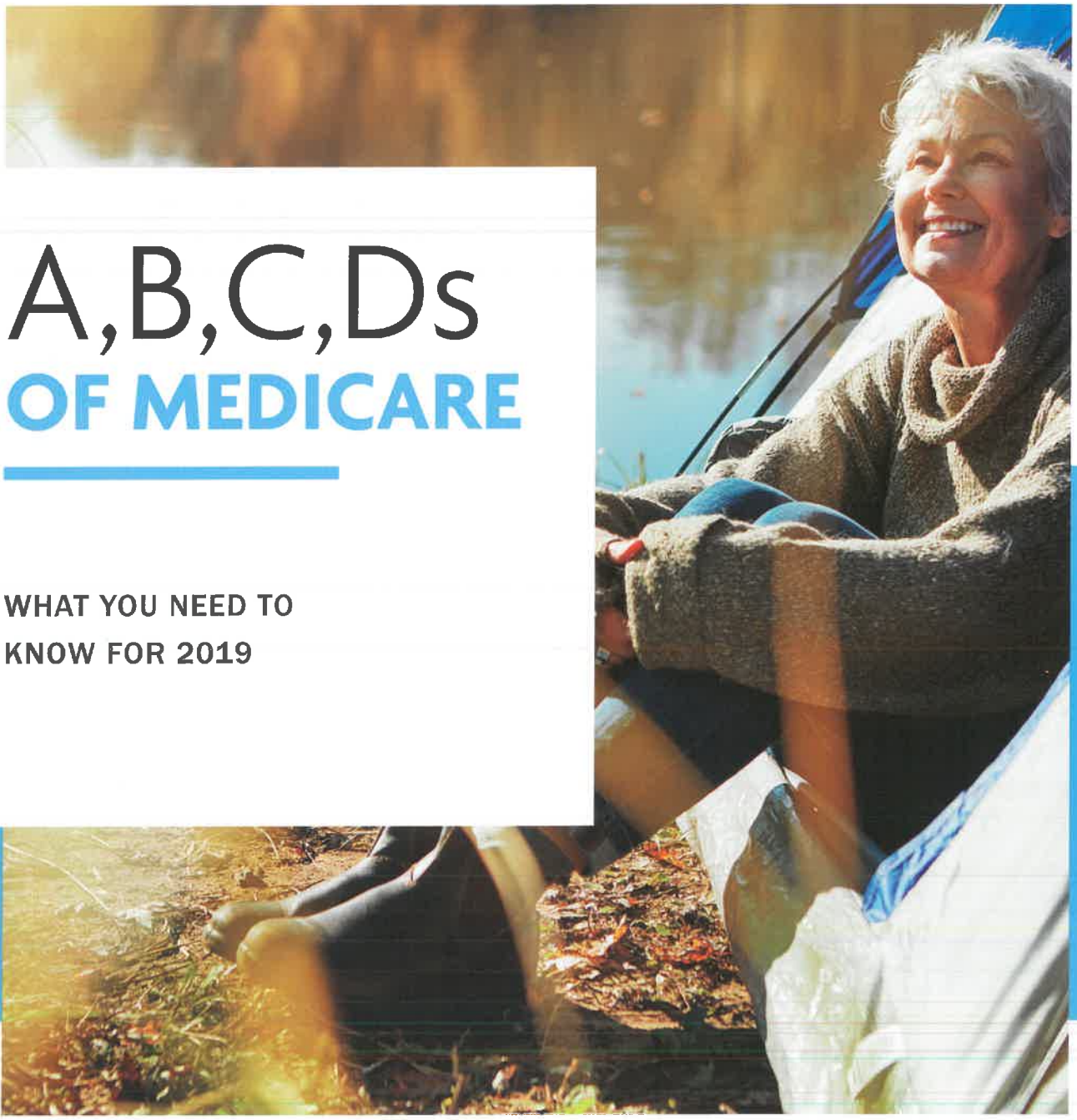
Emeriti®
Retirement Health



A,B,C,Ds OF MEDICARE

WHAT YOU NEED TO KNOW FOR 2019

Emeriti Service Center
1-866-363-7484
Monday through Friday, 9AM to 5:30PM ET

FALL 2018

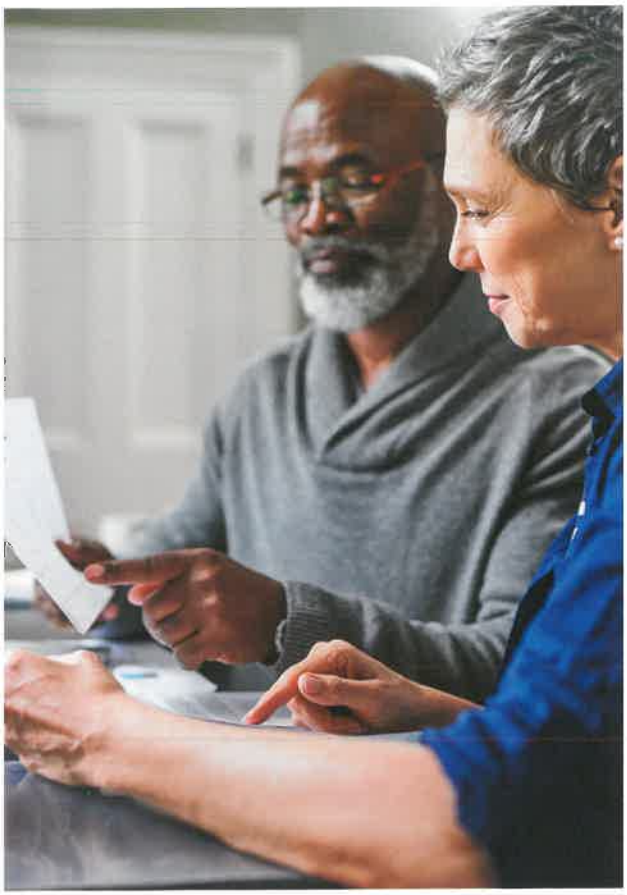
INTRODUCTION TO MEDICARE

Medicare provides an excellent foundation for the health care coverage of retirees, but the program is unlikely to meet all of your medical needs. It is important that you understand how Medicare operates and what choices you have.

Original Medicare (Parts A and B) is administered by the Centers for Medicare and Medicaid Services (CMS). For Part C or Medicare Advantage plans, a private insurer provides all of the benefits of Original Medicare Parts A and B, receives a subsidy from CMS, and may provide additional benefits. Medicare Part D, which covers prescription drugs, is administered by private insurance carriers that receive a subsidy from CMS.

The purpose of this booklet is to help you understand what the different parts of Medicare cover, and what they do not cover. The reality is that although Medicare is a comprehensive framework for health security in retirement, it doesn't cover everything, nor was it ever intended to do so. That's why access to supplemental insurance is so helpful because it helps you with healthcare costs that Medicare does not pay. You will also want to think about other out-of-pocket medical expenses beyond insurance coverage and factor them into your overall retirement budget. This booklet will help you to understand what your share of Medicare costs may be.

ENROLLING IN MEDICARE



If you have been paying into Medicare through FICA payroll taxes during your working years and are age 65 and ready to retire, you are probably eligible for Medicare.

Here are Medicare's enrollment guidelines:

- If you are not applying for or not planning to receive your Social Security benefits for a while, you will need to enroll in Part A three months BEFORE turning 65, even if you plan to work beyond 65.
- If you are applying for or already receiving Social Security benefits, you will be automatically enrolled in Part A and Part B at age 65.
- If you are receiving Social Security benefits and plan to keep working, you need to decline enrollment in Part B until you retire. You do not need to enroll in Part B until you actually retire.
- If you're under 65 and disabled, you'll automatically get Part A and Part B after you get disability benefits from Social Security.
- You may also be eligible if your spouse (or deceased spouse) has (had) Medicare, or if you are permanently disabled and have been receiving Social Security for 24 months.

FOR MORE INFORMATION ABOUT MEDICARE

Call or go online to obtain additional resources.

