Medicare Made Clear™
Quick Reference Guide

Helping your employees and volunteers understand Medicare.
Medicare helps more than 55 million older and disabled Americans save on their health care expenses. But Medicare is not one-size-fits-all. There are choices people need to make. This brochure provides an overview of Medicare, including how and when to enroll, and the different coverage options.
n4a is working with United-Healthcare to provide educational tools that Aging Network staff and volunteers can utilize to prepare for Medicare Open Enrollment.

A study of Medicare counselors was conducted by n4a and United-Healthcare to help identify information gaps in understanding Medicare, and to help trainers identify which educational tools and resources are available, training session dynamics and unmet needs. As a result, this quick reference guide was developed to help assist Medicare counselor staff and volunteers.

Note: This Medicare Counselor Training program was developed under a grant from United-Healthcare® through a joint project with the National Association of Area Agencies on Aging (n4a). However, nothing in these educational materials shall imply an n4a endorsement of any kind regarding United-Healthcare or its products and services or those of any Medicare Advantage, Medicare Prescription Drug or Medicare Supplement insurance plan. As a matter of practice, n4a does not endorse any insurance products or services.

Key facts about Medicare.

Who is eligible for Medicare?

Someone who is:
A U.S. citizen or legal resident for at least five consecutive years.

AND IS one of the following:
- Age 65 or older
- Younger than 65 with a qualifying disability
- Any age with a diagnosis of end-stage renal disease or ALS

Tip: Those who are self-insured or have an employer with fewer than 20 employees should talk to their benefit administrator to understand the rules and implications of waiting to enroll in Medicare Part B.

How do people know when they are eligible to enroll in Medicare?

People currently receiving benefits from Social Security or the Railroad Retirement Board (RRB) will receive a letter and informational materials confirming their Medicare eligibility three months before their 65th birthday or 25th month of disability:
- The materials explain what choices are available and what actions the person needs to take
- The person receiving the letter can change or postpone Medicare enrollment, or accept the enrollment as is
- If the person is still employed and the employer provides group health coverage, they may want to postpone Medicare enrollment until retirement. The person should check with their benefit administrator to see how their coverage works with Medicare.

People who are not receiving Social Security or RRB benefits when they turn 65 will not receive a letter notifying them of their Medicare eligibility. If they want to enroll in Original Medicare, they will need to contact a Social Security office for information and to enroll. To avoid a gap in coverage and possible late enrollment penalty, they should do this before their 65th birthday.

Note: There may be gaps in coverage and possible late enrollment penalties. To understand if there are late enrollment penalties, check with the plan provider.
What is Medicare and what Medicare choices are available?

Medicare has several parts, and each part provides a different type of medical coverage. Medicare recipients can choose which part(s) they want to enroll in, depending on their coverage needs.

**Medicare Choices**

**Step 1**
Enroll in Original Medicare when you become eligible.

**ORIGINAL MEDICARE**

- Covers hospital stays
- Covers doctor and outpatient visits

Government-provided

**Step 2**
If you need more coverage, you have choices.

**Option 1**
Keep Original Medicare and add:

**MEDICARE SUPPLEMENT INSURANCE**

- Covers some or all of the costs not covered by Parts A & B

Offered by private companies

and/or

**MEDICARE PART D**

- Covers prescription drugs

Offered by private companies

**Option 2**

**MEDICARE ADVANTAGE (PART C)**

- Combines Parts A & B
- Additional benefits
- Most plans cover prescription drugs

Offered by private companies
### When can a consumer enroll?

Enrollment times and procedures vary depending on which part(s) of Medicare one is signing up for:

<table>
<thead>
<tr>
<th>Part</th>
<th>When can a person enroll?</th>
<th>How does a person enroll?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>As soon as they become eligible for Medicare. If working beyond 65 with employer-sponsored insurance coverage, they may want to wait to enroll until they lose that coverage and should talk to their benefit administrator.</td>
<td>In most cases, if a person is already getting benefits from either Social Security or the Railroad Retirement Board (RRB), they are automatically enrolled in Part A. If a person is not getting benefits from Social Security, they can enroll in Part A online at <a href="https://www.SocialSecurity.gov">SocialSecurity.gov</a> or by visiting the local Social Security office.</td>
</tr>
<tr>
<td>Part B</td>
<td>As soon as they become eligible for Medicare. If working beyond 65 with employer-sponsored insurance coverage, they may want to wait until they lose that coverage or retire because Part B has a monthly premium that is based on their income. People who are self-insured or have an employer with fewer than 20 employees should talk to their benefit administrator to understand the rules and implications of waiting to enroll in Medicare Part B.</td>
<td>In most cases, if a person is already getting benefits from either Social Security or the Railroad Retirement Board (RRB), they are automatically enrolled in Part B. If a person is not getting benefits from Social Security and wants to either enroll in Part B or decline coverage, they can do so online at <a href="https://www.Medicare.gov">Medicare.gov</a> or by visiting the local Social Security office.</td>
</tr>
<tr>
<td>Part C</td>
<td>As soon as they are enrolled in Original Medicare (Parts A and B).</td>
<td>Medicare Advantage (Part C) plans are provided by private insurance companies. Medicare Advantage plans have their own enrollment process. People can find plans at Medicare.gov.</td>
</tr>
<tr>
<td>Part D</td>
<td>As soon as they are enrolled in Original Medicare (Parts A and B).</td>
<td>Part D (Prescription Drug) plans are provided by private insurance companies, which have their own enrollment process. People can find plans at Medicare.gov.</td>
</tr>
<tr>
<td>Med Supp</td>
<td>Sometimes referred to as “Medigap,” a Medicare supplement insurance plan can be purchased any time after a person turns 65 and enrolls in Medicare Parts A and B. A person is eligible for guaranteed acceptance as long as they enroll within six months of enrolling in Medicare Part B at age 65 or older. Also, there may be other situations when a person is eligible for guaranteed acceptance in a Medicare supplement plan and in some states, there is on-going open enrollment.</td>
<td>Medicare supplement plans are provided by private insurance companies, which have their own enrollment process. People can find plans at Medicare.gov.</td>
</tr>
</tbody>
</table>

**Tip:** Employer retiree health plans may work differently. A person should talk to their benefit administrator for more information.
What are the Medicare enrollment periods and when do they occur?

There are certain times during the year when a person can enroll in Medicare for the first time or switch Medicare plans. There are five different types of enrollment periods:

About Initial Enrollment Period (IEP).

**Applicable to:**
- Original Medicare (Parts A & B)
- Medicare Advantage (Part C)
- Medicare Prescription Drug Plans (Part D)

Eligibility period for Initial Enrollment Period:
- Eligibility month (65th birthday)
- 3 months before
- 3 months after

This is the seven-month time period when a person is first eligible for Medicare. It includes the month of the person’s 65th birthday and the three months before and after the birthday month. If a person becomes eligible for Medicare due to a disability, the timing of the IEP is based on their disability date.

Medicare Open Enrollment details.

**Applicable to:**
- Medicare Advantage (Part C)
- Medicare Prescription Drug Plans (Part D)

Eligibility period for Medicare Open Enrollment:
- Current year
- Upcoming year

This is the time period (October 15 – December 7) when any Medicare recipient can enroll in or change Medicare plans. After enrollment, the person’s coverage will begin on January 1 of the upcoming year.
What are the Medicare enrollment periods and when do they occur? (continued)

How the Special Enrollment Period (SEP) works.

**Applicable to:**
- Medicare Part B
- Medicare Advantage (Part C)
- Medicare Prescription Drug Plans (Part D)

This is for new beneficiaries who chose not to enroll or who were unable to enroll during their IEP. People must meet certain requirements to qualify for an SEP. If they qualify, they are granted time to enroll in Medicare without a late enrollment penalty.

**Example:** An SEP would be granted for someone older than 65 and still working, losing coverage or moving out of the plan’s “service area.”

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About the General Enrollment Period (GEP).

**Applicable to:**
- Medicare Part B

Each year, those who didn’t enroll in Medicare during their IEP or SEP have another chance to enroll between January 1 and March 31. In some situations, late enrollment penalties apply.

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Medicare Supplement Open Enrollment details.

**Applicable to:**
- Medicare supplement insurance plans

Medicare Supplement Open Enrollment is the sixth-month time period when a person can buy a Medicare supplement insurance plan. It begins the month a person turns 65 and is enrolled in Medicare Part B. During this time, a person has a guaranteed right to buy any Medicare supplement plan sold in their state, regardless of their health status.

If a person does not enroll in a Medicare supplement plan during this period, they can still apply for coverage at a later time, but an insurance company may deny coverage or charge a higher premium based on the beneficiary’s health status.

