



Medicare Insurance Basics

A free educational guide to understanding your Medicare options

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The Basics of Medicare Insurance



The ins and outs of Medicare insurance aren't always easy to grasp. To understand what Medicare insurance is, we have a few basics to go over.

The Parts of Medicare Insurance

Part A

Part A is your hospital coverage that assists in paying for your medical stays, whether they be hospital visits, skilled nursing facility stays, or hospice care.

Part B

Part B covers your medical services such as doctor's visits, ambulance rides or lab tests. Prescribed durable medical equipment like wheelchairs and sleep apnea machines is also covered.

Part C

The alternative to Original Medicare is Part C, which is also known as Medicare Advantage. Offered by federally approved private insurers, Medicare Advantage combines Parts A and B into one plan with one card. Some plans may offer additional benefits.

Part D

Medicare Part D is an optional plan that covers your prescription drugs. Much like Medicare Advantage, Part D is offered by federally approved private insurers. Your Part D plan defines covered drugs and the pharmacies where you can pick them up.

Medicare Supplements

Known commonly as Medigap plans, Medicare Supplements are sold by approved insurers and cover the copays and deductibles that Parts A and B do not. While you can combine a Medicare Supplement with Parts A and B, you cannot pair one with Medicare Advantage.

The Medicare Program Through History

The Medicare program has a long history of helping Americans afford their health care. Because of this, it's one of the most beloved and trusted federal programs in American history.

Early Beginnings

While the bill that created the Medicare program was signed into law in 1965, the roots of the bill go much deeper. The insurance landscape for seniors before the creation of the Medicare program was a harsh one. Only about half of Americans over 65 had insurance. The others were unable to afford coverage or were considered uninsurable. President Teddy Roosevelt felt this was such a big deal that he added it to his 1912 election platform.

President Harry Truman took the first major steps towards a national medical insurance. In 1945, Truman called on Congress to create a national health insurance fund. The plan was to cover all Americans. While the bill died in Congress, he tried again in 1947 and 1949.

Later, the Eisenhower administration passed the Dependents' Medical Care Act. This bill covered the family of servicemen and eventually gave the Medicare program its name. President John Kennedy reignited the call for national health insurance in 1961. The task force he organized suggested the creation of a program for Americans over 65.

The Medicare Program's First Baby Steps

President Lyndon Johnson was the next to take up the call. In 1964, Johnson addressed Congress to create what would become the Medicare program. The Medicare and Medicaid Act, also called the Social Security Amendments of 1965, passed Congress in a landslide, creating the Medicare program and Medicaid. President Truman, who Johnson hailed as the "true daddy of Medicare," became the first person covered by the Medicare program.

The next major expansion of the Medicare program was in 1972 under President Nixon. The first step in Medicare's expansion opened Medicare insurance coverage to citizens with long-term disabilities and end-stage renal disease.

A Modern Medicare Program

In 1997, private insurance plans, known as Part C or Medicare Advantage, were introduced under President Bill Clinton. Next, President George W. Bush expanded Medicare insurance further by adding drug coverage through Medicare Part D in 2003.

In 2010, President Barack Obama's signature Affordable Care Act expanded Medicare insurance coverage for Americans to specific preventative services. These services included mammograms, diabetes screenings, and flu shots.

Since the creation of the Medicare program, millions of Americans have gotten health care that they otherwise could not have. Today, more than 65 million Americans receive Medicare insurance benefits. With its history of helping millions every year, it's no wonder that it remains the popular program it is.

The Inflation Reduction Act of 2022 (IRA)

In the wake of the COVID-19 pandemic, President Joe Biden's administration passed the Inflation Reduction Act of 2022 (IRA). This bill saw one of the largest changes to the Medicare program since the Affordable Care Act. The bill gave CMS the ability to negotiate directly for certain medications, lowering the costs for consumers. It also capped the cost of insulin and out-of-pocket drug costs for Medicare beneficiaries, among other changes. We have a full write-up on the IRA's influence on Medicare insurance, so request these documents if you want to learn more.

What is Original Medicare?



Medicare Parts A and B (Original Medicare) make up the two public health insurance options provided by the government since President Lyndon B. Johnson created the program in 1964. Original Medicare was considered so successful that it remained unchanged for decades.

Today, Parts A and B continue to cover many of the health costs for millions of Medicare program enrollees. How does Original Medicare succeed in this, and what do the parts cover?

Medicare Part A

Medicare Part A can be thought of as your hospital insurance. It helps to pay for your stay at a health care facility, whether that is a hospital, skilled nursing facility, or nursing home, among others.

At these inpatient facilities, Part A helps cover many of the services, including meals, a semi-private room, prescription drugs taken during your treatment, and mental health care. Private nursing or rooms are not covered unless determined to be medically necessary.

In some circumstances, Part A can assist with services like hospice or home health care. Contact your doctor to see if you fall into a qualifying category.

Most people are automatically enrolled in Medicare Part A when they turn 65 as long as they're receiving Social Security benefits. They can also receive Part A premium-free in most circumstances if they paid Medicare taxes while working.

If you elect not to receive Social Security benefits, you won't be automatically enrolled at age 65. Depending on when you were born, 65 may not be your full retirement age. Instead, you may need to wait to begin receiving full retirement benefits. If you're not at your full retirement age, but want Original Medicare, you'll have to apply for Medicare program benefits separately.

Medicare Part B

Medicare Part B helps cover medically necessary services, including doctor visits, ambulance services, and physical therapy. Part B covers many preventive and screening services, as well.

If you need any durable medical equipment, Part B can help you pay for it. Durable medical equipment includes items that your primary care physician prescribes to you to use at home, like wheelchairs, blood sugar monitors, or hospital beds. It must be:

- Able to withstand repeated use, lasting for at least three years;
- Used for medical reasons;
- Generally, not useful to someone who isn't ill or injured;
- Used in your home.

Unlike Medicare Part A, all enrollees must pay a monthly premium for Part B. If you receive Social Security or similar benefits, these premiums come out of your benefit payment. In most cases, Medicare program enrollees will pay a standard premium.

The benefits of Medicare Parts A and B can make Original Medicare a strong asset in helping beneficiaries afford health services and supplies. To learn more about what Original Medicare covers, visit [Medicare.gov](https://www.Medicare.gov).



What is Medicare Part C (Advantage)?



Medicare Part C, commonly called Medicare Advantage, is a comprehensive alternative to Original Medicare offered by private insurance companies. Medicare Advantage has become a popular choice among Medicare program beneficiaries in recent years. Since 2022, nearly half of those covered by Medicare insurance were Medicare Advantage members¹.

What Do Medicare Advantage Plans Cover?

As an alternative to Original Medicare, Medicare Advantage plans must cover all Part A and B services. This means the plan aids in paying for hospital stays and most medical services (excluding hospice care). What sets Medicare Advantage apart is that the plans may cover additional benefits and may include coverage for prescription drugs, which are called Medicare Advantage Prescription Drug (MAPD) plans.

Some Medicare Advantage plans also include qualified prescription drug coverage, so you don't need to purchase a stand-alone Part D drug plan. These plans are marketed as Medicare Advantage Prescription Drug, or MAPD, plans.

What Do Medicare Part C Plans Cost?

Since you're still enrolled in Medicare insurance, you will still pay any required monthly premiums for Parts A and B. Beyond this, a Medicare Advantage plan's cost depends on several factors. These factors can be:

- Monthly premiums included in the plan
- Yearly deductibles
- Copayments or coinsurances included in the plan

A brief outline of Medicare Advantage plan costs is available on Medicare.gov.

¹<https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>

Is There Anything Else We Should Know About Part C?

Each year, you have two opportunities to make changes to your Medicare Advantage plan. The primary season is the Annual Enrollment Period, which runs from October 15 to December 7.

