Medicare Fact Sheet:

Medicare is federally governed. Medicare is financed by a portion of the payroll taxes paid by workers and their employers. It is also financed in part by monthly premiums deducted from Social Security checks. Medicare is our country's health insurance program for people 65 years or older. However, you don't have to be 65 if you have disabilities and have been receiving Social Security Disability Insurance (SSDI) for more than 24 months or you have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's Disease). Medicare helps with the cost of health care, but does not cover all medical expenses or the cost of most long-term care. You may purchase Medigap insurance from a private insurance company to pay some of the expenses that original Medicare Part A and B don't fund. As mentioned on the State Department of Financial Services website New York State law and regulation require that any insurer writing Medigap insurance must accept a Medicare enrollee's application for coverage at any time throughout the year. Insurers may not deny the applicant a Medigap policy or make any premium rate distinctions because of health status, medical condition, claims experience, or whether the applicant is receiving health care services. For more information on Medigap visit: http://nyhealthaccess.org

You can apply for Medicare through the Social Security Administration. The phone number is: 1-800-772-1213 (TTY 1-800-325-0778).

Medicare has four parts:

1. **Medicare Part A**—(sometimes referred to as hospital coverage) This pays for inpatient hospital care, and some coverage for home health care, hospice care, and inpatient care in a skilled nursing facility for a limited period immediately following a hospital stay.
2. **Medicare Part B**—(sometimes referred to as medical coverage) This is coverage for most medically necessary doctor's services, preventative care, durable medical equipment, hospital outpatient services, lab tests, x-rays, mental health, and some home health and ambulance services. Please refer to the following website: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=552. If a beneficiary is eligible for a Medicare Savings Program then the State will pay their Part B premiums and in some cases their Part B deductibles and coinsurance.
3. **Medicare Part C**—This is optional coverage. If you choose to buy a Medicare Advantage Plan you will receive Medicare Part A and B services under one private managed care plan (known as a Medicare Advantage

Plan). Those include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee for Service Plans (PFFSs), and Medical Savings Accounts (MSAs). You must have Medicare Part A and B to join a Part C plan (a Medicare Advantage Plan). Many will include Part D prescription drug coverage.

4. **Medicare Part D**—This is prescription coverage. If you choose to purchase Medicare Part D you may be eligible for co-payment assistance for Medicare Part D covered prescription medications. If you receive "Extra Help" because of financial circumstances you will get help paying for some of the costs of Medicare Prescription Drugs. For more information on this topic visit: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1479 or http://medicareinteractive.org or http://medicareadvocacy.org. For help choosing a Part D plan visit: http://www.medicare.gov/find-a-plan

   NOTE: For Dual Eligibles (those eligible for both Medicare and Medicaid) Medicare Part D is mandatory. Before 2006 Dual Eligibles' medications were covered under Medicaid. As of January 1, 2006 Dual Eligibles had to enroll in a Medicare Part D plan. Medicare Part D is provided through many private plans, so costs of medications will vary along with the medications that are covered. Part D only covers outpatient prescription drugs (not those administered in a hospital or doctor's office). Part A or B would cover them instead.

All plans have a **coverage gap** ("donut hole"). The coverage gap starts when your total medication costs, including what your plan and you have paid for drugs, reaches a specific amount since the beginning of the calendar year. One of the changes initiated by the Federal Health Reform (e.g., Patient Protection and Affordable Care Act or PPACA) is a gradual phasing out of the donut hole by 2020. As a result of the health reform beneficiaries receive discounts to help pay for medications during the coverage gap. In 2020 the doughnut hole will close completely when beneficiaries will typically pay no more than 25% of their medications during the year after meeting their deductible.

Catastrophic Coverage—In 2016, once beneficiaries spend a total of $4,850 in true out of pocket costs (Troop) in formulary drugs they leave the coverage gap and enter into catastrophic coverage. Catastrophic coverage is when the beneficiary

is responsible for only about 5 percent of the cost of each drug or $2.95 for generics and $7.40 for brand name drugs (whichever is greater).

**The information in this document is subject to change. Please refer to the websites listed above for updates. Materials provided by Elizabeth Berka, Health Information Specialist, Southern Tier Independence Center, 135 E. Frederick St., Binghamton, NY 13904, (607) 724-2111