LOCAL HELP FOR PEOPLE WITH MEDICARE

CHOICES

Original Medicare and Supplemental Options

With

- **Overview of Medicare**
- **Medicare Advantage**
- **Supplemental Insurance: Medigap"**
- **Special Low-Income Programs**

For Medicare Beneficiaries living in Connecticut

May 2009

Published and Compiled by: CHOICES (800) 994-9422

A cooperative program of the State of Connecticut Department of Social Services, the Area Agencies on Aging, and the Center for Medicare Advocacy that provides Connecticut residents with direction to benefit and support programs dealing with aging concerns.

Department of Social Services, Aging Services Division

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NOTE: This information, including any rates and services, is accurate to the extent available to CHOICES from the individual Medicare managed care plans and the Centers for Medicare and Medicaid Services as of May, 2009. For more comprehensive information or clarification regarding an individual plan or product, please contact the plan directly at the telephone number listed in this booklet. For additional information on Medicare issues, including the Original Medicare Plan, Medigap Supplemental Insurance, Prescription Drug Assistance, and other health insurance issues generally, you should call the CHOICES health insurance counselor at your regional Area Agency on Aging (1-800-994-9422). CHOICES publications can also be found on the Department of Social Services, Aging Services web site at www.ct.gov/agingservices. CHOICES *counselors do not sell or market insurance*. They provide the necessary information and assistance to enable you to make your own health insurance CHOICES.

DSS Publication N. 01-8nha (Rev. 5/2009)

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Medicare Overview

Medicare is the national health insurance program, which began in 1965, for older adults and people with disabilities. Medicare is available to all Social Security recipients who are aged 65 years or older and to those who are permanently disabled and have received Social Security benefits for at least 24 months. In addition, individuals receiving railroad retirement benefits and individuals with end stage renal disease are eligible to receive Medicare benefits.

Eligibility for Medicare is not based on the individual's financial status. Income and assets are not a consideration in determining eligibility for Medicare, and benefit payments are the same for all who qualify, regardless of their income.

Choices are available in how you get your Medicare coverage:
1) Original Medicare (available to all Medicare beneficiaries); and
2) Medicare Advantage plans: i.e., HMOs, PPOs & PFFS.

Coverage under Medicare is similar to that provided by private health insurance companies. Like health insurance, Medicare pays a portion of the cost of medical care, but not all. Often, deductibles and co-insurance (partial payment of initial and subsequent costs) are required of the beneficiary.

*** Information in this booklet is subject to change. For updates and further information contact your regional CHOICES counselor at 1-800-994-9422.**

Enrolling into Medicare

If you already get Social Security Benefits

You will not need to do anything. You will be automatically enrolled in Medicare Part A and Part B effective the month you are 65. For example, if your 65th birthday is February 20, 2001, your Medicare effective date would be February 1, 2001. (Note: if your birthday is on the 1st day of any month, Medicare Part A and Part B will be effective the 1st day of the prior month. For example, if your 65th birthday is February 1, 2009, your Medicare effective date would be January 1, 2009.) Your Medicare card will be mailed to you about 3 months before your 65th birthday. If you do not want Medicare Part B, follow the instructions that come with the card.

If you Want to Apply for Both Social Security Retirement Benefits and Medicare

If you are close to age 65 and not yet getting Social Security benefits or Medicare, you can apply for both at the same time. To make sure that your Medicare Part B coverage start date is not delayed, you should apply three months before the month you turn 65. This is the beginning of your 7 month Initial Enrollment Period. If you wait until you are 65, or in the last 3 months of your Initial Enrollment Period, your Medicare Part B coverage start date will be delayed.

To apply, you can call or visit your local Social Security office or call Social Security at 1-800-772-1213. You can apply online (using the Internet) if you meet certain rules. To apply online, visit www.socialsecurity.gov.

If you Do Not Yet Get Social Security Benefits and You Only Want to Apply for Medicare

If you are close to age 65 and not getting Social Security benefits, you must apply for Medicare. You can apply by calling or visiting your local Social Security office, or by calling Social Security at 1-800-772-1213. You should apply three months before the month you turn 65. This is the beginning of your 7 month Initial Enrollment Period. If you wait until you are 65, or in the last 3 months of your Initial Enrollment Period, your Medicare Part B coverage start date will be delayed. You currently cannot apply for Original Medicare online (using the Internet).

➔ What Does Original Medicare Cover?

Original Medicare helps pay for certain health care that is medically necessary to treat or diagnose an illness or injury. It only pays for some preventive services, and does not pay for eyeglasses, hearing aids, or for convenience items such as private rooms or private duty nurses.

Original Medicare has two coverage components, Part A and Part B. Part A covers inpatient hospital care, hospice care, some short-term inpatient care in a skilled nursing facility, and home health care services. Part B covers medical care and services provided by doctors and other medical practitioners, durable medical equipment, and some outpatient care and home health care services. Contrary to what many people think, Medicare does not pay for long term nursing home care. Additionally, on January 1st, 2006, Medicare began a new prescription drug benefit (Medicare Rx), please see page 6 for more information.

➔ Does Medicare Cost Anything?

Most beneficiaries do not pay a premium for Part A coverage. It is financed largely through federal payroll taxes paid into the Medicare Trust Fund by employers and

employees. People, who qualify for Social Security retirement benefits or for disability benefits for 24 months, also qualify for Part A, and do not have to pay a premium for it. Individuals who have not accumulated enough Social Security credit may choose to purchase Part A by paying a monthly premium after they turn 65. If a person has less than 30 quarters of coverage, they do not receive premium-free Part A coverage. In 2009 the Medicare Part A monthly premium is $443.00.

Part B is financed by monthly premiums which are paid by all beneficiaries who choose this coverage and by general revenues from the federal government. The monthly premium for **Part B is $96.40 in 2009**, higher for an individual who files a Federal Income Tax return and your income exceeds $85,000 or if you file a joint return your income is exceeds $170,000. Individuals who are automatically eligible for Part A will also be enrolled in Part B unless they **inform Social Security that they do not want to be enrolled.**

In addition, beneficiaries share the cost of Medicare through co-payments and deductibles that are required for many of the services covered under both Part A and B. Beneficiaries must pay an annual Part B deductible of $135.00 in 2009. The Part B deductible usually will increase on January 1st of each year.

➔ What Hospital Costs Will Original Medicare Cover?

Medicare Part A pays the full cost of up to 60 days of necessary hospital care during each benefit period after the individual has met a deductible payment. A "benefit period" begins the day you go to a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) 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 inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. The deductible is $1068.00 in 2009. If the individual needs more than 60 days of hospital care Medicare pays part of the care and the individual must cover the rest.

Hospital Coverage and Cost Sharing for 2009

Deductible:	$1068 for each benefit period
Days 1 - 60:	$0 co-insurance payment
Days 61 - 90:	$267 a day co-insurance payment
Days 91 - 150:	$534 a day co-insurance payment

➔ What Preventive Services does Original Medicare Help Cover?

While Medicare usually only pays if health care is needed to treat or diagnose an illness or injury, there are a number of specific preventive services covered by Medicare. Recently Congress has expanded the preventive services covered by Medicare. Currently they include the following:

- ⇨ Flu Shots, Pneumonia Shots, and Hepatitis Vaccines;
- ⇨ Screening Mammograms (annually), Pap Smears and Pelvic Exams;
- ⇨ Colorectal Cancer Screening and Prostate Cancer Screening;
- ⇨ Diabetic Testing Strips and Self Management Training;
- ⇨ Glaucoma screening for certain individuals;
- ⇨ Bone mass density tests for certain individuals;
- ⇨ One physical within the first 12 months enrolling in Medicare Part B;
- ⇨ Blood tests to screen for cardiovascular disease;
- ⇨ Diabetes screening for individuals at high-risk.
- ⇨ Cardiovascular Screening Blood Tests
- ⇨ Ultrasound Screening for abdominal aortic aneurysms

➔ Will Original Medicare Pay for Long Term Nursing Home Care?

No, Medicare generally does not pay for long term care in a nursing home. However, Medicare does cover a limited amount of short-term skilled nursing home care. The coverage is available under Part A. Coverage is only available for up to 100 days of care per benefit period, and only if the individual was first in a Medicare-covered hospital stay for at least 3 consecutive days and receives daily skilled nursing five days a week or therapy in the nursing home. If coverage is available, coverage is for all services; there is no deductible, but there is a daily co-insurance payment due from the beneficiary after the 20th day of a covered nursing home stay.

Nursing Home Coverage and Cost Sharing for 2009

Deductible:	$0
Days 1 - 20:	$0 co-insurance payment
Days 21 - 100:	$133.50 a day co-insurance payment due

➔ What Home Health Costs Will Original Medicare Cover?

Medicare covers home health care under both Parts A and B. Coverage is available as long as the individual cannot leave home without assistance or a taxing effort; this is called the "homebound" requirement. The individual must also need intermittent skilled nursing or physical therapy to get coverage. If coverage is available, Medicare pays for these services and also for occupational therapy, home health aides, medical social services, and supplies.

