1. Module 1: Overview Medicare Program Basics

2. Navigation Instructions

3. Terms and Conditions

The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

4. Learning Objectives

After reviewing "Module 1: Medicare Program Basics" you will be able to explain:

- The different ways to get Medicare benefits
- Eligibility for Part A and Part B
- New special enrollment periods for Medicare
- What is covered under Part A and Part B
- Original Medicare premiums
- Help for beneficiaries with limited income
- Original Medicare beneficiary protections
- Combining Original Medicare and Part D
- Medigap coverage

5. Training Roadmap: Module I

- Medicare Program Basics
- Original Medicare: Eligibility, Enrollment, Entitlement, and Premiums
- Help for Individuals with Limited Income
- Medicare Part A Benefits and Original Medicare Cost Sharing
- Medicare Part B
- Original Medicare
- Medigap Coverage

6. Title Page – Medicare Program Basics

7. Medicare Basics

- Medicare is the Federal health insurance program for individuals who are aged (65 and over) and younger individuals who have certain health conditions or are disabled.
- Medicare eligibility does not take into consideration an individual's income. However,
    - individuals may pay higher premiums based on income, and
    - low-income individuals may be eligible for additional assistance.
- Individuals can receive their Medicare medical coverage:
    - directly from the Federal Government, which pays for services on a fee-for-service basis (this program is known as "Original Medicare" or "Fee-for-Service Medicare"); or
    - through a private health plan.
- Individuals must receive their Medicare Part D outpatient drug benefits through a private health plan (even if they get their medical coverage through Original Medicare).

8. Overview of Medicare Benefits and Coverage -- Parts A, B, C, and D

- Medicare coverage is often known by the part of Medicare law under which it is authorized or regulated.
    - Part A is referred to as "Hospital Insurance Benefits." Part A also covers other inpatient care, including skilled nursing facilities, rehabilitation facilities, and hospice.
    - Part B is referred to as "Supplementary Medical Insurance Benefits." Part B covers a broad range of outpatient services such as physician care, and drugs that are administered by physicians or other health care professionals (such as certain vaccines and intravenous medications).
    - Part C regulates and authorizes Medicare Advantage plans, which must cover Part A (except for hospice) and Part B benefits.
        - Individuals enrolled in a Part C plan still get hospice benefits, but they are paid for by Original Medicare.
    - Part D covers prescription drug benefits (for self-administered drugs, such as those picked up at a pharmacy and taken at home) and regulates Medicare prescription drug plans.

9. Overview of Medicare – Part E

There is also a lesser-known Part E of Medicare law that regulates other miscellaneous programs including:

- Medicare cost plans (which also cover Part A and Part B benefits)
    - Medicare cost plans are only offered in a limited number of states and are most frequently found in rural areas.
- Medicare supplemental insurance (Medigap Plans)
- The program for all-inclusive care for the elderly (PACE)

10. Different Ways to Get Medicare

There are different ways that beneficiaries can choose to receive their Medicare coverage.

- Original Medicare (Part A and Part B coverage)
    - Can be combined with a Medicare Supplement Plan and/or a Medicare Prescription Drug Plan.
- Medicare Advantage Plans (Medicare Part C health plans, with or without Part D benefits)
- Medicare Prescription Drug Plans
- Medicare Cost Plans
- PACE Plans
- Medicare-Medicaid Plans

11. Different Ways to Get Medicare – Brief Overview

WAYS TO GET MEDICARE COVERAGE[1]				
COVERAGE TYPE	**BENEFITS**			
	Part A and B benefits	**Some of the cost sharing for Part A and B Benefits**	**Part D Benefits**	**Other benefits**
Original Medicare[3]	X			
Part C (Medicare Advantage)[4]	X	X	May cover depending on plan	X (most offer additional benefits)
Cost Plans [2,3]	X	X	May cover depending on plan	X (most offer additional benefits)
Medicare Prescription Drug Plans (PDPs)			X	
Original Medicare with a supplemental plan (Medigap)[3]	X (Original Medicare)	X (Medigap)		Some Medigap Plans cover foreign travel emergencies
PACE plans[2]	X	X	X	X (Adult day center, some meals, other benefits)
Medicare-Medicaid Plans[2]	X	X	X	X Integrates Medicaid benefits with Medicare benefits

[1] Brief overview. As detailed later, some ways can be combined and not all beneficiaries are eligible for all types of coverage.

