

THE ESSENTIALS

MEDICARE AND MEDICAID



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The Essentials: Medicare and Medicaid

The ability to access and afford health care services is an important concern for individuals of all ages. Two government programs are in place to assist Americans with this concern. One is Medicare, which is the country's health insurance program for most individuals age 65 and older. It is also available to people under 65 with certain disabilities. The other is Medicaid, which covers medical services for individuals of all ages who have limited income and assets and meet certain other conditions. Individuals or families applying for Medicaid coverage must meet the financial guidelines set forth for acceptance into the program.

Medicare is a Federal program which is administered by the Centers for Medicare & Medicaid Services (CMS). For many Americans Medicare is their only source of health insurance. It is not, however, all-inclusive in its coverage. It also has premiums, deductibles, and other costs associated with it. While Medicaid must meet certain Federal standards, it is a state-run program, with each state having its own rules surrounding eligibility and coverage. Some individuals are eligible for both Medicare and Medicaid.

This educational guide serves as a general introduction to the two programs. It gives an overview of how each program works by answering frequently asked questions. It also gives a listing of additional resources for those who are looking for more detailed information about either program. We trust you will find it helpful.

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Medicare

Q. Who Is Eligible for Medicare?¹

A. Most individuals age 65 and over who are U.S. Citizens or permanent legal residents would be eligible for Medicare Part A (hospital insurance) at no cost. It is funded through a portion of the payroll taxes paid by employees and employers.

To qualify individuals at age 65 must:

- be receiving or be eligible to receive Social Security benefits or railroad retirement benefits, or
- have worked or have a spouse (living or deceased, including those who are divorced) who has worked long enough in a government job where Medicare taxes were paid, or
- be a dependent parent of a fully insured (had worked a sufficient number of quarters to meet the eligibility requirements for Social Security Benefits and Medicare) deceased child.

Certain individuals under age 65 would also qualify for Medicare Part A at no cost. These include individuals who:

- have been eligible for Social Security disability benefits for 24 months, or
- are receiving a disability pension from the railroad retirement board and meet certain requirements, or
- have Amyotrophic Lateral Sclerosis (ALS) and are receiving Social Security disability benefits, or
- have permanent kidney failure and meet certain requirements, or

- › are children or widows or widowers age 50 and over whose spouse (including those who were divorced) had worked long enough in a government job where Medicare taxes were paid and who meet Social Security disability requirements.

Q. How Do I Apply for Medicare?

A. Social Security will automatically contact you a few months before you would be eligible for Medicare if you are already receiving Social Security retirement or disability benefits or a railroad pension. You will automatically be enrolled in Medicare Part A and Medicare Part B and receive your Medicare Card. If you reside in Puerto Rico or are a resident of another country you will not be automatically enrolled in Part B and must elect to do so.²

You will have the option to turn down Part B because it carries a monthly premium. However, if you do not enroll in Medicare Part B when first eligible and decide to enroll later, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but chose not to enroll, except in special circumstances outlined in the *Medicare and You* guide.³ Approximately 95% of beneficiaries with Part A enroll in Part B.⁴

If you are not yet receiving Social Security benefits, you should call or visit your local Social Security office about three months prior to your 65th birthday to inquire as to whether you should enroll in Medicare at that time. If you have questions about your eligibility for Medicare or about Part B enrollment you may call Social Security at 1-800-772-1213. TTY users may call 1-800-325-0778.⁵

Q. What Are the Premium Costs Associated with Medicare B?

A. Medicare Part B has a monthly premium which is adjusted each fall and becomes effective January of the following year. Individuals and couples with annual incomes over a certain amount (\$85,000 for individuals and \$170,000 for couples in 2010) will pay a premium higher than the standard premium based on their income. For most, the premium is deducted each month from their Social Security, Railroad Retirement, or Civil Service Retirement Benefit check. If an individual receives none of these, Medicare will send a bill every three months.⁶

In 2010, the standard premium for currently enrolled individuals who have their Part B premium deducted from their check will remain the same as that which they paid in 2009, \$96.40 monthly. For others, the standard premium will be \$110.50 in 2010, a 15% increase from the previous year. For individuals making \$85,000 or more (couples \$170,000 or more) monthly premiums will range from \$154.70 to \$353.60, depending on their income.⁷

There are instances in which state and government funding are available for assistance to cover some Medicare costs for individuals with limited income and assets. The program is called the “Medicare Savings Program.” Information on the program can be obtained by calling Medicare at 1-800-633-4227 and saying “Medicaid” to get the number for your state.⁸

Q. Does Medicare Have Options to Select From?

A. There are several parts of Medicare that are important for individuals to understand. These include the choices an individual makes regarding Medicare coverage. These decisions involve whether to enroll in Original Medicare, which includes two parts, Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), or Medicare Part C (Medicare Advantage), which includes Medicare's Managed Care Plans. Medicare also includes the option of enrolling in Medicare Part D, a voluntary prescription drug coverage offered through private companies. Each of these Medicare options will be discussed in subsequent questions.

