What you need to know for 2014

- How Medicare works
- What Medicare covers
- How much Medicare costs

An important resource for understanding your healthcare in retirement
INTRODUCTION

Now that you are about to retire or are already retired, you need to think about your continuing health care needs. 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 will be automatically enrolled in Medicare Part A at age 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. 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 24 months.

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. Original Medicare (Parts A and B) is administered by the Centers for Medicare and Medicaid Services (CMS). For Part C or Medicare Advantage plans, a private insurer provides all of the benefits of Original Medicare Parts A and B, receives a subsidy from CMS, and may provide additional benefits. Medicare Part D, which covers prescription drugs, is administered by private insurance carriers that receive a subsidy from CMS.

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. That’s why access to supplemental insurance is so helpful because it helps you with healthcare costs that Medicare does not pay. You will also want to think about other out-of-pocket medical expenses beyond insurance coverage and factor them into your overall retirement budget. On average, Medicare is likely to pay only about 62% of your health care costs in retirement.\(^1\) This booklet will help you to understand what your share of Medicare costs may be.

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

**Updates to the Affordable Care Act in 2014:**

- The Medicare Coverage Gap Discount Program will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving “Extra Help.” A **50% discount on the negotiated price of preferred and non-preferred brand drugs** (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount. This manufacturer discount is applied first to the total cost of your prescribed brand drug before you and the Prescription Drug Plan (PDP) pay your respective share of total drug costs at a retail pharmacy or through a mail order service. The amount that the pharmaceutical company pays, in addition to the amount that the members pays, contributes towards the True out of Pocket (TrOOP) amount.

If your PDP has an Open formulary and already includes coverage for brand drugs in the Gap, the 50% discount will further reduce your cost share obligations. If your PDP plan has the Open formulary but does not include coverage for brand drugs in the Gap, the 50% discount will also reduce your cost share obligations. If your PDP plan has the Standard formulary and offers no coverage for brand drugs in the Gap, the 50% discount will only apply to those brand drugs available on your PDP’s formulary.

- Your cost share in the Coverage Gap in 2014 can be no more than 72% for covered Part D generic drugs offered by the standard Part D benefit.

- As required by CMS, PDP plans will continue paying 2.5% of the total brand cost in the Coverage Gap. This is in addition to the 50% discount that pharmaceutical manufacturers are paying.
MEDICARE PART A

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 FICA contributions into the FICA system during your working years. You should receive information from Medicare about Part A enrollment several months before your 65th birthday.

Part A has a hospital deductible of $1,216 in 2014. The first 60 days of hospitalization, or the first 20 days in a skilled nursing facility, in a benefit period* are covered in full by Medicare; 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 2014:

WHAT IS COVERED AND WHAT YOU PAY

<table>
<thead>
<tr>
<th>Coverage</th>
<th>You Pay</th>
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<tbody>
<tr>
<td>Hospitalization</td>
<td>Days 1-60:* $1,216 hospital deductible</td>
</tr>
<tr>
<td></td>
<td>Days 61-90:* $304 per day</td>
</tr>
<tr>
<td></td>
<td>Days 91-150:* $608 per day lifetime reserve days (up to 60 days lifetime)</td>
</tr>
<tr>
<td></td>
<td>After lifetime reserve days are exhausted: you pay 100%</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Days 1-20:* $0</td>
</tr>
<tr>
<td>Facility</td>
<td>Days 21-100:* $152 per day</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. You pay $5 coinsurance for prescription drugs for pain management. You pay 5% for inpatient respite care.</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>Days 1-190 lifetime: Same cost sharing as inpatient hospitalization</td>
</tr>
<tr>
<td></td>
<td>Beyond 190 lifetime 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

Generally, 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 that you pay. These premiums are based on your annual taxable income, on a phased-in basis. If your annual taxable income is $85,000 ($170,000 for joint filers) or less, your **monthly premium is $104.90 for 2014** for new entrants into Medicare. If your income is higher, your premium could be higher.