During this period, you can:

Switch from Original Medicare to a Medicare Advantage plan

OR

Switch from a Medicare Advantage plan to Original Medicare

OR

Switch from one Medicare Advantage plan to another

The second time to make a change in your coverage is during the Medicare Advantage Open Enrollment Period. This window runs from January 1 to March 31 and allows Medicare Advantage plan holders to make a one-time switch to a different Medicare Advantage plan or return to Original Medicare. If you return to Original Medicare, you can purchase a Medicare Supplement and stand-alone prescription drug plan.

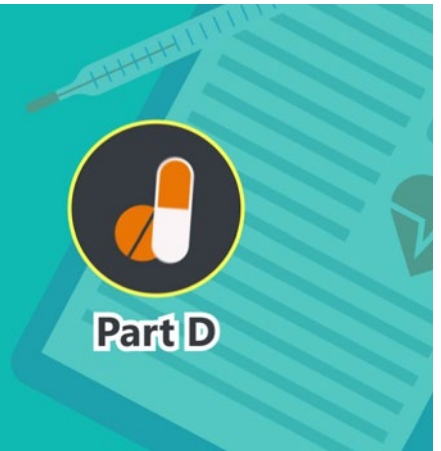
Part C Medicare Advantage



**Includes Parts A + B,
and sometimes Part D +
additional benefits.**



What is Medicare Part D?



Introduced in 2006, Medicare Part D prescription drug plans are the most recent addition to the Medicare program.

There are two ways of getting Part D coverage. The first is through purchasing a stand-alone plan to pair with Original Medicare coverage. The second is to enroll in a Medicare Advantage plan with prescription drug benefits, often called an MAPD plan.

Part D plans are sold by private insurers and are available to anyone enrolled in Original Medicare. There is no required physical exam, and you cannot be denied for financial or health reasons.

Though Medicare Part D coverage is optional, you may pay a late-enrollment penalty if you don't enroll as soon as you're eligible. This makes it worth at least exploring your options.

What Does Medicare Part D Cover?

Medicare Part D helps beneficiaries afford necessary medications. Because of this, Part D plans are sometimes known as PDPs, or prescription drug plans. How Medicare Part D works is that each plan offers a formulary that breaks out drugs into tiers. Each tier will cost you a different amount out-of-pocket. You'll also owe an annual Part D deductible before coverage will start each year. Your out-of-pocket costs are limited by the True Out-of-Pocket threshold, though. Once you've paid enough out-of-pocket, almost all of your costs are covered by your plan.

What Does Part D Cost?

The cost of a Part D plan varies from insurer to insurer. Each plan has a monthly premium, an annual deductible, and a share of the prescription costs, called a copay.

Through a combination of Medicare Parts A, B, and D, you can have a comprehensive health care plan.

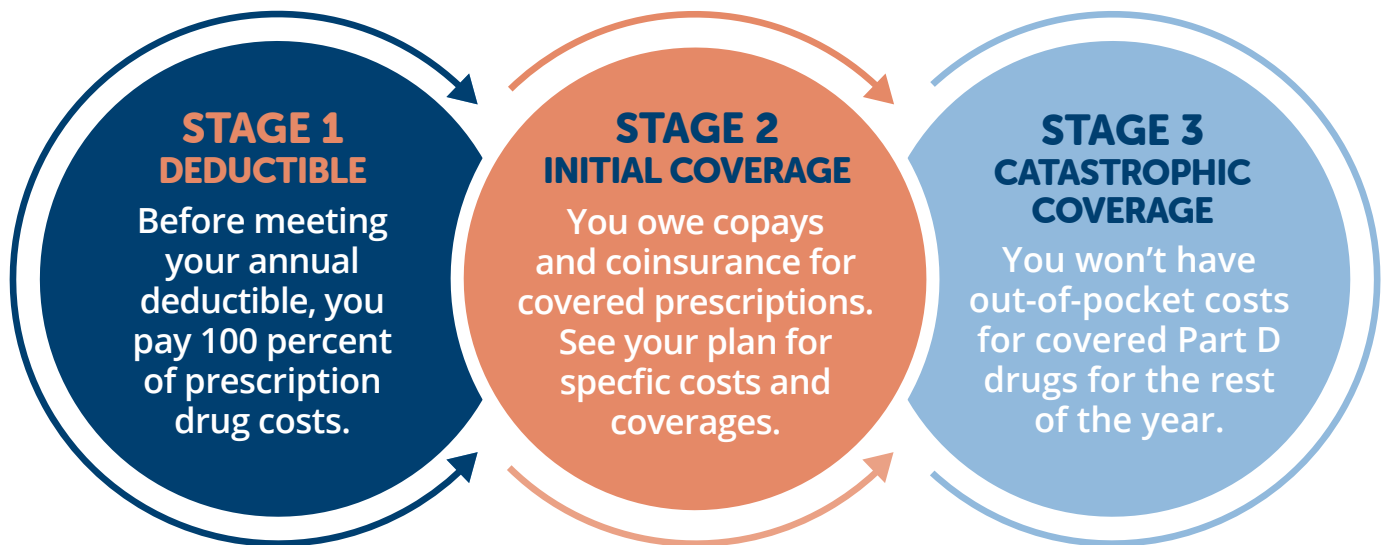


What is the Coverage Gap?

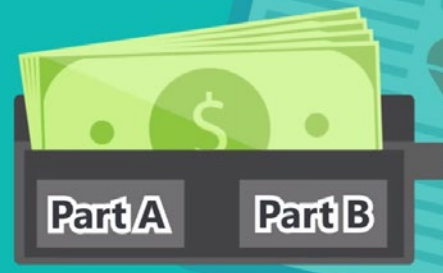
The coverage gap, sometimes called the donut hole, was the period after reaching your initial coverage limit when beneficiaries were responsible for a larger percentage of prescription costs.

Due to the Inflation Reduction Act of 2022 setting the out-of-pocket threshold for drug plans at \$2,000, the coverage gap has also been closed. Once you reach that limit, you now enter catastrophic coverage, which means the plan covers most of your out-of-pocket costs for the rest of the year.

THE STAGES OF MEDICARE PART D



What are Medicare Supplements?



Medicare Supplement insurance covers the out-of-pocket “gaps” in Original Medicare. That’s why it’s often known as Medigap.

Just like Medicare Part C and D, private insurers sell Medigap plans that are approved by the federal and state governments.

What Do They Cover?

Unlike other parts of the Medicare program, Medigap doesn’t really cover health benefits (that’s what Original Medicare is for). Instead, Medigap mainly helps pay for the deductibles and copays you’re responsible for out of your own pocket.

There are eight Medigap plans new Medicare program beneficiaries can choose from. They’re labeled by letters A, B, D, G, K, L, M, and N, and each plan letter has different coverage benefits. (Plans C, E, F, H, I, and J are no longer available. Plans C and F were discontinued for new enrollees in 2020.)

Conveniently, the minimum benefits of these plans are standardized across the country. There are only three states that are exceptions: Massachusetts, Minnesota, and Wisconsin. A licensed sales agent can help you navigate the different plans in those states.

Please note, Medigap plans will not cover costs for Medicare Advantage, Medicaid, VA benefits, or TRICARE.

How Do You Get a Medigap Plan?

To qualify for a Medicare Supplement, you must first enroll in Medicare Parts A and B. Once you turn 65 and enroll in Original Medicare, you will enter your personal Open Enrollment — the six-month period starting the first day of the month after you turn 65 and have a Part B plan. This is the best time to sign up for a Medigap plan.

You do have the option to enroll outside of your Open Enrollment Period, but acceptance is not guaranteed, and you may have to pass a health underwriting exam.

What Does It Cost?

Medigap plan monthly premiums differ depending on several factors, including:

- Age
- Location
- Tobacco Use
- Plan type (A through N)

Different insurers also vary their monthly rates depending on actuarial models, though many offer discounts to those who live with a spouse.

This table lays out what each Medicare Supplement plan covers. The state and federal governments set the minimum benefits that each plan must cover. The only states that don't follow this are Massachusetts, Minnesota, and Wisconsin.