Q. How Does Medicare Part A Work?

A. Medicare Part A is sometimes called “hospital insurance.”

The services covered are:

- hospitalizations
- skilled nursing facility stays
- home health care
- hospice care
- blood transfusions during a hospitalization or nursing facility stay

Service coverage is not all-inclusive and there are guidelines for reimbursement and deductibles.

Q. What Are the Guidelines, Deductibles, and Co-Payments for Hospital Care Under Medicare Part A?

A. Medicare has specific guidelines for hospital care, along with annually determined co-payments and deductibles. Time spent in a hospital is covered if ordered by the doctor and determined to be appropriate under Medicare guidelines. Lengths of stay in the hospital are reviewed by Utilization Review Committees. Medicare has a deductible for hospital stays (\$1,100 in per “Benefit Period” in 2010) as well as co-payments for days 61-90 (\$275 per day in 2010) and “Lifetime Reserve Days” after day 90 in each “Benefit Period” up to 60 total days over the course of your lifetime (\$550 per day in 2010). After the reserve days are used the individual is responsible for all hospital costs. The deductible and co-payment amounts are adjusted annually. Under Medicare a “Benefit Period” begins the day an individual goes into a hospital or skilled nursing facility and ends when an individual has not received any inpatient hospital care or skilled care in a skilled nursing facility for 60 days in a row. Under Medicare inpatient care for psychiatric treatment is limited to 190 days in a lifetime.⁹

Q. What Are the Guidelines, Deductibles, and Co-Payments for Skilled Nursing Facility Care Under Medicare Part A?

A. Medicare has specific guidelines for skilled nursing facility care, along with annually determined co-payments. Time spent in a Medicare-certified skilled nursing facility is covered if a three-day related hospital stay preceded the individual’s stay and a doctor prescribes skilled care. There are no co-payments for the first 20 days.

After day 20 there is a co-payment for each additional Medicare qualifying day up to day 100 (\$137.50 in 2010). It is important to note that the individual must continue to meet Medicare skilled criteria to receive benefits up to day 100. At the point where an individual no longer meets the criteria, benefits will cease. During each episode of care, Medicare will no longer reimburse nursing home care after day 100 even if the individual would otherwise meet the criteria for skilled care.¹⁰

Q. What Are Medicare Part A Guidelines for Home Health Care?

A. Under Medicare, home health care services are covered if a doctor prescribes skilled care provided by a health care professional such as a nurse or therapist and the individual meets Medicare guidelines to receive skilled care at home. The care must come from a Medicare-certified home health care agency and the services must be intermittent in nature. The person receiving the care must be homebound, which means that the person is not normally able to leave the home and leaving the home takes considerable and taxing effort. A person may leave on occasion such as doctor visits or to attend religious services. Medicare does not cover 24-hour in-home care or the use of an aide or assistant for personal care services on an ongoing long-term basis. There are no deductibles or co-payments for home health care services that meet Medicare guidelines for skilled care.¹¹

Q. What Are Medicare Part A Guidelines Related to Hospice Care?

A. Hospice benefits are available for those covered under Medicare Part A. Individuals choosing Medicare Hospice benefits would be selecting them instead of their regular Medicare benefits for care of their terminal illness. The hospice benefit covers an array of services to support individuals

who are terminally ill and their families. There are no co-payments or deductibles for most hospice care. However, Medicare hospice does not cover housing expenses or room and board in a care setting, such as a nursing home or assisted living facility except under the respite care benefit. This hospice benefit allows one to stay in a Medicare-approved facility such as a hospice facility, nursing home, or hospital for up to 5 days for each time respite is approved to give caregivers a rest. Medicare will cover the room and board in these instances, with the individual being responsible for 5% of the Medicare-approved amount for inpatient respite care. Under hospice individuals would be responsible for a co-payment up to \$5.00 per prescription for outpatient medication for pain or symptom management.¹²