[2] These types of plans are generally limited to certain geographic areas and are not available everywhere.
[3] These plans can be combined with coverage under a PDP.
[4] As discussed later, a few MA plan types (PFFS and MSAs) can be combined with coverage under a PDP.

12. Title Page – Original Medicare: Eligibility, Enrollment, Entitlement, and Premiums

13. Original Medicare

- Original Medicare covers only Part A and Part B benefits
    - Part A benefits include inpatient hospital, skilled nursing facility, hospice, and home health services
    - Part B benefits include outpatient and professional services such as those provided by a doctor (or non-physician professional such as a nurse practitioner or physician assistant), clinical lab services, durable medical equipment, preventive services, and other outpatient medical services

14. Eligibility for Part A and Part B

To be eligible for Medicare Part A and Part B, an individual must:

(1) Be age 65 or older, or be under age 65 with certain disabilities or health conditions, including:

- all who get disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.
- individuals with Amyotrophic Lateral Sclerosis (ALS), often referred to as Lou Gehrig's Disease or have an end-stage renal disease (ESRD).

(2) Be a U.S. resident; and

- be either a U.S. citizen, or
- be an alien who has been lawfully admitted for permanent residence and has been residing in the United States for 5 continuous years before the month of applying for Medicare.

15. Medicare Enrollment – Parts A and B

Some people are automatically enrolled in Parts A and B:

- Subject to the Part B exception below for Puerto Rico:
    - Individuals who are already getting benefits from Social Security or the Railroad Retirement Board (RRB) will automatically be enrolled in Part A and Part B starting the first day of the month they turn 65. (If their birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.) These individuals are also allowed to refuse Part B coverage. (See Medicare Part B for the potential consequences of refusing Part B).
    - Individuals with disabilities who are under age 65 are automatically enrolled in Parts A and B the month after they have received Social Security or Railroad Retirement disability benefits for 24 months. However, they have an opportunity to refuse Part B coverage.

    - Individuals with ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) get Part A and Part B automatically the month their Social Security disability benefits begin.
- Individuals living in Puerto Rico are not automatically enrolled in Part B. They must sign up for it.

16. Medicare Enrollment – Parts A and B, continued

Other individuals will have to sign up if they want to be enrolled in Parts A and/or B.

- Individuals who are close to 65 but are not getting benefits from Social Security or the Railroad Retirement Board (RRB) may sign up for Parts A and B during their **initial enrollment period**, which begins 3 months before their 65th birthday, including the month they turn 65 and ends 3 months after. (See Medicare Part B for the potential consequences of failing to sign up for Part B when first eligible).
- Individuals with end-stage renal disease (ESRD) may sign up for Medicare at any time. However, the date on which their Medicare coverage begins is usually on the fourth month after dialysis treatments begin but may be earlier if certain conditions are met.
- Individuals eligible for Premium-free Part A can also sign up for Part A any time after they turn 65. Their Part A coverage starts 6 months back from when they sign up but cannot start earlier than the month they turned 65. If they have not signed up by the time they apply for Social Security, they will automatically be signed up (and coverage will be retroactive for 6 months).

17. Enrollment Effective Date for Individuals During their Initial Enrollment Period

- If an individual enrolls during any of the first three months of their Initial Enrollment Period (IEP), their coverage will start the first month of eligibility (e.g., age 65).
- If an individual enrolls during their IEP in the month they become eligible, coverage will start the month after they enroll. Premium free-Part A coverage will be retroactive to the month they turned 65.
- If an individual enrolls during any of the last three months of their IEP, their coverage will start the month after they enroll. Premium free-Part A coverage will be retroactive to the month they turned 65.

