SHICK Initial Counselor Training Course 1 Introduction to Original Medicare – Parts A & B

Online Pre-Training

Rev. 2/2020

Pre-Training Objectives

- Course 1 provides basic training in Medicare Part A, Part B, Preventive Benefits, Medicare for people with disabilities, and Medicare for people with ESRD.
- You should thoroughly study the course including the notes. You will need to pass an exam after this course before continuing to Course 2.

AD ASTRA

What Is Medicare?

- Health insurance for people
  - 65 and older
  - Under 65 with certain disabilities
    - ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) without waiting period
  - Any age with End-Stage Renal Disease
- Administered by
  - Centers for Medicare & Medicaid Services

NOTE: To get Medicare Part A and/or Part B, you must be a U.S. citizen or be lawfully present in the United States

Understanding Medicare

AD ASTRA

Medicare currently provides health insurance coverage for over 59 million U.S. citizens. That's approximately 1 in every 6 Americans.

- Medicare is health insurance for generally 3 groups of people:

Those who are 65 and older

People under 65 with certain disabilities who've been entitled to Social Security disability benefits for 24 months—includes ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), without a waiting period

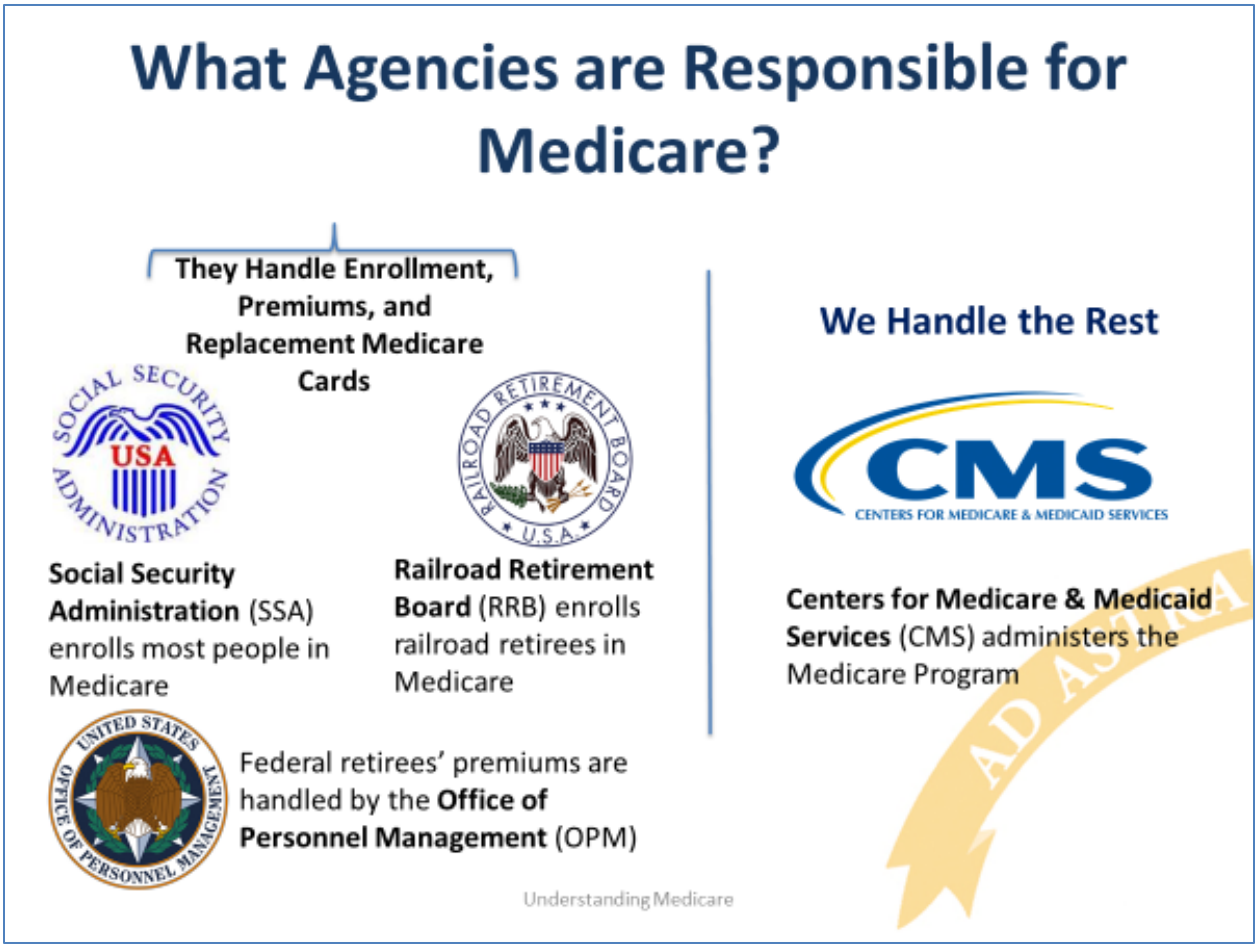
People of any age who have End-Stage Renal Disease (ESRD), which is permanent kidney failure that requires a regular course of dialysis or a kidney transplant

The Centers for Medicare & Medicaid Services administers the Medicare Program.

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or be lawfully present* in the United States. If you live in Puerto Rico, you must actively enroll in Part B.

*Lawfully present means you're in the U.S. legally, and includes non–U.S. citizens who have permission to live and/or work in the U.S. and have been residing in the United States for 5 continuous years prior to the month of filing an application for Medicare.

Resource: "Medicare & You" handbook (Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf)



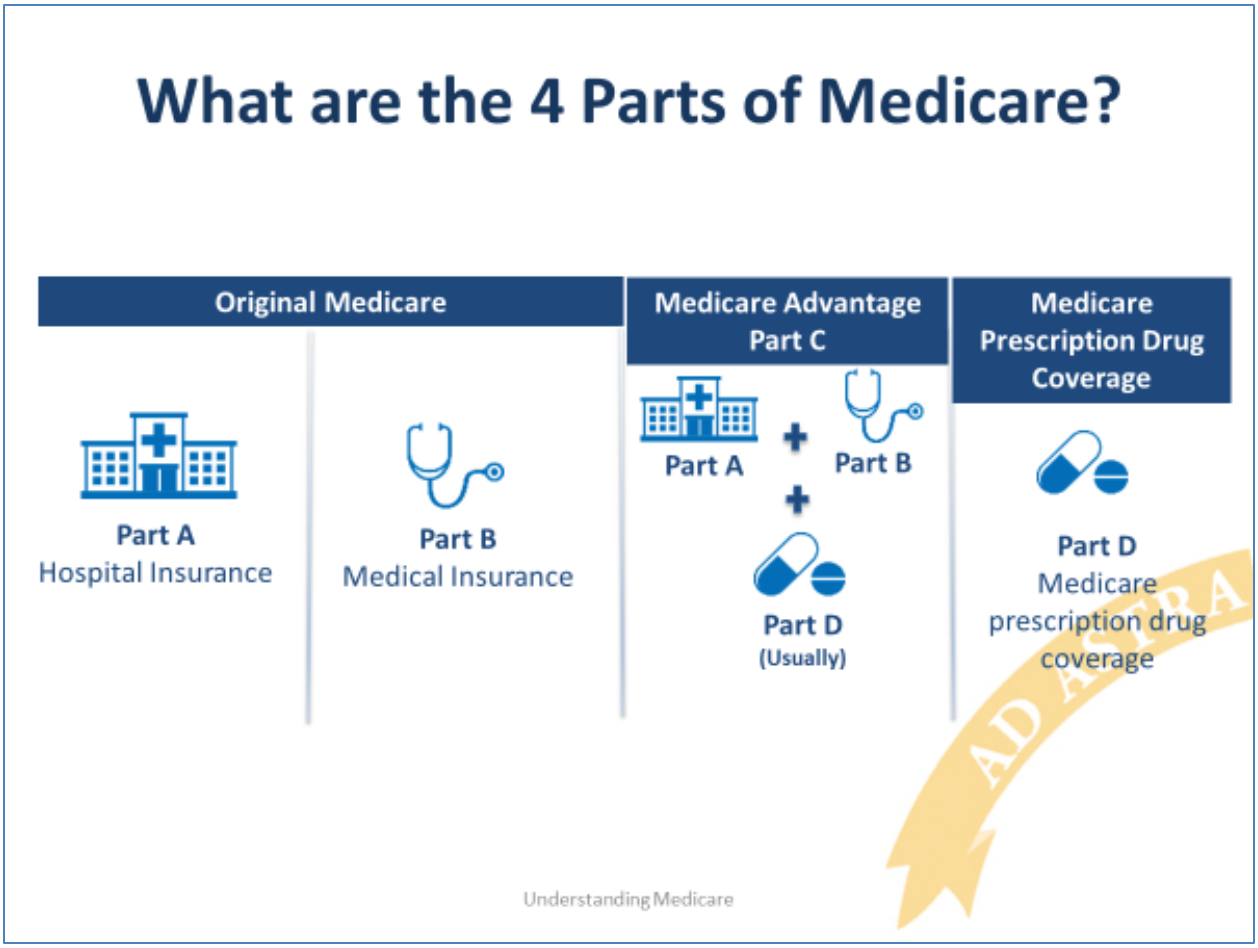
The Social Security Administration (SSA) is responsible for enrolling most people in Medicare.

The Railroad Retirement Board (RRB) is responsible for enrolling railroad retirees in Medicare.

SSA and RRB also collect premiums and determine the amounts of the Part A (if you must pay for it) and Part B premiums. They also handle replacement Medicare cards.

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS).

If you retired from federal service, contact the Office of Personnel Management regarding your premiums.



Medicare covers many types of services, and you have options for how to get your Medicare coverage. Medicare has 4 parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically necessary services like doctor's visits and outpatient care. Part B also covers many preventive services (including screening tests and shots), diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers. Together, Part A and Part B are also referred to as "Original Medicare."
- **Part C (Medicare Advantage [MA])** is another way to get your Medicare benefits. It combines Part A and Part B, and sometimes Part D (prescription drug coverage). MA Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services than Original Medicare.
- **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs. Part D may help lower your prescription drug costs and protect you against higher costs in the future.

Automatic Enrollment—Part A and Part B

- Automatic enrollment for those getting
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period Package
  - Mailed 3 months before
    - Your 65th birthday
    - 25th month of disability benefits
  - Includes your Medicare card

Understanding Medicare

If you're already getting Social Security benefits (for example, getting early retirement at least 4 months before you turn 65), you'll be automatically enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the first day of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

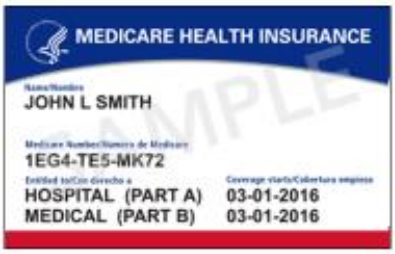
If you're not getting retirement benefits from Social Security or the Railroad Retirement Board (RRB), you must sign up to get Medicare (see page 9).

NOTE: If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65, or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Contact your local Social Security office or the RRB for more information.

"Welcome to Medicare," CMS Product No. 11095, is pictured on this page. It's part of the Initial Enrollment Period package. Visit https://www.medicare.gov/Pubs/pdf/11095-Welcome-to-Medicare.pdf.

Medicare Card

- Keep it and accept Medicare Part A and Part B
- Return it to refuse Part B
  - Follow instructions on back of card



Understanding Medicare

When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care services. The Medicare card shows the type of Medicare coverage (Part A and/or Part B) you have and the date the coverage started. Your card may look slightly different from this one; it's still valid.

NOTE: Social Security has an online service that lets you get a replacement Medicare card if your old one is lost or needs to be replaced. To create your account and learn more about "my social security" accounts, visit SSA.gov/myaccount.

If you get your Medicare card in your Initial Enrollment Period package and keep it, you keep Part B and will pay the Part B premium (unless Medicaid pays your premium). If you don't want Part B, and decide to enroll later, you'll likely pay a late enrollment penalty. If you don't want Part B, follow the directions on the back of the card, and return it. We'll describe reasons why you might want to delay taking Part B later in this presentation. If you choose a Medicare health plan, your plan will likely give you a card to use when you get health care services and supplies.

A new Medicare Number that's unique will only be used for Medicare coverage. The new card won't change coverage or benefits.

The new cards no longer include gender or a signature line. They are also smaller, the size of a standard credit card to fit in wallets easier and can be laminated.

Each MBI is unique, randomly generated, and the characters are "non-intelligent," which means they don't have any hidden or special meaning.

When Enrolling Isn't Automatic

- If you're not automatically enrolled
  - You need to enroll with Social Security
    - Visit socialsecurity.gov
    - Call 1-800-772-1213
    - TTY: 1-312-751-4701
    - Visit your local office
  - If retired from the Railroad, enroll with the Railroad Retirement Board (RRB)
    - Call your local RRB office or 1-877-772-5772
- Apply 3 months before you turn 65
  - Don't have to be retired to get Medicare

Understanding Medicare

AD ASTRA

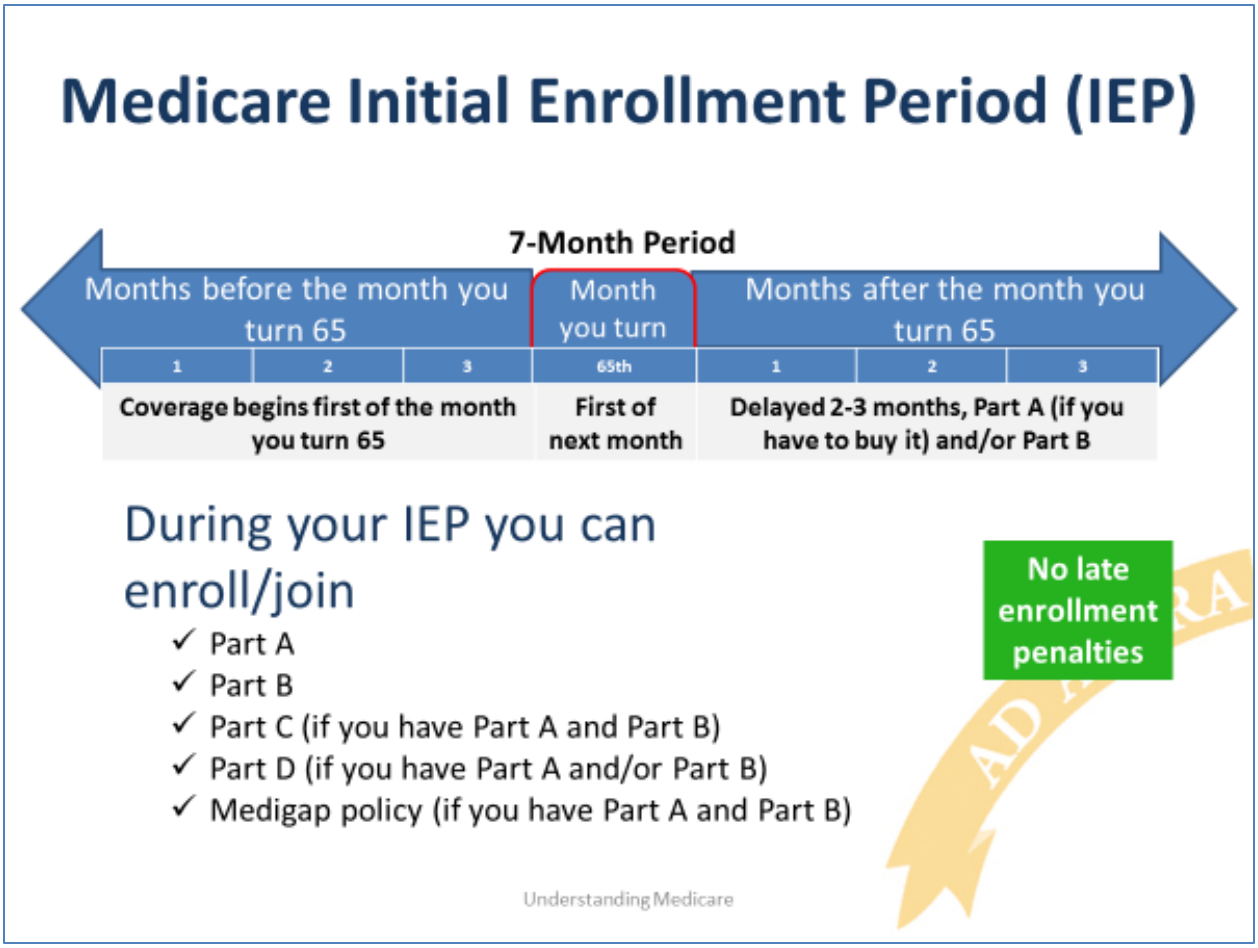
If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A and Part B (even if you're eligible to get Part A premium free). You should contact Social Security 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up. You don't have to be retired to get Medicare.

Full retirement age (also called "normal retirement age") had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959.

The 1983 Social Security Amendments included a provision for raising the full retirement age beginning with people born in 1938 or later. Congress cited improvements in the health of older people and increases in average life expectancy as primary reasons for increasing the normal retirement age.

For more information or to calculate your age for collecting full Social Security retirement benefits, visit SSA.gov/retirement/ageincrease.htm.

NOTE: Although the age to receive full Social Security retirement benefits is increasing, Medicare benefit eligibility due to age still begins at 65.



Your first opportunity to enroll in Medicare is during your **Initial Enrollment Period (IEP)**, which lasts 7 months. Your coverage starts based on when you enroll. If you enroll during the first 3 months of your IEP (the 3 months before the month you turn 65), your coverage will begin the first day of the month you turn 65.

