A simple guide to Medicare

Medicare Made Clear®
is brought to you by
UnitedHealthcare

United Healthcare®

We're here to help

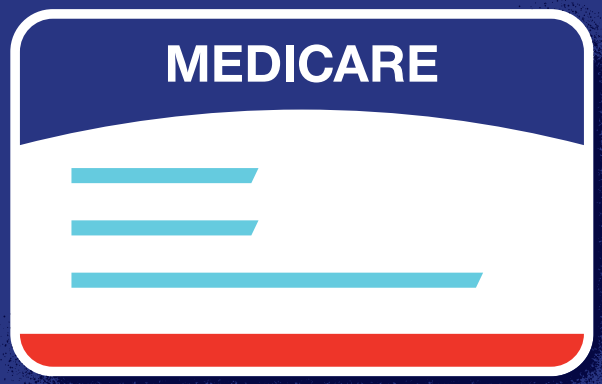
You have important decisions to make when you become eligible for Medicare. Our goal is to help you understand your options and feel confident about choosing coverage based on your needs — when you first enroll and every year after that.

Medicare Overview

Coverage and Costs

Enrollment

Resources



The first step is finding out if you're eligible

Medicare is a federal program that offers health insurance to American citizens and other eligible individuals based on age, disability or a qualifying medical condition. Medicare is individual insurance and doesn't cover spouses or dependents.

To be eligible for Medicare, you must be a U.S. citizen or legal resident

Legal residents must live in the U.S. for at least 5 years in a row, including the 5 years just before applying for Medicare.

You must also meet one of these requirements:

- Age 65 or older
- Younger than 65 with a qualifying disability
- Any age with a diagnosis of end-stage renal disease or ALS

When it's time to enroll:

- You should be automatically enrolled in Medicare Part A and Part B if you are receiving Social Security or Railroad Retirement Board benefits when you become eligible. You'll receive your Medicare card in the mail.
- You need to enroll in Medicare yourself if you aren't receiving Social Security or Railroad Retirement Board benefits when you become eligible. Go to **ssa.gov/benefits/medicare** to enroll online, or call or visit your local Social Security office.

Medicare is not Medicaid

Both Medicare and Medicaid are government programs. Both programs help people pay for health care. But that's where most similarities end. Medicare is generally for people who are older or disabled. Medicaid is for people with limited income and resources. Medicare is governed by the federal government. Medicaid programs are governed by the states.

Are you turning 65?

You are eligible for Medicare at age 65

You have a 7-month Initial Enrollment Period (IEP) for Medicare. It includes the month you turn 65, the 3 months before and the 3 months after. It begins and ends a month earlier if your birthday is the first day of the month.

Sign up early

Coverage begins the first day of your 65th birthday month if your enrollment is completed during the first 3 months of your IEP. If your birthday is on the first of the month, your coverage begins the month prior. Your coverage start date may be delayed if you sign up later.

You have choices

You may enroll in Medicare Part A, Part B or both. You may also add additional coverage such as a Medicare Advantage, Part D and/or Medicare Supplement (Medigap) insurance plan.

If you have a disability or medical condition

You will be automatically enrolled in Medicare Parts A and B after your 24th month of disability. You will still have a 7-month IEP. Enrollment timing for people with ESRD or ALS is based on the time of diagnosis and other factors.

Are you working past 65?

You still have an Initial Enrollment Period

Even if you have coverage through an employer plan (yours or your working spouse's), you have Medicare decisions to make at age 65. Your IEP happens when you turn 65 whether you continue to work or not. Depending on the employer coverage you have, you may be able to delay enrolling in Medicare without penalty.

Talk with your employer's benefits administrator to understand your options and to determine if your coverage is considered "creditable."

You may be able to delay if:

- The employer has 20 or more employees
- The employer-provided health insurance is considered "creditable"
- The employer doesn't require covered spouses to enroll in Medicare at age 65 in order to remain on the employer's plan

Pay attention to details

You must stop contributing to a health savings account (HSA) once you enroll in Part A or Part B. Also, get a notice of "creditable drug coverage" from your plan administrator. You must have this documentation to avoid the Part D penalty if you plan to delay enrollment.

Now, let's go over your main coverage choices

Original Medicare has two parts. Part A helps pay for hospital stays. Part B helps cover provider visits. But Original Medicare doesn't cover everything.

Many people choose additional coverage by enrolling in one or more private Medicare or Medicare-related plans, including:

Prescription drug plans (Part D)

Medicare prescription drug plans (Part D) help pay for medications prescribed by a licensed provider or other health care professional.

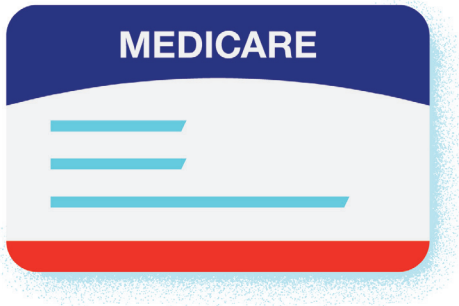
Medicare Supplement insurance plans

Medicare Supplement (Medigap) insurance plans help pay some of the out-of-pocket costs not paid by Original Medicare.

Medicare Advantage plans (Part C)

Medicare Advantage (Part C) plans combine Part A, Part B and Part D prescription drug coverage. Some plans may offer additional benefits such as coverage for routine vision and dental care.

Medicare coverage options



Step one

First, you need to enroll in Original Medicare

Provided by the federal government

Part A

Helps pay for hospital stays and inpatient care

Part B

Helps pay for licensed provider visits and outpatient care

Step two

Now, you may look at additional coverage options

Offered by private insurance companies

Option 1

Medicare Part D plan

Helps pay for covered prescription drugs

And, you can add:

Medicare Supplement insurance (Medigap)

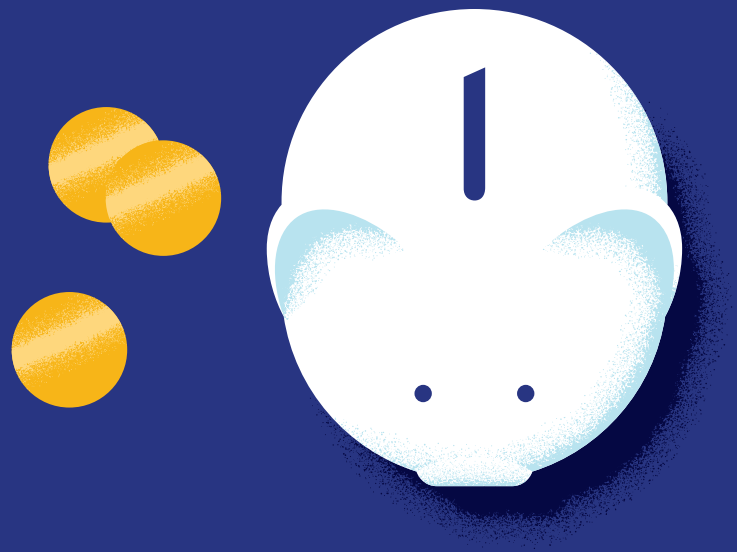
Helps pay some out-of-pocket costs not paid by Original Medicare

Option 2

Medicare Advantage plan (Part C)

Combines Original Medicare Part A & Part B coverage in one plan

- Usually includes Part D prescription drug coverage
- May offer additional benefits such as vision and dental coverage



Be sure to consider all of your costs

Medicare isn't free. The amount you'll pay depends on the coverage you choose and the health care services you receive.

Costs you may pay with Medicare:

Premium

Medicare Part B has a monthly premium. Some people also pay a premium for Medicare Part A. Medicare Advantage (Part C), Part D, as well as Medicare Supplement plans may also have premiums, and amounts may vary by carrier, plan and location.

Deductible A set amount you pay for covered services before your plan begins to pay its share of costs.

For example:

$500

You pay up to a limit **Plan pays the rest**

Copay A fixed amount you pay at the time you receive a covered service.

For example:

$20

You pay a fixed amount **Plan pays the rest**

Coinsurance A percentage of the cost you pay for a covered service.

For example:

$20

You pay a percentage **Plan pays the rest**

Examples are for illustration only. Your costs may be different.

Find out if you qualify for financial help

Many people assume they don't qualify for help, and they never look into it. Don't make that mistake.

If you have a low income and few assets, you may qualify for help through one or more of the following programs:

Medicaid

Medicaid provides health care coverage for people and families with limited incomes. It may also offer some services not covered by Medicare. Each state creates its own program, so contact your state Medicaid office for more information.

If you qualify for both Medicare and Medicaid, you are "dual eligible." In this case, you keep your Medicaid benefits and may get additional benefits from Medicare. The two programs can work together to cover most of your health care costs.

Extra Help program

This federal Medicare program helps pay some or all Part D premiums, deductibles and copays. This program may also be referred to as Low Income Subsidy (LIS).

Medicare Savings Programs

Medicare Savings Programs help pay some or all Part A and Part B premiums, deductibles and coinsurance. Also, you automatically qualify for the Extra Help program if you qualify for a Medicare Savings Program.

Program of All-Inclusive Care for the Elderly (PACE)

PACE combines medical, social and long-term care services for frail elderly people who live in the community, not in a nursing home. This program is not available in all states.

Income includes:

Money you get from retirement benefits or other money that you report for tax purposes. Income eligibility levels vary by state and program.

To learn more about the financial assistance programs that you may qualify for:

Visit **medicare.gov**

You can also contact your local Social Security office, Medicaid office or State Health Insurance Assistance Program.

There may be other assistance programs in your state.

