

SINCE YOU CARE

A Series of Guides from MetLife® in Cooperation with the National Alliance for Caregiving

Medicare and Medicaid Programs - The Basics

About the Subject

MEDICARE AND MEDICAID

America's population is aging. The cost of caring for aging adults is increasing in both time and money. Two programs are in place to assist with the provision of health care for older adults. One is Medicare which is available to individuals 65 years of age and older as well as to people under 65 with certain disabilities, including those with End-Stage Renal Disease¹.

The other is Medicaid. Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program is available to individuals of all ages, but eligibility for Medicaid is based on a person's income and assets. Individuals or families applying for Medicaid coverage must meet the guidelines set forth for acceptance into the program.



MetLife

Caregivers face many challenges as they search for information and make decisions about how best to provide care to their loved ones. To help meet their needs,

MetLife offers SinceYouCare® — a series of guides which provide practical suggestions and useful tools on a variety of specific care-related products.

Although the federal government has established broad guidelines for eligibility standards, each state is responsible for its own rigorous eligibility guidelines.² The Medicaid program pays for approximately 43.8% of long-term care services in the United States.³

These two important programs, Medicare and Medicaid, will be discussed in more detail with each having its own section of this guide.

MEDICARE

The Medicare system, with its guidelines, provider networks, rules and regulations, supplemental plans and other details can be confusing. It is important that Medicare beneficiaries and their families and caregivers understand what benefits and coverage Medicare provides.

Medicare was created in 1965 as a form of health care coverage for qualifying individuals. A qualifying individual:

- Is 65 years of age or older and has worked 40 or more quarters in Medicare-covered employment or
- Is 65 years of age or older and has a spouse who has worked 40 or more quarters in Medicare-covered employment or

- Is a person under age 65 with certain disabilities or End-Stage Renal Disease⁴.

Medicare covers some 39 million older adults and disabled Americans.⁵

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). For many Americans Medicare is their only source of health insurance. It is not, however, all-inclusive or comprehensive in its coverage. It also has premiums, deductibles, and other costs associated with it.

Beginning in 2004, Medicare approved drug discount cards became available. The drug discount card program is a temporary program and will begin to phase out in January 2006 when Medicare Prescription Drug Plans become available. People may enroll in the Medicare approved drug discount card program any time up until November 30, 2005. To get more information and compare Medicare approved drug discount cards that are available, you may visit www.medicare.gov. or call 1-800-633-4227.⁶

Beginning in 2006 Medicare will contract with private companies to offer voluntary prescription drug coverage. These companies will likely offer

various options with different covered prescriptions and different costs. While plans may vary, in general they will have a monthly premium which will be based on the plan chosen. After the individual pays \$250 annual deductible, the individual will pay 25% of the yearly drug costs from \$250 to \$2,250 while the plan pays 75%. The individual pays 100% of the drug costs from \$2,251 until his or her out-of-pocket costs reach \$3,600. The individual then pays 5% of drug costs or a small co-payment for the rest of the calendar year and the plan pays the rest. Plans may offer more generous benefits for a higher premium. Participation is voluntary. However, if an individual does not enroll when he or she is first eligible, the individual may have to pay a higher premium to join at a later time. Medicare participants should be receiving more information about the prescription drug plans during 2005.⁷

Things You Need to Know

Original Medicare, as it is now often called, has two distinct parts, Medicare Part A and Medicare Part B. They cover different services, have different deductibles and co-insurance payments, and differ in whether or not a standard premium is charged for participation.

Medicare Part A

- Medicare Part A is sometimes called hospital insurance. It is funded by a payroll tax of 1.45% paid by employees and employers.⁸

The services covered are:

- Hospitalizations
- Skilled nursing facility stays
- Home health care
- Hospice care
- Blood transfusions during a hospitalization or nursing facility stay.