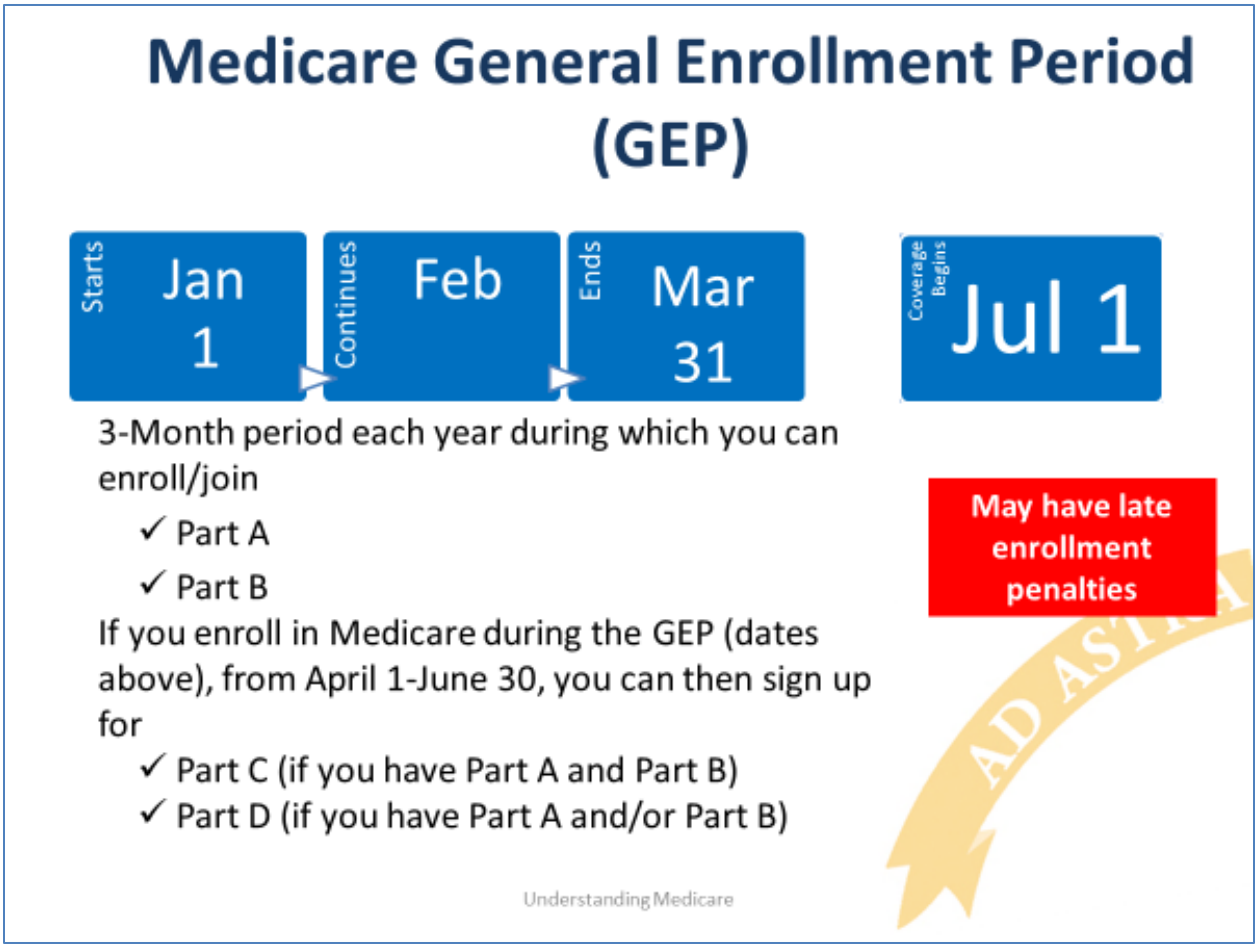
If you enroll in Part A (if you have to buy it) and/or Part B

- The month you turn 65, your coverage starts one month after you sign up
- One month after you turn 65, your coverage starts 2 months after you sign up
- 2 months after you turn 65, your coverage starts 3 months after you sign up
- 3 months after you turn 65, your coverage starts 3 months after you sign up
- During the January 1-March 31 General Enrollment Period, your coverage starts on July 1

If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods.

If you don't enroll in Part B (or Part A if you have to buy it) during your IEP, you may have to pay a penalty. For Part B, it's a lifetime penalty.

NOTE: For an individual whose 65th birthday is on the first day of the month, Part A coverage begins on the first day of the month preceding their birth month. For example, if an individual's birthday is on December 1, Part A begins on November 1.

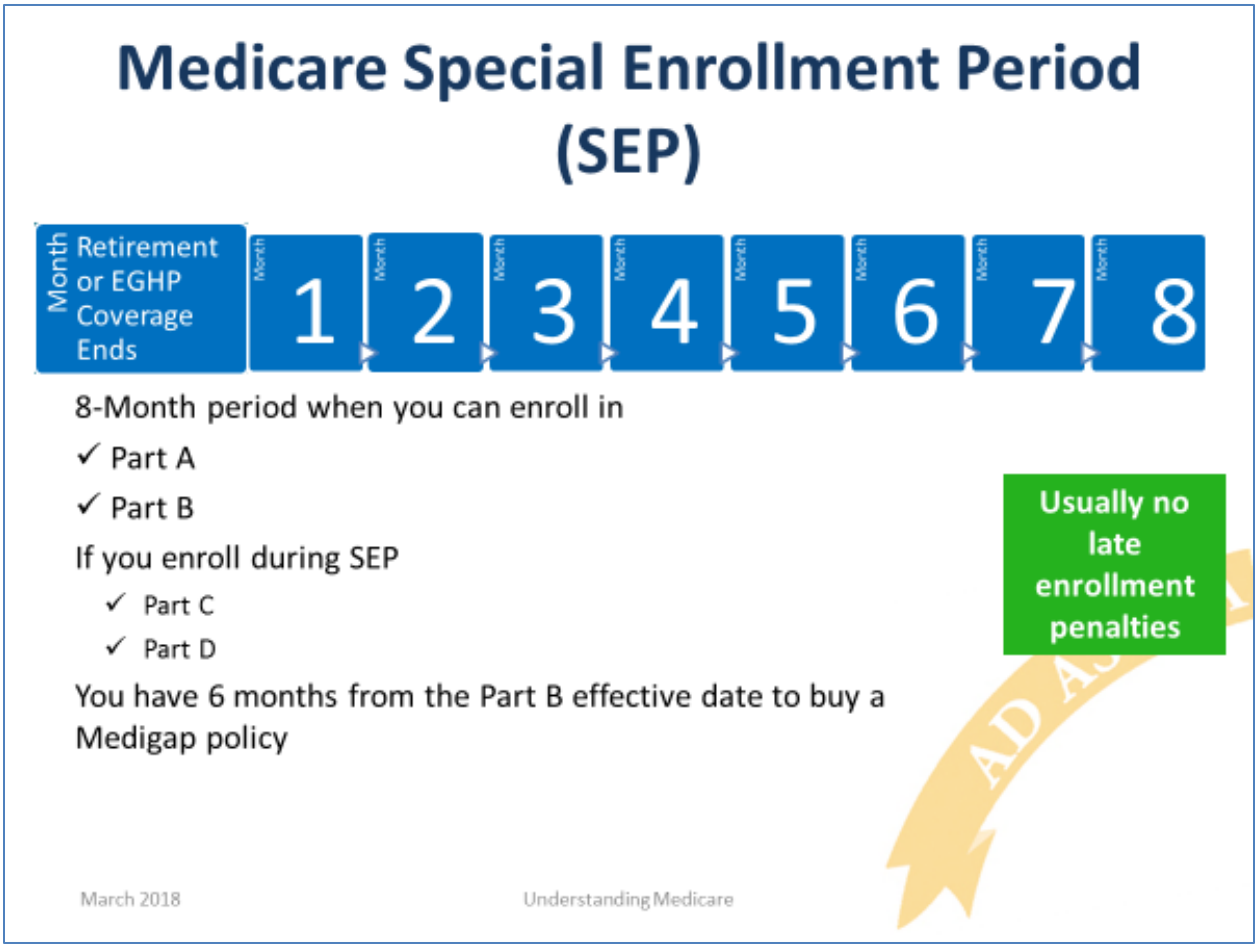


If you didn't sign up for Part B (or Part A, if you have to buy it) during your IEP, you can enroll during the GEP. For most people who don't enroll during their IEP, this is their only chance to enroll. The GEP occurs each year. It begins January 1 and ends March 31. If you enroll in the GEP, your coverage will start on July 1. This is required by law. In addition, if more than 12 months have passed since you turned 65, you'll likely have to pay a lifetime late enrollment penalty that's added to your monthly Part B premium. In most cases, you'll have to pay this penalty for as long as you have Part B. However, if you delayed Part B because you or your spouse were still working and had group health plan (GHP) (like from an employer) coverage, you won't have a late enrollment penalty and you may be able to enroll during an SEP. The SEP will be discussed in more detail later in this lesson.

If you delayed your enrollment in Part B, you must complete and submit the "Application for Enrollment in Medicare Part B (Medical Insurance)" form (Form CMS-40B, CMS.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf) to your local Social Security office. If you sign up during an SEP, include the "Request for Employment Information" form (Form CMS-L564, CMS.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf) with your Part B application. You must complete Section A and your employer must complete Section B on the form.

A domestic GEP package is being sent to those who refused or lost Part B. It contains information about their Medicare coverage options and an application for Medicare enrollment, including the

- "Welcome to Medicare" letter
- "Welcome to Medicare" booklet, CMS Product No. 11873
- Application for Medicare Part B, Form CMS-L40D



If you or your spouse are still working, and you didn't sign up for Part B (or Part A (if you had to buy it)) during your **Initial Enrollment Period** (IEP), you may be able to enroll during the **Special Enrollment Period (SEP)**. The SEP allows you to enroll after your IEP and not wait for the GEP. If eligible, you won't have to pay a penalty, but this SEP is limited.

To be eligible, you must have group health plan coverage based on active, current employment for all the months you were eligible to enroll in Part B, but didn't. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a member's current employment. It's important to note that COBRA, retiree coverage, long-term workers' compensation or Veterans Affairs coverage isn't considered active, current employment.

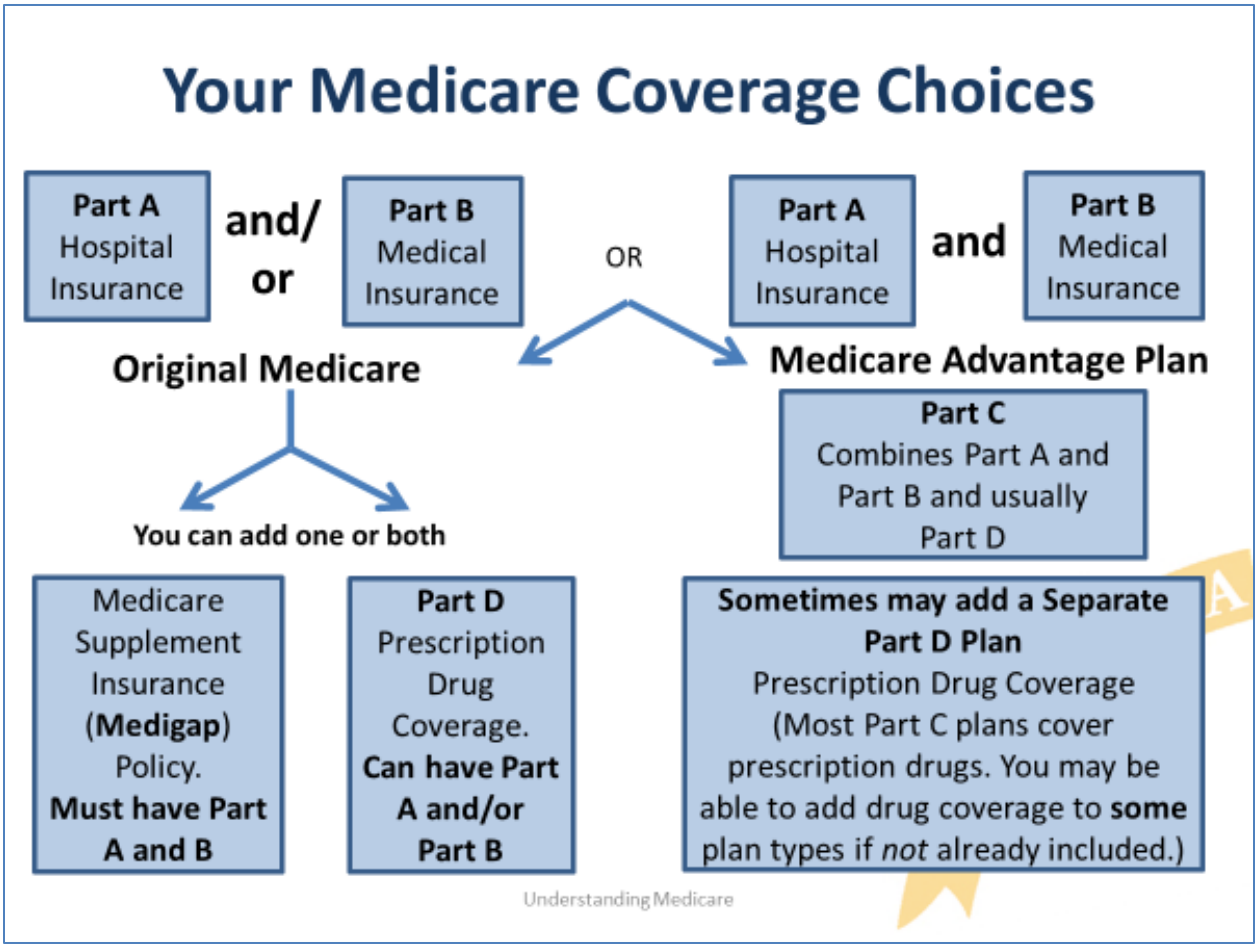
You have an 8-month SEP to sign up for Part A and/or Part B that starts at one of these times (whichever happens first):

- The month after the employment ends
- The month after group health plan insurance based on current employment ends

For information on joining a Part C or Part D plan see Course 2.

If you delay Part B and get it during your SEP, you start your Medigap Open Enrollment Period. You can buy a Medigap policy during 6 months after the Medicare Part B effective date.

If you don't enroll within the 8 months, you'll have to wait until the next GEP to enroll, you'll have a gap in your coverage, and you may have to pay a penalty.



There are 2 main ways to get your Medicare coverage, Original Medicare, or Medicare Advantage (MA) Plans. You can decide which way to get your coverage.

1. Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). You can choose to buy a Medigap Policy to help cover some costs not covered by Original Medicare. You can also choose to buy Medicare prescription drug coverage (Part D) from a Medicare Prescription Drug Plan (PDP).
2. MA Plans (Part C), like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover Part A and Part B services and supplies. They also may include Medicare prescription drug coverage (MA-PD). You can add a Medicare Prescription Drug Plan to a Medicare Private Fee-for-Service Plan or Cost Plan if they don't provide Part D coverage, and you can add it to a Medicare Medical Savings Account (MSA) Plans. You can't add a Part D plan to a Medicare HMO or PPO plan without drug coverage.

Medigap policies don't work with these plans. If you join a Medicare Advantage Plan, you can't use a Medicare Supplement Insurance (Medigap) Policy to pay for out-of-pocket costs while you are enrolled in an MA Plan.

Original Medicare

- Health care option run by the federal government
- Provides your Part A and/or Part B coverage
- See any doctor or hospital that accepts Medicare
- You pay
  - Part B premium (Part A is usually premium free)
  - Deductibles, coinsurance, or copayments
- Get Medicare Summary Notice
- Can join a Part D plan to add drug coverage

Understanding Medicare

AD ASTRA

Original Medicare is one of the coverage choices in the Medicare Program. You'll be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare health plan. Original Medicare is a fee-for-service program that's managed by the federal government. With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

If you have Medicare Part A, you get all medically necessary Part A–covered services. If you have Medicare Part B, you get all medically necessary Part B–covered services. As we mentioned earlier, Part A is premium-free for most people. For Medicare Part B you pay a monthly premium. The standard Medicare Part B monthly premium for those not "held harmless" is $134 in 2018.

In Original Medicare, you also pay deductibles, coinsurance, or copayments. After you receive health care services, you'll get a notice in the mail, called a "Medicare Summary Notice" (MSN), that lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There's information on the MSN about how to ask for an appeal.

If you're in Original Medicare, you can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage.

Assignment

- Doctor, provider, supplier accepts assignment
  - Signed an agreement with Medicare
    - Or is required to by law
  - Accepts the Medicare-approved amount
    - As full payment for covered services
    - Only charges Medicare deductible/coinsurance amount
- Most accept assignment
  - They submit your claim to Medicare directly
- Called "Participating providers"

Understanding Medicare

AD ASTRA

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. Participating providers have signed an agreement to accept assignment for all Medicare-covered services.

Here's what happens if your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less
- They agree to charge you only the Medicare deductible and coinsurance amount, and usually wait for Medicare to pay its share before asking you to pay your share
- They must submit your claim directly to Medicare and can't charge you for submitting the claim

In some cases, doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.

Don't Accept/Must Accept Assignment

- Providers and suppliers that **don't** accept assignment
  - Called "Non-Participating" providers
  - May charge you more
    - The limiting charge is 15% more
    - May have to pay entire charge at time of service
    - Non-participating DME providers may charge the difference between actual cost and Medicare approved amount
- Providers sometimes **must** accept assignment
  - Medicare Part B–covered prescription drugs
  - Ambulance suppliers

Understanding Medicare

AD ASTRA

"Non-participating" providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. If your doctor, provider, or supplier doesn't accept assignment:

- You might have to pay the entire charge at the time of service. Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. In some cases, you might have to submit your own claim to Medicare using form CMS-1490S to get paid back. Visit Medicare.gov/forms-help-and-resources/forms/medicare-forms.html for the form and instructions.
- They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge" or "excess charge." The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

To find out if your doctors, suppliers, and other health care providers accept assignment or participate in Medicare, visit Medicare.gov/physician or Medicare.gov/supplier.

