

Medicare 2008

Quick Reference Guide

For additional information
about Medicare services,
please contact your
rehabilitation/skilled nursing facility
or call
1.800.MEDICARE
(800.633.4227)

For TTY, call 877.486.2048

Deaconess Long Term Care Inc. (DLTC) is a not-for-profit company which owns and operates retirement and rehabilitation/ skilled nursing communities in Ohio, Kansas and Missouri.

Resident admissions, room assignments and resident services are provided without regard to race, color, national origin, creed, religion, sex, disability or age.

DLTC is a member of Deaconess Associations Inc., a diversified health services company headquartered in Cincinnati, Ohio.

www.DeaconessLongTermCare.com



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What is Medicare?

Medicare is the federal health insurance program for persons age 65 and over, and certain disabled persons. Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Part A of Medicare pays some of the costs of hospitalization, limited skilled nursing home care, hospice care, and blood provided during a covered stay. Part B primarily covers doctors' fees, most outpatient hospital services, and certain related services. Both Parts A and B cover many home health services. Medicare does not cover most prescription drugs or long-term nursing home care.

ORIGINAL MEDICARE PLAN

PART A (HOSPITAL INSURANCE)

In addition to the basic benefits for inpatient hospital care, Part A provides limited benefits for skilled nursing care, home health services (also covered under Part B), and hospice care. In most cases, you pay part of the costs of covered services. The amounts you and/or your insurance pay change each year, depending on national increases in hospital costs. The following description is based on 2008 amounts.

Hospital Benefits. When you are admitted as an inpatient to a hospital, you will have to pay an initial deductible of \$1,024. For the 61st through the 90th day, you will have to pay \$256 per day. After that, you can choose to pay \$512 per day for as many as 60 additional "lifetime reserve" days (or else pay the full charges yourself). Your "benefit period" ends 60 days after discharge from the hospital or skilled nursing facility. If another hospital admission occurs after that, you will have to pay another Part A deductible, as well as the other coinsurance amounts. Medical equipment such as pacemakers and artificial limbs that are permanently installed while in the hospital are covered without further cost sharing.

Nursing Facility Benefits. As a Medicare Beneficiary, you are entitled to skilled nursing and rehabilitation to get you to, and keep you at your highest practicable level. Daily skilled nursing or rehabilitation services must be medically required and available to you. Skilled Nursing Facility (SNF) benefits are available to you only following a hospital stay of at least three days and/or beginning within 30 days after discharge from the hospital.

If you qualify, you pay nothing for the first 20 days,

IF YOU CURRENTLY DO NOT HAVE PRESCRIPTION DRUG COVERAGE

- If you have the Original Medicare Plan with no drug coverage or if you are covered by a Medigap policy that does not cover prescription drugs, you must join a plan to get coverage. Contact your Medigap benefits administrator about changing your policy.

- If you only have a Medicare Advantage or Health Plan and want to add prescription drug coverage, you have three options.

- **Option 1:** Check to see if they offer it in 2008. If so, you will probably be required to get drug coverage from your current plan if you decide to stay. If they don't offer coverage in 2008 and you stay, you will have to pay a penalty if you want to switch to a plan that offers coverage later.

- **Option 2:** Switch to another plan in your area that offers a coverage plan.

- **Option 3:** Switch to the Original Medicare Plan and join a Medicare Prescription Drug Plan.

Getting Help

If you need help choosing Medicare prescription drug coverage that meets your needs, you can get personalized information by:

- Visiting www.medicare.gov or calling 1-800-MEDICARE. TTY users should call 1-877-486-2048. Have your Medicare card, a list of current drugs and the name of your pharmacy.

- Get a free copy of the booklet "Your Guide to Medicare Prescription Drug Coverage"

- Calling State Health Insurance Assistance Program:
 - Kansas – (800) 860-5260
 - Missouri – (800) 390-3330
 - Ohio – (800) 686-1578.

- Checking for local events for help enrolling.