Note: There is no deductible or co-insurance for home health care.

➔ What Physician Services Does Original Medicare Cover?

Physician services are covered under Medicare Part B. Most of the cost of going to your doctor when you are sick is covered by Medicare but Medicare generally does not cover "routine physicals" or "check ups." When coverage is available, Medicare

covers 80% of the Medicare approved charge for the doctor's services and the individual is responsible for the remaining 20%. In Connecticut most doctors accept this Medicare approved charge and, therefore, cannot bill the individual any more than the 20% of this Medicare rate. This is known as the doctor "accepting assignment."

➔ What Equipment and Supplies Does Original Medicare Cover?

Durable Medical Equipment (DME) includes, but is not limited to, the following items: canes, crutches, walkers, blood glucose monitors, ventilators, wheelchairs, patient lifts, hospital beds and accessories, home oxygen equipment and supplies. Certain diabetic supplies are also covered through the Medicare program, such as blood glucose test strips and lancets for people with diabetes.

➔ What Prescription Drug Costs Does Original Medicare Cover?

Generally, the only Medicare coverage for prescription drugs under Parts A & B is for prescription drugs which must be provided in the hospital, nursing home, or in the doctor's office. Some chemotherapy is also covered. Some Medicare Advantage plans (i.e. HMO's, PPO's & PFFS's) do offer prescription coverage under the Medicare Rx benefit.

Although original Medicare will continue to only offer limited prescription drug coverage, beneficiaries do have other coverage options available to them through add-ons to the Medicare program. In December, 2003 President Bush signed into law the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA) which has resulted in the most significant changes to the Medicare program since its inception. Since January 1, 2006 beneficiaries have been able to purchase prescription drug coverage by electing to enroll in the new Medicare prescription drug program, Medicare Rx, (Medicare Part D).

Medicare Part D

1. What is Medicare prescription drug coverage? Medicare prescription drug coverage is a program that pays for prescription drugs, insulin and insulin supplies, and "stop-smoking" drugs for people who have Medicare. It started on January 1, 2006. It's also known as "Medicare Rx" and "Medicare Part D."

Medicare doesn't administer the new program directly. Instead, it contracts with private companies to provide the coverage. In 2009, in Connecticut, there are 47 stand-alone Prescription Drug Plans, plans that provide only Rx coverage (PDPs), 32 Medicare Advantage (MA-PD) plans (i.e. HMO, PPO or PFFS) and 8 Special Needs Plans (SNPs are MA-PDs limited to individuals who receive both Medicare and Medicaid and have certain chronic conditions) that offer Medicare prescription drug coverage. Most of these companies, in turn, offer several plans with different levels of coverage and costs. In addition, some employers may "wrap around" the new program to offer coverage through their retirement health plans.

You need to enroll in one of these plans to have Medicare prescription drug coverage. The plan you join will give you a member card that you can use at participating pharmacies. Some plans also allow members to get their prescriptions through the mail.

2. Do I have to apply for Medicare prescription drug coverage or will I get it automatically because I'm on Medicare? Most people need to take action and enroll in a plan to get Medicare prescription drug coverage. But if you are on ConnPACE, Medicaid (Title 19), or Supplemental Security Income (SSI), or if the State pays your Part B premiums through a Medicare Savings Program (QMB, SLMB or ALMB), you will be automatically enrolled into a Medicare prescription drug plan if you do not select a plan on your own.

If you have both Medicare and Medicaid you most likely have already been enrolled into a Medicare Rx plan by Medicare. You should have received a letter telling you the plan that was selected for you. If you do not like the plan that you have been enrolled into you may change plans once per month. The change will be effective on the first day of the following month.

3. What drugs will Medicare cover? Each Medicare-approved plan offers its own selection of covered drugs, called a "formulary." Formularies vary from plan to plan.

Before deciding on a plan you should carefully review its formulary, (list of covered drugs) to be sure that it covers all of the medications that you take.
Medicare will cover most outpatient prescription drugs, insulin and insulin supplies, and "stop-smoking" drugs. Medicare-approved plans offer a choice of at least two drugs in each of 146 categories of drugs. Each Medicare-approved plan also includes in its formulary all drugs in the following six categories of drugs: anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immuno-suppressants and HIV/AIDS.

Some drugs are excluded, i.e., Medicare won't cover them. These include barbiturates, benzodiazepines, drugs for weight loss or gain, over-the-counter drugs and drugs that are covered by Medicare Part A or Part B. *(NOTE: a few plans cover some of the excluded drugs as an enhanced benefit for additional cost. Also, Medicaid and ConnPACE will cover some of these drugs for their members.*)

4. How does the Medicare prescription drug "standard benefit" work? You may pay a monthly premium. The premium can be deducted from your Social Security check, or the plan can debit your bank account each month, or you can pay the plan directly.

- There may be an annual deductible. In 2009, the deductible cannot be more than **$295** per year. Some plans do not have any deductible and others have a reduced deductible. **If your plan has a deductible you will need to pay the amount of the deductible before your coverage begins.**

- After you have met your deductible, you enter the **Initial Benefit Period**, during which your drug plan pays **75%** of the cost of each prescription and you pay **25%** (for the next $2405 in drug costs). The most you will pay during the Initial Benefit Period is **$601.25.** (25% of $2405).

- Once the total cost for medications reaches **$2700** you will enter the **COVERAGE GAP** (also called the **DOUGHNUT HOLE**). If the drug plan you have chosen has a coverage gap, you will pay **100% OF ALL PRESCRIPTION COSTS UNTIL YOU HAVE SPENT ANOTHER $3453.75 OUT-OF-POCKET**. (In 2009, 12 PDP's pay for some generic drugs during the coverage gap. No plans pay for brand name drugs during the coverage gap. Twenty-one MA-PD's pay for some generic drugs during the coverage gap. Two of those pay for some brand-name medications during the coverage gap.)

- Once you have spent a total of **$4350 ($295 + $601.25 + $3453.75)** in allowable **True Out-Of-Pocket costs (TrOOP)**, you will be eligible for **Catastrophic**

Coverage. **For the remainder of the year, Medicare will pay 95% of your prescription drug costs and you will pay only 5% of each prescription, or a $2.40 or $6.00 co-pay, whichever is greater.** In 2009 PDP premiums in Connecticut range from about $19.40/month to $111.30/month. MA-PD prescription premiums range from $0 to about $179 a month. Some plans have annual deductibles and all plans have co-pays or co-insurance (amounts you are responsible to pay for each prescription). Most plans have "tiered" co-pays, i.e., the co-pay amount varies with the type of drug. (Tier 1 = generic drugs; Tier 2 = preferred brand/value generics; Tier 3 = brand; Tier 4 = specialty drugs.) *NOTE: People with limited income and assets may qualify for "Extra Help" to pay for premiums, deductibles, co-pays and co-insurance. Ask your CHOICES counselor for the "Prescription Drug Assistance Guide."*
The following table shows how the Medicare prescription drug standard benefit works. **IMPORTANT:** Different plans may offer variations around this basic package. It is important to review the costs of each plan carefully before enrolling.

Standard Prescription Drug Plan for the Calendar Year 2009

Coverage	Total Prescription Costs	Medicare Pays	You Pay	Your out-of-pocket cost
Deductible (you pay this amount before your Medicare coverage begins)	**$0 -$295**	**0**	**100%**	**$295**
Initial Benefit Period (annual basic coverage)	**$295 - $2700**	**75%**	**25%**	**$601.25**
Coverage Gap (no coverage during this period)	**$2700-$6153.75**	**0**	**100%**	**$3453.75**
TOTAL	**$6153.75**	**$1803.75**	**70%**	**$4350**
Catastrophic Benefit	**$6153.75 & over**	**95%**	**5%**	**5%**

5. What are allowable out-of-pocket costs? As described above, once you have spent $4,350 in allowable out-of-pocket costs, you will have met your TrOOP requirement and you will qualify for Catastrophic Coverage. For the rest of the year, Medicare will pay 95% of your prescription drug costs**. It is important to know that only certain payments count toward meeting the $4,350 TrOOP requirement**.

Payments that you make (or payments made by your family or by a charitable group) for drugs that are on your plan's formulary count toward meeting the $4,350. (For

ConnPACE members, payments made by ConnPACE, in addition to payments made by the ConnPACE member, also count toward the $4,350.)
Premium payments, payments made by Medicare or other insurance payments made for drugs that are not on your plan's formulary, and payments for drugs purchased in Canada, do NOT count toward the $4,350 TrOOP requirement.

6. Can I get help to pay for Medicare prescription drug coverage? If your countable income is below $16,245 (single) or $21,855 (couple), and your countable assets (not including your house, car or certain types of savings) are below $12,510 (single) or $25,010 (couple), these rates include $1500 per person burial allowance you may qualify for Extra Help to pay for Medicare prescription drug coverage. This Extra Help will take the form of reduced premiums, deductibles and co-pays.