Service coverage is not all-inclusive and there are guidelines for reimbursement and deductibles. For example:

- Time spent in a hospital is covered if ordered by the doctor and determined to be appropriate under Medicare guidelines. Lengths of stay in the hospital are reviewed by Utilization Review Committees. Medicare has a deductible for hospital stays as well as co-payments for days 61-90 and 91-150 during a hospital stay. The amounts change from year to year.
- Time spent in a skilled nursing facility is covered if a three-day related hospital stay preceded the individual's stay and a doctor prescribes skilled care. After day 20 there is a co-payment for each additional Medicare qualifying day up to day 100. A person must meet

Medicare skilled criteria to continue receiving benefits up to day 100. During each episode of care after day 100, Medicare will no longer reimburse nursing home care.

- Home Health Care services are covered if a doctor prescribes skilled care provided by a health care professional such as a nurse or therapist and it qualifies under Medicare guidelines. The care must come from a certified Medicare Home Care Agency and the services must be intermittent in nature. The person receiving the care must be homebound which means that the person is not normally able to leave the home and leaving the home takes considerable and taxing effort. A person may leave on occasion such as for doctor visits or to attend religious services. Medicare doesn't cover 24-hour in-home care or the use of an aide or assistant for personal care services on an on-going long-term basis.
- Hospice benefits are available for those covered under Medicare Part A. Individuals selecting Medicare Hospice Benefits would be selecting them instead of their regular Medicare benefits for care of their terminal ill-

ness. The hospice benefit covers an array of services to support individuals who are terminally ill and their families. CMS produces a booklet which describes how the hospice benefit works. It can be printed from the web site at www.medicare.gov.

Medicare Part B

Medicare Part B, sometimes called "medical insurance," is available to individuals when they become eligible for Part A. It covers some medical and other services such as outpatient hospital services, certain outpatient therapies, doctor services, preventive health screens, durable medical equipment, laboratory services and some home health care benefits. Again, there may be requirements in order for Medicare Part B to pay these costs. There is a yearly deductible (\$110 in 2005) and then Part B pays 80% of the covered cost for most services. Some outpatient services may be fully covered and others maybe reimbursed by Medicare at less than 80%.⁹

Enrolling in Medicare¹⁰

In general, if individuals already receive Social Security benefits, they are automatically enrolled in Medicare Part A, effective the month they turn 65. Enrollment in Part B, which is offered at that time, is voluntary. If you choose

not to sign up for Part B when you become eligible, the cost per month may be slightly more should you choose to enroll at a later time than if you signed up for both Part A and B at the same time. Approximately 95% of beneficiaries with Part A enroll in Part B.¹¹ A Medicare card is sent out about three months prior to the date that people become eligible for coverage.

The application for Social Security or Medicare, for those who are not currently recipients of either, should begin three months prior to the 65th birthday. The initial enrollment period for Medicare Part B begins three months prior to the 65th birthday, includes the month the individual turns 65, and then concludes with the third month following. Delaying enrollment until one's 65th birthday will delay the effective date of Medicare Part B coverage.

Cost

An individual who has worked 10 or more years for an employer who paid into the Medicare system incurs no cost for Medicare Part A. However, Medicare Part B has a monthly premium which is adjusted each fall and becomes effective January of the following year. The premium is deducted each month from

an individual's Social Security, Railroad Retirement or Civil Service Retirement. If the individual receives none of these, Medicare will send a bill every three months.¹²

If a person has not worked at all in a Medicare covered employment or only partially so as not to have earned enough quarters, it may still be possible to pay premiums for Medicare. Information may be obtained by calling the Social Security Administration at 1-800-772-1213.

The Part B premium in 2005 is \$78.20 a month. Costs generally increase each year.¹³

There are instances where there are state and government funding available for assistance to cover some Medicare costs. The program is called the "Medicare Savings Program."¹⁶ Program eligibility is based on income and resources with guidelines for individuals as well as couples. Information on the program can be obtained at any office handling Medicaid applications. You may call your local Department of Human Services or Social Services. The number is usually in the blue pages of

your phone book. Information on your state can be found by going to www.medicare.gov. Scroll down the page and click on "Find Helpful Phone Numbers and Websites." Select "State Medical Assistance office" and identify your state.

Most providers of health care services, products and durable medical equipment contract with original Medicare Parts A & B but it is always good to verify coverage before receiving care or ordering services in order to verify payment.