If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare Program, they're supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Ambulance suppliers must accept assignment. For more information on ambulance coverage, visit Medicare.gov/coverage/ambulance-services.html.

Private Contracts

- Agreement between you and your doctor
  - Doctor doesn't furnish services through Medicare
  - Original Medicare and Medigap won't pay
  - Other Medicare plans won't pay
  - You'll pay full amount for the services you get
  - No claim should be submitted
  - Can't be asked to sign in an emergency
  - The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare

Understanding Medicare

AD ASTRA

A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare Program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medicare Supplement Insurance (Medigap) Policies won't pay for the services you get from the doctor with whom you have a private contract. You can't be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor

- No Medicare payment will be made for the services you get from the doctor.
- Your Medigap policy, if you have one, won't pay anything for the service.
- You'll have to pay whatever this doctor or provider charges you. (The Medicare limiting charge won't apply.)
- Other Medicare plans won't pay for the services.
- No claim should be submitted, and Medicare won't pay if one is submitted.
- Many other insurance plans won't pay for the service either.
- The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare.
- Providers who do not accept Medicare payment at all are called "Opt-out" providers.

NOT Covered By Part A and Part B

Some of the items and services that Part A and Part B of Medicare don't cover include:

- ✗ Most dental care
- ✗ Eye examinations related to prescribing glasses
- ✗ Dentures
- ✗ Cosmetic surgery
- ✗ Routine physical exams
- ✗ Massage therapy
- ✗ Acupuncture
- ✗ Hearing aids and exams for fitting them
- ✗ Long-term care
- ✗ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)

They may be covered if you have other coverage, like Medicaid or an MA Plan that covers these services

Understanding Medicare

AD ASTRA

Medicare doesn't cover everything. If you need certain services that aren't covered under Medicare Part A or Part B, you'll have to pay for them yourself unless

- You have other coverage (including Medicaid) to cover the costs
- You're in an MA Plan that covers these services

Some of the items and services that Medicare doesn't cover include:

✗ Most dental care

✗ Eye exams related to prescribing glasses
✗ Dentures
✗ Cosmetic surgery
✗ Routine physical exams
✗ Massage therapy
✗ Acupuncture
✗ Hearing aids and exams for fitting them
✗ Long-term care
✗ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)
They may be covered if you have other coverage, like Medicaid or an MA Plan that covers these services.

For more information about what isn't covered by Medicare, visit Medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html.

Original Medicare
Part A—Hospital Insurance Coverage

Part A
Hospital Insurance

Part A–Hospital Insurance helps cover medically necessary

- ✓ Inpatient hospital care
  - – Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).
- ✓ Inpatient skilled nursing facility (SNF) care
  - – After a related 3-day inpatient hospital stay
    - If you meet all the criteria

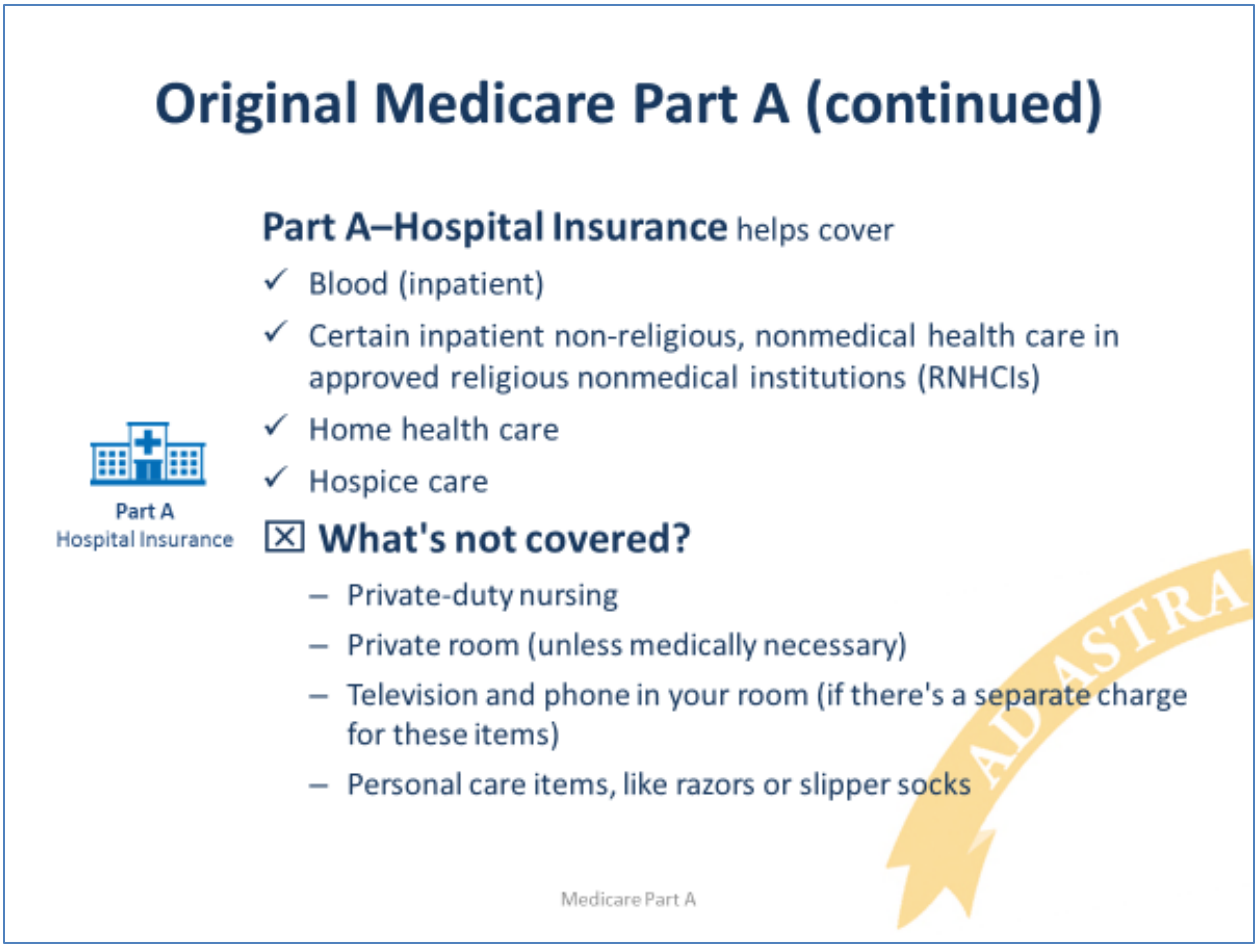
Medicare Part A

AD ASTRA

Medicare Part A (Hospital Insurance) helps cover medically necessary inpatient services.

- Hospital inpatient care–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).
- Inpatient skilled nursing facility (SNF) care (not custodial or long-term care) under certain conditions.
- Blood—In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker.
- Home health care—A doctor, or certain health care providers who work with the doctor, must see you face-to-face to certify that you need home health services. You must be homebound, which means that leaving home is a major effort.
- Hospice care—Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; as well as services Medicare usually doesn't cover, such as grief counseling.

NOTE: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the United States. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated.



Here is more detail about what is covered under Part A:

- Blood—In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs)—Medicare will only cover the inpatient non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker.
- Home health care.
- Hospice care.

What's not covered?

Private-duty nursing, private room (unless medically necessary), television and phone in your room (if there's a separate charge for these items), and personal care items, like razors or slipper socks aren't covered by Medicare.

Paying for Medicare Part A

- Most people don't pay a premium for Part A
  - If you or your spouse paid Federal Insurance Contributions Act (FICA) taxes at least 10 years
- If you paid FICA less than 10 years you can pay a premium to get Part A
- May have a penalty if you don't enroll when first eligible for premium Part A
  - Your monthly premium may go up 10%
  - You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up

Medicare Part A

AD ASTRA

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. Federal Insurance Contributions Act (FICA) tax is a United States federal payroll (or employment) tax imposed on both employees and employers to fund Social Security and Medicare. About 99% of people with Medicare don't pay a Part A premium since they've at least 40 quarters of Medicare-covered employment. Enrollees 65 and over and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium to receive coverage under Part A.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you're

- 65 or older, and you have (or are enrolling in) Part B, and meet the citizenship and residency requirements.
- Under 65, have a disability, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and have a disability, you may continue to get premium-free Part A for up to 8 1/2 years after you return to work.)

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

Social Security determines if you have to pay a monthly premium for Part A. In 2019, the Part A premium for a person who has worked less than 30 quarters of Medicare covered employment is $437 per month. Those who have between 30 and 39 quarters of coverage may buy Part A at a reduced monthly premium rate, which is $240 for 2019.

If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

If you have limited income and resources, your state may help you pay for Part A and/or Part B. Call Social Security at 1-800-772–1213 for more information about the Part A premium. TTY: 1-800-325-0778.

Inpatient Hospital Care

- Semi-private rooms
- Meals
- General nursing care
- Drugs that are part of your inpatient treatment
- Hospital services and supplies

AD ASTRA

Medicare Part A

Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.

Medicare covers certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient, non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker. Medicare doesn't cover the religious portion of RNCHI care. Medicare Part A (Hospital Insurance) covers inpatient, non-religious, nonmedical care when certain conditions are met.

NOTE: Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you've not been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility. For more information, read "Are You a Hospital Inpatient or Outpatient?" at Medicare.gov/Pubs/pdf/11435.pdf.

Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
  - In hospital or SNF
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
- No limit to the number of benefit periods you can have

Benefit periods can span across calendar years.

Medicare Part A

AD ASTRA

A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care or SNF care for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the Part A inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. Benefit periods can span across calendar years.

Examples:

- You spend 5 days in the hospital. You then enter a SNF for 20 days of rehabilitation. You then return home. Your benefit period will end when you've been out of the SNF for 60 days, or 85 days after you first entered the hospital. If you don't return to the hospital as an inpatient in that time frame, you'll pay another deductible for the next benefit period.
- You've returned home after being an inpatient in the hospital, or in a combination of a hospital and a SNF. After 2 weeks at home you must return to the hospital. You haven't been out of inpatient care for 60 days, so you're still in your first benefit period. You don't have to pay another hospital deductible.

NOTE: To qualify for post-hospital extended care services (i.e. SNF), you must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.

Are You an Inpatient or an Outpatient?

- Your hospital status affects how much you pay out-of-pocket, what is covered by Part A and/or Part B, and whether Medicare will cover subsequent skilled nursing facility (SNF) care.
- Medicare Outpatient Observation Notice (MOON) – provided when in observation status longer than 24 hours, but before 36th hour

Inpatient – When you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Outpatient – When the doctor hasn't written an order to admit you, even if you spend the night.

AD ASTRA

Medicare Part A

Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects how much you pay for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay. You're an inpatient starting when you're formally admitted to a hospital with a doctor's order. The day before you're discharged is your last inpatient day.

You're an outpatient if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor hasn't written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

An inpatient admission is generally appropriate when you're expected to need 2 or more midnights of medically necessary hospital care, but your doctor must order such admission and the hospital must formally admit you for you to become an inpatient. If you have a Medicare Advantage Plan (like an HMO or PPO), your costs and coverage may be different. Check with your plan.

The copayment for a single outpatient hospital service can't be more than the inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

The Medicare Outpatient Observation Notice (MOON) (Form CMS 10611-MOON) is a standardized notice to inform people with Medicare (including health plan enrollees) that they are outpatients receiving observation services and aren't inpatients of a hospital or critical access hospital (CAH).

The MOON is to be provided if observation is longer than 24 hours, but before the 36th hour of observation.

For more information, visit CMS.gov/medicare/medicare-general-information/bni/.

Paying for Inpatient Hospital Stays

For Each Benefit Period in 2020	You Pay
Days 1-60	$1,408 deductible
Days 61-90	$352 per day
Days 91-150	$704 per day (60 lifetime reserve days)
All days after 150	All Costs

Medicare Part A

For each benefit period in 2020 you pay

- $1,408 deductible and no copayment for days 1–60 each benefit period.
- $352 for days 61–90 each benefit period.
- $704 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).
    - In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.
- All costs for each day after the lifetime reserve days.

NOTE: Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Deductible - The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Coinsurance - An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Skilled Nursing Facility (SNF) Care Required Conditions for Coverage

- Require daily skilled services
  - Not just long-term or custodial care
- Hospital inpatient 3 consecutive days or longer
- Admitted to SNF within specific time frame
  - Generally 30 days after leaving hospital
- SNF care must be for a hospital-treated condition
  - Or condition that arose while receiving care in the SNF for hospital-treated condition
- Must be a Medicare-participating SNF

Medicare Part A

AD ASTRA

Part A will pay for skilled nursing facility (SNF) care if you meet the following conditions:

- Your doctor must certify that your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a SNF.
- This doesn't include custodial or long-term care. Medicare doesn't cover custodial care if it's the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
- You were an inpatient in a hospital for 3 consecutive days or longer before you were admitted to a participating SNF. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in 1 or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.
- You were admitted to the SNF within 30 days after leaving the hospital.
- Your care in the SNF is for a condition that was treated in the hospital or arose while receiving care in the SNF for a hospital-treated condition.
- The facility must be a Medicare-participating SNF.

For more information, read "Medicare Coverage of Skilled Nursing Facility Care" at Medicare.gov/Pubs/pdf/10153.pdf.

Skilled Nursing Facility Covered Services

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

Medicare Part A

AD ASTRA

If you qualify, Medicare will cover the following skilled nursing facility (SNF) services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications and medical supplies/equipment used in the facility
- Ambulance transportation to the nearest supplier of needed services that aren't available at the SNF when other transportation endangers health
- Dietary counseling

Paying for Skilled Nursing Facility Care

For Each Benefit Period in 2020	You Pay
Days 1-20	$0
Days 21-100	$176 per day
All days after 100	All Costs

Medicare Part A

Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. In 2020, under Original Medicare, days 21–100 of SNF care are covered for each benefit period except for coinsurance of up to $176 per day. After 100 days, Medicare Part A no longer covers SNF care.

You can qualify for SNF care again every time you have a new benefit period and meet the other criteria.

Home Health Care Coverage

Usually, a home health care agency coordinates the services your doctor orders for you.

✓Intermittent skilled nursing care
✓Physical therapy
✓Speech-language pathology services
✓Continued occupational services, and more

☒ Medicare doesn't pay for
- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services
- Personal care

Understanding Medicare

AD ASTRA

Covered home health services include the following:

- ✓ Intermittent skilled nursing care
- ✓ Physical therapy
- ✓ Speech-language pathology services
- ✓ Continued occupational services, and more
- ✓ May also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment, or injectable osteoporosis drugs

Usually, a home health care agency coordinates the services your doctor orders for you.

☒ Medicare doesn't pay for the following:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services
- Personal care

Five Required Conditions for Home Health Care Coverage

1. Must be homebound
2. Must need skilled care on part-time or intermittent basis
3. Must be under the care of a doctor
   - Receiving services under a plan of care
4. Have face-to-face encounter with doctor
   - Prior to start of care or within 30 days
5. Home health agency must be Medicare-approved

Medicare Part A

AD ASTRA

To be eligible for home health care services, you must meet all of these conditions:

1. You must be homebound. An individual shall be considered "confined to the home" (homebound) if the following 2 criteria are met: 1) The patient must either, because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, OR 2) have a condition such that leaving his or her home is medically contraindicated. If the patient meets only 1 of the 2 previous conditions, then the patient must ALSO meet these 2 additional requirements: 1) There must exist a normal inability to leave home, AND 2) Leaving home must require a considerable and taxing effort.
2. You must need skilled care on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
3. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
4. Prior to certifying your eligibility for the Medicare home health benefit, the doctor must document that the doctor or other health care provider has had a face-to-face encounter with you. The encounter must be done up to 90 days prior, or within 30 days after the start of care. The law allows the face-to-face encounter to occur via telehealth in rural areas, in an approved originating site. This means medical or other health services given to a patient using a communications system (like a computer, phone, or television), by a health care provider in a location different from the patient's.
5. The home health agency caring for you must be approved by Medicare.

NOTE: Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A–covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at Medicare.gov/Pubs/pdf/10969.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

Paying for Home Health Care

- In Original Medicare you pay
  - Nothing for covered home health care services
  - 20% of Medicare-approved amount
    - For durable medical equipment
      - Covered by Part B
- Plan of care reviewed every 60 days
  - Called episode of care

Medicare Part A

AD ASTRA

In Original Medicare, for Part A covered home health care, you pay nothing for covered home health care services provided by a Medicare-approved home health agency.

Durable medical equipment, when ordered by a doctor, is paid separately by Medicare. This equipment must meet certain criteria to be covered. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

To find a home health agency in your area, visit Medicare.gov and use the Home Health Compare tool, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

NOTE: Part A covers post-institutional home health services furnished during a home health "spell of illness" for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health "spell of illness." The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.

Part A Hospice Care

- Interdisciplinary team for those with a life expectancy of 6 months or less, and their family
- Sign election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness
- Focus is on comfort and pain relief, not cure
- Doctor must certify each "election period"
  - Two 90-day periods
  - Then unlimited 60-day periods
  - Face-to-face encounter
- Hospice provider must be Medicare-approved

Medicare Part A

AD ASTRA

Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You must sign an election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness. However, medical services not related to your hospice condition would still be covered by Medicare.