If you didn't get an application for Extra Help but think you may qualify, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also visit www.socialsecurity.gov on the web, or you can call CHOICES (1-800-994-9422) for assistance.

Important! If you are on Medicaid, SSI, or a Medicare Savings Program you automatically qualify for Extra Help and do not need to apply. Medicare has enrolled you in the Extra Help. You should have received a letter explaining the benefits that you will receive. For more information please contact CHOICES at 1-800-994-9422.

7. What if the cost of Medicare prescription drug coverage is more than I pay now for prescription drugs? If you now take only a small number of medications, or you have another form of prescription insurance, your current costs may be less than they would be under the standard Medicare prescription drug benefit. You still need to consider Medicare prescription drug coverage because:

- You may need additional, more expensive medications in the future.
- You may have to pay a higher premium if you don't enroll when you are first eligible.
- You may also have a waiting period for coverage if you don't enroll when you are first eligible.

8. When will I pay a higher premium? If you don't have any prescription insurance, or if your insurance is not "creditable" (meaning your coverage is, on average, not as good as Medicare prescription drug coverage), you will pay higher premium amounts if you enroll after the Initial Open Enrollment period. Your premium will be 1% higher for each month you could have enrolled in a Medicare prescription drug plan but did not. The 1% penalty is based on the national average monthly premium and it is a lifetime penalty. For example, if the national average premium is $27.35 per

month, and you wait 7 months to join a plan, your penalty would be $1.91 each month (.01 x $27.35 x 7 months). This amount would be added permanently to the premium of your chosen plan.

If you decline Medicare prescription drug coverage because you have existing insurance that offers "creditable coverage" you will not have to pay a higher premium if you decide not to enroll right away. However, if you lose that creditable coverage you must select and enroll in a Medicare prescription drug plan within **63 days** in order to avoid a higher premium and a possible waiting period for coverage.

During the fall of 2008, all insurers, including employer or union sponsored retirement health plans, should have sent notices to their members indicating whether their coverage is creditable. Note: Most "Medigap" policies are NOT considered creditable. VA, TRICARE, Federal Employee Health Benefits (FEHB), and State of Connecticut retiree policies are considered creditable.

9. When can I enroll in a Medicare prescription drug plan? You can enroll in a Medicare Rx plan November 15 – December 31 of each year. This is called the Annual Coordinated Election Period. Coverage will begin on January 1st of the following year.

If you are new to Medicare (i.e. you just turned 65) you have a 7 month Initial Enrollment Period (IEP). The 7 month period begins 3 months before you turn 65 and ends 3 months after your 65th birthday. If you do not enroll during the IEP you may have to wait until the next Annual Enrollment Period and you may be subject to a late enrollment penalty.

10. Can I change plans? Yes, under these circumstances:

- If you belong to a PDP you may change plans November 15th - December 31st of each year. This is called the Annual Coordinated Enrollment Period (ACEP). You can change plans more often if you qualify for a Special Enrollment Period (SEP). SEPs are granted under specific qualifying circumstances such as you moved out of your current plan's service area. Contact CHOICES to find out what other circumstances would qualify you for a SEP.

- If you belong to an MA (without prescription drug coverage) or a MA-PD (with prescription drug coverage), you may change plans January 1st – March 31st of each year. This is called the MA Open Enrollment Period (OEP). You can change more often if you qualify for a Special Enrollment Period (SEP) as described above. You cannot add or drop prescription drug coverage during this period. For example, if you are leaving a plan without prescription drug

coverage, you can only enroll in a plan without prescription drug coverage. If you are leaving a plan with prescription drug coverage, you can only enroll into a plan with prescription drug coverage. You can also leave your MA or MA-PD plan and return to Original Medicare, provided you do not change your drug coverage status. Ask CHOICES for more information.

- Individuals on Medicare and Medicaid and those on Medicare Saving Programs (QMB, SLMB and QI/ALMB) can change plans at anytime. The new plan will become effective the first of the month following the month in which the change was made.

  Important: Individuals on Medicare Savings Programs can change plans at anytime but must enroll in a benchmark plan, a standard plan that is under $31.74 to avoid paying a portion of the plan's premium. Ask CHOICES for more information.

NOTE: To avoid delays in coverage or problems with enrollment it is strongly suggested that you enroll in your new plan by the 8th of the month proceeding the month in which you want your new coverage to begin. For example, if you want to be in your new plan by July 1st, you should enroll by June 8th.

11. How do I choose a Medicare prescription drug plan? You may be receiving information from many sources, including Medicare and various plans that offer coverage in your area. You need to study this information and ask the following questions at a minimum:

- Do you live in the plan's service area?
- How much is the monthly premium?
- Is there an annual deductible?
- Are the medications that you take on the plan's formulary?
- Are there different co-pay amounts for different drugs?
- Is the plan accepted at the retail or mail order pharmacy that you use?
- Are your medications subject to utilization management tools such as prior authorization, quantity limits and step therapy

If you spend part of the year in another state, you may want to consider one of the national plans with a wider preferred provider network. Please refer to the CHOICES Enrollment Guide for more information about choosing a plan, and detailed information about the plans themselves.

12. Do I have to do anything if I am happy with an existing plan?

Before you decide whether to stay with your existing plan each year you need to find

out if your plan will change the following year. **The way to find out is to study the information your plan will send you at the end of October in its Annual Notice of Change (ANOC).**
The ANOC includes information about **changes to premium** and **deductible amounts**, **changes in "donut hole" coverage**, and **changes to formularies**, including the addition of utilization management tools such as prior authorization, quantity limits and step therapy on any of its formulary drugs. The ANOC also includes information about changes to tiered co-pay amounts, including the placement of drugs on a different tier.

IMPORTANT: If a plan granted an indefinite Exception in 2008 that it does not intend to continue in 2009, the plan should have notified the member of this change. This notice may have been included in the ANOC or it may have been sent in a separate notice mailed at the end of October.

If you remain satisfied with your plan after reading the ANOC you do not need to do anything. Your membership in the plan will automatically continue into the next year. If there are changes to the monthly Part D Premium, formulary changes etc., you may want to have a comparison done on the Medicare Drug Plan Finder by contacting 1-800-MEDICARE, CHOICES at 1800-994-9422 or go to the Medicare Web Site at www.medicare.gov

Important Dates for 2009

November 15, 2009– December 31, 2009 - The Annual Coordinated Election Period. Medicare-eligible individuals can enroll in or change their PDP. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their PDP for the rest of the calendar year.

December 8, 2009 – The date by which people who wish to change plans should enroll in their new plan in order to ensure coverage by January 1, 2010.
January 1, 2010 - New Medicare prescription coverage begins for **2010.**
January 1, 2010 – March 31, 2010 - The MA Open Enrollment Period. Medicare-eligible individuals can change their MA or MA-PD plan. With the exception of dual eligible individuals and MSP recipients (who can change plans at any time), or other individuals who qualify for a Special Enrollment Period (SEP), people are locked into their MA or MA-PD plan for the rest of the calendar year. People cannot add or drop prescription drug coverage during this period.

14. Where can I get more information? Call CHOICES at 1-800-994-9422 to speak to a counselor at the Area Agency on Aging serving your area of the state. CHOICES counselors are trained and certified to assist you with your Medicare issues and concerns. They can also help with comparing and enrolling in a Medicare prescription drug plan and getting Extra Help to pay for your premiums, deductibles, and co-pays.

You can also get more information from these on-line sources:

- State of CT, Department of Social Services: www.ct.gov/Medicarerx
- Medicare: www.medicare.gov
- Social Security: www.socialsecurity.gov
- Center for Medicare Advocacy: www.medicareadvocacy.org
- Department of Social Services, Aging Services Division: www.ct.gov/agingservices

Medicare Advantage

➔ What Is Medicare Advantage?

The other option through which some Connecticut Medicare beneficiaries can receive their Medicare benefits is through a Medicare Advantage plan. Medicare Advantage plans are often referred to as "HMOs," (which means "health maintenance organizations"), PPOs (which means "preferred provider organizations") PFFSs (which means Private Fee for Service plans), SNP's which means Special Needs Plans for people with certain chronic conditions, instutionialized or dual eligible, (Medicare/Medicaid) and MSA's (which means Medicare Savings Accounts). The Medicare Advantage plan benefits are different from the Original Medicare "fee-for-service" system.

Medicare Advantage plans use a limited network of health care providers and facilities and a system of "prior approval" from a primary care physician, sometimes referred to as a "gatekeeper." Most plans allow you to select a primary care doctor from those that are part of the plan. Generally, the doctor authorizes, arranges for, and coordinates your care, and decides what care is reasonable and necessary.

In Connecticut, each plan does, however, require co-payments most times that you go to the doctor or use other services. You also must continue to pay the Part B premium. You will get all of the Medicare hospital and medical benefits to which you are entitled

through the plan and retain all of your Medicare protections and appeal rights.

