health security in retirement, it doesn’t cover everything, nor was it ever intended to do so. You should consider buying supplemental insurance that helps you with the costs that Medicare does not pay. You should also think carefully about other out-of-pocket, health-related expenses beyond insurance coverage and factor them into your overall retirement budget. On average, Medicare is likely to pay only about half of your medical costs in retirement.* This booklet will help you to understand what your share of your health care costs may be. For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227) or visit the Medicare website www.medicare.gov. The Medicare publication Medicare and You is a very thorough and readable reference for detailed information about Medicare. Medicare and You, and Your Medicare Benefits, both from the Centers for Medicare and Medicaid Services (CMS) are the sources for the information about Medicare in this booklet.

The Emeriti Program, which may be offered to you through an Emeriti member institution, is designed to build on what Medicare pays. For more information about Emeriti, call 1-866-EMERITI (1-866-363-7484), visit the Emeriti website at www.emeritihealth.org, or read the Emeriti booklet, Your Emeriti Health Insurance Plan Options.

* The Employee Benefit Research Institute (EBRI) 2006 estimates from the 2003 Medical Expenditure Survey.
Medicare Part A provides coverage for stays in hospitals and skilled nursing facilities, as well as some other benefits. Part A also provides coverage for medically necessary home health care and hospice care. There is no additional cost for enrollment in Medicare Part A if you have made sufficient contributions into the system during your working years. You should receive information from Medicare several months before your 65th birthday.

There is a hospital deductible ($1,068 in 2009). The first 60 days of hospitalization, or the first 20 days in a skilled nursing facility, in a benefit period* are covered in full; thereafter you must share in the cost or pay it in full. The chart below shows the major types of coverages and benefit period or lifetime limits for Part A for 2009:

### WHAT’S COVERED AND WHAT YOU PAY

<table>
<thead>
<tr>
<th>Coverage</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>Days 1-60: $1,068 hospital deductible</td>
</tr>
<tr>
<td></td>
<td>Days 61-90: $267 per day</td>
</tr>
<tr>
<td></td>
<td>Days 91-150: $534 per day</td>
</tr>
<tr>
<td><strong>Over 150 days:</strong></td>
<td>You pay $534 for each reserve day in 2009.</td>
</tr>
<tr>
<td><strong>Beyond those limits:</strong></td>
<td>You pay 100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Days 1-20: $0</td>
</tr>
<tr>
<td><em>(certain requirements apply)</em></td>
<td>Days 21-100: $133.50</td>
</tr>
<tr>
<td></td>
<td>Beyond 100 days: you pay 100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$0 for medically-necessary care</td>
</tr>
<tr>
<td></td>
<td>20% of approved amount for durable medical equipment</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>$0 if you meet certain requirements</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Days 1-190 Lifetime: $0</td>
</tr>
<tr>
<td></td>
<td>Beyond 190 days: you pay 100%</td>
</tr>
</tbody>
</table>

*A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60 day period, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.

PLEASE NOTE: Medicare does not pay for custodial care or long-term care, whether at home or in a nursing home.
Medicare Part B is available to you if you are eligible for Part A. Part B services focus on physician visits, diagnostic testing, durable medical equipment, and some other services. There is an annual premium for Medicare Part B. These premiums are now based on your annual taxable income, on a phased-in basis. If your annual taxable income is $85,000 ($170,000 if you file jointly) or less, your monthly premium is $96.40 for 2009, but if your income is higher it could be as high as $308.50.

Generally you must enroll when you are first eligible or you will pay a penalty of 10% for each full 12-month period that you were eligible but did not enroll. You do not pay this penalty if you did not sign up because you were covered under an employer’s group plan, as long as you do sign up shortly after that coverage ends. (See Special Enrollment Period in Medicare and You.)