You can get hospice care as long as your doctor certifies that you're terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "election periods"—two, 90-day periods, followed by unlimited 60-day periods. At the start of each benefit period, your doctor must certify that you're terminally ill for you to continue getting hospice care.

Medicare also requires face-to-face visits. The doctor is required to meet with you within 30 days of hospice recertification, starting before the third election period and each subsequent recertification.

The hospice provider must be Medicare-approved.
For more information, read "Medicare Hospice Benefits" at Medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF.

Covered Hospice Services

- Physician and nursing services
- Physical, occupational, and speech therapy
- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care for pain and symptom management
- Respite care in a Medicare-certified facility
  - Up to 5 days each time, no limit to number of times
- Hospice aide and homemaker services
- Social worker services
- Grief, dietary, and other counseling

Medicare Part A

AD ASTRA

In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech language therapy, the hospice benefit also covers:

- Medical equipment (such as wheelchairs or walkers).
- Medical supplies (such as bandages and catheters).
- Drugs for symptom control and pain relief.
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management.
- Inpatient respite care, which is care given to you by another caregiver, so your usual caregiver can rest. You'll be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there's no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
- Hospice aide and homemaker services.
- Social worker services.
- Other covered services as well as services Medicare usually doesn't cover, like spiritual and grief counseling.
- Dietary and other counseling.

Paying for Hospice Care

- In Original Medicare you pay
  - Nothing for hospice care
  - Up to $5 per Rx to manage pain and symptoms
    - While at home
  - 5% for inpatient respite care
- Room and board may be covered in certain cases
  - Short-term respite care
  - For pain/symptom management that can't be managed at home
  - If you have Medicaid and live in a nursing facility

Medicare Part A

AD ASTRA

For hospice care in Original Medicare, you pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while receiving routine or continuous care at home, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'll pay $7.50 per day. The amount you pay for respite care can change each year.

Room and board are only payable by Medicare in certain cases. Room and board are covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board aren't covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in a nursing facility, room and board are covered by Medicaid.

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227), or your state hospice organization. TTY: 1-877-486-2048.

For more information, visit the "Medicare Benefit Policy Manual", Chapter 9, Coverage of Hospice Services under Hospital Insurance at CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf.

Medicare Part B—Medical Insurance Coverage

- Part B—Medical Insurance helps cover
  - Doctors' services
  - Outpatient medical and surgical services, supplies
  - Clinical lab tests
  - Durable medical equipment
  - Diabetic testing supplies
  - Preventive services
  - Home health care

Medicare Part B

AD ASTRA

Medicare Part B (Medical Insurance) helps cover medically necessary outpatient services and supplies.

- Doctors' services—Services that are medically necessary.
- Outpatient medical and surgical services and supplies—For approved procedures like X-rays or stitches.
- Clinical laboratory services—Blood tests, urinalysis, and some screening tests.
- Durable medical equipment like walkers and wheelchairs—You may need to use certain suppliers under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program. Visit Medicare.gov/supplierdirectory/.
- Diabetic testing supplies—You may need to use specific suppliers for some types of diabetic testing supplies.
- Preventive services—Exams, tests, screening and shots to prevent, find, or manage a medical problem.
- Home health services – You can use your home health benefits under Part A and/or Part B. Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A-covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at Medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

What Are Medicare Part B—Covered Services?

Doctors' Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. You pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures like X-rays, casts, or stitches. You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.

Medicare Part B

Medicare Part B covers a variety of medically necessary outpatient services and supplies. Certain requirements must be met.

Doctors' Services—Medicare covers medically necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies—Medicare covers approved procedures like X-rays, casts, or stitches. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. The Part B deductible applies.

Medicare Part B—Covered Services Continued

Durable Medical Equipment (DME)	Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. All Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program (CBP) contracts expire on December 31, 2018. Starting January 1, 2019, there will be a temporary gap in the DMEPOS CBP that CMS expects will last until December 31, 2020. During the temporary gap, any Medicare enrolled DMEPOS supplier may furnish DMEPOS items and services to people with Medicare. In most cases, people with Medicare won't need to switch suppliers on or after January 1, 2019. Visit Medicare.gov/supplier to find Medicare-approved suppliers in your area. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Medicare Part B

Durable Medical Equipment (DME)—Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.

All Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program contracts expired on December 31, 2018. As of January 1, 2019, there is a temporary gap in the entire DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020. For additional information, please see the Temporary Gap Period fact sheet.

If you need DME or supplies, visit Medicare.gov/supplier to find Medicare-approved suppliers. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For more information on the competitive bidding program, you can visit: CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.

More Medicare Part B—Covered Services

Home Health Services	Medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies. You pay nothing for covered services.
Other (including but not limited to)	Medically necessary medical services and supplies, such as ambulance services, clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary.

Medicare Part B

Home Health Services—Medicare covers medically-necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, as defined previously. You pay nothing for covered home health services.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B. For more information on Part B coverage, visit Medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html.

Other (including, but not limited to)—Ambulance services, medically necessary clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, EKGs, transplants, and other services are covered. Costs vary.

Medicare Part B
Costs for Most People

Yearly Deductible	$198.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

Medicare Part B

ADASTRA

In addition to premiums, there are other costs you pay in Original Medicare. This is what you pay in 2020 for Part B covered medically necessary services:

- The annual Part B deductible is $198 in 2020. If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. This means that you must pay the first $198 of your Medicare-approved medical bills in 2020 before Part B starts to pay for your care.
- Coinsurance for Part B services. In general, it's 20% for most covered services for providers accepting assignment.
- Some preventive services have no coinsurance, and the Part B deductible doesn't apply as long as the provider accepts assignment.
- You pay 20% for outpatient mental health services (visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions, or outpatient treatment of your condition [like counseling or psychotherapy] for providers accepting assignment).
- If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

What You Pay—Part B Premiums

- **Monthly Premium**
  - Standard premium is $144.60 (may have to pay a higher amount depending on your income, see next slide)
  - Some people who get Social Security benefits pay less than this amount

Medicare Part B

AD ASTRA

You pay a premium for Part B each month. The standard Part B premium amount in 2020 is $144.60. You may have to pay a higher amount depending on your income (see next slide). However, some people who get Social Security benefits pay less than this amount. For 2020, about 3.5% of people with Medicare will pay less than the full Part B standard premium due to the statutory hold harmless provision, which limits the increase in the Part B premium to be no greater than the increase in their Social Security benefits.

REMEMBER: This premium may be higher if you didn't choose Part B when you first became eligible. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but didn't take it. An exception would be if you can enroll in Part B during an SEP because you or your spouse (or family member if you're disabled) is still employed and you're covered by a GHP through that employment.

You'll pay the standard premium (or higher) in 2020 if you:

- Enroll in Part B for the first time in 2020
- Don't get Social Security benefits
- Are directly billed for your Part B premiums
- Have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $144.60 in 2020).
- Had a modified adjusted gross income (MAGI) as reported on your IRS tax return from 2 years ago above a certain amount. If so, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium (see next slide).

Monthly Part B Standard Premium—Income-Related Monthly Adjustment Amount for 2020

Chart is based on your yearly income *in 2018* (for what you pay in 2020)

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	In 2020 You Pay
$87,000 or less	$174,000 or less	$87,000 or less	$144.60
above $87,000 up to $109,000	above $174,000 up to $218,000	Not applicable	$202.40
above $109,000 up to $136,000	above $218,000 up to $272,000	Not applicable	$289.20
above $136,000 up to $163,000	above $272,000 up to $326,000	Not applicable	$376.00
above $163,000 and less than $500,000	above $326,000 and less than $750,000	above $87,000 and less than $413,000	$462.70
$500,000 or above	$750,000 and above	$413,000 and above	$491.60

NOTE: You may pay more if you have a Part B late enrollment penalty.

Medicare Part B

Since 2007, people with Medicare with higher incomes have paid higher Medicare Part B monthly premiums. These income-related monthly premium rates affect roughly 5% of people with Medicare. The total Medicare Part B premiums for people with high income for 2020 are shown in the following table:

For those whose income is

- $87,000 or less, and file an individual tax return, file a joint tax return with a yearly income of $174,000 or less, or file married with separate tax returns, the Part B premium is $144.60 per month.
- $87,000.01–$109,000, and file an individual tax return, file a joint tax return with a yearly income above $174,000 up to $218,000, the Part B premium is $202.40 per month.
- $109,000.01–$136,000, and file an individual tax return, file a joint tax return with a yearly income of above $218,000 up to $272,000, the Part B premium is $289.20 per month.
- $136,000.01–$163,000, and file an individual tax return, file a joint tax return with an income above $272,000 up to $326,000, the Part B premium is $376.00 per month.
- Above $163,000 and less than $500,000, and file an individual tax return, file a joint tax return with an income above $326,000 and less than $750,000, or file married and file separate tax return with an income above $87,000 and less than $413,000, the Part B premium is $462.70 per month.
- $500,000 and above and file an individual tax return, file a joint tax return with a yearly income of above $750,000, or file married and file separate tax return with an income above $413,000, the Part B premium is $491.60 per month

If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY: 1-800-325-0778.

Paying the Part B Premium

- Deducted monthly from
  - Social Security benefit payments
  - Railroad retirement benefit payments
  - Federal retirement benefit payments
- If not deducted
  - Billed every 3 months
  - Medicare Easy Pay to deduct from bank account
- Contact Social Security, the Railroad Retirement Board, or the Office of Personnel Management about premiums

Medicare Part B

AD ASTRA

The Part B premium is deducted from monthly Social Security, Railroad Retirement, or federal retirement benefit payments.

If you don't get a retirement payment or your payment isn't enough to cover the premium, you'll get a bill from Medicare for your Part B premium. The bill can be paid by credit card, check, or money order.

For information about Medicare Part B premiums, call Social Security, the Railroad Retirement Board, or the Office of Personnel Management for retired federal employees.

If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

Part B Late Enrollment Penalty

- See how your insurance works with Medicare
  - Contact your employer/union benefits administrator
- Penalty for not signing up when first eligible
  - 10% more for each full 12-month period
  - May have a penalty as long as you have Part B
- Sign up during a Special Enrollment Period
- Usually no penalty if you sign up within 8 months of employer coverage ending

Medicare Part B

AD ASTRA

If you don't take Part B when you're first eligible, you may have to wait to sign up during the annual General Enrollment Period that runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.

If you don't take Part B when you're first eligible, you'll have to pay a premium penalty of 10% for each full 12-month period you could've had Part B but didn't sign up for it, except in special situations. In most cases, you'll have to pay this penalty for as long as you have Part B.

Having coverage through an employer (including federal or state employment, but not military service) or union while you or your spouse (or family member if you're disabled) is still working can affect your Part B enrollment rights. If you're covered through active employment (yours or your spouses), you have a Special Enrollment Period (SEP). This means you can join Part B anytime that you or your spouse (or family member if you're disabled) is working, and covered by a group health plan through the employer or union based on that work, or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first. Usually, you don't pay a late enrollment penalty if you sign up during a SEP. This SEP doesn't apply to people with End-Stage Renal Disease.

You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.

Part B Late Enrollment Penalty Example

Mary's Initial Enrollment Period ended September 30, 2009. She waited to sign up for Part B until the General Enrollment Period in March 2012.

- Total time Mary delayed Part B: 30 months
- Mary's Late Enrollment Penalty: 20% (30 months includes 2 full 12-month periods)
- The penalty is added to the Part B monthly premium
- Mary will have the penalty for as long as she has Part B

AD ASTRA

Medicare Part B

This is an example of how you might calculate a late enrollment penalty for Part B. Mary's Initial Enrollment Period ended September 30, 2009. She waited to sign up for Part B until the General Enrollment Period in March 2012.

- Total time Mary delayed Part B: 30 months
- Mary's Late Enrollment Penalty: 20% (30 months includes 2 full 12-month periods)
- The penalty is added to the Part B monthly premium
- Mary will have the penalty for as long as she has Part B

When You Must Have Part B

- If you want to buy a Medigap policy
- If you want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL) or CHAMPVA
- Your employer coverage requires you have it when you become eligible for Medicare (less than 20 employees)
  - Talk to your employer's or union benefits administrator
- Veterans Affairs (VA) benefits are separate from Medicare
  - You pay a penalty if you sign up late or if you don't sign up during your Medicare Initial Enrollment Period

Medicare Part B

AD ASTRA

You must have Part B if

- You want to buy a Medicare Supplement Insurance (Medigap) Policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL)* or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Your employer coverage requires you or your spouse/family member to have it when you become eligible for Medicare—less than 20 employees (talk to your employer's or union benefits administrator)

Veterans Affairs (VA) benefits are separate from Medicare. With VA benefits, you may choose to not enroll in Part B, but you pay a penalty if you don't sign up for Part B during your Initial Enrollment Period (visit VA.gov). If you have VA coverage, you won't be eligible to enroll in Part B using the Special Enrollment Period (SEP).

*TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to get TFL benefits. However, if you're an active-duty service member, or the spouse or dependent child of an active-duty service member, you don't have to enroll in Part B to keep your TRICARE coverage. When the active-duty service member retires, you must enroll in Part B to keep your TFL coverage. You can get Part B during a Special Enrollment Period if you have Medicare because you're 65 or older, or you're disabled. For more information, visit Tricare.mil/mybenefit.

You must have Part A and Part B to keep your CHAMPVA coverage.

NOTE: See also Medicare.gov/Pubs/pdf/02179.pdf for more information on "Who Pays First."

Medicare Preventive Services

- Medicare preventive services
  - May find health problems early, when treatment works best
- Covered by Medicare Part B (Medical Insurance)
  - Whether you get your coverage from
    - Original Medicare
    - Medicare Advantage (MA) Plan
    - Other Medicare health plans
- Coverage for preventive services is based on age, gender, and medical history

AD ASTRA

Paying for Preventive Services

- In Original Medicare you
  - Pay nothing for most preventive services if your provider accepts "assignment*"
  - May pay more if provider doesn't accept assignment
  - May have a copayment
    - If doctor performs other services that aren't part of covered preventive benefits, or
    - If you receive certain preventive services

***Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance.**

Preventive Services

Under Original Medicare, you'll pay nothing for most preventive services if you get the services from a doctor or other provider who accepts the assignment.

The assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance.

You'll pay nothing for certain preventive services. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under the preventive benefits, you may have to pay a copayment, and the Part B deductible may apply. Later, we'll discuss which preventive services require a copayment.

Medicare Part B–Covered Preventive Services

- "Welcome to Medicare" preventive visit
- Yearly "Wellness" visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (CVD) Risk Reduction Visit
- Cardiovascular disease screenings
- Cervical and vaginal cancer screening
  - Human Papillomavirus (HPV) Testing
- Colorectal cancer screenings
  - Screening fecal occult blood test
  - Screening flexible sigmoidoscopy
  - Screening colonoscopy
  - Screening barium enema
  - Multi-target stool DNA test
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots (Vaccine)
- Glaucoma tests
- Hepatitis B shots (Vaccine)
- Hepatitis C screening test
- HIV screening
- Lung Cancer Screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Pneumococcal shots
- Prostate cancer screening
- Sexually-transmitted infections screening and counseling
- Tobacco use cessation counseling

Preventive Services

AD ASTRA

Medicare covers many preventive services to help you stay healthy. Talk to your health care provider about which of these services are right for you.

"Welcome to Medicare" Preventive Visit

- Also called the "Initial Preventive Physical Examination" (IPPE)
- Provided once within first 12 months of getting Part B
- The doctor or health care provider will
  - Review your medical and social history
  - Take your blood pressure, height, weight, and body mass index (BMI)
  - Perform a simple vision test
  - Review risk factors for depression
  - Review functional ability and safety
  - Educate and counsel you to help you stay well
  - Refer you for additional screenings if needed
- You pay nothing if doctor accepts assignment
  - Lab tests aren't included
  - Copayment applies for additional testing such as an electrocardiogram (EKG)

Preventive Services

AD ASTRA

The "Welcome to Medicare" preventive visit, also called the "Initial Preventive Physical Examination" (IPPE), is a great way to get up-to-date information on important screenings and vaccines and to review your medical history. It's only offered one time within the first 12 months of getting Medicare Part B.

During your preventive visit, your doctor or health care provider will perform the following services:

- Review your medical and social history
- Take your blood pressure, height, weight, and body mass index
- Perform a simple vision test
- Review potential risk factors for depression
- Review functional ability and level of safety, which means an assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk, and home safety

You'll get advice to help you prevent disease, improve your health, and stay well. You'll also get a brief written plan (like a checklist), letting you know which screenings and other preventive services you need.

There is no cost if your doctor accepts Medicare assignment.

IMPORTANT: This service is a preventive visit and **not** a routine physical checkup. The "Welcome to Medicare" preventive visit doesn't include any clinical lab tests.

For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf.

Annual “Wellness” Visit

- Can’t be within 12 months of your "Welcome to Medicare" preventive visit
- Focus is on “wellness”
  - It’s not a “routine physical checkup”
- Available once every 12 months
  - After you’ve had Part B for longer than 12 months
  - You’ll pay nothing for this exam if the doctor accepts assignment

Preventive Services

AD ASTRA

After you’ve had Part B for longer than 12 months, you can get an annual "Wellness" visit to develop or update a prevention plan just for you. Medicare covers one annual “Wellness” visit every 12 months.

You don’t need to get the “Welcome to Medicare” preventive visit before getting an annual "Wellness" visit. If you got the “Welcome to Medicare” preventive visit, you’ll have to wait 12 months before you can get your first annual “Wellness” visit.

Medicare will cover an annual “Wellness” visit at no cost to you. You can work with your doctor to develop and update your personalized prevention plan. This benefit provides an ongoing focus on prevention that can be adapted as your health needs change over time.

