

Medicare 101

MEDICARE PART A (HOSPITALIZATION)

Original Medicare consists of two parts: Medicare Part A (hospital insurance) and

MEDICARE PART A (HOSPITALIZATION)

Medicare Part B (medical insurance). Medicare Part A covers Medicare inpatient care, including care received while in a hospital, a skilled nursing facility, and, in limited circumstances, at home.

Most people are automatically eligible for Medicare Part A at age 65 if they're already collecting retirement benefits from the Social Security Administration or the Railroad Retirement Board. You may qualify for Medicare Part A before 65 if you have a disability, end-stage renal disease (ESRD), or amyotrophic lateral sclerosis (ALS). You must be either a United States citizen or a legal permanent resident of at least five continuous years. Learn more about how to enroll in Medicare.

In general, Medicare Part A coverage includes*:

- Hospital care (inpatient)
- Limited home health services
- Skilled nursing facility care, provided that custodial care isn't the only care required
- Hospice care

*Please note that some of the above benefits are only covered in limited situations and if certain conditions are met.

Medicare Part A hospital care coverage

As a Medicare Part A beneficiary, you will receive coverage for hospital expenses that are critical to your inpatient care, such as a semi-private room, meals, nursing services, medications that are part of your inpatient treatment, and any other services and supplies from the hospital. This includes inpatient care that received through:

- Acute care hospitals
- Critical access hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Mental health care
- Participation in a qualifying clinical research study

Please note that Medicare Part A hospital insurance does not cover the costs for a private room (unless medically necessary), private-duty nursing, personal care items like shampoo or razors, or other extraneous charges like telephone and television.

Medicare Part A also does not cover the cost of blood. You do not need to pay anything if the hospital gets it from a blood bank at no charge. If the hospital does need to purchase blood for you, you must pay for only the first three units that you receive each calendar year, unless you have the blood donated by you or someone else.

Medicare Part A home health care benefits

Medicare Part A benefits for home health care services are covered when deemed medically necessary and ordered by your doctor.

Home health care services may include:

- Part-time or intermittent skilled nursing care
- Physical therapy
- Speech-language pathology services
- Occupational therapy
- Medical social services
- Part-time or intermittent home health aide services
- Durable medical equipment, when ordered by your doctor*

*If your doctor orders durable medical equipment as part of your care and the equipment meets eligibility requirements, this cost is covered separately under Medicare Part B. If you're eligible for coverage, Medicare typically covers 80% of the Medicare-approved amount for the durable medical equipment.

Medicare Part A does not cover 24-hour home care, meals, or homemaker services if they are unrelated to your treatment. It also does not cover personal care services, such as help with bathing and dressing, if this is the only care that you need.

Medicare Part A covers the entire cost for covered home health care services. As mentioned, if you need durable medical equipment and it's ordered by your doctor this is covered under Medicare Part B and you are responsible for 20% of the Medicare-approved amount.

The home health care must be provided by a Medicare-certified home health agency, and a doctor must certify that you are home-bound. According to Medicare, you are "homebound" if both of the following are true:

- Under normal circumstances, you cannot leave home and doing so would require substantial effort.
- It is medically inadvisable for you to leave home without the help of another person, transportation, or special equipment.

Medicare Part A nursing home coverage

Skilled nursing facility (SNF) stays are covered under Medicare Part A after a qualifying hospital inpatient stay for a related illness or injury. To qualify for SNF care, the hospital stay must be a minimum of three days, beginning on the day you are formally admitted as an inpatient. The day you are discharged does not count towards this minimum three-day requirement. Time spent under observation as an outpatient also does not count towards your qualifying stay.

The skilled nursing care must be provided at a Medicare-certified facility.

Medicare-covered skilled nursing care includes, but is not limited to:

- Semi-private room
- Meals
- Skilled nursing services
- Rehabilitation services, if they are medically necessary to treat your illness
- Medical social services
- Medications received while in SNF care
- Medical supplies and equipment used in SNF
- Ambulance transportation to nearest provider if needed services are not provided at the SNF
- Dietary counseling

Your doctor must certify that you need daily skilled care that you cannot receive at home, such as intravenous drugs or physical therapy. Medicare Part A does not cover long-term care (or personal care, if that is the only care you need).

Medicare Part A hospice coverage

If your doctor has certified that you have a terminal illness with an estimated six months or less to live, you may be eligible for hospice care coverage. In hospice care, the focus is on palliative care, not curing your disease. The goal is to relieve pain and make the patient as comfortable as possible.

To qualify for Medicare-covered hospice care, you must meet all of the following conditions:

- You must be enrolled in Medicare Part A.
- Your doctor or health provider must certify that you are terminally ill and have six months or less to live.
- You must agree to give up curative treatments for your terminal illness, although Medicare will still cover palliative (comfort-focused) treatment for your terminal illness, along with related symptoms or conditions.
- You must receive hospice care from a Medicare-approved hospice facility.

Medicare Part A hospice care is usually received in the patient's home. It may include, but is not limited to:

- Doctor services
- Nursing care
- Pain relief medications
- Social services
- Durable medical equipment
- Medical supplies
- Hospice aide services
- Homemaker services
- Physical and occupational therapy
- Dietary counseling
- Short-term inpatient care (if necessary for managing pain or symptoms)
- Short-term respite care

If a patient is under hospice care, Medicare Part A may also cover some costs that Medicare normally does not include, such as spiritual and grief counseling. Medicare Part A only pays for room and board in a hospital if the hospice medical team orders short-term inpatient stays for pain or other symptom management.

Although you must give up any curative treatments for your terminal illness to receive Medicare coverage, you have the right to stop hospice care at any time. If you are thinking about going back to curative treatments, talk to your doctor.

Eligibility for Medicare Part A

In general, you are eligible for Medicare Part A if:

- You are age 65 or older and a U.S. citizen or permanent legal resident of at least five years in a row.
- You are already receiving retirement benefits.
- You are disabled and receiving disability benefits.
- You have end-stage renal disease (ESRD).
- You have amyotrophic lateral sclerosis (Lou Gehrig's disease or ALS).

Most beneficiaries do not pay a premium for Medicare Part A if they have worked at least 10 years (or 40 quarters) and paid Medicare taxes during that time. Individuals who aren't eligible for premium-free Medicare Part A can still enroll in Part A and pay a premium. Beneficiaries who delay enrollment after they first become eligible for Medicare Part A may be subject to a late enrollment penalty once they sign up.

Initial Enrollment in Medicare Part A

If you turn 65 and are already receiving Social Security retirement benefits or benefits from the Railroad Retirement Board (RRB), enrollment in Medicare Part A is usually automatic. Medicare Part A benefits begin the first day of the month you turn 65. If your

birthday is on the first day of the month, your benefits will begin the month before you turn 65. If you enrolled in Medicare Part B when you applied for retirement, your Part B coverage will begin at the same time. Your red, white, and blue Medicare card will arrive about three months before your 65th birthday.

If you do not qualify for Social Security retirement benefits or benefits from the Railroad Retirement Board (RRB) then you must enroll in Medicare Part A manually during your Initial Enrollment Period(IEP). You can do so through the Social Security website, by visiting a local Social Security office, or by calling 1-800-772-1213 (TTY users 1-800-0778), Monday through Friday, from 7AM to 7PM.

The seven-month IEP begins three months before your 65th birthday, includes the month you turn 65, and ends three months later. The start of your coverage depends on which month you enroll during your IEP. Be careful not to wait until the last minute to enroll. If you do not enroll during your seven-month IEP, you will be required to wait until the next general enrollment period (January 1 to March 31) to enroll.

If you are disabled, enrollment in Medicare Part A hospital insurance (and Medicare Part B medical insurance) will begin after you have been receiving Social Security disability benefits for 24 months. Your coverage will begin in the 25th month. Your Medicare card will arrive about three months before your coverage begins.

If you have ALS (also known as Lou Gehrig's disease), your Medicare Part A hospital insurance (and Medicare Part B medical insurance) will automatically begin the same month that your Social Security disability benefits begin. Your Medicare card will arrive about one month after you sign up for Social Security disability benefits.

If you have end-stage renal disease (ESRD) and require dialysis, your Medicare effective date is usually the first day of the fourth month of your dialysis treatments. However, you need to apply for Medicare benefits; you're not automatically enrolled if you're younger than 65.

General Enrollment Period for Medicare Part A

If you delayed enrolling in Medicare Part A, you may enroll during the next available General Enrollment Period, unless you are eligible for a Special Enrollment period (see below). The General Enrollment Period occurs each year from January 1 to March 31. If you sign up during general enrollment, your coverage will begin July 1 of that year, and your Medicare card will arrive about three months before your coverage begins.

If you are not eligible for premium-free Medicare Part A and did not enroll when you were first eligible, you may be subject to a late-enrollment penalty when you do sign up.