There are five forms of managed care available to beneficiaries in CT. They are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee for Service plans (PFFSs), Medicare Saving Accounts (MSA's) and Special Needs Plans (SNPs).

HMOs

In 2009, there are several HMOs marketing plans in the State of Connecticut. Each plan has a network of providers operating through private practice offices. All of the HMO plans available in Connecticut have an in network provider requirement. That means that you generally must receive all covered care from the doctors, hospitals, and other health care providers who are affiliated with the plan. Exceptions include emergency care and urgent care.

PPOs

A PPO is also a Medicare Advantage plan similar to an HMO. There is a preferred network of service providers and medical facilities. However, unlike an HMO, PPOs allow members to utilize out of network providers and facilities, usually at a higher cost than if the beneficiary had used in-network physicians and hospitals.

PFFSs

A PFFS plan is also a Medicare Advantage plan. However, unlike HMOs or PPOs, PFFS plans set their own fees for services, not Medicare. PFFS plans decide how much they will pay for any covered Medicare service. Beneficiaries in a PFFS may see any Medicare-approved physician who accepts the rates set by the plan. Physicians who accept the terms of a PFFS plan may not charge more than 115% of the contracted rate.

Similar to HMOs and PPOs, PFFS plans may offer benefits in addition to Original Medicare coverage such as, extra days in a hospital.

MSA's

A Medicare Medical Savings Account (MSA) plans have two parts: a high deductible health plan and a bank account. Medicare gives the plan an amount each year, ($1570 for 2009). The money is deposited into your account. The amount deposited is usually less than your deductible amount so you will have to pay out-of-pocket before your coverage begins.

Money spent for Medicare-covered Part A and Part B services counts toward your plan's deductible, ($4000 for 2009). After you reach your deductible, your plan will cover your Medicare-covered services. Any money left in your account at the end of the year remains in your account along with the deposit for next year.

Medicare MSA plans can provide Medicare beneficiaries with more control over health care utilization, while still providing coverage against catastrophic health care expenses. The only option available for a MSA member who wants Medicare drug coverage is to also enroll in a PDP.

SNPs

Special Needs Plans are designed to meet the needs of beneficiaries in specific circumstances such as living a in a nursing home, being eligible for both Medicare and Medicaid (dual eligible) or living with a chronic illness. Special Needs plans often take the approach of coordinating care services to manage the health of clients in order to avoid hospitalization. Although any beneficiary may enroll in a Special Needs plans they are not the best option for beneficiaries who do not fall into one of the three categories listed above. It is a good idea to carefully review the plan's network of providers before enrolling in an SNP as it can be costly to use out-of-network providers.

While the benefits of **HMOs, PPOs, PFFSs, MSA's and SNPs** vary from plan to **plan, every plan is required by Medicare law to provide all of the Original Medicare benefits**. You must get all of your Medicare benefits through the plan.

A Medigap insurance policy will be of little or no value to you if you enroll in a Managed Care Plan in Connecticut since it will not pay any co-payments or premiums charged by the plan. The only situation where a policy might be of value is if you later decide to leave the plan to return to Original Medicare.

For more information on managed care plans, refer to the booklet, "Medicare Advantage Options in CT", available from the **CHOICES** program at 1-800-994-9422.

➔ What if an Individual is told that Medicare Coverage is not available for a Medical Service?

The Medicare program is complex. It is not uncommon for individuals to be told that coverage is not available for a medical service when it should be granted. Sometimes these denials are a result of errors; sometimes they are a result of efforts to save money. Regardless of the reason for the denial, the Medicare program has an appeal system that is meant to correct mistakes and help beneficiaries receive the Medicare coverage to which they are entitled.

➔ When Should a Denial of Medicare Coverage Be Appealed?

Individuals should appeal if the health services in question are ordered by their attending physician and if the services are not clearly excluded from coverage, (like most eyeglasses, hearing aids, and nursing home care when the individual did not have a prior hospital stay).

Appeal as soon as possible. There are deadlines which must be met for an appeal to be accepted. For a Medicare denial, the first step in a Part A or Part B appeal must be filed within 120 days of the denial. Forms for Medicare appeals are available at local Social Security offices which is where the individuals can file their appeals. Time is of the essence; do not delay. You can also file an appeal on the back of you Medicare Summary Notice

There is also an expedited appeals process, for certain cases. In an urgent situation, when the life or health of a person (or the person's ability to regain maximum function) could be in jeopardy if he or she waited for the regular appeals process, an expedited appeal must be made. If requested (often with the doctor's help), an expedited decision generally must be made within 72 hours.

Note: The individual's attending physician is a key component to a successful appeal. Obtain a statement from the doctor explaining why the services are medically necessary and file this statement with the request for an appeal. Always keep copies of everything you submit.

➔ Where Can I Get Help With Medicare Questions and Appeals?

The Medicare program and appeal system may seem too complex to handle alone. Help is readily available at no cost for residents of Connecticut at the **Center for Medicare Advocacy, Inc. at 1-800-262-4414.**

Supplemental Insurance: "Medigap"

Health insurance that helps pay when Original Medicare doesn't cover the full cost of services is known as "Medigap" insurance. Medigap insurance provides supplemental coverage for beneficiaries in the Original Medicare program. Medigap insurance is

necessary because, as described above, Medicare often covers less than the total cost of the beneficiary's health care. Some of these gaps in Medicare Part A & Part B insurance may be covered by through the addition of a Medigap insurance plan. It is important to obtain Medigap insurance to cover these costs.

There are twelve standard Medigap policies which are labeled A through L. Policy A contains the basic or "core" benefit plan. The other eleven policies contain the core benefits plus one or more additional benefits. **NONE of the Medigap plans have drug coverage.** Note: **Those enrolled in plans H, I or J prior to January 1, 2006**
had the option of renewing their policies and retaining the prescription drug benefit associated with that plan. If you did not enroll in a Medicare Rx Plan you were subject to the 1% penalty. Once an individual enrolls in a Medicare Rx Plan the policy's prescription drug benefit. The prescription drug component of the Medigap policy will end on the first day that the Medicare Rx plan becomes effective.

The following is a list of the benefits that are contained in the core policy and that must be contained in all Medigap policies:

- ⇨ Part A hospital coinsurance for day's 61-90 $267/day in 2009;
- ⇨ Part A hospital lifetime reserve coinsurance for day's 91-150 $534/day in 2009;
- ⇨ 365 lifetime hospital days beyond Medicare coverage;
- ⇨ Parts A and B three pint blood deductible;
- ⇨ Part B 20% coinsurance.

Additional benefits are offered through policies B through L. Each plan offers a different combination of these benefits in addition to the core benefits. Additional benefits are:

- ⇨ Part A skilled nursing facility coinsurance for days 21-100 ($133.50/day in 2009);
- ⇨ Part A hospital deductible ($1068 per benefit period in 2009);
- ⇨ Part B deductible ($135/year in 2009);
- ⇨ Part B charges above the Medicare approved amount (if provider does not accept assignment);
- ⇨ Foreign travel emergency coverage;
- ⇨ At-home recovery (home health aid services);
- ⇨ Preventive medical care.

Hospice Benefit under Medicare

H**ospice Care** is an elected benefit covered under Medicare Part A for a beneficiary who meets all of the following conditions:

- ⇨ The individual is eligible for Part A;
- ⇨ The individual is certified as having a terminal illness with a prognosis of six months or less if the illness runs its normal course;
- ⇨ The individual receives care from a Medicare-approved hospice program; and
- ⇨ The individual signs a statement indicating that he or she elects the hospice benefit and waives all other rights to Medicare payments for services for the terminal illness and related conditions. In addition to covered hospice services, Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Hospice is not a basic benefit under the Medicare Advantage (MA) Program and MA Plans are not required to provide a hospice benefit. Enrollees in MA Plans receive the hospice benefit under Original Medicare. Upon enrollment, and annually thereafter, MA Plans must inform enrollees of the availability of the Medicare hospice option and any approved hospices in the MA Plan's service area including those that the MA organization owns, controls, or in which it has a financial interest.

For more information on the Medicare Hospice Benefit please contact CHOICES at 1-800-994-9422.

MEDIGAP PLANS K & L OFFER DIFFERENT COST SHARING

Plan K covers:

- ⇨ the cost sharing for Part B preventive services;
- ⇨ the Part A hospital co-insurance and an additional 365 days of hospital coverage;
- ⇨ 50% of the Part A and Part B blood deductibles;
- ⇨ 50% of the Part B co-insurance;
- ⇨ 50% of the skilled nursing facility co-insurance;
- ⇨ 50% of the hospice Part A coinsurance;
- ⇨ 50% of the Part A hospital deductible;
- ⇨ 100% of all cost sharing under Medicare Parts A and B for the rest of the calendar year once a beneficiary reaches an out-of-pocket limit of $4,620 in 2009.

