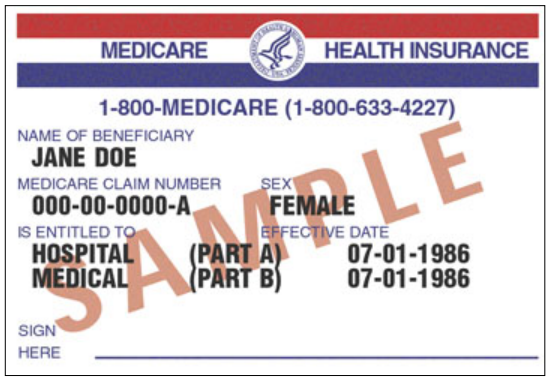
Life Guide

Retirement and Medicare



The rising cost of health care in the United States has become an important risk to a financially-secure retirement. With that in mind, it's important to understand the various components of Medicare, the federal government program that provides health insurance to most Americans age 65 and older.

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What Is Medicare?

The Medicare and Medicaid programs were signed into law at the Truman Library in Independence, Missouri by President Lyndon Johnson on July 30, 1965, with former President Harry Truman looking on. In 1945, President Truman was the first sitting president to endorse national health insurance.

The original Medicare legislation (Title XVIII) extended healthcare coverage to almost all Americans age 65 or older and on July 1, 1966, when Medicare was implemented, more than 19 million Americans initially enrolled in the program. In 2023, Medicare beneficiaries numbered approximately 65.7 million elderly and disabled Americans.

Since Medicare was originally signed into law in 1965, subsequent legislation has made a number of changes to the program, including:

- **1972**: Medicare was first made available to individuals under age 65 with certain disabilities, as well as to individuals of any age with end-stage renal disease (ESRD).
- **1980**: Supplemental insurance intended to pay for healthcare costs not covered by Medicare, also known as "Medigap" insurance, was brought under Federal oversight.
- **1997**: The Medicare+Choice program (now known as Medicare Advantage) was enacted, establishing a variety of new Medicare managed care and other private health plan choices for Medicare beneficiaries.
- **2003**: The Medicare Prescription Drug, Improvement and Modernization Act made the most significant changes to Medicare since its enactment in 1965, including voluntary prescription drug plans (first available in 2006) and requiring that Medicare beneficiaries with higher incomes begin paying a greater share of their Medicare Part B premiums beginning in 2007.
- **2011**: The Patient Protection and Affordable Care Act of 2010 improved coverage for certain preventive services and required discounts and subsidies for Medicare prescription drug plans.

How Is Medicare Financed?

There are three primary sources of Medicare funding:

- **Medicare Part A (Hospital Insurance):** Medicare Part A is financed largely through a 2.9% payroll tax paid by employees and their employers (1.45% each; increases to 2.35% on earnings over $200,000 single/$250,000 married, employees only), which goes into the Part A Trust Fund that helps pay the eligible hospital expenses of Medicare beneficiaries.
- **Medicare Part B (Medical Insurance):** Medicare Part B, which helps pay for doctors' services, outpatient care and home health care, is paid for primarily by general government revenues, with Medicare beneficiary premiums accounting for about 25% of the Part B financing.
- **Medicare Part D (Prescription Drug Coverage):** Medicare Part D, which helps cover the cost of prescription drugs, is also paid for primarily though general government revenues, with some state payments and beneficiary premiums financing the balance.

Who Is Eligible for Medicare?

Medicare Part A (Hospital Insurance) is provided at no cost to U.S. citizens and permanent residents of the United States who meet certain eligibility requirements. Anyone enrolled in Medicare Part A can, on an optional basis, enroll in Medicare Part B (Medical Insurance) by paying a monthly premium. Medicare beneficiaries with higher incomes will pay higher Part B premiums.

- ☐ **Age 65 or Older:** Beginning at age 65, you are eligible for Medicare if you or your spouse worked for at least 10 years (40 quarters) in Medicare-covered employment and you are a citizen or permanent resident of the United States. You do not need to be receiving Social Security retirement benefits in order to qualify for Medicare at age 65.

- ☐ **At Any Age:** A citizen or permanent resident of the United States who has end-stage renal disease (ESRD) can get Medicare at any age. In addition, regardless of age, someone who has been entitled to Social Security disability benefits for 24 months or who receives a disability pension from the Railroad Retirement board and meets certain conditions is eligible for Medicare. Finally, someone with ALS (Lou Gehrig's disease) will automatically receive Medicare the month Social Security disability benefits begin.

If you are not certain about your eligibility for Medicare, you can call the Social Security Administration toll-free at 800-772-1213.

Enrolling in Medicare at Age 65

There are two ways in which you can enroll in Medicare at age 65:

- ☐ **Already Receiving Social Security or Railroad Retirement Benefits:** If you're already receiving Social Security retirement or disability benefits or Railroad Retirement benefits, you will automatically be enrolled in Medicare at age 65. You should receive a package of Medicare information, together with your Medicare card, in the mail. If you don't receive the package by your 65th birthday, contact the Social Security Administration toll-free at 800-772-1213.

- ☐ **Not Yet Receiving Social Security or Railroad Retirement Benefits:** If you'll be turning age 65 in a few months and are not yet receiving Social Security or Railroad Retirement benefits because, for example, you've decided to delay retirement, you need to call or visit your local Social Security office in order to enroll in Medicare. You can also enroll in Medicare online at https://www.ssa.gov/benefits/medicare/. You can enroll in Medicare at age 65 even if you don't plan to retire at age 65. The recommendation is that you contact your local Social Security office or enroll online about three months before your 65th birthday.

- ☐ **Medicare Part B:** You will be automatically enrolled in Medicare Parts A and B. Because, however, you have to pay a premium for Medicare Part B, you have the option of turning it down. If you do not enroll in Medicare Part B during your initial enrollment period, you can enroll later during a "general enrollment period" from January 1 through March 31 of each year, with your coverage then beginning the following July. **However, your monthly premium may increase 10% for each 12-month period you were eligible for, but did not enroll in, Medicare Part B.**

Medicare Coverage Options

Medicare provides you with choices on how to receive your Medicare benefits. You can choose to receive your Medicare benefits either through Original Medicare or through a Medicare Advantage plan:

☐ **Original Medicare (Parts A and B):** Original Medicare is operated by the federal government and consists of Part A - Hospital Insurance and Part B - Medical Insurance. With Original Medicare, you choose your doctors, hospitals and other healthcare providers. Most people do not have to pay a premium for Part A because they or their spouse paid Medicare taxes while employed. Part B is optional because it does require payment of a monthly premium.

Most people enrolled in Part B will pay a premium of $174.70 per month in 2024 (those enrolled in Part B whose modified adjusted gross income in 2022 was $103,000 or less if filing an individual tax return or $206,000 or less if filing jointly). However, higher income Medicare beneficiaries will pay more:

If Your Modified Adjusted Gross Income* in 2022 Was:		Your 2024 Medicare Part B Premium Is:
File Individual Tax Return	**File Joint Tax Return**	
$103,000 or less	$206,000 or less	$174.70
$103,001 - $129,000	$206,001 - $258,000	$244.60
$129,001 - $161,000	$258,001 - $322,000	$349.40
$161,001 - $193,000	$322,001 - $386,000	$454.20
$193,001 - $500,000	$386,001 - $750,000	$559.00
$500,001 and above	$750,001 and above	$594.00
* Modified adjusted gross income is your taxable income plus your tax exempt interest income from your tax return two years prior to the current year.		

You have the option to join a **Part D - Medicare Prescription Drug Plan**, run by private insurance companies, to help cover the cost of your prescription drugs. Since there are gaps in the coverage provided by Parts A and B, you also have the option to purchase a **Medicare Supplement or "Medigap" insurance policy**, again sold by private insurance companies, to help fill those gaps.

☐ **Medicare Advantage Plans (Part C):** Medicare Advantage plans are generally HMO or PPO plans, although private fee-for-service plans are also available, and are run by private insurance companies approved by and under contract with Medicare.

You can choose to receive your Medicare benefits through a Medicare Advantage plan if you elect both Medicare Parts A and B. The Medicare Advantage plan will then provide the benefits covered by Parts A and B, with the exception of hospice care, and may provide additional benefits that aren't otherwise covered by Original Medicare, such as prescription drug coverage. Unlike Original Medicare, Medicare Advantage plans usually require that you either use plan doctors, hospitals and other healthcare providers or you pay more for the services you receive.

With a Medicare Advantage plan, you do not need and cannot purchase a supplemental Medigap insurance policy. Medicare Advantage plans, however, may have a monthly premium you must pay, in addition to the Medicare Part B premium. You may also be charged a copayment amount for covered services that you utilize.

Medicare Initial Enrollment Periods

When you initially enroll in Medicare, you'll need to choose between Original Medicare and Medicare Advantage.

☐ **Initial Medicare Enrollment Period:** You'll need to choose between Original Medicare and Medicare Advantage when you initially enroll in Medicare. Your initial enrollment period is the seven-month period that begins three months before you turn age 65, includes the month you turn age 65 and ends three months after the month you turn age 65.

If you do not sign up for Medicare Part B when you are first eligible, you may have to pay a late enrollment penalty. If you then enroll in Part B at a future date, your monthly Part B premium may go up 10% for each full 12-month period you could have had Part B, but didn't enroll. There are exceptions, however. For example, if you wait to sign up for Part B because you or your spouse are currently working and covered by a group health plan, you can sign up for Part B without penalty at anytime while you still have the group health coverage or during the earlier of the eight-month period beginning the month after employment ends or the group health plan coverage ends.

If you decide to enroll in Original Medicare, you'll then need to decide if you want to purchase a Medicare Prescription Drug Plan and/or a Medigap policy:

☐ **Initial Medicare Prescription Drug Plan (Part D) Enrollment Period:** If you enroll in Original Medicare, you can join a Medicare Prescription Drug Plan during the same seven-month period during which you initially become eligible for Medicare (the seven-month period that begins three months before you turn age 65, includes the month you turn age 65 and ends three months after the month you turn age 65).

If you do not join a Medicare Prescription Drug Plan when you are initially eligible, you may have to pay a late enrollment penalty to join a drug plan in the future. The amount of the penalty may change each year and will be quoted by the plan you select. There is, however, an exception to the penalty if you have other **creditable prescription drug coverage**. If you receive prescription drug coverage from an employer or union that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage, you can keep that coverage without having to pay a penalty if you later decide to enroll in a Medicare Prescription Drug Plan.

☐ **Initial Medigap Open Enrollment Period:** If you enroll in Original Medicare, you have an initial six-month Medigap open enrollment period which begins on the first day of the month in which you are both age 65 or older **and** enrolled in Medicare Parts A **and** B.

If you do not buy a Medigap policy during your Medigap open enrollment period, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the policy. This means that, depending on any health problems you have, the insurance company may decline to sell you a Medigap policy or may charge a higher premium. On the other hand, if you apply for a Medigap policy during your Medigap open enrollment period, you can buy any Medigap policy the company sells, regardless of any health problems you may have, and pay the same premium as people with good health.

Medicare Annual Enrollment Periods

While your initial choice of Medicare options is an important decision, it is not an irrevocable decision. Each year you'll have these opportunities to change your Medicare coverage:

☐ **Open Enrollment Period:** You can make these changes during the annual open enrollment period (between October 15 and December 7), with the new coverage taking effect on January 1 of the next year:

- **An individual covered by Original Medicare** can switch to a Medicare Advantage Plan; and/or
- **An individual with Original Medicare** can add or switch Medicare Prescription Drug Plans and/or Medigap insurance policies. There may, however, be medical underwriting requirements.
- **An individual with a Medicare Advantage Plan** can switch between Medicare Advantage Plans or **drop** Medicare Advantage, switch to Original Medicare and add Medicare Prescription Drug Plan and/or Medigap insurance coverage.

☐ **Medicare Advantage Disenrollment Period (January 1 – February 14):** An individual enrolled in a Medicare Advantage Plan can switch to Original Medicare and can also join a Medicare Prescription Drug Plan. Coverage begins on the first day of the month after the plan gets your enrollment form. Note, however, that there is no right to buy a Medigap plan without satisfying medical underwriting requirements.

☐ **5-Star Medicare Advantage Special Enrollment Period (anytime during the year):** Medicare uses information from member satisfaction surveys, plans and health care providers to give overall performance ratings to plans. Medicare Advantage Plans can receive a rating between one and five stars, with a 5-star rating considered excellent. At any time during the year, you can switch from your current Medicare Advantage Plan to a 5-star Medicare Advantage Plan, if one is available in your area. You can use this special enrollment feature only once each year.

☐ **5-Star Medicare Prescription Drug Plan Special Enrollment Period (anytime during the year):** As with Medicare Advantage Plans, Medicare uses information from member satisfaction surveys, plans and health care providers to give overall performance ratings to Medicare Prescription Drug Plans, which can receive a rating between one and five stars, with a 5-star rating considered excellent. At any time during the year, you can switch from your current Medicare Prescription Drug Plan to a 5-star Medicare Prescription Drug Plan, if one is available in your area. You can use this special enrollment feature only once each year.

☐ **General Medicare Part B Enrollment Period (January 1 - March 31):** An individual who did not enroll in Medicare Part B when first eligible can sign up from January 1 through March 31 of each year, with the coverage taking effect on July 1 of that year. If you didn't sign-up for Part B when you were initially eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your Part B premium may increase 10% for each 12-month period that you could have had Part B coverage, but didn't sign up for it.

☐ **Special Enrollment Period:** There are situations where you may not need to enroll in Medicare Part B when you first become eligible. For example, you or your spouse may still be working and covered by a group health plan, meaning that you don't need Part B coverage. In this instance, you can enroll in Part B without a late enrollment penalty at the following times:

- **Anytime while you have group health coverage** based on current employment; or
- **During the 8-month period** that begins the month after the employment ends or the group health plan coverage ends, whichever happens first. If you have COBRA coverage, you must enroll in Part B during the 8-month period beginning the month after the employment ends.

If you enroll in Part B during a special enrollment period, you then have a 6-month Medigap open enrollment period, which gives you a guaranteed right to purchase a Medicare Supplement Insurance policy.

CAUTION: If you receive health care coverage, including prescription drug coverage, from a current or former employer, union or other source, you should contact the benefits administrator before dropping any of your current coverage and/or enrolling in any of the Medicare coverage options. It is important that you understand how your insurance works with Medicare before making any changes.

Selecting Your Medicare Coverage: Step 1

The first step in deciding what Medicare coverage is right for you is to decide between Original Medicare and a Medicare Advantage Plan. Beginning on page 19, review Appendices A, B and C for more detailed information on Original Medicare and Medicare Advantage Plans.

	Original Medicare (Parts A and B)	Medicare Advantage Plan (Part C)
Your Out-of-Pocket Costs	➢ You pay a monthly premium for Part B ($174.70 for most people). ➢ You pay for part of every service you use, known as coinsurance, which is generally 20% of the Medicare-approved amount. ➢ For an additional monthly premium, you can purchase a Medigap policy to pay for the approved costs not paid by Original Medicare, such as the coinsurance payment.	➢ You pay the monthly Part B premium ($174.70 for most people). ➢ Depending on the plan you select, you may have to pay an additional monthly premium. ➢ You pay a copayment or coinsurance amount for each service you use, the amount of which depends on the plan you select. ➢ You do not need a Medigap policy.
Choice of Doctors and Hospitals	➢ You can go to any doctor or hospital in the country, so long as they accept Medicare (most do). ➢ You can go directly to a specialist without a referral from a primary care doctor.	With an HMO or PPO plan: ➢ You're expected to use the doctors and hospitals in the plan's network. If you don't, you'll pay more. ➢ In an HMO plan, you'll need a referral from your primary care doctor in order to see a specialist; no referral is needed in a PPO plan. With a Fee-for-Service plan: ➢ You can go to any doctor, including specialists, or hospital that accepts the plan's payment.
Prescription Drugs	➢ Not covered. ➢ For an additional monthly premium, you can purchase a Part D Medicare Prescription Drug Plan.	➢ May provide prescription drug coverage. ➢ You may pay extra for this benefit.
Travel Coverage	➢ In the U.S., you are covered anywhere in the country. ➢ Outside the U.S., you are not covered in most cases. ➢ A Medigap policy may cover emergency care outside the U.S.	With an HMO or PPO plan: ➢ In the U.S., except for emergency care, you are covered only in the plan's service area. With a Fee-for-Service plan: ➢ In the U.S., you can go to any doctor or hospital that accepts the plan's payment. Coverage outside the U.S.: ➢ Depends on the plan.

Selecting Your Medicare Coverage: Steps 2 and 3

After you choose between Original Medicare and a Medicare Advantage Plan, you need to decide whether you are going to include prescription drug coverage and, in the case of Original Medicare, whether you want to purchase a Medigap policy that fills the gaps in Original Medicare's coverage.

	If You Decide You Want Original Medicare (Parts A and B)	If You Decide You Want a Medicare Advantage Plan (Part C)
Step 2: Decide If You Want Prescription Drug Coverage (Part D)	➢ If you want prescription drug coverage, you must select and join a Medicare Prescription Drug Plan. ➢ These plans are approved by Medicare and operated by private insurance companies. ➢ You will pay an additional monthly premium for a Prescription Drug Plan. ➢ See page 12 for more information about Medicare Prescription Drug Plans.	➢ If you want prescription drug coverage and it's offered in the Medicare Advantage Plan you select, you generally must get the coverage through your plan. ➢ If your Medicare Advantage Plan does not offer prescription drug coverage, you can select and join a Medicare Prescription Drug Plan for an additional monthly premium.
Step 3: Decide If You Want Supplemental "Medigap" Coverage	➢ You may want to purchase a Medigap policy that fills the gaps in the coverage provided by Original Medicare. ➢ Medicare Supplement Insurance, or Medigap, policies are available from private insurance companies. ➢ You will pay an additional monthly premium for a Medigap policy. ➢ Before purchasing a Medigap policy, check to see if your employer or union offers similar coverage. ➢ See Appendix D on page 22 for more information on Medigap policies.	If you join a Medicare Advantage Plan, you do not need and cannot purchase a Medigap policy. If you already had a Medigap policy before joining a Medicare Advantage Plan, you cannot use the Medigap policy to pay for your out-of-pocket costs under the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you cannot be sold a Medigap policy.

You can visit www.medicare.gov for assistance in selecting your Medicare coverage. The website enables you to "Find health & drug plans." You can also call Medicare toll-free at 800-633-4227 for additional information. Finally, ***Medicare & You***, published by the Centers for Medicare & Medicaid Services, is the official government handbook on Medicare. If you did not receive a copy in the mail, you can download it at www.medicare.gov.

Original Medicare or Medicare Advantage?

When initially choosing or later changing your Original Medicare or Medicare Advantage coverage, these are some of the factors you should consider:

☐ **Your Health Care Priorities:** When it comes to health care, what is important to you? Are you primarily concerned with keeping your out-of-pocket costs as low as possible? Do you want to have the freedom to go to any doctor and hospital of your choice? Do you take a lot of prescription drugs? How important are additional benefits, such as prescription drug, vision and dental benefits, to you? Do you travel a lot? Do you have retiree health insurance from an employer or a union?

☐ **Cost:** The amount you'll pay for your health care during retirement depends on factors such as:

- **Which Medicare plan you choose:** With Original Medicare, you'll pay a premium for Part B, as well as for a Medicare Prescription Drug Plan and/or a Medigap insurance policy if you decide to join either or both. With a Medicare Advantage Plan, you'll have to pay the Part B premium, but you won't need a separate Medicare Prescription Drug Plan or Medigap policy. You may, however, have to pay a monthly Medicare Advantage Plan premium.
- **How frequently you use health care services:** With Original Medicare, you'll be responsible for paying a portion of doctor and hospital charges. If you have a Medigap policy, however, it will pay most or all of those charges for you. Most Medicare Advantage Plans require that you make a co-payment for the services you receive. If you select a Medicare Advantage Plan HMO or PPO and use doctors or hospitals outside the plan's network, you'll have to pay more.

☐ **Choice:** Do you want to be able to go to any doctor or hospital in the country that accepts Medicare? Do you want to be able to visit a specialist without a referral from a primary care physician? If yes, then you may prefer Original Medicare or a Medicare Advantage Private Fee-for-Service Plan. With Medicare Advantage HMO and PPO Plans, you're generally limited to the doctors and hospitals in the plan's network or, if you go outside the network, you pay more. Finally, Medicare Advantage HMO Plans require a referral before you can see a specialist.

☐ **Additional Benefits:** Original Medicare does not cover the cost of prescription drugs, so you may want to consider purchasing a Medicare Prescription Drug Plan. Many Medicare Advantage Plans include prescription drug coverage, and may include other benefits, such as vision care, not included in Original Medicare. There may, however, be limits placed on the additional benefits provided, so check them carefully before buying the plan.

☐ **Travel:** Original Medicare covers you anywhere in the United States, but provides very limited coverage outside the U.S. If you join a Medicare HMO or PPO plan, your coverage may be limited to the plan's service area. Be sure to understand your coverage before you travel.

☐ **Other Coverage:** If you receive retiree health insurance from an employer or union, be sure to check with your benefits administrator before making any decisions about your Medicare coverage.

Medicare Prescription Drug Plans

When you first become eligible for Medicare, you can also join a Medicare prescription drug plan. If you decide not to join a Medicare prescription drug plan when you're first eligible, you may have to pay a late enrollment penalty in the form of higher premiums if you join later.

There are two ways you can get Medicare prescription drug coverage:

1. **Medicare Prescription Drug Plans:** These plans add prescription drug coverage to Original Medicare, as well as to some Medicare Advantage Plans.
2. **Medicare Advantage Plans:** Instead of receiving your Medicare benefits through Original Medicare, you join a Medicare Advantage Plan that includes prescription drug coverage.

In order to join a Medicare Prescription Drug Plan, if you receive your health care through Original Medicare, you must have Medicare Part A **and/or** Part B. If you want to get prescription drug coverage through a Medicare Advantage Plan, you must have **both** Medicare Part A **and** Part B.

Finally, you must live in the service area of the Medicare Prescription Drug Plan you want to join.

Medicare sets a minimum standard of coverage that all Medicare drug plans must provide. Beyond this minimum standard, however, the exact coverage and costs are different for each Medicare Prescription Drug Plan.

Each Medicare Prescription Drug Plan has its own formulary...the list of prescription drugs covered by the plan. In addition, many plans place drugs into different tiers, with drugs in each tier having a different cost. For example, a drug in a lower tier, such as a generic drug, will cost you less than a drug in a higher tier. Finally, your costs may be less if you use a pharmacy in your plan's network.

Other Medicare Prescription Drug Plan costs you need to evaluate include:

- **Monthly Premium:** If you purchase a Medicare Prescription Drug Plan to supplement Original Medicare, you will be charged a monthly premium that varies by plan. In addition, upper income seniors (singles with AGIs over $103,000 and married couples with AGIs over $206,000) have to pay a Part D premium surcharge ranging from $12.90 to $81.00 per month in 2024:

If Your Modified Adjusted Gross Income* in 2022 Was:		Your 2024 Medicare Part D Surcharge Is:
File Individual Tax Return	**File Joint Tax Return**	
$103,000 or less	$206,000 or less	$0.00
$103,001 - $129,000	$206,001 - $258,000	$12.90
$129,001 - $161,000	$258,001 - $322,000	$33.30
$161,001 - $193,000	$322,001 - $386,000	$53.80
$193,001 - $500,000	$386,001 - $750,000	$74.20
$500,001 and above	$750,001 and above	$81.00
* Modified adjusted gross income is your taxable income plus your tax exempt interest income from your tax return two years prior to the current year.		

If you belong to a Medicare Advantage Plan that includes prescription drug coverage, the cost of the drug coverage may be included in the monthly premium you pay.

- **Annual Deductible:** You may have to pay a fixed amount of the cost of your prescription drugs before your plan begins to pay. Not all plans have a deductible.

- **Copayments or Coinsurance:** After any annual deductible is satisfied, you'll pay for a portion of each covered prescription you purchase and your drug plan will pay its share.

- **Coverage Gap:** Most plans have a coverage gap, which begins after you and your drug plan have paid a certain amount of money for covered drugs. If you enter the coverage gap in 2024, there is a temporary limit on what the drug plan will cover for drugs. While in the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Once the plan's out-of-pocket limit is reached, you'll get catastrophic coverage for the rest of the year, meaning that you'll pay only a small copayment or coinsurance amount for covered drugs.

You can visit www.medicare.gov and select "Find health & drug plans" or call Medicare toll-free at 800-633-4227 for additional information on Medicare Prescription Drug Plans available in the area where you live.

***Medicare & You**, published by the Centers for Medicare & Medicaid Services, also contains information about Medicare Prescription Drug Plans offered in your state.*

Medigap Plans

Original Medicare pays for many, but not all, of your health care costs. You'll have out-of-pocket costs for copayments, coinsurance and deductibles.

A Medigap policy can help pay some of those "gaps" in Original Medicare coverage. Some Medigap policies also provide coverage for services not included in Original Medicare, such as for medical care when you travel outside of the United States.

If you choose to receive your Medicare benefits through a Medicare Advantage Plan, you do not need and cannot purchase a Medigap policy.

Medigap policies are sold by private insurance companies and must follow Federal and state laws designed for your protection. Medigap insurance companies can sell you only a standardized Medigap insurance policy identified in most states by the letters A through N (see Appendix D on page 22). All of the plans provide the same basic benefits, but some plans offer additional benefits, giving you the opportunity to compare and select the coverage that works best for you. (**Note:** In Massachusetts, Minnesota and Wisconsin, Medigap policies are standardized in a different way. In some states, you may be able to buy another type of Medigap policy called Medicare SELECT, which requires you to use specific hospitals and, in some cases, specific doctors in order to receive full benefits.)

Medigap insurance companies are generally allowed to use medical underwriting to decide if you will be offered coverage and, if so, how much to charge you for that coverage. During your **Medigap open enrollment period**, however, you can buy any Medigap policy the company sells, **regardless of any health problems you have**, for the same premium as people with good health. Your Medigap open enrollment period is the six-month period that begins on the first day of the month in which you are both age 65 **and** enrolled in Medicare Part B. If you do not apply for Medigap insurance during your open enrollment period, there is no guarantee that an insurance company will sell you a Medigap policy if you do not meet the medical underwriting requirements.

You'll pay a Medigap premium to the insurance company. Also keep in mind that a Medigap policy covers only one person. If you're married, you and your spouse must each buy a Medigap policy. While Medigap insurance plans are standardized, different insurance companies may charge different premiums for exactly the same Medigap coverage, so it pays to shop.

- ☐ **Decide on Benefits:** Decide which benefits you need from a Medigap policy.
- ☐ **Select a Medigap Plan:** Select the Medigap Plan A through N that best meets your needs. Appendix D, starting on page 22, provides additional information.
- ☐ **Identify and Compare Insurance Companies:** Find out which insurance companies sell Medigap policies in your area and compare the costs, stability and service of the companies. For assistance, you can visit www.medicare.gov and select "Compare Medicare Health Plans and Medigap Policies in Your Area".
- ☐ **Select the Insurance Company:** After comparing costs and companies, select the insurance company from which you want to purchase a Medigap policy and complete the enrollment requirements.

If You Need Help With Premiums

If you cannot afford to pay your Medicare premiums and other health care costs, there are federal and state programs available for people with limited income and resources.

- ☐ **Medicare Savings Programs:** States have programs that pay Medicare premiums and, in some cases, may also pay Medicare Part A and B deductibles and coinsurance amounts. To qualify for a Medicare Savings Program, you must have Medicare Part A and meet specific state requirements in regard to your income and financial resources. To find out if you qualify, call or visit your State Medical Assistance (Medicaid) office or call Medicare at 800-633-4227 and ask about getting help to pay your Medicare premiums.

- ☐ **Extra Help Paying for Medicare Part D Prescription Drug Coverage: You automatically qualify** to receive extra help paying for Medicare Prescription Drug Coverage if you (1) have full Medicaid coverage, (2) belong to a Medicare Savings Program **or** (3) you receive Supplemental Security Income (SSI) benefits. You **may qualify** for the Medicare low-income subsidy (LIS) to help pay prescription drug costs if your annual income and your financial resources are below specified limits. For more information, contact your State Health Insurance Assistance Program (SHIP) or Medicare at 800-633-4227.

- ☐ **Medicaid:** Medicaid is a joint Federal and state program that helps pay medical costs if you have limited income and financial resources and meet other eligibility requirements. Some people qualify for both Medicare and Medicaid ("dual eligibles"). Medicaid requirements vary from state to state. You should contact your State Medical Assistance (Medicaid) office for more information, as well as to see if you qualify.

- ☐ **State Pharmacy Assistance Programs (SPARs):** Some states have State Pharmacy Assistance Programs that help certain people pay for prescription drugs based on criteria such as financial need, age or medical condition. Each SPAR has its own rules and helps in different ways. To find out about a SPAR in your state, call your State Health Insurance Assistance Program (SHIP).

What Is Long-Term Care?

Long-term care is used to describe a variety of services that include both medical and non-medical care for people who have a chronic illness or disability. Long-term care services can be provided at home, in the community, in an assisted living facility or in a nursing home.

In order to understand what long-term care services Medicare will and will not pay for, it is necessary to distinguish between **two types of long-term care services**:

- **Medically-necessary care:** Medicare will pay for medically-necessary care provided in a skilled nursing facility or through home health care only if **certain conditions are met**. Specifically, Medicare will pay for your stay in a **skilled nursing facility** only if it follows a minimum three-day inpatient hospital stay for a related illness or injury and your doctor certifies that you need daily skilled care like intravenous injections or physical therapy. Medicare will pay for medically-necessary **home health services**, such as intermittent skilled nursing care or physical therapy, if a doctor orders the care, if a Medicare-certified home health agency provides the care and if you are homebound, meaning that leaving home is a major effort.

  IMPORTANT NOTE: According to ***Medicare & You***, "staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility."

- **Custodial care:** Custodial care is non-skilled personal care, including homemaking services and help with the activities of daily living, such as bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. **Medicare and most health insurance plans, including Medigap policies, do not pay for custodial care.**

According to the National Clearinghouse for Long-Term Care Information (http://www.healthinaging.org):

"At least 70 percent of people over age 65 will require some long-term care services at some point in their lives. And, contrary to what many people believe, Medicare and private health insurance programs do not pay for the majority of long-term care services that most people need - help with personal care such as dressing or using the bathroom independently. Planning is essential for you to be able to get the care you might need."

NOTE: If you receive your Medicare benefits from a Medicare Advantage Plan, you should check with your plan regarding the long-term care coverage it provides.

How Can You Pay for Long-Term Care Services?

Since Medicare and Medigap policies will not pay for the majority of long-term care services that people need, the following are some payment options you should evaluate:

- ☐ **Personal Financial Resources:** You can use your personal savings and investments to pay for long-term care services.
- ☐ **Long-Term Care Insurance:** This is a type of insurance policy sold by private insurance companies that can be used to help pay for the cost of long-term care services, including both skilled and non-skilled/custodial care. Before purchasing a policy, you should carefully evaluate and compare different policy premiums and the benefits provided, when they begin and for how long they are paid.
- ☐ **Medicaid:** Medicaid is a joint Federal and state program that pays for certain health services for people with limited income and financial resources. Medicaid requirements vary from state to state. You should contact your State Medical Assistance (Medicaid) office for more information, as well as to see if you qualify.
- ☐ **Programs of All-inclusive Care for the Elderly (PACE):** PACE is a joint Medicare/Medicaid program designed to enable people who might otherwise need a nursing-home level of care to remain in the community. For more information, visit www.npaonline.org, sponsored by the National PACE Association, or call Medicare at 800-633-4227.

What Is Hospice Care?

Hospice care is a special way to care for people with a terminal illness (those expected to live six months or less). The goal of hospice is to provide end-of-life care, not to cure the illness. Hospice care provides treatment to relieve symptoms and keep the individual comfortable, and includes medical and nursing care, social services, drugs, durable medical equipment, counseling and other types of items and services. **The Medicare hospice benefit pays for a substantial amount of these services.**

Most hospice patients receive care from a Medicare-approved hospice organization in the comfort of their home and with their families. Depending on the patient's condition, hospice care can also be given in a Medicare-approved hospice facility, hospital or nursing home.

Print Publications

To receive a copy of these publications, call Medicare at 800-633-4227 or visit www.medicare.gov.

- ☐ **Medicare & You:** A general guide to Medicare that is updated each year. A copy should be mailed to you when you initially enroll in Medicare and each year thereafter.
- ☐ **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare:** A guide to other health insurance plans that supplement your Medicare coverage; includes shopping hints.
- ☐ **Medicare at a Glance:** A fact sheet providing basic information about Medicare and Medicare plan choices.
- ☐ **Medicare Basics: A Guide for Families and Friends of People with Medicare:** Designed for family and friends who assist a Medicare beneficiary.

Online Resources

Visit www.medicare.gov, the official U.S. government website for people with Medicare. It's a comprehensive, easy-to-use online resource that allows you to:

- Check your Medicare eligibility.
- Review what Medicare covers.
- Compare Medicare health plans, prescription drug plans and Medigap plans in your area, including how much they cost and the services they provide.
- Locate helpful phone numbers and websites, such as for your State Health Insurance Assistance Program (SHIP).
- Learn about your Medicare rights and how to file a Medicare appeal.
- Download many helpful Medicare-related publications.

Medicare also provides a secure online service for accessing your personal Medicare information, located at www.MyMedicare.gov. After registering on the site, you'll be able to:

- Complete a questionnaire that will enable Medicare to process your bills correctly.
- Track your health care claims.
- Request a replacement Medicare card.
- Check your Medicare Part B deductible status.
- Track the preventive services you can receive.

Find information about your current Medicare health and/or prescription drug plan or search for a new one.

Hospital Insurance

The following is a recap of many Medicare Part A covered services and the portion of the cost that you must pay. For more information on what is covered by Part A, visit www.medicare.gov or call Medicare toll-free at 800-633-4227.

	What Is Covered	What You Pay
Inpatient Hospital Stays	➢ Semi-private room, meals, general nursing, drugs as part of your inpatient treatment and other hospital supplies and services. ➢ Private room charges are not included unless medically necessary. ➢ Private-duty nursing is not included.	In 2024, you pay: ➢ $1,632 deductible and no coinsurance for days 1-60 each benefit period. ➢ $408 coinsurance per day for days 61-90 each benefit period. ➢ $816 per "lifetime reserve day" after day 90 each benefit period (up to a maximum of 60 reserve days in your lifetime). ➢ All costs for each day after the lifetime reserve days.
Home Health Services	➢ Limited to medically-necessary part-time or intermittent skilled nursing care or physical, speech or occupational therapy. ➢ Must be ordered by your doctor and provided by a Medicare-certified home health agency. ➢ You must be homebound.	In 2024, you pay: ➢ $0 for home health care services. ➢ 20% of the Medicare-approved amount for durable medical equipment.
Skilled Nursing Facility Stay	➢ Semi-private room, meals, skilled nursing and rehabilitative services. ➢ Must follow a 3-day minimum inpatient hospital stay for a related illness or injury. ➢ Your doctor must certify that you need daily skilled care (e.g., intravenous injections or physical therapy). ➢ Long-term or custodial care is **not** covered.	In 2024, you pay: ➢ $0 for the first 20 days each benefit period. ➢ $204.00 per day for days 21-100 each benefit period. ➢ All costs for each day after day 100 in a benefit period. **NOTE:** A **benefit period** begins the day you go into a hospital or skilled nursing facility and ends when you haven't received any inpatient hospital or skilled nursing facility care for 60 days in a row.
Hospice Care	➢ Pain relief and symptom management services, together with other services provided by a Medicare-approved hospice in your home or other facility. ➢ Your doctor must certify that you are expected to live for 6 months or less.	In 2024, you pay: ➢ $0 for hospice care. ➢ $5 per prescription for pain and symptom management. ➢ 5% of the Medicare-approved amount for inpatient respite care.

Medical Insurance

Assuming you enroll in Part B and pay the monthly premium, the following is a recap of the types of services covered by Medicare Part B and the portion of the cost that you must pay. For more information on what is covered by Part B, visit www.medicare.gov or call Medicare toll-free at 800-633-4227. Medicare Part B has an annual deductible that you must pay. In 2024, you pay the first $240 for Medicare Part B covered services or items.

	What Is Covered	What You Pay
Medically-Necessary Services	➢ Outpatient and some hospital inpatient doctor services. ➢ Fees for approved surgical procedures in an Ambulatory Surgical Center. ➢ Ambulance services. ➢ Covered durable medical equipment, such as walkers and wheelchairs. ➢ Medically-necessary home health services. ➢ Physical therapy, when the need is certified by your doctor. ➢ Diagnostic tests, such as X-rays, MRIs, CT scans and EKGs. ➢ Diabetes training and supplies. ➢ Certain transplants and resulting immunosuppressive drugs.	You pay 20% of the Medicare-approved amount and the Medicare Part B deductible applies ($240 in 2024). **NOTE:** The Medicare-approved amount is the amount a doctor or supplier that accepts a Medicare assignment can be paid. It may be less than the actual amount a doctor or supplier charges.
Physical Exam	You are entitled to a one-time "Welcome to Medicare" physical exam, if you get it within the first 12 months you have Part B. After you've had Part B for longer than 12 months, you can get a yearly "wellness" exam.	You pay nothing if your doctor accepts a Medicare assignment.
Preventive Services	A variety of preventive services intended to prevent illness or detect it at an early stage are covered by Medicare Part B. Examples include Pap tests, flu shots, colorectal cancer screenings, cardiovascular screenings, diabetes screenings, mammograms and prostate cancer screenings.	You pay nothing for most preventive services if you get the services from a doctor or other health care provider who accepts a Medicare assignment, but you may have to pay coinsurance for the office visit.
Clinical Laboratory	Includes certain blood tests, urinalysis and some screening tests.	You pay $0 for Medicare-approved services.
Emergency Room Services	➢ Hospital emergency room visits.	You pay a specified copayment for the emergency room visit and 20% of the Medicare-approved amount for the doctor's services. The Medicare Part B deductible applies.

Medicare Advantage Plans

A Medicare Advantage Plan is another choice available under Medicare. If you join a Medicare Advantage Plan, the plan will provide all of the services covered by Medicare Part A - Hospital Insurance and Medicare Part B - Medical Insurance, plus you will be covered for emergency and urgent care. While Medicare Advantage Plans do not cover hospice care, Original Medicare does even if you are enrolled in a Medicare Advantage Plan.

Medicare Advantage Plans may cover additional services not covered by Original Medicare, such as vision, hearing, dental and/or health and wellness programs. Most include Medicare prescription drug coverage as well. If you select a Medicare Advantage Plan that does not include prescription drug coverage, you can purchase Part D - Medicare Prescription Drug Coverage.

In addition to paying the Medicare Part B premium, you generally must also pay a Medicare Advantage Plan monthly premium. With a Medicare Advantage Plan, however, a Medicare Supplement or "Medigap" insurance policy is not needed.

The most common types of Medicare Advantage Plans are:

- Health Maintenance Organization (HMO) Plans.
- Preferred Provider Organization (PPO) Plans.
- Private Fee-for-Service (PFFS) Plans.
- Medical Savings Account (MSA) Plans.
- Special Needs Plans (SNP).

The companies that offer Medicare Advantage Plans are paid a fixed amount for your care every month by Medicare and must follow rules set by Medicare. Keep in mind, however, that each Medicare Advantage Plan can charge different premiums and out-of-pocket costs and have different rules for how you receive services. For example, except for emergency or urgent care, you may have to receive care and services from doctors and hospitals in the plan's network or pay a higher cost. You may need to get a referral from a primary care doctor before you can see a specialist. You may need to get prior approval for certain procedures to avoid higher costs. Generally speaking, HMO Medicare Advantage Plans are the least expensive (but most restrictive), with PFFS plans being the most expensive (but least restrictive).

Before you join a Medicare Advantage Plan, make sure you understand the plan's rules for how you receive services and what your costs will be, including any monthly premiums, annual deductibles, co-payment and/or coinsurance amounts, prescription drug coverage (if included) and whether the plan has a yearly limit on your out-of-pocket costs for all medical services. Finally, you must live in the service area of the Medicare Advantage Plan you want to join.

You can visit www.medicare.gov or call Medicare toll-free at 800-633-4227 for additional information on Medicare Advantage Plans available in the area where you live. ***Medicare & You****, published by the Centers for Medicare & Medicaid Services, also contains information about Medicare Advantage Plans offered in your state*.

Medicare Supplement Insurance Policies

*The following information is taken from **2024 Medicare & You**, which is available at www.medicare.gov.*

This chart gives you a quick look at the benefits of standardized Medigap Plans A though N. **Note:** Plans D and G bought on or after June 1, 2010 have different benefits than D or G plans bought before June 1, 2010. Plans E, H, I and J could not be sold after May 31, 2010. However, anyone who purchased those plans before June 1, 2010 can keep the plan. Beginning January 1, 2020, Medigap Plans C and F, which cover the Part B deductible, are no longer available. People covered by either of those plans prior to January 1, 2020 will be able to keep them.

Every insurance company must make Medigap Plan A available if it offers any other Medigap policy. Not all types of Medigap policies may be available in your state.

If a checkmark appears in a column of this chart, this means that the Medigap policy covers **100%** of the described benefit. If a column lists a percentage, this means the Medigap policy covers that percentage of the described benefit. If no percentage appears or if a column is blank, this means the Medigap policy **doesn't** cover that benefit. **Note:** The Medigap policy covers **coinsurance** only after you have paid the **deductible** (unless the Medigap policy also covers the deductible).

	Medigap Plans									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	√	√	√	√	√	√	√	√	√	√
Medicare Part B Coinsurance or Copayment	√	√	√	√	√	√	50%	75%	√	√**
Blood (First 3 Pints)	√	√	√	√	√	√	50%	75%	√	√
Part A Hospice Care Coinsurance or Copayment	√	√	√	√	√	√	50%	75%	√	√
Skilled Nursing Facility Care Coinsurance			√	√	√	√	50%	75%	√	√
Medicare Part A Deductible		√	√	√	√	√	50%	75%	50%	√
Medicare Part B Deductible			√		√					
Medicare Part B Excess Charges					√	√				
Foreign Travel Emergency (Up to Plan Limits)			80%	80%	80%	80%			80%	80%

** Plans F and G also offer a high-deductible option in some states. You must pay for Medicare-covered costs up to the high-deductible amount before your Medigap policy pays anything.*

*** Pays 100% of the Plan B coinsurance except up to $20 copayment for office visits and up to a $50 copayment for emergency department visits that don't result in inpatient admission.*

Medicare Supplement Insurance Policies

What Is Medicare SELECT?

Medicare SELECT is a type of Medigap policy that is sold in some states and may require you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be any of the standardized Medigap Plans A through L reviewed on the previous page.

Medicare SELECT policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

How does Medigap pay your Medicare Part B bills?

In most Medigap policies, when you sign the Medigap insurance contract you agree to have the Medigap insurance company get your Medicare Part B claim information directly from Medicare and then pay the doctor directly. Some Medigap insurance companies also provide this service for Medicare Part A claims.

If your Medigap insurance company **doesn't** provide this service, ask your doctors if they "participate" in Medicare. (This means that they accept "assignment" for all Medicare patients.) If your doctor participates, the Medigap insurance company is required to pay the doctor directly if you request.

If you have any questions about Medigap claim filing, call Medicare at 800-633-4227. TTY users should call 877-486-2048.

What Medigap policies are available to residents of Massachusetts, Minnesota and Wisconsin?

Residents of Massachusetts, Minnesota and Wisconsin can find additional information on the Medigap policies available in their states by:

- Visiting www.medicare.gov and selecting "Compare Health Plans and Medigap Policies in Your Area."
- Downloading ***Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare***, which is available at www.medicare.gov.
- Calling their State Insurance Department.

Disclosure Information

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