Special Enrollment Period for Medicare Part A

If you (or your spouse) lose your employer- or union-sponsored group hospital insurance, or if you were a volunteer serving in a foreign country, you may enroll in Medicare Part A immediately or during a Special Enrollment Period (SEP). This is the

eight-month period that begins the month after your employment or other group coverage ends (whichever happens first). If your employment ends during what would be your IEP, you would follow the standard rules for initial enrollment in Medicare Part A. You usually do not have to pay the late-enrollment penalty (if you pay a premium for Part A) if you qualify for an SEP. Your Medicare Part A coverage will begin the first of the month after you enroll, and your Medicare card should arrive within 30 days of your enrollment.

MEDICARE PART B (MEDICAL COVERAGE)

Medicare Part B (medical insurance) is part of Original Medicare and covers medical services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment. It also covers part-time or intermittent home health and rehabilitative services, such as physical therapy, if they are ordered by a doctor to treat your condition.

Some of the preventive services Medicare Part B covers include a one-time “Welcome to Medicare” preventive visit, flu and hepatitis B shots, cardiovascular screenings, cancer screenings, diabetes screenings, and more. For a full list of preventive services covered under Medicare Part B, refer to the Medicare handbook, “Medicare and You.”

If you are in a Medicare Advantage plan, you would get both your Medicare Part A and Part B coverage through a private health insurance company contracted with Medicare. By law, Medicare Advantage plans must offer at least the same level of coverage as Original Medicare, and some plans include additional coverage not included in Original Medicare such as routine dental and/or vision, hearing, and even prescription drug coverage.

Eligibility for Medicare Part B

Anyone who is eligible for premium-free Medicare Part A is eligible for Medicare Part B by enrolling and paying a monthly premium. If you are not eligible for premium-free Medicare Part A, you can qualify for Medicare Part B by meeting the following requirements:

- You must be 65 years or older.
- You must be a U.S. citizen, or a permanent resident lawfully residing in the U.S for at least five continuous years.

You may also qualify for automatic Medicare Part B enrollment through disability. If you are under 65 and receiving Social Security or Railroad Retirement Board (RRB) disability benefits, you will automatically be enrolled in Medicare Part A and Part B after 24 months of disability benefits. You may also be eligible for Medicare Part B enrollment

before 65 if you have end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (also known as ALS, or Lou Gehrig's disease). Learn more about who is eligible for Medicare.

When to enroll in Medicare Part B

If you are receiving retirement benefits before age 65 or qualify for Medicare through disability, generally you're automatically enrolled in Medicare Part A and Part B as soon as you become eligible.

If you do not enroll during your initial enrollment period and do not qualify for a special enrollment period, you can also sign up during the annual General Enrollment Period, which runs from January 1 to March 31, with coverage starting July 1. You may have to pay a late enrollment penalty for not signing up when you were first eligible.

If you're not automatically enrolled, you can apply for Medicare through Social Security, either in person at a local Social Security office, through the Social Security website, or by calling 1-800-772-1213 (TTY users 1-800-325-0778) from 7AM to 7PM, Monday through Friday.

Keep in mind that once you are both 65 years or older and have Medicare Part B, your six-month Medigap Open Enrollment Period begins. This is the best time to purchase a Medicare Supplement insurance plan because during open enrollment, you have a "guaranteed-issue right" to buy any Medigap plan without medical underwriting or paying a higher premium due to a pre-existing condition*. Once you are enrolled in Medicare Part B, be careful not to miss this one-time initial guaranteed-issue enrollment period for Medigap.

Delaying Medicare Part B enrollment

Some people may get Medicare Part A "premium-free," but most people have to pay a monthly premium for Medicare Part B. Because Medicare Part B comes with a monthly premium, some people may choose not to sign up during their initial enrollment period if they are currently covered under an employer group plan (either their own or through their spouse's employer).

If you are still working, you should check with your health benefits administrator to see how your insurance would work with Medicare. If you delay enrollment in Medicare Part B because you already have current employer health coverage, you can sign up later during a Special Enrollment Period without paying a late penalty. You can enroll in Medicare Part B at any time that you are still covered by a group plan based on current employment. After your employer health coverage ends or your employment ends (whichever comes first), you have an eight-month special enrollment period to sign up for Part B without a late penalty. If you have questions about working passed 65, read the article: [Do I need to sign up for Medicare if I'm still working at 65?](#)

Keep in mind that retiree coverage and COBRA are not considered health coverage based on current employment and would not qualify you for a special enrollment period. If you have COBRA after your employer coverage ends, you should not wait until your COBRA coverage ends to sign up for Medicare Part B. Your eight-month Part B special enrollment period begins immediately after your current employment or group plan ends (whichever comes first). This is regardless of whether you get COBRA.

Medicare Part B premiums

Medicare Part B premiums may change from year to year, and the amount can vary depending on your situation. For many people, the premium is automatically deducted from their Social Security benefits.

The standard monthly Part B premium: \$144.60 in 2020.

If your income exceeds a certain amount, your premium could be higher than the standard premium, as there are different premiums for different income levels.

See below for more details about the Medicare Part B premium.

If you are receiving Social Security, Railroad Retirement Board, or federal retirement benefits, your Part B premium will be deducted directly from your monthly benefit. If not, you will be sent a bill every three months.

The chart below shows the Medicare Part B monthly premium amounts, based on your reported income from two years ago (2017 in this example). These amounts may change each year. A late enrollment penalty may be applicable if you did not sign up for Medicare Part B when you were first eligible. Your monthly premium may be 10% higher for each 12-month period that you were eligible, but didn't enroll in Part B.

Medicare Part B monthly premium in 2020	You pay	If your yearly income is	If you filed an individual tax return	If you filed a joint tax return
\$144.60	\$87,000 or less	\$174,000 or less	\$202.40	\$87,001 – \$109,000
\$174.00	\$109,001 – \$136,000	\$218,001 – \$272,000	\$289.20	\$174,001 – \$218,000
\$218.00	\$136,001 – \$163,000	\$272,001 – \$326,000	\$376.00	\$218,001 – \$272,000
\$272.00	\$163,001 to less than \$500,000	\$326,001 to less than \$750,000	\$462.70	\$272,001 to less than \$326,000
\$462.70	\$500,000 or more	\$750,000 or more	\$491.60	\$326,001 to less than \$413,000
\$491.60			\$413.00	\$413,000 or more

Medicare Part B deductible and coinsurance amounts

The annual deductible for Medicare Part B is \$198 in 2020. You will also be responsible for a 20% coinsurance for many covered services. If your doctor or health care provider accepts assignment for a covered service, you would pay the Part B deductible along with 20% of the Medicare-approved amount for services rendered. Accepting assignment means that your doctor will not charge you more than the Medicare-approved amount for the covered service. You would still be responsible for cost-sharing.

Just by entering your zip code in the form on this page, you can start comparing Medicare plans in your area instantly. But you're also more than welcome to reach out to us (contact information is below this article).

*Pre-existing conditions are generally health conditions that existed before the start of a policy. They may limit coverage, be excluded from coverage, or even prevent you from being approved for a policy; however, the exact definition and relevant limitations or exclusions of coverage will vary with each plan, so check a specific plan's official plan documents to understand how that plan handles pre-existing conditions.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits may change on January 1 of each year.

MEDICARE PART C (MEDICARE ADVANTAGE)

Medicare Advantage, also known as Part C, Medicare Private Health Plan, or Managed Care Plan, and formerly known as Medicare+Choice, is the part of Medicare concerning private health plans. It lets you get your Medicare benefits from a private health plan contracted by the government to provide this coverage. All Medicare Advantage Plans must offer at least the same benefits as Original Medicare (Part A and Part B), but can do so with different rules, costs and coverage restrictions. Some plans (MAPDs—Medicare Advantage Prescription Drug Plans) offer Part D drug coverage as part of their benefits packages. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Medicare Advantage Plans include HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), PFFS (Private Fee-for-Service) plans, SNPs (Special Needs Plans) and MSAs (Medical Savings Accounts), and may have a POS (Point-of-Service) option.

What Are Medicare Part C Costs?

Before you choose to enroll in a Part C (private Medicare Advantage or MA) health plan, you should check to see what costs you may have. These costs may include:

Part C Medicare Premiums

In 2022, the average monthly MA plan premium is \$19 per month according to the Center for Medicare and Medicaid (CMS), but this premium may vary significantly between plans, anywhere from \$0 to over \$100. Remember that you must have Medicare Parts A & B to join a Medicare Advantage plan.

You pay your usual Part B premium plus any additional premium that the plan may charge. Some MA plans may pay a portion of your Part B premium; check with the plan to see if this is the case.

Part C Medicare Deductibles

Only some Medicare Advantage Plans have an annual deductible, in addition to the standard Part B deductible. Plans that include prescription drug coverage may charge another deductible for drug coverage.

Copayments

Copayments are for specific services, such as doctors' visits. Usually copays are a flat dollar fee, unlike the coinsurance percentage of traditional Medicare. Some types of plans charge higher copays to see providers out of your network.

Each year, plans establish the amounts they charge for premiums, deductibles and services. Each Part C plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities or suppliers that belong to the plan for non-emergency or non-urgent care).