Plan L will cover:

- ⇨ 75% of the cost sharing for Part B preventive services;

- ⇨ the Part A hospital co-insurance and an additional 365 days of hospital coverage;
- ⇨ 75% of the Part A and Part B blood deductibles;
- ⇨ the Part B co-insurance;
- ⇨ 75% of the skilled nursing facility co-insurance;
- ⇨ 75% of the hospice Part A coinsurance;
- ⇨ 75% of the Part A hospital deductible;
- ⇨ 100% of all cost sharing under Medicare Parts A and B for the rest of the calendar year once a beneficiary reaches an out-of-pocket limit of $2,310 in 2009

Policies B through L vary considerably. Each beneficiary must review the policies carefully and decide which coverage best suits their needs. There are many considerations when purchasing Medigap insurance. The most important consideration is a person's medical needs. The individual should look at his or her current needs and also look to potential future medical needs. Another major consideration is cost. A person must be able to afford the particular policy he or she desires. Also, a person should consider what the preexisting conditions are under the policy.

Please refer to the Medigap charts on the following pages for more information on the benefits and rates.

Your Rights to Buy a Medigap Policy

What plans are you guaranteed to get into?

- ⇨ Connecticut residents age 65 and over are guaranteed acceptance into Medigap plans A-L
- ⇨ Persons under 65 with disabilities are guaranteed acceptance into Medigap plans A, B, and C only

What are the Pre-existing Condition Protections when choosing a Medigap policy in Connecticut?

- ➢ Pre-existing conditions are covered by Original Medicare and also by Medicare managed care plans. Medigap policies may have a waiting period between two (2) to six (6) months (maximum) for coverage of these conditions. After that, your pre-existing condition must be covered.
- ➢ Some insurance companies selling Medigap do not have a pre-existing condition waiting period. That means that if you have a medical condition before you join the plan, it will be covered as soon as the plan starts. For more information, please refer to the **CHOICES** Medigap rate chart on the following pages.
- ➢ If you have been in a Medicare Advantage plan for at least 6 months or are replacing employer group health insurance that you have had for at least 6 months, a pre-existing condition *must* be covered immediately with no waiting period.
- ➢ If you have been enrolled in a Medicare Advantage plan or had employer group health insurance for less than 6 months:
- ➢ You are given credit for the number of months you spent in the Medicare Advantage or employer group health insurance plan.
  - ▪ For example, if you have had the Medicare Advantage plan for four months, and the Medigap policy you want to join has a six month waiting period, you will be given credit for four months. Your waiting period for your condition to be covered will be two months.

Did you enroll in Medicare Advantage Plan upon turning 65 but less than 12 months ago?

If yes, you have the right to choose between enrolling in another Medicare Advantage plan if any are available, or to disenroll and purchase *any* Medigap policy. Your pre-existing conditions will be covered immediately. You must purchase the Medigap policy within 63 days of disenrolling from the Medicare Advantage plan. Consider the cost of the plans and how much you can afford.

Did you enroll in a Medicare Advantage plan for the first time after turning 65, but less than 12 months ago? If yes, as a Connecticut resident, you have the right to:

- Enroll in another Medicare Advantage plan if any are available, *OR*
- Disenroll from the Medicare Advantage plan and purchase the same Medigap coverage previously held (if any) from the same company if it is still being sold, *OR*
- Disenroll from the Medicare Advantage plan and purchase Medigap plans A through L. Refer to section above for information on rules for coverage of pre-existing conditions. Consider the cost of the plan and how much you can afford.

For more information on Medigap rights and protections, please contact the CHOICES program at 1-800-994-9422.

MEDIGAP TEN STANDARD MEDICARE SUPPLEMENTAL PLANS

CORE BENEFITS	A	B	C	D	E	F	G	H	I	J	K*	L**
Hospital coinsurance: Days 61 to 91	X	X	X	X	X	X	X	X	X	X	X	X
Hospital coinsurance: Days 91 to 150	X	X	X	X	X	X	X	X	X	X	X	X
Hospital Payment in full: 365 additional days	X	X	X	X	X	X	X	X	X	X	X	X
Part A and Part B blood deductible: First three pints of blood	X	X	X	X	X	X	X	X	X	X	50%	75%
Part B 20% coinsurance: Physician and other services	X	X	X	X	X	X	X	X	X	X	50%	75%

ADDITIONAL BENEFITS	A	B	C	D	E	F	G	H	I	J	K*	L**
Skilled Nursing Facility coinsurance: Days 21 to 100 - $133 per day in 2009			X	X	X	X	X	X	X	X	50%	75%
Part A Hospital Deductible: $1068 in 2009		X	X	X	X	X	X	X	X	X	50%	75%
Part B Annual Deductible : $135 in 2009			X			X				X		
Part B Excess Charges: Coverage for up to 115% percent of Medicare's approved charge (Medigap policy will either pay 80% or 100% of excess charge)						100%	80%		100%	100%		
Foreign Travel Emergency: $250 deductible, 80% of the cost of emergency care during the first two months of the trip, $50,000 lifetime limit			X	X	X	X	X	X	X	X		
At-Home Recovery: Maximum benefit of $1,600 annually				X			X		X	X		
Preventive Medical Care: $120 maximum Annually for preventive services ordered by doctor					X					X		

- Plan K covers 100% of cost sharing for Medicare Part B preventive services and 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year once an individual has reached the out-of-pocket limit on annual expenditures of $4,620 in 2009.

****** Plan L covers 100% of cost sharing for Medicare Part B preventive services and 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year once an individual has reached the out-of-pocket limit on annual expenditures of $2,310 in 2009.

CHOICES 1-800-994-9422

05/01/2009- Monthly Medicare Supplement Rates for Standardized Plans in Connecticut

CHOICES
Hotline
1-800-994-9422

COMPANY	Telephone Number	Pre-ex. Cond. (1)	Disabled (2)	Date Approved (3)	A	B	C	D	E	F	F (4) High Deduct	G	H (6) w/out Rx	I (6) w/out Rx	J (6) w/out Rx	K (7*)	L (7*)
INDIVIDUAL PLANS:																	
American Progressive L&H Ins. of NY	800-645-4116	3 mos	A,B,C	04/04/08	$221.56	$286.80	$345.48	$313.76	$319.97	$328.07	$66.01	$288.02					
Anthem Blue Cross & Blue Shield	800-238-1143	N/A	A,B,C	11/10/08	$143.12	$174.04	$218.27	$204.87		$218.70	$57.00				$220.95		
Bankers Life and Casualty	800-621-3724	N/A	A,B,C	10/22/08	$326.34	$305.46	$373.15	$329.46	$338.52	$394.27	$39.90	$330.18			$285.34	$122.23	$172.79
Genworth Life & Annuity Assurance Co.	877-825-9337	N/A	A,B,C	05/1/09	$281.92	$343.57			$347.31	$418.24	$67.73						
Globe Life & Accident Insurance Co.	800-801-6831	2 mos.	A,B,C	02/19/09	$110.50	$149.00	$172.00			$173.50							
Humana Insurance Company	800-872-7294	3 mos.	A	07/01/08	$170.38					$201.48	$79.27	$191.57				$100.70	$146.13
Mutual of Omaha	800-775-6000	N/A	A	01/28/09	$341.12			$357.95		$296.00		$217.13					
Pennsylvania Life Insurance Co.	877-366-5433	6 mos.	A	11/26/07	$189.00			$204.00		$236.00		$196.00					
State Farm Mutual Automobile Ins. Co.	866-855-1212	N/A	A,C	09/04/08	$208.76		$314.84			$317.99							
United American Ins. Co. (Bankdraft)	800-331-2512	2 mos.	A,B,C	12/18/07	$165.00	$243.00	$283.00	$278.00		$287.00	$92.00	$273.00				$134.00	$188.00
United of Omaha Life Insurance Co.	877-778-0829	N/A	A	02/19/09	$266.00					$190.00		$176.32					
United Teacher Associates Ins. Co.	800-880-8824	6 mos.	A,B,C	04/01/09	$305.00	$358.04	$425.89	$360.16		$428.00		$362.27					
USAA Life Ins. Co.	800-531-8000	N/A	A	01/26/09	$208.59			$220.32		$225.59		$220.15					
GROUP PLAN:																	
United HealthCare – AARP (5)	800-523-5800	3 mos.	A,B,C	09/25/08	$120.00	$160.50	$193.75	$181.00	$181.75	$194.75		$182.00	$168.50	$170.50	$184.00	$91.25	$127.00

(1) Applicability of waiting period for pre-existing conditions now limited due to new laws. Contact the individual company or CHOICES for further clarification.
(2) Disabled plans are available to individuals on Medicare due to disability.
(3) The date the rate change is approved is not necessarily the date the rate change will go into effect. Check with the company for the effective date.
(4) High Deductible Plan provides the same benefits as Plan F after policyholder pays calendar year deductible ($2,000 for 2009.) Detailed deductible information available from the plan.
(5) Individuals 65 or older must be members of AARP in order to purchase the United HealthCare group policy. Individuals under 65 can join either the individual plan from United HealthCare or if they are members of AARP, they may purchase the group plan.
(6) Plan may only be sold on or after 1/1/06; In-force plans H,I & J with prescription drug coverage may continue to be renewed after 1/1/06 but not plans H,I or J may sold with Rx coverage on or after 1/1/06. Rates for plans H, I &J with Rx coverage are not reflected on this chart. Call specific company directly for rate information. (7) Plan may only be sold on or after 1/1/06. *Out-of-pocket (OPP) limit in 2009 for Plan K = $4,620 and for Plan L = $2,310.