WHAT’S COVERED AND WHAT YOU PAY

There is an annual deductible of $135 in 2009 for Part B services, which means that you pay in full for the first $135 of Medicare Part B expenses. Thereafter, your costs vary, depending on the service, as follows:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician charges</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical laboratory services and diagnostic tests</td>
<td>0% for Medicare-approved services, 20% for covered diagnostic tests and x-rays</td>
</tr>
<tr>
<td>Preventive services</td>
<td>generally, 20% (flu shots; mammograms; pap tests, pelvic exams; prostate cancer screenings; other screenings for those at high risk) NOTE: Not all preventive services are covered every year. Check with Medicare (see below) for the coverage provisions for the appropriate service or screening.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient therapy</td>
<td>20% (may be limits and exceptions)</td>
</tr>
<tr>
<td>Home health services</td>
<td>0% for Medicare-approved services</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Coinsurance varies by service</td>
</tr>
<tr>
<td>Mental health services</td>
<td>50% for outpatient care</td>
</tr>
<tr>
<td>Blood</td>
<td>100% for 1st 3 pints, 20% thereafter</td>
</tr>
</tbody>
</table>

Medicare covers a variety of other services, with varying amounts of coinsurance or co-payments. For more information, call 1-800-MEDICARE (1-800-633-4227) or check the web site at www.medicare.gov.
There are many health-related expenses that are not covered by Original Medicare. Until 2006, the biggest gap in Original Medicare coverage was prescription drugs, which are now covered under the relatively new Part D (see page 8), with varying levels of cost-sharing, depending on the plan selected and your prescription drug usage.

Original Medicare also does not cover:
- dental care and dentures
- routine vision and hearing care
- most eyeglasses and hearing aids
- custodial or long term care
- routine physical exams (except for an entry-year exam)
- some shots, tests and lab tests
- some diabetic supplies
- routine foot care
- acupuncture and certain chiropractic services
- cosmetic surgery
and, of course, deductibles, coinsurance, and co-payments that you pay for the services that Medicare covers.

Medicare also provides no coverage for health care expenses while you are traveling outside the United States. (There are various exceptions to a number of these exclusions; contact Medicare for more specific provisions.)

NOTE: Providers who do not agree to Medicare's allowable cost limits can balance bill you up to an additional 15% of the cost for covered services. Medicare does not pay any of this additional cost, nor do Medicare Supplement or Medicare Advantage (Part C) plans.

As you can see, Medicare provides a solid foundation for your retiree health care, but there are also coinsurance requirements on specific services, and there are no out-of-pocket limits for most Medicare-covered services. It is for these reasons that Medicare suggests that you may want to purchase supplemental insurance that builds on the foundation of Original Medicare. The Emeriti Program offers a range of retiree health insurance plan options, available to you through a retiree health plan adopted by your institution.
In Medicare Advantage, or Part C plans, your Medicare Parts A, B, and usually D benefits are assigned to a private insurer who provides you with comprehensive health care coverage. Medicare pays the insurer a fee to assume all of the benefit coverages defined by Medicare. The insurer becomes responsible for all of the Medicare-eligible health care costs and sometimes offers additional benefits beyond Original Medicare’s eligible services. The expectation is that the premium you pay for Medicare Part C plans will likely be lower than for traditional medical plans supplementing Original Medicare, although that is not always the case; Part C premiums vary considerably from county to county, based on Medicare’s reimbursement schedule. In terms of your share of costs for Medicare-eligible services, Medicare Advantage plans may be structured in various ways, with co-payments and no annual out-of-pocket limits, or with coinsurance (% cost-sharing and an annual out-of-pocket maximum. The amount that Part C plans pay for Medicare-eligible expenses may be different from what Original Medicare would pay. In all cases you pay Part B premiums.

There are two major approaches to Medicare Advantage plans. The first is an HMO arrangement, which many people mistakenly believe is the only Part C option. In an HMO you must use in-network services for non-emergency care, and you must select a primary care physician as part of the insurance enrollment process. The network is usually limited to a specific geographic area; if you were to move out of the area, you would need to try to find another HMO plan in your new location, or try to purchase a Medigap policy and a Part D plan to put together a similar level of insurance coverage.