Medicare Part A

Part A helps pay for covered hospital stays and most of the inpatient services

Coverage includes:

- A semi-private room
- Hospital meals
- Skilled nursing services
- Care in special units, such as intensive care
- Drugs, medical supplies and medical equipment used during an inpatient stay
- Lab tests, X-rays and medical equipment as an inpatient
- Operating room and recovery room services
- Some blood transfusions in a hospital or skilled nursing facility
- Inpatient or outpatient rehabilitation services after a qualified inpatient stay
- Part-time, skilled care for the homebound after a qualified inpatient stay
- Hospice care for the terminally ill, including medications to manage symptoms and control pain

Part A costs in 2025

Premium

$0

Per month

If you or your spouse made payroll contributions to Social Security for at least 10 years (40 quarters).

Otherwise, your premium could be up to:

$518

Per month

Your premium may be higher if you don't sign up for Medicare when you are first eligible.

Deductible

$1,676

Per benefit period

A benefit period begins the day you are admitted to the hospital and ends when you've been out of the hospital 60 days in a row.

Coinsurance

Home hospice patients may pay a small coinsurance amount for inpatient respite care or durable medical equipment used at home.

Plus, copays for:

Hospital stays

$0*
Days 0–60
*after you pay your Part A deductible

$419
Per day
Days 61–90

$838
Per day
Days 91+

You have 60 lifetime reserve days of coverage you can use if you're in the hospital longer than 90 days.

Each lifetime reserve day may be used only once, but you may apply the days to different benefit periods. Lifetime reserve days may not be used to extend coverage in a skilled nursing facility.

Skilled nursing facilities

$0
Days 1–20

$209.50
Per day
Days 21–100

Hospice care

Copays during home hospice care may include up to $5 per prescription for pain and symptom management.

Medicare Part B

Part B helps pay for covered care at a clinic or at a hospital as an outpatient

Coverage includes:

- Doctor visits, including in the hospital
- Annual Wellness Visit
- Ambulatory Surgery Center (ASC) services
- Ambulance and emergency room services
- Skilled nursing services
- Preventive services, such as flu shots or mammograms
- Clinical laboratory services, such as blood and urine tests
- X-rays, MRIs, CT scans, EKGs and some other diagnostic tests
- Some health programs, such as smoking cessation, obesity counseling and cardiac rehab
- Physical therapy, occupational therapy and speech-language pathology services
- Diabetes screenings, diabetes education and certain diabetes supplies
- Mental health care
- Durable medical equipment for use at home, such as wheelchairs and walkers
- Telehealth visits

Not all providers offer virtual care. Some services may have limitations. Preventive services and screenings are covered on set schedules, such as a yearly flu shot. Other covered services and supplies must be medically necessary to diagnose or treat a disease or condition.

Part B costs in 2025

Premium

$185 – $628.90

Per month

Part B has a monthly premium that is either deducted from your monthly Social Security benefits check or that you pay directly to Medicare. The amount you pay can vary depending on your tax reported income from two years prior. Monthly Part B premium costs range from $185.00-$628.90, but $185 is considered the "standard amount."

You'll qualify for the standard amount if:

- You enroll for the first time in 2025
- You aren't receiving Social Security benefits
- Your premiums are billed directly to you
- You have Medicare and Medicaid, and Medicaid pays your premiums
- Your 2023 reported income was less than or equal to $106,000 for individuals or $212,000 for couples

You may pay less if:

You enrolled in Part B in 2024 or earlier and your premium payments are deducted from your Social Security check.

You may pay more if:

You will pay an income related monthly adjustment amount (IRMAA) if your reported income from 2023 was above $106,000 for individuals or $212,000 for couples. Visit **medicare.gov** to learn more about IRMAA.

Deductible

$257

Per year

Coinsurance

20%

of covered services

You generally pay 20% of the Medicare-approved amount for the covered services you use, with no annual out-of-pocket maximum. Medicare pays the remaining 80%.

Medicare approved amount:

The amount Medicare decides providers should be paid for covered services.

Doctors and other providers may accept assignment and take the Medicare-approved amount as payment in full, even if it's less than what they usually charge.

Doctors who do not accept assignment may charge more than the Medicare-approved amount and bill you for the difference. The additional amount they may bill is called the "limiting charge."

- The provider can only charge you up to 15% over the amount that non-participating providers are paid.
- Non-participating providers are paid 95% of the fee schedule amount.
- The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.

Enroll in Original Medicare (Parts A & B) on time to avoid late enrollment penalties

Part A late enrollment penalty

10%

of the premium

If you must pay a Part A premium and enroll late, you could pay a penalty. The late enrollment penalty is 10% of the premium. You pay the penalty in addition to your premium for twice the number of years you delay enrollment.

For example

If you delayed enrollment for 2 years, you will pay an additional 10% of the Part A premium for 4 years.

2	x	2	=	4
Years of delay				Years of penalty

Part B late enrollment penalty

10%

of the premium

The Part B penalty is 10% of the monthly premium amount for each full 12-month period enrollment is delayed. You pay the penalty in addition to your premium for as long as you have Medicare Part B.

For example

If you delayed enrollment for 3 years, you will pay an additional 30% of the Part B premium as long as you have Part B.

10%	x	3	=	30%
of Part B premium		Years of delay		Total penalty

Original Medicare (Parts A & B) doesn't cover everything, such as these benefits:

- Most care outside the United States
- Personal expenses while hospitalized, such as a TV or phone
- Custodial care (care that helps with daily life activities such as eating or bathing)
- Long-term care
- Days spent in a psychiatric hospital beyond set limits
- Hospital days beyond set limits
- Routine eye exams, eyeglasses or contact lenses
- Routine hearing exams or hearing aids
- Routine dental care: dental exams, cleanings and X-rays
- Most prescription drugs
- Wellness benefits such as gym memberships

Medicare Part C

Medicare Advantage (Part C) plans combine Part A and Part B benefits

Medicare Advantage plans are offered by private insurance companies approved by Medicare. In addition to Part A and Part B benefits, many plans offer:

- Part D prescription drug coverage
- Routine hearing exams and hearing aids
- Routine dental care
- Routine eye exams, eyeglasses or contact lenses
- Wellness benefits such as gym memberships

Benefits vary by plan and could include other extra benefits such as transportation to medical appointments and credits to buy health products.

Medicare Advantage plan costs vary by plan provider

Medicare Advantage plans often offer $0 premiums

Some plans may charge premiums, deductibles, copays or coinsurance and plan premiums can change each year.

You will continue to pay your Part B premium directly to Medicare, and your Part A premium too, if you have one. Copay amounts may vary based on the covered item or service and deductibles may be applied to drug benefits and not medical benefits when a plan covers both. Coinsurance may apply for some services.

Where you get care can affect your costs

Many Medicare Advantage plans are coordinated care plans and contract with a network of doctors and hospitals.

Some plans may require you to choose a primary care provider from their network, and each plan creates its own network. Certain plan types may allow for more freedom in choosing providers, but costs could vary based on the selected provider.

Costs for providers and services can vary if they are considered in-network vs out-of-network. In most cases, you pay less for care received from in-network providers than for providers outside the network. All plans are required to offer national coverage for emergency care, urgent care and renal dialysis.

Understanding the out-of-pocket maximum

Medicare Advantage plans are required to set an out-of-pocket maximum, which is the total amount you may pay for Part A and Part B services covered during the plan period — usually a calendar year. The goal of the out-of-pocket maximum is to help provide some financial protection against out-of-pocket costs. Original Medicare doesn't offer an out-of-pocket maximum.

Plans can have different out-of-pocket maximums so long as the amount doesn't exceed the year's out-of-pocket maximum limit that is set by Medicare. This limit can change each year. For 2025, it is $9,350.

If you reach the out-of-pocket maximum, your plan will then pay for all your covered costs for the remainder of the plan period.

The following costs **do not** count toward the out-of-pocket maximum:

- Premium payments
- Drug costs
- Costs of extra health services a plan may offer such as vision or dental

Medicare Advantage coverage and costs will vary by plan, provider and location

Health Maintenance Organization plans (HMO)

Network

Requires you to seek care from providers in your network and choose a primary care provider, who may then manage any care you receive from specialists.

Extra Costs

DOES NOT cover any of the cost for care outside the plan's network, except for emergency care, urgent care and renal dialysis.

Referrals

MAY require you to get a referral for specialty services.

Point of Service plans (POS)

Network

A type of HMO plan that lets you see providers outside the plan network for certain covered services.

Extra Costs

Out-of-network care **MAY** result in higher copays or coinsurance.

Referrals

MAY require you to get a referral for specialty services.

Preferred Provider Organization plans (PPO)

Network

Has a provider network you can use but also offers more freedom to choose doctors and other providers outside the plan network for all covered services.

Extra Costs

Out-of-network care **MAY** result in higher copays or coinsurance.

Referrals

DOES NOT require you to get a referral for specialty services.

Medicare Advantage plans operate within defined geographic service areas. You must live in a plan's service area to become a member. You may have the following plans to choose from:

Private-Fee-For-Service plans (PFFS)

Provider Choice

MAY allow you to see any provider in the United States who accepts Medicare and the plan's payment terms and conditions.

Plan Design

Vary in their coverage and costs.

Referrals

DO NOT require you to get a referral for specialty services.

Special Needs Plans (SNP)

Plan Design

Designed for people with specific health care needs and usually have plan-specific eligibility requirements.

- Dual-Eligible Special Needs Plans (D-SNPs) for people who have both Medicare and Medicaid.
- Chronic Special Needs Plans (C-SNPs) for people living with qualifying chronic conditions.
- Institutional Special Needs Plans (I-SNPs) for people who live in a contracted skilled nursing facility.
- Institutional-Equivalent Special Needs Plans (IE-SNPs) for people who live in the community and need the same kind of care as those who live in a skilled nursing facility.