NOTE: These rates reflect the lowest possible rates of availability from each company and may place certain restrictions on method of payment. They are accurate to the extent available to CHOICES from the CT Department of Insurance as of this date. Rates are subject to change. For complete information, please call the specific insurance company. CHOICES is a cooperative program of the State of Connecticut Department of Social Services, the Area Agencies on Aging, and the Center for Medicare Advocacy.

TRICARE for Life

TRICARE for Life (TFL) is a Medicare supplemental coverage program developed and offered by the Department of Defense for retired military personnel. This program began October 1, 2001. TRICARE provides medical services and support to Medicare eligible military retirees (including retired members of the Guard and Reservists) and their Medicare eligible dependents. Widows and certain former spouses may also be eligible for coverage under TFL if they were eligible for military retiree's benefits before the age of 65.

If eligible, beneficiaries receive all Medicare covered benefits under the Original Medicare Plan, plus all TFL covered benefits. TRICARE offers three health care options:

1. TRICARE Prime
2. TRICARE Standard
3. TRICARE Extra

TRICARE also offers a prescription drug plan called the TRICARE Senior Pharmacy Program which began April 1, 2001.

In order to be eligible for TRICARE you MUST:

1. Be registered with all current information in the Defense Enrollment Eligibility Reporting System (DEERS)
2. Be retired from the military, Guard or Reserves (or be a qualified dependent or former spouse)
3. Be enrolled in Medicare Part A & B

Other eligibility requirements may apply.

NOTE: Not all veterans qualify for TRICARE. To find out if you qualify for any of the above programs and to receive more information on TRICARE for Life call 1-888-DOD-LIFE or for information on the TRICARE Senior Pharmacy Program contact 1-877-DOD-MEDS or on the Web at www.tricare.osd.mil

All beneficiaries entitled to Medicare Part A and Part B must enroll in both in order to remain eligible for TRICARE. These beneficiaries will only be responsible for paying the standard monthly premium of $96.40 in 2009.

For more information on TRICARE changes log onto www.tricare.osd.mil/medicare

Eligibility Screening Tool

BenefitsCheckUp - Eligibility Screening Tool

Are you in search of financial and prescription drug assistance? You may want to try BenefitsCheckUp. BenefitsCheckUp is a free online eligibility screening tool developed by the National Council on Aging (NCOA) to assist seniors and their caregivers in finding state and federal programs and services for which they may be eligible. www.benefitscheckup.org

A new feature to this site is BenefitsCheckUpRx which can assist you in finding prescription drug discount programs. It takes approximately fifteen minutes to complete the online questionnaire. It does require that you provide some financial information. However, the questionnaire is anonymous and does not ask for any personal identifying information. At the conclusion of the screening you will get a report outlining programs for which you may be eligible.

You may complete the questionnaire on your own by logging onto www.ct.gov/agingservices and clicking on "BenefitsCheckUp" or you may call the CHOICES program at 1-800-994-9422 and a CHOICES counselor will assist you.

Special Low Income Assistance Programs

Special Assistance Programs

There are several programs through the Department of Social Services which provide health care assistance. These programs include QMB, SLMB, ALMB, ConnPACE, ConnMAP, and Medicaid for Medicare beneficiaries of modest financial means. To qualify the individual must be eligible for Medicare and must meet income guidelines.

➔ What is QMB?

QMB is the Qualified Medicare Beneficiary program. The **QMB** program provides

- ⇨ Monthly income allowed in CT: $1,181 for an individual and $1,771 for a couple. These figures change on April 1st each year.

- ⇨ Personal assets, including cash, bank accounts, stocks, and bonds cannot exceed $4,000 for an individual and $6,000 for a couple.

If the individual qualifies for the **QMB** program, the following benefits are available:

- ⇨ Payment of Medicare Part A monthly premiums (if applicable, $443/month in 2009);
- ⇨ Payment of Medicare Part B monthly premiums ($96.40 in 2009);
- ⇨ Payment of Part B annual deductible ($135/year in 2009);
- ⇨ Payment of co-insurance and deductible amounts for services covered under both Medicare Parts A and B.

Note: Individuals who are eligible for QMB probably do not need to purchase or retain a Medigap insurance policy. Check to see if the Medigap policy covers important services not covered by the QMB program. See the Medicare Rx section of this booklet to learn how individuals on QMB may qualify for the new Medicare prescription drug program and the Extra Help to cover the associated costs.

➔ What is SLMB?

SLMB is the Specified Low-Income Medicare Beneficiary program. The **SLMB** program provides limited payments for some Medicare beneficiaries. To qualify the individual must be eligible for Medicare and must meet income guidelines.
The Income Guidelines as of April 1, 2009 are:

- ⇨ Monthly income allowed in CT: $1,361.50 for an individual and $2,014. for a couple. These figures change on April 1st each year.

- ⇨ Personal assets, including cash, bank accounts, stocks, and bonds can not exceed $4,000 for an individual and $6,000 for a couple.

If the individual qualifies for the **SLMB** program, the following benefits are available:

- ⇨ Payment of Medicare Part B monthly premiums ($96.40 in 2009);

**** See the special note in the Medicare Rx section of this booklet to learn how individuals on SLMB may qualify for the new Medicare prescription drug program and the Extra Help to help to cover the associated costs.**

➔ What is ALMB (QI)? **

ALMB is the Additional Low-Income Medicare Beneficiary program. Another name for this program is the Qualifying Individual (QI) program. The **ALMB** program provides the same benefits as the SLMB program (payment of Part B premium), but is **subject to available program funding**. The income guidelines are also different from SLMB:

- ⇨ Monthly income allowed in CT in 2009: $1,497.05 for an individual and $2,196.25 for a couple. These figures change April 1st each year.

⇨ALMB (QI) program has been extended through December 2010.

**** See special note in the Medicare Rx section of this booklet to learn how individuals on ALMB may qualify for the new Medicare prescription drug program and the Extra Help to help to cover the associated costs. Applications and information about the QMB, SLMB, and ALMB programs are available at the individual's local Connecticut Department of Social Services office, listed in Appendix M-1 through Appendix M-3 in this booklet.**

CONNPACE

ConnPACE, the Connecticut Pharmaceutical Assistance Contract to the Elderly, helps eligible persons pay for most prescription drugs.

Who is Eligible?

- You must be 65 or older on Medicare A or B or a person over age 18 with a disability; and
- Your income must not exceed maximum limits. Effective **January 1, 2009**: Single applicants: $25,100; married couple: $33,800. *Income limits increase each January 1st based on the Social Security Cost of Living increase; and
- You must have been living in Connecticut for at least 183 days prior to application.
- In most cases, you **may not** have another insurance plan that covers a portion of all of your prescriptions.
- You **may** have an insurance plan that provides a maximum of benefits. Eligibility will be granted when you have reached your maximum benefit.
- You **may** have an insurance plan that covers only generics; under certain circumstances, ConnPACE may cover brand name drugs for which there are no generic equivalents as well as brand name versions of drugs that have generics.
- If you are eligible for ConnPACE, you are also automatically eligible for the Connecticut ConnMAP program. ConnMAP requires Connecticut Medicare providers to accept assignment.

How much does it cost?

♦Enrollment in the ConnPACE program is $30 per year per person.

♦A maximum co-payment of $16.25 will be charged by the pharmacy for each prescription filled.

What is Prior Authorization?

There are two situations in which ConnPACE recipients need to have their physician or pharmacist obtain prior authorization in order to have ConnPACE pay the program's portion of the prescription drug costs. The two circumstances requiring Prior Authorization are:

- Being issued a prescription written as "Brand Medically Necessary" when there is a therapeutic equivalent generic available.
- Seeking a refill when less than 75% of the previously issued drug has been utilized

Prior Authorization (PA) for brand name prescriptions and for some early refills (controlled drugs) requires the prescribing physician to complete certain forms in order to obtain PA for you. In instances when you are obtaining a refill early (most drugs) the Pharmacist will initiate the PA process for you. You should not have to do anything except remind your prescribing physician that you are on ConnPACE and may need PA.

For more information on Prior Authorization and to view Prior Authorization forms log onto www.ctpharmacyprogram.com or call ACS the Department of Social Services' contractor for Prior Authorization at 1-866-759-4113.

How will ConnPACE works with the Medicare Prescription Drug Program (Medicare Rx)?