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 do not sign up for Part B because you are covered under an employer’s active group plan or enrolled under a spouse/partner’s health plan, as long as you do sign up shortly after that coverage ends. (See Special Enrollment Period in *Medicare and You* at www.medicare.gov.)

WHAT IS COVERED AND WHAT YOU PAY

There is a **calendar year annual deductible of $147** in 2014 for Part B services, which means that you pay in full for the first $147 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>
</tbody>
</table>
| Preventive services                     | generally, 20% (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.* |
| Durable medical equipment               | 20%                                                                     |
| Outpatient therapy                      | 20% (may be limits and exceptions)                                      |
| Home health services                    | 0% for Medicare-approved services                                       |
| Outpatient hospital services            | Coinsurance varies by service                                           |
| Mental health services                  | 40% for outpatient care                                                 |
| Blood                                   | 100% for 1st 3 pints, 20% thereafter                                   |
WHAT MEDICARE PART A AND PART B DO NOT COVER

There are many health-related expenses that are not covered completely by Original Medicare (Parts A and B); and some others, such as vision, dental and hearing services, and long term care, where it provides no benefit.

Original Medicare (Parts A and B) does not cover:

• dental care and dentures
• routine vision and hearing care
• most eyeglasses and hearing aids
• routine foot care
• custodial or long term care
• some shots, tests and lab tests
• some diabetic supplies
• acupuncture and certain chiropractic services
• cosmetic surgery

And, of course, there are deductibles, coinsurance, and co-payments that you pay for the services that Medicare covers.

It is important to remember that Medicare 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 cost-sharing 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 the retiree health plan adopted by your institution.
**MEDICARE PART C, MEDICARE ADVANTAGE PLANS**

**Medicare Advantage Plans**
In Medicare Advantage, sometimes called “Part C” or “MA Plans,” your Medicare Parts A, B 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 Original Medicare. The insurer becomes responsible for all of the Medicare-eligible health care costs and sometimes offers additional benefits, often extensive preventive services, beyond Original Medicare’s eligible services.

The CMS payments for Part C plans are dependent on Medicare’s reimbursement to providers, which vary significantly from one geographic area to another. Medicare Advantage plans may be structured in various ways, with co-payment and annual out-of-pocket limits, or with coinsurance (%) cost-sharing, and include 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.

One type of Medicare Advantage plan is **Preferred Provider Organization (PPO) Plans**. The plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all types of Medicare Advantage Plans, you’re always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you’re in a Medicare Advantage Plan. **Medicare Advantage Plans are not supplemental coverage plans; a Medicare Advantage plan would become your primary insurance.**

**Medicare Cost Plans**
A **Medicare Cost Plan** is another type of Medicare Part C plan that contracts as a Medicare Health Plan. Enrollees maintain their Medicare Part A and Part B benefits, enabling them to seek services by a non-contract provider. Cost plans 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.
MEDICARE PART D, PRESCRIPTION DRUG

The Medicare Part D prescription drug benefit is designed 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 your portion of the cost of covered Part D prescription drugs after the deductible according to the Part D plan’s tier structure for the Initial Coverage and Coverage Gap stages, often with a different cost share by drug tier in each stage;
- if you enter the catastrophic stage in a calendar year, the plan covers nearly all of the remaining costs of your prescription usage (typically the plan pays 95% or all but a small participant co-pay) for the rest of the calendar year.

There are many variations on the Medicare Part D design. One of the most important prescription drug plan provisions that you should evaluate when thinking about Rx coverage is the type of formulary that the plan has. A formulary is a listing of covered drugs under the insurance plan. It outlines under what tier a drug would be covered so that you can determine the cost share that you will be responsible for for a specific drug. All Medicare Part D plans must comply with government requirements. CMS requires that the formulary provides access to an acceptable range of Part D drug choices, and that it includes drug categories and classes that cover all disease states.