Extra Care

MAY include coverage for care managers or nurse practitioners to help members get the care they need.

Medical Savings Account plans (MSA)

Plan Design

Combine high-deductible health plans with special savings accounts.

Coverage

Funds received from Medicare are deposited into the savings account and may be withdrawn tax-free to pay for qualified health care expenses.

Prescription

DO NOT include prescription drug coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescriptions and some vaccines

Coverage includes:

Drugs most commonly prescribed for Medicare beneficiaries as determined by federal standards

Specific brand name drugs and generic drugs included in the plan's formulary (list of covered drugs)

Most commercially available vaccines not covered by Medicare Part B

Medicare Part D plans typically do not cover:

- Drugs not listed on a plan's formulary
- Drugs prescribed for anorexia, weight loss or weight gain
- Prescriptions for fertility and sexual or erectile dysfunction (ED)
- Prescriptions for cosmetic purposes or hair growth
- Prescription vitamins and minerals
- Non-prescription drugs (e.g. over-the-counter medications)

You can get Part D prescription drug coverage through a private insurance company in one of two ways: a standalone Part D plan or a Medicare Advantage plan that includes Part D coverage

The following pages will cover what you need to consider when choosing a Part D plan, such as:

1. Costs vary by plan and provider
2. Each plan has its own formulary (drug list)
3. Some plans have network pharmacies
4. Your costs can vary depending on the drug coverage stage you are in

You must live in the service area of the Part D plan or Medicare Advantage plan that includes Part D coverage to enroll.

You can find explanations of specific drug costs in your Evidence of Coverage materials or each Part D plan's Summary of Benefits.

A note to veterans

People who have benefits through the Department of Veterans Affairs (VA) may be able to get prescription drug coverage through the VA and may not need Medicare drug coverage. Talk with your VA benefits administrator before making any decisions.

Part D plan costs vary by the plan and provider you choose

Premium

Standalone Part D plans charge a premium, and the amount will vary based on the plan. Medicare Advantage plans with drug coverage may or may not charge a premium. If they do, generally they charge one premium for all the plan's benefits – medical, hospital and prescription drugs.

Deductible

Some Medicare Advantage or Part D plans charge deductibles. Some don't. Plans may also have a deductible for certain drugs and not for others. Deductible amounts can vary from plan to plan and from one drug tier to another. However, Medicare does set a maximum deductible amount each year that Part D plans can charge. The 2025 annual deductible limit is $590.

Copay

A copay is generally required each time you fill a prescription for a covered drug. Copay amounts may vary based on a plan's formulary tiers (typically, the lower the tier, the lower your cost) as well as which pharmacy you use (in-network vs out-of-network). Each plan sets its own copay terms and amounts, and these can vary from plan to plan.

Coinsurance

Some plans may also set coinsurance rates for certain drugs or drug tiers. You'll want to review the plan's coinsurance terms carefully to understand how much you will pay and how much the plan will pay.

Some plans have a network of pharmacies for you to choose from, while other plans may offer nationwide coverage.

If a plan has a network of pharmacies, your costs may be higher if you fill a prescription outside the network.

Plans may also offer cost-savings opportunities, such as a mail order pharmacy benefit.

Review the plan's formulary to see if your drugs are covered

A formulary is a list of prescription drugs covered by a plan.

Medicare sets standards for the types of drugs Part D plans must cover, but each plan chooses the specific brand name and generic drugs to include on its formulary.

- Plans may add or remove specific drugs from their formulary from year to year.
- Changes may be made during the year under certain circumstances, such as if a drug is removed from the market.

Your total prescription drug costs will also be affected by:

1. The number of prescriptions you take
2. How often you take them
3. If you get them from an in-network or out-of-network pharmacy
4. What Part D coverage stage you are in

Learn more about drug coverage stages on the next page

Your drug costs can vary by the plan's drug tiers

Formulary Tiers

Typically, drugs on low tiers cost less than drugs on high tiers. Additionally, plans may charge a deductible for certain drug tiers and not for others, or the deductible amount may differ based on the tier.

Tier 1	**$**
Tier 2	**$$**
Tier 3	**$$$**
Tier 4	**$$$$**
Tier 5	**$$$$$**

Some medications are subject to coverage rules or limits

Some medications may have coverage rules or limits on the amount you can get in order for the plan to cover them. This includes programs like Step Therapy, Quantity Limits, and Prior Authorization. If your drug has one of these rules or limits, you or your doctor will need to work with your plan before your drug may be covered.

Step Therapy means your plan may require you to first try other prescriptions that treat the same medical condition.

Prior Authorization means the plan needs more information from your health care provider before covering the drug.

Quantity Limit means the plan will cover only a certain amount of the drug over a period of time.

You may go through different drug coverage stages throughout the year

There are three stages, and it's important to understand how each one affects your prescription drug costs. You may not go through all the stages. People who take few prescription drugs may remain in the **annual deductible stage** or move only to the **initial coverage stage**. People with higher cost medications may move into the **catastrophic stage**.

The coverage stage cycle starts over at the beginning of each plan year, usually January 1

Annual deductible	Initial coverage	Catastrophic coverage
You pay for your drugs until you reach your plan's deductible. If your plan doesn't have a deductible, your coverage starts with the first prescription you fill.	**You pay a copay or coinsurance, and your plan pays the rest.** You stay in this stage once you, and others on your behalf, have paid a combined total of $2,000 in 2025.	**You pay nothing out of pocket for your Medicare covered Part D drugs.** You stay in this stage for the rest of the plan year.

To learn more about the Medicare Inflation Reduction Act (IRA) visit **medicareira.com**

Extra Help

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays.

To see if you qualify for Extra Help, call:

- Medicare at **1-800-Medicare** (**1-800-633-4227**), TTY **1-877-486-2048,** 24 hours a day, 7 days a week
- The Social Security Administration at **1-800-772-1213**, TTY **1-800-325-0778**
- Your state Medicaid office

What are total drug costs?

The total amount you, the plan and others have paid toward your Medicare-covered Part D drugs for the year.

What are out-of-pocket costs?

The total amount you (and others on your behalf) have paid for Medicare-covered Part D drugs. The maximum out-of-pocket costs for 2025 is $2,000.

Part D late enrollment penalty

1% of the premium

The Part D late enrollment penalty is an additional 1% of the national base beneficiary premium (NBBP) for each month you delayed enrollment. You generally pay the penalty every month for as long as you have Part D drug coverage. The penalty amount can increase or decrease year-to-year as the NBBP changes each year.

You may have to pay a Part D late enrollment penalty if either of the following are true:

- You didn't enroll in prescription drug coverage when initially eligible for Medicare and didn't have other creditable drug coverage to qualify for enrollment during a Special Enrollment Period.
- You didn't enroll in prescription drug coverage within 63 days of losing your creditable drug coverage (usually from an employer health plan).

For example

If you delayed enrollment for 29 months, you will pay an additional 1% of the Part D premium.

29	x	1%	=	30%
Months of Delay				**Monthly Penalty**

Medigap

Medicare Supplement insurance (Medigap) plans can help pay some of the out-of-pocket costs not paid by Parts A & B

Plans are offered by private insurance companies but are standardized by the federal government.

All include full or partial coverage for:

- Part A hospital coinsurance
- Part B coinsurance or copays
- Cost of blood transfusions (first 3 pints)
- Costs for 365 extra hospital days
- Hospice care coinsurance

Some may also help pay for:

- Part A deductible
- Part B deductible*
- Foreign travel emergency care up to plan limits
- Part A skilled nursing facility care coinsurance

*Not available for those newly eligible for Medicare Part A in 2020 or beyond.

Medigap plans set their own premium costs

Premium

Medigap plans set their own premiums, though as a general rule, the more generous the coverage, the higher the premium.

Premiums also will vary by provider, even if the plan letter is the same, and premium amounts can change year to year.

Different plans pay different costs

The level of coverage and what you will pay varies by plan.

Some plans split certain costs with you up to a set limit. Others leave certain costs for you to pay on your own.

Some Medigap insurers offer value-added services

Medigap insurers may make value-added services available either free or on a discounted basis. These services may come from the insurer or other companies.

Some things that are offered may include:

Discounts on vision, hearing, or dental services

24-hour nurse phone lines

Free or discounted gym memberships

Medigap plans are offered by private insurance companies but are standardized by the federal government

Each plan is labeled with a letter, and all plans with the same letter offer the same basic benefits nationwide. However, Massachusetts, Minnesota and Wisconsin standardize plans differently.

Important note about Medigap Plan C and Plan F

Plan C and Plan F are only available to individuals who were eligible for Part A or turned 65 before 1/1/20.

Benefits Covered by Chosen Medigap Plan
Part A hospital coinsurance and 365 extra hospital days
Part A deductible
Part B coinsurance or copays
Part B annual deductible
Part B excess charges
Cost of blood transfusions (3 pints)
Foreign travel emergency (up to plan limits)
Hospice care coinsurance cost
Part B preventive care coinsurance
Skilled nursing facility care coinsurance
Yearly out-of-pocket limit before benefits paid at 100%

	Plan A	Plan B	Plan D	Plan G**	Plan K	Plan L	Plan M	Plan N	Plan C	Plan F**
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		100%	100%	100%	50%	75%	50%	100%	100%	100%
	100%	100%	100%	100%	50%	75%	100%	100%*	100%	100%
									100%	100%
				100%						100%
	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
			80%	80%			80%	80%	80%	80%
	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
			100%	100%	50%	75%	100%	100%	100%	100%
					$7,220	$3,610				

* Except certain copays

** Plans F and G also have high deductible versions with a $2,870 deductible before the plans pay the benefits shown.

Is Medicare Advantage or Medigap right for you?

