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Understanding Medicare

When choosing medical coverage as a senior citizen 65 years old and over, you can make one of three choices: These choices go into effect the first of the month you turn 65. If your birthday is on the first of the month coverage starts the month prior.

There is a form if you are 65 or over, Request for Employment Information. This form needs to filled out by the employee and United Airlines. You can access this form from Flying together>Employee Services>Tools and Resources> Help Hub. OMB no. 0938-0787.

Understanding the Medicare Late Enrollment Penalty

When learning about enrollment, it's important to keep a few key things in mind when it comes to rules and risks. Medicare costs enough without additional penalty fees. Learn how to avoid these fees and make your Medicare experience as seamless and pain-free as possible.

Medicare Part A penalty

Most people eligible for Medicare are entitled to Part A for free. This is because you or your spouse already paid the Medicare tax when you were still working. (This is the FICA deduction on your paycheck.) If you did not previously work or did not work long enough, you can still get Part A but you may have to pay a premium.

If you did not get automatically enrolled or sign up during your Initial Enrollment Period, you will have a late penalty premium for Part A when you do sign up later on.

The enrollment periods and premium penalties are the same whether you are entitled to Medicare Part A or can voluntarily buy Medicare Part A.

The penalty premium is 10% of the current Part A premium. You will continue to pay the penalty premium for twice the number of years you were eligible for Part A but did not enroll.

Medicare Part B Penalty

If you sign up late for Medicare Part B, you will have to pay a late penalty premium every month for the rest of your life, along with your Part B premium. Your monthly Part B premium will go up 10% for each full 12-month period that you could have had Medicare Part B but did not take it. You will pay this higher premium as long as you have Medicare Part B.

You may not have to pay the penalty if you qualify for a Special Enrollment Period (SEP). You might qualify for an SEP if you had health insurance through your job or your spouse's job when you were first eligible to sign up for Medicare Part B.

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Medicare Part D penalty

There is a late penalty premium for not joining a Medicare Part D drug plan when you first become eligible for Medicare. Generally, you are late if you did not join within 3 months after your Medicare Part A or Part B becomes effective.

You do not have to pay the penalty if you are eligible for the Extra Help with costs.

You may not have to pay the penalty if you qualify for a Special Enrollment Period (SEP) because you had other drug coverage that is as good as Medicare (creditable coverage) at the time you turned 65. Examples of creditable coverage include:

- Coverage through your job or your spouse's job, OR
- Retiree coverage, OR
- Coverage through the Veterans Administration.

The penalty premium is added onto the regular premium that you pay to your Medicare drug plan. The fee is calculated as 1% of the average monthly prescription drug premium (1% of $33.19 in 2019) times the number of months you were late, rounded to the nearest 10 cents. This penalty is permanent – you would have to pay it for as long as you have Medicare Prescription Drug Coverage.

In 2019, the average monthly prescription drug premium is $33.19. Therefore, the penalty fee will be calculated as 1% of $33.19, times the number of months you are late enrolling in Part D. If you were 12 months late in enrolling, your penalty would be $3.98, paid on top of your drug plan's monthly premium. This amount may go up each year you're enrolled in a Part D plan.

Coverage Choices When You Qualify for Medicare

1. Traditional Medicare, which has co-pays and deductibles.
2. Traditional Medicare with Medigap (a private supplemental policy) that covers Medicare's co-pays and deductibles.
3. Medicare Advantage, private insurance that varies greatly depending on the policy you choose.

Most Comprehensive Coverage
The most comprehensive coverage, which will likely result in the fewest unexpected out-of-pocket expenses, is a traditional Medicare plan paired with a Medigap policy with this combination, you can go to any doctor who accepts Medicare. Be aware that with traditional Medicare and Medigap, you will also need part D prescription drug coverage

Medicare
Medicare will become your primary health insurance when you reach age 65. You must sign up for Medicare three months before your 65th birthday to maximize your benefit and minimize your costs. Sign up at the Social Security website, *www.socialsecurity.gov*. The Medicare website *ww.medicare.gov* is a good source of information regarding Medicare

Part A: Free - pays a portion of hospital costs (Co pay for services).

Part B: Monthly Premium based on MAGI - pays a portion of the doctor bills, outpatient services and medical supplies.

Part C: Covers all the services that original Medicare Plans cover except hospice care, and may cover other services, (dental, and health wellness). Medicare Advantage plans may sound enticing. Many offer $0 premiums, but the devil is in the details. You will find that most have unexpected out-of-pocket expenses when you get sick.
Also known as Part C, these plans, which private insurers provide as an alternative to traditional Medicare, must provide the coverage required by Medicare at the same overall cost level. However, what they pay can differ depending upon your overall health.

