BlueCross BlueShield of Texas

Ease into Medicare℠

Benefit of Blue℠

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Want to make smart Medicare choices?

Start here.

If you are ready to enroll in Medicare now, or soon will be, it is important to understand what it does and does not cover. This booklet from **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation**, tells you more about Medicare. You'll learn about your options for coverage. This booklet can help you get ready to select the Medicare health plan that is right for you.

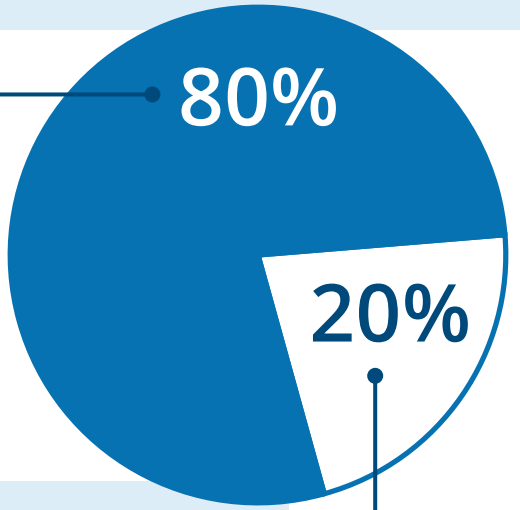
How Medicare works:

Original Medicare doesn't cover everything.

Original Medicare was not designed to cover all of your health care costs. It covers only about 80% of your hospital and medical costs. You may be responsible for paying the other 20%.*

Most prescriptions aren't covered by Original Medicare. You must get that coverage in a separate plan.

REMEMBER:
Original Medicare covers only about 80% of your Medicare-eligible hospital and medical expenses.



You MAY BE responsible for the other 20%.

* Source: Medicare 2023 costs at a glance; Medicare.gov.

Introduction to Medicare

There are four parts to Medicare, each providing coverage for different types of health care services.

Part A is hospital coverage.

Part A helps cover your inpatient care in hospitals, including critical access and long-term care hospitals, skilled nursing care and hospice. Most people automatically get Part A without having to pay a monthly premium.

Part B is medical coverage.

Most Medicare beneficiaries pay a premium for Part B coverage. Part B helps cover medical services like doctors' office visits and outpatient care that is medically necessary. You pay the Part B premium each month.

Part A and Part B are considered Original Medicare.

Part C is Medicare Advantage.

Medicare Advantage is managed care that combines Part A, Part B, and usually Part D.* Medicare oversees private insurers who manage your coverage. These plans may offer benefits beyond Original Medicare. The plans are usually Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) with provider networks to help manage costs.

* Medicare Advantage plans usually require you to use network hospitals and doctors for maximum coverage and in non-emergency medical situations.

Part D is prescription drug coverage.

Part D coverage helps to lower your prescription drug costs. Part D coverage is available as a stand-alone plan or may be included as part of a Medicare Advantage plan.

Medicare Supplement Insurance Plan †‡

A Medicare Supplement Insurance Plan helps to fill the gaps in Original Medicare. It does not include prescription drug coverage so you may want to add a Part D plan to complete your coverage if you choose this option. Medicare Supplement Insurance Plans are generally accepted by any provider that accepts Medicare. The best time to buy a Medicare Supplement insurance policy is around the time you turn 65. You have guaranteed acceptance on the first day of the month in which you turn 65 and are enrolled in Medicare Part B. If you are under age 65, have Medicare Part A and are enrolled in Medicare Part B, your acceptance is guaranteed within six months of your Part B effective date or another qualifying event. In any scenario, you must have Medicare Part B to be eligible for a Medicare Supplement insurance policy.

You cannot have a Medicare Advantage Plan and a Medicare Supplement Insurance Plan at the same time.

† You are free to use any hospital or physician that is a Medicare contracted provider.

‡ Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

What are the costs of Medicare?

Premiums

- Part B – you must pay this no matter what other plans you choose.
- Medicare Advantage, Part D and Medicare Supplement Insurance plans may have monthly premiums, too.

Coinsurance

- A percentage of the cost you pay depending on the product or service received.

Copay

- A set amount you pay depending on the product or service received.

Deductible

- Some plans require you to pay up to a certain amount before the plan will start paying.

Out-of-pocket limits

- Medicare Advantage and Part D plans have limits on how much you are expected to pay out of pocket each year.

When can you enroll?

Part A and Part B

You are eligible to enroll in Medicare if you answer yes to at least one of the following questions.

- Are you age 65 or older and entitled to Social Security or Railroad Retirement Board benefits?
- Are you under age 65 with certain disabilities?

Enroll at your local Social Security office or online at **www.ssa.gov**.

Part C or Part D

You may enroll in a Part C or Part D (prescription drug) plan only during the following designated enrollment periods.

Enrollment Periods

Initial Enrollment Period (IEP) — 3 months before the month of your 65th birthday to 3 months after
This is for people like you, who are just becoming eligible for Medicare. Enroll as soon as you can so your benefits begin the first day of your Medicare eligibility. If you miss your IEP, you will have to wait until the next Annual Enrollment Period to enroll.

Annual Enrollment Period (AEP) — October 15 – December 7
The AEP is when you can enroll in a Medicare plan if you missed your IEP. It is also your chance to enroll in a different plan if your current one isn't meeting your needs.

Special Enrollment Period (SEP)
A Special Enrollment Period lets you change your Medicare Advantage or prescription drug coverage if certain events happen in your life such as moving outside your plan's coverage area or losing your current coverage.

Compare Medicare to your employer or individual plan.

Who pays?

With Medicare, your coverage is guaranteed by the federal government. Original Medicare is basic coverage and includes only Part A and Part B. It has no out-of-pocket maximum. You pay for everything beyond what Original Medicare covers, regardless of how much that may cost. For this reason, consider adding one of the plans detailed in this booklet.

What is different?

Employer plan:

- If you had a group plan from your employer, you may be used to having coverage for you and members of your family. Medicare only covers one person, so family members will need to enroll in different plans.
- You also may have had options for dental and vision care. Emergency services and only some preventive services are covered by Original Medicare.
- Some employers offer coverage for retirees or workers over age 65. Before you enroll in any plan on your own, check with your employer to see what is offered.
- If your employer has nothing to offer, you will manage your own enrollment. You can work with an insurance agent in person, directly with the plan by phone or online, or through the Medicare website.

Plan you purchased yourself:

- If you bought health insurance on your own through an insurance agent or a government exchange, you are probably familiar with how much plans really cost. Usually, the more benefits your plan has, the higher your monthly premium. This is true with Medicare Advantage and Medicare Supplement Insurance Plans, too.
- You can shop for a plan in person with an insurance agent, directly with the plan by phone or online, or through the Medicare website.

Drug Coverage

Medicare Advantage and Part D plans usually cover a broad range of prescription drugs. The formulary (list of covered drugs) may be different from what you're used to. It's a good idea to share the formulary of the plan you are interested in with your doctor to see if the drugs you take now are included. You can save money by using generic drugs. Ask your doctor or pharmacist if this is an option for you.

In Medicare Advantage and Part D plans, prescription drugs are placed into tiers. The costs for drugs in each tier are different. Tier 1 drugs will cost less than Tier 5 drugs.

The tiers may look like this:

Tier 1 **Preferred Generic Drugs**
Tier 2 **Generic Drugs**
Tier 3 **Preferred Brand Drugs**
Tier 4 **Non-Preferred Brand Drugs**
Tier 5 **Specialty Drugs**

Prior authorization, step therapy and quantity limits

Before you can be covered for some medications, your doctor may need to get authorization from the plan. You may first need to try other clinically appropriate or cost-effective drugs. Quantity limits may be set for some drugs for cost or safety reasons.

Provider Network

If you choose a Medicare Advantage plan, you will get the most from your benefits when you use providers in the plan's network. Your current doctors may be in the network. It usually includes local primary care providers and a wide range of specialists. If you choose an HMO plan, you must select a primary care provider (PCP).

In some cases, you may need to seek care from a provider that is out of network, which may cost you more. If your current provider is not in the network, the plan can help you find a new one.

Plans work with your provider to deliver care.

Certain high-cost medical services that have more cost-effective alternatives need prior authorization from the plan before your provider can proceed. Medicare Advantage plans follow government guidelines in this area to ensure you receive the most appropriate, cost-effective care available.

Annual Plan Check-up

Just like you get an annual check-up from your doctor, you should review your Medicare plan every year to be sure it still works for you.

If you have a PDP or MAPD plan, you will get an Annual Notice of Change mailing in September telling you about any changes to rates or benefits coming for the next year.

If you have a Medicare Supplement Insurance Plan, you will get a mailing before December about any changes to Medicare Part A and Part B copays and deductibles. A few months later, you'll get another mailing with the premium update to your plan.

These documents can help you decide if you need to make a change during the AEP. If your plan still works for you, no action is needed. You will automatically stay enrolled in that plan. If you find it is not meeting your needs, it's time to shop for a new plan.

Choosing a Plan

How do you decide which kind of plan to get? Here are some helpful tips:

The plan you choose should meet your own health care needs. So when looking at the options, take into account your medical needs and the prescription drugs you take, as well as your budget and lifestyle.

You may prefer a Medicare Supplement Insurance Plan if you:

- Want flexibility when choosing your providers
- Frequently go to the doctor and need to keep the cost of office visits low
- Would rather pay a higher monthly premium and keep your out-of-pocket costs low
- Travel a lot
- Have chronic medical needs
- Are willing to enroll in a separate prescription drug plan
- Don't mind keeping track of multiple plans, paperwork and premiums (Original Medicare, Medicare Supplement Insurance Plan, and Prescription Drug Plan)

You may prefer a Medicare Advantage Plan if you:

- Are used to, or don't mind, using a plan's network of providers if required
- Like all your benefits in one plan with one premium
- Want your prescription drug coverage included as a plan benefit
- Like the convenience of the plan managing all your benefits, paperwork and premiums

Research all your options then enroll in a plan that best fits your needs. You can change every year or during a SEP if you have a qualifying event.

Questions about Medicare?

Look for helpful resources online:

Medicare

You'll find good information on the government website:

www.Medicare.gov

Social Security Administration

Visit your local office or save time by using the website.

www.ssa.gov

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare Advantage members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Medicare Part D Plan Notice:
Prescription drug plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal.

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-774-8592**. Someone who speaks English/Language can help you. This is a free service. Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-774-8592**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.