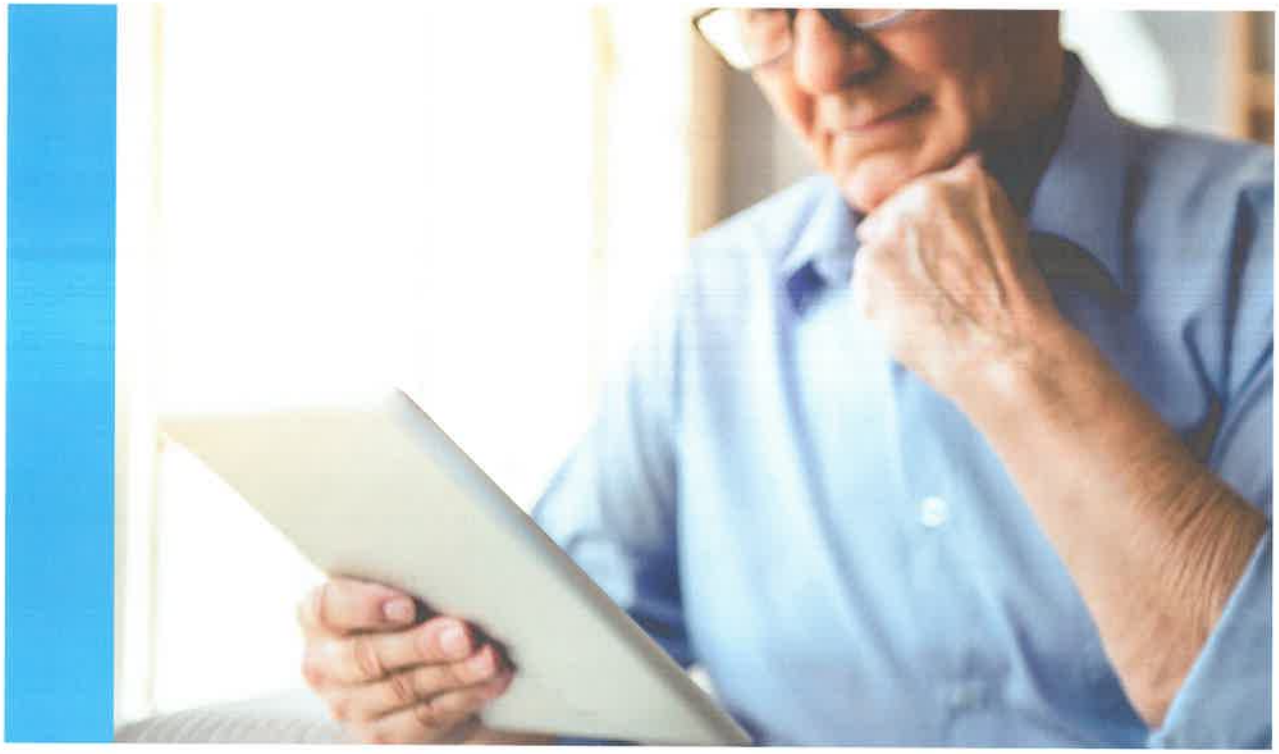
Medicare.gov

Call 1-800-MEDICARE (1-800-633-4227) or visit the Medicare web site at medicare.gov, where you can download the Medicare publication, *Medicare and You*.

Medicare and You and *Your Medicare Benefits*, both from the Centers for Medicare and Medicaid Services (CMS), are the sources for the information about Medicare in this booklet.

FORWARD-THINKING RETIREMENT PLANNING INCLUDES HEALTHCARE

AN AVERAGE COUPLE, AGE 65, CURRENTLY NEEDS MORE THAN $273,000[1] TO COVER THEIR HEALTHCARE COSTS IN RETIREMENT



Will Medicare cover everything?

Medicare provides an excellent foundation for the healthcare coverage needs of retirees. However, it's important to note that there are many health expenses that Medicare doesn't cover completely, and others, such as vision, dental and hearing services, and long term care, where it provides no benefit.

[1]EBRI Notes, December. 20, 2017, Vol. 38, No. 10 . National average. Savings needed for Medigap Plan F premiums, Medicare Part B premiums and out-of-pocket (median) drug expenses. Does not include long term care. For a couple with a goal of having a 90 % chance of having enough savings to cover health care expenses in retirement, they need $273,000.

When planning for retirement, it's important to take into account not only the things you want to do, but also the things that can happen—like illness or injury.

MEDICARE PART A
HOSPITAL

MEDICARE PART A PROVIDES COVERAGE FOR INPATIENT CARE IN A HOSPITAL AND SKILLED NURSING FACILITY, HOSPICE CARE, HOME HEALTH CARE, AND SOME OTHER BENEFITS.

There is no monthly premium for enrollment in Medicare Part A if you have made sufficient FICA contributions during your working years. You should receive information from Medicare about Part A enrollment several months before your 65th birthday.

Part A has a hospital deductible of $1,340 in 2018[1]. The first 60 days of hospitalization, or the first 20 days in a skilled nursing facility, in a benefit period[2] are covered in full by Medicare; thereafter you must share in the cost or pay it in full. Some copays and coinsurance may also apply. The chart on the right shows the major types of coverages and benefit period or lifetime limits for Part A for 2018[1].

[1]*2019 information was not available at time of publication.*
[2]*A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60 day period, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.*

Medicare Part A Coverage	You Pay[1]
Hospitalization	Days 1-60:[2] $0 coinsurance. Days 61-90:[2] $335 coinsurance per day Days 91-150:[2] $670 coinsurance per each lifetime reserve day after day 90 for each benefit period. Up to 60 days over your lifetime. After lifetime reserve days are exhausted, you pay 100%.
Skilled Nursing Facility	Days 1-20:[2] $0 Days 21-100:[2] $167.50 per day Beyond 100 days:[2] you pay 100%
Home Health Care	$0 for medically-necessary care 20% of approved amount for durable medical equipment
Hospice Care	$0 if you meet certain requirements. You pay $5 copay for prescription drugs for pain management. You pay 5% for inpatient respite care.
Mental Health	Days 1-90 lifetime: Same cost sharing as inpatient hospitalization Days 91 and beyond: you pay $644 per each lifetime reserve day.
Blood	If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you, get in a calendar year or have the blood donated by you or someone else.

[1]2019 information was not available at time of publication.
[2]A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60 day period, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.

MEDICARE PART B **MEDICAL**

PART B SERVICES FOCUS ON PHYSICIAN VISITS, DIAGNOSTIC TESTING, DURABLE MEDICAL EQUIPMENT, AND SOME OTHER SERVICES. PART B ALSO COVERS MANY PREVENTIVE SERVICES.

There is a monthly premium for Medicare Part B that you pay. These premiums are based on your annual taxable income, on a phased-in basis.

Starting January 1, most people with Medicare will see a small increase in their Part B premium, to an average of $109.00 per month[1]. But about 30 percent of people covered by Medicare will see a minimum Part B premium of $134.00[1]. This difference in premium amounts is due to a federal law which is commonly called the "hold harmless" provision. This provision prevents about 70 percent of beneficiaries from seeing major increases in Medicare Part B premiums when Social Security cost of living adjustments (COLAs) are nonexistent or very small. Those who are held harmless will not see their Part B premium increase by an amount that is greater than the dollar amount of their COLA increase.* New beneficiaries not subject to the "hold harmless" provision will pay $134.00 in 2018[1]. For existing beneficiaries, if your annual taxable income, as reported on your IRS tax return is $85,000 ($170,000 for joint filers) or less, your monthly premium is $109.00 for 2018[1].

[1]*2019 information was not available at time of publication.*

You should enroll when you are first eligible or you will pay a penalty of 10% for each full 12-month period that you were eligible but did not enroll. You do not pay this penalty if you do not sign up for Part B because you are covered under an employer's active group plan or enrolled under a spouse/partner's health plan. Just be sure to sign up shortly after that coverage ends. (See Special Enrollment Period in *Medicare and You* at medicare.gov.)There is a calendar year annual deductible of $183.00 in 2018 for Part B services, which means that you pay in full for the first $183.00 of Medicare Part B expenses[1]. Thereafter, your costs vary, depending on the service, as follows:

Medicare Part B Coverage	You Pay
Physician Charges	20%
Clinical Laboratory Services and Diagnostic Tests	0% for Medicare-approved services, 20% for covered diagnostic tests and x-rays.
Preventive Care	Generally you pay nothing if you get your preventive care from a provider that accepts Medicare assignment, (mammograms; pap tests, pelvic exams; prostate cancer screenings; other screenings for those at high risk) NOTE: Not all preventive services are covered every year. Check with Medicare for the coverage provisions for the appropriate service or screening.
Durable Medical Equipment	20%
Outpatient Therapy	20% (may be limits and exceptions)
Home Health Services	0% for Medicare-approved services
Outpatient Hospital Services	Coinsurance varies by service

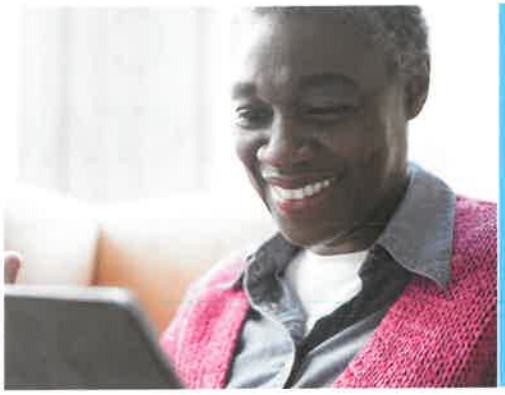
[1]*2019 information was not available at time of publication.*

MEDICARE PARTS A & B
WHAT IS NOT COVERED

THERE ARE MANY HEALTH-RELATED EXPENSES THAT ARE NOT COVERED COMPLETELY BY ORIGINAL MEDICARE (PARTS A AND B); AND SOME OTHERS, SUCH AS VISION, DENTAL AND HEARING SERVICES, AND LONG TERM CARE, WHERE IT PROVIDES NO BENEFIT.

ORIGINAL MEDICARE (PARTS A & B) DOES NOT COVER:

- DENTAL CARE AND DENTURES
- ROUTINE VISION AND HEARING CARE
- MOST EYEGLASSES AND HEARING AIDS
- ROUTINE FOOT CARE
- CUSTODIAL OR LONG TERM CARE
- SOME SHOTS, TESTS AND LAB TESTS
- SOME DIABETIC SUPPLIES
- ACUPUNCTURE
- CERTAIN CHIROPRACTIC SERVICES
- COSMETIC SURGERY



For more information, visit Emeritihealth.org.

THE IMPORTANCE OF **ADDITIONAL INSURANCE**

Providers who do not accept Medicare assignment can balance bill you up to an additional 15% of the cost for covered services. This is called the Medicare Limiting Charge. Medicare does not pay any of this additional cost. Some supplemental plans may pay this cost.

If you're in a Medicare Advantage Plan or other Medicare plan, you may have different rules, but your plan must give you at least the same coverage as Original Medicare. Some services may only be covered in certain settings or for patients with certain conditions.

Medicare provides a solid foundation for your retiree health care, but there are also cost-sharing requirements on specific services, and there are no out-of-pocket limits for most Medicare-covered services.

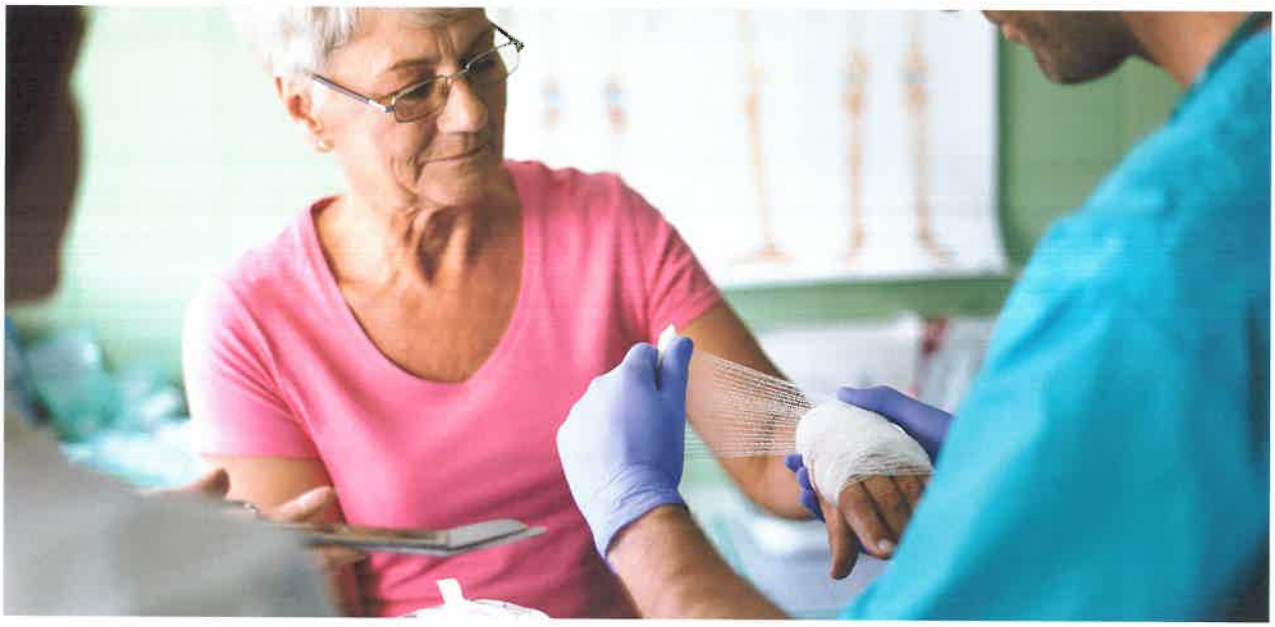
It is for these reasons that Medicare suggests that you may want to purchase additional insurance that builds on the foundation of Original Medicare.

And, of course, there are deductibles, coinsurance, and co-payments that you pay for the services that Medicare covers.

It is important to remember that Medicare provides no coverage for healthcare expenses while you are traveling outside the United States. (There are various exceptions to a number of these exclusions; contact Medicare for more specific provisions.)

MEDICARE PART C
MEDICARE ADVANTAGE PLANS

SOMETIMES CALLED "PART C" OR "MA PLANS," YOUR MEDICARE PARTS A AND B ARE ASSIGNED TO A PRIVATE INSURER WHO PROVIDES YOU WITH COMPREHENSIVE HEALTH CARE COVERAGE.



Medicare pays the insurer a subsidy to assume all of the benefit coverages defined by Original Medicare. The insurer becomes responsible for all of the Medicare-eligible healthcare costs and sometimes offers additional benefits, often extensive preventive services, beyond Original Medicare's eligible services.

The CMS payments for Part C plans are dependent on Medicare's reimbursement to providers, which vary significantly from one geographic area to another. Medicare Advantage plans may be structured in various ways, with co-payment and annual out-of-pocket limits, or with coinsurance (%) cost-sharing, and include an annual out-of-pocket maximum. The amount that Part C plans pay for Medicare-eligible expenses may be different from what Original Medicare would pay, but generally speaking the Medicare Advantage plan must pay at least what Medicare would have paid. In all cases you pay Part B premiums.

One type of Medicare Advantage plan is Preferred Provider Organization (PPO) Plans. The plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all types of Medicare Advantage Plans, you're always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you're in a Medicare Advantage Plan. Medicare Advantage Plans are not supplemental coverage plans; a Medicare Advantage plan would become your primary insurance.

You should enroll when you are first eligible or you will pay a penalty of 10% for each full 12-month period that you were eligible but did not enroll. You do not pay this penalty if you do not sign up for Part B because you are covered under an employer's active group plan or enrolled under a spouse/partner's health plan, as long as you do sign up shortly after that coverage ends. (See Special Enrollment Period in Medicare and You at medicare.gov.)

Medicare Cost Plans

A Medicare Cost Plan is another type of Medicare Part C plan that contracts as a Medicare Health Plan. Enrollees maintain their Medicare Part A and Part B benefits, enabling them to seek services by a non-contract provider. Cost plans do not have to offer a Medicare Part D option. If they decide to offer a Medicare Part D plan, the same Medicare rules apply to Cost plans.

MEDICARE PART D
PRESCRIPTION DRUG PLANS

THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT IS DESIGNED TO HELP MEDICARE-ELIGIBLE RETIREES MANAGE THE INCREASING COSTS OF PRESCRIPTION DRUGS.

Here are the basics of Part D coverage:

- you choose an insurer, and then you choose a plan of coverage
- you pay an annual premium for this insurance coverage
- you may also pay a separate premium directly to Medicare if you are in a higher income bracket
- you typically pay an initial deductible each year
- you pay your portion of the cost of covered Part D prescription drugs after the deductible according to the Part D plan's tier structure for the Initial Coverage and Coverage Gap stages, often with a different cost share by drug tier in each stage
- if you enter the catastrophic stage in a calendar year, the plan covers nearly all of the remaining costs of your prescription usage (typically the plan pays 95% or all but a small participant co-pay) for the rest of the calendar year

There are many variations on the Medicare Part D design. One of the most important prescription drug plan provisions is the type of formulary that the plan has. A formulary is a listing of covered drugs under the insurance plan. It outlines under what tier a drug would be covered to help you determine the cost share that you will be responsible for a specific drug. All Medicare Part D plans must comply with government requirements. CMS requires that the formulary provides access to an acceptable range of Part D drug choices, and that it includes drug categories and classes that cover all disease states.

Understanding Formularies

An open formulary means that all Part D drugs are available for coverage, although the plan may be designed with lower member cost sharing for generic and preferred brand drugs.

A closed (or standard) formulary is a subset of Medicare Part D drugs, and requires you to use only those medications that are designated as covered under the insurer's preferred drug list. If your brand drug is not covered on the closed formulary, you can speak to your doctor about switching to a drug that is on the preferred drug list; or your doctor may request a medical exception from the insurer for the drug to be covered. If you decide to continue taking medications not covered on the closed formulary without obtaining a medical exception, you will pay the full cost; and these expenses will not count toward the plan's deductible or out-of-pocket limits.

Enrolling in Part D Coverage

It is important to consider enrolling in a Part D plan when you are first eligible. A late enrollment penalty will be added to your Part D premium if you don't enroll during your initial enrollment period or if you don't have other creditable prescription drug coverage that pays, on average, at least as much as Medicare's standard prescription benefit. This would permanently increase your premiums by 1% of the "national base beneficiary premium" for each month you did not enroll or did not have creditable coverage. You do not pay the late enrollment penalty if you are eligible for the low income subsidy program. You can enroll in only one Part D plan at a time. Each year, during the Medicare open enrollment period in the fall, you can switch to a different

MEDICARE PART D
HOW IT WORKS

EMERITI'S PART D PLANS ARE DERIVED FROM THE MEDICARE PART D BENEFIT EACH YEAR. IN ORDER TO UNDERSTAND HOW EMERITI'S PLANS WORK, IT'S HELPFUL TO REVIEW MEDICARE'S PART D DESIGN IN THE DIAGRAM BELOW. EMERITI'S PLAN OPTIONS ARE RICHER THAN THE BENEFIT BELOW, WHICH REPRESENTS THE MINIMUM AMOUNT OF COVERAGE THAT MEDICARE ALLOWS.

2019 MEDICARE PART D DESIGN (NON LOW-INCOME SUBSIDY ELIGIBLES)

DEDUCTIBLE PHASE	INITIAL COVERAGE PHASE	COVERAGE GAP	CATASTROPHIC COVERAGE
YOU PAY FIRST $415 AS THE DEDUCTIBLE	YOU PAY 20% OF TOTAL DRUG COSTS UNTIL YOU REACH $3,850	THEN YOU PAY FIRST 25% OF BRAND[1] AND 37% OF GENERIC (YOU REACH THIS PHASE AFTER YOU HAVE $3,850 IN TOTAL COSTS)	THEN YOU PAY GREATER OF $3.40 OR 5% FOR COVERED GENERIC (INCLUDING BRAND DRUGS TREATED AS GENERIC) DRUGS. GREATER OF $8.50 OR 5% FOR ALL OTHER DRUGS (YOU REACH THIS PHASE AFTER $5,100 IN TRUE OUT-OF-POCKET COSTS)

[1]*Includes 70% discount from drug manufacturer and 15% payment from the plan, leaving a 35% cost share for Medicare enrollees*

The 2019 Medicare Standard plan design includes several phases of cost-sharing by you and the Plan. First, you pay a monthly premium. Then, as you begin to incur drug expenses, you pay the full cost, up to the annual Deductible amount. Then, you pay 25% coinsurance (the Plan pays 75%) for each prescription, up to the Initial Coverage Limit (total costs paid by you and the Plan). If you have additional costs in the calendar year, you enter the Coverage Gap, and you pay 25% of brand drug and 37% of generic drug costs and receive a 70% discount on the cost of covered Part D brand drugs until your True Out-of-Pocket (called TrOOP) expenditures reach $5,100. If your Rx expenditures exceed $5,100, you move to Catastrophic Coverage, where you pay the greater of 5% or $3.40 for covered Part D generic drugs (including brand drugs treated as generic drugs), and the greater of 5% or $8.50 for all other covered Part D drugs.

Healthcare Reform (ACA)

The Medicare Coverage Gap Discount Program will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving "Extra Help." A 70% discount on the negotiated price of preferred and non-preferred brand drugs (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount at point-of- purchase.

Please visit medicare.gov for additional information.

EMERITI PROVIDES ACCESS TO GROUP RETIREE INSURANCE, WITH NO MEDICAL UNDERWRITING

NATIONAL COVERAGE PROVIDED BY AETNA. MINNESOTA COVERAGE PROVIDED BY HEALTHPARTNERS.

Having reviewed how Medicare works, you no doubt appreciate why Medicare suggests that you consider purchasing additional insurance that builds on Original Medicare, to help pay for those expenses that Medicare does not pay in full. One option is to enroll in post-65 group retiree medical insurance that coordinates with or supplements Medicare. The Emeriti Retirement Healthcare Savings Program, offered by your institution, provides a choice of post-65 group health plans that build on Original Medicare.

Aetna provides retiree insurance options nationally, and for Minnesota-resident retirees from Minnesota institutions, HealthPartners provides coverage. All insurance choices through Emeriti include Medicare-approved Part D plans.

The Aetna plans provide retiree health insurance on a nationwide basis, so no matter where you live in the U.S., you will be covered. Coverage through Aetna includes plans with no networks and richer coverage and added benefits.

All of the insurance options through Emeriti also provide catastrophic coverage, which limits your exposure to very high medical or drug costs within a calendar year.

Each year during Emeriti's open annual enrollment you will be able to switch to a different medical and drug plan based on your needs for the upcoming year. Even if you develop a very different medical situation, you can change plans for the next year, with no medical underwriting.

Retiree Health Plans on the Individual Market

Individual Medigap plans are tightly regulated by Medicare, and they coordinate with Medicare Parts A and B. There are a number of coverage options at varying costs, offered by different insurance companies that choose to participate in various state and local markets. New Medigap policies cannot offer prescription drug coverage; you will need to find a separate Part D plan if you want drug coverage.

One thing to keep in mind is that once you select an open market individual Medigap plan, it could become difficult to switch to a different plan as your needs change each year. Individual market plans require medical underwriting in some states, and you may be deemed uninsurable or be required to pay a higher premium by the insurance provider. And if your insurer leaves your local market, you may become part of a closed group, with potentially much higher premiums.

Please note that these restrictions do not apply to insurance plans offered through Emeriti.

FOR MORE INFORMATION ABOUT EMERITI'S

INSURANCE PLAN OPTIONS

Visit EmeritiHealth.org. You may also call the Emeriti Service Center at 1-866-363-7484, Monday through Friday, 9AM to 5:30PM ET

Emeriti®
Retirement Health

READY TO ENROLL?

CALL THE EMERITI SERVICE CENTER TO REQUEST THAT A WELCOME KIT BE MAILED TO YOUR RESIDENCE, THEN:

1. ENROLL IN MEDICARE PARTS A & B
2. CONSIDER ADDING A RETIREE MEDICAL INSURANCE PLAN
3. ADD A MEDICARE PART D PLAN

Emeriti, TIAA, CBIZ RPS, Aetna Life Insurance Company, and HealthPartners are independent corporations and are not legally affiliated. The full name of Emeriti Retirement Health is The Emeriti Consortium for Retirement Health Solutions, an Illinois Nonprofit Corporation. Emeriti Retirement Health is not an insurance company, insurance broker or insurance provider.

The Emeriti Program is delivered in collaboration with TIAA, CBIZ RPS, Aetna Life Insurance Company, and HealthPartners.

Teachers Insurance and Annuity Association of America (TIAA) is Emeriti's accumulation record keeper, trust services provider, and investment manager. TIAA is a leading provider of financial services to nonprofits offering investing, banking, advice and guidance, and retirement services. TIAA has helped institutions and individuals pursue financial well-being for 100 years.

CBIZ RPS provides services in connection with the Emeriti group insurance administration and Emeriti medical expense reimbursement processing. Headquartered in Cleveland, Ohio, CBIZ RPS has 26 offices around the country and more than forty years of experience in providing full-service benefits services supporting employees and retirees in organizations nationwide.

Aetna Life Insurance Company is the primary health insurer for the Emeriti Program, providing fully insured medical insurance and health-related products. For over 150 years, Aetna has been an innovator in the delivery of insurance solutions and is a nationwide provider of Medicare-approved Part D prescription drug services.

For Minnesota institutions and their Minnesota-resident retirees, HealthPartners provides participants with medical insurance and healthrelated products. HealthPartners is the largest consumer-governed nonprofit health care organization in the nation.

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