These rules can change each year, but what you pay may change only once a year, on January 1. For current Medicare beneficiaries, the maximum out-of-pocket spending limit is \$6,700 in 2019. If you use out-of-network providers, the limit may be higher. Some plans offer an out-of-pocket limit below the \$6,700 maximum.

What are the costs of Special Needs Plans (SNPs)?

Special Needs Plans (SNPs) are Part C plans for people with Medicare who:

- Have certain serious chronic medical conditions, or
- People who have Medicaid and Medicare, or
- People who live:
 - In certain nursing homes or
 - At home but have high care needs and could qualify for a nursing home.

If you have both Medicare and Medicaid, most of your costs will be covered by those programs. If you don't have Medicaid or get help from other programs (such as Medicare Savings Programs), your costs may be similar to what you would pay in a regular Medicare Advantage plan.

What is Medicare Part C coverage for inpatient care?

Under Original Medicare, inpatient care is generally covered by Medicare Part A. Medicare Part C covers the same benefits as Medicare Part A including:

- Inpatient care in a hospital
- Inpatient skilled nursing facility care

- Home health care

Medicare Part C may have different cost sharing amounts for inpatient care and home health care than Original Medicare has. With Medicare Advantage, your hospice care benefits will still be covered by Original Medicare.

What is Medicare Part C coverage for outpatient care?

Under Original Medicare, outpatient care is generally covered by Medicare Part B. Outpatient care includes medically necessary services and preventive services to prevent or detect disease. Medicare Part C covers the same benefits as Medicare Part B including:

- Doctor visits (primary care doctor and specialists)
- Laboratory tests and X-rays
- Ambulance services in an emergency
- Both inpatient and outpatient mental health services
- Durable medical equipment such as walkers and wheelchairs
- Preventative tests and vaccines, including flu shots
- Physical therapy
- Occupational therapy
- Speech and language pathology

Medicare Part C may have different cost sharing amounts for outpatient care than Original Medicare has.

What is Medicare Part C coverage for extra benefits?

Unlike Original Medicare, Medicare Part C generally offers coverage for prescription drugs you take at home. The exact prescription drugs that are covered are listed in the plan's formulary. Formularies may vary from plan to plan.

Other extra benefits that Medicare Part C may cover include:

- Routine dental care including cleanings, x-rays, and dentures
- Routine vision care including contacts and eyeglasses
- Routine hearing care including hearing aids
- Fitness benefits including exercise classes

Not all Medicare Part C plans cover extra benefits in the same way. For example, some Medicare Part C plans may only cover "Medicare-covered dental benefits" which generally only means dental care in the event of an accident or disease of the jaw. If your Medicare Part C covers dental benefits more extensively, you may have a higher monthly premium for that coverage.

What should I do if my Medicare Part C plan doesn't cover something I need?

If you are denied coverage for something you need, the first thing you may be able to do is file an appeal. You can appeal for a health care service, supply, item, or prescription drug that you think you should be able to get or that you already got. You also can appeal to pay less than you originally were requested to pay.

If your appeal is denied or if you have other frustrations with your plan, you can switch Medicare Advantage plans during the Annual Election Period (AEP) which is October 15 – December 7 every year.

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

Before deciding whether to sign up for Medicare prescription drug coverage, you need to understand how the program works together as a whole. Grasping the big picture makes it easier to deal with the details.

Who can get Medicare drug coverage?

Anyone on Medicare (with either Part A or Part B) is entitled to drug coverage (known as Part D) regardless of income. No physical exams are required. You cannot be denied for health reasons or because you already use a lot of prescription drugs.

Do I have to sign up?

For most people, joining Part D is voluntary. However, if you now get your drugs from Medicaid, you must get them from a Medicare drug plan as soon as you become eligible for Medicare.

You won't need to sign up if you have other drug coverage that is better than Medicare's – for example, benefits from a current or former employer or union. (See [Do You Need Medicare Part D?](#))

But if you don't have other drug coverage that's considered as good as Medicare, and you delay signing up, you'll incur a late penalty that adds to your premiums for as long as you're in the program, except in certain circumstances, and you'll be able to enroll only during open enrollment at the end of the year.

What if I don't take any prescription drugs right now?

The same sign-up rules apply. Part D is insurance – you buy it so that it will protect you if and when you need it. If you don't need any prescription drugs at the present time, enrolling in the Part D plan with the lowest premium in your area ensures that you have coverage if you suddenly need it, but at the least cost.

How do I get Medicare prescription drug coverage?

You must enroll in one of the private insurance plans that Medicare has approved to provide it. Wherever you live, you can get drug coverage in one of two ways:

- Through a “stand-alone” plan (PDP) that offers only drug coverage. This type is mainly intended for people who choose to receive their other health benefits from the traditional Medicare fee-for-service program.
- Through a Medicare Advantage plan (MA-PD) that covers both medical services and prescription drugs. This type is for people who choose to receive all their Medicare benefits in one package, usually through a health maintenance organization (HMO) or a preferred provider organization (PPO).

What will my premium be?

There is no single monthly premium for Part D prescription drug coverage. Each drug plan sets its own premium for each calendar year. Some Medicare Advantage plans do not charge an extra premium for drug coverage.

Does my income affect how much I pay?

It may. People with incomes over a certain level pay a surcharge for Part D drug coverage on top of their plan premiums. You pay this surcharge if your modified adjusted gross income, as shown on your latest tax returns, is more than \$85,000 (for a single person) or \$170,000 (for a married couple filing joint tax returns). People with these higher incomes have paid surcharges on their Part B premiums since 2007. If you’re liable for the Part D surcharge, you pay it directly to Medicare while still paying the regular premium to your drug plan.

Be aware that you may need to pay this higher-income surcharge even if your drug coverage comes from your former employer or union as a retiree benefit. If your former employer or union receives a subsidy from the federal government for providing drug coverage, you will *not* be liable for the surcharge. But if the employer/union has contracted with Medicare to provide Part D coverage – either through a Part D drug plan or through a health care plan that includes Part D coverage – you are liable for the Part D surcharge if your income is above the specified level. Your plan administrators can tell you what kind of coverage you have. (For more details, see “Who Pays the Part D Higher-Income Surcharge.”)

If your income suddenly goes down due to a “life changing” event such as retirement or divorce, you can apply to Social Security (1-800-772-1213) to have both the Part B and Part D surcharges reduced or removed. If your income spikes and pushes you over the surcharge threshold because of a one-time event—such as the sale of a house or cashing in an IRA—you will be liable for the surcharge, but it will be reduced or removed if your income later dips below the threshold.

What will I get and what will it cost?

Under the standard benefit (the minimum set by law), over the course of a calendar year, you pay:

- A monthly premium (amount varies from plan to plan).
- An annual deductible (no more than \$360 in 2016; \$400 in 2017) before coverage kicks in.
- A share of the cost of each prescription (either a flat copay or a percentage of the cost) during the initial coverage period. This continues until your total drug costs – what you and your plan have paid – reach a certain amount ((\$3,310 in 2016; \$3,700 in 2017) from the beginning of the year.
- A percentage of costs in the coverage gap (also known as the “doughnut hole”) if you exceed the initial coverage limit. In 2016, you pay 45 percent of your plan’s price for brand-name drugs and 58 percent for generic drugs in the gap unless you have other coverage. In 2017, you pay 40 percent and 51 percent respectively. The doughnut hole phase ends when certain costs reach a level set by law ((\$4,850 in 2016; \$4,950 in 2017). (See “Moving In and Out of the Doughnut Hole.”)
- No more than 5 percent of your drug costs in the “catastrophic period” of coverage. This begins after you’ve reached the out-of-pocket spending limit, which gets you out of the coverage gap, and continues until the end of the calendar year.

It is important to note that your actual costs in Part D – and whether or not you hit the coverage gap – depend on the prescription drugs you take and the drug plan you choose. Also, if you qualify for Extra Help, you will have continuous coverage throughout the year (no coverage gap) and much lower costs.

Does everyone get the same coverage?

No. Each plan must offer a minimum level of coverage specified in law. But some offer better benefits, lower costs and different overall designs than the one Congress originally envisaged.

Also, you may get more coverage and pay less out of pocket if your income is limited and you qualify for Extra Help, or you are in a state pharmacy assistance program, or you have employer or union coverage that supplements Medicare.

Do drug plans vary much?

Yes. There are big differences in premiums and deductibles, in the range of drugs that plans cover, the copays they charge and the pharmacies they use. In particular, copays vary enormously among different plans, even for the same drug. To determine exact costs and benefits, it is important to carefully compare plans in your area. Learn about 8 ways we help you save money on your medicare.

Why don't the plans match the standard designed by Congress?

Congress established a “minimum” benefit that plans had to meet or exceed. But many plans offer better deals to attract enrollees.