18. Parts A and B After the Initial Enrollment Period

- Individuals who do not enroll in Part B (or Part A if they have to buy it) when they are first eligible, can enroll during a **General Enrollment Period** (GEP) each year from January 1 – March 31.
    - Coverage begins the first day of the month following the month in which the beneficiary enrolls.
- Individuals who have group health plan coverage based on their current employment or the employment of a spouse may enroll in Part A (if they have to buy it) and/or Part B anytime while covered under the group health plan or during a **Special Enrollment Period** that occurs during the 8-month period immediately following the last month they have group coverage.
- Individuals who are eligible for premium-free Part A may sign up at any time.

19. New Special Enrollment Periods (SEPs) for 2023 and Beyond

The new SEPs for enrollment in Part B and Part A if an individual is not eligible for premium-free Part A, apply to:

- Individuals impacted by an emergency or disaster - allows eligible individuals or their authorized representatives who missed an enrollment opportunity because they were impacted by a disaster or other emergency as declared by a Federal, state, or local government entity to enroll the individual up to six months after the end of the emergency declaration.
- Individuals impacted by a health plan or employer error – applies where an eligible individual can demonstrate that their employer or health plan (including brokers or agents of plans) materially misrepresented information related to enrolling in Medicare premium Part A timely. The individual may enroll up to six months after the individual notifies Social Security of the error.
- Formerly incarcerated individuals – allows eligible individuals to enroll following their release from correctional facilities up to 12 months post-release. Such individuals may choose between retroactive coverage back to their release date (not to exceed 6 months) or coverage beginning the month after the month of enrollment. If an individual selects retroactive coverage, they must pay the premiums for the retroactive covered time period.

20. New Special Enrollment Periods (SEPs) for 2023 and Beyond, continued

- Individuals whose Medicaid coverage is terminated -- allows eligible individuals who have missed a Medicare enrollment period to enroll in Medicare after termination of Medicaid eligibility for up to 6 months. Such individuals may choose between retroactive coverage back to the date of termination from Medicaid (but no earlier than January 1, 2023) or coverage beginning the month after the month of enrollment. If an individual selects retroactive coverage, they must pay the premiums for the retroactive covered time period.
- Individuals with other exceptional conditions – allows CMS, on a case-by-case basis, to grant a 6-month SEP to an individual when circumstances beyond the individual's control prevented them from enrolling during the IEP, GEP or other SEPs.

21. Medicare Part A Entitlement and Part B Enrollment

An individual is entitled to Part A if they are eligible for premium-free Part A or if the individual has enrolled in Part A and continues to pay the premium (or have the premium paid on their behalf).

For an individual to enroll in Part B and remain enrolled in Part B, the individual must pay the Part B premium (or have the premium paid on their behalf).

22. Other Ways to get Medicare - Eligibility Overview

To get Medicare benefits other than through Original Medicare, beneficiaries must meet certain eligibility criteria.

Part C[1]	Part D	Cost Plans	Medicare-Medicaid Plans	PACE Plans
Individuals must: ○ be entitled to Part A and enrolled in Part B; and ○ reside in the MA plan's service area.	Individuals must: ○ be entitled to Part A and/or enrolled in Part B; and ○ reside in the Part D plan's service area.	Individuals must: ○ be entitled to Part A and/or enrolled in Part B (if they are not entitled to Part A, they will not have coverage of Part A benefits under the cost plan); and ○ reside in the cost plan's service area.	Individuals must: ○ be eligible for both Medicare and Medicaid; ○ meet eligibility requirements specific to the state; and ○ reside in the plan's service area.	Individuals must: ○ Be age 55 or older; ○ be certified as eligible for nursing home care by their state; ○ be able to live safely in a community setting at the time of enrollment; ○ reside in the PACE organization's service area; ○ Meet any additional program-specific eligibility conditions imposed under the plan's PACE Program Agreement

[1] Note that certain types of Part C plans such as Medical Saving Account plans and Special Needs Plans have additional eligibility requirements.