Many people ask the question “Should I get a Medicare Advantage plan or Medicare Supplement insurance?” Both are offered by private insurance companies, and with either choice, you continue to pay your monthly Part B premium to Medicare.

Think about these questions as you compare plans:

- Are you comfortable choosing a health care provider from within a provider network or do you want to be able to choose any provider that accepts Medicare patients?
- Would you rather have prescription drug coverage included in one plan or buy a separate Part D prescription drug plan?
- Would you rather pay a low or $0 monthly premium and copays for in-network services as you use them or potentially pay more in monthly premiums and have lower out-of-pocket costs for services you receive?

Use this chart to help quickly compare plans.

Enrollment

Costs

Prescription drug coverage

Network

Doctors and hospitals

Referrals

Medicare Advantage plans	Medicare Supplement (Medigap) insurance plans
You can enroll in a Medicare Advantage plan during your Initial Enrollment Period and the Medicare Annual Enrollment Period. If you meet certain criteria, you can enroll in or switch to a different plan during the Medicare Advantage Open Enrollment Period or a Special Enrollment Period. You can't be denied coverage or charged more based on your health status.	You can get a Medigap plan after you are 65 or older, and have enrolled in Medicare Parts A & B. You can apply to buy a plan at any time; however, you do have a 6-month Medicare Supplement Open Enrollment Period that begins after you are 65 (or older) and enrolled in Parts A & B. If you enroll during this time, you are guaranteed coverage at the best available rate regardless of health status. Outside of this time, your pre-existing health conditions may influence your eligibility for the plan and how much you pay.[1]
Generally, you pay a low or $0 monthly plan premium in addition to your Part B premium. You will pay any applicable copays, coinsurance and deductibles when you use services. Your total costs may vary depending on whether services are received in-network or out-of-network.	You pay a monthly plan premium in addition to your Part B premium. When you use services, your out-of-pocket costs are limited. Your out-of-pocket costs vary by the Medigap plan you select.
Prescription drug coverage is included with most plans. Only certain Medicare Advantage plans can be combined with standalone Part D plans.	Prescription drug coverage is not included. Consider adding a standalone Part D plan.
You may have a network from which to choose providers. You may choose out-of-network providers, but your plan may not provide coverage or may charge you more for services received. Emergency care is covered in the U.S. and sometimes abroad.	Coverage goes with you when you travel in the U.S. and may cover emergency care when traveling abroad. Medigap plans do not have networks.
You may be required to use doctors and hospitals in the plan network, though some plans give you the freedom to see any provider that accepts Medicare and the plan.	You can select any provider or hospital that accepts Medicare patients.
You may or may not need referrals to see specialists, depending on the plan.	You can see specialists without referrals.

Some states may have additional Open Enrollment rights under state law.

You have many options when it comes to your Medicare coverage

How do you begin to narrow down your choices?

How do you decide which is right for you?

Your Medicare choices should reflect your personal health and lifestyle needs

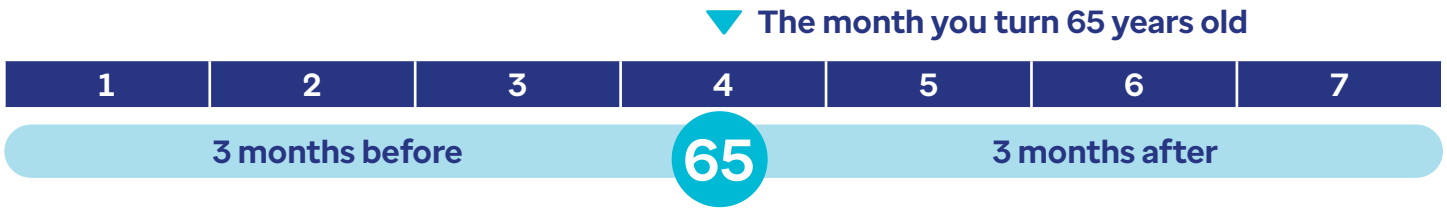
Answering these questions may help you feel more confident when shopping for a Medicare plan

1. Generally, how often do you visit a licensed doctor?
2. What prescription medications do you take? How often?
3. Do you have any major health conditions that you need special care for?
4. What did you pay out-of-pocket for health care in the last 12 months? What did you pay for prescription drugs?
5. Do you want coverage for dental, vision, hearing care services or items?
6. Do you need help paying for Medicare?

Here's an overview of the different times you can enroll in Medicare

IEP | The Initial Enrollment Period (IEP) is for enrolling near your 65th birthday

For those who become eligible due to age, it includes your 65th birthday month, the 3 months before and the 3 months after. Your IEP begins and ends one month earlier if your birthday is on the first of the month.



Eligible due to a disability?

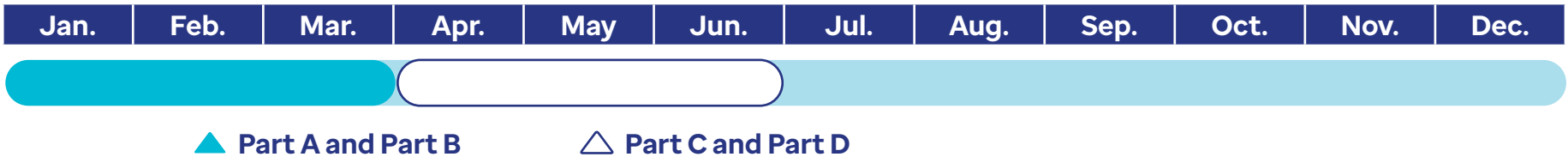
Your 7-month IEP includes the month you receive your 25th disability check, the 3 months before and 3 months after.

You have 6 months to be guaranteed coverage in a Medicare Supplement (Medigap) insurance plan, starting the first month you are age 65 or older and enrolled in both Medicare Part A and Part B.

You may apply at other times, but you could be denied coverage or charged a higher premium based on your health history. Some states have additional Open Enrollment rights under state law.

GEP | The General Enrollment Period (GEP) is for those who did not sign up around their 65th birthday

The GEP happens every year from January 1 to March 31, with coverage beginning the month after you sign up. You can enroll in Medicare Part A, Part B or both. You may enroll in a Medicare Advantage (Part C) plan or a Part D prescription drug plan from April 1 to June 30 the same year.



SEP | Medicare provides a Special Enrollment Period (SEP) for enrolling after retiring or losing your employer coverage

If you plan to work past 65 or have employer health coverage through a spouse, you have options:

1 **If an employer has 20 or more employees,** you can generally choose to delay Medicare enrollment, drop your employer coverage for Medicare, or have both Medicare and employer coverage.

2 **If an employer has fewer than 20 employees,** you will likely need to enroll in Medicare during your Initial Enrollment Period.

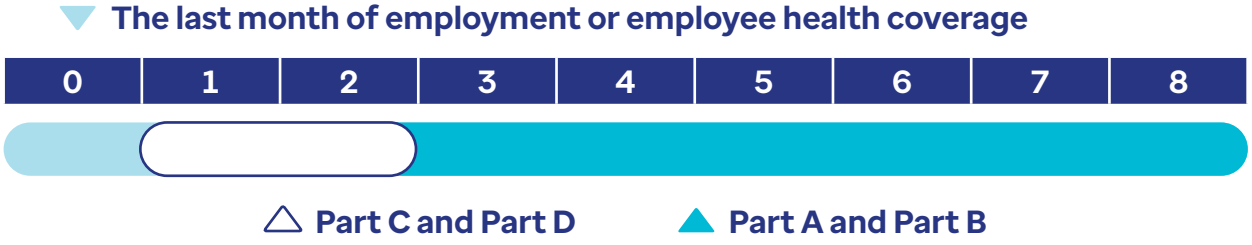
3 **If you have health coverage through a spouse's employer,** you may be able to delay enrollment, or you may need to enroll at age 65 depending on the employer.

You need to have creditable drug coverage to qualify to delay. Creditable drug coverage means the employer drug coverage is at least as good as standard Medicare Part D plan coverage. Without this, you could face late penalties for Part D if you enroll after your IEP ends.

If you qualify to delay enrolling in Medicare, there are some important things to understand:

- ✔ **You can choose to delay Medicare Part A, Part B or both.** Some people choose to still get Medicare Part A at age 65 because it's usually premium-free for most people.
- ✔ **If you have a health savings account (HSA),** be aware that once you enroll in any part of Medicare you can't continue to make contributions to your HSA.
- ✔ **You will need to provide written proof** of your creditable drug coverage from your employer to avoid Part D penalties.
- ✔ **You do not need to provide notice** that you will delay enrolling unless you're already receiving Social Security or Railroad Retirement Board benefits.
- ✔ **You can delay without penalty** as long as you enroll within 8 months of losing your (or your spouse's) employer coverage.

You will have 8 months to enroll in Part A and Part B and only 2 months for Part C and Part D



You have exactly 63 days to get a standalone Part D plan or Medicare Advantage plan with prescription drug coverage without penalty.