Some states have additional open enrollment periods, including those for people under age 65.

There may be other situations in which your acceptance may be guaranteed.
Introducing Medicare Advantage (Part C).

How it works.
Medicare Advantage (Part C) plans are run by private insurance companies. These plans combine coverage for certain hospital costs, doctor visits and other medical services in one plan. They may also include prescription drug coverage, often with no added premium.

What providers can people see?
With some plans, people choose an in-network primary care doctor. With others, they can go to any Medicare-eligible provider who accepts the plan’s terms, conditions and payment rates. Medicare Advantage plans have specific “service areas” and offer nationwide emergency coverage.

Coverage limits.
Plans vary. Check the limits and exclusions of each plan to understand the coverage limits.

What isn’t covered?
Medicare Advantage (Part C) plans generally cover, at a minimum, the same services as Original Medicare (Parts A and B), except for hospice care, which is provided under Part A.

Costs.
People will continue to pay their Medicare Part B premium. And in many cases Medicare Part C plans may have their own premiums too. Plan premiums vary widely.

• **A person’s share of the costs.**
  Some plans have deductibles. Some don’t. Many charge co-pays or co-insurance. Look at the plan for details.

• **Out-of-pocket limits.**
  All Medicare Advantage (Part C) plans limit the amount people have to spend.
There are different types of Medicare Advantage (Part C) plans.

Here are the most common types of Part C plans:

**Coordinated care plans.**
- Health Maintenance Organization (HMO) plans
- Preferred Provider Organization (PPO) plans
- Special Needs Plans (SNP)
- Health Maintenance Organization Point of Service (HMOPOS) plans

**Other plans.**
- Private Fee-For-Service (PFFS) plans
- Medical Savings Account (MSA) plans

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**What’s an HMO?**
- Health Maintenance Organization
- Plan with a network of physicians, hospitals and other health care professionals
- Generally, the person must get routine care from an approved network of doctors and hospitals
- Many plans include prescription drug coverage and additional benefits

**What is a PPO?**
- Preferred Provider Organization
- Hospital costs, doctor and outpatient care in one plan
- Many plans include prescription drug coverage and additional benefits

**What is an SNP?**
- Special Needs Plan
- Designed for people with special or complex health care needs
- Plans may be available for:
  - Residents of nursing homes
  - People eligible for both Medicare and Medicaid
  - People with certain chronic diseases such as diabetes or heart disease

**What is a PFFS?**
- Private Fee-For-Service
- Offered by private insurance companies
- Many plans may offer prescription drug coverage
- Doctors and hospitals must accept the payment terms and conditions of the private insurance company
- Payment comes from the Private Fee-For-Service plan, not Medicare
- Important to make sure the doctor or hospital will accept payment from the person’s specific plan each time before receiving services

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For more information, visit MedicareMadeClear.com
Introducing Medicare supplement insurance (Medigap) plans.
A Medicare supplement insurance plan works alongside Original Medicare.

How it works.
Private insurance companies offer this type of coverage to help people cover some or all of the costs that Medicare Parts A and B don’t cover. There are 10 standardized plans, labeled Plan A, B, C, D, F, G, K, L, M and N, which are available in most states.

What providers can people see?
They can see any doctor who participates in the Medicare program and who is accepting new patients. They can also see specialists without referrals.

Coverage limits.
- All Medicare supplement insurance plans provide benefits for an additional 365 days of inpatient hospital stay beyond Medicare lifetime reserve days. Several Medicare supplement plans provide benefits for 100 days of stay in a skilled nursing facility following an eligible inpatient hospital stay.
- A person’s Medicare supplement coverage travels with them anywhere in the United States. Some policies that offer benefits outside of the United States for emergency medical situations.

When people won’t get help.
These policies help cover some of the costs not paid by Original Medicare (Parts A and B); for instance, deductibles, co-pays or co-insurance. They don’t cover routine vision, dental or hearing care; hearing aids or eyeglasses; or private-duty nursing.

Costs.
As a general rule, the more generous the coverage, the higher the premium. Premiums vary widely.

A person’s share of the costs.
Medicare supplement insurance plans cover expenses approved by Original Medicare (Parts A and B).

**Deductible.**
Some plans pay the person’s Part A and Part B deductibles.

**Co-pay.**
Only one plan requires Medicare Part B co-pays for doctor visits and emergency room trips.

**Co-insurance.**
A few plans use co-insurance to split costs until they reach the plan’s out-of-pocket limit.

Note: Plans are different in Massachusetts, Minnesota and Wisconsin.
Introducing Medicare Part D.

