Benefits Outreach Center

(Specializing in Benefits for Medicare-Eligibles)

Medicare 2012 Fact Sheet

Medicare Part B Coverage
Medicare Monthly Premiums
Medicare Prescription Drug Plan
Services Not Covered
Important Related Subjects

Part A Medicare Benefits

Inpatient Hospital Care

Includes a semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.

Benefits are paid on the basis of "benefit periods." A benefit period begins the first day you are hospitalized and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. If you enter a hospital again after 60 days, a new benefit period begins.

In 2012, a Medicare beneficiary is responsible for a deductible of $1,156 for the first day of each benefit period, after which Medicare pays for up to 60 days of full hospital care. For days 61-90, the beneficiary is responsible for $289 per day (co-payment). In addition, a beneficiary has 60 lifetime reserve days, and would be responsible for a co-payment of $578 per day for days 91-150. There is no Medicare coverage for days 150-365.

Skilled Nursing Facility (SNF) Care

A semi-private room, meals, skilled nursing, rehabilitative services, and other services and supplies are provided after a hospital stay of at least 3 consecutive days if ordered by the doctor. Medicare covers 100 days of skilled nursing or rehabilitative care in a SNF, provided the SNF is approved by Medicare and your treatment is connected with the illness that caused you to be hospitalized. You must need skilled nursing care or skilled rehabilitative care on a daily basis. Medicare pays days 1-20 in full; the beneficiary is responsible for a $144.50 per day co-payment for days 21-100. No custodial or intermediate nursing home care is provided.

Hospice Care

Medicare pays for unlimited hospice care for terminally ill patients in a Medicare-approved hospice program, through four benefit periods. There are no deductibles or co-payments, except for covered prescription drugs and inpatient respite care. Individuals must choose hospice care. You pay a copayment of up to 5 dollars for outpatient prescription drugs and 5 percent of the Medicare-approved amount for inpatient respite care (short term care given by another caregiver so the usual caregiver can rest.)

Home Health Care

Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment, supplies, and other services.

Medicare provides for full payment of intermittent part-time skilled care from registered nurses, therapists, and home health aides from a Medicare-approved home health agency. Intermittent part-time care is generally defined as care for 2-3 days a week up to 4 or 6 weeks. In exceptional cases, longer care may be provided. In order to be eligible, a beneficiary must meet all the following criteria: (1) Be under the care of a doctor, (2) Need care for a specific illness, (3) Be homebound, (4) Need skilled services, and (5) Need services on a part-time or occasional basis.

If you require skilled services (nursing, physical therapy, or speech therapy), you may also receive occupational therapy, social work services, and home health aide services if your physician determines you need them. Prior hospitalization is not necessary to receive home health services under Medicare. You pay nothing toward home health services and 20 percent of the Medicare-approved amount for durable medical equipment.

Part B Medicare Benefits

Physician Services (Inpatient and Outpatient), Outpatient Services, Outpatient Physical, Speech, and Occupational Therapy, and Durable Medical Equipment and Supplies

A Medicare beneficiary pays a $141.50 annual deductible and a 20 percent co-payment for Medicare-approved charges and services. Medicare pays 80 percent of its approved charge. A beneficiary pays all costs above Medicare-approved charges ("excess charge.") Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge Medicare beneficiaries for covered services. The limiting charge is 115 percent of the fee schedule amount for non-participating physicians. NOTE: Certain Medicare covered services, such as mental health services, physical and occupational therapy, and certain services rendered by special practitioners have special payment rules.

Drugs and Biologicals

Medicare pays the full-approved charge for flu shots and pneumococcal vaccine and its administration. Neither the annual Part B deductible nor the 20 percent co-payment apply to these services. Medicare covers certain oral anti-cancer drugs, subject to the Part B premium and 20 percent co-payment rules. Medicare helps pay for Hepatitis B vaccine and its administration, furnished to beneficiaries considered to be at high or intermediate risk of contracting the disease. Medicare also pays for immuno-suppressive drugs post transplant, if the transplant was Medicare-approved.

Preventive Health Benefits

- Welcome to Medicare visit during first 12 months on Medicare Part B. Medicare pays 100 percent.
- Annual wellness visit. Medicare pays 100 percent.
- A beneficiary 40 years of age and older is entitled to one screening mammogram every year. Medicare will pay a maximum of 100 percent of the approved charge; the Medicare Part B deductible will not apply. Beneficiaries must receive their mammography services at a Medicare-approved mammography site.
- Medicare pays for one Pap smear screening and related medically necessary physician services, including a physician's interpretation of the results of the tests every two years, or more frequently for women at high risk of developing cervical or vaginal cancers.
- Medicare will provide coverage for colon cancer screening tests; there are a variety of tests covered depending upon a person's risk of developing colon cancer.
- Medicare covers the costs of blood glucose monitors and most of the cost of test strips for people with diabetes, (both insulin and non-insulin dependent), and will provide coverage for educational and training services furnished to an individual with diabetes by a qualified provider at the direction of the beneficiary's physician.
- For an individual at high risk, Medicare provides coverage (100 percent) of bone mass measurement tests that detect bone loss and qualify to determine the likelihood of the person developing osteoporosis.
- Medicare will cover prostate cancer screening, (digital rectal exams and prostate specific antigen tests) for men age 50 and older, 80 percent coverage for the exam, no co-insurance or deductible for the PSA test.
- Medicare will pay 80 percent glaucoma screenings, once every 12 months for an individual who is at risk for glaucoma, including people with diabetes or a family history of glaucoma.
- Vaccinations include a flu shot once a year, a pneumonia vaccination once in your lifetime and a hepatitis shot for high risk individuals - 100 percent coverage.
- Medicare covers 100 percent of diabetic screenings, up to one to two tests per year, depending on your risk level.
- Medicare covers 100 percent of blood test screenings for cholesterol, lipid and triglycerides levels once every five years.