IF YOU HAVE PRESCRIPTION DRUG COVERAGE

- If your current coverage is not at least as good as standard Medicare coverage, you have three options.
 - **Option 1:** You can keep your current plan and join a Medicare plan to enhance your coverage.
 - **Option 2:** Only keep your current drug plan, but know if you join a Medicare plan after May 15, there will be a penalty.
 - **Option 3:** Drop your current coverage, return to the Original Medicare Plan, and join a Medicare Prescription Drug Plan or join a Medicare Advantage or Health plan that covers prescription drugs. Know that if you drop your employer coverage, you may not be able to get it back. It's also possible that you cannot drop drug coverage without also dropping health coverage.
- If you currently have coverage from a former/current employer/union, Medicare will continue to provide retiree drug coverage that meets Medicare's standards. If it's at least as good as the Medicare coverage (called Creditable Prescription Drug Coverage), you can keep it as long as it is still offered by your employer or union; if it halts and you join a Medicare drug plan within 63 days, you can do so penalty-free.
- If you have coverage from a Medicare Advantage or Health Plan, you will get a notice from your plan about your prescription drug choices.
- If you have the Original Medicare Plan that covers prescriptions through a Medigap policy, Medicare will help pay for drugs and lower premiums if you join a plan that provides at least as good coverage. Tell your Medigap insurer that you have joined, and the drug coverage will be removed.
- If you get prescription drug coverage from TRI-CARE, the Department of Veteran's Affairs (VA) or the Federal Employee Health Benefits Program (FEHB), and you qualify, your drug coverage is not changing. Contact your benefits administrator before considering any changes. If you no longer qualify, you join penalty free as long as it's within 63 days of losing coverage.
- If you had full coverage from your state Medicaid program, Medicare now pays for your drugs through a plan they chose for you in October 2005. You can choose a new plan at any time. As long as you join a Medicare Prescription Drug Plan, Medicare will pay for almost all of the cost of your drugs.

except for any charges that Medicare does not allow (phone, cable, TV, newspaper, beauty/barber, etc.). For the next 80 days, you pay charges up to \$128 per day, and Medicare pays all remaining allowable charges. Secondary coverage will be billed, including Medicaid. No benefits are available after 100 days of care in a "benefit period."

Home Health Services Benefits. Home health services, such as part-time or intermittent skilled nursing care, physical therapy, medical social services, medical supplies, and some rehabilitation equipment, may be paid for in full by Medicare when you are confined at home, as long as the services are prescribed by a doctor. Even if you have just Part A or Part B, all covered services will be paid by Medicare if provided by a participating agency, but with 20% coinsurance for equipment.

Hospice Benefits. A hospice organization furnishes a coordinated program of inpatient, outpatient, and home care for the terminally ill. Emphasis is on pain-reduction-control counseling, but not curative treatment.

You pay no more than \$5 for each prescription for outpatient drugs for symptom management and pain relief. When you are an inpatient in a facility in order to provide respite for your usual caretaker (not to exceed five consecutive days), Medicare pays the hospice for your hospice care, and you pay 5% of the Medicare payment amount for inpatient respite care. When you choose a hospice benefit, you are waiving your Medicare benefit; therefore you will become responsible to pay for room and board rates privately if occupying any skilled nursing facility.

PART B (MEDICAL INSURANCE)

You or your insurance pay the first \$135 of charges allowable by Medicare for covered medical services provided to you in a calendar year. This is the annual deductible.

After that, you or your insurance will pay 20% coinsurance for covered expenses (which may not exceed the charges allowed by Medicare) plus any additional amount that the physician or other Part B provider is allowed to charge. In 2008, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. Call 1-800-633-4227.

Covered items include:

- Physician services (except routine exams) and supplies
- Physical therapy, speech pathology, and occupational therapy. There may be limits in 2008.

- Non-routine vision services by qualified optometrists, if they would be covered when performed by a physician
- X-ray, MRI, CT, EKGs and some other diagnostic tests
- Blood for transfusions, after the first three pints/year
- Medical supplies such as ostomy bags, surgical dressings, splints, casts and some diabetic supplies
- Ambulance services when necessary
- Rental of durable medical equipment used in the home, including oxygen tanks, hospital beds, and wheelchairs (sometimes, purchase of such equipment)
- Home health services
- Outpatient mental health (50% coinsurance applies)
- Certain prosthetic and orthotic devices
- Therapeutic shoes for severe diabetic foot disease
- Medical nutritional therapy services for patients with diabetes or kidney disease with a doctor's referral
- Artificial replacements for parts of the body (covered by Part A under some circumstances)
- Certain oral drugs for cancer, immunosuppressive drugs used after organ transplant and certain injectable drugs
- Braces for limbs, back or neck
- Transplants — heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under conditions)
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation
- Second surgical opinions (in some cases)
- Kidney dialysis
- Routine costs in approved clinical trials
- Clinical laboratory services

