1. Module 1: Overview: Medicare Program Basics

2. Navigation Instructions

3. Terms and Conditions

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
- 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
- When Medicare is the secondary payor to an employer group plan

5. Training Roadmap: Module I

- Medicare Program Basics
- Medicare: Eligibility, Enrollment, Entitlement, and Premiums
- Help for Individuals with Limited Income
- Medicare Part A Original Medicare Cost-Sharing
- Medicare Part B Original Medicare Cost-Sharing
- Original Medicare Beneficiary Protections
- Medigap Coverage
- Medicare Coordination with Employer Group Plans (GHPs)

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 serious 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. Medicare Background

- Medicare began as a fee-for-service program (now referred to as "Original Medicare") under which beneficiaries could receive their health care benefits from any Medicare provider and have the provider paid directly by the Federal government (through its administrative contractors).
- Medicare evolved to give beneficiaries the option of receiving their benefits and care through managed care plans that maintained contracts with networks of providers.
- Beginning in 2006, Medicare began providing coverage for outpatient prescription drugs through private health plans.

9. Overview of Medicare Benefits and Coverage

Medicare coverage is often known by the part of Medicare law under which it is authorized or regulated. Parts A and B define the basic Medicare benefits. These benefits are covered regardless of how an individual chooses to receive their Medicare benefits.

- Part A is referred to as "Hospital Insurance Benefits" but also covers other inpatient benefits and home health services.
- 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)

10. Overview of Medicare Benefits and Coverage- Part B

Part B is referred to as "Supplementary Medical Insurance Benefits." It covers a broad range of outpatient services.

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

11. Other Part B Items and Services

- Ambulance services
- Chiropractic services – for limited situations
- Opioid use disorder treatment
- Certain preventive health services such as vaccines, mammograms, and smoking cessation counseling (there is no cost-sharing for many services)
- Diabetic supplies
- Kidney dialysis
- Outpatient mental health care (limits apply)
- Virtual check-ins (using video and audio technology)
- Continuous Positive Airway Pressure (CPAP) devices

12. Overview of Medicare Benefits and Coverage- Part C

Part C regulates and authorizes Medicare Advantage plans. Medicare Advantage plans are private health plans that contract with the government to provide and administer Medicare benefits. Medicare Advantage plans must cover Part A (except for hospice) and Part B benefits. Medicare Advantage plans may also cover items and services not covered by Original Medicare.

- Individuals enrolled in a Part C plan still get hospice benefits, but Original Medicare pays for them.

13. Overview of Medicare Benefits and Coverage - Part D

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.

- Part D benefits are only offered through private health plans, including certain Medicare Advantage Plans, some Medicare Cost Plans, PACE plans, and stand-alone Medicare Prescription Drug Plans.

14. Overview of Medicare Benefits and Coverage – 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)

15. Different Ways to Get Medicare

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

- Original Medicare:
    - Original Medicare covers only Part A and Part B benefits
    - Under Original Medicare, beneficiaries can receive covered services from any physician or facility that accepts Medicare anywhere in the United States.
    - No referrals are required under Original Medicare.
    - Original Medicare has substantial deductibles and other cost sharing.
    - Original Medicare can optionally be combined with a Medicare Supplement Plan (Medigap) 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 (can be combined with a Medicare Prescription Drug Plan)
- PACE Plans

16. 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)

[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.

17. Title Page –Medicare Eligibility, Enrollment, Entitlement and Premiums

18. 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.

19. Eligibility – Individuals with ESRD

Individuals eligible for Medicare based on end-stage renal disease (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, 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.

20. 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.

21. Medicare Enrollment – Parts A and B

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 Part A/Part B **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 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 prior to when they signed 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).

22. Parts A and B After the Part A/Part B 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 **Part A/Part B 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 **Part A/Part B Special Enrollment Period** that occurs during the 8-month period immediately following the last month they have group coverage.
- Individuals eligible for premium-free Part A may sign up at any time.
- There are also Part A/Part B Special Enrollment periods that allow individuals to enroll after the Part A/Part B IEP due to issues such as emergencies or federally declared disasters in their area, release from incarceration, loss of Medicaid, health plan or employer error that caused them to miss the IEP or other exceptional conditions.

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

24. 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	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 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.