23. Eligibility – Individuals with ESRD

Individuals eligible based on ESRD generally lose eligibility 36 months after the month in which the individual receives a kidney transplant, unless the individual is eligible for Medicare on another basis, such as age or disability. However, beginning in 2023, such individuals may remain enrolled in Part B only but solely for coverage of immunosuppressive drugs if they have no other health care coverage that would cover the drugs.

24. Medicare Premiums– Part A

Most individuals are entitled to Part A without paying a premium.

- For individuals age 65 or older to be entitled to premium-free Part A, the individual or their spouse must have worked and paid Medicare taxes for at least 10 years; or
- All individuals eligible for Medicare due to a disability, End-Stage Renal Disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS) are eligible for premium-free Part A.

For those individuals who do not automatically qualify for premium-free Part A coverage, the monthly Part A premium in 2023 is:

- $506, for individuals or their spouses who paid Medicare taxes for less than 30 quarters.
- $278, for individuals or their spouses who paid Medicare taxes for 30-39 quarters.

- Individuals who are not eligible for premium-free Part A and those who don't buy Part A when they are first eligible may pay a late penalty of up to 10% unless they enroll during a special enrollment period. (They will have to pay the higher premium for twice the number of years they could have had Part A but did not sign up.)

25. Medicare Premiums for Part B

Beneficiaries enrolled in Part B must pay a monthly premium.

- In 2023, the standard monthly premium for Part B is $164.90. Most people pay the standard monthly premium. However, some people pay more based on their income (as reported to the IRS two years prior in 2021).

26. Medicare Premiums for Part B and the IRMAA

- Individuals with incomes in 2021 over $97,000 or filing jointly with incomes over $194,000, pay more in 2023, up to $560.50 a month, based on the income-related monthly adjustment amount (IRMAA).

Individual tax return	Joint tax return	2021 Part B premium
< $97,000	<$194,000	$164.90
>$97,000 to $123,000	>$194,000 to $246,000	$230.80
>$123,000 to $153,000	>$246,000 to $306,000	$329.70
>$153,000 to $183,000	>$306,000 to $366,000	$428.60
>$183,000 and less than $500,000	>$366,000 and less than $750,000	$527.50
= or > $500,000	= or > $750,000	$560.50

* There are separate standards for beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses

27. Medicare Premiums for Part B: Payment Mechanisms and Penalties

- Part B premiums may be deducted from Social Security checks, Railroad Retirement checks, or Office of Personnel Management (civil service annuity) checks. If an individual does not get these checks, they will get a premium bill from Medicare every 3 months.
- Employers may pay monthly Part B premiums on behalf of retirees.
- For individuals who do not enroll in Part B when first eligible, the Part B premium is increased 10% for each full 12-month period the beneficiary could have had Part B but did not enroll. This is known as a “late enrollment penalty.”

Exception from Penalty: Individuals who have group health plan coverage based on their current employment or the employment of a spouse are not subject to the premium increase penalty if they enroll in Part B anytime while covered under the group health plan or during the special enrollment period that occurs during the 8-month period immediately following the last month they have group coverage. In addition, individuals enrolling during any other SEP are not subject to the penalty.

28. Medicare Premiums for Part B – Examples

Example: Ms. Klein plans on retiring in March. She is 72 years old but has never enrolled in Part B coverage because she has employer group coverage for a minimal monthly contribution. She will lose her group coverage upon her retirement. Ms. Klein has until November to enroll in Medicare Part B without incurring a late penalty.

Example: Mr. O'Hare, who is 70 and does not have Part B, is retired, but he has health coverage through his wife's current employer. If Mr. O'Hare decides to get Part B while the group coverage is in effect or within 8 months after his last month of group coverage, he can do so without incurring a late enrollment penalty.