Q. How Does Medicare Part B Work?

A. Medicare Part B, sometimes called “medical insurance,” is available to individuals when they become eligible for Part A. It covers some medical and other services such as outpatient hospital services, certain outpatient therapies, doctor services, preventive health screening, durable medical equipment, laboratory services, and some home health care benefits. Again, certain requirements may have to be met for Medicare Part B to cover these costs. Once an annual deductible is met which in 2010 is \$155, Part B pays 80% of the covered cost for most services. Some outpatient services, such as Medicare-approved laboratory services, may be fully covered, while others such as most outpatient mental health (Individual pays 45% of cost.) may be reimbursed by Medicare at less than 80%. While most doctors, providers, and suppliers accept Medicare assignment, which means you would only be responsible for the Medicare deductible and co-insurance on the

Medicare-approved charges, some may not. In these instances, they may charge more than the Medicare-approved amount and you may have greater out-of-pocket expenses. You should always check to make sure your doctor, supplier, or other provider accepts assignment.¹³

Q. How Can I Cover the Out-of-Pocket Expenses Associated with Original Medicare?

A. Medigap, also known as Medicare Supplement Insurance, is not a government-sponsored program. Rather, it is a series of products offered by private insurance carriers providing supplemental insurance to the Medicare program. As the name implies, it covers the “gaps” for deductibles, co-insurance, co-payments and other charges not covered by Original Medicare. To be eligible to elect a Medigap policy, an individual must be enrolled in Medicare Parts A & B. It is best to enroll in a Medigap Plan when you first enroll in Medicare Part B. After the initial enrollment, your options for Medigap coverage may be limited. Medigap policies are required to follow Federal and state laws to protect consumers and each policy must be clearly defined as “Medicare Supplement Insurance.”¹⁴

The government has defined 12 standardized Medigap plans, labeled A through L. With the exception of Massachusetts, Minnesota, and Wisconsin, which have made modifications to some of the Medicare defined plans, all other states offer Medigap plans as defined by Medicare. However, as in any privately marketed product, the number of plans offered in a state, as well as the premiums for them, can vary. When making comparisons among insurance companies, make sure you are comparing costs for the same plan, as each of the Medigap plans provides coverage that is different from the others. For instance, in looking at costs compare Plan F with Plan F from each company.¹⁵

Q. Are There Similarities Among the Various Medigap Plans?

A. Until 2006 there were 10 Medigap Plans (Plans A through J). Each of these Plans is required to include the following basic benefits:

- the Medicare Part A co-insurance for days 61-90 and the “Lifetime Reserve Days” of a hospital stay
- coverage of up to 365 additional days of a hospital stay during your lifetime after you use up all Medicare hospital benefits
- co-insurance or co-payment amounts for Medicare Part B services after you meet the yearly deductible
- the first three pints of blood or equal amounts of packed red cells per calendar year

In addition to the basic benefits, Plans A through J offer some additional benefits depending on the plan selected. These may include skilled nursing facility co-payments, Medicare Part A and Part B deductibles, foreign travel emergency care, some preventive care, and some additional at-home recovery care.¹⁶

Q. How Do the Newer Medigap Plans Work?

A. Plans K and L were added to the Medicare defined standard Medigap plans in 2006. These plans differ somewhat from the original 10 plans in their basic benefits. Plans K and L have lower premiums but higher out-of-pocket annual limits before paying 100% of co-insurance and co-payments.

(In 2010, Plan K had a \$4,620 annual out-of-pocket limit, while Plan L had a \$2,310 limit.¹⁷) As part of the basic benefits, they pay a percentage rather than the full Medicare Part B deductible and co-insurance and co-payments for most services until the annual out-of-pocket limits are met. They do, however, provide 100% of the coinsurance for Medicare Part B preventive services and a percentage of the hospice cost sharing for all Medicare Part A covered expenses and respite care. It is important to note that “excess charges,” which are charges above what Medicare approves are not covered and do not count toward the out-of-pocket-limit.¹⁸

Two new Medigap plans, M and N, are being introduced in June 2010. At the time that these two plans are introduced, plans E, H, J, and I will no longer be available for purchase. However, anyone already enrolled in one of these plans will be able to keep it.¹⁹ Plans M and N will include the basic benefits covered in plans A through J. They will have a lower premium than some of the other Medigap plans as they both use a cost sharing model. Individuals who Select Plan M would split the Medicare Part A deductible with the insurance company 50/50. The Plan does not cover the Part B deductible at all but there are no doctor’s office co-payments after the deductible is met. Plan N uses co-payments rather than deductibles for cost sharing. Co-payments are expected to be set at \$20 for an office visit and \$50 for an emergency room visit. It is anticipated that the co-pays would take place once the Part B deductible is met.²⁰

Q. How Do I Know What Plans Are Available in My State?

A. To find out what policies are available and who the providers are in your state, contact your state's Insurance Department. For information to assist you in determining which Medigap plan might be right for you, contact your State Health Insurance Counseling and Assistance Program (SHIP). See "Resources" for contact information on local SHIP programs.²¹

Q. Can Someone Enroll in a Medigap Plan at Any Time²²

A. An individual may enroll in any Medigap plan during his or her open enrollment period. The open enrollment period begins the first day of the month in which a person is 65 and is enrolled in Medicare Part B. During this open enrollment, an insurer cannot deny an individual a policy based on pre-existing conditions or charge more because of them.