Standard Medicare Supplement Plans & Benefits

BENEFITS	A	B	D	G ¹	K	L	M	N	C ⁴	F ^{4,5}
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes ²	Yes	Yes
Blood (first 3 pints)	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	50%	75%	Yes	Yes	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	50%	75%	50%	Yes	Yes	Yes
Part B deductible	No	No	No	No	No	No	No	No	Yes	Yes
Part B excess charge	No	No	No	Yes	No	No	No	No	No	Yes
Foreign travel exchange (up to plan limits)	No	No	80%	80%	No	No	80%	80%	80%	80%
Out-of-pocket limit ³	N/A	N/A	N/A	N/A	Yes	Yes	N/A	N/A	N/A	N/A

¹Enrollees in high-deductible Plan G must pay for their Medicare-covered costs up to the deductible amount before the Med Supp begins to pay.

²Med Supp pays 100% of the Part B coinsurance, excluding copayments of up to \$20 for some office visits and up to \$50 for ER visits that don't lead to inpatient admission.

³Upon meeting your annual out-of-pocket (OOP) limit and annual Part B deductible, the Med Supp pays 100% of all covered services for the remainder of the calendar year. Talk to your licensed insurance agent for current OOP limits.

⁴Plan only available to those eligible for Medicare before January 1, 2020.

⁵Enrollees in high-deductible F must pay for their Medicare-covered costs up to the deductible amount before the Med Supp begins to pay.

Note: Med Supp plans are standardized differently in MA, MN, and WI.

Yes means the benefit is covered 100% by your plan. **No** means it's not. **Percentages** are the amount the plan covers, not how much you owe.

Only Plans K and L have out-of-pocket limits. In these plans, once you hit the yearly limit, your gap plan picks up 100 percent of the covered services.

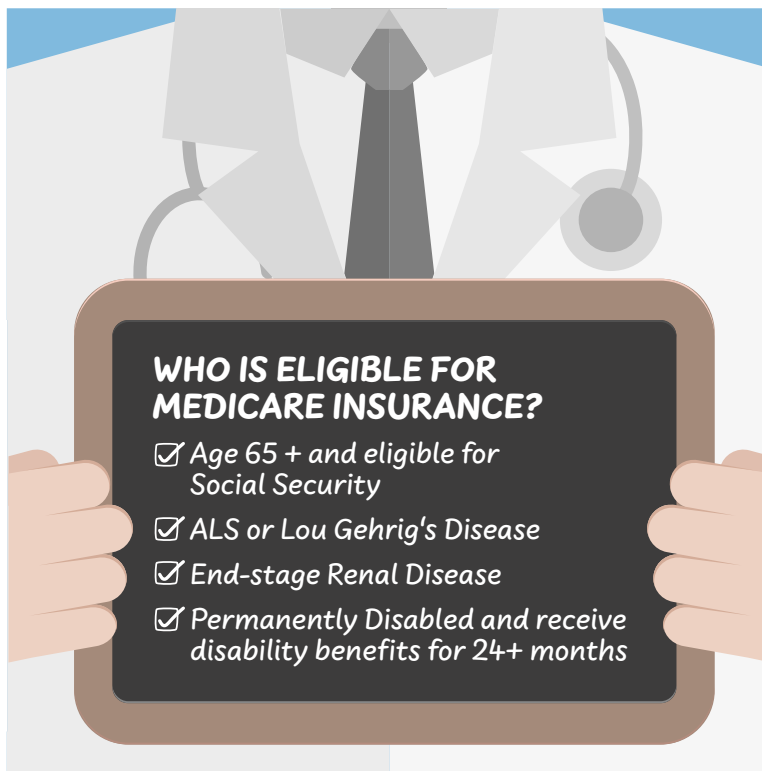
Am I Eligible for Medicare Insurance?



Once you have a foundational understanding of the four parts of the Medicare program, the only question that remains is do you qualify for Medicare insurance?

Isn't It Based on Age?

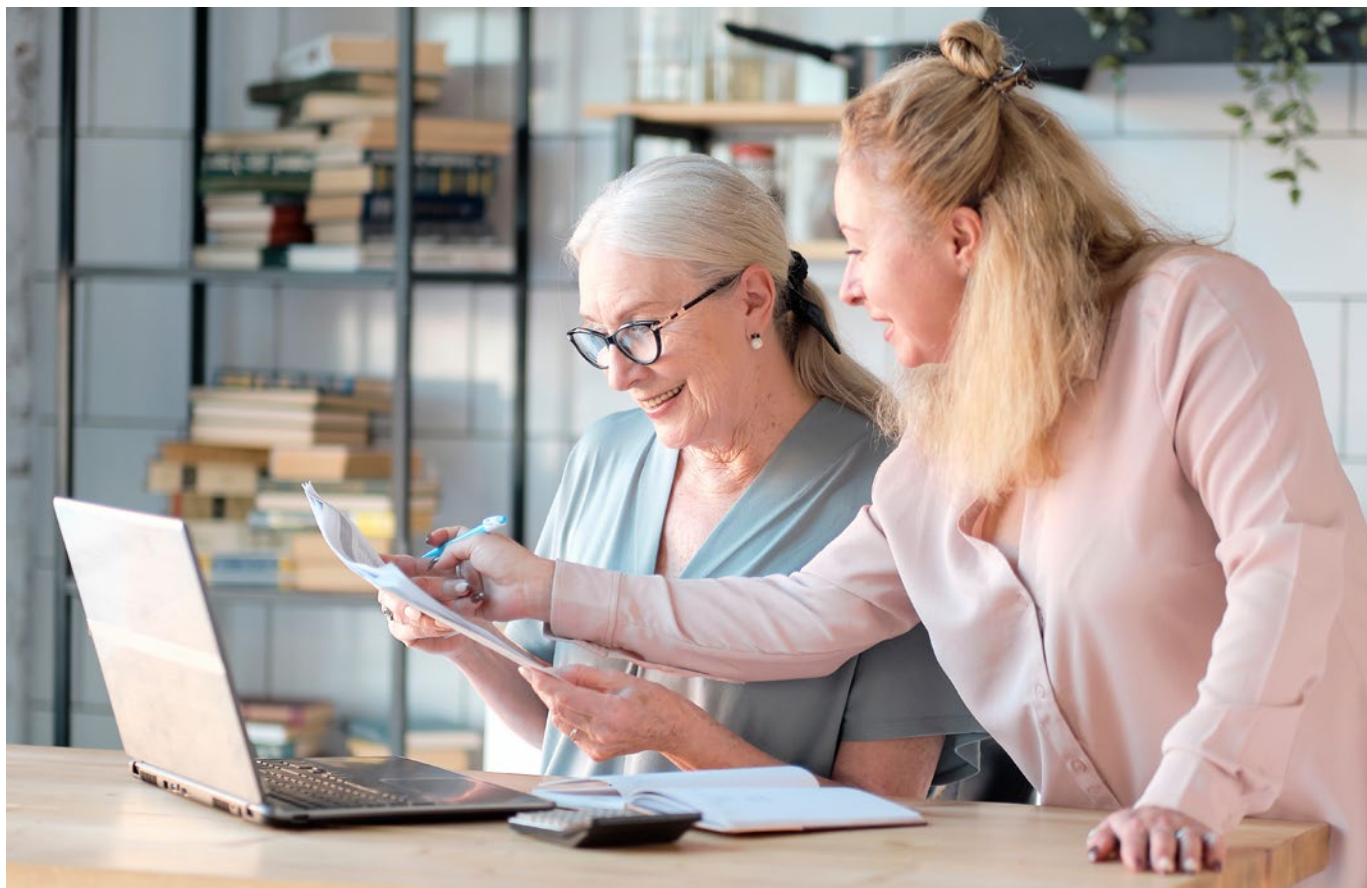
There are actually a few boxes that you can tick to be eligible for Medicare insurance. The first of these is to be 65 or older. This is the simplest way to qualify for Medicare enrollment. All you need is patience.



I'm Not 65. Does That Mean I Can't Enroll?

No, that's not always the case. While being 65 is the most common way to qualify, it's not the only method. If you receive Social Security Disability Insurance (SSDI), you'll be automatically enrolled into Medicare insurance once you roll into the 25th month of receiving SSDI checks. One exception, which begins your eligibility immediately, is if you have Amyotrophic Lateral Sclerosis, better known as Lou Gehrig's Disease or ALS.

Additionally, you're eligible for Medicare insurance if you have End-Stage Renal Disease (ESRD) and are undergoing dialysis treatments or receiving a kidney transplant.



Are There Other Criteria?

There are other factors that affect what you'll pay for your coverage. If you or your spouse paid Medicare taxes during at least 10 years of work, you qualify for "premium-free" Part A coverage. If you don't have enough credits, you can still get Medicare insurance, but you must pay for your Part A coverage.

Finally, to qualify, you must be a U.S. citizen or a permanent resident who's been here for at least five years. You automatically qualify if you were a Federal employee on January 1, 1983.

Should I Enroll in Medicare Insurance When I'm First Eligible?



You may see phrases like “Medicare penalty” or “late-enrollment penalty” while researching the Medicare program. If you don’t sign up for certain parts of the Medicare program in the proper time, these penalties may apply to you.

As you know, most people age into Medicare insurance eligibility when they turn 65. Your Initial Enrollment Period (IEP) starts three months before the month of your 65th birthday, continues through your birth month, and lasts for three months after it, unless your birthday is on the first of a month. In this case, your IEP starts one month earlier and ends one month earlier.

So, if you don’t enroll in Medicare insurance when you’re first eligible, what’s the damage? The penalties differ depending on which part of the Medicare program you are enrolling in.

Part A

If you’re collecting Social Security or Railroad Retirement Board (RRB) benefits, you’ll be automatically enrolled in Medicare Part A and don’t need to fear any enrollment penalties. If you delay receiving Social Security benefits past age 65, you’ll need to sign up for Original Medicare yourself or find a local licensed sales agent to help.

You’re eligible for premium-free Part A if you or a spouse paid Medicare program taxes for at least 40 quarters (10 years) before enrollment.

The Penalty

If you’re not eligible for premium-free Medicare Part A and you didn’t enroll during your IEP, your monthly premium may grow by 10 percent for twice the number of years you could have been enrolled in Part A. For example, if you could have signed up when you were 65, but waited until you were 69 (four years), the penalty will last for eight years.

To avoid a penalty for Part A, you should apply for Medicare insurance online or visit your local Social Security office during your IEP if you don’t already receive Social Security or RRB benefits.

Part B

Just like Part A, if you're collecting Social Security or RRB benefits when you turn 65, you'll be automatically enrolled in Medicare Part B. You can turn down Part B benefits at this time by contacting Social Security or following the instructions in your Medicare insurance welcome packet to return your card. However, you should only do this if you're still on qualified group health plan coverage through your or your spouse's employer.

The Penalty

If you fail to enroll in Part B during your IEP and don't have qualified group health plan coverage, your monthly premium may rise 10 percent for each 12-month cycle that you were not enrolled. That means if you waited 24 months (two years) to enroll in Part B after you were able, you may receive a 20-percent penalty on top of your monthly premium for as long as you have the plan. If you drop your Part B plan, only to sign up again later, you may still have the penalty.

If you don't sign up when you're first eligible and you're not eligible for a Special Enrollment Period (covered below), you may also have to wait until the General Enrollment Period to enroll in Part B. This period runs from January 1 to March 31. If this happens, your coverage will start the month after you sign up.

To avoid a penalty for Part B, you should apply for Medicare insurance online or visit your local Social Security office during your IEP if you don't already receive Social Security or RRB benefits or have qualified group health plan coverage from an employer.

Part D

If you go without creditable prescription drug coverage for any continuous period of 63 days or more, you may be subject to a premium penalty when you eventually buy a prescription drug plan.

Acceptable forms of coverage could include drug coverage from a current or former employer or union, TRICARE or VA benefits.

The Penalty

The size of your Part D penalty grows by one percent each month you go without creditable coverage. If you are without coverage for 25 months, your penalty will be 25 percent.

Twenty-five percent of what? Your penalty is based on the "national base beneficiary premium" (Example: \$33). In this example, your penalty will be \$8.30 ($33 \times .25 = 8.25$, rounded to the nearest \$.10). The national base beneficiary premium may change each year, and the penalty will change with it.

To avoid a penalty for Part D, you should join a Medicare drug insurance plan during your IEP to prevent going 63 days or more in a row without creditable drug coverage.

Special Enrollment Periods

The common theme in avoiding a Medicare insurance penalty is to get coverage during your IEP. However, as we noted, there are some special exceptions that allow you to delay enrollment past your IEP without a penalty.

If you're still covered under a qualified group health plan from your employer, you have a Special Enrollment Period (SEP) to enroll in Original Medicare at any time as long as you or your spouse is working and your health plan is based on that employment.

Additionally, you have an eight-month SEP to enroll in Original Medicare that begins the month after your employment or the health plan attached to that employment ends (whichever comes first).

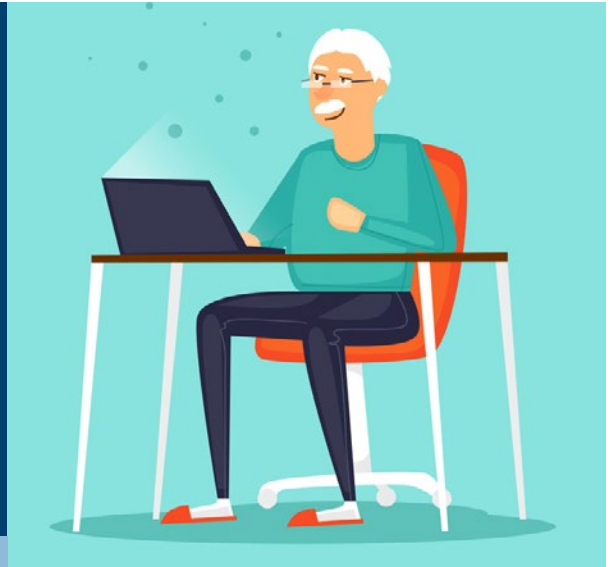
Extra Help and Appeals

If you have a limited income or resources, your state may help you afford Original Medicare. You can also apply for Extra Help for Part D coverage.

If you disagree with a Part D penalty, you can ask for a reconsideration. Your drug plan will detail the reconsideration process. You must start the process within 60 days of learning about your penalty. You should also send any supporting evidence that you had creditable coverage along with a completed reconsideration form.

Nobody wants the first time they hear about Medicare insurance penalties to be when they're receiving them. Knowing what causes these penalties is an important step in avoiding them.

What Can I Do During the Medicare Annual Enrollment Period?



The Medicare Annual Enrollment Period (AEP) is here! If you're new to the Medicare program or haven't heard of the AEP before, this may seem like a whirlwind. What is the AEP, and when does it open and close? Most importantly, who can help you make a plan choice?

What is the Annual Enrollment Period?

The Annual Enrollment Period runs from October 15 to December 7 every year. This is your chance to make changes to your Medicare insurance plan!

During AEP you can:

- Enroll in a Medicare Advantage plan if you have Original Medicare (Parts A and B).
- Return to Original Medicare from a Medicare Advantage plan by not renewing for the next calendar year.
- Move from one Medicare Advantage plan to another.
- Enroll in a Medicare Part D plan.
- Switch from one Part D plan to another.
- Drop your Part D plan completely.

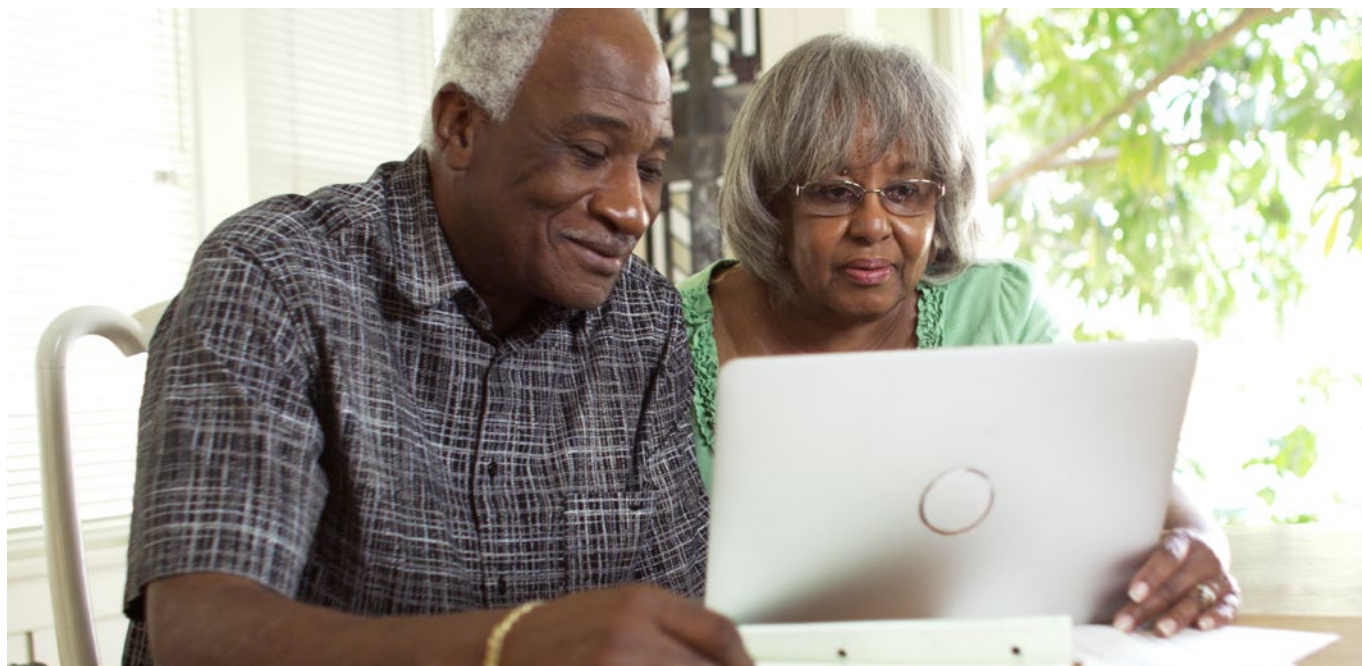
Unless your Initial Election Period (IEP) coincides with this 54-day period, you cannot use the AEP to sign up for Original Medicare for the first time.

Information about the next year's health and drug plans become available each October, and we recommend working with a licensed sales agent to make sense of your current coverage and future options. Independent, licensed sales agents cannot charge you for their services and are required to represent your best interests.

If your plan is changing or you weren't satisfied with your coverage, you may be interested in changing your plan. Comparing different plans can also help you save money or receive coverage that better fits you. Any coverage changes you make go into effect January 1 of the following year.

When researching AEP, you may see it called a few different names. Don't worry, they're all referring to the same period of time. Alternative AEP names you might hear include:

- Annual Election Period
- Annual Coordinated Election Period
- Open Enrollment Period (OEP)
- Fall Open Enrollment Season



Can I Make Changes Outside of the AEP?

Once the Annual Enrollment Period ends, you may still be able to make changes to your coverage. For example, January 1 to March 31 is the Medicare Advantage Open Enrollment Period. During this time, you may be able to make a one-time switch to a new Medicare Advantage (Part C) plan or return to Original Medicare without incurring a penalty.

If any number of special circumstances apply to you, you may make changes to your Medicare Advantage and Part D coverage by using a Special Election Period (SEP).

How and When Can I Change Medicare Insurance Plans?



Many people love their Medicare insurance plan. It offers them the coverage they need for a price they can afford. But each year, some people look to make a change with their plans. This isn't to say that the plans are bad, it just makes sense for that person.

There are plenty of reasons why you may be interested in making a change. In fact, we suggest that you at least review your Medicare insurance plan each year to make sure it still fits your needs. Your medical needs could change. You may find a less expensive plan. You could move, necessitating a new plan network. Whatever your reason, knowing when you're permitted to change your plan and how to go about it allows you to ensure you're getting the benefits that best fit your needs.

Annual Enrollment Period

October 15 — December 7

The Annual Enrollment Period (AEP) runs every year from October 15 to December 7. This window of time is the primary Medicare insurance shopping season. During AEP, you can change to a different type of Medicare insurance plan. The only thing you can't do is enroll in Original Medicare for the first time, unless your Initial Enrollment Period happens to occur during AEP. Specifically, you can:

- Enroll in a Medicare Advantage plan if you have Original Medicare (Parts A and B)
- Return to Original Medicare from a Medicare Advantage plan by not renewing for the next calendar year
- Move from one Medicare Advantage plan to another
- Enroll in a Medicare Part D plan
- Switch from one Part D plan to another
- Drop your Part D plan completely

This is an excellent time for Medicare insurance beneficiaries to explore their options because there are different coverage options on the table. Do you have Original Medicare and love it, but want some additional coverage? You may be able to enroll in a Part D plan or Medicare Supplement. Enjoy your Medicare insurance, but want to consider private coverage? Look into a Medicare Advantage plan. Whatever your preference, there's an option out there for you to explore.

Medicare Advantage Open Enrollment Period

January 1 — March 31

The Medicare Advantage Open Enrollment Period (OEP) is another window to make a change to your Medicare Insurance coverage. You can switch from Medicare Advantage to Original Medicare and a Part D plan, as well as pick up a Medicare Supplement if you qualify. Most importantly, you can use this time to switch from one Medicare Advantage plan to another.

Special Enrollment Periods

The third window that you may encounter is a Special Enrollment Period (SEP). Unlike the AEP and OEP, an SEP is based on the circumstances that created it. For example, if you're working when you turn 65 and have creditable coverage, you can begin an SEP when you retire and lose that coverage through your work. Another common reason for an SEP is if you move or change your address and your new address is outside of your current plan's service area.

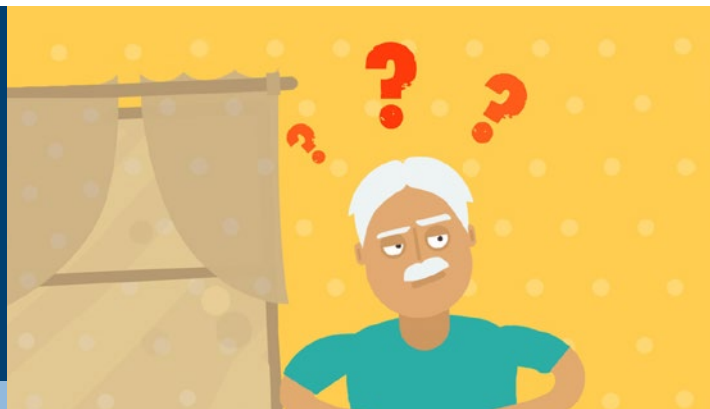
There are many different reasons why you may get an SEP and each allows you to do different things. Moving, for example, allows you to switch to Original Medicare or to a new Medicare Advantage plan that's within your network. If the Medicare program terminates its contract with your Medicare Advantage plan, you'll be able to switch to a new Medicare Advantage plan. The length of time also varies depending on the reason for the SEP.

Changing Your Medicare Insurance Plan

While some Medicare insurance plans may automatically disenroll you from an old plan when you get a new one, other product and plan types may have specific disenrollment processes and/or timeframes. Speak with your licensed insurance agent or your insurance plan directly to learn more.