One source of confusion is that Congress specified that enrollees would pay 25 percent of the cost of drugs in the initial coverage period in a year. Many plans instead charge flat copays for each prescription – for example, \$7, \$35 or \$70 depending on the drug – and sometimes these are higher or lower than 25 percent of the cost of the drugs.

Medicare officials say plans must prove that they provide the same value “on average” as the standard benefit. That average is based on the expected costs of everybody enrolled in the plan, not on individual costs. So, they say, some people will pay more and some less than the 25 percent.

How many plan choices do I have?

Dozens of different drug plans are available to you wherever you live. They include stand-alone drug plans (state-wide plans and some nationally available plans), which you would use if you're enrolled in the traditional Medicare program; and regional and local Medicare Advantage plans that combine medical and drug coverage in their benefit packages.

What will I pay for my drugs?

You could pay a different price for the same drug according to the phase of coverage that you're in at any point during the year.

- **Deductible:** If your plan has a deductible, you pay full price for your drugs until the deductible amount is met and coverage kicks in. “Full price” means the price your plan has negotiated with each drug's manufacturer. This price may be less than you would pay retail at the pharmacy.
- **Initial coverage period:** Your share of each prescription is either a flat copayment (for example, \$20) or a percentage of the drug's cost (for example, 25 percent). Most plans have three or four levels (known as “tiers”) of copays, rising in price from the least expensive generic drugs through “preferred” brand-name drugs to “nonpreferred” brands and finally to specialty or high-cost drugs.
- **Coverage gap (“doughnut hole”):** In 2016 you pay 45 percent of your plan's price for brand-name and biologic drugs in the gap and 58 percent for generics. In 2017 you pay 40 percent and 51 percent respectively. Fifty percent of the discount for brand drugs is provided by their manufacturers; the rest of the discount for brand drugs and the whole discount on generics is provided by the federal government. If your plan provides any coverage in the gap, these discounts are applied to your remaining costs.

- Catastrophic level of coverage: Your share of each prescription is about no more than 5 percent of the cost of the drug. You would also pay a different price if you receive Extra Help or have additional coverage from elsewhere (such as retiree drug benefits or assistance from a state pharmacy assistance program).

Why does the same plan charge different copays for different drugs?

Most plans arrange their charges in “tiers.” Typically, Tier 1 is the copay for low-cost generics, Tier 2 for medium-cost “preferred” brand-name drugs, Tier 3 for higher-cost “non-preferred” brand names, and Tier 4 for very expensive or rare drugs. But some plans use more than four tiers and some use only one, charging the same percentage price for all drugs. All plans charge a percentage of the cost (typically 25 or 33 percent) for the most expensive drugs in the highest tier.

Why does one plan charge a lot more for the same drug than another plan?

Each plan negotiates the price of each drug with its manufacturer. If a plan gets a good discount on one brand-name drug but not on a competing drug used to treat the same condition, the plan charges a lower copay for the former (“preferred”) drug and a higher copay for the latter (non-preferred).

Different plans may place the same drug in different tiers of charges varying by as much as \$50 or more between tiers. Also, some plans charge a percentage of the cost of a drug, while other plans charge a flat dollar copay, which can cause enormous differences in charges among different plans. That’s why it is important to compare copays (as well as premiums and deductibles) when choosing a plan.

What if I can’t afford the costs?

A special part of the Medicare drug program, known simply as Extra Help, provides continuous drug coverage at low cost for people with limited incomes and savings (see Extra Help Paying for Drugs). Some state pharmacy assistance programs offer similar or better help.

Does Medicare subsidize Part D drug coverage for everyone, or just for people with low incomes?

The federal government subsidizes coverage for everyone enrolled in any Part D drug plan. But it gives much bigger subsidies to those with low incomes (who qualify for Extra Help) and for people of any income level whose drug costs are high enough to take them to the catastrophic level of coverage in a year. The government also gives subsidies to employers, unions and others that provide retirees and active employees

age 65 and over with drug coverage that is at least of equal value to Medicare drug coverage.

Are there any cost breaks for married couples?

No. Each spouse pays separate premiums, deductibles and copays for prescriptions and will reach each level of coverage according to his or her own drug costs over each calendar year. Ideally, each spouse should choose a Part D plan according to his or her own drug needs, rather than automatically signing up with the same plan.

How do I pay the premium?

You can choose to have it deducted from your monthly Social Security check or pay it directly to your Medicare drug plan by check or electronic bank transfer. (You may want to pick one of the latter options, especially if you're likely to switch to another Part D plan at the end of the year, because Social Security doesn't always deduct the correct amount in a timely manner.)

What does a "year" of coverage mean?

It means a calendar year, Jan. 1 through Dec. 31, regardless of when you enroll. The cycle of coverage (deductible, initial coverage period, coverage gap, catastrophic coverage) starts over each Jan. 1.

What if I join Medicare and enroll in a Part D plan partway through the year?

The cycle of coverage follows the same order (deductible, initial coverage period, coverage gap, catastrophic coverage), starting when you join the plan. There is no reduction in the deductible (if your plan has one) if you start partway through the year.

Will I be able to get all the drugs I take now?

Maybe, but not necessarily. Each plan has a list of preferred drugs it covers, known as a formulary. No Part D plan covers every prescription drug.

A plan must cover at least two drugs in each class of drugs used to treat the same medical condition. It must also cover nearly all drugs used in six classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals (for HIV/AIDS), immunosuppressants (for transplants) and anticancer drugs.

A few drugs are excluded from Medicare coverage by law. Among them are medications for fertility, erectile dysfunction, weight problems and cosmetic uses, over-the-counter drugs and certain anti-anxiety treatments (barbiturates and benzodiazepines such as Valium and Xanax). However, under a recent change in the law, barbiturates and benzodiazepines began to be covered under Part D in 2013.

Plans are allowed to change some of the drugs they cover during the year. If this affects a drug you are using, your plan must inform you of the change at least 60 days in advance, unless it has been withdrawn from the market for safety reasons.

You have the right to ask your plan to cover a drug not on its formulary by requesting an "exception" to its policy (also known as a "coverage determination") if your doctor can show that a non-formulary drug is necessary for your health.

Before granting an exception, a plan may require you to try a drug that is already on its formulary and similar to the non-formulary one you take now, to see if it is equally effective in treating your medical condition.

If a plan doesn't cover one of my drugs, do I have to switch to an alternative drug immediately?

No. Medicare requires plans to give new enrollees a grace period of at least 30 days, during which plans must cover existing prescriptions for drugs not on their formularies. This applies both to people joining a Medicare drug plan for the first time and to people switching to a new plan after being enrolled in another. People who move into nursing homes receive a 90-day grace period.

During the grace period, it's important to make arrangements to get the drug you need when the 30 (or 90) days are up. You can either:

- Ask your doctor if you could switch to a similar drug that is on the plan's formulary; or
- Ask your doctor to request that the plan makes an exception to its policy and covers the drug for you because of medical necessity. If you win an exception, the plan will cover your prescribed drug until the end of the year.

What do "prior authorization," "step therapy" and "quantity limits" mean?

You may see one or more of these terms applied to drugs on a plan's formulary (its list of covered medications). Or you might be at the pharmacy trying to fill a prescription when you first find out that the drug you need comes with one of these restrictions.

They are all methods that plans use to try to keep costs down or, in some case, protect patients' health. Here's what they mean:

- Prior authorization means that you, with your doctor's help, must get the plan's approval before it will cover a particular drug (often a high-priced or very potent one). To get approval, your doctor must show why this specific medication is necessary for your health or why alternative drugs might be harmful. (Sometimes this approval is required to clarify whether the drug you are taking falls under Part D or another part of Medicare. Drugs prescribed in the hospital are usually covered under Part A; those administered in a doctor's office are covered under Part B; those used at home are covered under Part D.)
- Step therapy means you must first try a generic or less expensive "preferred" drug to treat your condition to see if it works as well as the one prescribed. If it does, you (and the plan) will save money. If it doesn't, your doctor can request coverage for the original prescription. Your doctor can also request that the plan waive this restriction if you have already tried less expensive drugs that have not proved effective.

- Quantity limits does not mean that your supply of drugs will be cut off after a certain time or restricted to a certain number of prescriptions a year. It means that the plan will not cover more than the dosage or quantity it regards as normal to treat your condition, unless your doctor says that a higher dosage or quantity is medically necessary for you and that lesser ones have already proved ineffective.

To get your plan to waive any of these restrictions, you need your doctor to provide a statement saying why it is not appropriate in your case and why your prescribed drug is necessary for your health. If the plan turns down this request for an exception to its policy, you have the right to appeal

How do I apply for an exception?

You have the right to ask your plan to cover a drug it doesn't normally cover, or to waive a restriction on a drug you take, for medical reasons. This process is called requesting an "exception" or a "coverage determination." (Under a regulation that began in 2013, pharmacies should provide you with instructions on what to do if your Part D plan will not immediately cover your prescribed drug.)