If an individual has a Medigap plan and decides to drop it, it is possible that he or she may not be able to re-enroll at a later date. However, if the person moves out of the service area or the company selling the Medigap plan doesn't renew its contract with Medicare, the person would have the right to re-enroll. There are other times when an you would have a guaranteed right to enroll in certain Medigap Plans as long as you do so within 63 calendar days of the earlier coverage ending. These include:

- when you have a Medicare Advantage Plan and your plan is no longer available or it moves out of your service area and you enroll in Original Medicare, or

- you have an employer plan that serves as a supplement to Original Medicare and that plan ends, or
- you have original Medicare and a Medicare SELECT (a policy that requires you to use specific providers to be covered for benefits)Policy and you move from the Medicare SELECT's policy area, you can keep your Medigap policy or switch to one of those above, or
- you dropped a Medigap policy to join Medicare Advantage for the first time and you've been in the plan for less than a year and want to switch back.

Q. What Is Medicare Advantage?

A. Congress passed a law in 1997 that implemented new Medicare health plans, called Medicare Advantage, also known as Medicare Part C. Under the Medicare Advantage option, private companies contract with Medicare to provide health care services to Medicare recipients. Currently, with over 44 million Americans in the Medicare program, more than 10 million have chosen Medicare Advantage Options.²³

In these plans, individuals are enrolled in the Medicare system, but their health care benefits are administered by Medicare Managed Care Plans such as:

- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Private Fee-for-Service (PFFS) Plans
- Special Needs Plans
- Medical Savings Account (MSA) Plans

Medicare pays a set amount to the Medicare Advantage Plan and, in turn, the plan determines the cost reimbursement to the provider, as well as to the insured individual. All Medicare Advantage plans must offer at least the same services as Original Medicare, except hospice care which is covered under Original Medicare, even if you have a Medicare Advantage Plan. Many Medicare Advantage Plans cover additional services, such as eye exams and routine physicals, but sometimes with added costs and restrictions. Not all areas of the country will offer the same number or type of plans. Benefits, premiums, and co-payments may all change from one year to the next. You would need to check with the Medicare provider as to the specifics of coverage. With a Medicare Advantage Plan you do not need a Medigap plan and you cannot be sold one if you are in Medicare Advantage. It is, however, important to understand that if you have a Medigap Plan and drop it when you join a Medicare Advantage Plan, you will not be able to get it back in many instances. You may keep the Medigap Plan if you switch to Medicare Advantage, but it cannot be used to provide any co-payments or deductibles under your Medicare Advantage Plan.²⁴

Q. How Do the Different Types of Medicare Advantage Plans Work?²⁵

A. Medicare Advantage Plans vary widely in services offered, provider requirements, and premium costs. It is important to look closely at the details of any plan you are considering, paying close attention to what it covers and what it costs. It is often helpful to consult with an expert when making these decisions. For information about which Medicare Advantage Plans may be available in your

area or to compare plans, you can call Medicare at 1-800-633-4227 or visit www.medicare.gov.

Note that many of Medicare Advantage Programs include prescription drug coverage as part of the premium. If it is included in a Medicare Advantage Plan, in most circumstances, individuals must obtain their Medicare Prescription Drug coverage through the Medicare Advantage Plan. For any plans that do not include prescription drug coverage, individuals may purchase a stand-alone Medicare Part D Plan. The prescription drug coverage is discussed in subsequent questions.

The basics of the most common Medicare Advantage Plans are described below:

- **Medicare HMO:** In most instances, individuals must use network providers. They will usually need a primary care doctor to provide referrals for specialists. Services may be more expensive or not covered if they are out of the service area and network providers are not used. Providers must accept HMO payment as payment in full.
- **Medicare PPO:** Individuals may use network providers, but they may also go out of the network and pay more. Primary care doctors or referrals for specialists are not generally required.
- **Private Fee for Service:** Individuals may usually go to any physician or hospital willing to provide care and accept the plan's payment. There is often a co-payment. Depending on the plan, the provider may be able to charge more than the plan's reimbursement amount for services, which means you will incur higher costs. It is important to check with the company offering the plan about service payments and premiums.

