Understanding Medicare with your DoD NAF HBP
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Medicare and DoD NAF HBP/Aetna

• For employees who retire before age 65, you will continue on the plan available in your service area, either the Choice POS II plan or the Traditional Choice Indemnity Plan.
  – The DoD NAF HBP will remain primary until you’re eligible for Medicare.

• Once you and/or all covered family members reach age 65, you will need to enroll in the Traditional Choice Indemnity Plan. Contact your servicing Human Resources office to find out what action you may need to take to enroll. Depending on which NAF you are in you may be automatically enrolled in the Aetna Traditional Choice Indemnity Plan and will receive a letter and benefits information regarding the plan.
  – When eligible for Medicare, Medicare will be primary, DoD NAF HBP will be secondary.
  – DoD treats claims as if you are enrolled in Part A & B, so enroll in both as soon as you are eligible.
  – You are responsible for Medicare Premiums.

• You are automatically enrolled in Part A and Part B after you receive disability benefits from Social Security or certain disability benefits.

Key Points with the DoD NAF HBP

• If you are still working and are enrolled in the DoD NAF HBP, enrollment in Medicare Part A is not required but is recommended.

• You can delay Medicare Part B and paying premiums (with no penalty) if you are still employed.
  – To avoid late enrollment penalties, obtain and complete the form CMS-L564 and submit to Medicare. Additional information is provided at slide 5 of this slide deck.

• Medicare Part C (also known as a Medicare Advantage plan) is not needed. Your DoD NAF HBP would still be secondary in coverage, just as if you were under regular Medicare.

• You do not need to enroll in Medicare Part D because you have prescription coverage through your HBP that has been deemed “creditable”. The DoD NAF HBP does not coordinate with other prescription drug coverage. Reimbursement for a prescription drug expense can be made only from one plan.
Automatic Enrollment – Part A and Part B

- Automatic for those receiving Social Security benefits, Railroad Retirement Board benefits
  - Part A - If you paid Federal Insurance Contributions Act (FICA) taxes for at least 10 years, you may receive Part A premium free. Contact CMS for additional information.
  - If you paid FICA less than 10 years, you can pay a premium to get Part A. You may have a penalty if not enrolled when first eligible.
- Initial Enrollment Package includes your Medicare card and is mailed 3 months before:
  - Age 65
  - 25th month of disability benefits

If not Automatically Enrolled, when Can I Enroll in Part B?

<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Enrollment Period (IEP)</td>
<td>7-month period surrounding your birthday month</td>
</tr>
<tr>
<td>General Enrollment Period (GEP)</td>
<td>Enrollment Period</td>
</tr>
<tr>
<td>Special Enrollment Period (SEP)</td>
<td>8-month period beginning the month after you retire or lose employer based coverage, whichever comes first</td>
</tr>
</tbody>
</table>
Who Should Consider Enrolling in Medicare Part A?

- Anyone working or retired and age 65 or above
- Premium free for most people
- Automatic enrollment if receiving Social Security or Railroad retirement benefits
- Starts the first day of the month you turn 65

Who Should Consider Enrolling in Medicare Part B?

- If you’re 65, still working, and have HBP
  - It may be to your advantage to delay Part B (this includes spouse covered under HBP)
    - HBP remains primary payer
    - Spouse age 65 remains covered under HBP as primary payer
  - Apply for Part B upon retirement (enroll during 8-month Special Enrollment Period, penalty waived)
    - Get Form CMS-L564 (Request for Employment Information) and employing office completes it
    - Available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009718.html](http://CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009718.html)
  - Consider Part B as it:
    - Pays for costs involved with seeing providers outside of the HBP plan’s network
    - Is also required for Medicare Advantage and TRICARE For Life
    - OCONUS Retirees should refer to the next page for more information.
    - DoD NAF HBP coordination considers Medicare payment to determine benefits due.
Should you Delaying Enrollment in Medicare?

- You should enroll in Part A when you become eligible. However, people who are actively working and have health insurance from their (or their spouse’s) current employer may be able to delay enrolling in Part B until retirement.
- If you do not enroll in Part A and Part B during your Initial Enrollment Period, you will have to wait to sign up. This may cause a gap in your coverage and you may have to pay a lifetime late enrollment penalty—and that penalty increases the longer you wait.
- You are required to enroll in both Part A and Part B to keep your TRICARE/TRICARE for Life or CHAMPVA coverage.

OCONUS Retirees and Medicare

If you delay joining Medicare Part B until returning to the U.S. without qualifying for Special Enrollment Period eligibility, you will pay a 10% per year penalty for every year without Part B coverage. That penalty is paid in perpetuity on top of regular premiums. Medicare Parts A and B enrollment are required when enrolled in "Tricare for Life". If you plan to move back to the U.S. one day or will travel back frequently, you need to think carefully about what parts of and when to enroll in Medicare. You can contact the Social Security Administration and Medicare to discuss options. If you return to the U.S either temporarily or permanently and are not enrolled in Medicare (both parts A and B) your DoD NAF HBP will pay as if you do have Medicare.

What if I Have TRICARE?

- If retired from the military, you must enroll in Part A and Part B to keep TRICARE
- If you are an active-duty member, you don’t need to have Part B to keep TRICARE.
- If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan because you have creditable coverage under TRICARE.
  - If you do, your Medicare drug plan pays first, and TRICARE pays second
Medicare – Four Parts

Part A
Hospital Insurance

Part B
Medical Insurance

Part C
Medicare Advantage Plans
If you are in the DoD NAF – not needed

Part D
Medicare Prescription Drug Coverage
If you are in the DoD NAF – not needed
# Medicare Part A Coverage

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Stays</strong></td>
<td>Semi-private room, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. Includes care in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals. Includes inpatient care as part of a qualifying clinical research study and mental health care (lifetime 190-day limit).</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.</td>
</tr>
<tr>
<td><strong>Home Health Care Services</strong></td>
<td>Can include part-time or intermittent skilled care, and physical therapy, speech-language pathology, a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies.</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>For terminally ill and includes drugs, medical care, and support services from a Medicare-approved hospice.</td>
</tr>
<tr>
<td><strong>Blood</strong></td>
<td>In most cases, if you need blood as an inpatient, you won’t have to pay for it or replace it.</td>
</tr>
</tbody>
</table>
### Paying for Inpatient Hospital Stays

<table>
<thead>
<tr>
<th>For Each Benefit Period in 2017</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-60</td>
<td>$1,316 deductible</td>
</tr>
<tr>
<td>Days 61-90</td>
<td>$329 per day</td>
</tr>
<tr>
<td>Days 91-150</td>
<td>$658 per day</td>
</tr>
<tr>
<td></td>
<td>(60 lifetime reserve days)</td>
</tr>
<tr>
<td>All days after 150</td>
<td>All Costs</td>
</tr>
</tbody>
</table>

### Paying for Skilled Nursing Facility Care

<table>
<thead>
<tr>
<th>For Each Benefit Period in 2017</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-20</td>
<td>$0</td>
</tr>
<tr>
<td>Days 21-100</td>
<td>$164.50 per day</td>
</tr>
<tr>
<td>All days after 100</td>
<td>All Costs</td>
</tr>
</tbody>
</table>

* Must be transferred from a qualifying hospital stay for Medicare to pay these benefits.
## Medicare Part B Coverage

<table>
<thead>
<tr>
<th><strong>Doctors’ Services</strong></th>
<th>Services that are medically necessary (includes outpatient and some doctor services you get when you’re a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Medical and Surgical Services and Supplies</strong></td>
<td>For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor’s services (if the doctor accepts assignment). You also pay the hospital a copayment for each service. The Part B deductible applies.</td>
</tr>
</tbody>
</table>
| **Home Health Care Services** | - Medically necessary part-time or intermittent skilled nursing care  
- Physical therapy  
- Speech-language pathology services  
- Occupational therapy  
- Part-time or intermittent home health aide services  
- Medical social services  
- Medical supplies  
- Durable medical equipment  
- Injectable osteoporosis drugs  

**NOTE:** You pay nothing for covered services. |
| **Durable Medical Equipment** | Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. Medicare has a program called “competitive bidding.” If you live in a competitive bidding area, you must use specific suppliers, or Medicare won’t pay for the item and you’ll likely pay full price. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. |

Part B also covers some additional medically necessary medical services and supplies. Costs vary.  
Preventive Care Coverage
Included in Medicare Part B Coverage

- Abdominal aortic aneurysm screening
- Bone mass measurements
- Cardiovascular disease (behavioral therapy)
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- HIV screening
- Mammograms (screening)
- Obesity screenings & counseling
- One-time “Welcome to Medicare” preventive visit
- Flu shots
- Pneumococcal shots
- Yearly “Wellness” visit
- Alcohol misuse screenings & counseling
- Cardiovascular disease screenings
- Cervical & vaginal cancer screening
- Depression screenings
- Diabetes self-management training
- Hepatitis C screening test
- Lung cancer screening
- Nutrition therapy services
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Hepatitis B shots
- Tobacco use cessation counseling

Up-to-date listing: www.medicare.gov/coverage/preventive-and-screening-services.html
Prescription Drug Coverage

• If you are enrolled in the DoD NAF HBP you do not need to enroll in Medicare Part D (Rx).
• The DoD prescription drug expenses are not coordinated with other prescription drug coverage. Reimbursement for a prescription drug expense can be made only from one plan.
• You cannot be reimbursed for the cost of a prescription drug, in whole or in part, by another plan and this plan.
• Coverage/Use of Coupons:
  • The DoD plan currently allows members to apply coupons or discount cards at a retail pharmacy.
  • Aetna Rx Home Delivery (Mail Order) does not have the capability to apply coupons or discount cards, so they cannot be utilized at MOD.
What is Not Covered by Medicare?
Examples of items and services that are not covered by Medicare include:

- Long-term care (also called custodial care)
- Most dental care *
- Eye examinations related to prescribing glasses, including eyewear *
- Dentures *
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them *
- Routine foot care

* These items are eligible under the DoD NAF medical and/or dental plan

What Happens if Medicare Denies a Claim?

- If Medicare denies a claim, the claim is still forwarded to Aetna electronically for processing.
- If Medicare excludes a service, Aetna will review the claim as if we are the primary carrier, it will then be subject to medical necessity and your regular plan of benefits.
- When Medicare denies a claim, they will typically state one of two things:
  - They will deny the service and state the member is responsible for the charge in full, or
  - They will deny and state that there is no member responsibility.
- If they indicate the member is responsible for the charge, Aetna will consider the service and view as if we are primary.
- If Medicare denies the charge and indicates that there is no patient responsibility, then Aetna will not pay on that service and the member owes nothing for the service.
Who Pays First – Coordination of Benefits

• If you have coverage under other group plans or Medicare, the DoD plan will coordinate the benefits it pays with the benefits paid by the other plans. This process is known as Coordination of Benefits (COB).

• The Plan’s COB process ensures that total payments from all of your group plans are not greater than what this Plan would pay if it were your only coverage.

• The first step in the COB process is determining which plan is primary. The primary plan pays benefits first. The secondary plan then calculates its benefits, based on its COB process.

<table>
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<th>If . . .</th>
<th>Which Plan is Primary?</th>
<th>Which Plan is Secondary?</th>
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</thead>
<tbody>
<tr>
<td>Retiree and all dependents are not eligible for Medicare</td>
<td>DoD NAF Plan (or HMO plan, if applicable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Retiree is Under 65 and Dependent is eligible for Medicare</td>
<td>For Retiree: DoD NAF Plan</td>
<td>For Retiree: N/A</td>
</tr>
<tr>
<td></td>
<td>For Dependent Eligible for Medicare: Medicare</td>
<td>For Dependent: DoD NAF Plan</td>
</tr>
<tr>
<td>Retiree is Over 65 and Dependent is NOT eligible for Medicare</td>
<td>For Retiree: Medicare</td>
<td>For Retiree: DoD NAF Plan</td>
</tr>
<tr>
<td></td>
<td>For Dependent not Eligible for Medicare: DoD NAF Plan</td>
<td>For Dependent: N/A</td>
</tr>
<tr>
<td>Retiree and All Dependents are eligible for Medicare</td>
<td>Medicare</td>
<td>DoD NAF plan – Traditional Choice</td>
</tr>
</tbody>
</table>

• In general, health care you get while traveling or living outside the U.S. isn't covered. The 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are considered part of the U.S.
How does Coordination of Benefits work if I signed up for a Medicare Advantage Plan?

• Medicare Advantage Plans are considered Medicare replacement plans. If you sign up for a Medicare Advantage plan for medical, your DoD NAF HBP will still be secondary.

• After your Medicare Advantage Plan pays, then Aetna will process the claims based upon your normal plan of benefits, just as if you were under regular Medicare.

• The one exception is if you choose a Medicare Advantage Plan that also has the Medicare Part D (Prescription Drug coverage) included with it. Your DoD NAF HBP will not coordinate as secondary coverage on the prescription portion of the plan.
Medicare Direct Program

- Medicare Direct is the electronic process that eliminates the need for a retiree and his/her Part B provider to file a supplemental claim to Aetna when Medicare Part B is primary.
- Providers do not need to bill us, we receive nearly all Medicare claims automatically.
- There is no cost to the member or provider for this program.
- How to enroll in program:
  - Quarterly: Aetna notifies retirees approaching 65 about this, explains how to enroll
  - In case you don’t take action then, each fall, Aetna automatically enrolls those age 65 or older into the program.

Once enrolled in Medicare Direct:

1. Ask doctor to send your claims to Medicare.
2. Medicare processes your claims according to their rules.
3. Medicare then sends the claims straight to Aetna
4. Aetna processes your claims.
5. = EASY FOR RETIREE!
Medicare Removing SSN from Medicare cards

Starting on April 1, 2018, CMS will begin a fraud and identity theft prevention initiative that removes the SSN-based Health Insurance Claim Number (HICN) from Medicare cards. The new card will contain a new number, also called the Medicare Beneficiary Identifier (MBI), that is unique to each person and will only be used for Medicare coverage. Medicare members will be instructed on how to safely and securely destroy their old Medicare card and keep their new Medicare number confidential. The new Medicare card and number will not change coverage or benefits for people with Medicare.
Medicare Resources

- www.nafhealthplans.com/retiree
- Medicare.gov
  - Medicare Publications—Medicare.gov/publications
- Centers for Medicare & Medicaid Services (CMS), call 1-800-MEDICARE (800-633-4227)
  - TTY: 1-877-486-2048
- CMS.gov
  - CMS publications—CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html
- Social Security Administration (SSA) at 1-800-772-1213
  - TTY: 1-800-325-0778
- To see videos on Medicare topics, go to www.nafhealthplans.com and click on the Video Library tab at the top of the page.
- CONUS: Aetna Member Services: 1-800-367-6276
- OCONUS: Aetna International Member Services: 1-888-506-2278 or 1-813-775-0189 (collect)