To apply for an exception, call your plan to ask for its coverage determination form. You also need your doctor to provide a statement saying why the drug you've been prescribed is necessary for your medical condition and (in the case of step therapy restrictions) show that less expensive meds don't work for you or (in the case of quantity limit restrictions)

are Part B (medical insurance). Medicare Part A covers Medicare inpatient care, including care received while in a hospital, a skilled nursing facility, and, in limited circumstances, at home.

Most people are automatically eligible for Medicare Part A at age 65 if they're already collecting retirement benefits from the Social Security Administration or the Railroad Retirement Board. You may qualify for Medicare Part A before 65 if you have a disability, end-stage renal disease (ESRD), or amyotrophic lateral sclerosis (ALS). You must be either a United States citizen or a legal permanent resident of at least five continuous years. Learn more about how to enroll in Medicare.

In general, Medicare Part A coverage includes*:

- Hospital care (inpatient)
- Limited home health services
- Skilled nursing facility care, provided that custodial care isn't the only care required
- Hospice care

*Please note that some of the above benefits are only covered in limited situations and if certain conditions are met.

Medicare Part A hospital care coverage

As a Medicare Part A beneficiary, you will receive coverage for hospital expenses that are critical to your inpatient care, such as a semi-private room, meals, nursing services, medications that are part of your inpatient treatment, and any other services and supplies from the hospital. This includes inpatient care that received through:

- Acute care hospitals
- Critical access hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Mental health care
- Participation in a qualifying clinical research study

Please note that Medicare Part A hospital insurance does not cover the costs for a private room (unless medically necessary), private-duty nursing, personal care items like shampoo or razors, or other extraneous charges like telephone and television.

Medicare Part A also does not cover the cost of blood. You do not need to pay anything if the hospital gets it from a blood bank at no charge. If the hospital does need to purchase blood for you, you must pay for only the first three units that you receive each calendar year, unless you have the blood donated by you or someone else.

Medicare Part A home health care benefits

Medicare Part A benefits for home health care services are covered when deemed medically necessary and ordered by your doctor.

Home health care services may include:

- Part-time or intermittent skilled nursing care
- Physical therapy
- Speech-language pathology services
- Occupational therapy
- Medical social services
- Part-time or intermittent home health aide services
- Durable medical equipment, when ordered by your doctor*

*If your doctor orders durable medical equipment as part of your care and the equipment meets eligibility requirements, this cost is covered separately under Medicare Part B. If you're eligible for coverage, Medicare typically covers 80% of the Medicare-approved amount for the durable medical equipment.

Medicare Part A does not cover 24-hour home care, meals, or homemaker services if they are unrelated to your treatment. It also does not cover personal care services, such as help with bathing and dressing, if this is the only care that you need.

Medicare Part A covers the entire cost for covered home health care services. As mentioned, if you need durable medical equipment and it's ordered by your doctor this is

covered under Medicare Part B and you are responsible for 20% of the Medicare-approved amount.

The home health care must be provided by a Medicare-certified home health agency, and a doctor must certify that you are home-bound. According to Medicare, you are “homebound” if both of the following are true:

- Under normal circumstances, you cannot leave home and doing so would require substantial effort.
- It is medically inadvisable for you to leave home without the help of another person, transportation, or special equipment.

Medicare Part A nursing home coverage

Skilled nursing facility (SNF) stays are covered under Medicare Part A after a qualifying hospital inpatient stay for a related illness or injury. To qualify for SNF care, the hospital stay must be a minimum of three days, beginning on the day you are formally admitted as an inpatient. The day you are discharged does not count towards this minimum three-day requirement. Time spent under observation as an outpatient also does not count towards your qualifying stay.

The skilled nursing care must be provided at a Medicare-certified facility.

Medicare-covered skilled nursing care includes, but is not limited to:

- Semi-private room
- Meals
- Skilled nursing services
- Rehabilitation services, if they are medically necessary to treat your illness
- Medical social services
- Medications received while in SNF care
- Medical supplies and equipment used in SNF
- Ambulance transportation to nearest provider if needed services are not provided at the SNF
- Dietary counseling

Your doctor must certify that you need daily skilled care that you cannot receive at home, such as intravenous drugs or physical therapy. Medicare Part A does not cover long-term care (or personal care, if that is the only care you need).

Medicare Part A hospice coverage

If your doctor has certified that you have a terminal illness with an estimated six months or less to live, you may be eligible for hospice care coverage. In hospice care, the focus is on palliative care, not curing your disease. The goal is to relieve pain and make the patient as comfortable as possible.

To qualify for Medicare-covered hospice care, you must meet all of the following conditions:

- You must be enrolled in Medicare Part A.
- Your doctor or health provider must certify that you are terminally ill and have six months or less to live.
- You must agree to give up curative treatments for your terminal illness, although Medicare will still cover palliative (comfort-focused) treatment for your terminal illness, along with related symptoms or conditions.
- You must receive hospice care from a Medicare-approved hospice facility.

Medicare Part A hospice care is usually received in the patient's home. It may include, but is not limited to:

- Doctor services
- Nursing care
- Pain relief medications
- Social services
- Durable medical equipment
- Medical supplies
- Hospice aide services
- Homemaker services
- Physical and occupational therapy
- Dietary counseling
- Short-term inpatient care (if necessary for managing pain or symptoms)
- Short-term respite care

If a patient is under hospice care, Medicare Part A may also cover some costs that Medicare normally does not include, such as spiritual and grief counseling. Medicare Part A only pays for room and board in a hospital if the hospice medical team orders short-term inpatient stays for pain or other symptom management.

Although you must give up any curative treatments for your terminal illness to receive Medicare coverage, you have the right to stop hospice care at any time. If you are thinking about going back to curative treatments, talk to your doctor.

Eligibility for Medicare Part A

In general, you are eligible for Medicare Part A if:

- You are age 65 or older and a U.S. citizen or permanent legal resident of at least five years in a row.
- You are already receiving retirement benefits.
- You are disabled and receiving disability benefits.
- You have end-stage renal disease (ESRD).

- You have amyotrophic lateral sclerosis (Lou Gehrig's disease or ALS).

Most beneficiaries do not pay a premium for Medicare Part A if they have worked at least 10 years (or 40 quarters) and paid Medicare taxes during that time. Individuals who aren't eligible for premium-free Medicare Part A can still enroll in Part A and pay a premium. Beneficiaries who delay enrollment after they first become eligible for Medicare Part A may be subject to a late enrollment penalty once they sign up.

Initial Enrollment in Medicare Part A

If you turn 65 and are already receiving Social Security retirement benefits or benefits from the Railroad Retirement Board (RRB), enrollment in Medicare Part A is usually automatic. Medicare Part A benefits begin the first day of the month you turn 65. If your birthday is on the first day of the month, your benefits will begin the month before you turn 65. If you enrolled in Medicare Part B when you applied for retirement, your Part B coverage will begin at the same time. Your red, white, and blue Medicare card will arrive about three months before your 65th birthday.

If you do not qualify for Social Security retirement benefits or benefits from the Railroad Retirement Board (RRB) then you must enroll in Medicare Part A manually during your Initial Enrollment Period (IEP). You can do so through the Social Security website, by visiting a local Social Security office, or by calling 1-800-772-1213 (TTY users 1-800-0778), Monday through Friday, from 7AM to 7PM.

The seven-month IEP begins three months before your 65th birthday, includes the month you turn 65, and ends three months later. The start of your coverage depends on which month you enroll during your IEP. Be careful not to wait until the last minute to enroll. If you do not enroll during your seven-month IEP, you will be required to wait until the next general enrollment period (January 1 to March 31) to enroll.

If you are disabled, enrollment in Medicare Part A hospital insurance (and Medicare Part B medical insurance) will begin after you have been receiving Social Security disability benefits for 24 months. Your coverage will begin in the 25th month. Your Medicare card will arrive about three months before your coverage begins.

If you have ALS (also known as Lou Gehrig's disease), your Medicare Part A hospital insurance (and Medicare Part B medical insurance) will automatically begin the same month that your Social Security disability benefits begin. Your Medicare card will arrive about one month after you sign up for Social Security disability benefits.

If you have end-stage renal disease (ESRD) and require dialysis, your Medicare effective date is usually the first day of the fourth month of your dialysis treatments. However, you need to apply for Medicare benefits; you're not automatically enrolled if you're younger than 65.

General Enrollment Period for Medicare Part A

If you delayed enrolling in Medicare Part A, you may enroll during the next available General Enrollment Period, unless you are eligible for a Special Enrollment period (see below). The General Enrollment Period occurs each year from January 1 to March 31. If you sign up during general enrollment, your coverage will begin July 1 of that year, and your Medicare card will arrive about three months before your coverage begins.

If you are not eligible for premium-free Medicare Part A and did not enroll when you were first eligible, you may be subject to a late-enrollment penalty when you do sign up.