You’ll pay nothing for this exam if the doctor accepts assignment.

IMPORTANT: The annual "Wellness" visit isn’t a routine physical checkup.

For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf.

Initial Annual "Wellness" Visit Providing Personalized Prevention Plan Services

- Includes
  - Personalized prevention plan
  - Health risk assessment
  - Blood pressure, height, weight, and BMI measurements
  - Review of potential risk factors for depression
  - Review of functional ability and level of safety
  - Written screening schedule
  - Personalized health advice
  - Referrals for health education and preventive counseling to help you stay well
  - Detection of cognitive impairments

Preventive Services

ADASTRA

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop a personalized plan to help prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your health professional will ask you to answer some questions before your visit. This is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your initial "Wellness" visit and all subsequent yearly "Wellness" visits.

During the initial visit, your health care professional will

- Record your blood pressure, height, and weight measurements
- Review your potential risk factors for depression
- Review your functional ability and level of safety, which includes assessing your
- Hearing
- Ability to successfully perform activities of daily living (like walking, eating, etc.)
- Fall risk
- Home safety

You'll also receive advice to help you prevent disease, improve your health, and stay well. You'll get a brief written plan, like a checklist, letting you know which screenings and other preventive services you'll need over the next 5 to 10 years.

Subsequent Annual "Wellness" Visits

- Includes:
  - Updates to your medical/family history
  - Measurements of weight, blood pressure, and other routine measurements
  - Updates to your list of medical providers
  - Detection of cognitive impairments
  - Updates to your written screening schedule as provided in the initial yearly "Wellness" visit with updates to your risk factors and conditions
  - Discussion of personalized health advice
  - Referrals for health education and preventive counseling to help you stay well
  - Updated health risk assessment

Preventive Services

AD ASTRA

Subsequent annual "Wellness" visits providing personalized prevention plan services (PPPS) include the following:

- Updates to your medical/family history
- Measurements of your weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on your medical and family history
- Updates to the list of your current medical providers and suppliers that are regularly involved in your medical care, as was developed at the first yearly "Wellness" visit
- Detection of any cognitive impairment that you may have
- Updates to your written screening schedule as developed at the first yearly "Wellness" visit
- Updates to your list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for you, as was developed at your first yearly "Wellness" visit
- Discussion of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs
- An updated health risk assessment

Abdominal Aortic Aneurysm Screening

- Abdominal aortic aneurysms (weak area bulges)
- One-time ultrasound screening
- You're covered if you have Part B, and you're at risk.
  - You're considered at risk if you meet one of these criteria:
    - Family history of abdominal aortic aneurysms, or
    - Men 65–75 who've smoked more than 100 cigarettes in their lifetime
- No copayment or deductible with Original Medicare
- No longer requires referral from "Welcome to Medicare" preventive visit
  - Can get referral from your doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist at any time

Preventive Services

AD ASTRA

Medicare Part B covers a one-time abdominal aortic aneurysm ultrasound. You must get a referral for it from your doctor.

The aorta is the largest artery in your body. It carries blood away from your heart. When it reaches your abdomen, it's called the abdominal aorta.

The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it's called an abdominal aortic aneurysm (AAA). Aneurysms develop slowly over many years and often have no symptoms. If an aneurysm expands rapidly, tears open (ruptured aneurysm), or blood leaks along the wall of the vessel (aortic dissection), serious symptoms may suddenly develop.

For a one-time screening ultrasound, you must get a referral from your doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist.

You are considered at risk if any of the following apply to you:

- A family history of AAA
- You're a man 65 to 75 and have smoked at least 100 cigarettes in your lifetime
- You're a person with Medicare who has other risk factors in a category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

If any of these apply to you, Medicare covers ultrasound screening for abdominal aortic aneurysms with no deductible or copayment if the doctor accepts assignment.

For more information on risk factors, visit Healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm.

Alcohol Misuse Screening and Counseling

- Annual screening
  - Up to 4 face-to-face counseling sessions if you
    - Misuse alcohol, but don't meet criteria for alcohol dependence
    - Are competent and alert when counseled
  - Counseling must be furnished
    - By a qualified primary care provider
    - In a primary care setting
- Medicare doesn't identify specific screening tool
- No copayment or deductible if your provider accepts assignment

Preventive Services

ADASTRA

Medicare covers an annual alcohol misuse screening. Various screening tools are available to determine alcohol misuse. Medicare doesn't identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

For those who screen positive, Medicare covers up to 4 brief (15-minute), face-to-face behavioral counseling interventions per year for people with Medicare (including pregnant women) who meet the following requirements:

- Misuse alcohol, but whose levels or patterns of alcohol consumption don't meet criteria for alcohol dependence (defined as at least 3 of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; use continues despite adverse consequences)
- Are competent and alert at the time that counseling is provided
- Counseling is furnished by qualified primary care doctors or other primary care practitioners in a primary care setting

A primary care setting is defined as one in which there's provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices aren't considered primary care settings under this definition.

Bone Mass Measurement

- Measures bone density
  - Osteoporosis is a disease that thins and weakens the bones
- Covered if you are at risk for osteoporosis or meet one or more of these conditions
  - You're a woman whose doctor or qualified health care provider determines you're estrogen deficient and at risk for osteoporosis based on your medical history and other findings
  - Your X-rays show possible osteoporosis, osteopenia, or vertebral abnormalities
  - You're taking prednisone or steroid-type drugs for more than 3 months
  - You have primary hyperparathyroidism
  - You're being monitored to assess your response to U.S. Food and Drug Administration-approved osteoporosis drug therapy
- Every 24 months (more often if medically necessary)
- No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

Osteoporosis is a disease in which your bones become weak and are more likely to break. It's a silent disease, meaning that you may not know you have it until you break a bone.

Bone mass measurement is covered once every 24 months, or more often if medically necessary, you are at risk for osteoporosis or meet one or more of these conditions:

- Women whose doctor or qualified health care provider determines she's estrogen-deficient and at risk for osteoporosis based on her medical history and other findings
- Individuals receiving (or expecting to receive) steroid therapy for more than 3 months
- Individuals with X-rays show possible osteoporosis, osteopenia, or vertebral abnormalities
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess their response to U.S. Food and Drug Administration-approved osteoporosis drug therapy

In Original Medicare, there's no cost if provider accepts assignment.

Resource: MedlinePlus medlineplus.gov/osteoporosis.html

Breast Cancer Screening (Mammogram)

- Covered for all women with Medicare
  - One baseline mammogram
    - Between 35 and 39
  - Once a year starting at 40
- No cost if provider accepts assignment

NOTE: Diagnostic mammograms are covered if you have signs/symptoms or history of breast disease

Preventive Services

AD ASTRA

Breast cancer is the most frequently diagnosed non–skin cancer in women, and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age.

A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease. The procedure includes a doctor's interpretation of the results.

Medicare provides coverage of an annual screening mammogram for women with Medicare who are 40 and older. Medicare also provides coverage of one baseline screening mammogram for women ages 35 through 39.

You don't need a doctor's referral, but the X-ray supplier will need to send your test results to a doctor.

In Original Medicare, there's no deductible or copayment if the doctor or qualified health care provider accepts assignment.

Diagnostic mammograms are done to check for breast cancer in men and women after a lump or other sign of breast cancer is found, if you have a history of breast cancer, or if your doctor judges by your history and other significant factors that a mammogram is appropriate. The coinsurance or copayment and the Part B deductible applies for diagnostic mammograms.

Cardiovascular Disease (CVD) Risk Reduction Visit

- One CVD (also referred to as cardiovascular disease) risk reduction visit per year
  - Behavioral therapy
  - Provided by a primary care provider in a primary care setting
- The visit includes these components:
  - Encouraging aspirin use if benefits outweigh risks
  - Screening for high blood pressure
  - Intensive behavioral counseling to promote healthy diet

Preventive Services

AD ASTRA

Medicare covers intensive behavioral therapy for cardiovascular disease (referred to as a CVD risk reduction visit).

Medicare covers one face-to-face CVD risk reduction visit per year for people with Medicare who are competent and alert at the time that counseling is provided. Counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting.

A primary care setting is defined as one in which there's a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices aren't considered primary care settings under this definition.

The CVD risk reduction visit consists of these components:

Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men 45–79 and women 55–79

Screening for high blood pressure in adults 18 or older

Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease

Cardiovascular Disease Screening

- Blood test for early risk detection
  - Heart disease
  - Stroke
- Medicare covers
  - Lipid panel test that includes:
    - Total cholesterol
    - High-density lipoproteins
    - Triglycerides
- Covered once every 5 years
- No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

Medicare covers cardiovascular screening tests that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke.

Lipid panel test that include total cholesterol, high-density lipoproteins (HDL) cholesterol, and triglyceride levels are covered once every 5 years for all people with Medicare who have no apparent signs or symptoms of cardiovascular disease.

In Original Medicare, there's no cost if the provider accepts assignment.

Cervical and Vaginal Cancer Screening

- Pap tests and pelvic exams with clinical breast exam
  - Pap tests help find cervical and vaginal cancer
  - Screening pelvic exam helps find fibroids and ovarian cancers
  - Clinical breast exam helps detect masses, lumps, and breast cancer

AD ASTRA

Preventive Services

Medicare covers Pap tests (Papanicolaou test), pelvic exams, and clinical breast exams.

- The screening Pap test covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a doctor's interpretation of the test.
- A screening pelvic examination is performed to help detect fibroids (benign tumors in women of childbearing age), pre-cancers, genital cancers, infections, sexually transmitted infections (STIs), other reproductive system abnormalities, and genital problems.
- In addition, a Medicare-covered screening pelvic examination includes a clinical breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer.

Cervical and Vaginal Cancer Screening (continued)

- Covered for all women
  - Once every 24 months
  - Once every 12 months, if you're either
    - At high risk for cervical or vaginal cancer
    - Of childbearing age, and had an abnormal Pap test in past 36 months
- Part B also covers human papillomavirus (HPV) tests (as part of Pap tests)
  - Once every 5 years if you're age 30-65 without HPV symptoms
    - No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

These tests are covered services for all women with Medicare, and will usually be performed during the same office visit. These services are covered once every 24 months for most women. However, they may be covered every 12 months if one of the following applies:

- You're at high risk for cervical or vaginal cancer (based on your medical history or other findings)
- You're of childbearing age, and had an abnormal Pap test in the past 36 months

High risk factors for cervical or vaginal cancer include the following:

- Early onset of sexual activity (under 16)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including human immunodeficiency virus)
- Fewer than 3 negative or no Pap tests within the previous 7 years
- DES (diethylstibestrol)-exposed daughters of women who took DES during pregnancy

Part B also covers human papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you're age 30–65 without HPV symptoms.

In Original Medicare, there's no cost if provider accepts assignment.

Colorectal Cancer Screenings

- Helps prevent or find cancer early
- Helps find pre-cancerous growths
- One or more of the following tests may be covered:
  - Screening fecal-occult blood testing
  - Screening flexible sigmoidoscopy
  - Screening colonoscopy
  - Barium enema
  - Multi-target stool DNA test (like Cologuard™)

Preventive Services

AD ASTRA

In the United States, colorectal cancer is the fourth most common cancer in men and women. If caught early, it's often curable.

To help find pre-cancerous growths and help prevent or find cancer early, when treatment is most effective, your doctor may order one or more of the following tests if you meet certain conditions: screening fecal occult blood test; screening flexible sigmoidoscopy, screening colonoscopy; barium enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy), or a multi-target stool DNA test (like Cologuard™).

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or polyps
- Family history of familial polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis
- For people with Medicare at high risk of developing colorectal cancer, the frequency of covered screening tests varies from the frequency of covered screenings for those not considered at high risk.

NOTE: If a polyp or other tissue is found and removed during a screening colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

Colorectal Cancer Screenings

Screening Test	If Normal Risk Covered Once Every	If High Risk, Covered Once Every	You Pay
Screening fecal-occult blood testing age 50 or older	12 months	12 months	No deductible or copayment for this test
Screening flexible sigmoidoscopy age 50 or older	4 years, or 10 years after a previous screening colonoscopy	4 years	No deductible or copayment for this test
Screening colonoscopy No minimum age	10 years (generally) or 4 years after a previous flexible sigmoidoscopy	24 months	No deductible or copayment for this test

Preventive Services

All people with Medicare age 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Fecal-occult blood test every year
- Flexible sigmoidoscopy once every 4 years or 47 months have passed (unless a screening colonoscopy has been performed, and then Medicare may cover a screening sigmoidoscopy after 10 years or at least 119 months)
- Colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed, and then Medicare may cover a screening colonoscopy after at least 4 years have passed) (no minimum age)

All people with Medicare age 50 and older who are at high risk for colorectal cancer are covered for the following screenings:

- Fecal-occult blood test every year
- Flexible sigmoidoscopy once every 4 years (or 47 months have passed)
- Colonoscopy once every 2 years

People with Original Medicare don't pay a copayment or deductible for fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy if the provider accepts assignment.

NOTE: If during the course of a screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, this becomes a diagnostic procedure (G0105). The procedure may be subject to a copayment and/or coinsurance.

Colorectal Cancer Screenings (continued)

Screening Test	If Normal Risk, Covered Once Every	If High Risk, Covered Once Every	You Pay
Barium enema age 50 or older	4 years when used instead of a flexible sigmoidoscopy or colonoscopy	24 months (as an alternative to a covered screening colonoscopy or flexible sigmoidoscopy)	There is no deductible for this test. You pay 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, you pay a copayment.
Multi-target Stool DNA test (like Cologuard™)	3 years	3 years	There is no deductible or copayment for this test.

Preventive Services

All people with Medicare age 50 and older who **aren't** at high risk for colorectal cancer are covered for the following screenings:

- Barium enema every 4 years when used instead of a sigmoidoscopy or colonoscopy
- Multi-target stool DNA test (like Cologuard™) every 3 years

All people with Medicare age 50 and older who are at high risk for colorectal cancer are covered for the following screenings:

- Barium enema every 24 months as an alternative to a covered screening colonoscopy
- Multi-target stool DNA test (like Cologuard™)

People with Original Medicare don't pay a deductible for a screening barium enema, if the provider accepts assignment; however, you pay the Medicare-approved amount for the doctor's services. In a hospital setting, you pay a copayment. There is no deductible or copayment for the multi-target stool DNA test.

Depression Screening

- Annual screening must be done in a primary care setting
  - With staff-assisted depression care supports
    - To ensure accurate diagnosis, effective treatment, and follow-up
- Various screening tools are available
  - Choice of tool at discretion of clinician
- No copayment or deductible if provider accepts assignment

Preventive Services

AD ASTRA

Medicare covers an annual screening for depression (up to 15 minutes) for people with Medicare in primary care settings that have staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

Various screening tools are available for screening for depression. CMS doesn't identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and doesn't include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression. Furthermore, the depression screening doesn’t address therapeutic interventions such as pharmacotherapy (treatment with drugs), combination therapy (counseling and medications), or other interventions for depression.

Among people older than 65, one in 6 suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. It's estimated that 50–75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are limited to: feeling sad or empty, less interest in daily activities, weight loss or gain when not dieting, less ability to think or concentrate, tearfulness, feelings of worthlessness, and thoughts of death or suicide.

You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20% of the Medicare-approved amount for the other service and the Part B deductible may apply.

Diabetes Screening

- For people at risk of
  - High blood pressure
  - High cholesterol and triglyceride levels
  - Obesity
  - History of high blood sugar
  - Family history of diabetes
  - History of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds
- Testing includes fasting blood glucose test
- Talk with your doctor about frequency
  - Up to twice in a 12-month period with certain risk factors or if you're pre-diabetic
  - If not at risk, covered once in a 12-month period
- No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

Diabetes is a disease in which your blood glucose, or sugar levels, are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy.

With Type 1 diabetes, your body doesn't make insulin. With Type 2 diabetes, the more common type of diabetes, your body doesn't make or use insulin well. Without enough insulin, the glucose stays in your blood.

Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes is the leading cause of acquired blindness among adults in the United States. Diabetes can also cause heart disease, stroke, and even the need to remove a limb. Pregnant women can also get diabetes, called gestational diabetes.

Other people at risk are those with high blood pressure, high cholesterol and triglyceride levels, obesity, history of high blood sugar, and a family history of diabetes.

Medicare covers diabetes screenings for all people with Medicare with certain risk factors for diabetes or diagnosed with pre-diabetes. The diabetes screening test includes a fasting blood glucose test.

Talk with your doctor about how often you should get tested. For people with pre-diabetes, Medicare covers a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who've not been diagnosed as pre-diabetic or who've never been tested, Medicare covers one diabetes screening test within a 12-month period. A normal fasting blood sugar level is 100 mg/dL. Diabetes diagnosis occurs at 126 mg/dL, and a person with blood sugar readings between 101–125 mg/dL is considered pre-diabetic.

Medicare provides coverage for diabetes screenings as a Medicare Part B benefit after a referral from a doctor or qualified non-doctor practitioner for an individual at risk for diabetes. You pay nothing for this screening if the provider accepts assignment.

Covered Diabetes Supplies

- Blood sugar testing supplies
- Insulin and related supplies
  - Insulin pumps
  - Therapeutic shoes
- In Original Medicare
  - You pay 20% after Part B deductible if the provider/supplier accepts assignment
- Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022)

Preventive Services

AD ASTRA

Medicare Part B covers some diabetes supplies, including insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.

Insulin associated with an insulin pump is covered by Medicare Part B. Injectable insulin not associated with the use of an insulin pump is covered under Medicare prescription drug coverage (Part D).

In Original Medicare, you pay 20% of the Medicare-approved amount after the yearly Part B deductible for a glucometer, lancets, and test strips.

Medicare provides coverage for diabetes-related durable medical equipment (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier doesn't accept assignment, the amount you pay may be higher. In this case, Medicare will provide you with payment of the Medicare-approved amount.

Continuous glucose monitors (CGMs) monitor a patient's glucose level on a continuous basis (for example, every 5 minutes). Some therapeutic CGMs approved by the FDA are considered DME if used to replace a blood glucose monitor for use in making diabetes treatment decisions. For more information see CMS Ruling-1682-R dated January 12, 2017, at CMS.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf.

For more information, please review Medicare Coverage of Diabetes Supplies & Services (CMS Product No. 11022) at Medicare.gov/Pubs/pdf/11022-Medicare-Diabetes-Coverage.pdf.

Covered Diabetes Services

- Diabetes Self-Management Training (up to 10 hours per calendar year)
  - Up to 2 hours of follow-up training in subsequent years
  - Education about diet and exercise
  - Insulin treatment plan
  - In Original Medicare you pay 20% after the Part B deductible
- Foot Exams and Treatment
  - For diabetes-related nerve damage
  - In Original Medicare you pay 20% after the Part B deductible
  - In a hospital outpatient setting, you also pay the hospital copayment

Preventive Services

AD ASTRA

Medicare provides coverage of diabetes self-management training for people with Medicare who've recently been diagnosed with diabetes, were determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible under Medicare.

Medicare Part B covers up to 10 hours of diabetes outpatient self-management training during a calendar year. It includes education about how to monitor your blood sugar, diet, exercise, and medication. You must get an order from your doctor or qualified provider who's treating your diabetes.

Each session lasts for at least 30 minutes and is provided in a group of 2 to 20 people.

Exception: You can get individual sessions if no group session is available, or if your doctor or qualified provider says you have special needs that would prevent you from participating effectively in group training.

You may also qualify for up to 2 hours of follow-up training each year if any of the following apply:

- Your doctor or a qualified provider ordered it as part of your plan of care
- It takes place in a calendar year after the year you got your initial training
- The Medicare Part B deductible and coinsurance or copayment apply. Some providers must accept assignment.

Medicare also covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Flu Shot (Influenza)

- Influenza, also known as the flu
  - Medicare generally covers the flu shot once every flu season
- All people with Medicare are eligible
- No copayment or deductible for the vaccine with Original Medicare if the provider accepts assignment

AD ASTRA

Preventive Services

Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza can lead to pneumonia.

Medicare Part B provides coverage of one seasonal flu shot per flu season for all people with Medicare. This may mean that people with Medicare may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a doctor determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. For example, if someone gets a flu shot late in the flu season in January 2019, he or she will also be covered if he or she receives a shot in October, November, or December of 2019 because that is the start of a new flu season.

You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

Glaucoma Test

- Glaucoma is caused by increased eye pressure
- Exam covered once every 12 months if at high risk
  - Diabetes
  - Family history of glaucoma
  - African American, and 50 or older
  - Hispanic Americans, and 65 or older
- In Original Medicare you pay
  - 20% of the Medicare-approved amount and the Part B deductible applies for the doctor visit
  - A copayment in a hospital outpatient setting

Preventive Services

AD ASTRA

Glaucoma is an eye disease caused by above-normal pressure in the eye. It usually damages the optic nerve and you may gradually lose sight without symptoms. It can result in blindness, especially without treatment. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

You are considered high risk for glaucoma and eligible for Medicare coverage of the glaucoma test if any of the following apply:

- You have diabetes
- You have a family history of glaucoma
- You are African American, and 50 or older
- You are Hispanic Americans, and 65 or older

An eye doctor who’s legally authorized by the state must perform the test. You pay 20% of the Medicare-approved amount and the Part B deductible applies for the doctor’s visit. In a hospital outpatient setting, you pay a copayment.

NOTE: Medicare doesn't provide coverage for routine eye refractions.

Hepatitis B Shots (Vaccine)

- Hepatitis is a serious disease (virus attacks the liver)
  - Can cause lifelong infection resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death
- Covered for people at medium to high risk, including but not limited to
  - End-Stage Renal Disease, hemophilia, and diabetes mellitus
  - Conditions that lower resistance to infection
  - Certain health care professionals
- No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

Hepatitis B is a serious disease caused by the Hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic (lifelong) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Medicare provides coverage for the Hepatitis B vaccine (series of shots) and its administration for people with Medicare at intermediate or high risk of contracting HBV.

High-risk groups currently identified include the following:

- Individuals with End-Stage Renal Disease (ESRD)
- Individuals with hemophilia who received Factor VIII or IX
- Individuals with diabetes mellitus
- Clients of institutions for the developmentally disabled
- Individuals who live in the same household as an HBV carrier
- Men who have sex with men
- Illicit injectable drug users

Intermediate risk groups currently identified include the following:

- Staff in institutions for the developmentally disabled
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

People with Original Medicare don't pay a copayment or deductible for this vaccine if their providers accept assignment.

Hepatitis C Screening Test

- Hepatitis C virus (HCV) is a serious disease (virus attacks the liver)
  - Can cause chronic liver disease, cirrhosis (scarring of the liver), liver cancer, liver failure, and even death
- Covered when ordered by primary care practitioner in a primary care setting
  - Single, once-in-a-lifetime HCV screening test if born from 1945 to 1965
  - Annually, if high-risk person with continued illicit drug use since prior negative HCV screening test
- No copayment or deductible if your provider accepts assignment

Preventive Services

AD ASTRA

Hepatitis C virus (HCV) is an infection that attacks the liver, and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal liver functions, which leads to liver failure. Cirrhotic livers are more prone to become cancerous, and liver failure leads to serious complications, even death.

This screening is covered when ordered by the primary care practitioner within the context of a primary care setting for people with Medicare who meet either of the following conditions:

A single once-in-a-lifetime screening test is covered for adults who don't meet the high-risk determination, and were born from 1945 through 1965.

Repeat screening for high-risk persons is covered annually only for people who've had continued illicit injection drug use since the prior negative screening test.

The determination of "high risk for HCV" is identified by the primary care doctor or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual "Wellness" visit, and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment. Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care doctor or practitioner.

Human Immunodeficiency Virus (HIV) Screening

- Except for individuals who are pregnant, Medicare covers one annual voluntary HIV screening for people
  - Between the ages of 15 and 65, without regard to perceived risk
  - Younger than 15 and older than 65, who are at increased risk.
  - For people with Medicare who are pregnant, up to 3 voluntary screenings during a pregnancy are covered
- No cost for the test if provider accepts assignment
- Pay 20% of Medicare-approved amount for visit

Preventive Services

Human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV attacks the immune system by destroying a type of white blood cell that is vital to fighting off infection. Once infected, it may take years for recognizable illness to develop. A person may be infected with HIV for years before the condition is suspected.

Except for pregnant women, Medicare covers one annual voluntary HIV screening for people with Medicare between the age of 15 and 65, without regard to perceived risk. Except for pregnant people with Medicare, Medicare will also cover one annual, voluntary screening for people who are younger than 15 or older than 65, who are at increased risk for the infection.

The following people are considered at increased risk for HIV infection:

- Men who have sex with men
- Men and women having unprotected sex
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons who have acquired or request testing for other sexually-transmitted infectious diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request the HIV test despite reporting no individual risk factors
- Persons with new sexual partners
- Persons whose individualized medical history, as properly assessed and documented by an appropriate health care professional, indicates an increased risk for the disease

For people with Medicare who are pregnant, up to 3 voluntary screenings during a pregnancy are covered.

There's no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.

Lung Cancer Screening

- Medicare covers lung cancer screening counseling and shared decision making visit.
- Low-dose computed tomography once per year for people with Medicare who meet all of these criteria:
  - Are 55–77
  - Are either a current smoker or have quit smoking within the last 15 years
  - Have a tobacco smoking history of at least 30 "pack years"
  - Get a written order from their doctor or qualified non-doctor practitioner

August 2017 Preventive Services

AD ASTRA

- Medicare covers lung cancer screening with low-dose computed tomography (x-ray machine scans the body and uses low doses of radiation to make detailed pictures of the lungs) once per year for people with Medicare who meet all of these criteria:
  - Are 55-77,
  - Are either a current smoker or have quit smoking within the last 15 years,
  - Have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years), and
  - Get a written order from their doctor or qualified non-doctor practitioner
- Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

You pay nothing for this service if the primary care doctor or other qualified primary care practitioner accepts assignment.

Resource: cdc.gov/cancer/lung/basic_info/screening.htm

Medical Nutrition Therapy Services

- Medicare covers medical nutrition therapy services and certain related services, which may include
  - An initial nutrition and lifestyle assessment
  - One-on-one nutritional counseling
  - Follow-up visits to check on your progress
- To be eligible, you must have Part B, and meet at least one of the following conditions
  - Have diabetes
  - Have kidney disease
  - Had a kidney transplant in the last 36 months

Preventive Services

AD ASTRA

Medicare Part B covers medical nutrition therapy (MNT) services and certain related services. A registered dietician or nutrition professional who meets certain requirements can provide these services, which may include an initial nutrition and lifestyle assessment, one-on-one nutritional counseling, and follow-up visits to check on your progress in managing your diet.

If you're in a rural area, a registered dietician or other nutritional professional in a different location may be able to provide MNT to you through telehealth.

If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care.

People with Part B who meet at least one of these conditions are eligible:

- Have diabetes
- Have kidney disease
- Have had a kidney transplant in the last 36 months

People with Part B must get a referral from their doctor or qualified non-doctor practitioner for the service. You pay nothing for these services if the doctor or other health care professional accepts assignment.

Obesity Screening and Counseling

- Obesity = body mass index (BMI) ≥ 30 kg/m2
- Intensive behavioral therapy consists of
  - Screening for obesity using BMI measurement
  - Dietary (nutritional) assessment
  - Intensive behavioral counseling and therapy
  - In primary care setting
- Coverage includes
  - One face-to-face visit every week for the first month
  - Then every other week for months 2–6
  - Then every month for months 7–12
    - Must lose 6.6 lbs. in first 6 months to continue
- No cost if primary care doctor/practitioner accepts assignment

Preventive Services

Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m2, is reasonable and necessary for the prevention or early detection of illness or disability. It's appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period.

Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m2)
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions of diet and exercise

For people with Medicare with obesity, who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting, Medicare covers one face-to-face visit every:

- Week for the first month
- Other week for months 2–6
- Month for months 7–12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement as discussed below

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, people must have achieved a reduction in weight of at least 3 kg (6.6 lbs.) over the course of the first 6 months of intensive therapy. This determination must be documented in the doctor's office records, consistent with usual practice. For those who don't achieve a weight loss of at least 3kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

Pneumococcal Shots

- Medicare covers
  - An initial pneumococcal vaccine for all people with Medicare who've never received the vaccine under Medicare Part B
  - A different second pneumococcal vaccine one year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)
- All people with Medicare are eligible
- No copayment or deductible for the vaccines with Original Medicare if the provider accepts assignment

Preventive Services

AD ASTRA

Medicare covers the following:

- An initial pneumococcal vaccine for all people Medicare who've never received the vaccine under Medicare Part B
- A different second pneumococcal vaccine one year after the first vaccine was administered (11 full months have passed following the month in which the last pneumococcal vaccine was administered)

Since the updated Advisory Committee on Immunization Practices recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a person with Medicare who's 65 or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the 2 recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare doesn't require that a doctor of medicine or osteopathy order the vaccines; therefore, people with Medicare may receive the vaccine upon request without a doctor's order and without doctor supervision.

Medicare Part B covers these vaccines. You pay no coinsurance and no Part B deductible in Original Medicare for the vaccine if your health care provider accepts assignment.

Prostate Cancer Screening

- All men are at risk of prostate cancer
- Screening covered for all men with Medicare once every 12 months
  - Beginning the day after 50th birthday
- Tests include
  - Prostate-Specific Antigen (PSA) blood test
  - Digital rectal exam
- In Original Medicare you pay
  - Nothing for the PSA blood (lab) test
  - 20% after Part B deductible for digital rectal exam
  - In hospital outpatient setting, hospital copayment applies

Preventive Services

AD ASTRA

All men are at risk for prostate cancer. However, the causes of prostate cancer aren't yet clearly understood. Through research, several factors have been identified that increase your risk, including the following:

- Family history of prostate cancer
- Men 50 and older
- Diet of red meat and high fat dairy
- Smoking

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer once every 12 months for all men with Medicare 50 and older (coverage begins the day after their 50th birthday). The 2 most common screenings used by doctors to detect prostate cancer are the screening prostate-specific antigen (PSA) blood test and the screening digital rectal examination.

The screening PSA test must be ordered by a doctor. You pay nothing for the screening PSA blood test (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit) although a copayment may apply in a hospital outpatient setting. The Medicare Part B deductible and copayment apply to the digital rectal exam.

Sexually Transmitted Infections (STI) Screening and Counseling

- Covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B
- Covered for pregnant women and for certain people who are at risk
- Covered once every 12 months or at certain times during a pregnancy
- Covers up to 2 individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year
- No cost if the provider accepts assignment

Preventive Services

AD ASTRA

Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people with Medicare who are pregnant, and for certain people who are at increased risk for an STI, when the tests are ordered by a primary care doctor or other primary care practitioner. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare covers up to 2 individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other practitioner, and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment.

Smoking and Tobacco-Use Cessation Counseling

- Medicare covers cessation counseling
  - Two attempts (each attempt includes 4 sessions) of up to 8 face-to-face visits in a 12-month period
  - Inpatient or outpatient
  - Intermediate or intensive
- In Original Medicare you pay
  - No copayment or deductible for these services if the doctor or other health care provider accepts assignment

Preventive Services

AD ASTRA

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare covers counseling to prevent tobacco use for outpatient and hospitalized people with Medicare

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease
- Who are competent and alert at the time that counseling is provided
- Whose counseling is furnished by a qualified doctor or other Medicare-recognized practitioner

Medicare will cover 2 cessation attempts per year. Each attempt may include up to 4 counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period.

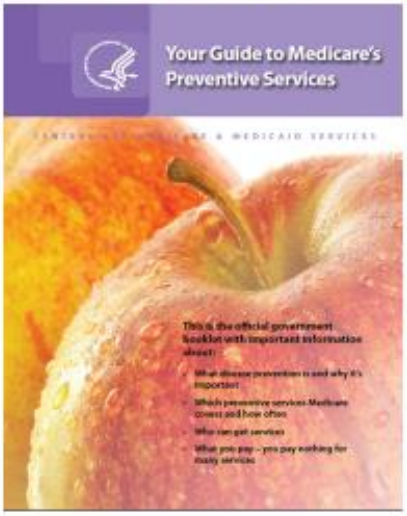
Tobacco cessation counseling services can be provided in the hospital, or on an outpatient basis. However, tobacco cessation counseling services aren't covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (doctor, doctor's assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

Both the copayment and deductible are waived if the counseling sessions are furnished by a doctor or other health care provider who accepts assignment. A copayment may apply in a hospital outpatient setting.

Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a doctor.

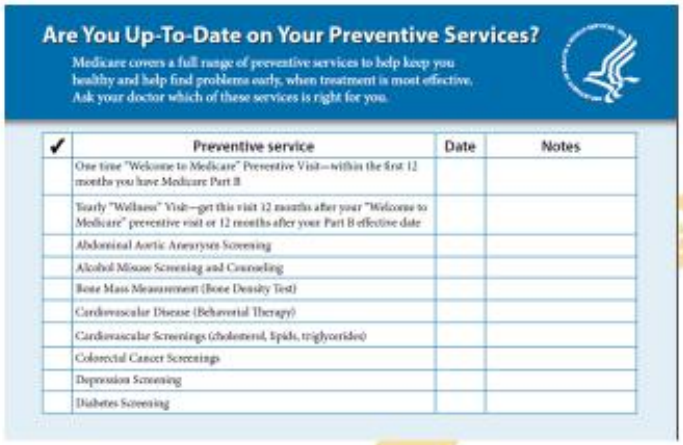
Your Guide to Medicare's Preventive Services

- CMS Product No. 10110



Preventive Services Checklist

- CMS Product No. 10420



Are You Up-To-Date on Your Preventive Services?

Medicare covers a full range of preventive services to help keep you healthy and help find problems early, when treatment is most effective. Ask your doctor which of these services is right for you.

✓	Preventive service	Date	Notes
	One time "Welcome to Medicare" Preventive Visit—within the first 12 months you have Medicare Part B		
	Yearly "Wellness" Visit—get this visit 12 months after your "Welcome to Medicare" preventive visit or 12 months after your Part B effective date		
	Abdominal Aortic Aneurysm Screening		
	Alcohol Misuse Screening and Counseling		
	Bone Mass Measurement (Bone Density Test)		
	Cardiovascular Disease (Behavioral Therapy)		
	Cardiovascular Screenings (cholesterol, lipids, triglycerides)		
	Colorectal Cancer Screenings		
	Depression Screening		
	Diabetes Screening		

Preventive Services

"Your Guide to Medicare's Preventive Services" is a publication written in plain language so that people with Medicare can better understand the preventive benefits that are covered, the criteria for who is covered, the frequency of coverage, and the costs associated with these services. This publication is available at Medicare.gov/Pubs/pdf/10110.pdf.

A helpful checklist is available for people with Medicare. It lists Medicare-covered preventive services and can help them keep track of when they receive those services for which they qualify. This can be found at Medicare.gov/Pubs/pdf/11420.pdf.

Medicare for People With Disabilities

- People with disabilities
  - The fastest-growing Medicare population group
    - About 16% of people with Medicare
  - About 9 million have Part A and/or Part B
  - Are often uninsured before qualifying for Medicare
  - May qualify for both Medicare and Medicaid

A 20-year-old worker has a 1-in-4 chance of becoming disabled before reaching retirement age.

Medicare and Other Programs for People With Disabilities

People with disabilities:

- Represent the fastest-growing group of the Medicare-eligible population
- Make up about 16% of people with Medicare (2015)
- Approximately 9 million have Part A or Part A and Part B (2015)
- Are often uninsured before they qualify for Medicare
- May qualify for both Medicare and Medicaid

Social Security studies show that a 20-year-old worker has a 1-in-4 chance of becoming disabled before reaching retirement age.

For more information, visit kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/ and ssa.gov/disabilityfacts/facts.html.

Defining Disability

- Social Security defines a disability as the
  - Inability to do substantial work because of a medical (physical or mental) condition or combination of impairments, and
  - Inability expected to last at least 12 months or to result in death
- Considers age, education, and work experience
- Visit socialsecurity.gov/disabilityfacts/

Medicare and Other Programs for People With Disabilities

AD ASTRA

To qualify for Medicare based on a disability, an individual must meet the Social Security (SSA) definition of having a disability. SSA defines a disability as the inability to do substantial work because of a medical impairment, which is expected to last at least a year or to result in death.

This is a strict definition of disability. SSA program rules assume that working families have access to other resources to provide support during periods of short-term disabilities, including workers' compensation, insurance, savings, and investments. For more information, visit socialsecurity.gov/disabilityfacts/.

Social Security Programs for People With Disabilities

- Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) Disability
  - Federal programs provide monthly cash benefits for people with disabilities
  - Administered by Social Security (SSA)
  - Programs don't provide monthly cash benefits for people with partial or short-term disability
  - Certain family members of disabled workers can also get monthly cash benefits from SSA

Medicare and Other Programs for People With Disabilities

AD ASTRA

There are two federal programs that provide cash benefits to certain people with disabilities. These programs, administered by Social Security (SSA), include

- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI) Disability

SSA pays benefits to people who meet the strict definition of disability. Unlike some other programs, SSA doesn't give monthly cash benefits to people with partial disability or short-term disability.

Certain family members of disabled workers can also get monthly cash benefits from SSA.

Social Security Disability Insurance (SSDI)

- SSDI pays monthly cash benefits if you meet the Social Security definition of disability
  - To you and certain members of your family
  - If you're insured, meaning you:
    - Worked long enough
    - Worked recently enough
    - Paid SSA taxes
- Monthly cash benefit amount is based on average lifetime earnings

Medicare and Other Programs for People With Disabilities

AD ASTRA

Social Security Disability Insurance pays monthly cash benefits to you and certain members of your family if you're insured—meaning you worked long enough, recently enough, and paid Social Security (SSA) taxes.

Generally, you need 40 credits, 20 of which were earned in the last 10 years ending with the year you become disabled. However, younger workers may qualify with fewer credits.

The monthly cash benefit you're eligible for is based on your average lifetime earnings.

Generally, your disability benefits will continue as long as your medical condition hasn't improved and you can't work. Benefits won't necessarily continue indefinitely. Because of advances in medical science and rehabilitation techniques, many people with disabilities recover from serious accidents and illnesses. If you get benefits, SSA will review your medical condition from time to time to make sure you continue to have a qualifying disability.

Who Can Get Social Security Disability Benefits?

Worker	Widow(er)	Child
▪ You must've paid into Social Security long enough and recently enough. ▪ When you're disabled, members of your family may qualify for benefits based on your record: children, spouse, and divorced spouse.	▪ At 50 if you're a disabled widow(er).	▪ Disabled before 22 and remain disabled. Must be 18 or older and not married.

Medicare and Other Programs for People With Disabilities

The people who can get Social Security Disability Insurance include:

The worker, if he or she paid enough into Social Security (SSA) to qualify

A spouse

- At 62 or older
- At any age if caring for a child who's under 16 or disabled
- At 50 if the person applying is a disabled widow(er)

If something happens to a worker, benefits may be payable to their widow, widower or surviving divorced spouse with a disability if the following conditions are met:

- He or she is between ages 50 and 60,
- Their condition meets the definition of disability for adults, and
- The disability started before or within seven years of the worker's death

Divorced spouses may qualify if

- Married to the worker for at least 10 years
- Unmarried
- Not entitled to a higher Social Security benefit on his or her own record

A child

- A child under 18 may be disabled, but SSA doesn't need to consider the child's disability when deciding if he or she qualifies for benefits as a person's dependent. The child's benefits normally stop at 18, unless he or she is a full-time student (benefits can continue until 19), or is disabled
- Not married and disabled before 22

Waiting Period for Social Security Disability Insurance (SSDI)

- There's a 5-month waiting period from the time disability began until SSDI benefits begin
  - Except people eligible for childhood disability benefits

    AND
  - Some people who were previously entitled to disability benefits (in the past 5 years)

Medicare and Other Programs for People With Disabilities

AD ASTRA

In most cases, there's a waiting period of 5 full calendar months from the time your disability began, until your Social Security Disability Insurance benefits can begin. Once your application is approved, you'll get your first Social Security benefit starting on the 6th full month after the date your disability began.

- If SSA decides your disability began on January 15, your first disability benefit would be paid for the month of July.
- Social Security benefits are paid during the month after the month in which they're due, so you'd get your July benefit check in August.

The 5-month waiting period for cash benefits doesn't apply to people who get childhood disability benefits, or to some people who were previously entitled to disability benefits (in the past 5 years).

Qualifying for Supplemental Security Income (SSI) Disability

- Generally, to be eligible for SSI, you must
  - Be 65 or older, blind, or disabled
  - Have limited income and resources
    - Less than $2,000 in resources for an individual, less than $3,000 for a married couple
  - Be a citizen or national of the United States, or qualified alien, and
  - Reside in 1 of the 50 states, the District of Columbia, or the Northern Mariana Islands

Medicare and Other Programs for People With Disabilities

AD ASTRA

Generally, to be eligible for Supplemental Security Income, you must

- Be 65 or older, blind, or disabled
- Have limited income and resources—less than $2,000 in resources for an individual and less than $3,000 for a married couple
- Be a U.S. citizen or national, or a qualified alien (lawfully present non-citizen who was lawfully residing in the United States on August 22, 1996)
- Reside in 1 of the 50 states, the District of Columbia, or the Northern Mariana Islands

Qualifying for Medicare Based on Disability

- Medicare usually begins after getting Social Security Disability Insurance (SSDI) for 24 months
  - Unless you have Amyotrophic Lateral Sclerosis
    - Medicare begins first month entitled to SSDI
- Generally, this means you get Medicare in the 30th month after you become disabled
  - 5-month waiting period for SSDI benefits
  - Followed by 24-month waiting period for Medicare

Medicare and Other Programs for People With Disabilities

AD ASTRA

Medicare also covers 2 groups of individuals under 65:

- People under 65 with a disability who have been entitled to Social Security (SSA) benefits for 24 months.
- People with End-Stage Renal Disease (ESRD) who have earned at least 6 work credits (or are the dependent child or spouse of someone who has earned 6 work credits) in a period of 13 calendar quarters ending with the quarter of ESRD onset. People with ESRD don't need to be entitled to Social Security benefits to qualify for Medicare. However, if they're also entitled to disability benefits, they may qualify under both programs.

In most cases, you must be entitled to disability benefits for 24 months before Medicare can begin. Since there is a 5-month waiting period for Social Security Disability Insurance, the earliest that Medicare can start is usually the 30th month after you become disabled. However, there are 2 exceptions:

- The 5-month waiting period for cash benefits doesn't apply to people who get childhood disability benefits, or to some people who were previously entitled to disability benefits (in the past 5 years).
- The 24-month Medicare waiting period doesn't apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig's Disease). People with ALS get Medicare the first month they're entitled to disability benefits.

Automatic Enrollment in Medicare

- You're automatically enrolled in Medicare if you qualify based on disability
- You'll get an Initial Enrollment Period package
  - 3 months before 25th month of disability benefits
  - If you have Amyotrophic Lateral Sclerosis—about 4 weeks after Medicare entitlement
- You need to decide whether to
  - Keep Part B
  - Enroll in Part D

Medicare and Other Programs for People With Disabilities

AD ASTRA

You'll automatically get Part A and Part B 24 months after you get disability benefits from Social Security (SSA), or certain disability benefits from the Railroad Retirement Board. If you have Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease), you'll automatically get Part A and Part B the month your disability benefits begin.

You'll get your red, white, and blue Medicare card in the mail 3 months before your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums. If you don't keep Part B and decide to enroll later, you'll likely pay a late enrollment penalty. Call SSA at
1-800-772-1213 if your card doesn't arrive.

Having employer or union coverage while you or your spouse (or family member, if you're disabled) is still working can affect your Part B enrollment. You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment. In certain situations, when you're enrolled in Part A, you must also be enrolled in Part B, like if

- You want to buy a Medicare Supplement Insurance (Medigap) policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE
- Your employer coverage requires you or your spouse or family member to have it (talk to your employer's or union's benefits administrator)

Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan (Part D). If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty if you join a plan later.

Retroactive Entitlement to Medicare

- In some cases, your entitlement to Medicare may be retroactive, like, if
  - You win an appeal of your disability determination
  - It takes a long time to process your application
  - Your disability benefits are retroactive
- Your Medicare card will show effective date
  - If you got Medicare-covered services before you got your Medicare card
    - You may request that your provider submit those claims to Medicare
    - The date of service can't be before the effective date on your Medicare card

Medicare and Other Programs for People With Disabilities

AD ASTRA

In some cases, a disability determination may be made based on an appeal, giving you an earlier date of entitlement to disability benefits. In other cases, if your application isn't processed in a timely manner, you may be entitled to retroactive Medicare Part A coverage.

In some cases, your entitlement to Medicare may be retroactive:

- If your disability benefits are retroactive
- Your Medicare card will show effective date

If you got Medicare-covered services before you got your Medicare card, you may request that your provider submit those claims to Medicare. The date of service can't be before the effective date on your Medicare card.

Information Received With Retroactive Determination

- You'll get this information with your determination:
  - Your effective date of Part A coverage (the 25th month of disability benefit entitlement)
  - Your effective date of Part B coverage (the month of processing), and the option to choose Part B coverage starting with the 25th month of disability benefit entitlement
    - To exercise your option to get retroactive Part B coverage you must submit a written request and agree to pay all retroactive premiums due

Medicare and Other Programs for People With Disabilities

ADASTRA

You'll get this information with your determination:

- Your effective date of Part A coverage (the 25th month of disability benefit entitlement)
- Your effective date of Part B coverage (the month of processing), and the option to elect Part B coverage starting with the 25th month of disability benefit entitlement

To exercise your option to get retroactive Part B coverage, you must submit a written request and agree to pay all retroactive premiums due. If you choose retroactive Part B coverage, you'll get a second letter stating that you have retroactive Part B coverage. The letter also gives instructions for the provider to file Part B claims outside the timely filing limit.

Regardless of the situation, your Part A start date will always be the 25th month after your disability benefit is approved. Your Part B start date will be the 25th month after your disability benefit is approved, if, at the time the disability application is processed, you owe less than 6 months of previous Part B premiums. If you owe 6 or more months of premiums, Part B becomes effective the month your disability application is processed.

NOTE: Because there's uncertainty in determining the Initial Enrollment Period (IEP) for an individual filing for re-entitlement to disability benefits, the Part B enrollment request is deemed to have been filed in the 3rd month of the IEP. This ensures that you have the opportunity for coverage at the earliest possible date.

How Long Are You Entitled to Medicare?

- As long you meet the SSA definition of disability
- SSA has work incentives if you go back to work and are still disabled
  - You can get premium-free Part A for 8½ years after you return to work
  - You may purchase Part A coverage afterward
  - Continue paying premiums to keep your Part B
- The reason your Medicare entitlement changes at 65
  - Any penalty you may have had for late enrollment is removed at that time

Medicare and Other Programs for People With Disabilities

You're entitled to Medicare as long as you continue to meet the requirements for Social Security disability benefits. If Social Security (SSA) determines that your disability benefits should be stopped because your condition has improved and you're no longer considered disabled, your Medicare will end the same month your disability benefits end.

SSA has work incentives to support people who are still medically disabled but try to work. Continuation of Medicare coverage is a type of incentive.

- You may have at least 8½ years of extended Medicare coverage if you return to work. Medicare continues even if SSA determines you can no longer get cash benefits because you earn too much.
- If, after you've exhausted your 8½ years of extended Medicare coverage, you continue to work and continue to have a disability, you may buy Part A, or Part A and Part B for as long as you continue to be disabled. This is called "Medicare for the Working Disabled." In some cases, your state may help you pay your Part A premiums. See slide 45 for more information.
- If you were paying an increased Part B premium during the time you were getting premium-free Part A, but now are eligible for Part B because you're enrolling in Part A for the working disabled, your Part B penalty can be removed.

If you're getting Medicare based on disability when you reach 65, you'll have continuous coverage with no interruption. You'll get Part A for free, even if you've been buying it. However, the reason for your Medicare entitlement changes from disability to age. If you didn't have Part B when you were disabled, you'll automatically be enrolled in Part B when you turn 65, and will again be able to decide whether or not to keep it. If you don't enroll in Part B when first eligible, and you don't qualify for a Special Enrollment Period (SEP), you may have to pay a late enrollment penalty for as long as you have Part B. Your Part B premium may be increased 10% for every full 12 month period in which you could've been enrolled in Part B but weren't. If you were paying a Part B late enrollment penalty while you were disabled, the penalty will be removed when you reach 65.

Create a "*my* Social Security" Account (socialsecurity.gov/myaccount)

- Request a replacement Social Security card (if you meet certain requirements)
- Check the status of your application or appeal
- Keep track of your earnings (verify them every year)
- Get an estimate of your future benefits if you're still working
- Get a letter with proof of your benefits if you currently get them
- Manage your benefits
  - Change your address and phone number
  - Start or change your direct deposit
- Get a replacement Medicare card
- Get replacement SSA-1099 (Social Security income) or SSA-1042S (Social Security income for non citizens) tax forms

Medicare and Other Programs for People With Disabilities

AD ASTRA

Even if you don't have a disability, you probably plan to get Social Security benefits someday. You'll want a my Social Security account to

- Request a replacement Social Security card (if you meet certain requirements)
- Check the status of your application or appeal
- Keep track of your earnings (verify them every year)
- Get an estimate of your future benefits if you're still working
- Get a letter with proof of your benefits if you currently get them
- Manage your benefits

Change your address and phone number
Start or change your direct deposit

- Get a replacement Medicare card
- Get replacement SSA-1099 (Social Security income) or SSA-1042S (Social Security income for non-citizens) tax forms. These forms are not available for people who get Supplemental Security Income (SSI).

In addition, Social Security (SSA) also has a factsheet to help you or others create an account at ssa.gov/pubs/EN-05-10540.pdf.

Medicare for People with End-Stage Renal Disease

This session should help you

- Define End-Stage Renal Disease (ESRD)
- Explain Medicare eligibility and enrollment rules for those with ESRD
- Determine what's covered under Medicare
- Identify coverage options for people with ESRD

Medicare for People with ESRD

AD ASTRA

This session should help you

- Define End-Stage Renal Disease (ESRD)
- Explain Medicare eligibility and enrollment rules
- Determine what's covered under Medicare
- Identify coverage options for people with ESRD

NOTE: From this point on we will use the acronym ESRD when discussing End-Stage Renal Disease.

ESRD Basics

- ESRD – permanent kidney failure that requires a regular course of dialysis or a kidney transplant
- Dialysis – treatment that cleans your blood when your kidneys don't work
- Kidney transplant – surgery that puts someone else's healthy kidney into your body
- You may be eligible for Medicare based on ESRD
  - Expanded coverage for people with ESRD began in 1973

Medicare for People with ESRD

AD ASTRA

End-Stage Renal Disease (ESRD) is defined as permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful waste, extra salt, and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments may help you feel better and live longer, but they aren't a cure for permanent kidney failure.

A kidney transplant is a type of surgery that puts someone else's healthy kidney into your body. This donated kidney does the work that your own kidneys can no longer do. You may get a kidney from someone who has recently died, or from someone who's still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested to see how well they match yours so that your body won't reject the new kidney. To be covered by Medicare, your kidney transplant must be done in a hospital that's Medicare-certified to do kidney transplants.

There are 5 stages of chronic kidney disease (CKD). The National Kidney Foundation developed guidelines to help identify the levels of kidney disease. If you have Stage 5 CKD, you may be eligible for Medicare based on ESRD. Visit kidney.org/atoz/content/about-chronic-kidney-disease for more information about CKD, and kidney.org/sites/default/files/01-10-7278_HBG_CKD_Stages_Flyer3.pdf to learn more about the 5 stages of CKD.

In 1972, Medicare was expanded to include 2 new groups of people—people with certain disabilities, and those with ESRD. The expanded coverage began in 1973.

Eligibility for Medicare Part A (Hospital Insurance) Based on ESRD

- You can get Medicare no matter how old you are if
  - Your kidneys no longer work, and
  - You need regular dialysis or have had a kidney transplant, and
  - One of these applies to you:
    - You've worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee
    - You're already getting or are eligible for Social Security or RRB benefits
    - You're the spouse or dependent child of a person who meets either of the requirements listed above

Medicare for People with ESRD

ED ASTRA

You can get Medicare no matter how old you are if your kidneys no longer work, you need regular dialysis, or have had a kidney transplant, and one of these applies to you:

- You've worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee
- You're already getting or are eligible for Social Security or RRB benefits
- You're the spouse or dependent child of a person who meets either of the requirements listed above

You must also file an application and meet any deadlines or waiting periods that apply.

Review "Medicare for Children With End-Stage Renal Disease: Getting Started" (CMS Product No. 11392) at Medicare.gov/Pubs/pdf/11392-Medicare-Children-ESRD.pdf for more information on children with ESRD.

Medicare Part B (Medical Insurance) Eligibility

- You can enroll in Part B if you're entitled to Part A
  - You pay the monthly Part B premium
    - You may have to pay a late enrollment penalty if you delay Part B
- You need both Part A and Part B for complete coverage
- For more information on enrollment and eligibility
  - Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778
  - Railroad retirees call the RRB at 1-877-772-5772; TTY: 1-312-751-4701
- You may be able to get help from Medicaid paying for your dialysis treatments if you don't qualify for Medicare

Medicare for People with ESRD

AD ASTRA

If you qualify for Medicare Part A (Hospital Insurance), you can also get Medicare Part B (Medical Insurance). Enrolling in Part B is your choice and isn't automatic. If you don't enroll in Part B when you get Part A, you must wait until a General Enrollment Period (GEP) (January 1–March 31 each year) to apply, and you may have to pay a late enrollment penalty. Coverage would start July 1. You will get an Initial Enrollment Period (IEP) when you turn 65. You'll need both Part A and Part B to get the full benefits available from Medicare to cover certain dialysis and kidney transplant services.

Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD, and for more information about the amount of work and earnings needed under Social Security or as a federal employee to be eligible for Medicare. You can contact Social Security at socialsecurity.gov or 1-800-772-1213; TTY: 1-800-325-0778. If you work or worked for a railroad, call the RRB at 1-877-772-5772; TTY: 1-312-751-4701.

If you don't qualify for Medicare, you may be able to get help from your State Medical Assistance (Medicaid) office to pay for your dialysis treatments. Your income must be below a certain level to get Medicaid. In some states, if you have Medicare, Medicaid may pay some of the costs that Medicare doesn't cover. To apply for Medicaid, talk with the social worker at your hospital or dialysis facility, or contact your State Medical Assistance (Medicaid) office.

For dialysis information, visit Medicare.gov/people-like-me.

How to Enroll in Part A and Part B

- Enroll at your local Social Security office
- Get your doctor/dialysis facility to complete the "End-Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration" form (Form CMS-2728)
  - If Social Security gets the form before you enroll, they may contact you to see if you want to enroll

AD ASTRA

Medicare for People with ESRD

You can enroll in Medicare Part A and Part B based on End-Stage Renal Disease (ESRD) at your local Social Security office. Social Security will need your doctor or the dialysis facility to complete the "End-Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration" form (Form CMS-2728) to document that you have ESRD and can get Medicare. If Form CMS-2728 is sent to Social Security before you apply, they may contact you to ask if you want to complete an application.

NOTE: If you're already enrolled in Medicare based on age or disability, and you're already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible, the penalty will stop when you become eligible for Medicare based on ESRD.

Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778 to make an appointment to enroll in Medicare based on ESRD.

Delaying Medicare Part B

- If you enroll in Part A and delay enrolling in Part B, you
  - Must wait for a General Enrollment Period (GEP) to enroll (January 1 to March 31 each year, coverage effective July 1 of the same year)
  - May have to pay a higher premium for as long as you have Part B (10% for each 12-month period you were eligible, but not enrolled)
- No Special Enrollment Period (SEP) for those with ESRD
- There are shorter time periods for eligibility and enrollment for transplant recipients

Medicare for People with ESRD

AD ASTRA

If you enroll in Part A and wait to enroll in Part B, you may have a gap in coverage since most expenses incurred for ESRD are covered by Part B rather than Part A. You'll only be able to enroll in Part B during a General Enrollment Period (GEP), January 1 to March 31 each year, with Part B coverage effective July 1 of the same year.

In addition, your Part B premium may be higher. This late enrollment penalty is 10% for each 12-month period you were eligible but not enrolled.

There's no Special Enrollment Period (SEP) for Part B if you have ESRD. This includes individuals who are dually entitled to Medicare based on ESRD and age or disability.

If you plan to get a kidney transplant, get the facts about eligibility and enrollment. There are shorter time periods for eligibility and enrollment for transplant recipients.

For more information, visit secure.ssa.gov/poms.nsf/lnx/0600801247.

Enrolling in Medicare Part B

- Enrollment based on ESRD may eliminate your Part B penalty if you already had Medicare due to age or disability
  - If you didn't enroll when you were first eligible
- If you have Medicare due to ESRD and turn 65
  - You have continuous coverage
  - Those not enrolled in Part B will be automatically enrolled
    - You can decide whether or not to keep it

Medicare for People with ESRD

AD ASTRA

If you're already enrolled in Medicare based on age or disability, and you're already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible, you'll no longer have to pay the penalty when you get Medicare based on End-Stage Renal Disease (ESRD). You'll still have to pay the Part B premium. Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

If you're already getting Medicare benefits based on ESRD when you turn 65, your coverage won't be interrupted, as long as you meet the eligibility criteria for Medicare based on age. If you didn't have Part B before you turned 65, you'll automatically be enrolled in Part B when you turn 65, but you can decide whether or not to keep it.

When Medicare Coverage Starts Based on ESRD

Your Coverage Starts	Under the Following Circumstances
1st day of the 4th month	You get a regular course of dialysis in a facility
First month	You participate in a home dialysis training program during the first 3 months of your regular course of dialysis (with expectation of completion)
1st day of the month	You get a kidney transplant
Same month	You're admitted to a Medicare-certified hospital for a kidney transplant (or for health care services that you need before your transplant) if your transplant takes place in the same month or within the next 2 months
2 months before the month of your transplant	Your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant **or** for health care services you need before the transplant

NOTE: If you're eligible for Medicare based on ESRD and don't enroll right away, you may be eligible for up to 12 months of retroactive coverage, once you're enrolled in Medicare.

Medicare for People with ESRD

Medicare coverage usually starts on the 1st day of the 4th month of a regular course of dialysis.

Coverage can begin the first month of a regular course of dialysis treatments if you meet all of these conditions:

- You participate in a home dialysis training program offered by a Medicare-approved training facility during the first 3 months of your regular course of dialysis
- Your doctor expects you to finish training and be able to do your own dialysis treatments

NOTE: Medicare won't cover surgery or other services needed to prepare for dialysis (like surgery for a blood access (fistula)) before Medicare coverage begins. However, if you complete home dialysis training, your Medicare coverage will start the month you begin regular dialysis, and these services could be covered. If you're already receiving Medicare due to age or disability, Medicare will cover physician-ordered fistula placement or other preparatory services before dialysis begins.

Medicare coverage can begin the month you're admitted to a Medicare-certified hospital for a kidney transplant (or health care services that you need before your transplant) if your transplant takes place in that same month or within the next 2 months.

Medicare coverage can start 2 months before the month of your transplant if your transplant is delayed more than 2 months after you're admitted to the hospital for the transplant, **or** for health care services you need before your transplant.

NOTE: If you're eligible for Medicare based on ESRD and don't enroll right away, you may be eligible for up to 12 months of retroactive coverage, once you're enrolled in Medicare. For more information on how the 12-month period of retroactive coverage works, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

Medicare and Group Health Plan (GHP) Coverage (30-Month Coordination Period)

- If Medicare eligibility is based solely on ESRD
  - Your coverage can't start until the 4th month of dialysis ("waiting period")
  - Your GHP/employer coverage is the only payer during the first 3 months of dialysis treatments
- Once you get Medicare coverage based on ESRD (fourth month of dialysis)
  - Your GHP/employer will pay first on your hospital and medical bills for 30 months (whether or not you're enrolled in Medicare)
  - Medicare will pay second ("30-month coordination period")

NOTE: There's a separate 30-month coordination period each time you enroll in Medicare based on ESRD.

Medicare for People with ESRD

AD ASTRA

If you're eligible for Medicare based solely on ESRD, your coverage usually can't start until the 4th month of dialysis (also known as the "waiting period"). Therefore, Medicare generally won't pay for anything during your first 3 months of dialysis (unless you already have Medicare based on age or disability). If you're covered by a group health plan (GHP), that plan is generally the only payer for the first 3 months of a regular course of dialysis (unless you have other coverage).

Once you have Medicare coverage because of ESRD (usually the fourth month of dialysis), your GHP will pay first on your hospital and medical bills for 30 months, whether or not you're enrolled in Medicare. During this time, Medicare will pay second, if you're enrolled in Medicare. This is called the "30-month coordination period."

Your GHP pays first during this period no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare pays first. This rule applies to most people with ESRD, whether you have your own GHP coverage, or you're covered as a family member.

Enrollment Considerations—30-Month Coordination Period

- You may want Medicare during the 30-month coordination period to
  - Pay the GHP yearly deductible, coypayment, coinsurance
- If you're getting a transplant soon
  - Affects coverage for immunosuppressive drugs
  - There's coverage for a living donor (see slide 30)
- Delaying Part B or Part D could mean
  - Waiting for an applicable enrollment period to enroll
  - Possible penalty for late enrollment

Medicare for People with ESRD

AD ASTRA

- The 30-month coordination period starts the first month you're able to get Medicare, even if you haven't signed up yet.
- If you're covered by a GHP, you generally have two options—get Medicare during the 30-month coordination period, or delay applying until after the coordination period.
- Here are some things to consider for each option:
- You may want Medicare during the 30-month coordination period to
- Pay the GHP yearly deductible, copayment, coinsurance
- If you're getting a transplant soon
- Affects coverage for immunosuppressive drugs
- There's coverage for a living donor
- Delaying Part B or Part D could mean
- Waiting for an applicable enrollment period to enroll
- Possible penalty for late enrollment
- If you have employer or union group health plan coverage, tell your health care provider that you have this coverage. This is very important to make sure that your services are billed correctly. At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may still pay for services not covered by Medicare. Check with your plan's benefits administrator.

Enrollment Considerations—30-Month Coordination Period (continued)

- You may want to consider delaying Medicare if your GHP pays all of your health care costs with no deductible or coinsurance
  - If you pay a deductible or coinsurance under your GHP, enrolling in Medicare Part A and Part B could pay those costs
- If you enroll in Part A, but delay Part B, you won't pay the Part B premium during this time
- If you enroll in Part A, but delay Part D (Medicare prescription drug coverage), you don't have to pay a Part D premium during this time

Medicare for People with ESRD

AD ASTRA

If you're covered by a GHP, you may want to delay applying for Medicare. Here are some things to consider, if your GHP pays all of your health care costs with no deductible or coinsurance, you may want to delay enrolling in Medicare until shortly before the 30-month coordination period ends to avoid a break in coverage. Many GHPs will cut off primary payment after the 30th month.

- If you pay a deductible or coinsurance under your GHP, enrolling in Medicare Part A and Part B could pay those costs.
- If you enroll in Part A, but delay Part B, you won't pay the Part B premium during this time. However, you'll have to wait until the next GEP (January 1–March 31) to enroll (coverage effective July 1) and your Part B premium may be higher for late enrollment.
- If you enroll in Part A, but delay Part D (Medicare prescription drug coverage), you don't have to pay a Part D premium during this time. You may have to wait until the next Open Enrollment Period (OEP) to enroll (from October 15–December 7, with coverage effective January 1) and you may have to pay a lifetime late enrollment penalty if you don't have other creditable drug coverage (drug coverage that is expected to pay on average as much as standard Medicare prescription drug coverage).

Enrollment Considerations—Immunosuppressive Drugs

If You	Your Immunosuppressive Drugs
Are entitled to Part A at time of transplant **and** ▪ Medicare paid for your transplant and the transplant took place in a Medicare-approved facility, **or** ▪ Medicare was secondary payer but made no payment	Are covered by Part B ▪ Medicare pays 80% ▪ You pay 20% • If you have Part D, your Part B coinsurance costs don't count toward Part D catastrophic coverage (TrOOP)
Didn't meet the transplant conditions above	May be covered by Part D (unless you would be covered by Part B, if you had it) ▪ Costs vary by plan ▪ Helps cover drugs needed for other conditions

Medicare for People with ESRD

Immunosuppressive drug therapy is only covered by Medicare Part B if you were entitled to Part A at the time of a kidney transplant, provided that

- The transplant was performed in a Medicare-approved facility, and
- Medicare made a payment for the transplant, or
- If Medicare made no payment, Medicare was the secondary payer

Medicare entitlement ends 36 months after a successful kidney transplant if ESRD is the only reason for Medicare entitlement (i.e., the person isn't 65 or older and doesn't get disability from Social Security or the Railroad Retirement Board (RRB)). Enrolling in Part D (Medicare prescription drug coverage) doesn't change this period.

If Part B covers these drugs, and you have a Part D plan, the Part B coinsurance costs don't count toward your Part D catastrophic coverage (true out-of-pocket costs (TrOOP)).

People who don't meet the conditions for Part B coverage of immunosuppressive drugs may be able to get coverage by enrolling in Part D. However, Part D won't cover immunosuppressive drugs if they would be covered by Part B, if you had it.
Part D could help pay for outpatient drugs needed to treat other medical conditions, like high blood pressure, uncontrolled blood sugar, or high cholesterol.

When Coverage for ESRD Ends or Continues

- When coverage ends
  - Entitlement based solely on ESRD
    - Coverage ends 12 months after the month you no longer require a regular course of dialysis, **or**
    - 36 months after the month of your kidney transplant
- When coverage continues
  - No interruption in coverage (and no new application is necessary) if
    - You start a regular course of dialysis again or get a kidney transplant **within** 12 months after regular dialysis stopped, or
    - You start a regular course of dialysis or get another transplant **within** 36 months after transplant

Medicare for People with ESRD

ADASTRA

If you're eligible for Medicare coverage based solely on ESRD, your Medicare coverage will *end*

- 12 months after the month you stop a regular course of dialysis treatments, **or**
- 36 months after the month you have a kidney transplant

Medicare coverage will *continue* without interruption if

- You start a regular course of dialysis again, or get a kidney transplant **within** 12 months after you stopped getting a regular course of dialysis, **or**
- You start a regular course of dialysis or get another kidney transplant **within** 36 months after a transplant

It's important to note that for coverage to continue, it isn't necessary to file a new application.

When Coverage for ESRD Resumes

- You must file a new application for your Medicare coverage to resume if
  - You start dialysis again, or you get a kidney transplant more than 12 months after the month you stopped getting dialysis
  - You start dialysis or get another kidney transplant within 36 months after the month you get a kidney transplant

Medicare for People with ESRD

AD ASTRA

Medicare coverage will *resume* with no waiting period if

- You start a regular course of dialysis again or get a kidney transplant **more than** 12 months after you stopped getting a regular course of dialysis, **or**
- You start a regular course of dialysis or get another kidney transplant **more than** 36 months after the month of a kidney transplant

It's important to note that for coverage to resume, you must file a new application for this new period of Medicare entitlement, which means you must go back to Social Security with another Form CMS-2728 from your doctor.

What Medicare Covers for People With ESRD

- All services covered by Original Medicare
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)
- Special services for ESRD (dialysis and transplant patients)
  - Immunosuppressive drugs
    - Under certain conditions
  - Other special services

Medicare for People with ESRD

AD ASTRA

As a person entitled to Medicare based on ESRD, you're entitled to all Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) services covered under Original Medicare. You may also choose to get the same prescription drug coverage (Part D) as any other person with Medicare.

In addition, special services are available for people with ESRD. These include coverage for immunosuppressive drugs for transplant patients, as long as certain conditions are met (described earlier), and other services for transplant and dialysis patients.

Visit Medicare.gov/coverage/dialysis-services-and-supplies.html for more information on covered services and supplies.

Covered Dialysis Services

- Covered under Part A
  - Inpatient dialysis treatments
- Covered under Part B
  - Outpatient dialysis treatments
  - Outpatient doctors' services
  - Home dialysis training
  - Home dialysis equipment and supplies
  - Certain home support services
  - Most drugs for home and in-facility dialysis
  - Other services and supplies that are a part of dialysis

Medicare for People with ESRD

AD ASTRA

If you have Medicare based on ESRD, your covered treatments and services are covered by Part A or Part B, and may include the following:

- Part A—Inpatient dialysis treatments (if you're admitted to a hospital for special care)
- Part B
  - Outpatient dialysis treatments (if you get treatments in a Medicare-approved dialysis facility)
  - Outpatient doctors' services
  - Home dialysis training (includes instruction for you and the person helping you with your home dialysis treatments)
    - Home dialysis equipment and supplies (like the machine, water treatment system, basic recliner, alcohol, wipes, sterile drapes, rubber gloves, and scissors)
    - Certain home support services (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and to check on your dialysis equipment and water supply)
    - Most drugs for home and in-facility dialysis
    - Other services and supplies that are a part of dialysis (like laboratory tests)

For more details on Medicare for People with End-Stage Renal Disease (ESRD), you can review Module 6 Medicare for People with End-Stage Renal Disease (ESRD) on the CMS National Training site, https://cmsnationaltrainingprogram.cms.gov/resources.

Course Completion

- Thank you for completing this pre-training course!
- You have reviewed the following:
  - Medicare Core Basics
  - Medicare Part A
  - Medicare Part B
  - Preventive Benefits
  - Medicare for People with Disabilities
  - Medicare for People with ESRD
- You should now follow the instructions on the next page to complete the course exam.

AD ASTRA

Course Examination

- Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/
- Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 1 Exam.
- After successful completion of the Course 1 Exam, continue to *Course 2 Introduction to Medicare Part C (Advantage), Medicare Part D, and Medigap*, covering Medicare Part C, Medicare Part D, and Medicare Supplement Insurance (Medigap)

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