- **Medicare Special Needs Plans:** These plans are specially designed for individuals with certain chronic conditions or other special health care needs. They provide all Part A and B services, as well as Medicare Prescription Drug coverage. They often provide additional services and have lower co-payments than Original Medicare. They often have a care coordinator to develop a care plan for the individual and coordinate all of the services involved in the care.
- **Medicare Medical Savings Account Plans:** Introduced in 2007, these plans are similar to Health Savings Account Plans that are available outside of Medicare. They include two parts. The first is a Medicare Advantage Plan with a high deductible which must be met before the plan will pay for services, and the second is a Medicare Savings Account into which Medicare deposits money which may be used to pay for health care costs. After you reach your out-of-pocket limit, your plan covers your Medicare-covered services in full. Any amount remaining in your account at the end of the year stays there and is added to the following year's deposit. In 2010 these plans are only available in Pennsylvania.

Q. How Does Enrollment in Medicare Advantage Work?

A. Any individual who opts for a Medicare Advantage plan must have both Medicare Parts A and B prior to enrollment and continue paying the Part B premium while in the Medicare Advantage Plan. Individuals can generally join a Medicare Advantage Plan that is available in their area when they

are first eligible for Medicare or during open enrollment periods between November 15 and December 31 of each year. They can generally also join or switch Medicare Advantage Plans or switch to Original Medicare between January 1 and March 31 of any year as long as they maintain their Medicare Prescription Drug coverage. Also, under certain circumstances, individuals may join Medicare Advantage at any time, such as when they move out of the service area that their current plan covers.²⁶

Q. How Are Prescription Drugs Covered Under Medicare?

A. Medicare offers a voluntary Prescription Drug Program, known as Medicare Part D. This program was established under the Medicare Prescription Drug Improvement and Modernization Act of 2003 with the intent of lessening the financial burden of prescription drug costs for beneficiaries, especially those with low incomes and those with extremely high out-of-pocket expenses. Under the law, Medicare Part D will pay for outpatient drug coverage through Medicare-approved private drug plans, giving beneficiaries access to a standard drug benefit or its equivalent. Medicare has defined the minimum requirements for standard coverage. While plans may vary, in general they will have a monthly premium based on the plan an individual chooses and include deductibles and co-pays. There is a gap in coverage, often referred to as the doughnut hole, where the individual is responsible for 100% of the drug costs as demonstrated in the chart below. Like Medicare Part B, while the Medicare Prescription Drug Program is voluntary, there can be penalties for delayed enrollment, unless you have coverage under another prescription plan, such as an employer plan, that is at least comparable to the Medicare Standard Prescription Drug Plan.²⁷

Medicare

The chart below illustrates how, in most instances, the Medicare-Approved Standard Prescription Drug Plan worked in 2010. Deductibles and co-pays are subject to change annually. The chart does not include premiums for the coverage.

Medicare-Approved Standard Prescription Drug Plan 2010^{28*}

Prescription Drug Costs	Medicare Pays	Individual Pays
\$0-\$310	\$0	100%
\$310-\$2,830	75% of drug costs up to \$1,890	25% of drug costs up to \$630
\$2,830-\$6,440	0% of drug costs	100% of drug costs up to \$3,610
Subtotal	Up to \$1,890	Up to \$4,550 out-of-pocket
Over \$6,440 (Catastrophic Benefit)	95%	\$2.50 (co-pay generic) \$6.30 (co-pay brand name) or 5% (whichever is higher) ²⁹

*Estimates are rounded to the nearest dollar with the exception of catastrophic coverage figures. Those enrolled in a non-standard plan may have different out of pocket expenses based on their plan design and cost-sharing amounts.

Q. How Do I Find Out What Medicare Part D Plans Are Available in My Area and What Would Work Best for Me?

A. There are multiple prescription drug plans available to Medicare beneficiaries. If you are considering a plan, check to see that your current medications are covered under any plan you are considering. The Medicare plans will cover both generic and brand-name drugs, but plans may have different rules about which drugs are covered in different categories. Most plans will have a formulary that lists the drugs covered under the plan. The list must meet Medicare's requirements, but it can change over time. A company is required to inform the beneficiary at least 60 days before discontinuing or changing its costs on any drug the person may be using. If a beneficiary's doctor feels that a drug not included in the list is needed, or if a drug an individual is taking is being removed from the list and is needed, the beneficiary or doctor can apply for an exception or appeal the decision.

