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SPECIALIZING IN ASSET PROTECTION

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WHAT IS MEDICARE?

Medicare is a federal insurance program for people who are 65 or older, have been disabled for at least two years, or have End Stage Renal Disease (ESRD). There are two types of Medicare coverage. Medicare Part A provides for hospital insurance, and Medicare Part B provides for medical insurance.

MEDICARE COVERAGE CRITERIA FOR SKILLED NURSING CARE

1. You must have had a prior inpatient hospital stay of at least three days, with one of those days being while Medicare eligible, not counting day of hospital discharge.
2. Your admittance to a Medicare approved skilled nursing facility must be within 30 days of discharge from the hospital or within 30 days of a previous Medicare covered stay.
3. Your doctor must have certified that following your hospital stay, you require a daily skilled service provided by a licensed nurse or therapist in a certified Medicare unit.

MEDICARE COVERED SERVICES / SUPPLIES

- Room and Board
- Routine Nursing Care
- Medical Supplies & Complex Equipment
- Pharmacy
- Physical, Occupational & Speech Therapy
- Respiratory Therapy
- Oxygen
- Lab Services
- X-Ray
- EKG
- IV'S

COVERED LIMITATIONS

Medicare will cover up to 100 days of a qualified skilled nursing facility stay. During the first 20 days of your stay, Medicare pays 100% of the cost of covered services and supplies. From day 21 to day 100, Medicare pays a significant percentage of the cost of your covered services and supplies, while you provide a daily coinsurance payment.

From day 1 to day 20 of your skilled nursing facility stay, you pay only for non-covered services you receive. Non-covered services include a private room (unless medically necessary) and personal convenience items, such as private phone and television.

From day 21 to day 100 of your skilled nursing facility stay, you pay a daily coinsurance amount, which is established annually by Medicare, for the covered services you receive, and continue to pay the full amount for any non-covered services.

If your skilled nursing facility stay goes beyond 100 days, Medicare payments end and you become fully responsible for all nursing care charges incurred during the remainder of your stay.

If your condition improves during the 100 day benefit period, and you no longer meet Medicare criteria for coverage, the facility will notify you that your Medicare Part A coverage has ended.

MEDICARE PART A BENEFITS

SERVICES	MEDICARE COVERAGE	PATIENT'S RESPONSIBILITY
Physician Services	90 days per benefit period*, plus 60 day lifetime reserve Services include: • semi-private room • meals • routine nursing care • lab tests and x-rays (billed by hospital) • medical supplies and equipment • rehabilitation therapies	• $1340 deductible per benefit period • $335 coinsurance per day for days 61-90 • $670 coinsurance per day for lifetime reserve days expenses beyond 90 days unless lifetime reserve days are chosen **Services not covered:** • personal convenience items • private duty nurses • extra charges for a private room
Outpatient Medical Services & Supplies at a Hospital	100 days per benefit period in a nursing facility Medicare-certified skilled unit (three day Medicare covered inpatient hospital stay and physician confirmation that there is a need for daily skilled nursing and/or rehabilitative care required prior to utilization of skilled nursing facility care) • semi-private room • meals • routine nursing care • rehabilitation therapies and supplies • medical supplies & use of equipment • medications furnished by facility • laboratory services • X-ray services • pharmacy services	• $167.50 ciinsurance per day for days 21-100 • Expenses beyond 100 days of treatment are NOT covered. **Services not covered:** • personal convenience items • private duty nurses • extra charges for a private room • custodial nursing care
Ambulance	100% of eligibility requirements are met	$0 if Home Health Care criteria coverage is met
Respite Care	Unlimited coverage of services including nursing care, physician services, medications, medical supplies and appliances, outpatient physical, occupational and speech therapies, home health aide, home-maker services, respite care and counseling	5% of the medicare-approved amount for inpatient respite care

* A benefit period begins on the first day the patient receives inpatient care in a hospital or Medicare skilled nursing services in a nursing facility.

* All Medicare Advantage Plans must cover the same services. Costs vary by the plan but may be either higher or lowers than those noted above. Check with your plans.

MEDICARE PART B BENEFITS

SERVICES	MEDICARE COVERAGE	PATIENT'S RESPONSIBILITY
Physician Services	80% of Medicare allowable charges*	• $183 deductible per calendar year • 20% coinsurance after Medicare • amounts billed in excess of allowable charges
Outpatient Medical Services & Supplies at a Hospital	80% of Medicare allowable charges*	• $183 deductible per calendar year • 20% coinsurance after Medicare • amounts billed in excess of allowable charges
Ambulance	80% of Medicare allowable charges*	• $183 deductible per calendar year • 20% coinsurance after Medicare • amounts billed in excess of allowable charges
Respite Care	No benefit	100% respite care cost
Prescription Drugs	Benefits are available under Medicare Part D	

* Allowable charges are the amount Medicare considers reasonable and customary for that service.

MEDICARE ADVANTAGE PLANS - Also known as Medicare Part C or Medicare Replacement Plans

Medicare Advantage Plans are insurance policies offered by private insurance companies approved by the Centers for Medicare & Medicaid Services (CMS). When a person enrolls in a Medicare Advantage Plan, the plan will cover all of Part A, Part B, and sometimes Part D coverage. Medicare Advantage Plans often offer extra coverage above & beyond traditional Medicare such as vision, hearing, dental, and/or wellness programs. Although the plans are governed by CMS, they are not obligated to follow the same co-pays, deductibles, and out-of-pocket expenses applicable to traditional Medicare.

Also, each company has different rules that define which providers (hospitals, physicians, & skilled nursing facilities) members can see. Some allow members to seek care at any Medicare-approved provider while most plans require members to seek care from a contracted provider to avoid higher out-of-pocket expenses. Members & healthcare providers should contact the insurance company to determine Benefits & Eligibility for specific healthcare providers and healthcare services. Many Medicare Advantage Plans require that healthcare providers secure Prior Authorization from their Care Coordination Department. In an effort to contain cost, the service may be denied for financial coverage if the insurance company determines there is no medical necessity.

Some Medicare Advantage Plans waive the 3-day hospital stay required for inpatient skilled nursing & rehabilitation under traditional Medicare.