An open formulary means that all Part D drugs are available for coverage, although the plan may be designed with lower member cost sharing for generic and preferred brand drugs. A closed formulary is a subset of Medicare Part D drugs, and 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 you or your doctor may request 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 consider enrolling in a Part D plan when you are first eligible. A late enrollment penalty will be added to your Part D premium if you don’t enroll during your initial enrollment period or if you don’t have other creditable prescription drug coverage that pays, on average, at least as much as Medicare’s standard prescription benefit. This would permanently increase your premiums by 1% of the “national base beneficiary premium” for each month you did not enroll or did not have creditable coverage. You do not pay the late enrollment penalty if you are eligible for the low income subsidy program. You can enroll in only one Part D plan at a time. Each year, during the Medicare open enrollment period in the fall, you can switch to a different provider or plan, with coverage becoming effective January 1st.
The 2014 Standard plan design includes several phases of cost-sharing by you and the Plan. First, you pay a monthly premium. Then, as you begin to incur drug expenses, you pay the full cost, up to the annual Deductible amount. Then, you pay 25% coinsurance (the Plan pays 75%) for each prescription, up to the Initial Coverage Limit (total costs paid by you and the Plan). If you have additional costs in the calendar year, you enter the Coverage Gap, and you pay 97.5% of brand drug and 72% of generic drug costs and receive a 50% discount on the cost of covered Part D brand drugs until your True Out-of-Pocket (called TrOOP) expenditures reach $4,550. If your Rx expenditures exceed $4,550, you move to Catastrophic Coverage, where you pay the greater of 5% or $2.55 for covered generic (including brand drugs treated as generic) drugs. The greater of 5% or $6.35 for all other drugs.

In addition to your deductible and cost-sharing, in most plans you will 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 (except as identified by CMS for Part D inclusion)
- prescription vitamins and mineral products
- drugs for treatment of sexual or erectile dysfunction
- weight control medications
- all other drugs that are not eligible for coverage under Medicare coverage guidelines (see www.medicare.gov for additional information)

*Refer to information on the Medicare Coverage Gap Discount Program on page 3.
Having reviewed how Medicare works, you may appreciate why Medicare suggests that you consider obtaining supplemental insurance that builds on Original Medicare, to help pay for those expenses that Medicare does not pay in full.

One option is to enroll in group retiree medical insurance that coordinates with or supplements Medicare. The Emeriti Program, offered under your institution’s Emeriti Retiree Health Plan, provides a choice of group health plans that build on Original Medicare in different ways. In 2014, Emeriti offers the Aetna Traditional Choice plan that coordinates with Medicare and Aetna Supplemental Retiree Medical Plans K and L that each build on the services provided by Original Medicare.

Emeriti also offers two Medicare Advantage PPO (PPO ESA) Plans, where Aetna provides all benefits covered under Original Medicare, plus additional benefits beyond Original Medicare. For Minnesota-resident retirees from Minnesota institutions, HealthPartners provides Cost plans, that contracts as a Medicare health plan. The PPO and Cost plans both provide extensive preventive services. All Emeriti coverage choices include Medicare-approved Part D insurance at different levels of coverage and cost. Emeriti offers retiree health 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. Each year during Emeriti’s fall annual enrollment you will be able to switch to a different medical and drug plan based on your needs for the upcoming year. Even if you develop a very different medical situation, you can change plans for the next year, with no medical underwriting.

The Emeriti Program, offered through your institution, is designed to build on what Medicare pays. For more information about Emeriti, call 1-866-EMERITI (1-866-363-7484), and visit the Emeriti web site at EmeritiHealth.org.

What To Look For In Open Market Medigap Plans

Another 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 an open market Medigap plan, it is very difficult and perhaps impossible to switch to a different plan as your needs change each year. Open market plans require medical underwriting and you may be deemed uninsurable by the insurance provider. This means 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. Please note that these restrictions do not apply to Emeriti insurance plans.
NEXT STEPS...

**CHOOSE ONE**

**ORIGINAL MEDICARE PLAN**

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

**OR**

**MEDICARE PART C PLAN**

**MEDICARE ADVANTAGE PLANS**

• e.g. HMOs, PPOs, and COST PLANS

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

**THEN ADD**

**MEDICARE PART D PLAN**

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