Medigap

Medigap is not a government-sponsored program; rather, it is a series of products offered by private insurance carriers providing supplemental insurance to the Medicare program. As the name implies, it covers the "gaps" for deductibles, co-insurance and other charges not covered by Medicare. To be eligible to elect a Medigap policy, an individual must be enrolled in Medicare Part A & B.

The government has devised ten standardized plans to simplify Medigap coverage. These plans are lettered A through J. All states, with the exception of Massachusetts, Minnesota and

Wisconsin, offer the same standardized plans. However, as in any privately marketed product, the number of plans offered in a state as well as the premiums for them can vary.

Every Medigap plan must include the basics:

- The Medicare Part A co-insurance for day 61-90 and days 91-150 of a hospital stay
- Coverage of up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits
- Co-insurance or co-payment amount for Medicare Part B services after you meet the yearly deductible
- The first three pints of blood or equal amounts of packed red cells per calendar year.¹⁶

An individual may enroll in any Medigap plan during his or her open enrollment period. The open enrollment period begins the first day of the month in which a person is 65 and is enrolled in Medicare Part B.¹⁶ During this open enrollment time, an insurer cannot deny an individual a policy based on pre-existing conditions or charge more because of them.

If an individual has a Medigap plan and decides to drop it, it is likely that he or she will not be

able to re-enroll at a later date. However, if the person moves out of the service area or the company selling the Medigap plan doesn't renew its contract with Medicare, the person would have the right to re-enroll.

If a person is enrolled in a Medicare Advantage Plan (see next section), there is no need for a Medigap plan. It is illegal for a company to sell someone a Medigap policy knowing the person is enrolled in a Medicare Advantage Plan.¹⁷

A Medigap policy is not required if someone is in a Medicare Advantage Plan.

To find out what policies are available and who the providers are in your state, contact your state's Insurance Department. For information to assist you in determining what Medigap plan might be right for you, contact your State Health Insurance Assistance Program (SHIP). These numbers can be found by going to www.medicare.gov. Scroll down the page and click "Find Helpful Phone Numbers and Websites." Then click on "Related Websites," to reach SHIP. Search by organization and state to obtain contact information.

Medicare Advantage
Congress passed a law in 1997 that implemented new



Medicare Health plans called Medicare Advantage.¹⁸ Under the Medicare Advantage option, private companies contract with Medicare to provide health care services to Medicare recipients. Currently, with nearly 40 million¹⁹ Americans in the Medicare program, over 4,600,00 individuals²⁰ have chosen Medicare Advantage Options.

In these plans individuals are enrolled in the Medicare system, but their health care benefits are administered by Medicare Managed Care Plans such as:

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Private Fee-for-Service Plans (PFFS).

Medicare pays a set amount to the Managed Care Plan or PFFS plan and in turn, the plan determines what the cost reimbursement will be to the provider as well as to the insured individual. All the Medicare Advantage plans must offer at least the same services as Original Medicare. Most offer more, such as medications, eye exams, routine physicals, but sometimes with added costs and restrictions. Not all areas of the country will offer the same number or type of plans. Benefits, premiums and co-payments may all change from one year to the

next. You would need to check with the Medicare provider as to the specifics of coverage.

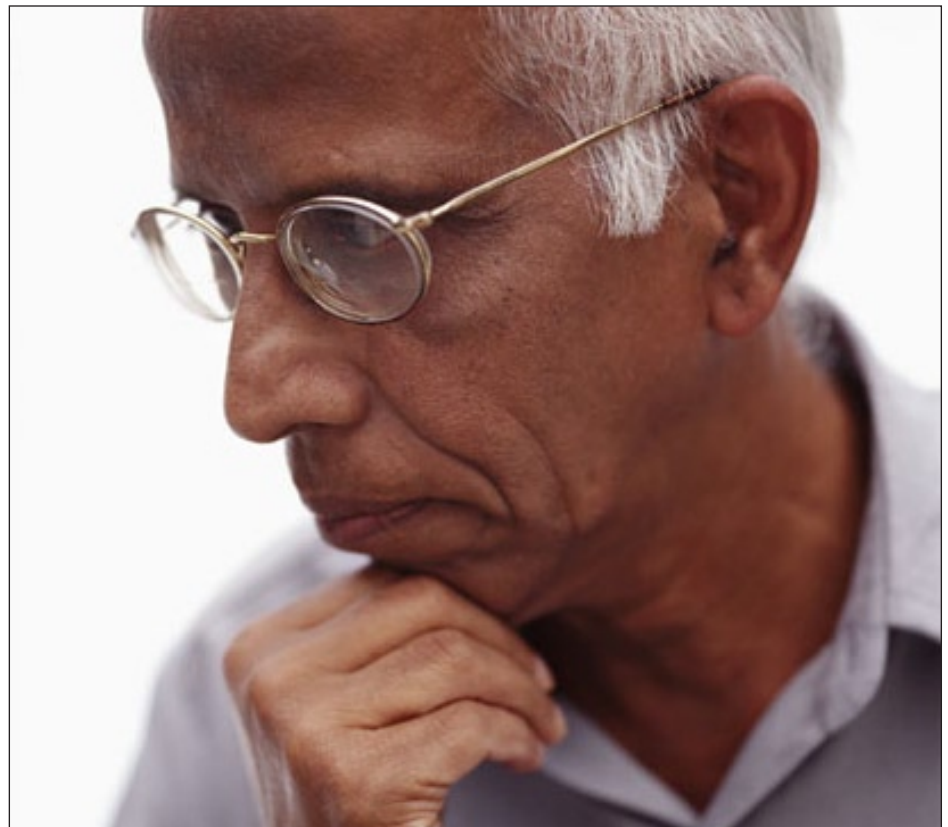
Enrollment

Any individual who opts for a Medicare Advantage plan must have both Medicare Parts A & B prior to enrollment and continue paying the Part B premium while in the Medicare Advantage Plan. Enrollment in a Medicare Advantage Plan can take place anytime as long as the plan is accepting new members, but a plan can limit its numbers. If the plan is still open to new members, it must accept them from November 15 - December 31 of each year.²¹

Leaving the Plan

Medicare Advantage Plans may discontinue their Medicare contract at the end of each year, if they choose to do so. They must notify their members if they are going to leave the program. If an individual's plan stops providing services in his or her area or leaves altogether, the individual has the right to join another Medicare Advantage Plan in the area or return to Original Medicare.

If a plan leaves the service area, individuals have the right by law to purchase Medigap policies A, B, C or F or in some instances other options depending on their length of stay in the plan or state-



specific laws which may provide additional rights.²² They must apply for Medigap within 63 days of the end date of the non-renewing Medicare Advantage plan, during which time the company selling the Medigap plan cannot deny coverage or increase premiums due to pre-existing health conditions or past and present health problems.²³

Types of Medicare Advantage Plans

Medicare HMO

- Individuals must use network providers. They will need a primary care doctor who will provide a referral for a specialist if necessary. Services may be more expensive or not covered if they are out of the service area and network providers are not used. The plan can charge a premium above the monthly Part B premium but only up to a limit. Providers must accept HMO payment as payment in full.

Medicare PPO

- Individuals may use network providers but they may also go out of the network and pay more. Primary care doctors or referrals for specialists are not generally required. The plan can charge a premium above the monthly Part B premium but only up to a limit.

Private Fee for Service

- Individuals may usually go to any physician or hospital willing to provide care and accept the plan's payment. There is often a co-payment amount. Depending on the plan, the provider may be able to charge you more than the plan's reimbursement amount for services, which means you will incur a higher cost. The plan can charge a premium above the monthly Part B premium. It is important to check with the company offering the plan regarding the service payment amounts as well as premiums.

These are general guidelines. For plan specifics and payment amounts, you should call the plan you are interested in and ask that an information packet be sent to you.

In an effort to maintain member satisfaction with the care provided by private health plans to its Medicare members, CMS has standards that a health care plan provider must meet before entering into a contract with Medicare:

- All doctors accepting Medicare payment must be licensed in the state in which they are practicing

- Hospitals, nursing homes, home care agencies and suppliers must be Medicare certified
- Medicare Advantage plans must meet state and federal government standards for care
- Managed Care Plans must have a quality assurance program in place before entering into a contract with Medicare²⁴

Aside from these markers, quality of care can vary. For questions and to check ratings, access the CMS Web site or call Medicare. The information can be found under *Resources to Get You Started* at the back of this guide.

Bills have already been introduced that propose changes to significant portions of the new Medicare law. Full or partial passage of these bills may change much of the information presented in this guide. If you have specific questions regarding your coverage or eligibility, it is important to contact the Centers for Medicare and Medicaid Services via the Internet at www.cms.hhs.gov or call (toll-free) 877-267-2323 or TTY (toll-free) 866-226-1819.

MEDICAID

(Sometimes called Title 19)

Medicaid became law in 1965 and began as a cooperative venture, jointly funded by federal and state governments, to assist in furnishing medical assistance to eligible needy persons. It is, at present, the largest source of funding for medical health-related services for America's poor. In 2000, 43 million people²⁵ received health care services through Medicaid at an average cost of \$3,935 per person.²⁶ However, unlike Medicare, individual states control much of their Medicaid coverage and eligibility.

The federal government established broad national guidelines under which each state can:

- Establish its own eligibility standards
- Determine the type, amount, duration and scope of services
- Set the rate of payment for services
- Administer the program.

Because each state can set its own standards, there is much variation in Medicaid services from state to state. Even those in close geographic proximity to one another can vary greatly in the amount, duration or scope of services.

Basic Services

The federal government allows for a certain degree of flexibility in how the states administer Medicaid funding, but it also has some mandatory requirements for services if a state is to receive matching federal funds. A state's Medicaid program must provide certain basic services such as:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Nursing home services for those 21 years or older
- Home Health Care services for those persons eligible for skilled nursing care.

A state may also offer a variety of optional services, some of which are:

- Diagnostic services
- Clinic services
- Prescription drugs and prosthetic devices
- Transportation services
- Rehabilitation and therapy services
- Home and Community Based Care (HCBS) to certain persons with chronic impairments.

In addition to the federally funded and matched funds of Medicaid, many states also have state-funded assistance programs that are not federally matched.

Medicare and Medicaid — Dual Eligibility

Some individuals enrolled in the Medicare program also qualify for Medicaid assistance. In an instance where an individual meets full eligibility for a state's Medicaid program and is enrolled in Medicare, Medicaid supplements the Medicare health care coverage. Any individuals eligible and covered by Medicare are first covered under the Medicare program. Medicaid pays for the remainder of services, as it is always the last payor.

Some Medicare participants, depending on their state's requirements, may be able to receive assistance with paying Medicare premiums and co-payments through Medicaid programs. It is best to speak with your local Medicaid office or Department of Human Services to discuss these programs.

The Medicaid program utilizes HMO provider networks and allows individuals some choices in the care they receive. Dependent on the situation, states may require minimal co-pays and deductibles on some services. Many providers accept Medicaid payment as payment in full.



Helpful Hints

- You can reach Medicare customer assistance 24 hours a day, 7 days a week at 800-633-4227. TTY users should call 877-486-2048.
- The Medicare program adjusts coinsurance amounts, deductibles, benefits, and premium rates in the autumn of each year. This is a good time to review your Medicare plan for any changes that you might like to make. Any changes made go into effect in January of the next year.

Resources to Get You Started

Books and Publications

All About Medicare - 2004

This publication provides pertinent information about Medicare and Medicaid in a topic related

question and answer format. It also includes state specific contact information for Medicare insurers, insurance counseling and Medicare Quality Improvement Organizations which can answer questions about quality of care and access to care in Medicare-certified facilities.

Fenton, John H. ed, (2004), The National Underwriter Company, \$16.95, ISBN: 0872186474

Medicare and Other Health Insurance as You Retire

This is a free publication booklet offered by AARP. You may request a copy by accessing the AARP web site at www.aarp.org. Enter "Order Popular AARP Booklets" in the search field. You may write to AARP at 601 E. Street NW, Washington, DC 20049 or call 888-687-2277, Monday-Friday. 8 a.m. - 8 p.m. E.T. Request booklet #D17739.

