Health Protection Plans

Medicare Insurance for New Entrants. How to sift through choices

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www.HealthProtectionPlans.com

Phone 407-972-6060

Agenda

01 Our Mission and Our Main Insurance Products

02 Entitlement for (original) Medicare Insurance and its components

03 Eligibility for flavors of Medicare Insurance

04 How Health Insurance Works and Why Its Important you have it

Our Mission and Our Key Insurance Products for age above 65

Section 1

Health Protection Plans: Your Experts in Health Insurance

What We Do: Offer healthcare insurance solutions from known industry carriers

UnitedHealthcare

UnitedHealthcare for above 65

- ✓ Medicare Advantage Plans
- ✓ Medicare Supplement Plans

THE IHC GROUP

The IHC Group for below 65

- ✓ Short Term Medical Plans 1 to 36 months.
- ✓ Accident and Critical Illness
- ✓ Supplemental - Hospital Insurance,
- ✓ Health and Wellness Discount Plan,
- ✓ Telemedicine, dental, and more

UnitedHealthOne
Underwritten By Golden Rule Insurance Company

UnitedHealthcare for below 65

- ✓ Short Term Medical Plans 1 to 36 months.
- ✓ TriTerm Medical Plans up to 36 months.
- ✓ Supplemental Insurance
- ✓ Hospital Insurance,
- ✓ Telemedicine, Dental, Term Life, Critical Illness, and more.

TOKIO MARINE HCC

Tokio Marine HCC for Students and Travelers

- ✓ International Students Medical Insurance: Four levels of plans
- ✓ International Travelers: Individual, Group, and Multi-Trip

Health Protection Plans: Our Signature Products

01 **Medicare Advantage and Medicare Supplement Plans** by UnitedHealthcare.

02 **Major Medical Plans (Obamacare)** by Oscar and Bright Health

03 **Short Term Medical** plans combined with Supplemental Medical Plans by The IHC Group and UnitedHealthcare.

04 **Supplemental Medical Plans** by The IHC Group and UnitedHealthcare.

05 **International Students health insurance** by Tokio Marine HCC anywhere in the world.

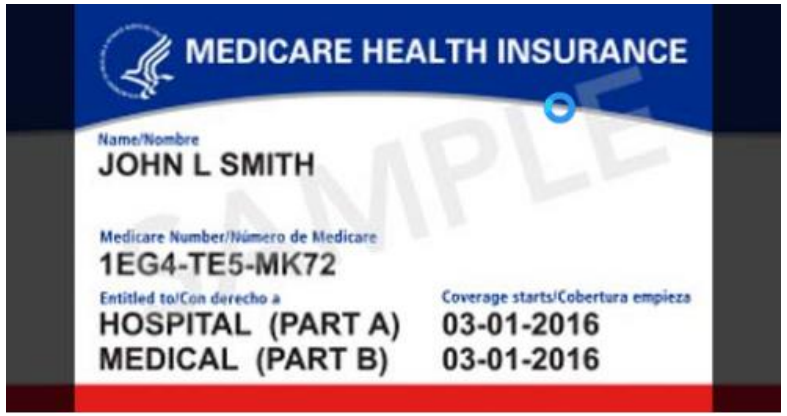
06 **International Travelers insurance** by Tokio Marine HCC anywhere in the world.

Entitlement for (original) Medicare Insurance and its components

Section 2

Components of Medicare Insurance Part A, B, C and D

Components refer to chapters of Medicare Law – Title XVIII of Social Security Act.



Original Medicare comprises of four components:

Part A: (Hospital Insurance) covers inpatient hospital stays, care in skilled nursing home facility, hospice care, and some home health care services.

Part B: (Medical Insurance) covers professional services of medical doctors or non-physician, outpatient care, medical supplies, preventive services, and other medical services.

Part C: (Medicare health plans) These are Medicare Advantage plans by private insurance companies who enter into annual contracts with Centers of Medicare and Medicaid Services (CMS) under Department of Health and Human Services. These plans must include Part A and Part B services, but may or may not include Part D services.

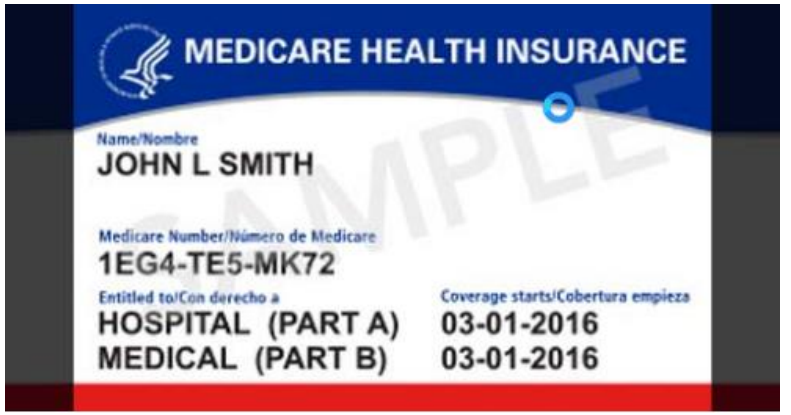
Part D: Prescription drugs coverage.

Get more information at site Medicare.gov

Entitlement for Original Medicare Insurance

Medicare Entitlement for Age below 65

- ✓ If you have disability and you have collected Social Security Disability Insurance for more than 24 months. You will be automatically enrolled in Medicare Part A and Part B on 25th month. Call Social Security at Phone: 1-800-772-1213. Enroll in Part D.
- ✓ If you have End Stage Renal Disease, call Social Security at Phone: 1-800-772-1213 or preferably visit Social Security office.
- ✓ If you have Lou Gehrig's disease (ALS), get Social Security Disability Insurance (SSDI) and enroll in in Medicare at Social Security office.



Medicare Entitlement for age close to and above 65

- ✓ You are a U.S. Citizen or a permanent legal resident who has lived in the United State for at least five years.
- ✓ You are receiving social security or railroad retirement benefits.
- ✓ You or your spouse have earned more than 40 credits of work paying Medicare insurance taxes for at least 10 years.
- ✓ If you have earned social security benefits and are above 65, you get automatically enrolled for Part A and Part B. Part A is premium-free,
- ✓ You or your spouse had Medicare covered government employment.

Entitlement for Original Medicare Insurance - Continued

What does it cost to buy components of Original Medicare?

- ✓ If you are on disability benefits, you are enrolled automatically for Part A, premium-free. For Part B and Part D, you have to pay premiums to sign up. Call social security (1-800-772-1213) to sign up and pay premiums.
- ✓ If you are above 65 and do not quality for premium-free Part A due to shortage of social security credits, you have to sign for Part B in order to buy Part A.
- ✓ Monthly premium for buy into Medicare for year 2021 for Part A is between $259 to $471 depending on Medicare taxes you paid.
- ✓ For Part B premiums, it's applicable to all categories of candidates for Medicare coverage based on sliding scale of minimum $148.50 for income level below $87,000 to $491.60 for income level above $500,000.
- ✓ For Part D, it is typically $7.50/month or more as may be applicable.
- ✓ If you are qualified for purchase of Part B and Part D, and you decided not to purchase due to its equivalent qualified availability elsewhere, or not required, there will be penalty per month for late Enrollment if you decided to delay.

What does beneficiary pay for coverage in Original Medicare coverage?

For Part A Services (Hospital Insurance)

- ✓ Deductible of $1,484 applied per Benefit Period. Must be paid before Medicare pays for Part A related costs.
- ✓ A Benefits Period is the timeframe hospital stay without re-admission within 60 days. No deductible is applied for benefit period for skilled nursing facility.
- ✓ There may be multiple Benefit Periods, each having its deductible of $1,484.00.
- ✓ For hospital stay costs per Benefit Period:
  - For days 1-60, you pay $0 coinsurance;
  - For days 61-90 you pay $371 per day coinsurance;
  - For 91+ days, you pay $742/day for maximum of 60 lifetime days. After this, all costs are on you.
- ✓ For stay in Skilled Nursing Facility, coinsurance for each Benefit Period is:
  - For days 1-20, you pay $0
  - For days 21-100, you pay $185.50
  - For days 101 and beyond, you pay all costs.
- ✓ It is premium-free if you or your spouse paid Medicare taxed while employed. Otherwise you may buy in to Part A for $471/month.
- ✓ Penalty for late enrollment.

Following services are excluded:

- Custodial care
- Long-Term care
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care

What does beneficiary pay for coverage in Original Medicare coverage?

Continued….

For Part B Services (Medical Insurance)

Following expenses are borne by the beneficiary:

- ✓ Typically, about 20% coinsurance of costs of professional fees and services what Original Medicare approves for payment.
- ✓ Some non-routine tests may not be covered.
- ✓ Beneficiary pays monthly premium to Social Security: Min $148.50 to Max $491.60 depending upon your income level.
- ✓ There is annual deductible of $203.00
- ✓ Penalty for late enrollment.

What does beneficiary pay for coverage in Original Medicare coverage?

Continued….

For Part D Services (Prescription Drugs) : Standalone Plan

Following expenses are borne by the beneficiary:

- ✓ You subscribe premium to optional Part D plan.
- ✓ You buy a standalone Prescription Drugs Plan from a private insurance company, and pay its premiums.
- ✓ Plans vary substantially by monthly premium costs depending on the:
  - formulary or drugs list of the plan,
  - annual deductible for tier levels of drugs,
  - copays for different tier levels of drugs,
  - monetary expense on prescription medication related to stages of deductible, initial coverage stage, coverage gap stage, and catastrophic coverage.
- ✓ Retail prices of same drugs vary substantially between chain pharmacies and local pharmacies.
- ✓ Pharmacies are categorized often as standard, preferred retail, and mail order pharmacies having their own pricing model.
- ✓ Compare annual drug cost between pharmacies for selection of retail pharmacy for your medications.
- ✓ Look for discount pharmacies to compare prices with insurance plan covered drugs, especially for relatively expensive brand name drugs.

What are Medicare Advantage Plans by Private Insurance Companies?

Part C (Medicare Advantage Plan) = Part A + Part B + Part D + Add-on services.

- ✓ Medicare Advantage Plans are annual contracts between Private Insurance Companies and with Centers of Medicare and Medicaid Service (CMS) under Department of Health and Human Service and are offered to the public under license by Department of Insurance of the State.
- ✓ Covers fully Part A and Part B listed services by Original Medicare, and substantially improves on them.
- ✓ Most plans include services which are excluded by Original Medicare, except Long-Term Care.
- ✓ Most plans are inclusive of Prescription Drugs coverage (Part D).
- ✓ Most plans have a number of add-on services to make the plan wholesome, competitive, and attractive.
- ✓ The plans are serviced by the insurance company who sells them to the public. Strength, solvency, and reputation of the private insurance company is very important.
- ✓ Healthcare medical providers, healthcare support providers, and support entities enter into contracts with insurance company to commit to highly in-network discounted fees and charges of their ‘Customary, Usual and Reasonable’ bills to patients upon acceptance of insurance card from the beneficiary patients.
- ✓ The insurance company controls the discounted payment of the bills to healthcare providers, discounts most of a bill as ‘Adjustments’, pays to the providers per contract, and notifies the clients of their share of payment.
- ✓ Pharmacies in-network of the insurance company have contract to supply medications based on contract with the insurance company.

What are Medicare Supplement Plans by Private Insurance Companies?

This is coverage of gaps in Original Medicare: Part A & Part B

- ✓ As name implies, these plans are designed to fill gaps of coverage in Original Medicare Part A and B.
- ✓ These plans are offered by private insurance companies and are state controlled under annual license from Department of Insurance.
- ✓ Depending upon the level of coverage of gaps in Part A and Part B of Original Medicare related to premiums, plans are offered designated as A to N. Plan F is most comprehensive.
- ✓ An eligible Medicare beneficiary can either have Medicare Advantage Plan or Medicare Supplement plan.
- ✓ Healthcare providers have to bill Original Medicare, and Medicare Supplement company separately. It may open up balance billing on beneficiary if Medicare Supplement insurance does not pick up to close the bill.
- ✓ Risk coverage are standardized, but underwriting of existing medical conditions is not.
- ✓ Medicare beneficiaries can buy this plan within 6 months of initial enrollment in Part A and Part B without medical underwriting, however, insurance company may make you wait for 6 months before coverage begins to determine preexisting conditions.
- ✓ Unlike Medicare Advantage plan, transfer of Medicare Supplement plan to another company will often require medical underwriting.
- ✓ You have buy standalone Prescription Drugs Plan under Part D from an insurance company.

Medigap Plans A-N

Medicare Supplement Insurance Plans	A	B	C	D	F[1]	G	K[2]	L[2]	M	N
Basic Benefits*	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	Copay[3]
Skilled Nursing			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess					100%	100%				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

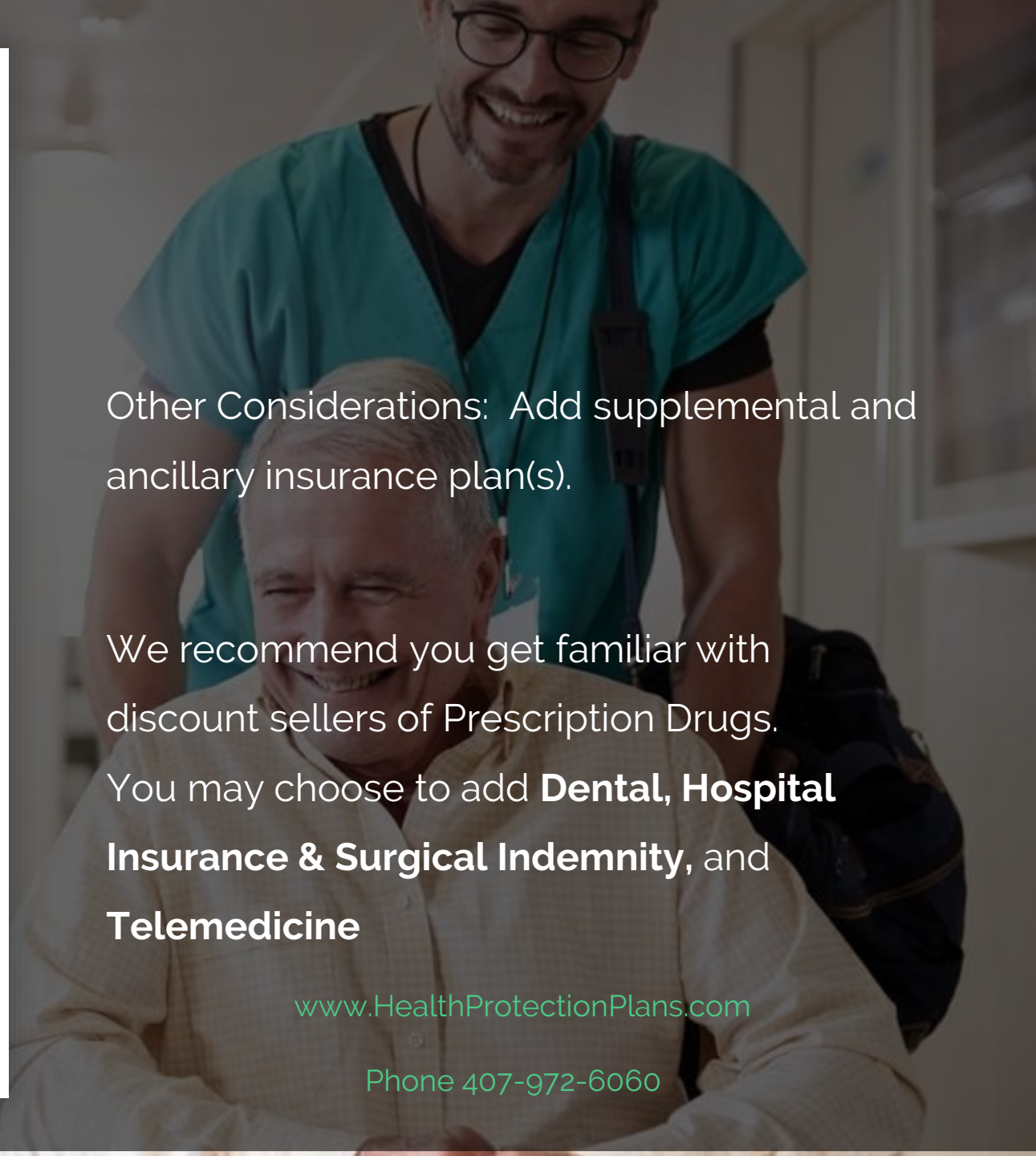
What to Look for When Shopping for Health Insurance

Section 3

Basic Insurance Terms You Should Know

When buying most plans, there are decisions to consider to determine cost of plan :

- ✓ Deductible
- ✓ Co-insurance
- ✓ Maximum Out-of-Pocket
- ✓ Maximum Limit of Plan
- ✓ Plan having in-network of Preferred Provider Organization (PPO) for independent and larger access.
- ✓ Know the Power of using in-network healthcare providers



Other Considerations: Add supplemental and ancillary insurance plan(s).

We recommend you get familiar with discount sellers of Prescription Drugs.
You may choose to add **Dental, Hospital Insurance & Surgical Indemnity,** and **Telemedicine**

www.HealthProtectionPlans.com

Phone 407-972-6060

Know the Power of In-Network Healthcare Providers Vs. Out-of-Network Providers

- ✓ Insurance company you choose must have Preferred Provider Organization (PPO) networks, preferably nationwide, to provide healthcare services at in-network discounted contract rates.
- ✓ Healthcare medical providers, healthcare support providers, and support entities enter into contracts with insurance company to commit to highly in-network discounted fees and charges, typically as low as 15% to 25% of their 'Customary, Usual and Reasonable' bills to patients upon acceptance of insurance card from the beneficiary patients.
- ✓ Acceptance of Medicare Advantage insurance by providers is contractual acceptance of discounted rates of service, and the beneficiary takes picks up its share of responsibility, called coinsurance. Original Medicare pays flat fees to providers by diagnostic codes.
- ✓ Typically, providers bill insurance company based on their 'Customary, Usual, and Reasonable' rates and list of supplies. The insurance company rejects most of the bill, discounts it by the term known as 'Adjustments' or Patient Savings, and compels its acceptance by healthcare providers. A win-win situation between insurance company and patient results.
- ✓ The providers typically file frivolously exaggerated bills to insurance companies get paid about 15% to 25% of their bills. Many times it may appear unfair, but they have to make up on volume in stiff competition of free market.
- ✓ Out-of-Network providers may accept payment from patient's insurance company if insurance company agrees to pay its usual share. The patient often has to pick up the balance of bills at much higher rates of service.
- ✓ Providers' bills to the uninsured patients generally very usurious, and they often land up for collection and negotiation.
- ✓ NEVER GO TO OUT-OF-NETWORK providers. Expensive bills are yours!

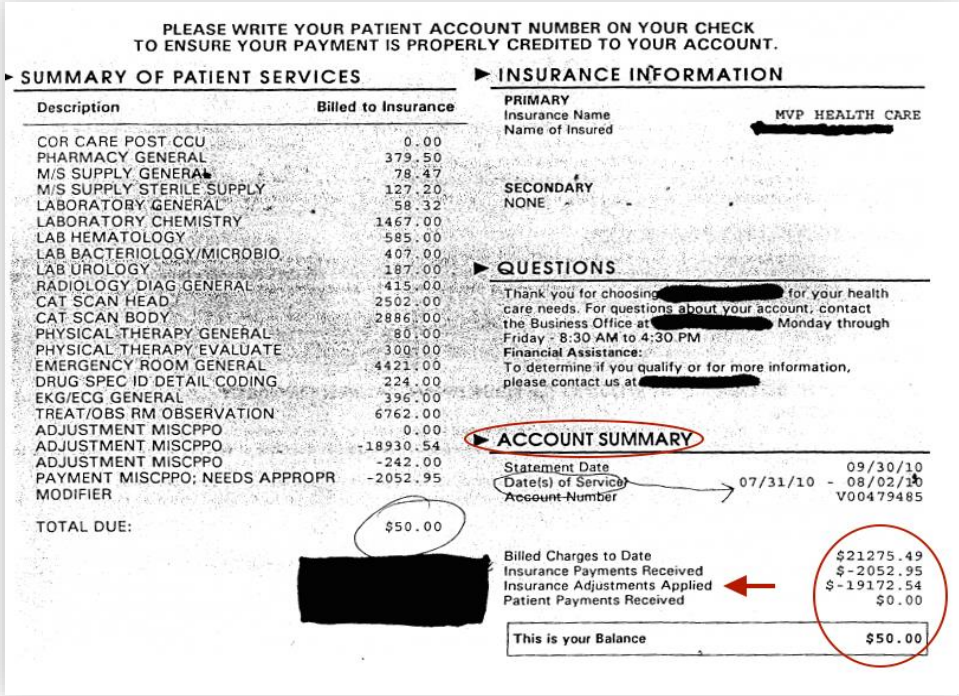
Hospital Billing and Reimbursements to In-Network Providers

EXAMPLE 1:

See how insurance company prunes down provider's bills based on their 'usual, reasonable, and customary charges'.

It pays a low percentage to providers, and leaves a little bit for the patient to pay based on the policy purchased.

If you don't have insurance, you will end up owing and paying the higher non-negotiated rate for any services.



PLEASE WRITE YOUR PATIENT ACCOUNT NUMBER ON YOUR CHECK
TO ENSURE YOUR PAYMENT IS PROPERLY CREDITED TO YOUR ACCOUNT.

SUMMARY OF PATIENT SERVICES

Description	Billed to Insurance
COR CARE POST CCU	0.00
PHARMACY GENERAL	379.50
M/S SUPPLY GENERAL	78.47
M/S SUPPLY STERILE SUPPLY	127.20
LABORATORY GENERAL	58.32
LABORATORY CHEMISTRY	1467.00
LAB HEMATOLOGY	585.00
LAB BACTERIOLOGY/MICROBIO	407.00
LAB UROLOGY	187.00
RADIOLOGY DIAG GENERAL	415.00
CAT SCAN HEAD	2502.00
CAT SCAN BODY	2886.00
PHYSICAL THERAPY GENERAL	80.00
PHYSICAL THERAPY EVALUATE	300.00
EMERGENCY ROOM GENERAL	4421.00
DRUG SPEC ID DETAIL CODING	224.00
EKG/ECG GENERAL	396.00
TREAT/OBS RM OBSERVATION	6762.00
ADJUSTMENT MISCPPO	0.00
ADJUSTMENT MISCPPO	-18930.54
ADJUSTMENT MISCPPO	-242.00
PAYMENT MISCPPO; NEEDS APPROPR	-2052.95
MODIFIER	
TOTAL DUE:	$50.00

INSURANCE INFORMATION

PRIMARY
Insurance Name: MVP HEALTH CARE
Name of Insured: [redacted]

SECONDARY
NONE

QUESTIONS

Thank you for choosing [redacted] for your health care needs. For questions about your account, contact the Business Office at [redacted] Monday through Friday - 8:30 AM to 4:30 PM
Financial Assistance:
To determine if you qualify or for more information, please contact us at [redacted]

ACCOUNT SUMMARY

Statement Date	09/30/10
Date(s) of Service	07/31/10 - 08/02/10
Account Number	V00479485
Billed Charges to Date	$21275.49
Insurance Payments Received	$-2052.95
Insurance Adjustments Applied	$-19172.54
Patient Payments Received	$0.00
This is your Balance	$50.00

This is a hospital bill processed by the Insurance Company. The insurance company discounted the bill by 90% as noted by the words :Insurance Adjustment Applied, and paid less than 10% of the bill to the hospital. The patient paid $50.00.

Courtesy of Source:
http://truecostofhealthcare.org/hospitalization/

Hospital Billing and Reimbursements to In-Network Providers

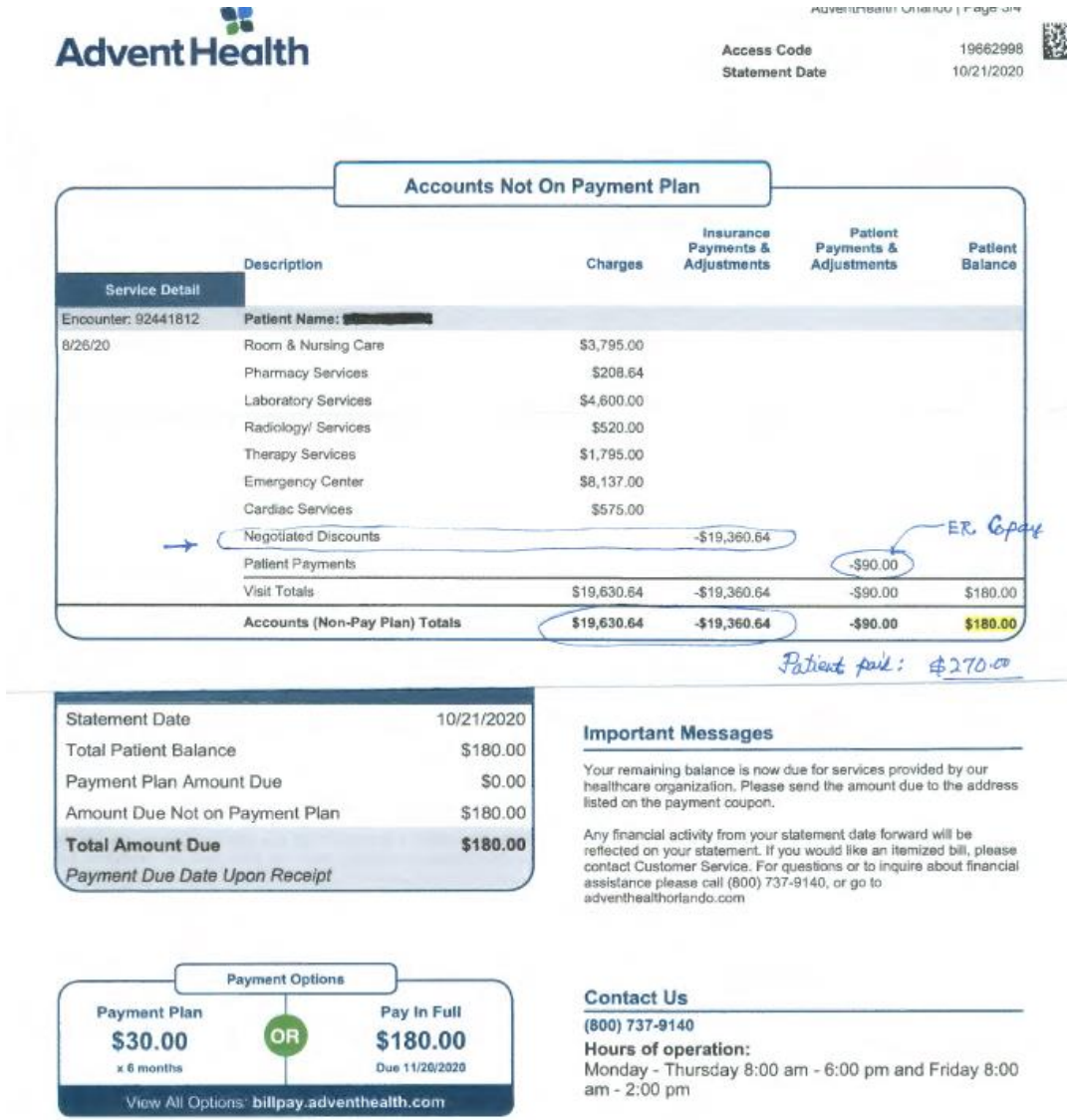
Medicare Advantage (PPO) Plan

EXAMPLE 2:

See how insurance company prunes down provider's bills based on their 'usual, reasonable, and customary charges'.

This is a hospital bill processed by the Insurance Company. The insurance company discounted this bill by -98.63% (-$19,360) as noted on line "Negotiated Discounts" or "Adjustments)" . Insurance paid $0.00 to Hospital. The patient paid 1.37% ($270) of the bill to the hospital for 1 day stay in hospital including ER services.

Think of what did Hospital get for all the services for one day stay and all medical service. $0.00!!



AdventHealth

Access Code 19662998
Statement Date 10/21/2020

Accounts Not On Payment Plan

Service Detail	Description	Charges	Insurance Payments & Adjustments	Patient Payments & Adjustments	Patient Balance
Encounter: 92441812	Patient Name: [redacted]				
8/26/20	Room & Nursing Care	$3,795.00			
	Pharmacy Services	$208.64			
	Laboratory Services	$4,600.00			
	Radiology/ Services	$520.00			
	Therapy Services	$1,795.00			
	Emergency Center	$8,137.00			
	Cardiac Services	$575.00			
	Negotiated Discounts		-$19,360.64		
	Patient Payments			-$90.00	
	Visit Totals	$19,630.64	-$19,360.64	-$90.00	$180.00
	Accounts (Non-Pay Plan) Totals	**$19,630.64**	**-$19,360.64**	**-$90.00**	**$180.00**

ER Copay

Patient paid: $270.00

Statement Date	10/21/2020
Total Patient Balance	$180.00
Payment Plan Amount Due	$0.00
Amount Due Not on Payment Plan	$180.00
Total Amount Due	**$180.00**
Payment Due Date Upon Receipt	

Important Messages

Your remaining balance is now due for services provided by our healthcare organization. Please send the amount due to the address listed on the payment coupon.

Any financial activity from your statement date forward will be reflected on your statement. If you would like an itemized bill, please contact Customer Service. For questions or to inquire about financial assistance please call (800) 737-9140, or go to adventhealthorlando.com

Payment Options

Payment Plan $30.00 x 6 months OR Pay In Full $180.00 Due 11/20/2020

View All Options: billpay.adventhealth.com

Contact Us

(800) 737-9140

Hours of operation:
Monday - Thursday 8:00 am - 6:00 pm and Friday 8:00 am - 2:00 pm

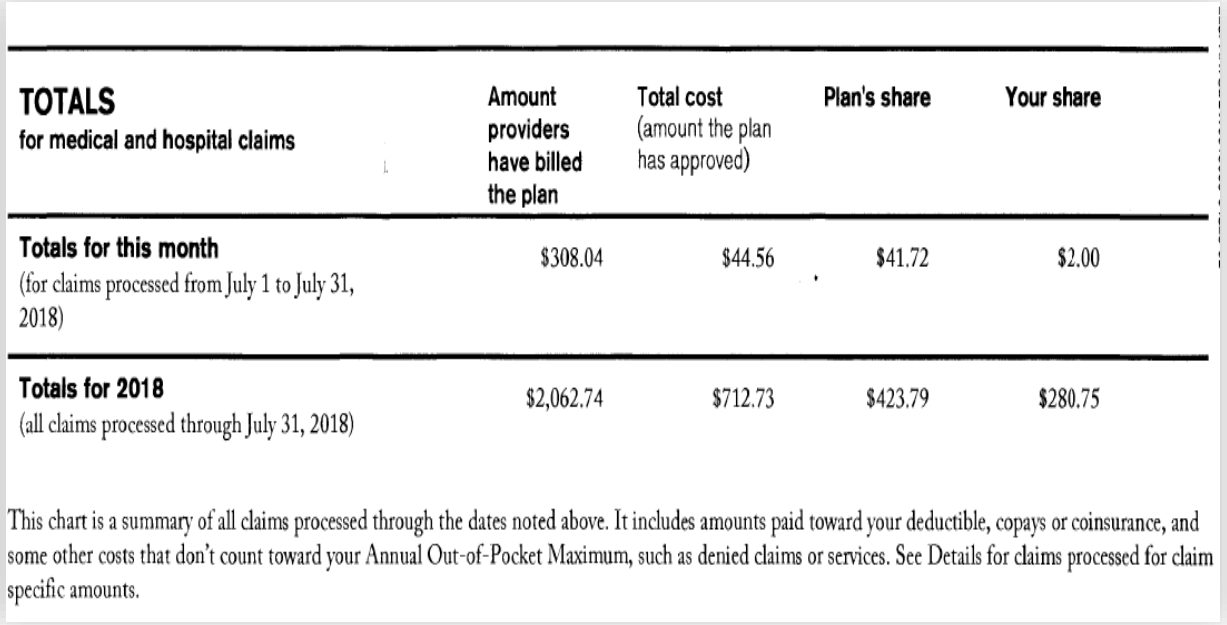
Physician's Visits Billing and Reimbursements to In-Network Providers

Medicare Advantage (PPO) Plan

EXAMPLE 3:

See how insurance company prunes down provider's bills based on their 'usual, reasonable, and customary charges'.

It pays a low percentage to providers, and leaves a little bit for the patient to pay based on the policy purchased.



TOTALS for medical and hospital claims	Amount providers have billed the plan	Total cost (amount the plan has approved)	Plan's share	Your share
Totals for this month (for claims processed from July 1 to July 31, 2018)	$308.04	$44.56	$41.72	$2.00
Totals for 2018 (all claims processed through July 31, 2018)	$2,062.74	$712.73	$423.79	$280.75

This chart is a summary of all claims processed through the dates noted above. It includes amounts paid toward your deductible, copays or coinsurance, and some other costs that don't count toward your Annual Out-of-Pocket Maximum, such as denied claims or services. See Details for claims processed for claim specific amounts.

This is a relatively small bill of routine visits to doctor for consulation.s. Insurance received bill of $2,062, approved payable as $712 (34.5%). Insurance paid 20.55% of bill, and patient paid 13.6% of bill. The rest 65.4% is written off as Adjustments by Insurance. Company.

Examples illustrate how In-Network providers make contract deal with their patients through contracts with the insurance companies.

This is 3-way win-win-win

Diagnostics Billing and Reimbursements to In-Network Providers

Medicare Advantage (PPO) Plan

EXAMPLE 4:

See how insurance company prunes down provider's bills based on their 'usual, reasonable, and customary charges'.

It pays a low percentage to providers, and leaves a little bit for the patient to pay based on the policy purchased.

Provider Name: QUEST DIAGNOSTICS INC

Claim Number: 062174396 (In-Network Provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Hemoglobin A1C level (billing code 83036)	02/06/20 - 02/06/20	$74.25	$8.99	$8.99	$0.00
NOTE: WE HAVE PAID THE ALLOWED AMOUNT. YOU SHOULD NOT BE BILLED FOR THE BALANCE, BUT YOU MAY NEED TO PAY A COPAYMENT, COINSURANCE, OR DEDUCTIBLE.					
Blood test, lipids (cholesterol and triglycerides) (billing code 80061)	02/06/20 - 02/06/20	$148.10	$12.40	$12.40	$0.00
NOTE: WE HAVE PAID THE ALLOWED AMOUNT. YOU SHOULD NOT BE BILLED FOR THE BALANCE, BUT YOU MAY NEED TO PAY A COPAYMENT, COINSURANCE, OR DEDUCTIBLE.					
Blood test, comprehensive group of blood chemicals (billing code 80053)	02/06/20 - 02/06/20	$88.07	$9.78	$9.78	$0.00
NOTE: WE HAVE PAID THE ALLOWED AMOUNT. YOU SHOULD NOT BE BILLED FOR THE BALANCE, BUT YOU MAY NEED TO PAY A COPAYMENT, COINSURANCE, OR DEDUCTIBLE.					
	TOTALS:	$310.42	$31.17	$31.17	$0.00

This is a relatively small bill of lab tests claims. Insurance received bill of $31.0.42, approved $31.17 and paid about 10%. Patient paid $0.00.

Examples illustrate how In-Network providers make contract deal with their patients through contracts with the insurance companies.

This is 3-way win-win-win. However, it looks low payment to Lab!

How Health Insurance Works and Why Its Important you have it

Section 4

What does Health Risk Coverage mean with Insurance?

Insurance is all about risk assessment and coverage of probability or likelihood of occurrence. Unlike occurrence-based coverage of risk, health insurance has three significant elements of life to cover:

01

Ongoing maintenance of health and wellness.

02

Reduction and avoidance of probability of severe consequences to health, wellness and disease if it is ignored or deferred

03

Occurrence based heavy medical and care expenses in the event of hospitalization.

How Does an Insurance Company Operate?

- ✓ Inflow of premiums by large number of clientele
- ✓ Claims by healthcare providers on behalf of the insured clientele
- ✓ Organize network of healthcare providers: doctors, hospitals, and ancillary support services providers like labs, rehab centers, medical equipment providers, nursing homes, hospice etc.
- ✓ Enters into contracts with healthcare providers for rates of services for localized geographical areas.
- ✓ Insurance companies as payers have their own contracts to offer to providers to accept for reimbursement of services.
- ✓ Design insurance products and get approval from State Department of Insurance to put it out in the market
- ✓ Bring the insured clients and medical service provider to get services from providers
- ✓ Providers verify from insurance company the insured client and splitting of the bills between the insurance company and the insured client.

What does Financial Protection mean when you get Health Insurance?

01 The bills belong to the patient.

02 The patient has contract (Policy) with insurance company to pay its share to the contracted provider on his/her behalf.

03 The contracted or the in-network provider is obligated to accept the share of insurance payment (co-insurance), patients pays its share, and the provider then releases the patient.

04 The insurance company decides how the adjusted or discounted bill is divided between itself for in-network provider and its insured client, the patient, as to what is payable to the providers, and. what patient will pay since the provider has accepted the in-network insurance card from the patient to serve the patient.

Risk Management of Health and Wellness

Best self-check of your health is looking good, feeling healthy and generally keeping well.

Toxicity that builds up within your body is often irreversible, though avoidable and manageable.

One has no control on the criticalities of events that can land one in hospital. Costs of such risks can be high.

Be treated with respect by healthcare providers by having right and active insurance.

Be served by In-Network healthcare providers at pre-negotiated prices by insurance company with providers.

In Conclusion

To be covered for services under Medicare Insurance, you have two choices:

- Stay in Original Medicare, buy Medicare Supplement and Prescription Drugs plans.
- Enrol in Medicare Advantage Plan during its specified enrollment periods. It covers all three elements: Hospital, Medical, and Prescription Drugs.

Our Recommendation:

- Enrol in Medicare Advantage Plan (PPO)
- We offer AARP UnitedHealthcare Medicare Advantage Plans throughout the year.