How it works.
Medicare Part D plans help with the cost of prescription drugs. These plans are optional, and if a person doesn’t sign up when they become eligible, they may pay a premium penalty if they enroll later.

What is covered.
Part D is sold by private insurance companies. Plans offer different costs and different drug lists. A formulary is a list of drugs that the insurance plan covers. The federal government sets the guidelines. Some Medicare Advantage plans include prescription drug coverage.

Coverage limits.
Terms vary widely. Plans offer various levels of cost sharing until a person spends a stated amount in a year.

What isn’t covered?
Different plans cover different drugs, so make sure a person’s drugs are covered before they enroll. Most plans also have a coverage gap, or “donut hole,” during which they have to pay some of the costs.

Costs.
While plans may cover some of the same drugs, the monthly premiums may vary. In October each year, the federal government announces the premiums for the coming year. A person may pay a late enrollment penalty set by Medicare if they don’t sign up for Part D coverage as soon as they’re eligible. This penalty amount is added to the monthly Part D premium.

Formulary: A list of drugs that the insurance plan covers.
Understanding the Drug Stages.

Each plan has different stages of drug coverage. When a prescription is filled, the amount paid depends on the stage the person is in.

**Annual Deductible.**

If a plan has a deductible, people pay the total cost of drugs until they reach the deductible amount set by their plan. Some plans may have a deductible for only specific drug tiers. If a plan has this type of deductible, people pay the total cost of their drugs on those tiers until they reach the deductible. Then they move to the initial coverage stage. If they don’t have a deductible, their coverage begins in the initial coverage stage.

<table>
<thead>
<tr>
<th>Initial Coverage</th>
<th>Coverage Gap (Donut Hole)</th>
<th>Catastrophic Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this drug payment stage:</td>
<td>After a person’s <strong>total drug costs</strong> reach $3,310:</td>
<td>After a person’s <strong>total out-of-pocket costs</strong> reach $4,850:</td>
</tr>
<tr>
<td>● A person pays a co-pay or co-insurance (percentage of a drug’s total cost), the plan pays the rest</td>
<td>● A person pays:</td>
<td>● A person pays a small co-pay or co-insurance amount</td>
</tr>
<tr>
<td>● A person stays in this stage until the <strong>total drug costs</strong> reach $3,310</td>
<td>● 45% of the cost of brand name drugs</td>
<td>● A person stays in this stage for the rest of the plan year</td>
</tr>
<tr>
<td></td>
<td>● 58% of the cost of generic drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● A person stays in this stage until their <strong>total out-of-pocket costs</strong> reach $4,850</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Above costs are for 2016.

**Total Drug Costs:**

This is the amount people pay (or others pay on their behalf) and the plan pays for prescription drugs. This does not include premiums.

**Total Out-of-pocket Costs:**

This is the amount people pay (or others pay on their behalf) for prescription drugs. This does not include premiums, or the amount the plan pays for prescription drugs.
How do age and retirement affect Medicare choices?

Health insurance and Medicare coverage options vary depending on whether people have reached 65 and whether they are retired or are still working.

Here are Medicare coverage options.

Retiring Before 65:

Medicare:
Persons younger than 65 are not eligible for Medicare unless they have a qualifying disability. Employees who retire before 65 will need to find other health care insurance. Find more information at SocialSecurity.gov.

Retiree coverage:
Some employers or unions may provide supplemental health care coverage as part of their retiree benefits.

Individual health insurance:
This is designed for individuals and families with members under 65. A variety of plans are available with different levels of coverage. Professional or alumni associations the retiree belongs to are often good sources for health insurance plans.

COBRA:
The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides workers with group health coverage for limited periods of time under certain circumstances, including job loss, a reduction in work hours and other life events.

Retiring at 65:

Medicare:
Employees turning 65 can enroll in a Medicare plan.

If a company offers health insurance to retirees, a Medicare plan may work with the employer-sponsored coverage. Make sure to review the company’s health plan to see if it requires retirees to enroll in Original Medicare (Parts A and B).

If a company doesn’t offer health insurance to retirees, the person should consider enrolling in Medicare during their initial enrollment period.

Once retirees enroll in Original Medicare, they may also want to see what plans are available to help cover their other/additional Medicare costs.