Preventative Services Covered:

- “Welcome to Medicare” physical examination: One time only, within the first six months you have Part B. Height, weight, blood pressure, EKG, education and counseling.
- Bone mass measurements for certain people at high risk for losing bone mass.
- Cardiovascular screening: Includes blood tests to check cholesterol, lipid and triglyceride levels and others for early detection or high risk.
- Colorectal cancer screening tests for persons age 50 and over, with no minimum age limit for colonoscopy. Frequency and co-payment amounts vary depending on type of test and whether patient is at high risk.
- Diabetes screening: Frequency set by physician, includes fasting plasma glucose test. Usually for people with Medicare who are at risk for diabetes.
- Diabetes self management: blood glucose, test strips, and lancets for persons with diabetes; also diabetes self-management training, if requested by your doctor.

Like other insurance, there are monthly premiums. Almost one in three people with Medicare qualify for help that will cover 85% - 99% of drug costs. Most who qualify for this help will pay no premiums, deductibles and no more than \$5 for each prescription. The amount of help depends on your income and resources.

Remember, if you have Medicare, full Medicaid coverage, and are living in an institution, you will pay nothing for your covered prescription drugs.

To enroll for new Medicare prescription drug plans, you must have Medicare Part A or B. To join, you will need to decide which of two types of plans best fits your needs. One is a part of Medicare Advantage Plans and other Medicare Health Plans, where you get all of your Medicare health care; the other adds coverage to the Original Medicare Plan, and some Medicare Cost and Private Fee-for-Service plans, which are offered by insurance companies and other private companies approved by Medicare. The plan you choose affects drug coverage, cost, convenience and security for your drug coverage future should you need more prescriptions later.

Remember – Medicare Prescription Drug Coverage is insurance. It is not doctor samples, discount cards, Medicare-approved drug discount cards, free clinics or drug discount web sites. Private companies provide the coverage. You choose a plan and pay a monthly premium.

Your costs will vary depending on which drugs you use, whether you get extra help paying your Part D costs, and which Medicare drug plan you choose. Most drug plans charge a monthly premium that varies by plan. You pay this in addition to the Part B premium, ranging from \$96.40-\$238.40. Some drug plans charge no premium. If you have limited income and resources, you may get extra help to pay for your Medicare drug plan costs. Depending on what you can afford, you may be able to pick a plan with or without a monthly premium, deductible or coverage gap.

You should receive a prescription drug card for your plan. Show it when you get your prescriptions filled. You must go to pharmacies that belong to the plan that you join; otherwise, in most cases, your drug won't be covered and you will have to pay full price. Each plan also has its own list of covered prescriptions that it will cover.

(Continued from page 5)

- **Private Fee-For-Service Plans** allow you to go to any doctor or hospital that accepts your plan's payment. The private company decides on how much it will pay for the services you get.

- **Specialty Plans** provide more focused health care to manage a specific disease or condition for specific people. Plus, you get all of your Medicare health care as well. Managed Care coverage for a skilled nursing facility renews yearly; Medicare renews every sixty days. Managed Care co-pays for skilled nursing facilities are much more than the co-pays for Medicare.

MEDIGAP

Medigap insurance coverage is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage as a supplemental insurance. You can no longer buy new Medigap policies covering prescription drugs because private companies approved by Medicare will offer this coverage. Plans H, I, or J may still be sold, but without drug benefits. If you already have a policy that covers drugs, you may be able to keep it. Plans K and L are new policies that help limit high out-of-pocket costs for doctor's services and hospital care. They will likely have a lower premium than other Medigap policies, but you will pay more Medicare coinsurance and deductible. Policies F and J may have a high deductible. In addition, any standardized policy may be sold as a Medicare SELECT policy, which will usually cost less because you must use specific hospitals and, in some cases, physicians to get full insurance benefits.