Special Enrollment Period for Medicare Part A

If you (or your spouse) lose your employer- or union-sponsored group hospital insurance, or if you were a volunteer serving in a foreign country, you may enroll in Medicare Part A immediately or during a Special Enrollment Period (SEP). This is the eight-month period that begins the month after your employment or other group coverage ends (whichever happens first). If your employment ends during what would be your IEP, you would follow the standard rules for initial enrollment in Medicare Part A. You usually do not have to pay the late-enrollment penalty (if you pay a premium for Part A) if you qualify for an SEP. Your Medicare Part A coverage will begin the first of the month after you enroll, and your Medicare card should arrive within 30 days of your enrollment.

MEDICARE PART B (MEDICAL COVERAGE)

Medicare Part B (medical insurance) is part of Original Medicare and covers medical services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment. It also covers part-time or intermittent home health and rehabilitative services, such as physical therapy, if they are ordered by a doctor to treat your condition.

Some of the preventive services Medicare Part B covers include a one-time “Welcome to Medicare” preventive visit, flu and hepatitis B shots, cardiovascular screenings, cancer screenings, diabetes screenings, and more. For a full list of preventive services covered under Medicare Part B, refer to the Medicare handbook, “Medicare and You.”

If you are in a Medicare Advantage plan, you would get both your Medicare Part A and Part B coverage through a private health insurance company contracted with Medicare. By law, Medicare Advantage plans must offer at least the same level of coverage as Original Medicare, and some plans include additional coverage not included in Original Medicare such as routine dental and/or vision, hearing, and even prescription drug coverage.

Eligibility for Medicare Part B

Anyone who is eligible for premium-free Medicare Part A is eligible for Medicare Part B by enrolling and paying a monthly premium. If you are not eligible for premium-free Medicare Part A, you can qualify for Medicare Part B by meeting the following requirements:

- You must be 65 years or older.
- You must be a U.S. citizen, or a permanent resident lawfully residing in the U.S for at least five continuous years.

You may also qualify for automatic Medicare Part B enrollment through disability. If you are under 65 and receiving Social Security or Railroad Retirement Board (RRB) disability benefits, you will automatically be enrolled in Medicare Part A and Part B after 24 months of disability benefits. You may also be eligible for Medicare Part B enrollment before 65 if you have end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (also known as ALS, or Lou Gehrig's disease). Learn more about who is eligible for Medicare.

When to enroll in Medicare Part B

If you are receiving retirement benefits before age 65 or qualify for Medicare through disability, generally you're automatically enrolled in Medicare Part A and Part B as soon as you become eligible.

If you do not enroll during your initial enrollment period and do not qualify for a special enrollment period, you can also sign up during the annual General Enrollment Period, which runs from January 1 to March 31, with coverage starting July 1. You may have to pay a late enrollment penalty for not signing up when you were first eligible.

If you're not automatically enrolled, you can apply for Medicare through Social Security, either in person at a local Social Security office, through the Social Security website, or by calling 1-800-772-1213 (TTY users 1-800-325-0778) from 7AM to 7PM, Monday through Friday.

Keep in mind that once you are both 65 years or older and have Medicare Part B, your six-month Medigap Open Enrollment Period begins. This is the best time to purchase a Medicare Supplement insurance plan because during open enrollment, you have a "guaranteed-issue right" to buy any Medigap plan without medical underwriting or paying a higher premium due to a pre-existing condition*. Once you are enrolled in Medicare Part B, be careful not to miss this one-time initial guaranteed-issue enrollment period for Medigap.

Delaying Medicare Part B enrollment

Some people may get Medicare Part A "premium-free," but most people have to pay a monthly premium for Medicare Part B. Because Medicare Part B comes with a monthly

premium, some people may choose not to sign up during their initial enrollment period if they are currently covered under an employer group plan (either their own or through their spouse's employer).

If you are still working, you should check with your health benefits administrator to see how your insurance would work with Medicare. If you delay enrollment in Medicare Part B because you already have current employer health coverage, you can sign up later during a Special Enrollment Period without paying a late penalty. You can enroll in Medicare Part B at any time that you are still covered by a group plan based on current employment. After your employer health coverage ends or your employment ends (whichever comes first), you have an eight-month special enrollment period to sign up for Part B without a late penalty. If you have questions about working passed 65, read the article: [Do I need to sign up for Medicare if I'm still working at 65?](#)

Keep in mind that retiree coverage and COBRA are not considered health coverage based on current employment and would not qualify you for a special enrollment period. If you have COBRA after your employer coverage ends, you should not wait until your COBRA coverage ends to sign up for Medicare Part B. Your eight-month Part B special enrollment period begins immediately after your current employment or group plan ends (whichever comes first). This is regardless of whether you get COBRA.

Medicare Part B premiums

Medicare Part B premiums may change from year to year, and the amount can vary depending on your situation. For many people, the premium is automatically deducted from their Social Security benefits.

The standard monthly Part B premium: \$144.60 in 2020.

If your income exceeds a certain amount, your premium could be higher than the standard premium, as there are different premiums for different income levels.

See below for more details about the Medicare Part B premium.

If you are receiving Social Security, Railroad Retirement Board, or federal retirement benefits, your Part B premium will be deducted directly from your monthly benefit. If not, you will be sent a bill every three months.

The chart below shows the Medicare Part B monthly premium amounts, based on your reported income from two years ago (2017 in this example). These amounts may change each year. A late enrollment penalty may be applicable if you did not sign up for Medicare Part B when you were first eligible. Your monthly premium may be 10% higher for each 12-month period that you were eligible, but didn't enroll in Part B.

Medicare Part B monthly premium in 2020	You pay	If your yearly income is	If you filed an individual tax return	If you filed a joint tax return
\$144.60	\$87,000 or less	\$174,000 or less	\$202.40	\$87,001 – \$109,000
\$174,001 – \$218,000	\$289.20	\$109,001 – \$136,000	\$218,001 – \$272,000	\$376
\$136,000 – \$163,000	\$272,001 –			

\$326,000 \$462.70 \$163,001 to less than \$500,000 \$326,001 to less than \$750,000 \$491.60 \$500,000 or more \$750,000 or more **You pay** **If you are married but you file a separate tax return from your spouse and your yearly income is** \$144.60 \$87,000 or less \$462.70 \$87,001 to less than \$413,000 \$491.60 \$413,000 or more

Medicare Part B deductible and coinsurance amounts

The annual deductible for Medicare Part B is \$198 in 2020. You will also be responsible for a 20% coinsurance for many covered services. If your doctor or health care provider accepts assignment for a covered service, you would pay the Part B deductible along with 20% of the Medicare-approved amount for services rendered. Accepting assignment means that your doctor will not charge you more than the Medicare-approved amount for the covered service. You would still be responsible for cost-sharing.

Just by entering your zip code in the form on this page, you can start comparing Medicare plans in your area instantly. But you're also more than welcome to reach out to us (contact information is below this article).

*Pre-existing conditions are generally health conditions that existed before the start of a policy. They may limit coverage, be excluded from coverage, or even prevent you from being approved for a policy; however, the exact definition and relevant limitations or exclusions of coverage will vary with each plan, so check a specific plan's official plan documents to understand how that plan handles pre-existing conditions.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

Benefits may change on January 1 of each year.

MEDICARE PART C (MEDICARE ADVANTAGE)

Medicare Advantage, also known as Part C, Medicare Private Health Plan, or Managed Care Plan, and formerly known as Medicare+Choice, is the part of Medicare concerning private health plans. It lets you get your Medicare benefits from a private health plan contracted by the government to provide this coverage. All Medicare Advantage Plans must offer at least the same benefits as Original Medicare (Part A and Part B), but can do so with different rules, costs and coverage restrictions. Some plans (MAPDs—Medicare Advantage Prescription Drug Plans) offer Part D drug coverage as part of their benefits packages. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Medicare Advantage Plans include HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), PFFS (Private

Fee-for-Service) plans, SNPs (Special Needs Plans) and MSAs (Medical Savings Accounts), and may have a POS (Point-of-Service) option.

What Are Medicare Part C Costs?

Before you choose to enroll in a Part C (private Medicare Advantage or MA) health plan, you should check to see what costs you may have. These costs may include:

Part C Medicare Premiums

In 2022, the average monthly MA plan premium is \$19 per month according to the Center for Medicare and Medicaid (CMS), but this premium may vary significantly between plans, anywhere from \$0 to over \$100. Remember that you must have Medicare Parts A & B to join a Medicare Advantage plan.

You pay your usual Part B premium plus any additional premium that the plan may charge. Some MA plans may pay a portion of your Part B premium; check with the plan to see if this is the case.

Part C Medicare Deductibles

Only some Medicare Advantage Plans have an annual deductible, in addition to the standard Part B deductible. Plans that include prescription drug coverage may charge another deductible for drug coverage.

Copayments

Copayments are for specific services, such as doctors' visits. Usually copays are a flat dollar fee, unlike the coinsurance percentage of traditional Medicare. Some types of plans charge higher copays to see providers out of your network.

Each year, plans establish the amounts they charge for premiums, deductibles and services. Each Part C plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities or suppliers that belong to the plan for non-emergency or non-urgent care).