- Medicare may cover 100 percent for medical nutritional therapy if you have diabetes or kidney disease, and your doctor refers you.
- Medicare pays 100 percent for one abdominal aortic aneurysm screening if referred during the welcome to Medicare visit.
- Medicare pays 100 percent for an annual alcohol misuse screening and up to 4 face-to-face counseling sessions with a qualified primary doctor or provider.
- Medicare pays 100 percent annually for a depression screening done in a primary care setting.
- Medicare pays 100 percent for one EKG screening if referred at the welcome to Medicare visit.
- Medicare pays 100 percent for HIV screening on an annual basis, unless pregnant.
- Medicare pays 100 percent for an obesity screening done once a year by primary care providers and for face-to-face counseling (call for detail).
- Medicare will pay 80 percent for diabetes self-management training with a written order from a provider.
- Medicare will pay 80 percent for diabetic supplies - blood sugar test strips, testing monitors, lancets and test solution.
- Medicare will pay 100 percent for smoking cessation by a qualified professional.

Some Typical Services Not Covered by Medicare:

- **Long term custodial care** (nursing home)
- Private hospital room (unless determined to be medically necessary,) telephone and television
- Private duty nursing
- First 3 pints of blood, if you cannot replace them in some manner
- Routine physical exams, including most pre-surgical exams and tests
- **Dental care and dentures**
- Routine hearing exams and hearing aids
- Routine eye exams and eyeglasses, except cataract lenses (Routine eye exams for individuals with medical conditions which affect sight may be covered)
- Eye refractions
- All over-the-counter drugs
- Routine podiatry care (Routine care for persons with certain medical conditions, such as diabetes or vascular heart disease may be covered)
- Inpatient psychiatric care, after 190 days (lifetime limit)
- Acupuncture, and most chiropractic services
- Cosmetic surgery, unless caused by accidental injury or to improve the function of a malformed body part
- Full-time home care, homemaker services, home delivered meals
- Christian Science practitioners and Naturopath's services
- Orthopedic shoes, unless part of a leg brace and included in orthopedist's charges
- Ambulance service from home to doctor's office
- Services provided outside the United States (except for certain hospital and physician services in Canada or Mexico, under certain conditions)

Medicare Monthly Premiums

Part A Premium

Most individuals are entitled to "premium-free" Part A benefits based on their or their spouse's work history. Other individuals may be eligible to purchase Part A benefits at $451 per month, 0-29 quarters, $248 0-39 quarters, if they have less than 40 quarters of Social Security coverage.

Part B Premium

The regular Part B premium will be $99.90 per month in 2012, if a person has an income of under $85,001 or a couple has an income under 170,000. Individuals who fall above the income requirements for this premium will be subject to an income-related monthly adjustment amount. To find out more information, contact the Centers for Medicare and Medicaid at 1-800-MEDICARE.

Important Related Subjects

Qualified Medicare Beneficiary Program (QMB)

Known as QMB or Quimby, this program will pay the premiums, deductibles, and coinsurance payments of the Medicare Program for older and disabled individuals who are financially eligible. The current QMB eligibility guidelines are: $951/month income and $8,440 in assets for an individual; and $1,281/month income and $13,410 in assets for a couple. QMB-eligible beneficiaries must go to medical care providers who participate in the Medical Assistance Program. In addition to the income and assets stated, an individual or couple may have a house, car, and a burial plan, and still be eligible for the QMB Program. Applications are made for the QMB Program through the local Departments of Social Services.

Specified Low-Income Medicare Beneficiary Program (SLMB)

Also known as SLMB or SLIMBY, this program will pay the Medicare Part B premium ($99.90 per month in 2012 for people whose income is slightly more than the QMB criteria. The current SLMB eligibility guidelines are: $952 - 1,277 month income and $8,440 in assets for an individual and $1,282 -1,723/month income and $13,410 in assets for a couple. As with the QMB Program, an individual or couple may hold certain assets (house, car, burial fund, etc.) which may be exempt from consideration. Applications are made for the SLMB Program through the local Departments of Social Services. Eligibility guidelines become effective April 2012. Check your local program!

Medicare Prescription Drug Plan

As of January 2006, the Medicare Prescription Drug Program will offer coverage to everyone with Medicare. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. You choose the drug plan. Although premiums and deductibles may vary according to the plan, in general they will be similar to the following for 2012:

- You will pay a premium average of around $34.57 per month.
- You will pay the first $320 (a deductible) the beginning of each year.
- You will pay about 25 percent of covered prescription drug costs from $320 to $2,930.
- You will pay 100 percent of the costs between $2,830 until you reach $6,440.
- You will pay 50 percent of brand drugs (discounted 50 percent) and 86 percent of generic drugs (discounted 14 percent) in the coverage gap.
- You will pay 5 percent of covered prescription drug costs over $6,440.
- At the catastrophic level of $6,657.50, you will have spent $4,700 in out-of-pocket costs.

Each plan will have its own list of covered drugs, called a formulary list. You can apply for the New Medicare Prescription Plan by making a list of your drugs then call 1-800-MEDICARE which is 1-800-633-4227 or visit www.medicare.gov/. By giving them your zip code and list of your drugs, they will tell you which Medicare Prescription Drug Plan covers all your drugs and will best fit your needs.

You will qualify for extra help to pay premium, deductible and co-payments if you are single and have an income level below $16,755, and a resource value of $13,070 or less. For couples, if your income is below $22,695 and your resources are below $26,120. In order to apply for the extra help, individuals will need to fill out an application from Social Security or apply online at www.ssa.gov/.