If you already have a Medigap policy with prescription drug coverage, you can keep that policy or you can join a Medicare Prescription Drug Plan to save money and limit high out-of-pocket cost for drugs.

2008 Medicare Prescription Drug Coverage

Medicare offers insurance coverage for prescription drugs through Medicare Prescription Drug Plans and other health plan options. Insurance companies and other private companies work with Medicare to offer these plans. This coverage can provide help with drug costs, no matter how you pay for your drugs today. If you were happy with your coverage last year, you do not have to do anything.

- **Mammogram screening:** one baseline for women 35-39 years old, and then once every 12 months after 40 years of age at a government certified facility.
- **Pap smears and pelvic examination:** frequency of testing and co-payment amounts vary. "High-risk" patients are covered for annual exams.
- **Prostate cancer screening** once every 12 months for men age 50 and older.
- **Vaccinations for influenza virus (flu) and pneumonia.** Hepatitis B vaccine shots are also covered if you are at medium to high risk for hepatitis.
- **Glaucoma screening** should be done once every 12 months for people who are at high risk for glaucoma, including people with diabetes or a family history of glaucoma.

MEDICARE ADVANTAGE (PART C)

Medicare Advantage gives you more coverage choices and better benefits. Medicare pays a set amount of money for your care every month to these private, regional health plans. Costs may vary by plan.

OPTIONS:

- **Medicare Medical Savings Account Plans (MSAs)** are similar to Health Savings Account Plans available outside of Medicare, and they have two parts. The first part is a Medicare Advantage Health Plan with a high deductible. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs. To see if any MSA plans are available in your area, visit www.medicare.gov on the web. Select "Find & Compare Medicare Plans." OR, call 1-800-633-4227.

- **Managed Care Plans** allow you to only see doctors, specialists or hospitals in the plan's network, except in an emergency. You may need to choose a primary care doctor and get referrals to see a specialist.

- **Regional Preferred Provider Organization Plans (PPO)** allow you to use doctors, specialists and hospitals on the plan's network. You can go to others, but it may cost extra. You don't need referrals to groups who aren't part of the network and you may pay lower copayments and get extra benefits.

(Continued on page 8)

MEDICARE PART A HOSPITAL INSURANCE

Kinds of Service	Requirements	Time Limit	You Pay	Medicare Pays	Not Covered
HOSPITAL INPATIENT Some private room accommodations, meals and regular nursing services includes drugs, supplies, appliances, equipment and linens and furnished linens and linen services	65 and over, eligible for Social Security, under 65 if having a valid "EC" number, or a patient getting hospital care under Medicare	First 60 days Next 40 days of continuous hospital care	\$174 \$75 a day	Balance	Private duty nurse, first 3 parts of blood, all services covered by Medicare (See Medicare Part B chart)
ADDITIONAL HOSPITAL RESERVE	Available for hospital stays only	Up to one limit 60 days	\$57 a day		
PSYCHOSPITAL Skilled care facilities that are certified by Medicare	Must occur within 40 days after a minimum 4 day hospital confinement. Must be a condition requiring daily skilled nursing care or skilled therapy services	First 90 days Next 80 days of continuous post hospital care	Nothing \$175 a day	100% Balance	Some as above and all personal convenience items such as food, furniture, private telephone and television (See Medicare Part B chart)
INPATIENT PSYCHIATRIC	Same as Hospital Inpatient Services but with 180 days lifetime care limit				

MEDICARE PART B MEDICAL INSURANCE

Kinds of Service	Requirements	Time Limit	You Pay	Medicare Pays	Not Covered
SURVICES BY CLINICIANS AND OTHERS Services of physicians and surgeons, and reimbursement for cost of artificial eyes and limbs, X-ray therapy, physical therapy, speech therapy, occupational therapy, diagnosis lab and X-ray services, certain ambulance fees, certain personal medical supplies, some medical supplies by a doctor or nurse that can't be self-administered	Must enroll and pay the current month's premium	Unlimited	\$35 plus 20% of the balance of reasonable charges Months premium starting at \$35-40	Balance of reasonable charges	Routine check-ups, eyeglasses, hearing aids, dental work, orthopedic shoes, cosmetic surgery, immunizations except flu, pneumonia and hepatitis B, private duty nurses, first three parts of blood, prosthetic limbs and patient services