These rules can change each year, but what you pay may change only once a year, on January 1. For current Medicare beneficiaries, the maximum out-of-pocket spending limit is \$6,700 in 2019. If you use out-of-network providers, the limit may be higher. Some plans offer an out-of-pocket limit below the \$6,700 maximum.

What are the costs of Special Needs Plans (SNPs)?

Special Needs Plans (SNPs) are Part C plans for people with Medicare who:

- Have certain serious chronic medical conditions, or
- People who have Medicaid and Medicare, or
- People who live:
 - In certain nursing homes or

- At home but have high care needs and could qualify for a nursing home.

If you have both Medicare and Medicaid, most of your costs will be covered by those programs. If you don't have Medicaid or get help from other programs (such as Medicare Savings Programs), your costs may be similar to what you would pay in a regular Medicare Advantage plan.

What is Medicare Part C coverage for inpatient care?

Under Original Medicare, inpatient care is generally covered by Medicare Part A. Medicare Part C covers the same benefits as Medicare Part A including:

- Inpatient care in a hospital
- Inpatient skilled nursing facility care
- Home health care

Medicare Part C may have different cost sharing amounts for inpatient care and home health care than Original Medicare has. With Medicare Advantage, your hospice care benefits will still be covered by Original Medicare.

What is Medicare Part C coverage for outpatient care?

Under Original Medicare, outpatient care is generally covered by Medicare Part B. Outpatient care includes medically necessary services and preventive services to prevent or detect disease. Medicare Part C covers the same benefits as Medicare Part B including:

- Doctor visits (primary care doctor and specialists)
- Laboratory tests and X-rays
- Ambulance services in an emergency
- Both inpatient and outpatient mental health services
- Durable medical equipment such as walkers and wheelchairs
- Preventative tests and vaccines, including flu shots
- Physical therapy
- Occupational therapy
- Speech and language pathology

Medicare Part C may have different cost sharing amounts for outpatient care than Original Medicare has.

What is Medicare Part C coverage for extra benefits?

Unlike Original Medicare, Medicare Part C generally offers coverage for prescription drugs you take at home. The exact prescription drugs that are covered are listed in the plan's formulary. Formularies may vary from plan to plan.

Other extra benefits that Medicare Part C may cover include:

- Routine dental care including cleanings, x-rays, and dentures

- Routine vision care including contacts and eyeglasses
- Routine hearing care including hearing aids
- Fitness benefits including exercise classes

Not all Medicare Part C plans cover extra benefits in the same way. For example, some Medicare Part C plans may only cover “Medicare-covered dental benefits” which generally only means dental care in the event of an accident or disease of the jaw. If your Medicare Part C covers dental benefits more extensively, you may have a higher monthly premium for that coverage.

What should I do if my Medicare Part C plan doesn’t cover something I need?

If you are denied coverage for something you need, the first thing you may be able to do is file an appeal. You can appeal for a health care service, supply, item, or prescription drug that you think you should be able to get or that you already got. You also can appeal to pay less than you originally were requested to pay.

If your appeal is denied or if you have other frustrations with your plan, you can switch Medicare Advantage plans during the Annual Election Period (AEP) which is October 15 – December 7 every year.

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

Before deciding whether to sign up for Medicare prescription drug coverage, you need to understand how the program works together as a whole. Grasping the big picture makes it easier to deal with the details.

Who can get Medicare drug coverage?

Anyone on Medicare (with either Part A or Part B) is entitled to drug coverage (known as Part D) regardless of income. No physical exams are required. You cannot be denied for health reasons or because you already use a lot of prescription drugs.

Do I have to sign up?

For most people, joining Part D is voluntary. However, if you now get your drugs from Medicaid, you must get them from a Medicare drug plan as soon as you become eligible for Medicare.

You won’t need to sign up if you have other drug coverage that is better than Medicare’s – for example, benefits from a current or former employer or union. (See Do You Need Medicare Part D?)

But if you don’t have other drug coverage that’s considered as good as Medicare, and you delay signing up, you’ll incur a late penalty that adds to your premiums for as long

as you're in the program, except in certain circumstances, and you'll be able to enroll only during open enrollment at the end of the year.

What if I don't take any prescription drugs right now?

The same sign-up rules apply. Part D is insurance — you buy it so that it will protect you if and when you need it. If you don't need any prescription drugs at the present time, enrolling in the Part D plan with the lowest premium in your area ensures that you have coverage if you suddenly need it, but at the least cost.

How do I get Medicare prescription drug coverage?

You must enroll in one of the private insurance plans that Medicare has approved to provide it. Wherever you live, you can get drug coverage in one of two ways:

- Through a “stand-alone” plan (PDP) that offers only drug coverage. This type is mainly intended for people who choose to receive their other health benefits from the traditional Medicare fee-for-service program.
- Through a Medicare Advantage plan (MA-PD) that covers both medical services and prescription drugs. This type is for people who choose to receive all their Medicare benefits in one package, usually through a health maintenance organization (HMO) or a preferred provider organization (PPO).

What will my premium be?

There is no single monthly premium for Part D prescription drug coverage. Each drug plan sets its own premium for each calendar year. Some Medicare Advantage plans do not charge an extra premium for drug coverage.

Does my income affect how much I pay?

It may. People with incomes over a certain level pay a surcharge for Part D drug coverage on top of their plan premiums. You pay this surcharge if your modified adjusted gross income, as shown on your latest tax returns, is more than \$85,000 (for a single person) or \$170,000 (for a married couple filing joint tax returns). People with these higher incomes have paid surcharges on their Part B premiums since 2007. If you're liable for the Part D surcharge, you pay it directly to Medicare while still paying the regular premium to your drug plan.

Be aware that you may need to pay this higher-income surcharge even if your drug coverage comes from your former employer or union as a retiree benefit. If your former employer or union receives a subsidy from the federal government for providing drug coverage, you will *not* be liable for the surcharge. But if the employer/union has contracted with Medicare to provide Part D coverage — either through a Part D drug plan or through a health care plan that includes Part D coverage — you are liable for the Part D surcharge if your income is above the specified level. Your plan administrators can tell

you what kind of coverage you have. (For more details, see “Who Pays the Part D Higher-Income Surcharge.”)

If your income suddenly goes down due to a “life changing” event such as retirement or divorce, you can apply to Social Security (1-800-772-1213) to have both the Part B and Part D surcharges reduced or removed. If your income spikes and pushes you over the surcharge threshold because of a one-time event—such as the sale of a house or cashing in an IRA—you will be liable for the surcharge, but it will be reduced or removed if your income later dips below the threshold.

What will I get and what will it cost?

Under the standard benefit (the minimum set by law), over the course of a calendar year, you pay:

- A monthly premium (amount varies from plan to plan).
- An annual deductible (no more than \$360 in 2016; \$400 in 2017) before coverage kicks in.
- A share of the cost of each prescription (either a flat copay or a percentage of the cost) during the initial coverage period. This continues until your total drug costs — what you and your plan have paid — reach a certain amount ((\$3,310 in 2016; \$3,700 in 2017) from the beginning of the year.
- A percentage of costs in the coverage gap (also known as the “doughnut hole”) if you exceed the initial coverage limit. In 2016, you pay 45 percent of your plan’s price for brand-name drugs and 58 percent for generic drugs in the gap unless you have other coverage. In 2017, you pay 40 percent and 51 percent respectively. The doughnut hole phase ends when certain costs reach a level set by law ((\$4,850 in 2016; \$4,950 in 2017). (See “Moving In and Out of the Doughnut Hole.”)
- No more than 5 percent of your drug costs in the “catastrophic period” of coverage. This begins after you’ve reached the out-of-pocket spending limit, which gets you out of the coverage gap, and continues until the end of the calendar year.

It is important to note that your actual costs in Part D — and whether or not you hit the coverage gap — depend on the prescription drugs you take and the drug plan you choose. Also, if you qualify for Extra Help, you will have continuous coverage throughout the year (no coverage gap) and much lower costs.

Does everyone get the same coverage?

No. Each plan must offer a minimum level of coverage specified in law. But some offer better benefits, lower costs and different overall designs than the one Congress originally envisaged.

Also, you may get more coverage and pay less out of pocket if your income is limited and you qualify for Extra Help, or you are in a state pharmacy assistance program, or you have employer or union coverage that supplements Medicare.

Do drug plans vary much?

Yes. There are big differences in premiums and deductibles, in the range of drugs that plans cover, the copays they charge and the pharmacies they use. In particular, copays vary enormously among different plans, even for the same drug. To determine exact costs and benefits, it is important to carefully compare plans in your area. Learn about 8 ways we help you save money on your medicare.

Why don't the plans match the standard designed by Congress?

Congress established a "minimum" benefit that plans had to meet or exceed. But many plans offer better deals to attract enrollees.

One source of confusion is that Congress specified that enrollees would pay 25 percent of the cost of drugs in the initial coverage period in a year. Many plans instead charge flat copays for each prescription – for example, \$7, \$35 or \$70 depending on the drug – and sometimes these are higher or lower than 25 percent of the cost of the drugs. Medicare officials say plans must prove that they provide the same value "on average" as the standard benefit. That average is based on the expected costs of everybody enrolled in the plan, not on individual costs. So, they say, some people will pay more and some less than the 25 percent.

How many plan choices do I have?

Dozens of different drug plans are available to you wherever you live. They include stand-alone drug plans (state-wide plans and some nationally available plans), which you would use if you're enrolled in the traditional Medicare program; and regional and local Medicare Advantage plans that combine medical and drug coverage in their benefit packages.

What will I pay for my drugs?

You could pay a different price for the same drug according to the phase of coverage that you're in at any point during the year.

- **Deductible:** If your plan has a deductible, you pay full price for your drugs until the deductible amount is met and coverage kicks in. "Full price" means the price your plan has negotiated with each drug's manufacturer. This price may be less that you would pay retail at the pharmacy.
- **Initial coverage period:** Your share of each prescription is either a flat copayment (for example, \$20) or a percentage of the drug's cost (for example, 25 percent). Most plans

have three or four levels (known as “tiers”) of copays, rising in price from the least expensive generic drugs through “preferred” brand-name drugs to “nonpreferred” brands and finally to specialty or high-cost drugs.

- Coverage gap (“doughnut hole”): In 2016 you pay 45 percent of your plan’s price for brand-name and biologic drugs in the gap and 58 percent for generics. In 2017 you pay 40 percent and 51 percent respectively. Fifty percent of the discount for brand drugs is provided by their manufacturers; the rest of the discount for brand drugs and the whole discount on generics is provided by the federal government. If your plan provides any coverage in the gap, these discounts are applied to your remaining costs.
- Catastrophic level of coverage: Your share of each prescription is about no more than 5 percent of the cost of the drug. You would also pay a different price if you receive Extra Help or have additional coverage from elsewhere (such as retiree drug benefits or assistance from a state pharmacy assistance program).

Why does the same plan charge different copays for different drugs?

Most plans arrange their charges in “tiers.” Typically, Tier 1 is the copay for low-cost generics, Tier 2 for medium-cost “preferred” brand-name drugs, Tier 3 for higher-cost “non-preferred” brand names, and Tier 4 for very expensive or rare drugs. But some plans use more than four tiers and some use only one, charging the same percentage price for all drugs. All plans charge a percentage of the cost (typically 25 or 33 percent) for the most expensive drugs in the highest tier.

Why does one plan charge a lot more for the same drug than another plan?

Each plan negotiates the price of each drug with its manufacturer. If a plan gets a good discount on one brand-name drug but not on a competing drug used to treat the same condition, the plan charges a lower copay for the former (“preferred”) drug and a higher copay for the latter (non-preferred).

Different plans may place the same drug in different tiers of charges varying by as much as \$50 or more between tiers. Also, some plans charge a percentage of the cost of a drug, while other plans charge a flat dollar copay, which can cause enormous differences in charges among different plans. That’s why it is important to compare copays (as well as premiums and deductibles) when choosing a plan.

What if I can’t afford the costs?

A special part of the Medicare drug program, known simply as Extra Help, provides continuous drug coverage at low cost for people with limited incomes and savings (see

Extra Help Paying for Drugs). Some state pharmacy assistance programs offer similar or better help.

Does Medicare subsidize Part D drug coverage for everyone, or just for people with low incomes?

The federal government subsidizes coverage for everyone enrolled in any Part D drug plan. But it gives much bigger subsidies to those with low incomes (who qualify for Extra Help) and for people of any income level whose drug costs are high enough to take them to the catastrophic level of coverage in a year. The government also gives subsidies to employers, unions and others that provide retirees and active employees age 65 and over with drug coverage that is at least of equal value to Medicare drug coverage.

Are there any cost breaks for married couples?

No. Each spouse pays separate premiums, deductibles and copays for prescriptions and will reach each level of coverage according to his or her own drug costs over each calendar year. Ideally, each spouse should choose a Part D plan according to his or her own drug needs, rather than automatically signing up with the same plan.

How do I pay the premium?

You can choose to have it deducted from your monthly Social Security check or pay it directly to your Medicare drug plan by check or electronic bank transfer. (You may want to pick one of the latter options, especially if you're likely to switch to another Part D plan at the end of the year, because Social Security doesn't always deduct the correct amount in a timely manner.)

What does a "year" of coverage mean?

It means a calendar year, Jan. 1 through Dec. 31, regardless of when you enroll. The cycle of coverage (deductible, initial coverage period, coverage gap, catastrophic coverage) starts over each Jan. 1.

What if I join Medicare and enroll in a Part D plan partway through the year?

The cycle of coverage follows the same order (deductible, initial coverage period, coverage gap, catastrophic coverage), starting when you join the plan. There is no reduction in the deductible (if your plan has one) if you start partway through the year.

Will I be able to get all the drugs I take now?

Maybe, but not necessarily. Each plan has a list of preferred drugs it covers, known as a formulary. No Part D plan covers every prescription drug.

A plan must cover at least two drugs in each class of drugs used to treat the same medical condition. It must also cover nearly all drugs used in six classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals (for HIV/AIDS), immunosuppressants (for transplants) and anticancer drugs.

A few drugs are excluded from Medicare coverage by law. Among them are medications for fertility, erectile dysfunction, weight problems and cosmetic uses, over-the-counter

drugs and certain anti-anxiety treatments (barbiturates and benzodiazepines such as Valium and Xanax). However, under a recent change in the law, barbiturates and benzodiazepines began to be covered under Part D in 2013.

Plans are allowed to change some of the drugs they cover during the year. If this affects a drug you are using, your plan must inform you of the change at least 60 days in advance, unless it has been withdrawn from the market for safety reasons.

You have the right to ask your plan to cover a drug not on its formulary by requesting an “exception” to its policy (also known as a “coverage determination”) if your doctor can show that a non-formulary drug is necessary for your health.

Before granting an exception, a plan may require you to try a drug that is already on its formulary and similar to the non-formulary one you take now, to see if it is equally effective in treating your medical condition.

If a plan doesn't cover one of my drugs, do I have to switch to an alternative drug immediately?

No. Medicare requires plans to give new enrollees a grace period of at least 30 days, during which plans must cover existing prescriptions for drugs not on their formularies. This applies both to people joining a Medicare drug plan for the first time and to people switching to a new plan after being enrolled in another. People who move into nursing homes receive a 90-day grace period.

During the grace period, it's important to make arrangements to get the drug you need when the 30 (or 90) days are up. You can either:

- Ask your doctor if you could switch to a similar drug that is on the plan's formulary; or
- Ask your doctor to request that the plan makes an exception to its policy and covers the drug for you because of medical necessity. If you win an exception, the plan will cover your prescribed drug until the end of the year.

What do “prior authorization,” “step therapy” and “quantity limits” mean?

You may see one or more of these terms applied to drugs on a plan's formulary (its list of covered medications). Or you might be at the pharmacy trying to fill a prescription when you first find out that the drug you need comes with one of these restrictions.

They are all methods that plans use to try to keep costs down or, in some case, protect patients' health. Here's what they mean:

- Prior authorization means that you, with your doctor's help, must get the plan's approval before it will cover a particular drug (often a high-priced or very potent one). To get approval, your doctor must show why this specific medication is necessary for your health or why alternative drugs might be harmful. (Sometimes this approval is required to clarify whether the drug you are taking falls under Part D or another part of Medicare.

Drugs prescribed in the hospital are usually covered under Part A; those administered in a doctor's office are covered under Part B; those used at home are covered under Part D.)

- Step therapy means you must first try a generic or less expensive "preferred" drug to treat your condition to see if it works as well as the one prescribed. If it does, you (and the plan) will save money. If it doesn't, your doctor can request coverage for the original prescription. Your doctor can also request that the plan waive this restriction if you have already tried less expensive drugs that have not proved effective.
- Quantity limits does not mean that your supply of drugs will be cut off after a certain time or restricted to a certain number of prescriptions a year. It means that the plan will not cover more than the dosage or quantity it regards as normal to treat your condition, unless your doctor says that a higher dosage or quantity is medically necessary for you and that lesser ones have already proved ineffective.

To get your plan to waive any of these restrictions, you need your doctor to provide a statement saying why it is not appropriate in your case and why your prescribed drug is necessary for your health. If the plan turns down this request for an exception to its policy, you have the right to appeal

How do I apply for an exception?

You have the right to ask your plan to cover a drug it doesn't normally cover, or to waive a restriction on a drug you take, for medical reasons. This process is called requesting an "exception" or a "coverage determination." (Under a regulation that began in 2013, pharmacies should provide you with instructions on what to do if your Part D plan will not immediately cover your prescribed drug.)

To apply for an exception, call your plan to ask for its coverage determination form. You also need your doctor to provide a statement saying why the drug you've been prescribed is necessary for your medical condition and (in the case of step therapy restrictions) show that less expensive meds don't work for you or (in the case of quantity limit restrictions)