The Medicare Website contains local and state specific information on available Medicare Prescription Drug Plans, a plan comparison capability based on an individual's Medicare number and demographic information, a formulary finder to allow individuals to search formularies in their state in relation to medications they are currently taking, and a section related to how to lower costs during the coverage gap. Utilize the Medicare Website; call Medicare if you have questions; and consider speaking with your pharmacist, who will likely be familiar with the available plans. There are multiple options from which to choose, and it may seem overwhelming at first, but there are resources that can help, through Medicare and at the state and local levels. (See Resources section for more information.)

Q. How Do Employee Retiree Health Benefits Work with Medicare?

A. If you are not yet retired but eligible for Medicare, you can defer enrollment in Medicare Part B if you have health benefits through your employer, as your employer would be your primary provider. Once you retire you would have a window to sign up for Medicare Part B, without paying any penalty.

Once you are retired and eligible for Medicare, Medicare serves as your primary health insurance. If you have retiree health benefits through your employer, your retiree health plan may be able to serve in the capacity of a Medigap Plan. You can compare the costs and benefits with those provided under the Medigap Plans to determine which would be in your best interest. If at some point your employer discontinued its retiree health plan, you would have a guaranteed right to join certain Medigap Plans, within a certain window of time.

If you have retiree prescription drug coverage, that is considered to be at least comparable to the Standard Prescription Drug Benefit under Medicare, you could use this plan in lieu of joining Medicare Part D. Medicare would consider your employer plan to be “Creditable” Prescription Drug Coverage. Should your employer discontinue retiree prescription drug benefits at a later date you would be eligible for Medicare Part D without any penalty, if you join within a window of time as defined by Medicare.

Q. Are There Health Care Services and Expenses Not Covered by Medicare?

A. Medicare does not cover all of the expenses you may incur related to changes in your health. Some of the items it does not cover are hearing aids, chiropractic care (except under Medicare-specified circumstances), routine dental care or dentures (with only a few exceptions), routine eye care or most eyeglasses, routine foot care (with only a few exceptions), care while traveling outside the U.S. and its territories (with only a few exceptions) and long-term care, often referred to as custodial care (including assistance with activities of daily living such as bathing, dressing and toileting), in a nursing home, assisted living facility, or at home.³⁰

There are discount programs, e.g., vision discounts, that you might access through associations such as AARP. Some of the services and care may be covered by insurance through your employer, an association, or a private individual plan, including dental insurance and long-term care insurance.

The costs for many of these non-covered services can be significant and can adversely impact your plans for retirement. This is especially true for ongoing long-term care expenses. In fact, because this is such an important concern, the government has established a website to educate consumers about long-term care and the importance of planning for the possibility of needing it. For more information and an order form to request Own Your Future long-term care planning kit visit: www.longtermcare.gov/LTC/Main_Site/index.aspx

Medicaid

Q. What Is Medicaid?³¹

A. Medicaid became law in 1965 and was started as a cooperative venture, jointly funded by federal and state governments, to assist in furnishing medical assistance to eligible needy persons. It is, at present, the largest source of funding for medical and health-related services for America's poor. In 2005, 55 million people, including 25% of U.S. children, were covered under Medicaid. Unlike Medicare, individual states control much of their Medicaid coverage and eligibility.

The federal government established broad national guidelines under which each state can:

- establish its own eligibility standards
- determine the type, amount, duration, and scope of services
- set the rate of payment for services
- administer the program

Because each state can set its own standards, Medicaid services vary greatly from state to state. Even those in close geographic proximity to one another can significantly differ in the amount, duration, or scope of services.

Some individuals enrolled in the Medicare program also qualify for Medicaid assistance. When an individual meets full eligibility for a state's Medicaid program and is enrolled in Medicare,

Medicaid supplements the Medicare health care coverage. Individuals eligible for and covered by Medicaid are first covered under the Medicare program. Medicaid pays for the remainder of services, as it is always the last payer. Some Medicare participants, depending on their state's requirements, may be able to receive assistance with paying Medicare premiums and co-payments through their state's Medicaid program. It is best to speak with your local Medicaid office or Department of Human Services to discuss these programs.

Depending on the situation, states may require minimal co-pays and deductibles on some services. Many providers accept Medicaid payment as payment in full.

