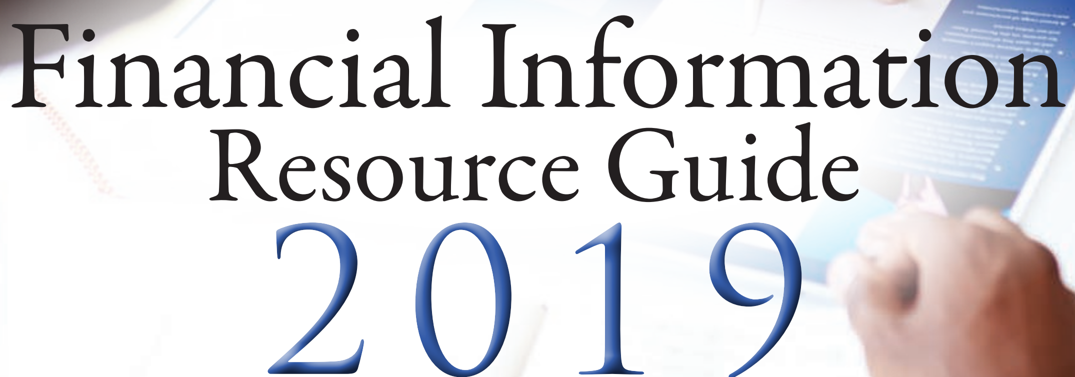
Genesis™



Financial Information Resource Guide 2019

Information contained within this pamphlet is effective January 1, 2019 through December 31, 2019.

Table of Contents

Medicare* .... Page 2

- **Medicare Part A** .... Page 3
- **Medicare Part B** .... Page 4-5
- **Medicare Managed Care & Part C** .... Page 6
- **Medicare Part D** .... Page 7-8

Enrollment .... Page 9

Managed Care .... Page 10

Medicaid .... Page 11-12

Applying for Medical Assistance (Medicaid) .... Page 13

Health Insurance Marketplace .... Page 14

Phone & Website Directory .... Back Cover

** Medicare information contained in this guide is accurate as of the date the booklet went to print.*

Glossary

What Terms Mean...

Skilled Nursing Center: A facility that provides care requiring daily skilled nursing or rehabilitation services.

Deductible: The amount you must pay before Medicare coverage begins.

Co-insurance: The amount of the approved charge that you have to pay:

- after you pay the Part A deductible (see chart on page 3); or
- after you pay the first deductible each year for Part B (see chart on page 5)

Co-payment: In some health plans, the amount you pay for each medical service, such as a doctor visit.

Medicaid: A joint federal and state program that helps with medical costs for certain individuals with low income and limited resources.

Medicare: The traditional per-visit arrangement that covers Part A and Part B services.

Medicare Benefit Period: Starts the day you are admitted to a hospital or skilled nursing center for covered services and ends when you haven't received covered hospital in-patient or skilled nursing center care for 60 consecutive days.

Premium: Monthly payments for health care coverage to:

- Medicare;
- An insurance company; or
- A health care plan.

Medicare Managed Care Plans: A group of health plans that include:

- HMO: Health Maintenance Organization
- POS: HMO with a Point-of-Service option
- PSO: Provider Sponsored Organization
- PPO: Preferred Provider Organization

Medicare

What is Medicare?

Medicare is a Federal Health Insurance Program administered by the Centers for Medicare and Medicaid Services (CMS) and is for:

- People 65 years of age and older* who are eligible to collect under Social Security;
- Certain younger people with disabilities; and
- People with end-stage renal disease.

Medicare is a pay-per-visit arrangement. You can go to any doctor, hospital or other health care provider who accepts Medicare. You must pay the deductible. Medicare then pays its share and you pay your share (co-insurance). Medicare is divided into two parts: Part A (hospital insurance) and Part B (medical insurance).

** Eligibility begins on the first day of the month in which you turn 65.*

** If Medicare is approved retroactively, any amounts Resident/Patient paid for services reimbursed under Medicare will be refunded.*

** If you're under 65 and have a disability, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. (If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.)*

Medicare Part A:

Medicare Part A helps pay for care in hospitals, skilled nursing centers, hospice care and some home health care. When you have been in a hospital as an inpatient for at least three consecutive days (midnights), you must meet the following requirements before your stay in a skilled nursing center will be covered by Medicare Part A.

- A skilled nursing center is the most appropriate place for your care.
- Skilled services are ordered by a physician.
- Nursing and/or rehabilitation services are provided daily.
- The skilled services you receive must be for a condition that was treated while you were in the hospital or one that arose in a skilled nursing center after your stay at the hospital.
- You must be admitted to the skilled nursing center within 30 days from your qualifying hospital visit. Your reason for being at the center must relate to a condition that was treated while you were in the hospital.
- You must have days available in your benefit period.

**An Observation Day in the hospital does not qualify as an Inpatient Hospital Day.*

Medicare Part A Covers:

- A semi-private room
- All meals, including special diets
- Routine nursing services
- Drugs, vaccines, lab tests and x-rays
- Physical, occupational, speech and respiratory therapy
- Medically-related social services
- Medical supplies, appliances and certain medical equipment
- Blood transfusions
- Housekeeping/laundry (towels, washcloths, gowns)
- Medication
- Routine personal hygiene items

** Not an exhaustive list, see Medicare & You Manual or visit www.medicare.gov for a complete list of Medicare Part A covered services.*

Medicare Part A -2019

Covered Services	What You Pay
Hospital Stays Semi-private room, meals, general nursing and other hospital services and supplies (but not private nursing, a television or telephone in your room, or a private room unless medically necessary).	**(Each Benefit Period)** • A total of $1,364 for days 1-60 • $341/day for days 61-90 • $682/day for lifetime reserve days • All costs for each day beyond lifetime reserve days.
Skilled Nursing Center Care* Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies (after a related three-day inpatient hospital stay).	**(Each Benefit Period)*** • Nothing for the first 20 days • $170.50 per day for days 21-100 • All costs beyond the 100th day in the benefit period
Home Health Care* Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers), supplies and other services.	• Nothing for home health care services • 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers).
Hospice Care* Support services and pain/symptom control for the terminally ill, usually in the home. Also covers necessary inpatient care and a variety of services otherwise not covered by Medicare.	• A co-payment up to $5 for hospice related outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (short-term care to a hospice patient so that the usual caregiver can rest).

* If you receive Medicaid, the Medicaid Program may pay for some or all of the payment you are responsible for under Medicare (may vary by state).

* Not a complete list of Medicare Part A covered services. Visit www.Medicare.gov for a comprehensive list of items and services covered under Medicare Part A and the coverage criteria.

Items/Services NOT Covered by Medicare Part A or B:

Note: You may be charged for these items and services if you ask for and receive them. Current price lists are available at each Center.

- Audiology services/hearing aids
- Beauty salon and barber shop
- Dental services/dentures
- Newspapers and other reading materials
- Optometry services/glasses
- Personal clothing and laundry
- Private room/private nurses or aides
- Special food items requested
- Telephone or television, including cable TV
- Non-medically necessary transportation by ambulance
- Non-ambulance modes of transportation, e.g., wheelchair van

Medicare Part B

Medicare Part B:

Medicare Part B helps pay for doctors, outpatient hospital care and some other medical services that Medicare Part A does not cover, such as outpatient physical and occupational therapy. Medicare Part B covers all doctor services that are medically necessary. Beneficiaries may receive these services anywhere, e.g., a doctor's office, clinic, nursing home, hospital or at home.

If you have been a Medicare Part B beneficiary for longer than 12 months, you may schedule a "Wellness" visit once every 12 months to develop or update a personalized plan to prevent disease based on your current health and risk factors.

Medicare Part B is voluntary. If you choose to enroll in Medicare Part B, the monthly premium is deducted from your Social Security, Railroad Retirement or Civil Service Retirement payment. Beneficiaries who do not receive any of the above payments are billed by Medicare every three months.

Medicare Part B also covers:

- X-rays, MRIs, CAT scans, EKGs and some other diagnostic tests
- Artificial limbs and eyes
- Arm, leg, back and neck braces
- Kidney dialysis and kidney transplants
- Preventive services
- Emergency care
- Medical supplies: ostomy bags, splints, casts, surgical dressings and some diabetic supplies
- Ambulance services (limited coverage)
- Services of practitioners such as clinical psychologists, clinical social workers and nurse practitioners
- Therapeutic shoes for people with diabetes (in some cases)
- Pneumococcal/influenza vaccines

* Not a complete list of Medicare Part B covered services. Visit www.Medicare.gov for a comprehensive list of items and services covered under Medicare Part B and the coverage criteria.

Therapy Payment Limitations

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Medicare Part B

Medicare Part B: Covered Services for 2019

Covered Services	What You Pay
Medical Expenses Doctors' services (except routine medical exams); inpatient and outpatient medical and surgical services and supplies that are medically necessary; physical, occupational and speech therapy*; diagnostic tests; and durable medical equipment (DME). ** Limitations apply*	**(Each Benefit Period)** • A 2019 Part B monthly premium based on income (go to www.medicare.gov for more information) • $185 deductible (paid once per year) • 20% of approved amount after the deductible • 20% of all therapy services
Clinical Laboratory Service Blood tests, urinalysis and more.	**(Each Benefit Period)** • Nothing for Medicare-approved services
Home Health Care* (If you do not have Medicare Part A) Intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services. ** Certain conditions apply*	• Nothing for Medicare-approved services • 20% of approved amount for durable medical equipment
Outpatient Hospital Services Services for the diagnosis or treatment of an illness or injury.	• A co-insurance or co-payment amount, which may vary according to the service

Optional Supplemental Insurance

In addition to Medicare, you may purchase supplemental insurance policies (Medigap or Medicare SELECT) for extra benefits. Some policies help pay Medicare's co-insurance amounts and deductibles.

Assistance With Meeting The Costs Of Medicare Premiums, Deductibles And Co-Pays

The Qualified Medicare Beneficiary Program (QMB), Specified Low-Income Medicare Beneficiary Program (SLMB) and Qualified Individual Program (QI), Qualified Disabled and Working Individuals (QDWI) Program are Medicare Beneficiaries Savings Programs that assist low-income elderly or disabled individuals who are eligible for Medicare through the Social Security Administration. To qualify, you must be eligible for Medicare and must meet certain income guidelines which change annually.

To apply for a Medicare Savings Program, visit your Medicaid Office and ask for Information about Medicare Savings Programs or call 1-800 Medicare.

Medicare Managed Care

There are some types of Medicare plans that provide health care coverage that are not part of Medicare Advantage, but are still part of the Medicare program. Medicare either pays a set amount of money for your care every month to these plans or reimburses the plan's reasonable cost for your care.

Covered Services

These plans may work in much the same way as the Medicare Advantage Plans. Each type of plan has special rules and exceptions.

- Medicare prescription drug coverage either through the plan, if offered, or through a stand-alone Medicare Prescription Drug Plan you can buy.

You Pay

- The Part B premium
- More if you don't follow plan rules
- An extra monthly premium, depending on the plan
- The plan co-payment per visit or service

Note: No supplemental insurance policy is necessary if you join a managed care plan

Medicare Part C

Medicare Advantage Plans (Part C)

If you join a Medicare Advantage Plan, you are still in the Medicare Program and retain Medicare rights and protections.

You can elect to join a Medicare Advantage HMO, PPO or Private Fee-for-Service Plan if:

- You have Medicare Part A and Part B
- You live in the service area of the plan you would like to join
- You don't have end-stage renal disease

Covered Services

You can get all the same coverage as Medicare and in some cases extra benefits depending on the plan.

- You usually get prescription drug coverage (Part D) through the plan.
- You may be able to get coverage for vision, hearing, dental and or health and wellness programs.

You Pay:

- The Part B Premium
- The Advantage Plan's premium that includes coverage for Part A, prescription drug coverage, and other extra benefits if offered.
- Depending on the plan, other costs such as co-payments or co-insurance.

Note: You don't need to buy a Medigap policy (Medicare Supplemental Insurance).

Medicare Advantage Plans also offer:

- Special needs plans for people with certain chronic diseases and other specialized health needs.
- Medicare Medical Savings Account Plans into which Medicare deposits money that you may use to pay healthcare costs.

Medicare Part D

Medicare Part D

Medicare Part D provides prescription drug coverage to seniors who have Medicare Part A or Part B and who do not currently have creditable prescription coverage through another program. Individuals may get Medicare prescription drug coverage through one of the many Medicare plans by choosing a plan that includes Part D or by adding Part D to a separate plan. For the latest information on covered drugs and services, refer to the Medicare website.

To the extent that you are eligible for and enroll in an approved drug plan, the following rights and obligations shall apply:

Voluntary Participation

While Medicare Part D is a voluntary program, you must enroll in a drug plan in order to receive prescription drug coverage. Plan options include a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) or other Medicare Health Plans that offer coverage. For a list of Prescription Drug Plans offered in your state, please ask your Center representative or go to the Medicare web site: www.Medicare.gov.

If you currently have prescription coverage through a private retirement plan and have been informed by your insurer that your coverage is 'creditable', this means your current prescription drug coverage, on average, is at least as good as standard Medicare prescription drug coverage. You will have to decide which coverage is right for you since you cannot have prescription drug coverage through both a private insurer and Medicare.

Things to consider <u>when deciding</u> between your private prescription plan and Medicare prescription coverage:

1. You may not be able to reinstate your private prescription drug coverage once it is dropped.
2. If your prescription drug coverage is provided together with your medical coverage, you may not be able to drop just the prescription coverage.
3. If you are the primary beneficiary of your private prescription plan and have added dependents, such as a spouse, the dependent may not be able to keep the plan if you drop coverage for yourself.
4. Deductibles, co-pays, and formularies (drugs covered or not covered by the plan) may be considerably different.
5. In most cases, co-pays/deductibles from private drug plans are NOT covered by State Medicaid programs and would be the responsibility of the Resident/Patient or his/her Responsible Party even when eligible for Medicaid coverage.

It is your responsibility to talk with your insurer, benefits administrator, State Health Insurance Program office, and Medicare Representative to fully understand all risks and benefits before making any change to your prescription drug coverage.

Medicare Part D

Enrollment

Key considerations when enrolling for Medicare Part D:

- Only you or your legal representative, such as your Power of Attorney, may enroll you in a plan.
- Dual eligibles (persons receiving both Medicaid and Medicare benefits) and/or Residents/Patients in a Skilled Nursing Facility are able to change their PDP at any time and as frequently as every 30 days. Otherwise, plans can only be changed annually during the open enrollment period.
- You can change your PDP plan up to 60 days following discharge from a Skilled Nursing Facility. Otherwise must wait until open enrollment to make a change. Beneficiaries can also switch to a Medicare Advantage Plan that has prescription drug coverage.

Cost and Resources

Your cost to join a PDP will vary depending upon the plan you choose and your payor source.

- Generally you will pay a monthly premium and an annual deductible, as well as a portion of the drug costs including a co-payment and co-insurance.
- Low income subsidy - If you have limited income and resources, you may qualify for extra help paying for the Medicare prescription drug premiums, deductible, co-insurance and co-payments.
- If you are in a Skilled Nursing Facility, approved for Medicaid, and have Medicare Part D prescription coverage, the premium, deductible, co-insurance and co-payment from your Part D plan will be waived if you are enrolled in an eligible zero premium plan.

Non-Covered Drug(s)/Services

Medicare prescription drug plans provide a one-time supply of your drug(s) when you join a new drug plan or when you enter a Center. During this transition period, you, your legal representative or your prescribing doctor can file for an exception to ask your plan to cover the drug(s) you need and/or to get the drug(s) at a lower cost-sharing amount.

Generally, the exception process takes 72 hours after your doctor provides supporting evidence. While the exception is processed, your plan must fill an emergency supply of your drug(s). If you cannot get your drug(s) covered, the Center will provide you with the drug(s) you need; however, you may be billed for these drug(s).

Grievance and Appeals

If your doctor or pharmacist tells you that your Medicare drug plan will not cover a drug as prescribed, or you are asked to pay a different cost sharing amount, you have the right to receive a written explanation from your Medicare drug plan and you, your legally authorized representative and/or the prescribing physician have the right to appeal the decision.

Enrollment

	Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D
Initial Enrollment Period	The initial enrollment period when you first become eligible for Medicare is a 7-month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after the month you turn age 65.			
General Enrollment Period	January 1 through March 31 Your coverage will begin July 1 and may be subject to premium penalties	January 1 through March 31 Effective July 1 and subject to 10% increase in premium for each 12-month period enrollment delay	January 1 through March 31 Your coverage will begin the first day of the month after the plan gets your enrollment form	October 15 through December 7 of each year.
Annual Enrollment Period	October 15 through December 7 Effective January 1	Refer to General Enrollment Period (above)	October 15 through December 7 Effective January 1, subject to plan application deadlines	October 15 through December 7 Effective January 1, subject to plan application deadlines and may be subject to premium penalties
Special / Open Enrollment Periods	Continuous enrollment for institutionalized individuals	Any time within 8 months if yours or your spouse's employment or group coverage ends Effective date subject to plan application deadlines	Continuous enrollment for institutionalized individuals	Upon admission, during stay or upon discharge from a long-term care facility Dual eligibles may change coverage every 30 days

Medicare Part D Solicitations

Since the implementation of Medicare Part D, there have been many incidences of seniors being contacted by individuals posing as Part D plan representatives who are looking to obtain personal identity information such as social security numbers. These representatives can call you to tell you about their plan but they cannot pressure you to sign-up. You need to call them to sign-up. If you suspect any scams or suspicious activity, please call Medicare.

Managed care

Managed Care
Managed Care programs are designed to make health care more affordable for members. In managed care programs, the managed care company contracts with providers to provide services to its members.

Managed Care Relationships with Providers
If your Center currently participates with your managed care plan, the Center agrees to abide by your managed care plan's applicable administrative policies and procedures, including but not limited to payment terms, utilization review, quality assessment and improvement, credentialing requirements, grievance procedures, confidentiality requirements and all other state and federal programs related to your care.

Note: The Center will not accept incentives to provide less than medically necessary services to our patients/residents from any managed care plan and will fully disclose to our patients/ residents all information regarding diagnosis, prognosis and treatment options.

Coverage With The Managed Care Plan
In the event, your health insurance lapses or terminates during your stay, you will be responsible for payment for services.

Covered Charges
If your Center currently participates with your managed care plan, the Center accepts remuneration from the Plan as payment in full when processed in accordance with the terms and conditions of the agreement between your plan and Center. Patients/residents are responsible for co-insurance, deductibles and co-payments. Co-payments may be collected upon admission when applicable.

Non-Covered Charges
If your Center currently participates with your managed care plan and services are rendered that are not covered by your managed care plan, you are responsible for reimbursing the Center. This includes services that are no longer medically necessary but the patient/resident wishes to continue to receive these services.

Speak with your Center's business office to discuss in detail those services which are non-covered. You will also be asked to sign a managed care financial waiver form acknowledging fiscal responsibility for such non-covered services.

Termination From Your Managed Care Plan
The Center will notify you in advance of its intent to terminate the agreement between your managed care plan and the Center. In such a case, the Center will manage transition of your care to another in-network facility in concert with the plan and in accordance with your state's insurance regulations department. In the event that you wish to remain at the Center after the termination, you will be financially responsible for your care.

Medicaid

Medicaid
Medicaid is a state health care insurance program provided at no cost to qualifying low-income families, children and people who are elderly or have a disability. Medicaid benefits vary by state. The following provides a general overview of Medicaid as well as information on who to call for more detailed information. If you have questions, members of our staff will be able to help you or contact your local Medicaid agency.

What's Covered
Medicaid will cover most of the costs of a nursing home stay for persons applying and receiving a grant for assistance. If you are also Medicare eligible and/or enrolled, you will be required to get your drug coverage through Medicare. Information about covered and non-covered items is available from the Center's office.

Who's Eligible
Eligibility depends on your medical eligibility for nursing home care and on whether your income and assets fall below certain levels.

Income
You should contact your local Medicaid agency to find out whether your income makes you eligible. If you qualify, some of your income is protected for your personal use while at the Center (varies by state).

Assets
Your local Medicaid agency will also evaluate your assets and tell you whether you qualify. The following are examples of things not counted as assets:

- your house if your spouse lives there;
- household goods;
- a certain amount of cash;
- personal property in your possession in the nursing home; and
- a certain amount of money for irrevocable burial arrangements.

The value of other assets transferred from you to others within a certain number of years prior to your need for Medicaid may be considered as available to pay for your care at the Center.

Medicaid Asset Transfer Law
The Medicaid Asset Transfer Provisions of the Deficit Reduction Act of 2005, signed into law and effective on February 8, 2006, has changed certain rules for Medicaid applicants that you should be aware of:

- The State will require the applicant to disclose current countable assets and asset transfers occurring within a lookback period of five years.
- The State imposes a period of ineligibility (penalty period) based on improper transfer of assets within this lookback period.
- If a penalty period is imposed, applicants may file and be granted a request to ignore the penalty period under certain circumstances.
- Additional asset rules may apply. Consult your local Medicaid office.

The Center will work with you and/or your legal representative to help assess your current needs and assist you in establishing Medicaid eligibility upon your consent.

Medicaid

Your Contribution

Depending on your income, you may be required to make a contribution toward the cost of your care, which amount is determined by the local Medicaid agency responsible for administering the program. For Medicare Part D enrollees, you will automatically receive the Extra Help (also called the Low-Income Subsidy) available to people with limited incomes and resources subject to guidelines established by CMS.

Retroactive Coverage

Medical bills that you received prior to your application for Medicaid may be covered by Medicaid. Prior time frames and levels of coverage vary by state. If application is approved retroactively, any amounts Resident/Patient paid for services reimbursed under Medicaid will be refunded.

Pending Medicaid Approval

If you require financial assistance to pay for care and believe you are eligible for Medical Assistance (Medicaid), you must submit an application to your local Medicaid agency. The agency approval process takes a minimum of 45 days and sometimes as long as six months.

Who to Contact if You Have a Question or Problem

Contact your Center representative if your application for Medicaid is denied, a service is not covered, or your coverage is terminated, as you may appeal to the local agency.

Notice

1. While your Medicaid Application is pending, you will continue to receive invoices for services provided. The invoice includes an estimated amount due from you to cover your share of the cost of services received. You may pay all or a portion of your invoice through the convenience of our Resident Fund Management Service (Direct Deposit).
2. If you are pending Medicaid coverage and receiving medications through a prescription plan, such as Medicare Part D, you will be responsible for medications not covered by the prescription plan while the Medicaid application is pending. You will also be responsible for non-covered medications provided prior to the effective date of coverage.
3. The Estimated Care Cost, is calculated by totaling your monthly income from all sources, including Social Security, pensions and other sources. An amount (often referred to as a Personal Needs Allowance) is subtracted as an allowance for your personal needs.
4. Your monthly payment to Genesis while your application is pending is also based on the type of Medicaid application you have filed:
    a) Resident with no spouse: Contributes the Estimated Care Cost (ECC) minus the Personal Needs Allowance (PNA).
    b) Resident with spouse or dependent child: Contributes the ECC minus the PNA. Some or all of your monthly income might also be protected for the benefit of your spouse or dependent child (Spousal/Dependent Allowance). If this applies to you, you or your Responsible Party should contact your caseworker at the local Medicaid agency to request an estimate of the monthly care cost amount to pay Genesis each month. Genesis will process any necessary adjustments to your account following approval of the Medicaid grant.

APPLYING FOR MEDICAL ASSISTANCE (MEDICAID)

To qualify for Medical Assistance in a Skilled Nursing Center, you will need to meet citizenship, residence, medical, and financial eligibility requirements mandated by the State.

- **Citizenship** - US Citizen or Qualified Non-Citizen (5 year rule and exceptions apply)
- **Residency** - Meet residency requirements determined by the State
- **Medical Need** - Determined by an assessment agency in your County or Region is based on how much assistance you require with your activities of daily living and medical care. To be eligible, you must require the level of care that is provided in a nursing facility setting.
- **Financial Need –** To be eligible, you must be below State determined asset and income limits. The Business Office representative can provide you with your State's income and asset limits. If you have a spouse, federal law protects a portion of your joint assets to provide the spouse with the means to remain in the community.
    - Gifting income or assets in the five years prior to applying for Medicaid may result in Medicaid denying your request for benefits or impose a penalty period during which you would not be eligible for Medicaid benefits.

The State will require you to disclose and provide verification of the following:

Citizenship	Income received by you and your spouse
Marital Status	Assets owned solely and/or jointly
Health Insurance Premiums	Transfer of income and assets in the last five years
Long Term Care Insurance	

What will I owe?

You may be required to make a monthly contribution toward the cost of your care, depending on your income. The estimated care cost is calculated by totaling your monthly income from all sources (Social Security, pensions, etc.) minus allowable deductions such as health insurance premiums, spousal allowance, and your personal needs allowance which is predetermined by the State.

While your Medicaid Application is pending, you may receive two invoices monthly:

- An invoice for your cost of care contribution
- An informational statement of Medicaid Pending charges in the event your Medicaid application is not approved.

Our Business Office staff is here to help:

- Determine when you will need Medicaid to cover the cost of your care
- Assist you in completing the Medicaid Application
- Submit the Application to the County agency
- Monitor the Application process, which may take several months
- Coordinate with your Attorney or other outside sources to file the Application, if applicable

During your stay - If you have questions regarding your insurance coverage or need assistance applying for further coverage, our Business Office Manager or designee will assist you with the process.

Health Insurance Marketplace

The Health Insurance Marketplace, a key part of the Affordable Care Act, is an easy way for qualified individuals, families, and qualified employees of small businesses to get health coverage. Medicare isn't part of the Marketplace.

If I have Medicare, do I need to do anything?

As long as you have Medicare Part A coverage, you're considered covered and you don't have to get any additional coverage. If you only have Medicare Part B, you aren't considered to have minimal essential coverage.

Can I get a Marketplace plan instead of Medicare, or can I get a Marketplace plan in addition to Medicare?

Generally, no. It's against the law for someone who knows you have Medicare to sell you a Marketplace plan, because that would be duplicate coverage. However if you're employed and your employer offers employer-based coverage through the Marketplace, you may be eligible to get that type of coverage.

Note: The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies, Medicare Advantage plans, or Medicare drug plans (Part D).

What if I become eligible for Medicare after I join a Marketplace plan?

You can get a Marketplace plan to cover you before your Medicare coverage begins. You can cancel the Marketplace plan when your Medicare coverage starts. When you're eligible for Medicare, you'll have an Initial Enrollment Period to sign up. In most cases it's to your advantage to sign up when your first eligible because:

- When you're considered eligible for Medicare part A, you won't qualify for Marketplace tax credits to help you pay your premiums or reductions in cost-sharing that may be available through the Marketplace.

- If you enroll in Medicare after your Initial Enrollment Period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.

Note: You can keep your Marketplace plan after your Medicare coverage starts. However once your Part A coverage starts, any premium tax credit and reduced cost sharing you get through the Marketplace will stop.

Phone & Website Directory

Name	Phone #	Website
	TTY *(Hearing and Speech Impaired)*	
Medicare	(800) 633-4227 TTY (877) 486-2048	www.medicare.gov
Personal Medicare	(800) 633-4227 TTY (877) 486-2048	www.mymedicare.gov
OIG: U.S. Department of Health & Human Services Fraud Line	(800) 447-8477 TTY (800) 377-4950	http://oig.hhs.gov/fraud/report-fraud/index.asp
Social Security Administration / Prescription Assistance	(800) 772-1213 TTY (800) 325-0778	www.ssa.gov/prescriptionhelp
Health Insurance Marketplace / Affordable Care Act	(800) 318-2596 TTY (855) 889-4325	www.healthcare.gov
NCOA / Public and Private assistance for Medicare Prescription Drug Coverage	(571) 527-3900	www.benefitscheckup.org
Railroad Retirement Board	(877) 772-5772 TTY (312) 751-4701	www.rrb.gov
Centers for Medicare & Medicaid Services (CMS)		http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices

Beneficiaries: Please contact Medicare directly regarding any beneficiary questions you may have.

866-745-2273

WWW.GENESISHCC.COM