Another type of HMO plan is a Medicare Cost Plan that contracts as a Medicare Health Plan. Unlike most other HMO options, enrollees maintain their Medicare Part A and Part B benefits. That enables them to seek services by a non-contract provider within their service area; with other HMO plans, any services obtained outside of the network would not be paid by the health plan or Medicare, unless they were due to an urgent or emergency situation. Cost plans also do not have to offer a Medicare Part D option. If they decide to offer a Medicare Part D plan, the same Medicare rules apply to Cost plans. The HealthPartners Freedom Plan, available under the Emeriti Program for institutions in Minnesota and their retirees living in Minnesota, has an open access network. You do not have to select a primary care physician and can obtain services from any of the HealthPartners contracted providers (including most doctors and hospitals throughout Minnesota) without a referral.

There is a recent addition to the Medicare Advantage family, called Private Fee-for-Service (PFFS), which is growing in popularity. In this type of arrangement, there is no network, no requirement to pick a primary care physician, and no gatekeeper function. You can go to any provider or facility that accepts Medicare and the private fee-for-service payment arrangement. Unlike Medicare HMOs, which tend to be restricted to limited geographical areas, PFFS plans can be nationwide. If you relocate anywhere in the U.S. you may keep the same PFFS plan. (Premiums will vary because Medicare reimbursements vary considerably from one part of the country to another, even from county to county.) Similar to other Medicare Advantage Plans, these plans typically offer a wide range of preventive services. The Emeriti Program includes two PFFS plans underwritten by Aetna.

Because Private Fee-for-Service is a relatively new type of arrangement, some providers may not be aware of it. Before you choose this option, be sure that your doctor or other health care providers will be willing to participate. (If not, they may not provide health care services to you, except in emergencies.) This is different from the way that Medicare Supplement Plans work.
Medicare introduced the Part D prescription drug benefit in 2006 to help Medicare-eligible retirees cope with the fastest rising component of their health care costs: prescription drugs. While the design of this benefit is rather complicated, here are the basics:

- you choose an insurer, and then you choose a plan of coverage;
- you pay an annual premium for this insurance coverage;
- you typically pay an initial deductible each year;
- you pay a portion of the cost of prescription drugs according to Part D's three-tier structure, often with a different cost-share by you in each tier; and
- if you enter the third tier in a calendar year (after you have paid out-of-pocket $4350 in 2009, for your covered prescription drugs), the plan covers nearly all of the remaining costs of your prescription usage (typically 95%, or all but a small co-pay) for the rest of the calendar year. This is Part D's catastrophic threshold.

Many retirees believe that there is only this standard Part D plan design. Actually, there are many variations on this design. One of the most important plan provisions that you should evaluate is the type of formulary (open or closed) and the eligible drugs covered by that plan’s Medicare-approved formulary. A formulary is a catalog of the prescription medications covered by the plan, and approved by Medicare. An open formulary means that the plan covers generic, preferred brand, and non-preferred brand drugs on the formulary, although the plan pays a greater share of costs for generic and preferred brand drugs. A closed formulary requires you to use only those medications that are designated as covered under the insurer’s preferred drug list. If your brand drug is not covered on the closed formulary, you can speak to your doctor about switching to a drug that is on the preferred drug list; or your doctor might obtain a medical exception from the insurer for the drug to be covered. If you decide to continue taking medications not covered on the closed formulary without obtaining a medical exception, you will pay the full cost; and these expenses will not count toward the plan’s deductible or out-of-pocket limits.

It is important to enroll in a Part D plan when you are first eligible, because CMS will impose a penalty for late enrollments, permanently increasing your premiums by 1% for each month you did not enroll. If you are newly eligible for Medicare, you must enroll no later than three months after the month you reach 65 to avoid a penalty. If you have creditable (equivalent) coverage, say through your employer or through your spouse’s employer, you do not need to enroll in Part D until that coverage terminates. Note too that you can enroll in only one Part D plan.
The diagram below illustrates how the Standard Part D design works, with its various coverage tiers and cost-sharing provisions.

1Standard Part D also has an annual premium.
2Greater of $2.40 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $6.00 or 5% for all other drugs.