Q. Who Is Eligible for Medicaid?³²

A. To qualify for Medicaid a person must meet financial eligibility requirements. Federal law requires states to cover individuals in certain “mandatory groups” to receive matching Federal Funds. These groups include:

- most elderly and persons with disabilities receiving Supplemental Security Income (SSI), for which income eligibility equates to 74% of the Federal Poverty Level (FPL) for an individual
- pregnant women and children under age 6 with a family income below 133% of the FPL
- children age 6–18 whose family income is below 100% of the FPL
- parents below states' July 1996 welfare eligibility levels (often below 50% of the FPL)

States have flexibility to expand the groups of individuals eligible for Medicaid to certain other optional groups. Eligibility can vary significantly from state to state so it is important to contact your state Medicaid office to determine whether you may be eligible for Medicaid. All applications would be handled within the state in which you reside. You can call the Centers for Medicare and Medicaid Services at 1-800-633-4227 to find state specific contact information. TTY users may call 1-877-486-2048.

Q. Can I Transfer Assets to Another Person and Be Eligible for Medicaid?

A. You cannot transfer your assets to someone else and become immediately eligible for Medicaid. Medicaid has a “Look-Back” period for transfer of assets. This is the time that precedes the application for Medicaid during which the state would look at any assets that you may have transferred to another person. After a certain period of time has passed Medicaid would not question any money or property you may have transferred. Under the Deficit Reduction Act of 2005 the length of the look back period was extended from 36 months (3 years) to 60 months (5 years). Based on how much was transferred, Medicaid uses a formula to determine the date when a person may become eligible for Medicaid. You may have a “period of ineligibility” from the time you apply for Medicaid because of assets you have transferred to another person during the 5 years prior to your application.³³

Q. What Services Does Medicaid Cover?³⁴

A. Medicaid offers a range of health and long-term care services. Medicaid covers 40% of the national funding for both nursing home care and long-term care and serves as the largest source of public funding for mental health services. In addition to the federally funded and matched funds of Medicaid, many states also have state-funded assistance programs that are not federally matched.

The federal government allows for a certain degree of flexibility in how the states administer Medicaid funding, but it also imposes several mandatory requirements for services a state must provide to receive matching federal funds. A state's Medicaid program must provide certain basic services, including:

- inpatient hospital services
- outpatient hospital services
- physician services
- certain laboratory and x-ray services
- nursing home services for those 21 years or older
- home health care services for those persons eligible for nursing home services under the state's Medicaid Plan
- early and periodic screening, diagnosis, and treatment for children under age 21
- family planning services and supplies
- pediatric and family nurse practitioner services
- transportation services.

Medicaid

A state may also offer a variety of optional services, such as:

- › diagnostic services
- › prescription drugs
- › clinic services
- › personal care services
- › dental services
- › prosthetic devices, eyeglasses, and durable medical equipment
- › rehabilitation and therapy
- › home and community based care (HCBS) to certain persons with chronic impairments under specialized programs called waiver programs, and
- › hospice care

Resources

USEFUL PUBLICATIONS

Social Security Administration (SSA) publication:

- *Medicare*, Social Security Administration, SSA Publication No. 05-10043, September 2009, accessed via Internet at <http://www.socialsecurity.gov/pubs/10043.pdf>

This guide provides an overview of the Medicare program and describes the steps one needs to take to apply for Medicare. It also discusses assistance programs for some low income people and how Medicare works if one has other insurance.

Centers for Medicare and Medicaid

Services (CMS) publications: The publications below from CMS can be downloaded and printed at the listed Web addresses or ordered by calling 1-800-633-4227. TTY users may call 1-877-486-2048.

- *Medicare & You 2010*, Centers for Medicare & Medicaid Services, CMS Pub. No. 10050, September 2009, accessed via Internet at: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

This guide provides detailed, easy-to-read information related to all aspects of Medicare.

- **2009: Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare**, Centers for Medicare & Medicaid Services, CMS Pub. No. 02110, Revised September 2008, Accessed via Internet at: <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>

This publication provides an overview of Medicare and detailed information related to the Medigap plans that are available.

- **Your Guide to Medicare Prescription Drug Coverage**, Centers for Medicare & Medicaid Services, CMS Pub. No. 11109, Revised, May 2009, Accessed via Internet at: <http://www.medicare.gov/Publications/Pubs/pdf/11109.pdf>

This guide provides an overview of all aspects of the Medicare Prescription Drug program, Medicare Part D.

- **Your Medicare Benefits**, The Centers for Medicare & Medicaid Services (CMS), CMS Product No. 10116, Revised December 2009, Accessed via Internet at: <http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf>

This guide provides an overview of the services and supplies Original Medicare covers, the costs under Medicare, and a listing of resources related to various aspects of Medicare.

The Henry J. Kaiser Family Foundation

publications: These publications can be downloaded and printed from the Web addresses below.