29. Title Page - Help for Individuals with Limited Income

30. Help for Individuals with Limited Income/Resources

- Beneficiaries may qualify for help to pay the Medicare Part A (if any) and Part B premium, the Part A and Part B deductibles and cost-sharing, and/or some Part D prescription drug costs.
- Beneficiaries may qualify for the following programs by applying to the State Medicaid office:
    - Medicare Savings Program: help paying for the Medicare Part A and Part B premiums and, in some cases, deductibles and cost-sharing.
        - The "Qualified Medicare Beneficiary" program is one type of Medicare Savings Program. Qualified Medicare Beneficiaries enrolled in Medicare Advantage plans also get help with their Medicare Advantage cost-sharing amounts.
    - Part D low-income subsidy (also known as "Extra Help"): help paying for prescription drug coverage. Persons interested in Part D help only may also call the Social Security Administration (SSA) at 1-800-772-1213 or apply online at www.ssa.gov/prescriptionhelp. Extra help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa.
        - Persons who do not qualify for the Part D low-income subsidy but are of limited means may qualify for help in paying Part D drug costs through a State's Pharmaceutical Assistance Program.
    - Medicaid: help with health care costs not covered by Medicare, such as custodial/long term care.

31. Assisting Individuals with Limited Income/Resources

- Beneficiaries with limited income and resources should be encouraged to apply to their State Medicaid office to determine eligibility for various (Federal or State) programs.

- Agents should tell beneficiaries who may be eligible to call or visit their Medicaid office and ask for information on Medicare Savings Programs. To get the phone number for the state, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) or contact the State Health Insurance Assistance Program (SHIP).

32. Title Page - Medicare Part A Benefits and Original Medicare Cost Sharing

33. Medicare Part A Benefits

- Part A provides coverage for:
    - Inpatient hospital care (including care provided by acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
    - Skilled nursing and rehabilitation care up to 100 days, but only after a three-day hospital stay (Medicare Advantage plans may waive the 3-day stay requirement)
    - Blood
    - Hospice care
    - Up to 100 days of home health care after an individual is in a hospital or skilled nursing facility (SNF) (Note that Part B covers home health care without the prior hospital or SNF stay if Part B conditions are met)
    - Inpatient psychiatric care (up to 190 lifetime days)

34. Medicare Part A – Original Medicare Cost-Sharing for Inpatient Hospital Care

In 2023, beneficiaries pay the following amounts for inpatient hospital care covered under Original Medicare:

- $1,600 deductible for each benefit period
    - A benefit period begins the day an individual is admitted to a hospital or skilled nursing facility (SNF) and ends when an individual has not received hospital or SNF care for 60 days in a row.
- Days 1–60: $0 after you pay your Part A deductible
- Days 61–90: $400 copayment per day of each benefit period
- Days 91 and beyond: $800 copayment per each "lifetime reserve day" after day 90 for each benefit period
    - Lifetime reserve days are days a beneficiary may use after they have been in an inpatient hospital for 90 days. A beneficiary has 60 such days to use in their lifetime.
- Beyond lifetime reserve days: all costs

35. Medicare Part A – Original Medicare Cost-Sharing for Skilled Nursing and Rehabilitative Care

In 2023 beneficiaries pay the following amounts for skilled nursing and rehabilitative care covered under Original Medicare:

- Days 1-20: $0 for each benefit period (as defined by Medicare)
- Days 21-100: $200.00 copayment per day of each benefit period
- Days 101 and beyond: all costs

36. Title Page - Medicare Part B

37. Medicare Part B Benefits

Part B generally covers:

- Physician and other health care professional services
- Outpatient hospital services
- Clinical lab and diagnostic tests, such as X-rays, MRIs, CT scans
- Durable medical equipment
- Home health care that is not covered under Part A (because the individual was not in a hospital or SNF or has exceeded 100 days)
- Physical and occupational therapy
- Ambulatory surgical center services
- Chemotherapy provided on an outpatient basis

38. Other Part B Items and Services

- Ambulance services
- Chiropractic services – for limited situations
- Opioid use disorder treatment
- E-visits
- Diabetic supplies
- Kidney dialysis
- Outpatient mental health care (limits apply)
- Certain telehealth services (During the COVID-19 public health emergency and for five months after, telehealth services are covered any location in the U.S. including the home).
- Continuous Positive Airway Pressure (CPAP) devices

39. Medicare Part B – Original Medicare Cost Sharing

In 2023, beneficiaries pay the following amounts for Part B services covered under Original Medicare:

- A $226 annual deductible. The deductible does not apply to certain Part B covered preventive services.
- After the deductible is satisfied, beneficiaries typically pay 20% of the Medicare-approved cost for Part B covered services.