Medicare for the Clueless: The Complete Guide to Government Health Benefits

This is a clear, straightforward manual on accessing Medicare's benefits. It provides directions for bill paying, outlines your rights as a beneficiary and helps remove the mystery from much of the Medicare system.

Conklin, J.H. (2002). Kensington Publishing Corporation, \$11.65, ISBN: 0806523166

The Complete and Easy Guide to Social Security, Healthcare Rights and Government Benefits (Complete and Easy Guide to Social Security and Medicare)

This is a wonderful resource book with a vast amount of information on Social Security, Medicare, Medigap and other programs. It has a clear and simply outlined table of contents allowing for quick and easy access to many questions surrounding navigation of the Medicare system. It also provides information on how to check quality standards and backgrounds on doctors, hospitals and HMOs. It provides many useful telephone numbers and contact information.

Jehle, F.F., (2000). Emerson Adams Press Inc., \$19.95, ISBN: 1892803143

Internet Sites

AARP

AARP is a nonprofit organization dedicated to people age 50 and over. AARP provides a vast range of benefits, products and services to its members. AARP hosts a Web site with a monthly online magazine, bulletin and Spanish newspaper. You do not have to be a member to take

advantage of the resources on this site. AARP offers many free brochures and publications on Medicare, health plans, medications and more. www.aarp.org

Benefits CheckUp

This site is maintained by the National Council on the Aging and helps individuals 55 years or older determine their eligibility for programs that may

help them cover the cost of medications, health care and other necessary services. All the information is completed on-line with a simple, confidential and straightforward questionnaire. Access the site at www.benefitscheckup.org.

FIRSTGOV for Seniors

The site is hosted and maintained by the Social Security Administration and provides access to useful information on health and education, tax assistance, links to federal sites, state specific information and much, much more. You can access the site at www.Firstgov.gov. You may also call 1-800-333-4636 for any question about government programs.

Centers for Medicare and Medicaid Services (CMS)

This is the main Medicare and Medicaid site maintained by the federal government. It provides information on benefits, on-line publications, prescription drug assistance, telephone contacts for information, assistance and much more. Access the CMS site at www.CMS.gov. To obtain information about Medicare you may contact CMS toll free 24 hours a day, 7 days a week at: 1-800-633-4227, TTY users should call 1-877-486-2048.



The Medicare website allows an individual to link to other websites to obtain information about state programs and social security. It is located at www.medicare.gov. Scroll down the page and click on “Find Helpful Phone Numbers and Websites.”

Social Security Administration (SSA)

This is the principal site of the Social Security Administration. You may order and download publications at this site, locate your local SSA office or obtain phone numbers for questions and assistance. Access the site at www.socialsecurity.gov. You may also reach Social Security toll free at 800-772-1213, Monday-Friday, 7 a.m. to 7 p.m. ET. Automated service is available 24 hours a day, seven days a week. TTY users should call 800-325-0778.

Useful Tools

- Enclosed is an Original Medicare Part B and Medicare Advantage Comparison chart.