- **Medicare a Primer 2009**, The Henry J. Kaiser Family Foundation, January 2009, Accessed via Internet at: <http://www.kff.org/medicare/upload/7615-02.pdf>

This guide provides an overview of Medicare, the populations it serves, the services it covers, and its financing and costs to the country.

- **Medicaid: A Primer**, The Henry J. Kaiser Family Foundation, January 2009, Accessed via Internet at: <http://www.kff.org/medicaid/upload/7334-03.pdf>

This publication provides an overview of Medicaid, the populations it serves, the services it covers, and its financing and costs to the country.

INTERNET SITES AND ORGANIZATIONS

Medicare Rights Center

www.medicarerights.org

The Medicare Rights Center is a nonprofit consumer service organization that helps individuals with Medicare to understand their rights and benefits and to navigate the Medicare system. Counselors are available between 9 a.m. and 5 p.m. Eastern Time at 1-800-333-4114 to answer questions about making insurance choices, dealing with payment denials or appeals, complaints about care, and Medicare billing. Their Website includes a section called Medicare Interactive Counselor which provides an overview of the various parts of Medicare, allows a search by specific topic, and provides links to local and national resources.

Benefits CheckUp

www.benefitscheckup.org

This site is maintained by the National Council on Aging and helps individuals 55 years and older determine their eligibility for programs that may help cover the cost of medications (including assistance with costs associated with the Medicare Prescription Drug Program), health care, and other necessary services. All information is completed online with a confidential and straightforward questionnaire.

Centers for Medicare & Medicaid Services (CMS)

www.cms.gov

This is the main Medicare and Medicaid site maintained by the federal government. It provides information on benefits, online publications, prescription drug assistance, and telephone contacts for information and assistance. To find consumer information specific to either Medicare or Medicaid, click on “People with Medicare & Medicaid” on the thin top blue bar on the home page. To apply for Medicaid or to request more information about Medicaid, call your state medical assistance office. To get the local phone number, call the Centers for Medicare and Medicaid Services at 1-800-633-4227; TTY users call 1-877-486-2048.

Medicare

www.medicare.gov

Individuals may also call Medicare with any questions related to coverage or to obtain publications at: 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. English- and Spanish-speaking customer service representatives at this number can answer questions about the Original Medicare Plan and provide up-to-date information regarding the health plans available in an individual’s area. TTY users may call 1-877-486-2048.

The Medicare Website provides detailed information about all aspects of Medicare, including useful tools and calculators related to selecting a prescription drug plan or making decisions about Medicare Advantage. It lets individuals look at what is available in their states and local areas and provides information on how individuals can obtain information about whether they are entitled to assistance with the Medicare

Prescription Drug Program. Individuals may also call Medicare with questions.

The “Search Tools” section provides the ability to go to specific sections of the site to obtain other useful Web links and telephone numbers including Medical Assistance Offices for state-specific Medicaid information. You can search for other sites or resources by either the topic or name of the organization. Another Medicare tool is www.mymedicare.gov which allows individuals to view their health care claims, track the preventive services they may need, and get up-to-date details as to how to best use their Medicare benefits.

State Health Insurance Assistance Program (SHIP)

www.shiptalk.org

Each state offers a State Health Insurance Assistance Program (SHIP) with counselors available to provide free one-on-one help for individuals with Medicare questions or problems. Through federal grants directed to states, SHIPs provide free counseling and assistance via telephone as well as face-to-face interactive sessions and educational presentations. If you want to know more about the SHIP program in your state, or you want to contact a SHIP counselor in your area, please click on the appropriate button under the “About SHIP” Menu at the left on the home page.

Social Security Administration (SSA)

www.ssa.gov

The Social Security Administration provides information related to Medicare including several publications and a question-and-answer section related to multiple aspects of Medicare including the application process, eligibility, Medicare replacement cards, and Medicare prescription drug coverage. It also provides information on applying for Medicaid.

Endnotes

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- ¹⁵ Ibid.
- ¹⁶ Ibid.
- ¹⁷ *Out-of-Pocket Limits for Medigap Plans K & L for Calendar Year 2010*, Centers for Medicare & Medicaid Services, August 2009, Accessed via the Internet at: http://www.cms.hhs.gov/medigap/04_kandl.asp.
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- ²⁰ Ball, Garret, *Medicare Supplement Plans: Medigap Plans M and N*, Ezine @rticles® accessed January 2010 via Internet at: <http://ezinearticles.com/?Medicare-Supplement-Plans-Medigap-Plans-M-and-N&id=2632050>.
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MMI00138(0410)

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