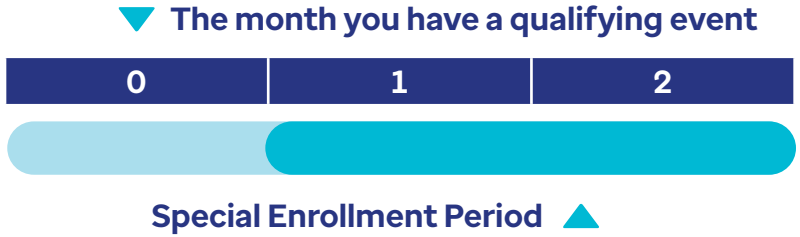
You can make plan changes at certain times of the year

SEP | Medicare also provides a Special Enrollment Period (SEP) for qualifying life events

Specific dates vary, but generally you have two full months after the month of a qualifying event to make plan changes. During this time, you may join, change or drop a Medicare Advantage or Part D prescription drug plan outside of the Medicare Annual Enrollment Period without penalty.

Common qualifying events include:

- Moving
- Leaving retiree, union or COBRA coverage



Call your local State Health Insurance Assistance Program (SHIP) office to learn more about qualifying events.

AEP

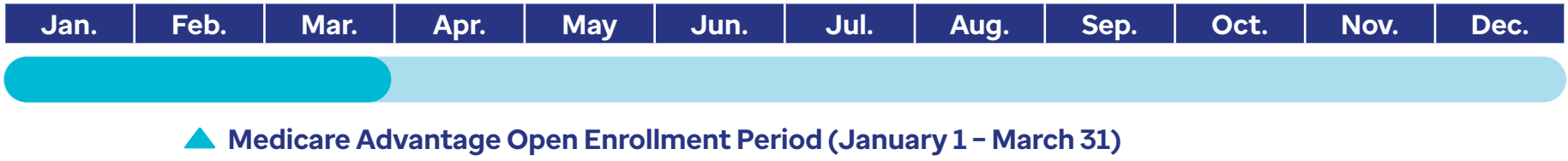
During the Medicare Annual Enrollment Period (AEP), also known as the Medicare Open Enrollment Period (OEP), you can join, switch or drop a Medicare Advantage or Part D prescription drug plan and/or apply for a Medicare Supplement insurance plan

You will automatically go back to Original Medicare if you drop a Medicare Advantage plan, and you will lose drug coverage if it was included with your plan. You may replace it with a standalone Part D prescription drug plan at this time without penalty. A penalty may apply if you drop drug coverage and decide to get it again later. You can also apply for a Medicare Supplement insurance plan if you revert to Original Medicare during the Annual Enrollment Period or later, but remember that your pre-existing health conditions can keep you from being accepted into the plan or may affect the premium amount you pay.

MA OEP

During the Medicare Advantage Open Enrollment Period (MA OEP) you can switch or drop Medicare Advantage plans

If you're enrolled in a Medicare Advantage plan on January 1, you can make one coverage change between January 1 and March 31. You may switch to a different Medicare Advantage plan or return to Original Medicare. If you go back to Original Medicare, you may also enroll in a Part D plan during this time.



Combine different Medicare parts and plans for coverage that fits your needs

Your combination options depend on whether you get Medicare Part A and Part B coverage through Original Medicare or through a Medicare Advantage (Part C) plan.

Original Medicare

When enrolling in Original Medicare (Parts A & B), you can add a Medicare Supplement (Medigap) plan, a standalone Part D prescription drug plan or both.

Part A Part B

Part A Part B + Part D

Part A Part B + Medigap

Part A Part B + Part D + Medigap

Medicare Advantage

You may choose to get your Part A and Part B benefits through a Medicare Advantage (Part C) plan. Many plans come with built-in prescription drug coverage. You can add a standalone Part D plan only with certain Medicare Advantage plan types.

Part C

A Medicare Advantage plan without drug coverage

Part C

Part D

A Medicare Advantage plan with built-in drug coverage

Part C

+

Part D

A Medicare Advantage plan with a standalone drug plan added*

*Only applies to certain plans.

How to enroll in:

Original Medicare (Parts A & B)

Original Medicare is provided by the federal government. You'll be automatically enrolled if at age 65 you are receiving Social Security or Railroad Retirement Board benefits, or if you become eligible for Medicare due to disability. If you're not enrolled automatically, you must enroll yourself.

Enroll online at **ssa.gov**, by phone **1-800-772-1213** (TTY **1-800-325-0778**) or visit your local Social Security office.

Part C, Part D and Medigap plans

These plans are only offered by private insurance companies. You will enroll directly with the plan provider – by phone, online or with a local agent.

Remember to review each plan carefully. Different carriers will offer different plans and benefits.

Meet David

David just turned 65 and is retiring. He doesn't have retiree coverage but is in his Medicare Initial Enrollment Period and he plans to enroll in Medicare.

David takes good care of himself and is generally healthy. He takes a daily prescription drug for his high blood pressure. He is careful to live within his budget.

His benefit wish list includes:

- Coverage for preventive care and other health care services
- Coverage that provides a safety net in case of a serious illness
- Access to specialists
- Prescription drug coverage in case he needs additional medications

David chose a Medicare Advantage (Part C) plan with built in prescription drug coverage

His plan includes:

- $0 Preventive care
- Fitness program at no additional cost
- Rx Built-in prescription drug coverage
- Network of local doctors and hospitals
- Out-of-pocket maximum of $4,900 per year

His monthly costs:

$185
Part B premium

+

$0
Part C premium

$185
Base total per month

On top of the base total, David may also have other costs

His out-of-pocket costs may include copays, coinsurance and deductibles. His total spending will vary depending on the specific cost-sharing terms of his plan, the health care services he uses, the prescriptions he fills, and whether the services or items were obtained in-network or out-of-network. Because David's plan has an out-of-pocket maximum of $4,900 for the year, once his out-of-pocket costs for Medicare covered services reach that number, his Medicare Advantage plan will be responsible for the rest.

Examples are for illustration only. Your costs may be different.

Meet Juanita

Juanita will be 65 in 3 months and plans to retire at that time. Then she plans on spending time traveling from her home in Colorado to visit family in California.

Juanita is in good health. She takes two prescriptions – one to keep her bones strong and another to control her cholesterol. She has a comfortable pension but wants to leave a financial legacy for her family so she is careful about what she spends on health care.

Her benefit wish list includes:

- Access to doctors and hospitals when she's in California visiting her children
- Help with paying for her prescription drugs
- Peace of mind of knowing that she will have help paying her health care costs if they are high

Juanita chose Original Medicare (Parts A & B) with a standalone Part D plan and Medigap plan G

Her plan includes:

- Discounted prices on the drugs she takes
- Access to doctors and hospitals throughout the U.S.
- Help with costs not paid by Original Medicare

Her monthly costs:

$185
Part B premium

+

$57
Part D premium

+

$140
Medigap plan G premium

$382
Base total per month

Juanita needs to consider how to pay for her prescriptions

A Medicare Supplement insurance plan covers most of Juanita's out-of-pocket costs with Original Medicare, but Juanita's prescription drug costs are not covered by her Medicare Supplement insurance plan. She will have to look at the cost-sharing terms for her Part D plan to determine additional monthly out-of-pocket costs.

Examples are for illustration only. Your costs may be different.

Meet Georgia

Georgia will be 65 next month. She has been working part-time since her husband died five years ago, but her income is limited. Georgia has heart disease, so she sees a heart specialist regularly and takes a blood-thinning medicine every day.

Her benefit wish list includes:

- Health care at an affordable price
- Access to her trusted doctors
- Discounted prices on her prescription drugs
- The possibility of help with her premiums and cost-sharing if she qualifies for low-income assistance

Georgia chose Original Medicare (Parts A & B) with a Part D stand-alone prescription drug plan

Her plan includes:

Access to the doctors and hospitals she uses now

Discounted prices on the drugs she takes

Her monthly costs:

$185
Part B premium

+

$57
Part D premium

$242
Base total per month

On top of the base total, Georgia may also have other costs

Georgia will have other out-of-pocket costs to cover when she receives different health care services and items. She will be responsible for any cost sharing for her Medicare Parts A & B covered services, as outlined in the Original Medicare cost sharing terms, as well as the cost sharing defined by her Part D plan. She will also be responsible for the costs of services and items not covered by Medicare Parts A & B.

Georgia should apply for financial help

Because Georgia has a limited income, she could explore financial help by seeing if she qualifies for the Extra Help program (to help with her Part D costs) and Medicaid. If she qualifies for either program, her costs could be significantly lower for both Original Medicare and Part D.

Examples are for illustration only. Your costs may be different.

Meet Matt

Matt is about to turn 65 and lives in Texas. He is an Army veteran with Veterans Administration (VA) benefits. Matt enjoys traveling each year to see his four grandchildren in Arizona and Wyoming. He is retired with good savings but wants to make sure he leaves each of his grandchildren something behind. Matt is in good health and takes only one prescription daily – for lowering his cholesterol. Matt gets this prescription, and any others he needs, through the VA.

His benefit wish list includes:

- Access to doctors and hospitals nationwide
- Peace of mind knowing that he will have help paying for health care costs if they are high

Matt chose Original Medicare (Parts A & B) with a Medigap Plan L

His plan includes:

Access to doctors and hospitals throughout the U.S.

Help with costs not paid by Original Medicare

A yearly out-of-pocket limit of $3,610 before 75% of benefit are paid at 100%

His monthly costs:

$185
Part B premium

+

$113
Medigap Plan L premium

$298
Base total per month

On top of the base total, Matt may also have other costs

Matt's Medicare Supplement insurance plan will help with the costs of his Original Medicare (Parts A & B) services, but he will still have some out-of-pocket costs to cover. His costs will vary based on the service he receives, but they will be lower after he meets his Medicare Supplement insurance plan's annual out-of-pocket limit. Matt will also be responsible for the costs of services and items not covered by Original Medicare (Parts A & B) or his Medicare Supplement insurance plan.

Matt's VA costs are not included as part of this example and will be separate from his Medicare costs.