Note: The person should work with his or her benefit administrator.
How do age and retirement affect Medicare choices? (continued)

**Continuing to Work After 65:**

**Medicare:**
Many people who choose to work past 65 enroll in only Medicare Part A because there is no monthly premium.

Others choose to enroll in both Medicare Parts A and B (Original Medicare). However, Medicare Part B comes with a monthly premium based on a person’s income; for that reason, many don’t enroll in Part B until they lose their employer sponsored coverage.

If a company offers health insurance, a Medicare plan may work with their employer sponsored coverage. People can review their company’s health plan to see if it makes sense to enroll in Original Medicare (Parts A and B) in addition to what their employer sponsored coverage provides.

Employees 65 and older should be sure to keep their health insurance coverage records so they can prove they had creditable coverage past their initial enrollment period for Medicare.

**Retiring After 65:**

**Medicare:**
When employees have worked past 65 and then choose to retire, they may be eligible for a Special Enrollment Period (SEP).

The SEP gives individuals 8 months after their employer sponsored coverage ends to enroll in Original Medicare (Parts A and/or B) without penalty. It is best to sign up before they retire to avoid a lapse in coverage.

During the SEP, individuals can enroll in a Medicare Advantage plan (Part C), a prescription drug plan (Part D) or a Medicare supplement insurance plan as long as they have already enrolled in Original Medicare (Parts A and B) first.

**What about coverage for spouses?**

Except in cases of disability, Medicare does not cover individuals under 65, even if their spouse is receiving Medicare benefits. If an employee retires and enrolls in Medicare, their spouse will need to find other health insurance if they are not yet 65. For more information visit Healthcare.gov.
What if people have concerns after they enroll?

What is an appeal?
An appeal is a type of complaint people can make when they want a decision (also called an “organization determination”) to be reconsidered. Appeals can be made regarding:

- A medical service
- The amount a Medicare Advantage plan pays for a medical service
- The amount a person must pay for a medical service

Depending on the Medicare coverage there are different ways to file an appeal.
If the person has Original Medicare they should contact Medicare at 1-800-MEDICARE.
Appeals for Medicare Advantage (Part C) plans and Prescription Drug (Part D) plans should be directed to the insurance company. The process and contact information can be found in plan’s Evidence of Coverage.

Why file an appeal?
People should file an appeal if they want a decision about a service, or the amount their health plan paid for a service, to be reconsidered.

What is a grievance?
A grievance is a type of complaint that does not involve payment or services by a person’s health plan or a contracting medical provider. People can file a grievance for:

- Quality of care during a hospital stay
- Their doctors’ behavior
- Waiting times on the phone, in the waiting room or in the exam room
- Lack of cleanliness or condition of doctors’ offices

Why file a grievance?
People should file a grievance when they have any type of complaint, other than an appeal, with their health plan. This is especially true if their complaint is the result of misinformation, misunderstanding or lack of information.

What additional coverage options are available?

- Medicare Advantage Special Needs plan
- Medicare supplement insurance (Medigap) plan
- Railroad Retirement plan
- PACE/PACENET
- Veterans Benefits, TRICARE for Life
- Federal Employees Health Benefit Plan (FEHBP)
- Employer, Retiree or Union group health insurance
- Other local and state programs may be available
Resources for more information.

- **MedicareMadeClear.com** has information about coverage, options and eligibility. You can also watch videos, sign up for newsletters, take quizzes, find time-saving tools and get answers to Medicare questions.

- Visit Medicare.gov
  - Or call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day/7 days a week

- Contact a State Health Insurance Assistance Program (SHIP) office in your area at ShipTACenter.org.

- Go to SMPResource.org for assistance with concerns about Medicare fraud.
Most states offer the following four Medicare Savings Programs. These programs can help pay Parts A and B premiums, deductibles, co-pays and co-insurance.