Part D: Covers prescription drug plans.
These plans are supplemental plans paid outside of Medicare.

Which drugs does Part D cover?

A Medicare Prescription Drug Plan (Part D) offers comprehensive prescription drug coverage to people with Original Medicare (Part A and Part B). In general, a Part D-covered drug must meet all of these conditions:

Available only by prescription
Approved by the Food and Drug Administration (FDA)
Used and sold in the U.S.
Used for a medically accepted indication, as defined under the Social Security Act
Not covered under Part A or Part B
Included on the plan's Part D drug list or coverage approved through the exceptions or appeals process

Each drug has a designation or Tier. The chart below describes the different options. Each Tier has a different cost structure so It is important to understand your personal needs and what that will cost when shopping for a part D plan.

Tier	You Pay	What is Covered	Cost Example*
1	Lowest copay	Most generic prescription drugs	$5.00
2	Medium copay	Preferred brand-name prescription drugs	$28.00
3	Higher copay	Non-preferred brand-name prescription drugs	$53.00
Specialty Tier	Higher percentage	Unique, very high-cost drugs	25%-33% of drug cost

What is a Formulary Drug or Prescription?

A formulary prescription is a prescription list that the insurance carriers believe to be well suited to be used medically by a majority portion of members; formulary drugs are drugs the insurance carrier trusts to help their members (the insured) rise back to health after administering. These formulary drug lists have prescriptions that have been tested and researched to be safe and effective, as well as less costly to both the insurance carrier and the member. The insurance companies see formulary drug lists as ways to: increase safety and effectiveness (although, it can be debatable if their formularies have the best prescriptions out there, it just depends on the specific case and insurance carrier) while also keeping costs down for both parties. Both brand name drugs and generic drugs can be found on formularies, however, generic drugs are almost always less costly and essentially chemically equivalent to brand name drugs.

What are non-formularies?

I am sure you have guessed it by now, but if you haven't, non-formulary prescriptions aren't on the insurance policies list of preferred drugs. Knowing that, non-formularies are more costly.

When should I buy non-formularies?

This is a question you should talk to your doctor about, because it really just depends on the specific drug and the purpose for taking it.

In Summary – Formulary versus Non-Formulary

Formularies are lists that have the insurance carriers preferred drugs. You can normally find both generic and brand name drugs in the formularies. Formulary prescription drugs are chosen for their cost, effectiveness, and their safety. **Non-formulary** drugs will cost the member more money than formularies.

Medicare Advantage plans may sound enticing. Many offer $0 premiums, but the devil is in the details. You will find that most have unexpected out-of-pocket expenses when you get sick and only want you as a customer when you're healthy.

Also known as Part C, these plans, which private insurers provide as an alternative to traditional Medicare, must provide the coverage required by Medicare at the same overall cost level. However, what they pay can differ depending upon your overall health.

Medicare Drug Coverage under Medicare Part A, Part B, Part C, & Part D The information below provides an overview of drug coverage under Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), Medicare Part C (Medicare Advantage) and Medicare Part D (Medicare prescription drug coverage).

Which drugs does Part A cover? People with Medicare may get drugs as part of their inpatient treatment during a covered stay in a hospital or skilled nursing facility (SNF). Generally, Part A payments made to the hospital, SNF, or other inpatient setting cover all drugs provided during a covered stay.

Which drugs does Part B cover? Generally, Part B covers drugs that usually aren't self-administered. These drugs can be given in a doctor's office as part of their service. In a hospital outpatient department, coverage generally is limited to drugs that are given by infusion or injection. If the injection usually is self-administered or isn't given as part of a doctor's service, Part B generally won't cover it, but a person's Medicare drug plan (Part D) may cover these drugs under certain circumstances. In most cases, the yearly Part B deductible applies to these drugs. This means that people with Medicare may have to pay the Part B deductible amount before Medicare pays its share. Part B also covers:

Certain shots (vaccinations): – Flu shots: In general, one flu shot per flu season. Flu shots typically are given before the start of the flu season, in the late summer, fall, or winter, but some people may get the shot in the spring. This means people with Medicare can sometimes get this preventive shot twice in the same calendar year.

Pneumococcal shots: Two shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Part B covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. People with Medicare should talk with their doctor or other health care provider to see if they need one or both of the pneumococcal shots.

Hepatitis B shots: A series of shots covered only for people at high or medium risk for Hepatitis B. A person's risk for Hepatitis B increases if the person has hemophilia, End-Stage Renal Disease (ESRD)—permanent kidney failure requiring dialysis or a kidney transplant—or certain conditions that increase the person's risk for infection. Other factors may also increase a person's risk for Hepatitis B. To determine if they're eligible for coverage, people with Medicare should check with their doctor to see if they're at high or medium risk for Hepatitis B.

Other shots: Some other vaccines when they're directly related to the treatment of an injury or illness (like a tetanus shot after stepping on a nail).

Durable Medical Equipment (DME) supply drugs: Medicare covers drugs administered through a covered item of DME, like an infusion pump or a nebulizer.

Injectable and infused drugs: Medicare covers most injectable and infused drugs given by a licensed medical provider if the drug is considered reasonable and necessary for treatment and usually isn't self-administered.

Injectable osteoporosis drugs: Medicare covers an injectible drug for women with osteoporosis who meet the coverage criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn to give herself the drug by injection. The home health nurse or aide won't be covered to provide the injection unless family and/or caregivers are unable or unwilling to give the drug by injection.

Some antigens: Medicare helps pay for antigens if they're prepared by a doctor and given by a properly instructed person (who could be the patient) under appropriate supervision.

Erythropoiesis stimulating agents: Medicare will help pay for erythropoietin by injection if a person with Medicare has ESRD and needs this drug to treat anemia. Medicare may also cover these drugs to treat anemia for people who don't have ESRD.

Blood clotting factors: If a person with Medicare has hemophilia, Medicare helps pay for clotting factors they give themselves by injection.

Immunosuppressive drugs: Medicare covers immunosuppressive drug therapy for people who received an organ transplant for which Medicare made payments. – If a person is entitled to Medicare only because of permanent kidney failure, their Medicare coverage will end 36 months after the month of the transplant. Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who aren't entitled to Medicare. –A person with ESRD and Original Medicare may join a Medicare drug plan (Part D). Part D may cover other immunosuppressive drugs not covered by Part B, even if Medicare didn't pay for the transplant.

Oral cancer drugs: Medicare helps pay for some cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. A prodrug is an oral form of a drug that when ingested breaks down into the same active ingredient found in the injectable form of the drug.

Oral anti-nausea drugs: Medicare helps pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for an intravenous anti-nausea drug.

Parenteral and enteral nutrition (intravenous and tube feeding): Medicare helps pay for certain nutrients for people who can't absorb nutrition through their intestinal tracts or can't take food by mouth.

Parenteral and enteral nutrition (intravenous and tube feeding): Medicare helps pay for certain nutrients for people who can't absorb nutrition through their intestinal tracts or can't take food by mouth

Intravenous Immune Globulin (IVIG) provided in the home: Medicare helps pay for IVIG for people with a diagnosis of primary immune deficiency disease. A doctor must decide that it's medically appropriate for the IVIG to be given in the patient's home. Part B covers the IVIG itself, but doesn't pay for other items and services related to the patient getting the IVIG in his or her home.

Does Part B cover self-administered drugs given in an outpatient setting, like an emergency department or hospital observation unit? Generally, no. A person's Medicare drug plan (Part D) may cover these drugs under certain circumstances. A person might need to pay out-of-pocket for these drugs and submit a claim to their Part D plan to get paid back. He or she should call the plan for more information. For more information, view the fact sheet "How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings" by visiting Medicare.gov/publications.

Which drugs does Part C cover? A Medicare Advantage Plan (Part C) (like an HMO or PPO) must cover the drugs that are covered under Part A and Part B. A person in a Medicare Advantage Plan will usually get their Medicare prescription drug coverage from their plan. They should contact their plan to see if it offers prescription drug coverage. In most Medicare Advantage Plans, if a person wants Medicare prescription drug coverage and their plan offers it, they must get it from their Medicare Advantage Plan. A person can't be enrolled in both a Medicare Advantage Plan and a Medicare Prescription Drug Plan.

Which drugs does Part D cover? A Medicare Prescription Drug Plan (Part D) offers comprehensive prescription drug coverage to people with Original Medicare (Part A and Part B). In general, a Part D-covered drug must meet all of these conditions:

■ Available only by prescription
■ Approved by the Food and Drug Administration (FDA)
■ Used and sold in the U.S.
■ Used for a medically accepted indication, as defined under the Social Security Act
■ Not covered under Part A or Part B
■ Included on the plan's Part D drug list or coverage approved through the exceptions or appeals process

Where can people get more information or help?

■ Visit Medicare.gov. – Look for more information on appeals at Medicare.gov/appeals. – Look for more information on Medicare drug coverage in the "Drug Coverage (Part D)" section. Select "Find health & drug plans."

■ Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
■ Contact a State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for a particular state, visit shiptacenter.org, or call 1-800-MEDICARE.

To obtain more information and decision guides here are a few carriers

Humana- HumanaMedicare.com 1 855 211 6292

Mutual of Omaha- MutualofOmahaCareAdvantage.com 1 855 936 0336

AARP United health care- AARPMedicareSupplement.com 1 866 700 3081

Teamsters- Teamstar.com 877 577 5148