Endnotes

- ¹ *Medicare & You - 2004*, via the Internet at www.medicare.gov/Publications/.
- ² Centers for Medicare & Medicaid Services, via the Internet at www.cms.hhs.gov/medicaid/whatismedicaid.asp.
- ³ *Who Pays for Long-Term Care?*, Department of Health and Human Services, Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, 2001.
- ⁴ *Medicare & You - 2004*, via the Internet at www.medicare.gov/Publications/.
- ⁵ *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, 2000*, p. 3 www.census.gov/prod/1/pop/p25-1127.pdf.
- ⁶ *Medicare & You - 2005*, via the Internet at www.medicare.gov/Publications/.
- ⁷ Ibid.
- ⁸ *Medicare at a Glance*, Fact Sheet, The Henry J. Kaiser Family Foundation, March 2004.
- ⁹ *Medicare & You - 2005*, via the Internet at www.medicare.gov/Publications/.
- ¹⁰ Medicare Enrollment data from Centers for Medicare & Medicaid via the Internet at www.medicare.gov, 2003.
- ¹¹ *Medicare & You - 2004 - What is Medicare Part B?*, via the Internet at www.medicare.gov/Publications/.
- ¹² Centers for Medicare & Medicaid via the Internet at www.medicare.gov.
- ¹³ Centers for Medicare & Medicaid via the Internet at www.medicare.gov.
- ¹⁴ For all info pertaining to Medicare Savings Program: AARP: *Medicare Savings Program* via the Internet at www.aarp.org/money/lowincomehelp/Articles/a2003-05-05-lowincome_medicare.html.
- ¹⁵ *Medigap Coverage*, Centers for Medicare & Medicaid via the Internet at www.medicare.gov, accessed 09/03.
- ¹⁶ Ibid.
- ¹⁷ *Medigap Policies - The Basics*, Centers for Medicare & Medicaid, accessed 8/03.
- ¹⁸ *Ask a Question*, www.Medicare.gov, accessed 2/04.
- ¹⁹ *Medicare Eligibility Tool*, Medicare.gov, via the Internet at www.medicare.gov, accessed 2/04.
- ²⁰ *Medicare Managed Care Contract Report*, via the Internet at www.cms.hhs.gov, accessed 2/04.
- ²¹ *Medicare Personal Plan Finder*, Centers for Medicare & Medicaid, via the Internet at www.medicare.gov, accessed 8/03.
- ²² FirstGov for Seniors
- ²³ Ibid.
- ²⁴ *Choosing a Medicare Health Plan*, Centers for Medicare & Medicaid, Publication No. 02219, revised 12/02 via the Internet at www.medicare.gov, accessed 9/03.
- ²⁵ *Medicaid: A Brief Summary*, Centers for Medicare & Medicaid Services, November 1, 2003, via the Internet at www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp.
- ²⁶ Ibid.

About the Authors of Since You Care®

Since You Care guides are prepared by the MetLife Mature Market Institute in cooperation with the National Alliance for Caregiving and MetLife's Nurse Care Managers.

MetLife Mature Market Institute® is the company's information and policy resource center on issues related to aging, retirement, long-term care and the mature market.

MetLife Nurse Care Managers are available to MetLife's long-term care customers and their caregivers, on a daily basis, to help identify and resolve caregiving questions and concerns through counseling and referral.

National Alliance for Caregiving is a non-profit coalition of 38 national organizations that focuses on issues of family caregiving.

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This information is general in nature. It is not a substitute for obtaining guidance from a healthcare, financial or other professional.

Medicare Plan Chart

Questions To Consider When Making Medicare Decisions

Medicare Advantage Plan

Original Medicare Part B

Provider Access

Can I see MDs both in/out of network, even if I have to pay more?

Yes No

Yes No

Do I need a primary MD?

Yes No

Yes No

Do I need referrals for specialists?

Yes No

Yes No

Can I keep my long-time physician?

Yes No

Yes No

What are payment arrangements if I am out of town and need care, or if I need emergency care?

Additional information: _____

Cost

Are there additional premiums?

Yes No

Yes No

Did premiums go up last year?

Yes No

Yes No

If so, how much? _____

What are the deductibles? _____

- Co-pay? _____

- Co-insurance amounts? _____

Do providers accept plans payment amount?

Yes No

Yes No

What is the monthly cost? _____

Additional information: _____

Questions To Consider When Making Medicare Decisions

Medicare Advantage Plan

Original Medicare Part B

Benefits

What are the extra benefits? _____

Is there dental coverage? Yes No Yes No

Is there vision coverage? Yes No Yes No

Is there foreign travel coverage? Yes No Yes No

Does it cover co-insurance and co-pays? Yes No Yes No

Is there a medication plan for generic and/or name brand drugs? Yes No Yes No

If there is a medication plan, is there a cap? Yes No Yes No

• A deductible? Yes No Yes No

Additional information: _____

Quality Compare/Ratings

Are bills submitted for reimbursement? Yes No Yes No

Who processes paperwork? _____

Are the hours of operation convenient? Yes No Yes No

Who can answer billing questions? _____

Additional information: _____

Medigap

Do I need a Medigap plan? Yes No Yes No