40. Medicare Part B Benefits - Preventive Services and Screenings

Beneficiaries covered under Original Medicare and Medicare Advantage plans will have no cost-sharing for most preventive services. Preventive services and screenings include, but are not limited to:

- One-time “Welcome to Medicare” physical
- Annual wellness visit after 12 months enrolled in Part B and annually thereafter

- Vaccines – pneumococcal, hepatitis B, annual flu shot, COVID (including boosters) (Note: certain vaccines, such as shingles shots are covered under Part D, not Part B)
- Bone mass measurement – every 24 months for certain conditions or meets certain criteria
- Pap test and pelvic exam - every 24 months for all women; every 12 months for those at risk
- Diabetes self-management training – for persons with diabetes
- Smoking and tobacco-use cessation counseling – for any illness related to tobacco use
- Glaucoma testing – once per year for those at high risk
- Mammogram (Breast Cancer Screening) – annual screening for most women
- Depression Screening – every 12 months
- Colorectal cancer screening
- Diabetes screenings – up to two per year for those with risk factors
- Prostate cancer screening – every 12 months for men over age 50

41. Not Covered by Medicare Part A & B

- Most dental care (however, Original Medicare may pay for some dental services before, or as part of, certain related medical procedures (like before certain cardiac or organ transplant procedures).
- Cosmetic surgery
- Custodial/long term care
- Health care while traveling outside the US
- Hearing aids
- Outpatient prescription drugs (this is covered under Part D)
- Massage Therapy
- Eye exams for glasses
- Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)
- Covered items or services provided by a doctor or other provider who has opted out of Medicare (except in the case of an emergency or urgent need)

42. Title Page - Original Medicare

43. Original Medicare and Part D Prescription Drug Coverage

- A beneficiary in Original Medicare may receive Part D prescription drug coverage through a stand-alone prescription drug plan (PDP).
- Generally, except for those dually eligible for Medicare and Medicaid, Medicare beneficiaries must actively select a Part D plan.
- Beneficiaries who enroll in Part D typically pay a monthly premium, annual deductible, and per-prescription cost-sharing.
- In selecting a Part D plan, beneficiaries should consider expected premiums and cost sharing, formulary, and network pharmacies.

44. Appeals related to Original Medicare Part A and Part B Coverage and Payment Determinations

Beneficiaries receiving their Part A and/or Part B services through Original Medicare have a right to appeal Medicare coverage and payment decisions.

- Beneficiaries should look at their "Medicare Summary Notice" (MSN).
- The MSN shows the Part A and Part B services and supplies that providers and suppliers billed to Medicare on their behalf.
- The MSN also shows what Medicare paid on the beneficiary's behalf and what the beneficiary may owe the provider. The MSN also shows if Medicare has fully or partially denied their medical claim.
- Beneficiaries can also track their Medicare claims or view electronic MSNs by visiting MyMedicare.gov.
- Beneficiaries must file an appeal related to Part A or B services within 120 days of the date they get the MSN in the mail. The appeal should be sent to the Medicare Administrative Contractor (MAC) that processed their claim (indicated on the MSN). Instructions for filing an appeal can be found on Medicare.gov.
- If a beneficiary disagrees with the MAC's decision on the appeal, they have 180 days after getting the decision notice to request a reconsideration by a Qualified Independent Contractor (QIC).
- Additional levels of appeal may also be available, depending on the amount in controversy.