The beauty of the Medicare program is that there are so many options available, so your chances of finding a plan that fits your needs is highly in your favor. That said, if you need to change your plan for whatever reason, you have options.

Can I Work and Have Medicare Insurance?



Whether they're concerned with affording retirement or love their job, Americans are working later in life. In fact, the percentage of older adults working today is the largest since the creation of the Medicare program in the 1960s.

Some individuals, maybe even you, will still be actively employed upon becoming eligible for Medicare insurance. Can you work full time and enroll in Medicare insurance, and if you choose to not enroll, will you get a penalty?

Can You Have Medicare Insurance While Working?

If you're working when you enter your Initial Enrollment Period (IEP), you can enroll in Medicare insurance plans. As long as you meet all the criteria needed to be eligible, it is your right to do so. You can also choose to delay your Medicare insurance coverage, though you may be penalized later.

If you don't receive health coverage through work, it's safe to say you should get Medicare insurance coverage.

What If I Have Non-Retiree Health Coverage Through Work?

If you have non-retiree health insurance through your or your spouse's employer when you become eligible, you'll have to choose if you want to enroll in Medicare Parts A, B, and/or D. Ultimately, this decision depends on the type of health coverage you or your spouse currently have and the size of your or your spouse's employer.

If the employer has fewer than 20 employees, you'll probably want to enroll in Parts A, B, and D upon becoming eligible for them. In this situation, Medicare insurance usually becomes your primary coverage. If the employer has 20 employees or more, you may want to delay Parts A, B, and/or D if you have sufficient group coverage and know you won't incur late enrollment penalties. Medicare insurance usually pays second to group coverage from larger employers.

Generally speaking, you should consider enrolling in Part A after qualifying for the Medicare program. For many seniors, Part A is premium-free and acts as great supplementary coverage. In some cases, it may not make sense to enroll in and pay the monthly premiums that come with Parts B and D right away. Before making the decision to delay any part of the Medicare program, compare the coverage to see

if enrolling in it while covered by your current health plan makes sense. If you have any questions, you can always reach out to a licensed insurance agent or your employers' Human Resources department.

When Can I Delay Medicare Enrollment Without a Penalty?

If you have non-retiree group coverage through your employer or your spouse's employer, you will most likely be able to delay Medicare Parts A, B, and/or D without getting penalized. You could be at risk for receiving late enrollment penalties:

- If the company you or your spouse works for has under 20 employees and you delay your Medicare insurance coverage
- If you get qualifying coverage through your domestic partner's workplace, but aren't married to him or her, and delay your Medicare insurance coverage
- If your employer does not offer creditable prescription drug coverage and/or you go at least 63 days without creditable drug coverage

What Happens with Medicare Insurance After I Retire?

Once your employment or non-retiree employee group coverage ends (whichever comes first), you'll enter a Special Enrollment Period (SEP). During this SEP, which starts the month after the qualifying event and lasts for the eight months afterwards, you can usually enroll in a Medicare insurance plan without incurring a penalty.

If you don't enroll in Parts A and/or B during the SEP, you'll start to accrue a penalty that will take effect if and when you enroll in them.

With so many retirees counting on the Medicare program for coverage, we often don't think about working while on Medicare insurance, but working and the Medicare program can go hand in hand. Whether you choose to have Medicare insurance while employed or rely on coverage through your work, you should look at your options to make sure it's right for you. The same goes for remaining on your partner's employee health plan after age 65. Knowing your options can keep you covered when you need it most and avoid a potential financial penalty.

What Does that Mean? A Medicare Insurance Glossary



A

Advance Directive

Another name for a Living Will. See *Living Will*.

Ambulatory Surgical Center

A health care facility that may perform certain surgeries on patients expected to require 24 hours of care or less.

Appeal

A request to reconsider a payment decision or coverage made by the Medicare program or your health care plan (health care or prescription drug). You can appeal if there has been a denial of your request:

- For a health care service, supply, item, or prescription drug you believe you should receive;
- Payment for a health care service, supply, item, or prescription drug that you have previously received;
- To change how much you pay for a health care service, supply, item, or prescription drug;
- To pay/provide for all or part of a health care service, supply, item, or prescription you believe you still need.

Assignment

An agreement with your health care provider (a doctor or otherwise) to be paid by Medicare insurance for services. Part of the agreement is that they will not charge you any more than a Medicare deductible and coinsurance.

B

Beneficiary

The person receiving health insurance benefits.

Benefit Period

The method Original Medicare uses to measure your hospital and skilled nursing facility services. The period runs from when you are admitted to an inpatient facility to 60 days after you stop receiving care. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Benefits

The services or health care items that are covered by your insurance plan.

C

Centers for Medicare & Medicaid Services (CMS)

A federal agency that manages the Medicare program, Medicaid, Children's Health Insurance Program (CHIP), and the federally facilitated Marketplace.

Claim

The payment request you make for received services or other benefits.

Coinsurance

The potential amount you pay for your share of service costs. This is calculated after you pay any necessary deductibles. Usually portrayed as a percentage.

Comprehensive Outpatient Rehabilitation Facility

A medical facility that can provide many services on an outpatient basis. This can include, but is not limited to doctor services, physical therapy, and rehabilitation.

Copayment

The amount you may be required to pay for a medical service or item. This is usually a specific amount, depending on your plan.

Cost-Sharing

The amount you may have to pay for a medical service or item. This includes copayments, coinsurance, and/or deductibles.

Coverage Determination

The first step in your Medicare Part D plan. Your drug plan will decide:

- Whether a drug is covered by your plan;
- If you meet the requirements to receive a drug;
- The amount you are required to pay for the drug;
- Whether to make an exception to a plan rule when it is requested.

This decision must be made within 72 hours of a standard request (24 hours for an expedited request) and can be appealed by the beneficiary.

Coverage Gap

Prior to qualifying for catastrophic coverage, the period of time that you pay higher cost-sharing for prescription drugs. The period starts when you and your plan pay a set amount for prescription drugs during the year.

D

Deductible

The amount you pay for health care services or prescription drugs before your insurance plan begins to cover a claim.

Dental Coverage

An insurance plan that helps to pay for dentist office trips. The plans can sometimes cover preventative services including teeth cleaning, fillings, etc.

Department of Health and Human Services (HHS)

The federal agency that oversees Centers for Medicare and Medicaid Services.

Drug List

The list of prescription drugs that are covered by your Part D plan or other insurance plan that offers drug coverage.

Durable Medical Equipment

Medical equipment that is ordered by your doctor to be used in your home. This can include a walker, wheelchair, or hospital bed.

Durable Power of Attorney

A legal document that gives someone else you trust the ability to make health care decisions for you. This is important in situations where you may not be able to make decisions yourself. walker, wheelchair, or hospital bed.

E

End-Stage Renal Disease (ESRD)

Permanent kidney failure, requiring dialysis, or a transplant. Those with ESRD automatically qualify for Medicare insurance.

Exception

A type of prescription drug coverage determination for Medicare insurance. The types are:

- Formulary Exception: A drug plan's decision to cover a drug not on the drug list or to waive a coverage rule.
- Tiering Exception: A drug plan's decision to charge a lower amount for a drug on its non-preferred drug-tier.

You or your doctor must request the exception. Your doctor or the prescriber must provide a supporting statement for why you require the exception.

Excess Charge

The difference between the amount a health care provider is legally permitted to charge and the Medicare-approved cost.

Explanation of Benefits (EoB)

In a Medicare Part C or D plan, a description of your coverage after you receive medical services or equipment. It explains what the plan billed Medicare insurance, the Medicare program's approved amount, what Medicare insurance paid, and what is expected to be covered by the beneficiary. The EoB is not a bill, but a description of what was paid and by whom.

Extra Help

A program that helps those with limited income/resources afford Medicare Part D plans.

F

Federally Qualified Health Center

A federally funded nonprofit health center or clinic helping medically underserved areas. These centers provide health care, even if you cannot afford it. Many work on a fee scale based on the patient's ability to pay.

Formulary

Another name for the drug list. See *Drug List*.

G

Generic Drug

A prescription drug that has identical active ingredients to a name-brand drug, often costing less.

Grievance

A complaint about the way your Medicare insurance plan is providing customer and patient service. This is separate from an appeal for a plan's refusal to cover a claim.

Group Health Plan

A health plan offered by an employer or organization that covers employees and families.

Guaranteed Issue Rights

The rights a beneficiary has in situations where an insurance company is required by law to sell or offer a Medigap policy. When this happens, a beneficiary cannot be denied a policy and an insurance company cannot place conditions on a plan. The beneficiary also cannot be charged extra for the Medigap policy because of past or current health concerns. Sometimes called Medigap Protections.

H

Health Care Facility

A location that provides health services. This can include hospitals, clinics, outpatient care centers, or specialized care centers.

Health Care Provider

An individual or group that is licensed to provide health care. This may include doctors, nurses, or hospitals.

Health Coverage

The legal entitlement to payment/reimbursement for your health care costs. This is usually through a contract with a health insurance company, an employer-offered plan, or a government program like the Medicare program.

Health Insurance Marketplace

A service that is operated by the federal or state government (depending on your state) that assists you in looking for and enrolling in affordable health insurance.

Health Maintenance Organization

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

High-Deductible Medigap Policy

A Medigap policy that has a high deductible, but also offers a lower premium.

Homebound

When you have difficulty leaving your home without assistance due to sickness or injury or leaving isn't recommended for the same reasons. You may also leave the home infrequently for a variety of reasons, like medical treatment or religious services.

Home Health Care

Health care services that are provided at your home under a plan from your doctor. This plan must be ordered by your doctor in order to be covered by Medicare insurance.

Hospice

A team-oriented service that addresses the many needs of terminally ill patients. This can include the medical, psychological, or even spiritual needs of the patient. Hospice care can also aid the patient's family or caregivers.

Hospital Outpatient Setting

The section of the hospital where outpatient services are provided. In many hospitals, these departments are: emergency department, observation unit, pain clinic, etc.

Hospital-Related Medical Condition

Any condition that was treated during your three-day stay at an inpatient hospital. This does not have to be the reason you went to the hospital.

I

Independent Review Entity

An organization with no connection to your health care plan that Medicare contracts to review a repeal case. They are called to review an appeal if the plan doesn't make a timely appeal decision.

Initial Coverage Limit

The maximum out-of-pocket limit that is reached by paying your yearly deductible, copayment, or coinsurance for each drug covered by your prescription drug plan. You then enter the plan's coverage gap.

In-Network

The group of health care providers — including pharmacies, hospitals, and doctors — that has agreed to provide services to beneficiaries of certain insurance plans at a discounted rate. Some insurance plans only cover in-network providers.

Inpatient Care

The health care services that you receive when you are admitted to a health care facility.

Inpatient Hospital Care

The services and treatment that a beneficiary receives at a hospital, including your bed, medical procedures, or nursing.

Inpatient Prospective Payment System (IPPS)

The system of payment where hospitals contract with the Medicare program to provide care and accept payment at a predetermined rate.

Inpatient Rehabilitation Facility

A hospital (either the entire hospital or part of it) that offers beneficiaries an intensive rehabilitation program.

L

Large Group Health Plan

A group health plan that covers at least 100 beneficiaries. Usually offered by an employer or an employee organization.

Lifetime Reserve Days

The additional days that Medicare insurance covers for hospital care after 90 days. This covers all regular costs except a daily coinsurance. The total is 60 days over the course of your lifetime and is offered through Original Medicare.

Limiting Charge

A part of Original Medicare, the highest amount you can be charged for a service offered by a health care supplier who hasn't accepted assignment. The charge will be 15 percent over Medicare insurance's approved amount. This will only apply to certain services.

Living Will

A legal document that lays out the type of treatments you want or don't want should you be unable to speak for yourself. This includes cases where you are unconscious. Also known as Advanced Directive and Medical Directive.

Long-Term Care

Services provided for people who are unable to perform the basics of everyday life. This can include dressing, bathing, or eating. These services can be offered in special communities, assisted living, nursing homes. Long-term care is often not covered by Medicare insurance.

Long-Term Care Hospital

A hospital that specializes in providing treatment for patients that stay an average of over 25 days. The services provided in these facilities can include: comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Generally, patients in long-term care hospitals are transferred from intensive or critical care units.

Long-Term Care Ombudsman

An independent advocate for residents of nursing or assisted living facilities. They act as intermediaries to help solve issues of residents and inform residents of their rights and protections.

M

Maximum Out-of-Pocket (MOOP)

Maximum dollar amount a member is required to pay out-of-pocket during a plan year.

Medical Directive

Another name for a Living Will. See *Living Will*.

Medical Emergency

An injury or illness you believe needs immediate medical attention due to the threat of disability or death.

Medically Necessary

Any health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms. These must meet the accepted standards of medicine.

Medical Underwriting

The process through which an insurance company decides whether to accept your application. It will also decide whether to add a waiting period for pre-existing conditions (if your state allows it) or how much to charge for the insurance. This decision is primarily based on your medical history.

Medicare Program

The federal health insurance program for people over the age of 65 or younger people in certain situations.

Medicare Administrative Contractor (MAC)

A company that processes claims for Medicare.

Medicare Advantage

Another name for Medicare Part C. See *Medicare Part C*.

Medicare Advantage Prescription Drug (MAPD) Plan

A Medicare Part C plan that offers coverage for both Original Medicare and prescription drug coverage.

Medicare-Approved Supplier

A person, agency, or company that is certified by the Medicare program to provide a medical item or service, except while you're an inpatient in a hospital or skilled nursing facility.

Medicare Certified Provider

A health care provider that has been approved by the Medicare program after passing a state-conducted inspection. Medicare insurance will only cover care provided by certified parties.

Medicare Cost Plan

A type of Medicare health plan that is available in certain areas. In this plan, if you receive services outside of the plan's network without a referral, the Medicare insurance-covered services are paid by Original Medicare. The Cost Plan covers emergency services or urgent care services.

Medicare Health Maintenance Organization (HMO) Plan

A type of Medicare Part C plan that is offered in certain parts of the United States. The plan only covers health care providers that are on a list provided by the HMO. Many plans also require you to choose a primary care physician. This physician will provide required referrals for any specialist visits.

Medicare Health Plan

A privately offered plan that contracts with the Medicare program to provide Part A and B services to Medicare insurance beneficiaries who enroll in the plan. This includes Medicare Part C, Medicare Cost Plans, Demonstration/Pilot Programs, and PACE plans.

Medicare Medical Savings Account (MSA) Plan

A combination of a high-deductible Medicare Part C plan and a bank account. The Medicare program deposits money into the account, which can be used to pay for health care costs. Only Medicare insurance-covered expenses count toward your deductible. Generally, the deposited amount is less than the deductible, so there will be out-of-pocket costs.

Medicare Part A

The part of Original Medicare that covers your stay at a health care facility, including hospitals, skilled nursing facilities, or nursing homes, among others.

Medicare Part B

The part of Original Medicare that covers medically necessary services, including doctor visits, ambulance services, and physical therapy. Part B covers many preventive and screening services, as well.

Medicare Part C

A comprehensive alternative to Original Medicare offered by private insurance companies. Plans may include additional benefits. Also known as Medicare Advantage.

Medicare Part D

Medicare Part D is an optional plan that covers your prescription drugs offered by private insurance companies. This can be paired with Original Medicare.

Medicare Preferred Provider Organization (PPO) Plan

A type of Medicare Part C plan where beneficiaries pay less if they use doctors, hospitals, or other health care providers within the plan's network. Health care providers outside of the network may be used at an additional charge. These plans are only available in certain areas.

Medicare Savings Program

A program designed to aid beneficiaries with limited income or resources pay some or all the Medicare insurance premiums, deductibles, or coinsurance. This program is offered through Medicaid.

Medicare SELECT

A type of Medicare Supplement plan that may require you to use hospitals and, in some cases, health care providers within its network to be eligible for full benefits.

Medicare Special Needs Plan (SNP)

A type of Medicare Part C plan that provides specialized care for specific groups of beneficiaries. Examples: Beneficiaries who have both Medicare insurance and Medicaid; Beneficiaries who live in nursing homes; Beneficiaries who have chronic medical conditions.

Medicare Summary Notice (MSN)

A notice given every three months to a beneficiary after a health care provider or supplier files a claim for Original Medicare services. The notice explains services provided, the amount Medicare insurance pays, and how much the beneficiary must pay.

Medicare Supplement Plan

Plans offered by private insurance companies to cover the "gaps" in Original Medicare coverage. Also known as Medigap coverage.

Medigap Basic Benefits

Benefits that all Medicare Supplement plans must cover, including Original Medicare coinsurance amounts, blood, and additional hospital benefits not within Original Medicare's coverage.

Monthly Premium

The dollar amount paid for insurance coverage on a recurring monthly basis.

Multi-Employer Plan

A group health plan sponsored by two or more employers jointly.

N

Network

The health care facilities, providers, and suppliers that have contracted with your insurer to provide services.

Network Pharmacies

Pharmacies that have contracted with certain Medicare insurance plans to provide services and supplies at a discounted rate. In certain plans, your prescriptions are only covered if you get them filled by these pharmacies.

Non-Preferred Pharmacy

A pharmacy that is part of a Medicare insurance plan's network but isn't defined as a preferred pharmacy. In these cases, you may pay higher out-of-pocket costs for prescription drugs.

O

Occupational Therapy

Treatment assisting beneficiaries to return to usual activities after an illness or injury. These activities can be bathing, preparing meals, housekeeping, etc. Original Medicare coverage is limited annually, although coverage is allowed for medically necessary therapy over the cap.

Optional Supplemental Benefits

Services not covered by the Medicare program, but that a plan may choose to offer. If the beneficiary chooses to purchase these benefits, they will pay for them directly, usually as a premium, copayment, and/or coinsurance. These services may be offered individually or as a group of services. They may be different for each Medicare health insurance plan.

Original Medicare

Another name that refers to Medicare Parts A and B.

Out-of-Network

A benefit that may be offered by a Medicare Part C plan. This benefit gives beneficiaries the choice to get a plan's services from outside of the network of health care providers. In some instances, the out-of-pocket costs may be higher.

Out-of-Pocket Costs

Health or prescription drug costs that a beneficiary must pay on their own since these aren't covered by Medicare insurance or other insurances.

Outpatient Hospital Care

Medical or surgical care a beneficiary receives from a hospital when a doctor hasn't written an order to admit the beneficiary to the hospital as an inpatient. Care includes, but is not limited to, emergency or observation services, outpatient surgery, lab tests, or x-rays. Care may be considered outpatient hospital care even if the beneficiary spends the night at the hospital.

P

Penalty

An amount added to a monthly premium for Medicare Part B or Part D plans if the beneficiary doesn't join when they are first eligible. This higher amount is paid as long as the beneficiary has Medicare insurance. There are some exceptions to this.

Pharmacy Network

A pharmacy that has agreed to provide beneficiaries of certain Medicare insurance plans with services and supplies at an agreed-upon rate. Some Medicare insurance plans will only cover your prescription costs if they are filled at network pharmacies.

Physical Therapy

Treatment for an injury or disease through physical or mechanical methods, such as exercise, massage, or light treatment.

Power of Attorney

A document that appoints a person of your choosing to make medical care decisions. Specifically used in situations where you are unable to make decisions for yourself. Also known as health care proxy, appointment of health care agent, or a durable power of attorney for health care.

Pre-Existing Condition

An injury, sickness, or health issue that was diagnosed or treated before the date health care coverage begins.

Preferred Pharmacy

A pharmacy that is part of Medicare drug insurance plan's network. You will typically pay lower out-of-pocket costs for prescriptions than at a non-preferred pharmacy.

Premium

The periodic payment made to the Medicare program, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services

Health care aimed at averting or detecting illness at an early stage, when treatment is most effective.

Primary Care Physician (PCP)

The physician who acts as a patient's first point of contact and provides any continuing care of certain medical conditions. Some Medicare Advantage plans require selection of a PCP.

Product Type

How a plan is classified based on its benefits and terms.

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

A special kind of plan that provides all care and services covered by Medicare insurance and Medicaid, as well as additional medically necessary care and services. These are based on the needs of the beneficiary, determined by an interdisciplinary team.

Typically serves frail seniors who need nursing home services but are also capable of living in a community. PACE combines medical, social, and long-term care services, as well as prescription drug coverage. PACE is only available in states that offer it under Medicaid.

Q

Qualified Disabled and Working Individuals (QDWI) Program

A state program that assists Part A beneficiaries with limited income or resources in affording their Part A premiums.

Qualified Individual (QI) Program

A state program that assists Part A beneficiaries with limited income or resources in affording their Medicare Part B premiums.

Qualified Medicare Beneficiary (QMB) Program

A state program that assists Part A beneficiaries with limited income or resources in affording Medicare Part A and Part B premiums and other cost-sharing (such as deductibles, coinsurance, or copayments).

R

Referral

A written order from your primary care physician directing you to see a specialist or receive certain medical services. Many Health Maintenance Organizations (HMOs) require a referral before covering certain services.

Rehabilitation Services

A health care service aimed at maintaining or improving physical capabilities that have been lost or impaired by illness or injury. These services may include physical or occupational therapy, speech-language pathology, or psychiatric services in inpatient and/or outpatient facilities.

Respite Care

Temporary care provided in a nursing home, inpatient hospice facility, or hospital so that the patient's caregiver can rest. This care is short-term.

S

Secondary Payer

An insurance policy, plan, or program that pays second on a medical care claim. This can include Medicare insurance, Medicaid insurance, or another insurance.

Skilled Nursing Care

A health care facility with the staff and equipment to provide skilled nursing care.

Skilled Nursing Facility

A health care facility with the staff and equipment to provide skilled nursing care.

Specified Low-Income Medicare Beneficiary (SLMB) Program

Like a QI program, a state program that assists Part A beneficiaries with limited income or resources in affording Medicare Part B premiums.

State Pharmaceutical Assistance Program (SPAP)

A state program that helps pay for drug coverage based on financial need, age, or medical condition.

Star Rating

The Medicare overall insurance plan rating as determined by the Centers for Medicare & Medicaid Services (CMS) that determines how well those plans perform. The rating combines scores for the types of services each plan offers.

Supplier

A person, agency, or company that gives a beneficiary a medical item or service, except when the beneficiary is in inpatient care at a hospital or skilled nursing facility.

T

Telemedicine

Any medical or health care service from a health care provider that can be accessed through a phone, computer, or television from a different location.

Tiers

The costs of different groups of drugs. Usually, a drug in a lower tier will be less expensive than one in a higher tier.

Treatment

A combination of medical services and prescription drugs that are used to treat a patient's illness or injuries.

U

Unassigned Claim

A claim that has been submitted for a service or item by a health care provider that does not accept assignment.

Urgently Needed Care

Care received outside of a Medicare insurance plan's service area for sudden illness or injury that requires immediate medical care but isn't considered life threatening.

W

Waiting Period

The timespan between when you sign up for a Medicare Part C or Medigap plan and when coverage begins. Days in the waiting period do not count toward creditable coverage or in determining a significant break in coverage. Waiting periods for Medicare insurance plans are most often imposed on plans of beneficiaries with pre-existing conditions.



Have questions about your Medicare options?

Choosing the right plan makes all the difference.
Let's review your needs together — at no cost to you.



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