Medicare by the Letter

Part A

Medicare part A is designed to help cover expenses for institutional care. These mean hospitals, skilled nursing facilities after a hospital stay, hospice and home health care. For people who paid Medicare taxes (or their spouse did) while working this coverage does not cost any money. A person might also be able to buy this coverage if they are disabled and meet residency requirements.

- People who are receiving disability from Social Security or the Railroad Retirement Board will automatically receive information near the time they will become eligible for Medicare. Those who are not receiving retirement benefits should contact Medicare 3 months before they turn 65. Even if a person does not retire at 65 they can still get Medicare coverage.
- Besides the eligibility criteria mentioned above, there are a few other special circumstances that would make a person eligible for Medicare.
- A disabled person between the ages for 50 to 65 who has not applied for disability because they are receiving money from another Social Security program.
- Government employees who become disabled before they turn 65
- A person that did not sign up or dropped their Medicare coverage they may be able to sign up again.
- Permanent kidney failure at any age.

Part B

Part B is designed to cover healthcare services that are provided to people who live at home, often referred to as outpatient services. Part B pays for home health care, durable medical equipment, flu shots and doctor office visits. These are medical services that are not covered by Part A. Everyone who is eligible for free Part A can sign up for Part B, but there is a monthly premium for this coverage. The cost may be higher for those who have a very high income. If a person is not eligible for free Part A they may be able to purchase Part B alone if they are 65 or older and meet residency requirements.

When a person is turning 65 and becomes eligible for Medicare Part A they have a 7 month window to sign up for Part B. This window starts 3 months before a person turns 65 and runs through the birthday month and the 3 months after the birthday.

If a person is disabled or has permanent kidney damage their eligibility will depend on the date that the disability or treatment began.

The Centers for Medicare and Medicare created a chart showing when Part B coverage will start based on when you sign up for coverage.

If you enroll in this month of your Initial enrollment period:	Then your Part B Medicare coverage starts:
1 (3 months before your 65th birthday)	The month you become eligible for Medicare
2 (2 months before your 65th birthday)	The month you become eligible for Medicare
3 (1 month before your 65th birthday)	The month you become eligible for Medicare
4 (your birthday month)	One month after enrollment
5 (1 month after)	Two months after enrollment
6	Three months after enrollment
7	Three months after enrollment

If a person does not sign up when they first become eligible they have another opportunity each year during general enrollment which runs January 1 through March 31. If they sign up during this period their coverage will not become effective until July of that year. The catch here is that for each year they wait to sign up, the premium goes up by 10%.

If a person is 65 or older and still covered by a group health plan either from their own or their spouse's current employment, they have a "special enrollment period". This means they may delay enrolling in Medicare Part B without having to wait for a general enrollment period and paying the 10% surcharge for late enrollment. This exception allows a person to enroll in Medicare Part B at any time while they are covered under a group plan based on current employment. Eligibility to sign up for Part B begins the month after employment ends or the 8 months after group coverage ends, whichever comes first. A person receiving disability payments but still covered by a group plan based on their own or their spouses employment, have a similar "special enrollment period".

Part C

Medicare Part C coverage is more commonly known as Medicare Advantage. These plans are available in many areas through different provider organizations. A person who has Part A and B can elect to receive their care through one of these organizations through Part C. There

are different types of Medicare Advantage Plans which include:

- Medicare managed care plans
- Medicare preferred provider (PPO) plans
- Medicare private fee for service plans
- Medicare specialty plans

If a person chooses to join one of the Medicare Advantage plans you may have to pay a monthly premium for any extra benefits that might be offered. They will also receive a different type of health card. A person can choose to sign up for one of these plans when they first become eligible for Medicare or during the annual enrollment period from November 15 through December 31 each year. Special circumstances may allow for special enrollment periods.

Part D

Medicare Part D helps to cover prescription medicines. Anyone with Part A, B, or C is eligible for Part D. Joining Part D is optional and voluntary. There is an extra cost associated with this additional coverage. Again the cost is higher for those with very high incomes. If a person has different prescription coverage they may wait to sign up for Part D. In general, if this coverage is at least as good as Part D, there will be a penalty in cost for waiting. A person can sign up for Part D when they first sign up for Medic are or during the annual enrollment period from November 15 through December 31 each year. Special circumstances may allow for special enrollment periods.

Drugs that are not approved by the Food and Drug Administration (FDA)This is the newest part of Medicare; Part D was signed into law in 2003 and went into effect January 1, 2006. Just like most health plans Part D will not help to cover:

- Those prescribed for off label use
- Drugs not available in the United States
- Drugs that would be covered under Medicare Part A or B
- Drugs that are excluded by Medicaid

There is a gap in coverage that is referred to as "the donut hole". The gap begins when the total retail drug costs reach a certain amount. This gap remains in effect until a person's out of pocket costs reach another set amount. Once past this gap a person is responsible for set amount per month for generic medications and a higher amount per month for name brand medications.

Click here [1] to learn more about "the donut hole"

References

Medicare http://www.medicare.gov/ [2]

Social Security Administration Online http://www.ssa.gov/history/lbjsm.html [3]

SSA Medicare Booklet http://www.socialsecurity.gov/pubs/10043.html#part5 [4]

Medicare Premium Rules for Higher Income Beneficiaries: http://www.socialsecurity.gov/pubs/10536.html#rules [5]

Medicare Prescription Drug Coverage: http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx [6]

Links
[1] http://blog.medicare.gov/2010/08/09/what-is-the-donut%C2%A0hole/
[2] http://www.medicare.gov/
[3] http://www.ssa.gov/history/lbjsm.html
[4] http://www.socialsecurity.gov/pubs/10043.html#part5
[5] http://www.socialsecurity.gov/pubs/10536.html#rules
[6] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx