Medicare overview

Medicare is a federal program that offers health insurance to Americans and other eligible individuals.

Eligibility

To be covered by Medicare, you must be a U.S. citizen or legal resident who has lived in the U.S. continuously for at least the last five years, including the five years just before applying for Medicare. You must also meet one of these criteria:

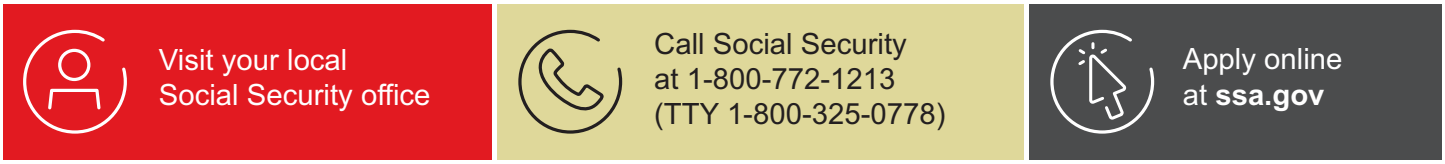
- Age 65 or older
- Younger than 65 with a qualifying disability
- Any age with a diagnosis of end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS)

Enrollment

Original Medicare (Parts A and B) helps pay for hospital stays and doctor visits, but it doesn't cover everything — nor does it cover prescription drugs.

You should be automatically enrolled in Original Medicare if you're receiving Social Security or Railroad Retirement Board benefits when you become eligible. If you're not receiving benefits, you need to sign up for Medicare when you become eligible.

You must have Medicare Parts A and B before enrolling in supplemental coverage. You can sign up in one of three ways:



If you worked for a railroad, call your local Railroad Retirement Board office or 1-877-772-5772.

While Congress has shifted the full retirement age for Social Security benefits from 65 to 66 (and 67 in the future), 65 has remained the eligibility age for Medicare.

Keep in mind that it may take up to 60 days to get approved for Medicare Part B, and up to three weeks to receive your Medicare card in the mail.

Many people who are still working sign up for Medicare Part A at 65 but delay signing up for Part B if they're covered by their employer's insurance. But you must sign up for Medicare Part B no later than eight months after you leave your job and lose group coverage, or you may have to pay a lifetime penalty and experience a gap in coverage.

If you miss the Part B initial enrollment period, you must wait to sign up for Part B until the next general enrollment period (January 1 to March 31), and coverage will begin July 1.

Understanding Medicare

Over time, your health care needs and budget may change. That's why there are options that allow you to select benefits that support those needs.

You can choose Original Medicare Part A for hospital stays and Part B for doctor visits, or you can choose a Medicare Advantage Plan (Part C) from a private insurance company. **Medicare Advantage Plans** combine Medicare Part A and Part B coverage, and many also include prescription drug coverage. Some plans come with hearing and vision care benefits as well.

Medicare Supplement Plans help pay some of your out-of-pocket costs. Available from private insurance companies, these plans pay for some of the expenses not covered by Original Medicare, like deductibles and copayments.

In general, here's what's covered under Medicare Parts A and B

Part A

- Inpatient care in hospitals
- Inpatient care in a skilled nursing facility
- Hospice care services
- Home health care services

In 2023, you pay:

- Typically a $0 premium

  Or
- A premium of up to $506 per month, based on your work history
- Deductible: per 60-day benefit period

Part B

- Medically necessary — Services or supplies to diagnose or treat a condition that meets accepted standards of medical practice
- Preventive — Health care to identify or stop illness at an early stage
- Doctor visits
- Outpatient hospital care
- Durable medical equipment and supplies

In 2023, you pay:

- Typically, the standard premium amount = $164.90
- 20% coinsurance, after $226 deductible

Note: Social Security will contact you if you have to pay more based on your income.

What's not covered by Medicare Parts A and B

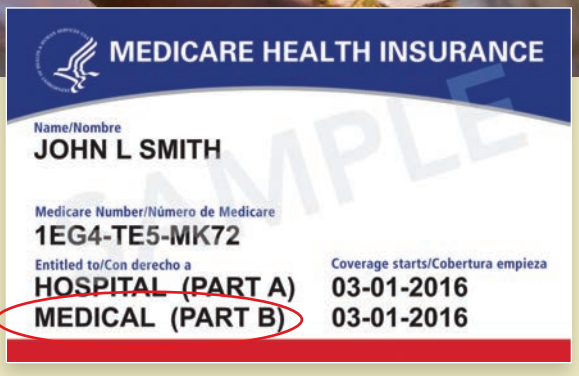
- Most prescriptions
- Health care services not approved by Medicare
- Long-term care (also called custodial care)
- Most dental care
- Eye examinations related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and associated exams
- Routine foot care

Even if a service or item is covered, you'll generally still have to pay deductibles, coinsurance or copayments without any annual limit on those costs.

There is no out-of-pocket cap for Medicare Parts A and B. That means your share of costs is unlimited. So it's a good idea to **plan for out-of-pocket costs by enrolling in an individual Medicare insurance plan.**

You can review your coverage and make changes during the Medicare Annual Enrollment Period (AEP), which runs October 15 – December 7 every year.

The Medicare Advantage Plan Open Enrollment Period (MA OEP) runs January 1 to March 31 and allows anyone currently enrolled in a Medicare Advantage Plan on January 1 the opportunity to change plans.



Good to know

Keep in mind that you must be enrolled in Medicare Parts A *and* B before you can enroll in an individual Medicare Advantage or Medicare Supplement Plan.

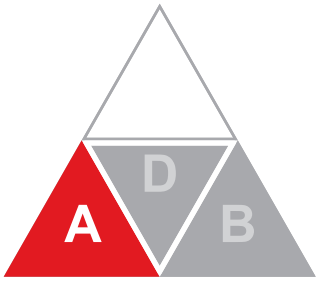
Beyond Original Medicare

As Medicare has evolved, the federal government allowed private insurance carriers to offer additional options that cover a wider range of services and help retirees manage the out-of-pocket costs. Because Medicare (Parts A and B) doesn't pay for everything, you may want to consider a Medicare Advantage Plan, or a Medicare Supplement Plan along with a Prescription Drug Plan.

MA **Medicare Advantage Plans** provide medical benefits as good as those covered by Medicare Parts A and B, but with greater financial protection. Many Medicare Advantage Plans also include Medicare Prescription Drug coverage.

With a Medicare Advantage Plan, sometimes abbreviated as "MA Plan" or called "Part C," the insurance company that offers the plan determines the monthly premium and cost-sharing amounts. If you join a Medicare Advantage Plan, you still have Original Medicare (Parts A and B), but a private insurance company is responsible for coordinating your care and paying claims. Ongoing changes to Medicare Advantage Plans include additional supplemental benefits designed to diagnose, treat, or prevent health conditions. Benefits may include transportation services, meal deliveries, or even home and bathroom safety devices.

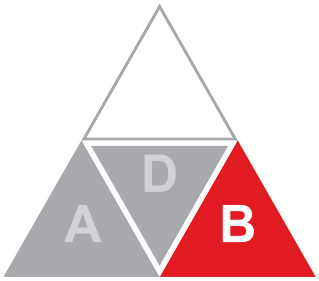
In this illustration, each of the triangles represent a different part of Medicare. Part C shows a full triangle because it includes Medicare Parts A, B and, in many cases, Part D, under one plan with one ID card.



Part A
Original Medicare

Covers:

- Inpatient hospital care
- Skilled nursing facility care
- Hospice care
- Home health care



Part B
Original Medicare

Covers:

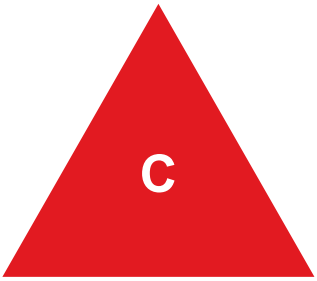
- Medically-necessary services: clinical research, ambulance services, durable medical equipment, mental health services, partial hospitalization, second opinions before surgery
- Preventive health care services
- Doctor visits
- Outpatient hospital care
- Durable medical equipment and supplies

MED SUPP **Medicare Supplement Plans** (also known as Medigap) are designed to “fill the gaps” of Medicare Parts A and B. However, these plans do not cover prescription drugs. While there are several different Medicare Supplement Plan levels, they are the same nationwide, except in Massachusetts, Minnesota and Wisconsin.

You’ll pay a monthly premium for a Medicare Supplement Plan in addition to your monthly Medicare Part B premium. When you choose a Medicare Supplement Plan, you must enroll in a Prescription Drug Plan. If you delay, you will pay a penalty.

PART D **Medicare Prescription Drug Plans** cover much of the costs for prescription drugs and can be useful in situations where prescription drugs aren’t already covered. Some plans have pharmacy networks that offer discounted prices. Plans may also offer a mail-order pharmacy benefit.

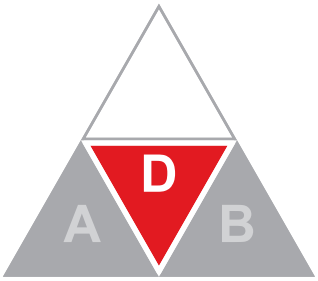
These optional plans are highly regulated and have standardized benefits: Medicare Advantage and Medicare Prescription Drug Plans are regulated by the federal government; Medicare Supplement Plans are regulated by individual states.



Part C
Medicare Advantage

Covers:

- Everything Medicare Parts A and B cover
- Many plans cover prescription drugs
- Many plans cover dental and vision



Part D
Prescription Drug

Covers:

- Prescription drugs

More a about Medicare Advantage Plans:

- You’ll usually pay a monthly premium for your Medicare Advantage Plan, but in most cases there are no deductibles.
- You’ll pay a copayment instead of coinsurance for most medical services.
- These plans have an out-of-pocket maximum, which protects you by setting a yearly cap on your cost for health services.
- If you need prescription drug coverage, check the plan to be sure your medications are covered.
- Check that your preferred doctors and specialists participate in the plan’s provider network or accept Medicare (depending on which plan type you choose).
- Before traveling, check with your provider to understand benefits available to you.
- You should review your plan details provided by your insurance company since benefits, premiums and terms can change annually.

Comparing your Medicare options

To help you explore which coverage would be better suited to your health care needs and budget, let's take a closer look at your options. Keep in mind these high-level comparisons:

Medicare Advantage Plans

- Medical benefits similar to those covered by Medicare Parts A and B
- Offer greater financial protection
- Most include Medicare Part D prescription drug coverage

OR

Medicare Supplement (Medigap) Plans

- Designed to “fill the gaps” of Medicare Parts A and B
- Do not cover prescription drugs

+

Medicare Prescription Drug Plans (Part D)

- Helps pay for medications

Types of Medicare Advantage Plans

In general, most Medicare Advantage Plans offer nationwide coverage for emergency room, urgent care and renal dialysis. Some Medicare Advantage Plans have you select a primary care physician from their network, enabling you to receive coordinated medical services, including specialist and hospital care.

Health Maintenance Organization (HMO) Plans: You're required to seek care from providers in the plan's network and you may need your primary doctor's referral to see specialists.

Preferred Provider Organization (PPO) Plans: Typically you're not required to get a referral to see a specialist and you can see providers outside the network without having to pay all the costs yourself.

Fee-For-Service Plans: You can get care from any Medicare-eligible provider who accepts your plan. These plans do not offer coordinated care.

Coordinated Care Plans: A network of doctors and hospitals work together to provide your care. Each plan creates its own network. In most cases, you will pay most or all costs if you see a provider outside the network.

Point of Service (POS) Plans: This HMO plan allows you to visit doctors and hospitals outside the network for some covered services, but your copayment or coinsurance is usually higher.

Special Needs Plans (SNPs): For people with a range of special needs, including those with chronic diseases, nursing home residents and people who are eligible for both Medicare and Medicaid.

Private Fee-For-Service (PFFS) Plan: You can see any provider in the U.S. who accepts Medicare. Medical Savings Account (MSA) plans combine Medicare Advantage Plan coverage with a special savings account that offers tax advantages to help pay for covered medical expenses.

Important considerations

- You must enroll in Original Medicare Parts A and B and pay any premiums.
- Enrollment in a Medicare Advantage Plan is through private insurance carriers. These plans are not offered by the federal government.
- At a minimum, all plans provide the same benefits as those available under Original Medicare.
- Most include prescription drug coverage as part of the premium.
- Many plans also include one or more benefits you'd otherwise have to purchase separately, such as dental, vision and/or hearing care, wellness programs, gym memberships and a nurseline.
- Many plans have an out-of-pocket maximum, which caps your financial liability in a given plan period. If your out-of-pocket costs exceed this amount, you pay $0 for additional eligible services until a new plan period begins.
- Most Medicare Advantage Plans are limited to a defined geographic area.

Medicare Cost Plans are a type of Medicare Advantage plan that's available in some states. These plans are provided by private insurance companies Medicare has approved. Medicare Cost Plans can vary in their costs and coverage. Talk with a Licensed Advisor to explore options in your area.

Types of Medicare Supplement Plans

There are a variety of standardized Medicare Supplement Plans to choose from. Each plan provides different benefits, so it's important to compare plans before choosing one. The monthly premium for your plan will vary and may be based on the coverage offered and which insurance company you choose.

2023 Coverage	A	B	C*	D	F*,1	G1	K2	L2	M	N3
Medicare Part A coinsurance and hospital costs (up to 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Skilled nursing facility care coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A hospice care coinsurance or copayments	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part B deductible			✓		✓					
Medicare Part B coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B excess					✓	✓				
Blood (first three pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Foreign travel emergencies (up to plan limits)			80%	80%	80%	80%			80%	80%

(A check mark ✓ indicates areas where the plan pays 100% of the benefit cost.)

*Plans C and F are only available to individuals eligible for Medicare prior to January 1, 2020.

[1] Plans F and G also offer high-deductible plans. If you choose these options, you must pay for Medicare-covered costs up to the deductible amount of $2,700 (in 2023) before your Medicare Supplement plan pays anything.

[2] Maximum out-of-pocket expenses of $6,940 for Plan K and $3,470 for Plan L apply (in 2023).

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission (in 2023).

Important considerations

- To enroll in a Medicare Supplement Plan, you must be enrolled in Medicare Parts A and B.
- Although most Medicare Supplement Plans cover expenses from any provider that accepts Medicare, some private insurance companies also offer a Medicare Select Plan, which provides coverage only within a defined network of providers. Check that your hospital is included in that particular plan's network.
- Most Medicare Supplement Plans don't require a copayment or coinsurance for hospital charges.
- If you enroll in coverage when you first become eligible at age 65, or if your employer stops providing a group retiree health plan, you may not be subject to a health screening or underwriting by the insurer.
- Medicare Supplement Plans are standardized in a different way in Massachusetts, Minnesota and Wisconsin. Go online to review the plans available in your area or discuss your options with a Licensed Advisor.

Planning for the future

While considering your plan options, if a Medicare Supplement Plan seems to fit your needs, consider future changes affecting Medicare Supplement Plans C and F.

Under the Medicare Access and CHIP Reauthorization Act (MACRA), existing Medicare Supplement Plans C and F have been replaced by new plans that do not include the Medicare Part B deductible.

- If you had Medicare Supplement Plans C or F in 2019, you're grandfathered in. After January 1, 2020, these plans are not available to NEW Medicare beneficiaries.
- Medicare Supplement Plans D and G offer mostly the same coverage as the plans they replaced, except they do not cover the Medicare Part B deductible.
- Switching from Medicare Supplement Plan C or F to plans D or G, or switching to a different insurance company, may trigger a review by medical underwriters. This means your medical history may influence your monthly premium.
- Medicare Advantage Plans will not be affected.