### Qualified Medicare Beneficiary (QMB)

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Individual/Couple Monthly Income Limits</strong></td>
<td>$1,010/$1,355</td>
</tr>
<tr>
<td><strong>Individual/Couple Resource Limits</strong></td>
<td>$7,280/$10,930</td>
</tr>
<tr>
<td><strong>Only Requirements</strong></td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td></td>
<td>• Does not qualify for any additional Medicaid benefits</td>
</tr>
<tr>
<td><strong>Plus Requirements</strong></td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td></td>
<td>• Qualifies for additional Medicaid benefits</td>
</tr>
<tr>
<td><strong>What costs do this program help to pay?</strong></td>
<td><strong>QMB Only:</strong> Pays for Medicare premiums, deductibles, co-pays and co-insurance (not including Part D).&lt;br&gt;<strong>QMB Plus:</strong> Pays for Medicare premiums, deductibles, co-pays and co-insurance as well as benefits under the State Medicaid plan (not including Part D).</td>
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</tbody>
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### Specified Low-Income Medicare Beneficiary (SLMB)

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<table>
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<tbody>
<tr>
<td><strong>Individual/Couple Monthly Income Limits</strong></td>
<td>$1,280/$1,622</td>
</tr>
<tr>
<td><strong>Individual/Couple Resource Limits</strong></td>
<td>$7,280/$10,930</td>
</tr>
<tr>
<td><strong>Only Requirements</strong></td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td></td>
<td>• Does not qualify for any additional Medicaid benefits</td>
</tr>
<tr>
<td><strong>Plus Requirements</strong></td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td></td>
<td>• Qualifies for full Medicaid benefits</td>
</tr>
<tr>
<td><strong>What costs do this program help to pay?</strong></td>
<td><strong>SLMB Only:</strong> Pays for Medicare Part B premium.&lt;br&gt;<strong>SLMB Plus:</strong> Pays for Medicare Part B premium and qualifies for full Medicaid benefits.</td>
</tr>
</tbody>
</table>

The income eligibility levels vary by state and program. Numbers listed are for 2016.

1 These are some examples, there are also state level programs.
## Savings programs at a glance

(continued)

<table>
<thead>
<tr>
<th>Qualified Individual (QI)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Individual/Couple Monthly Income Limits</td>
<td>$1,357/$1,823</td>
</tr>
<tr>
<td>Individual/Couple Resource Limits</td>
<td>$7,280/$10,930</td>
</tr>
<tr>
<td>Only Requirements</td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td>Plus Requirements</td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td>What costs does this program help to pay?</td>
<td>QI: Pays for Medicare Part B premium.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Qualified Disabled and Working Individual (QDWI)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual/Couple Monthly Income Limits</td>
<td>$4,045/$5,425</td>
</tr>
<tr>
<td>Individual/Couple Resource Limits</td>
<td>$4,000/$6,000</td>
</tr>
<tr>
<td>Only Requirements</td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td>Plus Requirements</td>
<td>• Income and resources are within limits listed above</td>
</tr>
<tr>
<td>What costs does this program help to pay?</td>
<td>QDWI: Helps pay Medicare Part A premium for certain working disabled Medicare beneficiaries who have exhausted their entitlement to a premium-free Part A benefit.</td>
</tr>
</tbody>
</table>

The income eligibility levels vary by state and program. Numbers listed are for 2016.

1 These are some examples, there are also state level programs.
Notes.

Local Social Security Office Contact Information:


Local Resources:


Local SNAP/Food Stamp Resources:


Water, Heat and Electric Assistance:


Medicaid State Guidelines:


For more information, visit MedicareMadeClear.com
## Additional savings programs.

### Extra Help or Low Income Subsidy (LIS)

| Full Subsidy Requirements | Individual/couple monthly income below $1,357/$1,823  
<table>
<thead>
<tr>
<th></th>
<th>Individual/couple resource below $8,780/$13,930</th>
</tr>
</thead>
</table>
| Partial Subsidy Requirements | Individual/couple monthly income below $1,505/$2,023  
|                          | Individual/couple resource below $13,640/$27,250 |
| Program Benefits          | LIS: Helps pay for some or all of a person’s Medicare Part D premiums, deductibles and co-pays or co-insurance. |

### Other Full Benefit Dual Eligible (FBDE)

| Full and Partial Subsidy Requirements | Consumers must meet their State Medicaid/MSP financial eligibility.  
|                                       | Eligible for Medicaid either categorically or through optional coverage groups based on medically needy status, special income levels for institutionalized individuals or home and community-based waiver. |
| Program Benefits                      | FBDE: May cover the Part B premium, deductibles, co-pays and co-insurance (varies by state) and qualifies for full Medicaid benefits. |

**Program of All-Inclusive Care for the Elderly (PACE):** Combines medical, social and long-term care services for frail elderly people who live in the community, not a nursing home. States set their own income eligibility levels.

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Limits are slightly higher in Alaska and Hawaii. Check with the state to find out specific income and resource levels.

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