45. Fast appeals under Original Medicare for Certain Services

- Beneficiaries receiving their Part A and/or Part B services through Original Medicare have a right to a fast appeal if they believe certain Medicare-covered services are ending too soon.
- This includes services provided by a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice.
- Their provider will give them written notice before the end of their services. The notice tells them how to ask for a fast appeal.

46. Grievances under Original Medicare

Beneficiaries may also file complaints about their Medicare providers or the quality of care they received. For example, a beneficiary may have a complaint about:

- unprofessional conduct by a provider
- improper care
- unsafe conditions
- abuse by a provider
- long waiting times or unclean conditions

Instructions for filing grievances can be found at: https://www.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance

47. Additional Beneficiary Protections under Original Medicare

- Medicare operates a 24-hour helpline at 1-800-Medicare. (TTY users should call **1-877-486-2048**.)
    - Beneficiaries can use this number to find out about their claim status, coverage and benefits, premium payments, or to ask other questions about Medicare.
- Beneficiaries can also get assistance with Medicare, including help filing an appeal or grievance, through their local State Health Insurance Assistance Program (SHIP).
    - Contact information for their SHIP can be found at https://www.shiptacenter.org/

48. For More Information about Medicare

- Centers for Medicare & Medicaid Services (technical information) www.cms.gov
- Medicare (beneficiary audience) www.medicare.gov
- Medicare & You Handbook https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf
- Your Medicare Benefits handbook https://www.medicare.gov/Pubs/pdf/10116-your-medicare-benefits.pdf

49. Title Page: Medigap Coverage

50. Medigap (Medicare Supplement Insurance)

Medigap insurance:

- Works only with Original Medicare.
- Is sold by private insurance companies to fill “gaps” in Original Medicare coverage, such as all or part of the deductibles or coinsurance amounts.
- It coordinates with Original Medicare coverage.
- Some Medigap policies cover limited benefits not covered by Part A or Part B of Original Medicare, such as extra days of coverage for inpatient hospital care or foreign travel emergency care. Generally, Medigap doesn’t cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

51. Medigap is NOT

- Medigap is NOT a Medicare Advantage (Part C) plan or other Medicare health plan.
- Medigap is NOT original Medicare. Medigap supplements Original Medicare benefits only.
- In addition,
    - A Medigap plan cannot be used with a Medicare Advantage health plan.
    - It is illegal to sell a Medigap plan to someone already in a Medicare Advantage health plan.

52. Further Information on Medigap (Medicare Supplement Insurance)

- Medigap policies are available in standardized benefit plans, identified by certain letters between A and N (however, different plans are offered in Massachusetts, Minnesota, and Wisconsin).

- Turning age 65 and signing up for Part B triggers a six-month Medigap open enrollment period when Medigap insurers must issue you a policy, regardless of any pre-existing conditions. This is called a guaranteed issue right.
- In certain limited instances, leaving a Medicare Advantage plan may trigger a guaranteed issue right. Some states have additional guaranteed issue periods for Medicare beneficiaries. Agents should look into state-specific Medigap laws.

53. Medigap Coverage

All Medigap plans pay for some or all of the following costs:

- Part A coinsurance
- Coverage for 365 additional hospital days when Medicare coverage for hospitalization ends
- Part B coinsurance or copayment
- Blood (First 3 pints)
- Hospice care coinsurance or copayment

54. Beneficiaries with Medigap Plans with/without Drug Coverage

- Medigap plans H, I, and J offer non-Medicare drug coverage. These plans could no longer be sold as of January 1, 2006. However, some beneficiaries may have decided to keep their H, I, or J policy with the drug coverage they had before January 1, 2006.
- Individuals who are enrolled in Medigap plans may only obtain Medicare drug coverage (Part D) through a stand-alone prescription drug plan.
- To enroll in Part D, individuals who have Medigap plans H, I or J may:
    - keep their Medigap coverage with the drug portion of the coverage removed and enroll in a Part D PDP plan; or
    - drop their Medigap coverage and enroll in an MA-PD or other health plans with a PDP.

