



2011 Guide to Medicare

What you need to know now

Look to Highmark to keep you informed.

At Highmark Blue Shield, we feel strongly that it's our responsibility to give you the information you need to make smart, informed choices for your health care.

For over 70 years, Highmark has been providing peace of mind to our neighbors. It's a responsibility we take very seriously.

Flip through this guide and make sure to take note of what you learn here. You'll be surprised that, in no time, you'll have a knowledge of Medicare and how the new Health Care Reform has affected it, plus the assurance of knowing that you don't have to worry about your coverage. It'll be there when you need it. And that's what health coverage is all about: peace of mind.



Has Health Care Reform Changed Medicare?

First things first: Medicare is still here for you.

The Patient Protection and Affordable Care Act — better known as Health Care Reform — was passed in March 2010. This landmark legislation will affect the way some people get health care insurance. Some of the provisions from Health Care Reform apply to Medicare.

This guide will help you understand how Medicare works today and what it all means to you.

Make the most of your guide.

We've designed the 2011 Guide to Medicare to give you three different kinds of important information. In a year of reform, you need to know more than just what your plan options are. You need to know how the reform affects you. We've arranged the information here to guide you through today's Medicare. Here's what you'll see:

- 1** The 2011 Medicare overview — how the different parts of Medicare work and what's new this year.
- 2** A tool to help you determine your Medicare needs and priorities, so you know how they match with the kinds of plans available.
- 3** The steps to choosing the right plan for you.

Medicare:

How it works in 2011.

Start with the facts.

There are four parts to Medicare. They are Part A, Part B, Part C and Part D. Each serves a different purpose, and some of them combine to give you more complete coverage. Let's go over them one at a time to give you a full picture of the Medicare coverage available to you and what's new with the recent Health Care Reform.

Medicare Part A — Hospital Insurance

Overview:

Most people get Part A coverage automatically from the federal government when they turn 65 if they have worked 40 quarters paying into Medicare. Part A covers medically necessary care requiring an overnight hospital stay. It also covers follow-up nursing care after a hospital stay, hospice care and some home health care for the homebound.

New in 2011:

Original Medicare (Parts A and B) used to pay for only a general check-up when you first entered the Medicare program. Now Part A has an added important benefit: coverage for annual check-ups. In addition, starting in 2011, Original Medicare will cover many preventive services without requiring copayments. Some preventive services will also be exempt from deductibles.

Medicare Part B — Medical Insurance

Overview:

Also provided by the federal government, Medical Insurance — or Part B — is optional and combines with Part A. If you choose to enroll in Part B, which most people do, you'll typically pay a premium of \$110.50 a month and get coverage for some services that don't require a hospital stay.

Part B covers medically necessary services such as doctor's office visits, hospital and clinic care that doesn't include an overnight stay, lab tests and some health screenings.

You cannot be denied Part B coverage, but to receive it, you must enroll and pay the monthly premium. Generally, most people have their Part B premium deducted from their Social Security check.

Coverage for more than the basics.

What Original Medicare won't cover

Original Medicare covers some — but not all — health care expenses. For example, Original Medicare does not pay for long-term personal care services at home or in a nursing home. Original Medicare also does not cover prescription drugs, routine eye exams, eyeglasses, hearing aids, routine dental care or non-emergency care provided outside the United States. Under Original Medicare, you are also responsible for deductibles and share some of the costs (coinsurance).

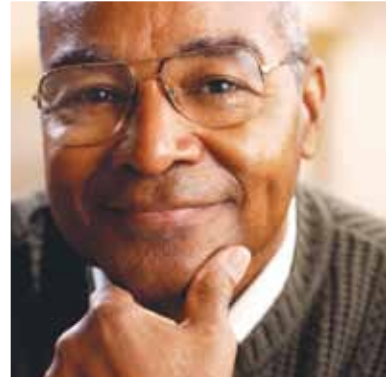
Private insurance companies offer Medicare Supplement (“Medigap”) plans, which fill some of the gaps in the benefits covered by Original Medicare. Private insurance companies also offer Medicare Advantage HMO and PPO plans. Medicare Advantage plans not only cover costs Medicare does not, but they also have more benefits than Parts A and B and a Medicare Supplement plan combined.

Medicare Part C — Medicare Advantage

Medicare Advantage plans include:

- Preferred Provider Organizations (PPOs)
- Health Maintenance Organizations (HMOs)

Medicare Advantage plans are offered by private companies like Highmark that have been approved by Medicare. These plans provide you with all your Part A and Part B coverage, as well as Part D prescription drug coverage (discussed on page 7) and other benefits Original Medicare doesn't cover.



Good news about Medicare Advantage!

If you are currently enrolled in a Medicare Advantage plan, or if you are thinking about enrolling in one, you are in good company. Currently, almost 1 in 2 people in western Pennsylvania with Medicare are enrolled in a Medicare Advantage plan.

Some reports have suggested that Medicare Advantage will be eliminated with reform, but that is not true. The Health Care Reform legislation will not eliminate the Medicare Advantage program. Medicare Advantage will continue to be available in 2011 and beyond. If you are looking for comprehensive coverage, we encourage you to consider the plans that best meet your needs and enroll accordingly.

Think about your options.

Medicare Advantage PPO Plan (Preferred Provider Organization)

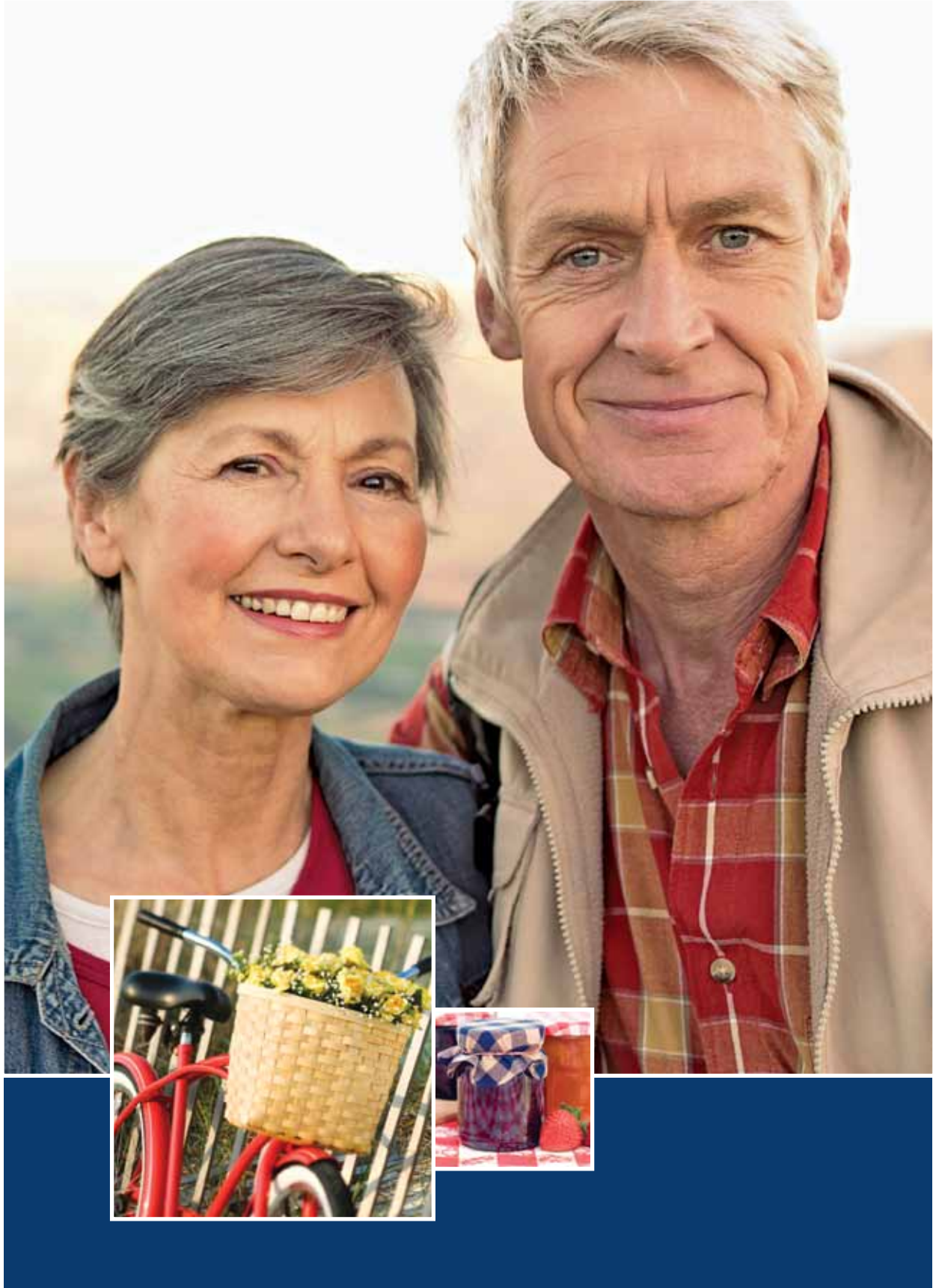
A Medicare Advantage PPO plan offers comprehensive coverage for your health care needs, starting with the coverage you'd get from Medicare Parts A and B. Most Medicare Advantage PPO plans also offer coverage for things such as vision and/or hearing, out-of-network/out-of-area services (like seeing a doctor when you travel) and preventive care benefits. Many Medicare Advantage PPO plans include Part D Prescription Drug coverage, allowing you to receive coverage for medical services and prescription drugs under just one plan.

Consider this plan if you want comprehensive coverage that includes more than just Parts A and B, with extras like vision, hearing and prescription drug coverage; and you want better coordination of coverage through a single plan and the freedom to see any doctor you choose.

Medicare Advantage HMO Plan (Health Maintenance Organization)

Like Medicare Advantage PPO plans, a Medicare Advantage HMO plan covers Original Medicare services. Many also offer other benefits that the Original Medicare plan does not cover — such as Part D Prescription Drug coverage, check-ups, vision care and hearing aids — allowing you to get coordinated care through a single insurer and its network. The primary difference between a Medicare Advantage HMO and a Medicare Advantage PPO is that HMOs require you to see providers in the plan's network, except in emergencies.

Consider this plan if you want comprehensive coverage with some of the “extras” of Medicare Advantage, and if you don't spend a large part of your year traveling. Make sure the network is large and includes those providers you'll want to see. Some Medicare Advantage HMOs also require a referral for providers other than your primary care physician.





Part D Prescription Drug coverage.

Medicare Part D — Prescription Drug plans

Original Medicare Parts A and B do not cover your prescription drugs. If you want coverage for prescription drugs through Medicare, you'll need to enroll in a Part D Prescription Drug plan.

You can enroll in a Part D Prescription Drug plan from a private insurance company to get prescription drug coverage along with Part A and/or Part B coverage or to complement a Medicare Supplement plan. If you do, you'll pay an additional premium as well as copayments and deductibles. This is called a “stand-alone” Part D plan. Or you can get Part D coverage through Medicare Advantage plans, which generally include Part D Prescription Drug coverage built in.

When choosing a prescription drug plan, you'll want to pay special attention to the list of medications it covers, called a formulary.

New this year!

Discounts through the coverage gap

With the new legislation comes good news about Part D Prescription Drug coverage. Effective immediately, many people with Part D coverage who enter the coverage gap — also known as the doughnut hole — will have a little more money left in their pockets.

In 2011, enrollees in Part D who are not already receiving Medicare Extra Help and who enter the coverage gap will receive a 50% discount on eligible brand-name and biologic prescription drugs administered during the coverage gap. If you take one or more brand-name drugs, this can mean a significant out-of-pocket savings for you.

For generic prescription drugs, enrollees in Part D who are not already receiving Medicare Extra Help and who enter the coverage gap will receive a 7% discount in 2011.

How Part D works for you.

You may have heard a lot about the gap in Part D Prescription Drug coverage. And you may wonder how that gap can cost you money. Although there will be positive changes in 2011, here's how Part D payments work:

Your premium

You pay this every month, unless you receive Part D coverage through a Medicare Advantage plan. Then, you pay only the Medicare Advantage premium.

Deductible up to \$310

If your plan has a deductible, you pay your yearly deductible until it is met. (It is important to note that many Part D plans do not have deductibles.)

Cost-sharing from \$310 to \$2,840

Once you've paid your deductible, you'll pay a share of your expenses until total medication costs reach \$2,840. This cost-sharing is called a copay or coinsurance. Your plan pays the rest.

The coverage gap

Under Medicare Part D, when your total costs reach \$2,840, you'll become responsible for all expenses until they reach \$4,550. This is the coverage gap, where the discounts and coverage discussed on page 7 start to work for you.

Exceeding \$4,550

When you've reached \$4,550 in total prescription drug expenses for the year, your coverage begins again and you pay a set copayment of \$2.50 for generic and \$6.30 for brand-name prescription drugs. Your plan pays the rest.

More good news about Part D.

The Part D Doughnut Hole Will Eventually be Filled.

Starting with the new discounts, the health care legislation will eliminate the Part D coverage gap over the next 10 years. Between 2011 and 2020, the coverage gap will gradually be eliminated. While this may sound like a long time, the savings will start now and continue to grow. The average savings while in the coverage gap is estimated to be \$700 in 2011, and this savings will grow annually to \$3,000 by 2020.

Supplemental coverage for Original Medicare.

Medicare Supplement plans (“Medigap”)

Overview:

Under Original Medicare, you’re generally responsible for 20% of all costs. And with the rising costs of health care, use of sophisticated tests and expensive surgery, 20% of a three-day hospital stay can be thousands of dollars in out-of-pocket costs. Private insurance companies offer Medigap plans to help you with these expenses.

There are several plan options to choose from, each with a different combination of benefits and different levels of coverage. The plans have standardized benefits that follow federal and state laws. That means all of the plans that private insurance companies offer have the same features and out-of-pocket costs. The differences can usually be seen in monthly premiums and value-added benefits and services. That makes them pretty easy to compare.

There are 11 different Medigap plans. Each plan is named with a letter (A–N). Different insurance companies offer different plans — many don’t offer all 11. So although the benefits in any Medigap plan are the same regardless of insurance company, the policies differ.

Generally, when you buy a Medigap policy, you must have Original Medicare and pay the monthly Medicare Part B premium. In addition, you will have to pay a monthly Medigap premium.

Remember, Medigap plans don’t include Part D Prescription Drug coverage. If you choose a Medigap plan, you’ll need a stand-alone Part D plan, as well.



Your Medicare needs and priorities.

A few questions to ask yourself.

To determine what you need from Medicare, take a minute to jot down your responses to these questions. They'll help you clarify what you want from your plan and suggest some of our plan options that might be best for you.

What role does your primary care physician play in the care you receive?

- 1. My family doctor advises me on most care choices, and I look to him/her to refer me when I need specialists.
- 2. I welcome the advice of my family doctor, but I am also comfortable selecting my own doctors for specialty care.
- 3. I am comfortable managing my health care; I do not want to be restricted by or referred to any specific doctor.

What is the right balance for you between cost and access to doctors and hospitals?

- 1. I look for the plan with the lowest monthly premium, understanding that I will likely have to pay coinsurance or a copay for doctor's office visits and other care through the plan's network.
- 2. I am willing to pay a reasonable monthly premium, as well as modest copays for the care I receive, as long as I can use doctors and hospitals both in and out of the plan's network.
- 3. I am willing to pay a high monthly premium in exchange for no network limitations and little to no cost when I use my benefits.

How often do you receive routine care when you travel during the year?

- 1. I rarely travel, and when I do, I expect to need care only in the event of an emergency.
- 2. I travel occasionally, and I occasionally need some care while away.
- 3. I spend much of my year (up to six months at a time) away from home, and I frequently receive routine care while I am away.

How important is coverage for things like prescription drugs, wellness services or fitness programs?

- 1. I take several prescription drugs, so prescription drug coverage is very important to me, as well as having coverage to access services and programs I need to stay healthy and live longer.
- 2. I occasionally need prescription drug coverage, and access to preventive services is important to me.
- 3. I want coverage for just basic medical care so I'll know I'm covered if I'm hospitalized. It is OK if my plan does not include prescription drug coverage or preventive services.

Answers:

If you answered mostly 1, a Medicare Advantage plan (like an HMO or PPO) might be right for you. These plans include a network of providers and offer comprehensive coverage at a reasonable cost.

If you answered mostly 2, consider Medicare Advantage PPO plans, which offer coverage in and out of the provider network.

If you answered mostly 3, consider Medigap plans. While these plans typically have higher monthly premiums, they do not have a provider network. A separate prescription drug plan would be needed, as these plans do not cover prescription drugs.



Medicare news! This year, there's no more “switching” period.

For coverage effective January 1, 2011, Medicare recipients can enroll in a Medicare Advantage plan (with or without Part D coverage included) or a stand-alone Part D plan during the six-week Annual Election Period (AEP) from November 15 through December 31. Historically, you could also switch plans — from one carrier’s plan to another, or between plans of the same carrier — during the Open Enrollment Period (OEP), from January 1 through March 31. Under reform, the rules for Medicare Advantage and prescription drug plan enrollment have been updated.

Starting in 2010, the only time most eligible people can enroll in a Medicare Advantage plan is during the AEP (November 15–December 31). At that time, Medicare recipients can select a Medicare Advantage plan with or without built-in Part D coverage.

The OEP period, January 1–March 31, no longer serves as an option to switch plans. Rather, this will now be the Medicare Advantage disenrollment period that will run for 46 days at the start of each year, from January 1 to February 15. During this time, Medicare Advantage enrollees may drop their Original Medicare plans and enroll in a stand-alone Part D plan . . . but for most Medicare beneficiaries, once they leave Medicare Advantage after January 1, they cannot reenroll until the next AEP (November 15–December 31).

This change is manageable. Just a little bit of planning can give you peace of mind down the road. You can start thinking about your Medicare options for the coming year as early as October, when all Medicare Advantage and Part D carriers are required to post the following year’s plans and benefits online. Do your own research or talk to your local carrier about your options. Be sure of your choice and enroll by December 31. You’ll be fine!

Steps to choosing the right plan.

You're almost there!

1. Consider all the costs you could have.

The purpose of insurance is to protect you from the costs you could face, so consider more than the monthly premiums. What about copayments associated with different health care services? Is there a deductible, and if so, is it affordable? How do the costs for various services differ from Original Medicare?

2. Make sure you can see the doctors and hospitals you want.

When choosing a plan, make sure your doctor and specialists are in the network. And take a look at the list of hospitals for the one you prefer.

3. Look for plans that offer you valuable extras.

Many private Medicare plans offer value-added benefits. Look for extras you'll use and enjoy. Vision, hearing and dental care could save you money. Are you fitness-conscious? Some plans offer ways to keep you healthy, including free gym memberships.

4. Make certain you choose a plan you can trust.

Not all private Medicare plans are the same. Make sure you look closely at each plan's policy and try to talk to plan members about their experiences. That way, you can make sure you're getting coverage from a reliable, stable company.

5. Don't hesitate to get help.

Medicare has resources you can use. If you have access to the Internet, go to <http://www.medicare.gov>. You can also call toll-free 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY/TDD users may call 1-877-486-2048. Your State Health Insurance Assistance Program (SHIP) also has information about plans available.

More ways we can help you have a greater hand in your health.

If you have any questions about your coverage, your choices or your Medicare plan, there are many additional services Highmark offers to help make Medicare simple for you:

Talk one on one with a Medicare expert. Call us and we'll set up a personal consultation to help you find the right coverage for your particular needs.

Visit us online at www.highmarkblueshield.com to review the plans available to you and all the details you'll need to choose the right Medicare coverage for your needs. And if you have any questions while you're browsing, give us a call!

We're here to help! Call toll-free 1-866-459-4415 (TTY/TDD users may call 711), 8 a.m.–8 p.m., seven days a week.



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