WHAT MEDICARE PART D DOES NOT COVER

Medicare Part D is designed with three tiers of coverage. After the deductible, if any, at each tier you are expected to share in the cost of your covered drugs. In the Standard Part D design you actually pay 100% of the cost of your covered drugs in Tier 2, also called the coverage gap or the donut hole. Enhanced plans generally fill in some of that gap, sharing in the continuing cost of your covered drugs. You should carefully review the specific design of the Rx plan because many enhanced plans cover only generic drugs in the gap. So even if your drugs are on the plan’s formulary, you will pay a lot of the cost if you need or prefer to take a brand drug. Beyond the gap (after $4350 of out-of-pocket expenditures by you under the plan in 2009), you may still have to pay 5% of your drug costs, although some enhanced plans pay 100% for the remainder of the calendar year.

In addition to your deductible and coinsurance cost-sharing, in most plans you will also be responsible for all costs for the following kinds of drugs:

- drugs not covered in a closed formulary plan, unless a medical exception is obtained
- nonprescription drugs
- drugs purchased outside of the U.S. and its territories
- barbiturates and benzodiazepines
- vitamins and mineral products
- drugs for treatment of sexual dysfunction or inadequacies
- weight control medications
- all other drugs that are not eligible for coverage under Medicare coverage guidelines
Having reviewed how Medicare works, you may appreciate why Medicare suggests that you consider obtaining additional insurance that builds on Original Medicare, to help pay for those expenses that Medicare does not pay in full.

One option is to go into the open market and buy a Medigap policy. These policies are tightly regulated by Medicare, and they coordinate with Medicare Parts A and B. There are a number of coverage options at varying costs, offered by insurance companies that choose to participate in various state and local markets. New Medigap policies cannot offer prescription drug coverage; you will need to find a separate Part D plan if you want drug coverage. One thing to keep in mind is that once you select a Medigap plan, it is very difficult and perhaps impossible to switch to a different plan as your needs change. You might have become uninsurable. So you may need to start out over-insured, or end up under-insured later. And if your insurer leaves your local market, you may become part of a closed group, with potentially much higher premiums.

A second option is to enroll in group retiree medical insurance that coordinates with Medicare, if your employer offers it. The Emeriti Program, offered under a member institution's Emeriti Retiree Health Plan, is a group insurance arrangement that provides a range of guaranteed issue insurance plan options. The options provide choices of Medicare Supplement plans (that build on Original Medicare) and Private Fee-for-Service plans (where private insurers provide all benefits covered under Original Medicare); or Cost plans (which share some of the attributes of both kinds of plans) for Minnesota retirees from Minnesota institutions. And all coverage choices include Medicare-approved Part D insurance at different levels of coverage and cost. Emeriti offers insurance nationwide, so no matter where you live in the U.S., you will be covered. All Emeriti insurance offerings provide an element of catastrophic coverage, which limits your exposure to very high medical or drug costs in a calendar year. And most importantly, Emeriti gives you an annual opportunity to switch to another Emeriti plan that might better meet your changing health and financial needs over time.

For more information about insurance in the Emeriti Program, see the booklets *Your Emeriti Health Insurance Plan Options*, and *Comparison Chart*. 
# MEDICARE RECAP

## CHOOSE ONE

### ORIGINAL MEDICARE

<table>
<thead>
<tr>
<th>PART A (HOSPITAL)</th>
<th>PART B (MEDICAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare provides these coverages</td>
<td>Part B is optional</td>
</tr>
<tr>
<td>You have your choice of providers</td>
<td></td>
</tr>
</tbody>
</table>

### MEDICARE PART C

Medicare Advantage Plans like HMOs, Medicare Cost Plans, and PFFS

- Private insurers approved by Medicare provide Parts A and B, and may offer Part D
- Some plans may have networks
- You may get extra benefits

## THEN ADD

### MEDICARE PART D

**PRESCRIPTION DRUG COVERAGE**

- Choose from a variety of Rx coverages
- Private insurers approved by Medicare provide this coverage
- Medicare approves the formularies
- Different plans cover different drugs with different cost sharing arrangements
Plans are offered by Aetna Life Insurance Company and its affiliates. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. State mandates apply. Product availability may vary by state. Please note: A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide health care services to you, except in emergencies. Providers can find Aetna's terms and conditions on Aetna's web site.

FOR MORE INFORMATION ABOUT EMERITI
CALL 1-866-EMERITI (1-866-363-7484)
OR VISIT WWW.EMERITIHEALTH.ORG.