If you have Medicare and want to enroll in ConnPACE, you need to enroll in a Medicare prescription drug plan. If you do not choose a plan yourself ConnPACE can choose one for you.

On December 1, 2005 Governor Rell signed into law a Bill that allows ConnPACE to "wrap-around" (meaning "work with" or coordinate benefits with) the new Medicare prescription drug program. ConnPACE recipients who are also enrolled in Medicare Part A and/or B are required to select and enroll in a Medicare Rx plan. Additionally, those recipients with incomes below $16,245 (single) or $21,855 (couple) and countable assets below $12,510 (single) and $25,010 (couple) (these rates include $1,500 burial allowance per person) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

How does ConnPACE work together with the Medicare Rx program?
Here is a summary of how the program works:

- The Medicare Rx plan that you enroll in will give you a member card that you will use at the pharmacy, just like you use your ConnPACE card now.

- You'll still pay your annual $30 ConnPACE membership fee.

- You won't have to pay any monthly premiums for Medicare coverage.

- The plan you select may have an annual deductible; however, during the time that you are meeting this deductible you'll never pay more that $16.25 for each prescription you fill.
- You won't have any gaps in coverage. The most you will pay in the coverage gap is $16.25.
- You will still have co-pay. The amount you pay will depend on the amount of your income and assets, but it will never be more than $16.25. It may even be less – as low as $2.40/$6.00 (for generic or brand-name drugs).
- The most you may be able to receive is a 90 day supply of medication at one time. This will depend on the pharmacy that you use.

How do I select and enroll in a Medicare Rx plan?
ConnPACE recipients have a few options for selecting and enrolling into a Medicare prescription drug plan.

1. **If you are new to ConnPACE you need to select and enroll in a Medicare Rx plan on your own.** Individuals can select and enroll into any one of the Medicare Rx plans on their own by logging onto www.Medicare.gov and using the online Medicare Rx plan finder tool. You can also call 1-800-Medicare or CHOICES at 1-800-994-9422 and a trained counselor will assist you. If you do not wish to enroll into a plan on your own you may request that ConnPACE select and enroll you into a plan by choosing that option on the ConnPACE application.

2. **If you were on ConnPACE prior to January 1, 2006 you should already be enrolled into a Medicare Rx Plan.** If you are **NOT please contact ConnPACE** at 1-800-423-5026 or a CHOICES counselor at 1-800-994-9422.

Can I change plans if I have ConnPACE?

Yes. You can change plans during the Annual Coordinated Enrollment Period, which is from November 15th – December 31st of each year. Your new coverage will be effective January 1st of the following year. Note: ConnPACE members are also entitled to a one time Special Enrollment Period per year.

NOTE: **If you have a Medicare Savings Program you are not limited to the Annual Coordinated Enrollment Period. You can change plans any time.**

How do I change plans?

To change plans, you just need to enroll in the new plan that you want. You don't need to disenroll from your existing plan! Your enrollment in the new plan will automatically cancel your enrollment in your former plan. **To avoid delays or problems with enrollment, it is strongly advised that you enroll in your new plan before the 8th of the month.** For example, if you want to be in your new plan by July 1, 2009, you should enroll by June 8, 2009

You can enroll in your new plan by calling the plan directly, calling 1-800-MEDICARE, or by calling CHOICES at 1-800-994-9422.

NOTE: If you are satisfied with the plan that you have you do not need make a change each year. You can remain in your current plan. You do not need to do anything to remain in your current plan.

I am on ConnPACE (or enrolling in ConnPACE for the 1st time) and qualify for the Extra Help to pay for the costs associated with Medicare Rx. Do I have to apply for the Extra Help?

Yes. ConnPACE recipients with incomes below $16,236 (single) or $21,852 (couple) and countable assets below $12,510 (single) and $25,010 (couple) (these rates include $1,500 burial allowance per person) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

Like the Medicare prescription drug benefit itself, the Extra Help subsidy will save you money. With ConnPACE and the Extra Help together, you will pay no premiums, and as little as $2.40/$6.00 per prescription. It will also save money for the State of Connecticut. For this reason, ConnPACE may have asked you to complete an application for Extra Help *if* your income is below the Extra Help income limit. If you are joining ConnPACE for the first time it is a good idea to complete an application for Extra Help before applying for the ConnPACE program. Contact the Social Security Administration at 1-800-772-1213 to receive an application for the Extra Help.

Who do I call if I have specific questions about Medicare Rx and the ConnPACE wrap-around?

For more information about how ConnPACE works with the Medicare prescription drug program contact CHOICES at 1-800-994-9422 and a trained counselor will be able to assist you.

Who do I call if I have specific questions about ConnPACE?

You may call ConnPACE directly from within the state at 1-800-423-5026 or you may call the CHOICES Program from within the state at 1-800-994-9422 and a trained counselor will assist you.

How Do I Apply for ConnPACE?

Call CHOICES at 1-800-994-9422 or ConnPACE 1-800-423-5026 for an application or for more information.
Please be aware that there may be additional changes to the ConnPACE Program in the future. For information regarding any new program changes please contact your regional Area Agency on Aging CHOICES Counselor listed at the back of this booklet.

WHAT IS CONNMAP?

ConnMAP is the Connecticut Medicare Assignment Program for **income-eligible residents** enrolled in Medicare Part B. ConnMAP assures, eligible persons, that Medicare providers will not charge more than the Medicare approved reasonable charge for Medicare Part B covered services. ConnMAP does not pay any portion of the bill. People with ConnMAP still have out-of-pocket expenses such as Medicare deductibles and co-insurances, unless they purchase supplemental insurance (Medigap) to cover these expenses. ConnMAP does not apply to Medicare Advantage plans.

Who is eligible?

- You must be enrolled in Medicare Part B
- You must meet income guidelines: **effective Jan. 1, 2009**; Single applicants: $41,415; married couple: $55,770. Income guidelines change Jan. 1st of each year.
- You must have been living in Connecticut for at least 183 consecutive days (6 months) immediately prior to the date of application.
- If you are eligible you will be issued a ConnMAP card. You must show the card to providers prior to treatment. **Providers may decline to treat patients with ConnMAP**
- If you are enrolled in ConnPACE and Medicare Part B, you don't need to apply for ConnMAP. A ConnPACE card may be used in lieu of a ConnMAP card.

How much does it cost?

There is no fee to enroll and participate in the ConnMAP program.
How do I apply?
For an application and more information call 1-800-443-9946.

WHAT IS THE LOW INCOME SUBSIDY (EXTRA HELP)?

It is a federal government program which offers you help to pay for Medicare's Prescription Drug coverage. It pays a portion of your premium, deductibles and co-pay amounts in all cases. It pays the entire premium for any PDP whose cost is below $31.74. It will reduce the co-pays for any medications on a Prescription Drug Plan's formulary, even if you are in a deductible period. You will pay no more than $2.40 for a generic and $6.00 for a brand name drug (if you qualify for the **LIS Full Subsidy** amount). Your income must be under $16,245 (single) or $21,855 (couple) and countable assets below $12,510 (single) and $25,010 (couple) (these rates include $1,500 burial allowance per person) are required to apply for Extra Help available to cover costs associated with Medicare Rx.

For Assistance in applying for Extra Help or more information please contact CHOICES at 1-800-884-9422 or Social Security at 1-800-772-1213.

WHAT IS MEDICAID?

Medicaid is a needs-based program which was created by Congress to help pay for medical care for certain elderly, disabled, and other persons who meet the very strict income eligibility criteria. Medicaid policies are complex and have been debated and changed often during recent years.

Also known as "Title 19," Medicaid is jointly financed by the federal and state governments. While each state is required to adhere to the basic eligibility and benefit requirements contained in the federal statute and regulations, significant details vary from state to state.

Like Medicare, Medicaid provides payment for health care services, but it is very different from Medicare in a number of ways. Unlike Medicare, Medicaid eligibility is predicated upon the income and assets of the beneficiary. In general, Medicaid is only available for individuals who do not have sufficient income and assets to pay for their own medical treatment - according to Medicaid's strict income criteria. However, Medicaid is not available to all such individuals. Only those who are 65 years of age or older, those who are disabled - as defined by the Social Security Administration, young children, and their caretaker relatives, may qualify for Medicaid.

Medicaid covers far more nursing home care than Medicare, since it pays for necessary custodial, as well as skilled care, and it has no limit on how long nursing home care may be covered for eligible individuals. Significantly, both Medicare and Medicaid can be a source of funding for home care which extends over a long period of time. Medicare, however, only covers home health care if the individual is homebound and needs some skilled nursing or therapy services. Medicaid, on the other hand, does not always require that a person be homebound in order to receive home health benefits, and it may or may not require that the person need a skilled service to qualify for the home care benefit.

Medicaid financial eligibility rules differ depending upon the state of residence and living arrangement of the applicant. In particular, the rules for establishing eligibility for Medicaid for a person living in the community are very different from the rules governing eligibility for those residing permanently in nursing homes.