Examples are for illustration only. Your costs may be different.

Meet Karen

Karen is about to turn 65 and retire. She doesn't take any prescription drugs currently and is in very good health. Karen also likes to travel, going to different U.S. National Parks every summer and fall. She is retiring from her position as vice president at a global software company with very strong savings and annual pension. Karen is not concerned about out-of-pocket health care costs and doesn't anticipate needing more than medical and hospital insurance.

Her benefit wish list includes:

- Access to doctors and hospitals throughout the U.S.
- Basic medical insurance

Karen chose Original Medicare (Parts A & B)

Her plan includes:

Access to doctors and hospitals throughout the U.S.

Basic medical and hospital insurance

Her monthly costs:

$185
Part B premium

$185
Base total per month

On top of the base total, Karen may also have other costs

Karen's Medicare coverage only works for health care items and services covered by Medicare Part A and Part B. Karen will be responsible for any cost sharing for her Medicare Parts A & B covered services, as outlined in the Original Medicare cost sharing terms. Because Karen did not get a Part D prescription drug plan or any other additional coverage, she will be 100% responsible for any prescription drugs she may need, as well as any costs related to health items and services not covered by Medicare Part A or Part B. If Karen decides to join a Part D plan later, she will likely have to pay Part D late penalties because she won't have had creditable drug coverage.

Examples are for illustration only. Your costs may be different.

Meet Leroy

Leroy is about to turn 65. He has had serious health problems for years. He suffers from diabetes and high blood pressure, and his primary care provider has told him he needs to lose a considerable amount of weight. Leroy takes insulin and blood pressure medication every day. He has had trouble in the past with interactions with the drugs he is taking.

His benefit wish list includes:

- Expert help with managing his health problems
- Help with improving his diet, exercise and weight management
- Discounted prices on prescription drugs

Leroy chose a Medicare Advantage Chronic Special Needs Plan (C-SNP) for people with diabetes, with built-in prescription drug coverage

His plan includes:

- Access to a care manager who will create a plan for coordinating his care
- Help with finding out if he qualifies for financial assistance with Medicare costs
- Discounted prices on the drugs he takes
- Help with adopting a healthier lifestyle

His monthly costs:

$185
Part B premium

+

$18
Medicare Advantage Chronic Special Needs Plan premium

+

$25
Insulin prescription copay

$228
Base total per month

On top of the base total, Leroy may also have other costs

Leroy pays out-of-pocket for services and items he receives during the year. How much he pays is determined by the cost-sharing terms as determined by his plan. His total spending will also depend on the specific health care services he uses and the medications he takes.

Leroy should see if he can also qualify for Medicaid

Because Leroy has been dealing with serious health problems for years, it's likely that his health care costs are high. Leroy should see if he qualifies for Medicaid in his state to see if he may get additional health care coverage and financial help that way.

Examples are for illustration only. Your costs may be different.

Medicare Quick Tips

1 There are two ways to get Medicare

- **Original Medicare (Parts A & B).** Part A is hospital coverage and Part B is medical coverage. Original Medicare is provided by the federal government. Benefits and coverage are the same across the country. With Original Medicare, you can also add a standalone Part D prescription drug plan and/or a Medicare Supplement insurance plan.
- **Medicare Advantage (Part C).** These plans combine your Part A and Part B coverage, and many also include Part D prescription drug coverage and other benefits such as hearing, vision, dental or fitness. Plans are offered by private insurance companies.

2 There are two ways to get drug coverage

- You may add a standalone Part D prescription drug plan to Original Medicare. Or you may enroll in a Medicare Advantage plan that includes prescription drug coverage.

3 Original Medicare doesn't cover everything

- Original Medicare (Parts A & B) doesn't cover everything that you may need for your health. It doesn't include prescription drug coverage, routine hearing, dental, vision, fitness memberships or additional financial protection. If you want additional coverage, explore plans provided by private insurance companies.

4 Location affects your coverage choices

- Medicare Advantage plans and prescription drug plans vary in coverage and cost. Medicare Supplement (Medigap) insurance plan basic benefits are standardized and are the same nationwide—except in Minnesota, Wisconsin and Massachusetts. Insurance companies may offer several plans where you live.

5 Calculate all your Medicare costs

- You are responsible for monthly premiums plus additional out-of-pocket costs such as deductibles, copays and coinsurance.
- Your costs will vary based on the Medicare coverage you choose, the health services you use during the year and if you have any financial assistance for Medicare costs.

6 Protection from high out-of-pocket costs is available

- Medicare Advantage plans put a cap on your out-of-pocket costs for Part A and Part B services covered by the plan. It's called the "annual out-of-pocket maximum" and it provides built-in financial protection. There is no out-of-pocket cap with Original Medicare. Total out-of-pocket costs and financial protections may vary for in-network vs out-of-network costs.
- Medicare Supplement insurance plans help pay some out-of-pocket costs not paid by Original Medicare, such as deductibles and coinsurance. A variety of plans are available that offer different levels of financial protection. Medigap plans are organized by letters, such as "Plan A" or "Plan G."
- Both Medicare Advantage and Medicare Supplement insurance plans are offered by private insurance companies. You can have either a Medicare Advantage or Medicare Supplement insurance plan, but not both together.

7 Timing matters when you first enroll

- Your Initial Enrollment Period (IEP) is your first chance to enroll in Medicare. It generally starts 3 months before your 65th birthday, includes the month of your birthday and ends 3 months after your 65th birthday, for a total of 7 months. If you qualify early due to a disability, your IEP is still 7 months long, but includes the month you receive your 25th disability check, the 3 months before and 3 months after.
- You may qualify to delay Medicare enrollment if you have creditable coverage through your employer or your spouse's employer. If you can delay, you'll have an 8-month Special Enrollment Period (SEP) that begins either when you lose the employer coverage or leave your job, whichever occurs first.
- If you enroll after your Initial Enrollment Period or Special Enrollment Period, you could face late penalties for Medicare Part A, Part B or Part D.

8 You may be able to enroll or make changes at other times

- Medicare offers a General Enrollment Period (GEP) every year from January 1 to March 31 for those who have missed their Initial Enrollment Period.
- Medicare provides Special Enrollment Periods (SEP) for qualifying life events. Examples include moving your primary residence or leaving an employer health plan. Visit **medicare.gov** for a complete list of qualifying events.
- The Medicare Advantage Open Enrollment Period (MA OEP) is from January 1 to March 31 each year. You may switch to a different Medicare Advantage plan or drop a plan and go back to Original Medicare at this time.
- The Medicare Annual Enrollment Period (AEP) happens every year from October 15 to December 7. You may change your coverage during this time if you decide to.

Tips for the Medicare Annual Enrollment Period

The Medicare Annual Enrollment Period (AEP) happens every year from October 15 to December 7

You may change your coverage during this time. You can switch from one Medicare Advantage or Part D plan to another, or you may switch from Original Medicare to a Medicare Advantage plan, or vice versa.

1. **Evaluate your overall health care needs,** especially if your health has changed in the last year

2. **Review your existing Medicare coverage** to evaluate how it fits your health care and lifestyle needs

3. **Review your Medicare plan Annual Notice of Change (ANOC) letter when you get it** (usually in September) to identify important plan changes to covered benefits, providers, costs and prescription drugs

4. **Evaluate your current health care needs and health care costs** to decide if your current coverage is still a good fit or if you should shop around

5. **Explore available Medicare plan options in your area** to see if something may be a better fit for your health or finances

Tips for caregivers helping make Medicare decisions

Caregivers often find themselves in a position to help a loved one make Medicare decisions, so it's important to be ready for either a loved one's Initial Enrollment Period or the Medicare Annual Enrollment Period (October 15 to December 7).

1. **Get authorized to obtain your loved one's personal health information** by completing a Medicare Authorization Form at **medicare.gov**

2. **Understand your loved one's health care needs** including their overall health status, daily medications, chronic conditions and more

3. **Understand your loved one's current Medicare coverage** (if they already have it) including what they have, what is and is not covered, how much it costs each month and who their provider is

4. **As you approach enrollment periods, gather up your loved one's Medicare, personal, insurance and financial information** to make things easier when you are ready to enroll

5. **Evaluate with your loved one** how well their Medicare coverage fits their health care and lifestyle needs each year and identify gaps you may need to fill

Do you need help paying for Medicare?

If you have a low income and few assets, you may qualify for help through one or more programs

- There may also be other assistance programs in your state
- Income includes money you get from retirement benefits or other money that you report for tax purposes
- Income eligibility levels vary by state and program
- Different programs cover costs for different Medicare items
- Some may help with Parts A and B, others with prescription drugs, and some may help with all your Medicare costs

Medicare Savings Programs

Medicare Savings Programs help pay some or all Part A and Part B premiums, deductibles and coinsurance. There are four types of Medicare Savings Programs.

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individuals (QDWI) Program

If you qualify for a QMB, SLMB or QI Medicare Savings Program you also automatically qualify for the Extra Help program, which helps with Medicare Part D costs.

Extra Help

A program specifically designed to help qualified beneficiaries pay some or all Medicare Part D premiums, deductibles, copayments and coinsurance. The dollar amount provided varies depending on a person's situation.

Medicaid

Medicaid is a joint federal and state health insurance program for low-income individuals and families. Medicaid helps pay costs not covered by Medicare Parts A & B and may also include some additional benefits and services Medicare does not provide, such as long-term care or prescription drug coverage. Each state creates its own program, so contact your state Medicaid office for more information. Remember, if you qualify for both Medicare and Medicaid, you are "dual eligible." In this case, you keep your Medicaid benefits and may get additional benefits from Medicare. The two programs can work together to cover most of your health care costs.