25. Medicare Premiums– Part A

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

- For individuals ages 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 2025 is:

  - $518, for individuals or their spouses who paid Medicare taxes for less than 30 quarters.
  - $285, 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.)

26. Medicare Premiums for Part B

Beneficiaries enrolled in Part B must pay a monthly premium.

- In 2025, the standard monthly premium for Part B is $185.00. 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 2023).

27. Medicare Premiums for Part B and the IRMAA

- Individuals with incomes in 2023 over $106,000 or filing jointly with incomes over $212,000, pay more in 2025, up to $628.90 a month, based on the income-related monthly adjustment amount (IRMAA).

Individual tax return	Joint tax return	2025 Part B premium
< $106,000	<$212,000	$185.00
>$106,000 to $133,000	>$206,000 to $266,000	$259.00
>$133,000 to $167,000	>$266,000 to $334,000	$370.00
>$167,000 to $200,000	>$334,000 to $400,000	$480.90
>$200,000 and less than $500,000	>$400,000 and less than $750,000	$591.90
= or > $500,000	= or > $750,000	$628.90

* 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

28. 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 by 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.

29. Medicare Premiums for Part B – Examples

Example: Ms. Welch just retired at the age of 72. She did not enroll in Part B when she was first eligible because she maintained employer group coverage while working. Ms. Welch can avoid the Part B penalty by enrolling within 8 months of the month her employer group insurance ends.

Example: Mr. Rawlings retired when he was 68. Before retirement, he was working part-time and was not eligible for employer group coverage. Instead, he maintained a disease-specific plan because cancer runs in his family. Mr. Rawlings did not enroll in Medicare Part B when he was first eligible because he thought his Part A and disease-specific policy offered enough coverage. However, he was recently diagnosed with diabetes and needs coverage for all his doctor and lab bills. Mr. Rawlings can enroll in Part B during the general election period but will have to pay the monthly Part B premium plus an additional 10 percent for each 12 month period since his initial enrollment period.

30. Title Page - Help for Individuals with Limited Income

31. Help for Individuals with Limited Income/Resources

- Certain beneficiaries with lower incomes and assets may qualify for help to pay the Medicare Part A and Part B premiums, the Part A and Part B deductibles and cost-sharing, and/or some Part D prescription drug costs.
- Beneficiaries may apply for the following programs through their 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 https://www.ssa.gov/medicare/part-d-extra-help. Extra help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa.
    - Medicaid: help with health care costs not covered by Medicare, such as custodial/long term care.

32. Help for Individuals with Limited Income/Resources

- 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.

- Agents should encourage beneficiaries with limited income and resources 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).

33. Title Page – Original Medicare Cost-Sharing

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

In 2025, beneficiaries pay the following amounts for inpatient hospital care covered under Original Medicare:

- $1,676 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: $419 copayment per day of each benefit period
- Days 91-150: $838 copayment per "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 2025, 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: $209.50 copayment per day of each benefit period
- Days 101 and beyond: all costs

36. Medicare Part B – Original Medicare Cost-Sharing

In 2025, beneficiaries pay the following amounts for Part B services covered under Original Medicare:

- A $257 annual deductible.
- After the deductible is satisfied, beneficiaries typically pay 20% of the Medicare-approved cost for Part B covered services.
- Beneficiaries have no cost-sharing for most preventive services.

37. Title Page - Original Medicare – Beneficiary Protections

38. 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 must file an appeal related to Part A or B services within 120 days of the date they get the Medicare Summary Notice (MSN) in the mail detailing their financial responsibility. The MSN will have instructions on where to send the appeal.
- Beneficiaries who believe their hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice services are ending too soon have a right to a fast appeal. Their provider will give them written notice before the end of their services. The notice tells them how to ask for a fast appeal. Beneficiaries must generally ask for a fast appeal no later than noon of the calendar day following receipt of the provider's notice of termination.
- If a beneficiary disagrees with the appeal decision, 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 of controversy.

39. 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

40. 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/

41. 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.