If you are a Medicaid recipient and are also eligible for Medicare Part A and/or B, you will receive your prescription drug coverage through the **Medicare prescription drug program**, **Medicare Rx,** not Medicaid. Medicaid recipients in most cases MUST be enrolled in a Medicare Rx plan in order to retain their Medicaid health insurance benefits. When you become eligible for both Medicare and Medicaid you will automatically be assigned to a Medicare Prescription Drug Plan to make sure you don't miss a day of coverage. You can also enroll in a plan of your own choosing that may better meet your prescription drug needs, for more information please contact CHOICES at 1-800-994-9422. Full dual eligible individuals in CT who are enrolled into a Medicare Rx plan will continue to have a co-pay of $0 for their medications.

NOTE: If you are a Medicaid recipient and live in the community, and you are **NOT** eligible for Medicare Part A and/or B your prescription drugs will continue to be covered by the Medicaid program as usual.

For more information on Medicaid in general contact your regional DSS office, listed in the back of this book or call CHOICES at 1-800-994- 9422 and a trained counselor will assist you.

Note: Applications and information about the Medicaid program are available at the individual's local Connecticut Department of Social Services office, listed in Appendix M-1 through Appendix M-2 in this booklet.

DEPARTMENT OF SOCIAL SERVICES OFFICES

Bridgeport Office **Telephone Number: 203-551-2700**
925 Housatonic Avenue **FAX Number: 203-579-6790**
Bridgeport, CT 06606-5700
Towns Served: Bridgeport, Easton, Fairfield, Monroe, Norwalk, Stratford, Trumbull, Weston, Westport

Danbury Office **Telephone Number: 203-207-8900**
342 Main Street **FAX Number: 203-207-8970**
Danbury, CT 06810-4783
Towns Served: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Sherman

Hartford Office **Telephone Number: 860-723-1000**
3580 Main Street **FAX Number: 860-566-7144**
Hartford, CT 06120-1187
Towns Served: Avon, Bloomfield, Canton, East Granby, Farmington, Granby, Hartford, Newington, Rocky Hill, Simsbury, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks

Manchester Office **Telephone Number: 860-647-1441**
699 East Middle Turnpike **Toll Free: 800-859-6646**
Manchester, CT 06040-3744
Towns Served: Andover, Bolton, East Hartford, East Windsor, Ellington, Enfield, Glastonbury, Hebron, Manchester, Marlborough, Somers, South Windsor, Stafford, Tolland, Vernon

Middletown Office **Telephone Number: 860-704-3100**
117 Main Street Extension **Clinton, Deep River, Essex,**
Middletown, CT 06457-3843 **Old Saybrook: 860-388-3515**
Guilford: 203-453-8009
Madison: 203-245-5655
FAX Number: 860-704-3057
Towns Served: Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Guilford, Haddam, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Old Lyme, Old Saybrook, Portland, Westbrook

New Britain Office **Telephone Number: 860-612-3400**
30 Christian Lane **FAX Number: 860-612-3505**
New Britain, CT 06051-4121
Towns Served: Berlin, Bristol, Burlington, New Britain, Plainville, Plymouth, Southington

DEPARTMENT OF SOCIAL SERVICES OFFICES

New Haven Office **Telephone Number: 203-974-8000**
194 Bassett Street **FAX Number: 203-789-6930**
New Haven, CT 06511-1059
Towns Served: Ansonia, Bethany, Branford, Derby, East Haven, Hamden, Milford, New Haven, North Branford, North Haven, Orange, Seymour, Shelton, Wallingford, West Haven, Woodbridge

Norwich Office **Telephone Number: 860-823-5000**
Uncas-on-Thames **FAX Number: 860-892-1583**
401 West Thames Street – Unit 102
Norwich, CT 06360-7167
Towns Served: Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Ledyard, Lisbon, Montville, New London, North Stonington, Norwich, Preston, Salem, Sprague, Stonington, Voluntown, Waterford

Stamford Office **Telephone Number: 203-251-9300**
1642 Bedford Street **FAX Number: 203-251-9310**
Stamford, CT 06905-4731
Towns Served: Darien, Greenwich, New Canaan, Stamford, Wilton

Torrington Office **Telephone Number: 860-496-6900**
62 Commercial Street, Suite 1 **Toll Free: 800-742-6906**
Torrington, CT 06790-9983 **FAX Number: 860-496-6977**
Towns Served: Barkhamsted, Bethlehem, Canaan, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Winchester, Woodbury

Waterbury Office **Telephone Number: 203-597-4000**
249 Thomaston Avenue **FAX Number: 203-597-4048**
Waterbury, CT 06702-1397
Towns Served: Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, Southbury, Waterbury, Watertown, Wolcott

Willimantic Office **Public Hours Mondays, Tuesdays & Fridays**
676 Main Street **Telephone Number: 860-465-3500**
Willimantic, CT 06226-2702 **Fax Number: 860-465-3555**
Towns Served: Ashford, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Eastford, Hampton, Killingly, Mansfield, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Willington, Windham (Willimantic) and Woodstoc

Find CHOICES *about your Health Insurance concerns at …*

Your Regional Area Agency on Aging

Each of Connecticut's regional Area Agencies on Aging are staffed with a **CHOICES** Program Coordinator and informational assistants who have received special training in health insurance matters such as Medicare, Medicaid, Medicare Supplement Insurance (Medigap), Long Term Care Insurance and other related state and federal programs. Trained volunteers are also available to meet with seniors and other Medicare beneficiaries at sites throughout Connecticut. Call your Area Agency on Aging for free written information or advice, or referral to a counselor for further assistance. *Counselors do not sell insurance. They provide the information and assistance necessary for consumers to understand their rights, receive benefits to which they are entitled, and make informed* ***CHOICES*** *about health insurance and other aging concerns.*

Connecticut's Area Agencies on Aging are private, nonprofit organizations which serve the needs of older persons as a focal point and resource center for information, program development and advocacy.

Senior Resources/Eastern CT Area Agency on Aging
4 Broadway 3rd Floor
Norwich, CT 06360; 860-887-3561
www.seniorresourcesec.org

Agency on Aging of South Central Connecticut
One Long Wharf Drive
New Haven, CT 06511; 203-785-8533
www.aoapartnerships.org

North Central Area Agency on Aging
151 New Park Avenue
Hartford, CT 06106; 860-724-6443
www.ncaaact.org

Southwestern CT Agency on Aging
10 Middle Street
Bridgeport, CT 06604; 203-333-9288
www.swcaa.org

Western CT Area Agency on Aging
84 Progress Lane
Waterbury, CT 06705; 203-757-5449
www.wcaaa.org

Or call them toll-free through the
CHOICES Health Insurance Hotline
1-800-994-9422 (in state only)

CHOICES Health Insurance Assistance Program

CHOICES is coordinated by the Aging Services Division of the CT Department of Social Services and operated through CT's five Area Agencies on Aging. Specifically, the acronym "CHOICES" represents **C**onnecticut's program for **H**ealth insurance assistance, **O**utreach, **I**nformation and referral, **C**ounseling, and **E**ligibility **S**creening. The purpose of this program is to enable older persons to understand and exercise their rights, receive benefits to which they are entitled, and make informed choices about quality of life issues. For more information, including publications such as "Medicare Managed Care (HMO) in CT" and "Prescription Drug Assistance" please go to www.ct.gov/agingservices.

CHOICES has been designated as the official State Health Insurance Program (SHIP) for the State of Connecticut. It is funded in large part by the Centers for Medicare and Medicaid Services (CMS) of the U. S. Dept. of Health and Human Services, which administers the Medicare program for the federal government. CMS publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by calling the Medicare Hotline at 1-800-638-6833. You can also see or print them from the Internet at: www.medicare.gov.

Center for Medicare Advocacy, Inc.
P. O. Box 350, Willimantic, Connecticut 06226
860-456-7790 or 1-800-262-4414

The Center for Medicare Advocacy is staffed by attorneys, nurses, paralegals, and technical assistants and provides legal advice, self-help materials, and representation to elders and people with disabilities who are unfairly denied Medicare coverage. The Center's advice, written materials, and legal assistance are free to residents of Connecticut.

The Center also produces a wide array of self-help packets, booklets, and brochures. These materials are free to all residents of Connecticut as a part of the state's comprehensive Medicare Information, Education, and Representation program.

The Center's staff members serve as consultants and trainers for groups which are interested in learning about Medicare coverage and appeals. The Center also responds to approximately 6,000 calls each year on its Connecticut toll-free line and provides legal support and training for Connecticut's CHOICES program. In addition, the organization is involved in policy development, education, and litigation activities of importance to Medicare beneficiaries nationwide and has an office in Washington, DC.

The Center is an integral member of the CHOICES team, funded in large part by a grant from the State of Connecticut Department of Social Services.
For up-to-date Medicare information and advocacy tips,
visit the Center's Website: www.medicareadvocacy.org