Program of All-Inclusive Care for the Elderly (PACE)

Programs that provide all the care and services covered by Medicare and Medicaid for individuals age 55 or older who need a nursing home level of care (as certified by their state), live in the service area of a PACE organization and are able to live safely in their community with PACE's help. This program is not available in all states.

Find out if you qualify for help

Many people assume they don't qualify for financial help, and they never look into it. Don't make that mistake.

Visit **medicare.gov** to learn more about financial assistance programs. You may also contact your local Social Security office, Medicaid office or State Health Insurance Assistance Program for help.

Here's a list of helpful contacts

Medicare Helpline

Call for questions about Medicare and detailed information about plans and policies in your area.

1-800-MEDICARE (**1-800-633-4227**),
TTY **1-877-486-2048**, 24 hours a day/7 days a week

Social Security Administration

Get answers to questions about Medicare eligibility and enrollment, Social Security retirement benefits or disability benefits. You can also ask about your eligibility for financial help.

1-800-772-1213, TTY **1-800-325-0778**
ssa.gov/benefits/medicare

medicare.gov

The Medicare website provides information and offers online tools to find and compare Part D plans, Medicare Advantage plans and Medicare Supplement insurance plans.

medicaid.gov

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Learn more about eligibility, benefits and how to apply.

State Health Insurance Assistance Program (SHIP)

Your State Health Insurance Assistance Program offers free counseling and can help with questions about buying insurance, choosing a health plan and your rights and protection under Medicare. See pages 54-55 for the number in your state.

shiphelp.org

medicaremadeclear.com

Watch videos, sign up for a newsletter, find helpful tools and resources to get answers to your Medicare questions.

Your current health plan provider

Your health plan's customer service center should be able to answer questions you have about your current coverage. Find the number on your member ID card.

aarp.org

AARP® provides information about Medicare, as well as other programs and services available to people as they age.

National Hospice and Palliative Care Organization

Learn about hospice care and hospice programs where you live. Your licensed provider or other health care professional may also be able to help you find local services.

nhpco.org

Administration on Aging

Discover local, state and community-based organizations that serve older adults and their caregivers.

1-800-677-1116, TTY **711**
eldercare.acl.gov

Helpful Medicare Made Clear® Resources

Medicare Plan Finder Worksheet

Use this simple chart to compare Medicare plans side-by-side, as well as get helpful steps for finding the right fit.

Medicare Plan Review Worksheet

Use this worksheet to see how well your current Medicare coverage is working for you, where any gaps might be and to decide whether you should make a change.

Initial Enrollment Period (IEP) Checklist

Get a head start on understanding your Medicare coverage options and timeline so you can make an informed decision when the time comes.

Annual Enrollment Period (AEP) Checklist

Use this checklist to help you prepare for the Medicare Annual Enrollment Period (AEP), October 15 to December 7.

Working Past 65 Quick Tips

Use this guide for important tips and quick answers to some commonly asked questions whether you enroll at age 65 or not.

You can download these checklists and worksheets at **getmedicareresources.com.**

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) offers free counseling and help with choosing Medicare coverage. There are SHIP offices in every state.

Alabama
1-800-243-5463

Alaska
In-state calls only: **1-800-478-6065**,
(TTY **1-800-770-8973**)
Out of state calls: **907-269-3680**

Arizona
1-800-432-4040

Arkansas
1-800-224-6330, **501-371-2782**

California
1-800-434-0222

Colorado
1-888-696-7213
Statewide Spanish Language Counseling/Longmont:
866-665-9668

Connecticut
In-state calls only: **1-800-994-9422**
Out of state calls: **860-424-5274**

Delaware
1-800-336-9500

Florida
1-800-963-5337,
(TTY **1-800-955-8770**)

Georgia
1-866-552-4464

Guam
1-671-735-7415

Hawaii
1-888-875-9229

Idaho
1-800-247-4422

Illinois
1-800-252-8966, (TRS **711**)
Email: **aging.ship@illinois.gov**

Indiana
1-800-452-4800,
(TTY **1-866-846-0139**)

Iowa
1-800-351-4664,
(TTY **1-800-735-2942**)
Email: **shiip@iid.iowa.gov**

Kansas
1-800-860-5260

Kentucky
1-877-293-7447

Louisiana
1-800-259-5300

Maine
1-800-262-2232, (TTY **711**)

Maryland
1-800-243-3425

Massachusetts
1-800-243-4636,
(TTY **1-877-610-0241**)

Michigan
1-800-803-7174

Minnesota
1-800-333-2433,
(TTY **1-800-627-3529**)

Mississippi
1-844-822-4622

Missouri
1-800-390-3330

Montana
1-800-551-3191

Nebraska
1-800-234-7119

Nevada
1-800-307-4444

New Hampshire
1-866-634-9412

New Jersey
In-state calls only: **1-800-792-8820**
Out of state calls: **860-424-5274**

New Mexico
1-800-432-2080,
(TTY **1-505-476-4846**)

New York
1-800-701-0501

North Carolina
1-855-408-1212

North Dakota
1-888-575-6611,
(TTY **1-800-366-6888**)

Ohio
1-800-686-1578,
(TTY **1-614-644-3745**)

Oklahoma
In-state calls only: **1-800-763-2828**
Out of state calls: **405-521-6628**

Oregon
1-800-722-4134

Pennsylvania
1-800-783-7067

Puerto Rico
1-877-725-4300,
(TTY **787-919-7291**)
The Ponce SHIP office phone number is **1-800-981-7735**

Rhode Island
1-888-884-8721, (TTY **401-462-0510**)

South Carolina
1-800-868-9095

South Dakota
1-800-536-8197

Tennessee
1-877-801-0044

Texas
1-800-252-9240,
(TTY **1-800-735-2989**)

U.S. Virgin Islands
1-340-772-7368 (STX)
1-340-714-4354 (STT/STJ)

Utah
1-800-541-7735

Vermont
In-state calls only: **1-800-642-5119**
Out of state calls: **802-865-0360**

Virginia
1-800-552-3402

Washington
1-800-562-6900,
(TTY **1-360-586-0241**)

Washington, D.C.
202-727-8370

West Virginia
1-877-987-4463

Wisconsin
1-800-242-1060, (TTY **711**)
1-855-677-2783 Wisconsin Medigap Part D and Prescription Drug Hotline
1-800-926-4862 (Part D Assistance for people with disabilities)

Wyoming
1-800-856-4398

Visit **shiphelp.org** or call your state SHIP office.

Common Medicare questions and answers

I have Original Medicare plus a Medicare Supplement (Medigap) insurance plan. If I choose to join a Medicare Advantage (Part C) plan, can my Medigap and Part C plans work together?

No. A Medicare Advantage (Part C) and Medicare Supplement (Medigap) insurance plan cannot work together. A Medigap plan cannot pay any of your Medicare Part C premiums, coinsurance, copayments, deductibles or any out-of-network claims. If you have a Medigap plan and join a Medicare Advantage plan, you must drop your Medigap policy.

How do I find out if my doctors, hospitals and pharmacies are in my Medicare plan's network?

You can check the plan's online provider directory or call the plan's customer service number and ask whether your providers and pharmacies are part of your plan's network. You can also call your doctor's office, preferred pharmacy and hospital directly and ask whether they accept the plan.

I have employer health insurance now. What happens to that when I retire?

If you plan to retire at age 65, you will most likely need to enroll in Medicare during your Initial Enrollment Period, which begins three months before your 65th birthday month. However, your employer may offer retiree coverage that could allow you to delay enrolling. Check with your employer's benefits administrator to learn about your options before making any Medicare decisions.

Do I have to enroll myself in Medicare?

It depends. If you are receiving Social Security or Railroad Retirement Board benefits when you become eligible for Medicare, you will be enrolled automatically. If you are not receiving these benefits, you will need to enroll yourself in Part A and Part B with the Social Security Administration. If you decide you want a Medicare Advantage (Part C) plan, a Part D prescription drug plan or a Medicare Supplement (Medigap) insurance plan, you will need to sign-up directly with the private insurance plan provider.

I am planning to work past 65. Do I have to get Medicare?

It depends on your situation. Typically, if your employer has 20+ employees, you may be able to delay without penalty. But if your employer has less than 20 employees, you will likely need to enroll in Medicare. If your spouse is on your employer plan, there may be options to consider as well. Check with your employer's benefits administrator to learn about your options. More tips on page 5.

What happens if I join a Medicare Advantage plan that uses a network of doctors and hospitals and my provider leaves the network?

Your Medicare Advantage plan will notify you if your provider leaves the plan network and you will be able to choose a new in-network provider. Generally, you can't change plans in this situation until the next Medicare Annual Enrollment (unless you qualify for an exception).

What happens if I join a Medicare Advantage plan, and then move? Can I take my plan with me?

If you stay within your current plan's service area, you can keep your plan. If you move out of your plan's service area, you may qualify for a Special Enrollment Period and enroll in a new plan. You could choose a new Medicare Advantage plan available in the area you're moving to, or you could return to Original Medicare (Part A and Part B), with the option of adding a Part D prescription drug plan, a Medicare Supplement plan or both. Call your current private insurance customer service department to find out the plan's service area.

My spouse is turning 65, retiring and joining Medicare. I'm 61, not working and have always been on my spouse's health insurance. What happens when my spouse joins Medicare?

Medicare is individual insurance, so it won't cover you until you reach age 65, even if your spouse is on Medicare. Find out whether your spouse's current health coverage can cover you after your spouse retires. You may be eligible for COBRA coverage or purchase an individual health insurance policy.