42. 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
- Medicare Getting Started https://www.medicare.gov/publications/11389-Medicare-Getting-Started.pdf

43. Title Page: Medigap Coverage

44. Medigap (Medicare Supplement Insurance)

Medigap insurance:

- Works only with Original Medicare. It is illegal to sell a Medigap plan to someone already in a Medicare Advantage health plan.
- Is sold by private insurance companies to fill “gaps” in Original Medicare coverage, such as all or part of the deductibles or coinsurance amounts.
- 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.

45. 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). States determine which standardized benefit plans may be offered in their state.
- Turning age 65 and signing up for Part B triggers a six-month Medigap open enrollment period when Medigap insurers must issue a beneficiary 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.
- Issuance and sales of Medigap plans are regulated by States, which have varying laws. For example, some states have additional guaranteed issue rights, specific requirements around

marketing Medigap plans, and requirements concerning commissions. Agents should familiarize themselves with their state's requirements for Medigap sales.

46. 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

47. 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 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.
    - If their Medigap policy lacks "creditable prescription drug coverage," the beneficiary may have to pay a late enrollment penalty. Having creditable coverage means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard drug coverage and gives the same value for your prescriptions as Part D.

48. 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.

49. 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 2	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. There is a high-deductible version of Plan F offered in some states that is only available to individuals eligible for Medicare before January 1, 2020. In 2025, a policyholder pays $2,870 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 2025, the out-of-pocket limits for Plan K and Plan L are $7,220 and $3,610, respectively.
4. There is a high deductible version of Plan G offered in some states. The deductible for 2025 is $2,870.

50. 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 some states. In 2025, a policyholder pays $2,870 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.
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 2025 the out-of-pocket limits for Plan K and Plan L are $7220 and $3,610, respectively.
4. There is a high deductible version of Plan G offered in some states. The deductible for 2025 is $2,870.

51. For More Information about Medigap

- Centers for Medicare & Medicaid Services: http://www.cms.gov/Medigap/
- 2025 Medicare & You Handbook: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

52. Title Page: Medicare Coordination with Employer Group Health Plans (GHPs)

53. Medicare Coordination with Employer Group Health Plans

The rules for what types of health plans employers may offer to their Medicare-eligible employees and whether Medicare or the group health plan pays primary depend on several factors, including:

- whether the coverage is offered by a large group health plan.
    - A large group health plan (GHP) has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
- whether the individual has coverage under the individual's or the individual's spouse's current employment.

Medicare is primary for retirees covered under large GHPs.

54. Medicare for Individuals Who are Still Working – Large Group Health Plans

Medicare law prohibits large GHPs from considering that an individual (or the individual's spouse) covered under the GHP based on current employment status is entitled to Medicare benefits.

It also requires large GHPs to provide any individual age 65 or older (and the spouse age 65 or older) who has current employment status the same benefits under the same conditions as any such individual (or spouse) under age 65.

55. Medicare for Individuals Who are Still Working – Large GHP prohibitions

It is illegal for a large GHP to encourage a Medicare-eligible employee to decline the employer's GHP and obtain Medicare instead or to offer them a different coverage than offered to individuals who are not Medicare eligible. This would include:

- offering its employees and their spouses a Medicare Advantage Plan.
- offering its employees and their spouses a Medicare Supplemental Plan.

Individuals with large GHP coverage as a result of their or a spouse's current employment may choose not to enroll in Part B when they first become eligible. If they maintain GHP coverage, they will not have to pay a late penalty if they enroll later.

56. Medicare for Individuals Who are Still Working – Small GHPs

Medicare is the primary payor for individuals who have group health coverage as a result of their or their spouse's current employment with a company that is not a large GHP. That is, Medicare will pay before the group health plan and the employer does not have to offer an individual who is Medicare eligible coverage under the group health plan.

In addition, small GHPs are not subject to the requirement to offer their age 65 and over employees and their spouses the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

Such employers can purchase or contribute towards the purchase of a Medicare Advantage plan for their employees and their spouses or offer them Medigap coverage (note that employers may not be limited to the Medigap standard plans).

The individuals in small GHPs should generally enroll in Medicare Part B when they become eligible for Medicare.

57. For More Information about Medicare Secondary Payer

Note that different rules apply concerning employees or their spouses who become eligible for Medicare because of ESRD or Disability status.

Medicare Learning Network: Medicare Secondary Payer https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MSP-Fact-SheetTextOnly.pdf

Medicare Secondary Payer Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017