USING YOUR MEDICARE COVERAGE

Know your coverage start date which depends on when you signed up. Once you sign up for Medicare, you will receive a Medicare card with your welcome packet. If you elected Part D, a Medicare Supplement or Medicare Advantage, you will receive separate insurance cards for those coverages. You will next check if your provider accepts Medicare (or Advantage plan if applicable) and be aware of services covered vs. not covered. If applicable, also coordinate benefits with other health coverage you may have as there are rules that decide which one pays first. Be sure to tell providers about all medical and drug insurance plans you have to ensure your bills are paid in the correct order.

Coverage always starts on the first day of the month, but which month depends on when you signed up:

INITIAL ENROLLMENT PERIOD

If you qualify for premium-free Part A, your Part A coverage starts the month you turn 65. If your birthday is on the first of the month, coverage starts the month before you turn 65. Part B coverage starts based on the month you sign up.

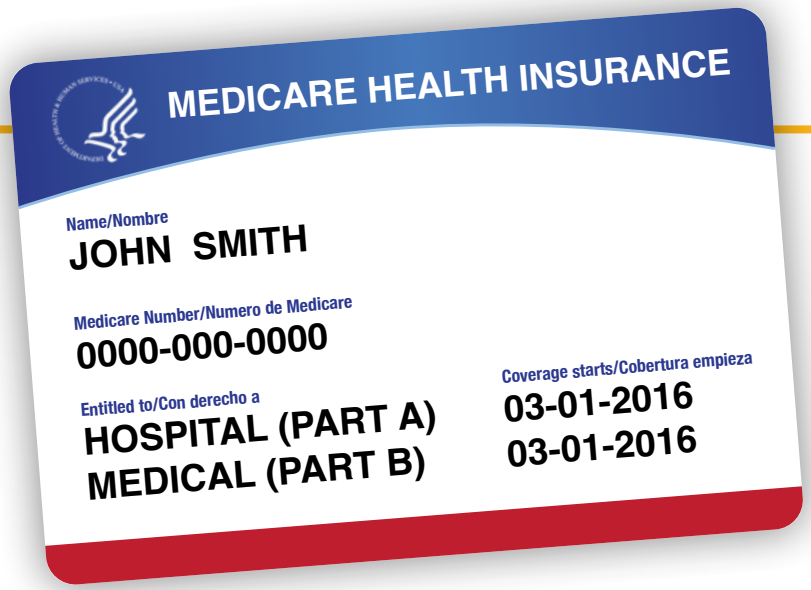
After your Initial Enrollment Period ends, you can only sign up for Part B and Part A (with a premium) during one of the other enrollment periods.

GENERAL ENROLLMENT PERIOD

If you sign up between January 1 and March 31 General Enrollment Period, your coverage starts the month after you sign up.

SPECIAL ENROLLMENT PERIOD

If you qualify for a special enrollment period, coverage normally starts the month after you sign up. To find out more about your particular situation, visit **www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods**



Once you're signed up for Medicare, your Medicare card will be mailed to you in your welcome packet. You can also log into (or create) your secure Medicare account to print your official Medicare card. Your card has a unique Medicare Number, which is different from your Social Security Number, to protect your identity.

The card is often referred to as your Red, White and Blue card and shows:

- You have Medicare Part A (listed as HOSPITAL), Part B (listed as MEDICAL), or both
- The date your coverage begins

HOW TO USE YOUR CARD IF YOU HAVE ORIGINAL MEDICARE

- Carry your Medicare card with you
- Show your Medicare card to your doctor, treatment facility, or healthcare provider when you receive care
- If you have Medicare Part D or other supplemental coverage, carry that plan card with you as well

HOW TO USE YOUR CARD IF YOU HAVE MEDICARE ADVANTAGE

- Use your Medicare Advantage plan card to get your services, not your Medicare card
- Keep your Medicare card safe at home in case you want to switch plans or change back to Original Medicare later

When you have Original Medicare, you do not need to choose a primary care provider, and in most cases, you don't need a referral to see a specialist. However, you will need to double-check if your doctor or healthcare provider accepts Medicare before you receive treatment.

Medicare Provider Costs

If you have original Medicare, before you get services, ask your healthcare provider if they charge the Medicare-approved amount. If they do, you won't be billed for more than the standard Medicare deductible and coinsurance (so you end up paying less out-of-pocket). If they don't, they can charge you

more than the amount Medicare approves for that service, and they may require you to pay the full cost at the time of service.

If you have a Medicare Advantage plan, call your plan to see if they have a network and check if your provider is in-network. Some plans allow you to use providers out-of-network, but it may cost you more out-of-pocket. Remember, you can always get emergency care and urgent care, even if the doctor or hospital isn't in-network, but let your Advantage Plan know as soon as possible if you have received those services.

If you have Part D, check with your plan to find out what pharmacies in your area are in-network. You will be able to look that up online or by calling the plan. In-network pharmacies are "preferred" and normally offer the lowest cost for drugs. There may be circumstances where it is cheaper to forego using your Part D to cover medications, but any amount you pay for non-covered drugs will not go toward your deductible. If you use an out-of-network pharmacy, you might have to pay the full cost.

Costs While in the Hospital

With Medicare Part A, you may have to pay a deductible for each benefit period when you stay in the hospital or receive mental healthcare as an in-patient. After you pay the deductible, you will have to pay a portion of the costs, called coinsurance. Your benefit period starts the day you are admitted as an in-patient and ends when you have not received any in-patient care for 60 days in a row. If you stay in the hospital after a benefit period ends, a new benefit period will begin. There is no limit to the number of benefit periods you may have. When you are in-patient for more than 90 days, Medicare will pay for additional days called Lifetime Reserve days. You are given a total of 60 reserve days that can be used throughout your lifetime. When using reserve days, Medicare will pay all covered costs except for your daily coinsurance. If you need to be in the hospital longer than your benefit period and Lifetime Reserve days, you would be responsible for 100% of the costs unless you had additional benefits through Medigap or another insurance coverage.

For services approved by Medicare under Part B, you will usually have to pay a 20% coinsurance after you meet your yearly deductible.

There are some services that Medicare does not cover. If you need these services, you will have to pay for them out-of-pocket or have other insurance coverage that covers them.

To find out if the items, services, or tests you need are covered under Medicare, you can visit the website www.medicare.gov/coverage. You can also talk to your provider's office to ask questions about Medicare coverage for recommended treatment. If your provider recommends a service or treatment that is usually covered by Medicare but your provider thinks it may not be covered in your case, you

Some services not covered by Medicare include:

- Long-term care/ custodial care
- Most dental care
- Dentures
- Eye exams to prescribe eyeglasses
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Routine foot care

will be asked to sign a form called the **Advanced Beneficiary Notice of Coverage (ABN)**. The ABN explains that you may have to pay for the service if Medicare doesn't approve it.

Coordination of Benefits

If you have Medicare and other health or drug insurance, each one is called a "payer." When there are multiple payers, there are rules that decide which one pays first, called Coordination of Benefits (COB). The first payer pays what they owe (up to the limits of the coverage), and then sends the rest of the bill to the second payer. The second payer only pays if there are costs the first payer didn't cover, and they may not pay all of the uncovered costs. In some cases, there might even be a third payer.

If the first payer denies coverage, the second payer may or may not pay some part of the cost.

It's important to tell your doctor, hospital, and all other healthcare providers about all of your health or drug insurance. This will help make sure your bills go to the right payers in the right order.

If you are still working, to ensure your healthcare services get paid correctly, you need to know:

- Whether your job-based insurance will pay first or second and,
- If your job-based insurance pays after Medicare, you need to know if and how it will pay if you don't enroll in Part A and/or Part B. Most retiree and small employer plans (employers with 20 or fewer employees) require enrollment in Part A and Part B.

COORDINATION OF BENEFITS

How Coverage Works With Medicare A & B

I'M STILL WORKING AND...	RULES THAT DECIDE WHICH "PAYER" PAYS FIRST
My (or my spouse's) job has **less than** 20 employees	• Medicare pays for services first, and your job-based insurance pays second. • If you don't sign up for Part A **and** Part B, your job-based insurance might not cover the costs for services you get. • Ask your employer if you need to sign up for Part A and Part B when you are eligible.
My (or my spouse's) job has **more than** 20 employees	• Your job-based insurance pays first, and Medicare pays second. • If you don't have to pay a premium for Part A, you can choose to sign up when you are eligible (or anytime later). • You can wait until you stop working (or lose your health insurance, if that happens first) to sign up for Part B, and you won't pay a late enrollment penalty.
I (or my spouse) get money from my employer to buy my own health insurance **OR** I (or my spouse) am still working, but I don't have health insurance through that job.	• Medicare probably doesn't work with your insurance. • Once you sign up, Medicare pays first. • Some private insurance have rules that lower what they pay (or don't pay at all) for services you get if you're eligible for other coverage, like Medicare. • Ask your health insurance company if you need to sign up for Part A **and** Part B when you are eligible.

Medicare and TRICARE For Life

TRICARE is government-sponsored health insurance provided to active duty and retired military personnel and their dependents. There are several different TRICARE programs. TRICARE For Life (TFL) is a Medicare supplement program for TRICARE-eligible retirees and their dependents. It helps to pay for Medicare cost-sharing, such as deductibles, coinsurances, and copayments. TFL may also pay for services that are not covered by Medicare, or when you have used up your Medicare benefits. The specific coverage and cost-sharing rules for TFL may vary depending on your circumstances. Generally, once you visit an authorized provider, your provider files your claim with Medicare. Medicare pays its portion and forwards the claim to TRICARE For Life who will then pay the provider directly for the TRICARE-covered services.