I already have Medicare. How do I know what kind of Medicare coverage I have?

The insurance card(s) you use when you see a licensed provider or a hospital can help you figure out what kind of coverage you have. Original Medicare (Parts A & B) card is red, white and blue, and issued by the federal government through the Social Security Administration. A private insurance card is a separate card issued by the plan provider which would be a Medicare Advantage (Part C) plan, a Part D prescription drug plan or a Medicare Supplement (Medigap) insurance plan. Call the number on your card to find out more about your plan type.

Here's a glossary of the terms used in this guide

Accept assignment
Doctors and other providers who accept assignment agree to take the Medicare-approved amount as full payment for their services. You may be charged a share of the cost. See page 13.

Benefit period
Under Medicare Part A, a "benefit period" is a period that begins when you are admitted to a hospital for an overnight stay and ends when you have been out of the hospital for 60 days in a row. See page 11.

Brand name drug
A prescription drug that is sold under a trademarked name.

Catastrophic coverage
A Medicare Part D payment stage. In this stage, you pay nothing. The plan pays the full cost for your Part D-covered drugs for the rest of the plan period, usually a calendar year. See page 24.

Centers for Medicare & Medicaid Services (CMS)
The federal government agency that runs the Medicare program and works with the states to manage their Medicaid programs.

Coinsurance
A percentage of the cost for a health care service that you pay when you receive it. For example, you might pay 20% of the total allowed cost of a licensed provider visit and Medicare or your Medicare plan would pay the remaining 80%. See page 8.

Coordinated care plan
A type of Medicare Advantage plan in which your care is coordinated by your primary care provider (PCP). These plans are also referred to as “managed care” plans. See page 17.

Creditable drug coverage
Prescription drug coverage that provides coverage at least as good as Medicare Part D. You may delay enrolling in Part D without penalty if you have creditable drug coverage.

Custodial care
Care that provides help with daily living activities, such as eating, bathing and getting dressed.

Deductible
A set amount you pay out of pocket for covered services before Medicare, your Medicare plan, or both, begins to pay. See page 8.

Dual eligible
A person who qualifies for both Medicare and Medicaid. See page 9.

Dual Special Needs Plan
A special kind of Medicare Advantage plan that combines your Medicare Part A and Part B benefits with your Medicare Part D prescription drug coverage. This plan coordinates with your Medicaid plan and provides extra health benefits not provided by either Medicare or Medicaid. See page 19.

Extra Help
A program that helps eligible people pay for some or all of their Medicare Part D premiums, deductibles and copays. See pages 9, 25.

Formulary
A list of covered prescription drugs. Each plan decides what drugs will be on its formulary. See page 23.

Generic drug
A type of prescription drug that doesn’t have a trademarked name but has the same active ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs. See page 20.

Group retiree health coverage
Offered by some former employers, unions or trusts to provide their Medicare-eligible retirees additional health and/or drug coverage as part of their retiree benefits package.

Guaranteed renewable policy
A feature of all Medicare supplement insurance plans that guarantees that you can keep the plan each year as long as you pay your premium and don’t commit fraud against the insurance company.

Health Maintenance Organization plan (HMO)
A type of Medicare Advantage plan that provides care through a network of doctors and hospitals. If you get care outside the network, you will be responsible for the cost of your care in most cases. Exceptions include emergency care, urgent care and renal dialysis.
See page 18.

Home health care
Skilled nursing care and therapy provided to those who are homebound on a part-time or intermittent basis.

Hospice care
Care provided to those who are terminally ill. Hospice care typically focuses on controlling symptoms and managing pain. See page 10.

Initial Enrollment Period (IEP)
A 7-month time period when you first become eligible and may sign up for Medicare. See page 34.

Inpatient care
Care that you receive after you are admitted to a hospital or skilled nursing facility for an inpatient stay. See page 7.

Late enrollment penalty
The additional amount added to your premium if you enroll outside set enrollment periods. Part A, Part B and Part D may charge late enrollment penalties.
See pages 14, 25.

Lifetime reserve days
An additional 60 days of inpatient care that Medicare Part A will cover if you are in the hospital longer than 90 days in one benefit period. Each lifetime reserve day may be used only once. Days may be applied to different benefit periods. See page 11.

Medicaid
A joint federal and state program that helps pay health care costs for individuals and families with low incomes and few assets. See page 9.

Medical Savings Account plan
A type of Medicare Advantage plan that combines a high-deductible health plan with a self-directed bank savings account. Funds in the account may be used tax-free to pay qualified medical expenses. See page 19.

Medically necessary care
Health care services or supplies that Medicare considers necessary to treat a medical condition.

Medicare
A federal health insurance program for U.S. citizens and legal residents 65 or older and others under 65 with a qualifying disability or medical condition. See page 4.

Medicare Part A
The part of Original Medicare that helps pay for the cost of hospital stays, skilled nursing services following a hospital stay and some other kinds of skilled care. See page 10.

Medicare Part B
The part of Original Medicare that helps pay for the cost of provider visits and other medical services that don't involve overnight hospital stays. See page 12.

Medicare Part C (Medicare Advantage)
A private insurance plan that provides Medicare Part A and Part B benefits plus additional coverage. Most also include Part D drug coverage. Plans are offered by Medicare-approved insurance companies as an alternative to Original Medicare. See page 16.

Medicare Part D
The part of Medicare that helps pay for the cost of prescription drugs. You can get Medicare Part D coverage as a standalone prescription drug plan or as part of a Medicare Advantage plan. See page 20.

Medicare Advantage Open Enrollment Period (MA OEP)
A yearly time period, January 1 to March 31, during which you may change or drop a Medicare Advantage plan. See page 37.

Medicare-approved amount
The amount Medicare says a provider who accepts assignment can be paid for a covered medical service. Medicare pays part of this amount, and you pay the rest. See also: accept assignment.

Medicare Annual Enrollment Period (AEP)
The period of time from October 15 to December 7 each year when you may join, drop or switch a Medicare Advantage plan or Medicare Part D prescription drug plan. See page 37.

Medicare Savings Programs
Federal financial assistance programs that help eligible people pay some or all of their Medicare premiums and deductibles. See pages 9, 51.

Medicare Supplement (Medigap) insurance plan
A type of insurance that helps pay for some of the out-of-pocket costs not paid by Original Medicare. Plans are sold by private insurance companies. See page 26.

Medicare Supplement Open Enrollment Period
The first 6 months you are enrolled in Medicare Part B at age 65 or older. During this time, you do not have to answer medical questions and cannot be denied coverage or charged a higher premium due to health problems. (Insurance companies will also require you to be enrolled in Part A to get a Medicare Supplement insurance plan.) See page 30.

Network
A group of health care providers, such as doctors, hospitals or pharmacies, that agree to provide care or services to members of a certain health care plan at agreed upon rates. See page 17.

Out-of-network
A health care provider, pharmacy or service not included in your plan's designated network (see above) that may result in extra costs. See page 17.

Out-of-pocket maximum
The most you could pay during a plan period (usually a calendar year) for covered health care services, if you have a Medicare Advantage plan. This amount does not include premium payments, prescription drug costs or the cost of extra services offered by your plan, such as routine vision or dental services. See page 17.

Outpatient care
Care provided to a patient who is not admitted to a hospital or skilled nursing facility. See page 7.

PACE
An acronym for Program of All Inclusive Care for the Elderly. PACE provides medical, social and long-term care services to help frail older adults live in their communities rather than in nursing homes or other long-term care facilities.

Point of Service plan (POS)
A type of Medicare Advantage HMO plan that helps pay for certain covered services received outside the provider network. You usually pay more for out-of-network care. See page 18.

Pre-existing condition
A medical condition you have when you are applying for an insurance policy.

Preferred Provider Organization (PPO)
A type of Medicare Advantage plan that allows you to see doctors and hospitals within or outside the plan's network. You will usually pay a larger share of the cost for care received outside the network. See page 18.

Premium
A fixed amount you pay for Medicare coverage. You may pay the premium to Medicare, your Medicare plan or both, depending on your coverage. Most premiums are charged monthly.

Preventive care
Medical care that is designed to keep you healthy or to find illnesses early, when treatment may be more effective. Examples of preventive care include diabetes screenings, flu shots and mammograms.

Prior Authorization
Prior Authorization means the plan needs more information from your health care provider before covering the drug. See page 23.

Private Fee-For-Service (PFFS) plan
A type of Medicare Advantage plan that allows you to use any provider or hospital that accepts Medicare and agrees to the plan's terms and conditions of payment. See page 19.

Provider
A person or organization that provides health care services, such as a doctor, hospital, pharmacy, laboratory or outpatient clinic.

Quantity Limit
Quantity Limit means the plan will cover only a certain amount of the drug over a period of time. See page 23.

Service area
The geographic area in which a Medicare Advantage or Part D plan operates. Plan members must live in the plan's service area. See page 18.

Skilled nursing care
Care provided by a licensed nurse.

Special Needs Plan (SNP)
A type of Medicare Advantage plan designed for people who have special health care needs. See page 19.

Step therapy
Step Therapy means your plan may require you to first try other prescriptions that treat the same medical condition. See page 23.

Tiered formulary
A drug list organized into groups based on cost. For example, a generic drug may be on a lower tier and have a lower copay than a brand name version of the drug.

We hope this helped and you find a plan that fits your needs.

Scan the QR code above to hear **8 Medicare Quick Tips** designed to help you get started on your Medicare journey

Want to learn more?

Visit **medicaremadeclear.com**

How to scan a QR code:

Step 1: Open your smartphone camera app
Step 2: Point your camera at the QR code
Step 3: Tap the link

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