55. Beneficiaries with Medigap Drug Coverage – Creditable Coverage

- Non-Medicare insurers (including Medigap plans) are required to notify beneficiaries annually whether or not the prescription drug coverage they have is creditable (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay).
- All beneficiaries who do not maintain creditable coverage must pay a Part D late enrollment penalty if they wish to enroll in Part D unless they qualify for 'Extra Help" or enroll in Part D during the special enrollment period for loss of creditable coverage (discussed later).
- Beneficiaries who previously had creditable coverage and are informed that their non-Medicare drug coverage is no longer creditable will have a special enrollment period to enroll in a Part D plan without the obligation to pay a Part D late enrollment penalty.

56. Medigap rules for individuals who became eligible for Medicare after December 31, 2019

- Individuals who attained age 65 on or after January 1, 2020, or first become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020, may not purchase a Medigap plan that pays the Part B deductible (generally plans C, F or high deductible F, but the prohibition also applies in waiver states with non-standard packages).
- Individuals previously enrolled in plans that cover the Part B deductible may remain enrolled in those plans.
- Individuals who became eligible for Medicare before 2020 may enroll in plans that cover the Part B deductible.

57. Medigap Plans

Plans available to all beneficiaries									Plans available only to beneficiaries eligible before 2020	
Medigap Benefits	A	B	D	G[4]	K[3]	L[3]	M	N	C	F[1]
Part A Coinsurance and Hospital Benefits	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B Coinsurance or Copayment	100%	100%	100%	100%	50%	75%	100%	100%[2]	100%	100%
Blood (First 3 pints)	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
Part A Hospice Care Coinsurance/ Copayment	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
Skilled Nursing Facility Care Coinsurance			100%	100%	50%	75%	100%	100%	100%	100%

1. Plan F also offers a high-deductible plan that is only available to individuals eligible for Medicare before January 1, 2020. In 2023, a policyholder pays $2,700 before the Medigap policy pays anything.
2. Plan N has a copayment of up to $20 for physician office visits and up to $50 for emergency room visits (waived in certain circumstances).
3. Plans K and L pay 100% after out-of-pocket limit is reached. In 2023 the out-of-pocket limits for Plan K and Plan L are-$6,940 and $3,470, respectively.
4. There is a high deductible version of Plan G. The deductible for 2023 is $2,700.

58. Medigap Plans, continued

Plans available to all beneficiaries									Plans available only to beneficiaries eligible before 2020	
Medigap Benefits	A	B	D	G[4]	K[3]	L[3]	M	N	C	F[1]
Medicare Part A Deductible		100%	100%	100%	50%	75%	50%	100%	100%	100%
Medicare Part B Deductible									100%	100%
Medicare Part B Excess Charges				100%						100%
Foreign Travel Emergency (up to plan limits)[2]			80%	80%			80%	80%	80%	80%

1. Plan F also has a high-deductible option. In 2022, a policyholder pays $2,490 before the Medigap policy pays anything. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. However, high deductible Plan F counts payment of the Medicare Part B deductible toward meeting the plan deductible.
2. The foreign travel benefit pays 80% of charges after a $250 deductible, up to a $50,000 lifetime maximum.
3. Plans K and L pay 100% after out-of-pocket limit is reached. In 2022 the out-of-pocket limits for Plan K and Plan L are-$6,620 and $3,310, respectively.
4. There is a high deductible version of Plan G. The deductible for 2022 is $2,490.

59. Medigap Plans – Case Study

Ms. Jackson just turned 65 and became eligible for Medicare this year. She is considering a Medigap plan. She says that she feels more comfortable paying a higher premium to avoid substantial cost-sharing each time she receives a service. The agent explains that Plans C and F, which cover 100 percent of the Part B deductible, are not available to her because she became eligible after January 1, 2020. However, Plans D, G, or N are most likely to fit the bill.

60. For More Information about Medigap

- Centers for Medicare & Medicaid Services: http://www.cms.gov/Medigap/
- 2023 Medicare & You Handbook: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf