YOUR COMPLIMENTARY HANDBOOK TO

MEDICARE

What is Medicare?

beyond my benefits

This is a Non-Government Site. Beyond My Benefits is not Affiliated with any Government Agency, including the Centers for Medicare and Medicaid Services or the Social Security Administration.

What is Medicare?

Medicare is a federal initiative that offers healthcare insurance to disabled and elderly individuals residing in the United States. The funding for medical treatment under Medicare is sourced from a combination of individual contributions and trust funds funded by employee taxes. The program is overseen by the Centers for Medicare & Medicaid Services (CMS), a federal agency.

Medicare is accessible for:

- Individuals aged 65 or older
- Individuals afflicted by end-stage renal disease (ESRD)
- Certain younger individuals with disabilities

The extent of coverage provided by Medicare is contingent upon the specific Medicare programs in which you are enrolled. To gain a deeper understanding of your coverage alternatives, please review the section titled "**Programs In Medicare**."

For information on how to qualify for Medicare on the basis of disability, consult the "**Defining Disability**" section.

Medicare vs. Medicaid

Medicare and Medicaid serve distinct roles in healthcare coverage. While Medicare focuses on seniors, Medicaid is tailored to support individuals and families with low income, covering children, adults, and pregnant women.

Medicaid covers disabled individuals and seniors concurrently enrolled in Medicare, termed "dual-eligible." Even though both programs fall under CMS supervision, they function autonomously. Medicaid's funding is derived from a combination of federal and state governments, leading to variations in eligibility, coverage, and costs specific to each state.

Unlike Medicare, which has enrollment restrictions tied to specific periods or events, Medicaid accepts applications throughout the year. For detailed information on Medicare enrollment, refer to the "**How to Apply for Medicare**" section in this guide.

General Medicare Contact Information

- **Phone Number:** 1-800-MEDICARE (1-800-633-4227) TTY Number: 1-877-486-2048
- **Mailing Address:** Medicare Contact Center Operations PO Box 1270 Lawrence, KS 66044

Centers for Medicare & Medicaid Services Regional Office Contact Information

Note: The District of Columbia, Maryland, and West Virginia do not have regional CMS offices. Residents from these areas may contact the general Medicare phone line above.

Click here for the full list

Additional Contact Resources
Find more contact info and resources by organization, state, and/or topic of interest at https://www.cms.gov/Center/Freedom-of-Information-Act/regional-contacts.htm.

Programs in Medicare

Medicare is divided into several different components, each with a different function. This section provides information on the different programs:

- Medicare Part A, hospital coverage
- Medicare Part B, medical coverage
- Medicare Part C, Medicare Advantage plans (including Special Needs Plans)
- Medicare Part D, prescription drug coverage
- Medigap Policies, plans that cover services not fully covered by Medicare
- Program of All-Inclusive Care for the Elderly (PACE)

Note: Please be aware that everyone enrolled in Medicare is automatically covered by Medicare Part A, and the majority also have Medicare Part B. Medicare Parts C and D are available as supplementary coverage choices.

Medicare Part A

Medicare Part A provides hospital-related coverage, including long-term hospital care, inpatient mental health care, inpatient hospital care, skilled nursing facility care, nursing home care, hospice care, home health care and Part-time or “intermittent” skilled nursing care

Who can get Medicare Part A? Part A is typically available to:

- Adults age 65 and older
- Disabled individuals
- Individuals with End-Stage Renal Disease

How to Qualify for Medicare Based on Disability

Disabled individuals may qualify for Medicare through automatic enrollment after 24 months of receiving disability benefits from Social Security or the Railroad Retirement Board (RRB).

Social Security Benefits

Social Security Benefits encompass various types of insurance provided by the Social Security Administration (SSA), a federal agency. This public insurance program provides various benefits that impact Medicare eligibility, including:

- Retirement benefits
- Disability benefits

Typically, individuals become eligible for Social Security retirement benefits after accumulating 40 work credits, equivalent to approximately 10 years of employment with contributions to Social Security taxes.

Individuals receiving retirement benefits from the SSA typically meet the criteria for premium-free Medicare Part A. Explore further details in the "**Medicare Part A Premiums**" section of this guide.

For benefits related to Social Security disability, eligibility is based on an individual's inability to work and meeting the SSA's definition of blindness or disability. Dive into the specifics of this definition in the "**Defining Disability**" section of this guide.

Now, turning to Railroad Retirement Board Benefits:

The Railroad Retirement Board (RRB), a federal agency, administers various insurance benefits for individuals with a work history in the railroad industry, impacting Medicare qualifications. These benefits include:

- Retirement benefits
- Disability benefits

Eligibility for RRB retirement benefits is contingent on accruing sufficient work hours in a railroad occupation. Those receiving RRB retirement benefits also qualify for premium-free Medicare Part A. Refer to the "**Medicare Part A Premiums**" section of this guide for more details.

Similarly, individuals can qualify for RRB disability benefits when they are unable to work and meet the RRB's definition of disability. Explore the intricacies of this definition in the "**Defining Disability**" section of this guide.

Defining Disability

Determining whether an individual qualifies as “disabled” is a process conducted by both the Social Security Administration (SSA) and the Railroad Retirement Board (RRB).

The SSA determines eligibility for disability benefits when the following conditions are satisfied:

- Inability to perform previous work due to the direct impact of the disability on work-related capacities, such as walking, lifting, remembering, or sitting.
- Incapacity to adjust to alternative work because of the medical condition(s)/disability.
- The disability must last for a minimum of one year or be anticipated to result in death.

The RRB evaluates disability eligibility by considering a permanent condition that prevents an individual from working. This determination includes assessing the individual’s ability to perform various functions, such as physical tasks, sensory functions, interpersonal skills, cognitive abilities, and adaptability to changes in the work environment.

Meeting additional requirements may be necessary for individuals to receive disability benefits from either the SSA or RRB.

For more details on Social Security benefits, refer to the SSA website at https://www.ssa.gov/disability/.

For additional information on Railroad Retirement benefits, visit the RRB website at https://rrb.gov/RB-17b/PartII/EligibilityRequirementsforaDisabilityAnnuity.

Medicare Part A Premiums

Medicare Part A Premiums

The majority of Medicare beneficiaries are eligible for premium-free Part A coverage. A premium is a payment made by the insured individual for coverage. Those with premium-free Medicare Part A are exempt from making such payments.

Who qualifies for premium-free Medicare Part A coverage?

Premium-free Medicare Part A is generally available to individuals aged 65 or older who:

- Already collecting retirement benefits from Social Security or the Railroad Retirement Board.
- Are eligible for retirement benefits from Social Security or the Railroad Retirement Board but have not yet applied.
- Have (or have a spouse who has) at least 40 work quarters of Medicare-covered government employment and paid Medicare taxes.
- Are currently married to a spouse eligible for premium-free benefits.
- Are currently divorced but were married for at least 10 years, and the ex-spouse is eligible for premium-free benefits.
- Are currently widowed but were married for at least nine months before the spouse's death, and the spouse was eligible for premium-free benefits.

Those under 65 can also qualify for premium-free Medicare Part A if:

- They have received Social Security or Railroad Retirement Board disability benefits for 24 months.
- They have End-Stage Renal Disease (ESRD).

Who is obligated to cover Medicare Part A premiums?

Generally, individuals with fewer than 40 work quarters (equivalent to 10 years of work) of paid Medicare taxes are required to pay premiums for Medicare Part A coverage.

Individuals not eligible for premium-free Part A will face the following premiums in 2024:

- Those with less than 30 quarters of work credits: $505 per month
- Those with 30-39 quarters of work credits: $278 per month

Hospital Inpatient and Long-Term Care Services

When individuals are admitted to a hospital, they receive inpatient care. Long-term hospital care constitutes an inpatient stay lasting an average of 25 days or more. Medicare Part A coverage includes specific charges for inpatient services, dependent on the duration of the stay within a given benefit period. This period starts on the first day of admission and concludes after discharge, remaining uninterrupted by hospital readmission for 60 consecutive days. There are no restrictions on the number of benefit periods in Medicare.

Medicare Part A provides coverage for up to 90 days of inpatient and long-term hospital care in each benefit period. If enrollees require more than 90 days, they receive an additional 60 days of coverage known as lifetime reserve days. While benefit periods reset after 60 days without hospitalization, lifetime reserve days do not renew. Enrollees are allocated a total of 60 lifetime reserve days, and once exhausted, no further coverage is available.

The enrollee admits to the SNF within 30 days of the qualifying hospital stay and still has available days in their benefit period. A physician determines the necessity of skilled nursing care for the treatment of a medical condition that:

- Was addressed during the qualifying hospital stay, even if it was not the primary reason for admission; or
- Originated while the enrollee was under care in an SNF for a hospital-related medical condition.

Enrollees will encounter the following charges for inpatient and long-term hospital care services in 2024:

- $1,632 deductible per benefit period: This is the amount paid out-of-pocket by enrollees for covered services before Medicare begins payment.
- Days 1-60 of hospital admission: $0 coinsurance per day.
- Days 61-90 of hospital admission: $408 coinsurance per day: Coinsurance is the enrollee's shared expense for a covered service, with Medicare covering the remaining cost.
- Days 91 and beyond of hospital admission: $816 coinsurance per lifetime reserve day.
- Days after lifetime limit: Responsible for the full cost of care.
- Enrollees also pay 20 percent of all Medicare-allowed costs for mental health services received from doctors while admitted to a mental health care facility.

Inpatient Mental Health Care Services

Medicare beneficiaries receive coverage for inpatient mental health care services offered at general hospitals and psychiatric facilities. These services aim to address mental health conditions, including depression and anxiety. Medicare covers the expenses for:

- Room and board
- Meals
- Nursing care
- Lab tests
- Medications
- Therapy and treatment for the patient's condition

However, Medicare does not cover the following during an inpatient mental health admission:

- Private duty nursing
- Television or phone in the patient's room
- Personal items (i.e. toothpaste, socks, razors)

A private room (unless a doctor states it is medically necessary)

There is no restriction on the provision of inpatient mental health care services at general hospitals. However, a lifetime limit of 190 days applies to inpatient care at psychiatric facilities. In both settings, patients can have multiple benefit periods.

Enrollees incur charges for inpatient mental health care based on the length of their stay during any given benefit period:|

- $1,600 deductible per benefit period
- Days 1-60 of hospital admission: $0 coinsurance per day
- Days 61-90 of hospital admission: $400 coinsurance per day
- Days 91 and beyond of hospital admission: $800 coinsurance per lifetime reserve day
- Days after the lifetime limit: Responsible for the full cost of care
- 20 percent of the Medicare-allowed cost for mental health services received from doctors while they are inpatients
- Enrollees also pay 20 percent of all Medicare-allowed costs for mental health services received from doctors while they are admitted to a mental health care facility.

Skilled Nursing Facility (SNF) Services

Skilled nursing care refers to health care treatment or services that can only be provided by a registered nurse or doctor. Enrollees receive this specialized care at Medicare-certified Skilled Nursing Facilities (SNFs). Medicare covers SNF services only if the following criteria are met:

- The enrollee has a qualifying hospital stay, requiring admission to a general hospital for a minimum of three days before entering an SNF. If the enrollee re-enters the SNF within 30 days, an additional three days of inpatient care are not necessary.
- The enrollee enters the SNF within 30 days of the qualifying hospital stay.
- The enrollee has remaining days in their benefit period.
- A doctor deems skilled nursing care necessary for treating a medical condition that either started during the qualifying hospital stay or was treated during that stay, even if it wasn't the reason for admission.

Enrollees will incur the following charges for SNF care:

- Days 1-20: $0
- Days 21-100: $200 coinsurance per day
- Days 101 and beyond: Responsible for the full cost of care

Hospice Care:

Medicare Part A covers hospice care at no cost for enrollees, providing end-of-life care for terminal illnesses. However, a $5 copay per prescribed medication may apply. Enrollees may also be responsible for up to 5 percent of the Medicare-allowed amount for respite care, where the patient's caregiver needs a break.

Medicare does not cover room and board costs for hospice patients receiving care at home or in living facilities. If a hospice coordinator deems short-term care in a hospice facility necessary, Medicare will cover the stay.

Home Health Care:

Medicare Part A covers home health care services at no cost, delivered by skilled healthcare professionals in the enrollee's home. Enrollees might pay 20 percent of the Medicare-approved cost for durable medical equipment (DME) like canes, walkers, wheelchairs, or hospital beds.

For home health care, the doctor must certify the enrollee as homebound. Medicare includes part-time skilled nursing care, physical, occupational, and speech-language therapy, part-time home health aide services, medical social services, and injectable osteoporosis drugs.

Medicare does not cover the following home services:

- Continuous 24/7 care
- Meal delivery services
- Homemaker services as the sole needed care (including shopping, cooking, and cleaning)
- Personal care as the sole needed care

Nevertheless, if a patient, under home health care, needs approved durable equipment such as a hospital bed or wheelchair, Medicare will cover 20% of the expenses.

Medicare Part B

Medicare Part B is an elective coverage choice that includes essential medical and preventive services, along with outpatient care provided outside hospital admissions. Enrollees are obligated to pay monthly premiums for this coverage.

Part B coverage includes:

- Clinical research
  - Diagnostic tests
  - Surgical procedures
  - Medications
  - Innovative patient care approaches

Ambulance Services

- Ground ambulance transportation
- Emergency air transportation
- Medically necessary non-emergency ambulance transportation

Durable Medical Equipment (DME)

- Blood sugar monitors
- Blood sugar test strips
- Canes
- Commode chairs
- Continuous passive motion devices
- Continuous Positive Airway Pressure (CPAP) devices
- Crutches

- Hospital beds
- Infusion pumps and supplies
- Lancet devices and lancets
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Pressure-reducing support surfaces
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs and scooters
- All other relevant equipment

Behavioral health services encompass various treatment modalities, including:

- Inpatient care
- Outpatient care
  - Annual depression screening
  - Individual and group psychotherapy
  - Family counseling
  - Psychiatric evaluation
  - Medication management
  - Specific prescription drugs administered by professionals
  - Diagnostic tests
  - Initial “Welcome to Medicare” preventive visit
  - Annual “Wellness” visit
    Partial hospitalization

Moreover, outpatient pres
cription drugs under Part B are predominantly those that are not self-administered, such as vaccinations, injections, and intravenous medication.

Who is eligible for enrollment in Medicare Part B?

Eligibility for Medicare Part B is contingent upon whether an individual needs to pay Medicare Part A premiums. Detailed information about Part A premiums, including the criteria for payment, is available in the "**Medicare Part A**" section of this guide.

Individuals exempt from paying Part A premiums can access Part B as soon as they qualify for Part A. Enrollment in Part B occurs automatically for these individuals*. Enrollees have the option to accept or decline Part B coverage. Opting out of coverage and later deciding to enroll may result in a late enrollment fee and limitations to specific enrollment periods. Further details on enrollment periods are provided in the "When to Apply for Medicare" section.

*Residents of Puerto Rico with Part A coverage will not be automatically enrolled in Part B; they must actively enroll in Part B using the Application for Enrollment – Medicare Part B (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf).

Those obligated to pay premiums for Part A coverage must satisfy all the specified requirements outlined below to be eligible for enrollment in Medicare Part B:

- Aged 65 years or older
- Residing in the United States and either a U.S. citizen or a lawful alien who has been officially admitted for permanent residence, having continuously lived in the U.S. for five years preceding the month of Medicare application.

Medicare Part B Costs

Individuals under Medicare Part B are obligated to cover the following expenses for their medical treatment.

Medicare Part B Premiums

In contrast to Part A, every Medicare beneficiary is responsible for monthly premiums under Part B. Individuals receiving benefits through Social Security, the Railroad Retirement Board, or the Office of Personnel Management will experience automatic deductions of their monthly premium payments from their benefit checks. Other enrollees will receive billing statements for their premium payments.

The regular monthly premium for the year 2024 is $174.70. Nevertheless, individuals with elevated incomes may be obligated to pay higher monthly premiums for Part B. This determination is contingent on the modified adjusted gross income (MAGI), which is calculated by summing up the total income for the entire year and adding back any tax-exempt interest or deductions.

The table below outlines monthly premium amounts for enrollees with incomes higher than $103,000 (or $206,000 for joint tax returns) as shown on their income tax return documents two years prior to when they applied for Medicare.

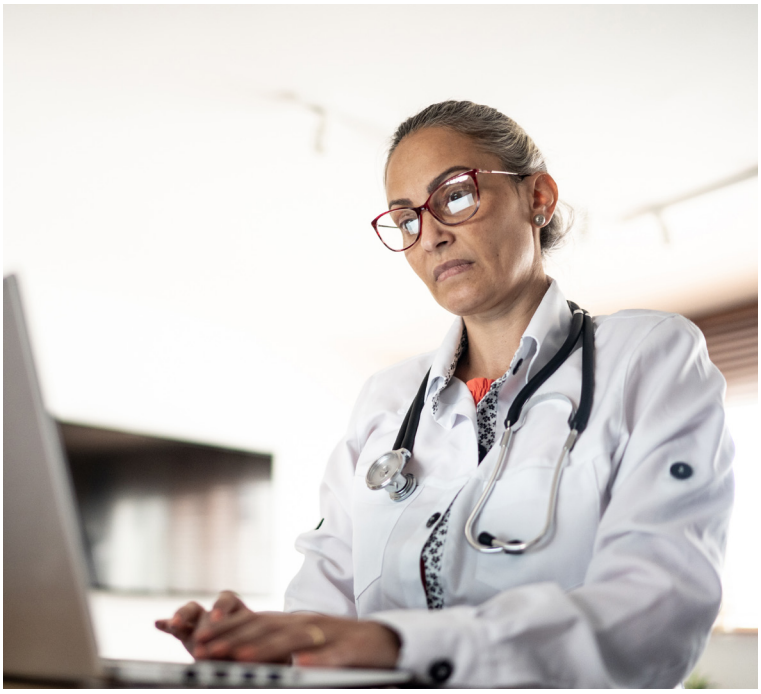
Individual Tax Return	Joint Tax Return	Married And Separate Tax Returns	Monthly Premium (2024)
$103,000 or less	$206,000 or less	$103,000 or less	$174.70
Between $103,000.01 and $129,000	Between $206,000.01 and $258,000	N/A	$244.60
Between $129,000.01 and $161,000	Between $258,000.01 and $322,000	N/A	$349.40
Between $161,000.01 and $193,000	Between $322,000.01 and $386,000	N/A	$454.20
Between $193,000.01 and $500,000	Between $386,000.01 and $750,000	Between $103,000.01 and $397,000	$559
$500,000.01 or more	$750,000.01 or more	$397,000.01 or more	$594

Medicare Part B participants encounter an **annual deductible,** representing a predetermined sum they must personally cover before Medicare contributes. The yearly deductible for 2024 stands at $240.

Once this deductible is satisfied, participants bear coinsurance, a percentage of healthcare expenses that they personally cover. The current coinsurance rate is 20%, with Medicare covering the remaining costs. Certain services such as laboratory services, home health care, and depression screening incur no copay and are fully covered.

Coinsurance applies to various services, including:

- Doctor visits
- Outpatient therapy
- Durable medical equipment (DME)



Clinical Trials

Medicare beneficiaries have the option to engage in clinical trials or research studies aimed at evaluating novel equipment, medications, or procedures. Participants are required to cover 20 percent of the Medicare-approved amount for any clinical trial they join. Additionally, the application of the Part B deductible is contingent upon the nature of the trial.

Ambulance Services:

Medicare Part B encompasses ambulance transportation to the nearest suitable hospital, skilled nursing facility, or critical access hospital. Medicare only covers expenses when ambulance usage is deemed medically necessary, and alternative transportation methods (like a car) could jeopardize the individual's health.

In cases where ground transportation is inaccessible or too slow, Medicare may also cover transportation by helicopter or airplane. Enrollees are responsible for 20 percent of the Medicare-approved amount for all ambulance services.

Additionally, the Part B deductible is applicable. If the enrollee has not met the annual deductible, they must personally cover expenses up to the deductible amount.

Durable Medical Equipment:

Medicare beneficiaries are eligible to receive durable medical equipment (DME) essential for treating their medical conditions, illnesses, or symptoms. A doctor must prescribe DME for use in the enrollee's home. Examples of DME include:

- Blood sugar monitors
- Blood sugar test strips
- Canes
- Commode chairs
- Continuous passive motion devices
- Continuous Positive Airway Pressure (CPAP) devices
- Crutches
- Hospital beds
- Infusion pumps and supplies
- Lancet devices and lancets
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Pressure-reducing support surfaces
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs and scooters

Medicare covers Durable Medical Equipment (DME) only if the enrollee's doctor and equipment supplier are Medicare participants. Non-participating entities result in claim denial, with enrollees bearing the full cost. Medicare-contracted doctors and suppliers, accepting assignment, can charge only coinsurance and the Part B deductible approved by Medicare.

Enrollees pay a 20 percent coinsurance for DME, applicable with the option to use their deductible. Equipment rental or purchase depends on the item and medical requirements.

Limited Outpatient Prescription Drugs:

A 20 percent patient responsibility applies to some medications administered in a doctor's office, including those used with DME (e.g., infusion pumps, nebulizers), select antigens, and injectable osteoporosis drugs.

In a hospital outpatient setting, a 20 percent copay is standard for prescription drugs. Participation in the 340B Drug Pricing Program by the patient's hospital often means a 20 percent charge based on the reduced price. This program mandates drug manufacturers to offer discounted outpatient drugs to healthcare organizations serving uninsured and low-income patients, allowing cost savings for patients.

For drugs not under Medicare Part B coverage, patients cover the entire cost unless they have prescription drug coverage via Medicare Part D or an alternate plan. Refer to the "Medicare Part D" section for more information on Part D coverage in this guide.

Outpatient Mental Health Care Services:

While Medicare Part A addresses inpatient mental health care (received during hospital or psychiatric facility admission), Part B encompasses outpatient mental health services delivered in doctors' offices or non-hospital office settings. Outpatient settings exclude admissions or overnight stays and include services for diagnosing, treating, or managing mental health conditions.

Medicare Part B covers the following outpatient mental health services:

- One complimentary annual depression screening by a primary care doctor (Medicare payment contingent on doctor or facility participation)
- Individual and group psychotherapy conducted by a doctor or licensed therapist, known as "talk therapy" to address challenges and modify behaviors
- Family counseling
- Psychiatric evaluations and testing
- Medication management
- Certain non-"self-administered" prescription drugs, such as injectables
- Diagnostic tests
- Partial hospitalization, a more intensive outpatient care without overnight stays, typically offered in hospital outpatient wings
- Treatment for substance and alcohol abuse

Enrollees are responsible for a 20 percent coinsurance of the Medicare-approved amount for outpatient mental health services, with the option to apply their deductible toward the payment.

Medicare Part C

Medicare Part C, also known as Medicare Advantage, is the option to receive Medicare coverage through a private insurance company. Part C (Medicare Advantage) plans are offered through private companies who have been approved by Medicare. These plans include all benefits that are offered in Plan A and Plan B, and frequently include Part D benefits as well.

These plans may provide more extensive coverage compared to standard Medicare, incorporating vision, hearing, and dental benefits.

Similar to a conventional health insurance plan, individuals under Medicare Part C must utilize the services within their plan's network to access benefits. In return, they enjoy more comprehensive coverage with reduced copayments compared to the standard charges typically associated with Medicare.

Who Qualifies for Medicare Part C?

Eligibility for enrollment in a Medicare Part C plan is generally extended to individuals who:

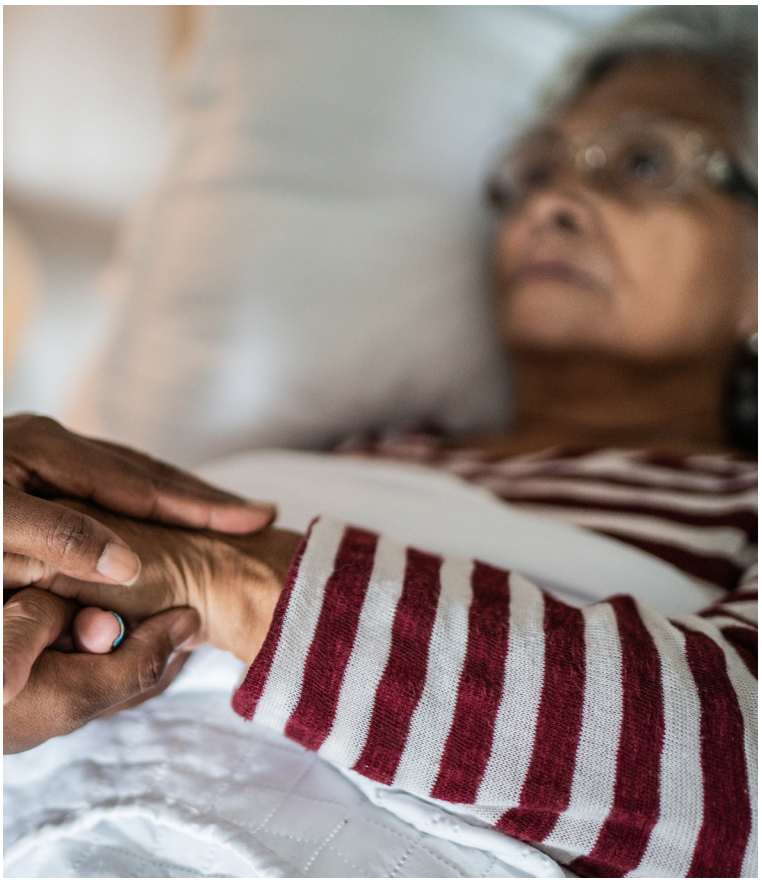
Possess both Medicare Part A and Part B coverage.
Are either a U.S. citizen, U.S. national, or hold lawful presence in the U.S.
Reside within the service area designated by the health plan.
(It's essential for those interested in Medicare Part C to choose a plan available in their residential region.)

Note: Starting in 2021, individuals eligible for Medicare with End-Stage Renal Disease (ESRD) can also enroll in Medicare Part C plans.

Selecting a Medicare Part C Plan:

A variety of Medicare Part C plans are accessible, including:

- **Health Maintenance Organization (HMO) Plans:** These plans offer coverage within the plan's network, with exceptions for emergencies. Typically, a specialist referral is required. Seeking care outside the network incurs higher costs, often the full expense, in contrast to in-network services
- **Preferred Provider Organization (PPO) Plans** — Similar to HMO plans, PPO plans require you to stay within the network for coverage. However, you can still obtain coverage for services outside the network, albeit at a higher cost to you. Typically, there is no requirement for referrals to consult with a specialist.
- **Private Fee-For-Service (PFFS) Plans** — PFFS plans exhibit greater resemblance to traditional Medicare compared to other Medicare Advantage plans. Participants have the flexibility to receive care from any Medicare-approved provider who agrees to the plan's terms. Certain PFFS plans come with networks that offer reduced costs, while others may not have such networks. In certain instances, prescription drug coverage may not be included in PFFS plans. If your PFFS plan lacks prescription coverage, consider enrolling in Medicare Part D for medications.



- Special Needs Plan (SNP) — Tailored for Medicare beneficiaries with particular illnesses or constrained incomes, SNPs, akin to HMOs and PPOs, usually confine care to network providers. Typically, having a primary care doctor or care coordinator is necessary for treatment planning. SNPs are mandated to incorporate Part D coverage. To be eligible for an SNP, you must fulfill one of the following criteria:

    - Living with a chronic illness
    - Residing in an institution or requiring home nursing care
    - Qualifying for both Medicare and Medicaid

- Medicare Savings Account (MSA) Plans — MSA plans allow you to use a medical savings account combined with a high-deductible plan to receive coverage. If you use MSA, you generally must join a Part D plan as well, unless you already have a Medigap policy with drug coverage.

The availability of Medicare Part C plans depends on the area in which you live. Some areas may offer all, some or none of these types of Part C plans. In addition, there may be several plans available in your area within the same category. Visit medicare.gov/plan-compare and enter your ZIP code to see the plans that are available in your area.

Medicare Part C Costs Overview

Expenses for Medicare Part C vary according to the specific plan. Monthly premiums may be applicable to HMO, PPO, PFFS, and SNP plans, each with its unique co-payment structure.

Apart from the Part C plan expenses, the obligation to pay Part B premiums persists.

Some Part C plans cover or charge $0 for Part B premiums. In the case of MSA plans, enrollees are responsible for Part B premiums but incur no additional premiums for Part C. Annual out-of-pocket costs for any plan are capped at $7,550, excluding prescription drug expenses. It's important to note that numerous plans establish lower limits on out-of-pocket expenses.

Special Needs Plans (SNPs)
Special Needs Plans (SNPs) represent a category within Medicare Part C, tailored to specific populations. These health care plans deliver equivalent benefits and coverage choices as other Medicare Part C plans. Further details about Part C plans can be found in the "Medicare Part C" section of this guide.

Insurance providers can offer SNPs in the following categories:
- Chronic SNP
- Institutional SNP
- Dual-Eligible SNP

What is a Chronic Special Needs Plan (SNP)?

A Chronic SNP is crafted for beneficiaries dealing with particular chronic or disabling conditions. Given that SNPs are administered by private insurance companies, coverage may be restricted to specific conditions. Before enrolling, beneficiaries should verify if their condition aligns with the SNP provider's coverage criteria.

What is an Institutional Special Needs Plan (SNP)?

An Institutional SNP caters to beneficiaries residing in specific institutions, like nursing homes. This plan is also accessible to individuals in need of nursing home-level care while staying at home.

What is a Dual-Eligible Special Needs Plan (SNP)?

A Dual-Eligible SNP is tailored for beneficiaries eligible for both Medicare and Medicaid.

Who is eligible for a Special Needs Plan (SNP)?

To be eligible for a SNP, individuals must fulfill the following criteria:

- Possess Medicare Parts A and B
- Reside within the plan's service area
- Meet the specific requirements for Chronic, Institutional, or Dual-Eligible plans

Medicare Part D

Medicare Part D, often referred to as a "prescription drug coverage plan," supplements Original Medicare (Parts A and B) by offering coverage for prescription medications. Given that Parts A and B do not include prescription drug coverage, beneficiaries can opt to enroll in Medicare Part D to access a range of prescription medications. Enrolling in Medicare Part D is optional; individuals may choose to do so if they lack drug coverage from other insurance plans.

Similar to Medicare Part C, the availability of drug coverage plans is contingent on the enrollee's location. Part D plans are provided by private insurance companies collaborating with Medicare to extend drug coverage to Medicare beneficiaries. Insurance costs, drug expenses, and plan options vary based on the enrollee's residence.

While plans differ, all Medicare Part D providers must adhere to specific drug class coverage options established by Medicare. This mandates that all plans cover medications falling within designated drug classes:

- Antidepressants
- Antipsychotics
- Anticonvulsants
- Cancer drugs
- HIV/AIDS drugs
- Immunosuppressants

Each provider of Medicare Part D has its own drug formulary, which is essentially a catalog of prescription medications it covers. The formulary typically organizes drugs into tiers based on cost and specialization. For instance, a Part D plan might categorize covered drugs into tiers such as generic medications, brand-name medications, and specialized medications. Generally, generic prescription drugs represent the most economical option in Part D plans.

Medicare mandates that Part D plans include at least two versions of a drug in their formulary. This ensures that if a specific brand of drug is unavailable, the plan will still cover a generic or an equivalent alternative.

Who is eligible for Medicare Part D?
Individuals with Medicare Part A and/or Part B can typically qualify for enrollment in Medicare Part D if they lack prescription drug coverage from another plan. Those under Medicare Part C may already have integrated prescription drug coverage and should verify their policy details before enrolling.

Costs of Medicare Part D

Enrollees in Medicare Part D are required to pay a monthly premium for coverage, with the specific amount varying based on the chosen plan. Those with higher incomes may incur an additional cost, known as the Part D-Income Related Monthly Adjustment Amount. In 2024, individuals with incomes exceeding $103,000 (for individual filers or married filing separately) or $206,000 (for married joint filers) generally need to pay extra costs. The Social Security Administration (SSA) will notify individuals about any additional payments based on their income.

Note: Should you delay enrolling in a Medicare Part D plan after becoming eligible, there is a possibility of incurring a late enrollment fee. Find detailed information about this fee in the "Penalties for Missing Medicare Part D Enrollment Deadlines" section.

Medigap Coverage

Medigap policies serve as insurance plans crafted to address healthcare services and treatments not entirely covered by standard Medicare. They extend coverage to include expenses such as copayments, coinsurance, and deductibles. Unlike Medicare, these health insurance policies are offered by individual health insurance companies rather than the federal government.

Requirements for Medigap Policies

- To qualify for enrollment in a Medigap health insurance plan, individuals must meet the following criteria:
- Possess both Medicare Parts A and B; enrollment is not available for those with Medicare Part C.
- Pay a monthly premium to the Medigap insurance provider, which is separate from any premiums for Medicare Part B coverage.
- Obtain a Medigap policy from a provider licensed in the individual's state. To explore available Medigap plans in your state, use your ZIP code on the official Medicare website: Medigap Plans Search.

Medigap Policy Characteristics

Individual Assignment:
Medigap policies are individually assigned, catering to a single person. There are no provisions for group, family, or spousal Medigap plans. Should a married couple seek Medigap coverage for both spouses, each individual must independently procure their own policy.

Incompatibility with Medicare Part C:
Medigap policies cannot be utilized in conjunction with Medicare Part C plans. They do not cover Part C copayments, deductibles, or premiums. It is unlawful for any insurance provider to sell a Medigap policy to individuals with a Medicare Part C plan.

Absence of Prescription Drug Coverage:
Medigap insurance plans do not incorporate prescription drug coverage. If such coverage is desired or required, a separate Medicare Part D plan can be purchased. For detailed information on drug coverage options, refer to the "Medicare Part D" section of this guide.

Standardization of Medigap Policies:
Medigap policies adhere to standardization, simplifying the comparison of plans across different insurance companies. All providers offering the same Medigap policy must furnish identical basic benefits. However, costs for the same policies may vary between companies.

Evaluating Medigap Policies

With the exception of Massachusetts, Minnesota, and Wisconsin, Medigap policies follow a standardized format across all states. Similar to Medicare plans, Medigap policies are classified by letters. The available Medigap plans include:

A	G
B	K
C*	L
D	M
F	N

Distinctions among these Medigap plans lie in variations in deductibles, copays, and coverage for skilled nursing facilities. It is the responsibility of each insurance company to determine which type of Medigap plan(s) it wishes to make available. When selling Medigap policies, all insurance providers must adhere to the following guidelines:

- Companies are not obligated to provide every Medigap plan.
- Companies must include Medigap Plan A in their offerings if they choose to offer any Medigap policy.
  - If a company offers any plan in addition to Medigap Plan A, it must also include either Plans C or F in its selection.

**This requirement pertains to offering Plans C or F if any plan beyond Medigap Plan A is provided.*

Important Information: Starting January 1, 2020, individuals newly eligible for Medicare are unable to acquire a Medigap plan covering their Part B deductible. Consequently, Plans C and F are not accessible to those new to Medicare. However, individuals already possessing these plans are permitted to retain them. Additionally, individuals eligible for Medicare before January 1, 2020, who have not yet enrolled, retain eligibility to purchase these plans based on their previous qualification.

Medigap Benefits Based on PolicyMedigap policies are classified into 10 plans, each offering distinct benefits to Medicare beneficiaries.

The chart below delineates the benefits provided by each type of Medigap plan in all states, excluding Massachusetts, Minnesota, and Wisconsin. For details on Medigap policies in these specific states, please refer to the "Medigap Policies in Massachusetts, Minnesota, and Wisconsin" section of this guide.

- **"Y"** signifies complete coverage of the benefit.
  "N" denotes no coverage for the benefit.
- A **percentage "%"** indicates coverage of the corresponding benefit at the listed percentage.
- **"N/A"** indicates that the benefit does not apply.

- **One asterisk (*)** signifies that the policy provides a high-deductible plan option in certain states. With this option, beneficiaries must bear the costs of Medicare-covered expenses (coinsurance, copayments, and deductibles) up to the deductible amount of $2,800 in 2024 before the Medigap policy initiates coverage.
- **Two asterisks (**)** indicate that the plan covers 100 percent of the costs of covered services for the remainder of the year after beneficiaries reach their out-of-pocket yearly limit and the yearly Medicare Part B deductible.
- **Three asterisks (***)** indicate that the plan covers 100 percent of the Part B coinsurance, with the exception of a copayment of up to $20 for certain office visits and up to a $50 copayment for emergency room visits that do not lead to inpatient admission.

Medicap Benefits	Medicap Plans									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Part A hospice care coinsurance or copayment	Y	Y	Y	Y	Y	Y	50%	75%	Y	Y
Part A deductible	N	Y	Y	Y	Y	Y	50%	75%	50%	Y
Part B coinsurance or copayment	Y	Y	Y	Y	Y	Y	50%	75%	Y	Y***
Part B deductible	N	N	Y	N	Y	N	N	N	N	N
Part B excess charges	N	N	N	N	Y	Y	N	N	N	N
Blood transfusions per year (first 3 pints)	Y	Y	Y	Y	Y	Y	50%	75%	Y	Y
Skilled nursing facility care coinsurance	N	N	Y	Y	Y	Y	50%	75%	Y	Y
Foreign travel exchange	N	N	80%	80%	80%	80%	N	N	80%	80%
Out-of-pocket limit for 2024**	N/A	N/A	N/A	N/A	N/A	N/A	$7,060	$3,530	N/A	N/A

Medigap Policies in Massachusetts, Minnesota, and Wisconsin

Medigap policies in Massachusetts, Minnesota, and Wisconsin follow a distinct standardization approach. For more information on Medigap in these three states, please refer to the sections below.

Medigap Policies in Massachusetts

Every Medigap policy in Massachusetts is obligated to provide coverage for the **fundamental benefits** listed below:

- Part A coinsurance
- Part A hospice cost sharing
  - Offers supplemental coverage for certain Medicare Part A beneficiaries who need to cover costs related to hospice care or services.

- Extended coverage of 365 days for Part A hospital services following the conclusion of Part A Medicare coverage.
- Part B coinsurance.

Coverage for the initial three pints of blood for transfusions per year

Beneficiaries in Massachusetts have the option to select from three categories of Medigap plans:

- Core Plan
- Supplement 1 Plan

Supplement 1A Plan

Core Plan

The Core Plan provides coverage for:

- All previously mentioned basic benefits
- 60 inpatient days in a mental health treatment facility annually
- State-mandated benefits, including yearly pap smears and mammograms.

Supplement 1 Plan

In addition to the coverage provided by the Core Plan, the Supplement 1 Plan includes:

- Part A inpatient hospital deductible
- Part A skilled nursing facility coinsurance
- Part B deductible
- Coverage for foreign travel emergency costs

120 inpatient days for mental health treatment annually

Supplement 1A Plan

The availability of the Supplement 1A Plan is restricted to individuals who enrolled in Medicare before January 1, 2020; it is not an option for newly-eligible Medicare patients. This plan extends coverage beyond the Core Plan, including:

- Part A inpatient hospital deductible
- Part A skilled nursing facility coinsurance
- Coverage for foreign travel emergency costs
- 120 inpatient days for mental health treatment annually

Medigap Policies in Minnesota

All Medigap policies in Minnesota are required to encompass the following fundamental benefits:

- Part A coinsurance
- Part B coinsurance
- Part A hospice care cost sharing
  - Provision of gap coverage for certain Medicare Part A enrollees obligated to pay for hospice care or services
- Cost sharing for Parts A and B home health services and supplies

Coverage for the initial three pints of blood for transfusions per year

There are two plans in Minnesota

- Basic Plan
- Extended Basic Plan

Basic Plan

The Basic Plan includes:

- All fundamental benefits mentioned earlier
- Part A skilled nursing facility (SNF) coinsurance
- Coverage for 100 days of care in a SNF
- 80 percent coverage for foreign travel emergency
- 50 percent coverage for outpatient mental health care costs
- Medicare-covered preventive care
- 20 percent coverage for physical therapy costs

State-mandated benefits, encompassing diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations

Extended Basic Plan

The extended basic plan provides coverage for:

- All fundamental benefits as described earlier
- Part A inpatient hospital deductible
- Part A skilled nursing facility (SNF) coinsurance, offering care for 120 days in a SNF
- Part B deductible
  - Please note that this coverage exclusion applies to newly-eligible Medicare recipients. As of January 1, 2020, individuals new to Medicare are ineligible for Medigap coverage of the Part B deductible.
- 80 percent coverage for costs related to a foreign travel emergency
- 50 percent coverage for outpatient mental health
- 80 percent coverage of usual and customary fees
- Medicare-covered preventive services
- 20 percent coverage for physical therapy
- State-mandated benefits, encompassing diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations.

Note:
Two asterisks (**) denote that the plan will cover 100 percent of costs once the beneficiary has incurred $1,000 in out-of-pocket expenses within a one-year period.

Medigap Policies in Wisconsin

All Wisconsin Medigap policies must cover the following basic benefits:

- Part A inpatient hospital coinsurance
- Part A hospice cost-sharing
  - Offers supplemental coverage for certain Medicare Part A enrollees who are obligated to pay for hospice care or services
- Part B coinsurance
- Coverage for the initial 3 pints of blood for transfusions per year

Wisconsin features a singular Medigap plan, referred to as the Basic Plan. However, insurers have greater flexibility in defining this Basic Plan, allowing them to incorporate specific benefits beyond the standard coverage options. All companies offering the Basic Plan include:

- All fundamental benefits mentioned earlier
- Part A skilled nursing facility (SNF) coinsurance
- Coverage for 175 days of inpatient mental health care once the Medicare inpatient mental health care limit is reached
- 40 additional home health care visits, exceeding the number allowed by Medicare
- State-mandated benefits

Wisconsin provides alternative Medigap plan choices with varying costs and benefits. The 50% and 25% cost-sharing plans mirror the standardized Medigap Plans K and L, as outlined in the table within the “Medigap Benefits by Policy” section. In 2024, insurance companies can offer Medigap Basic plans with a high deductible of $2,800. Moreover, companies have the option to incorporate the following benefits into their Medigap policies:

- 50% coverage of Part A deductible
- Part B deductible
  - *Note: This coverage exclusion applies to newly-eligible Medicare recipients. As of January 1, 2020, individuals new to Medicare are ineligible for Medigap coverage of the Part B deductible.*
- Part B copayment or coinsurance
- Part B excess charges
- Extra home health care
  - providing 365 visits, including those covered by Medicare

Expenses associated with a foreign travel emergency

PACE is a collaborative program involving both Medicare and Medicaid, designed to assist senior citizens in accessing healthcare within their local communities instead of mandating residence in a nursing home or long-term care facility. Participants benefit from a dedicated team of healthcare professionals committed to orchestrating their treatment.

Under PACE, all medically necessary treatments covered by Medicare and Medicaid are included, as determined by the individual's team of healthcare professionals. These treatments encompass:

- Adult day primary care
- Dentistry
- Doctor visits
- Emergency services
- Home care
- Hospitalizaciones
- Laboratory/X-ray services
- Meals
- Medical specialty services
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Physical therapy
- Prescription drugs
- Preventiva care
- Social services
- Social work counseling
- Transportation

As PACE is not a federally administered initiative, its availability varies by state. Rather than being universally accessible, distinct PACE programs cater to specific geographical regions. Presently, there are 146 PACE programs operating through 273 centers in 32 states.

As of now, Washington, D.C., along with the following states, is where a PACE program is currently in operation:

- Alabama
- Arkansas
- California
- Colorado
- Delaware
- Florida
- Indiana
- Iowa
- Kansas
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Nebraska
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Virginia
- Washington
- Wisconsin

Due to the localized nature of PACE programs, their availability may vary, and even if a program exists in your state, it might not be accessible in your specific location.

To determine the proximity of a PACE program to your area, utilize the PACE program locator tool available at: https://www.npaonline.org/pace-you/pacefinder-find-pace-program-your-neighborhood

Who is eligible for PACE?

To qualify for PACE, individuals must fulfill the following criteria:

- Attain the age of 55 or older.
- Reside within the designated service area covered by a PACE organization.
- Receive certification from the state indicating the need for a nursing home level of care.
- Demonstrate the ability to reside in the community with the support of PACE services.

PACE Costs

PACE program costs vary based on Medicare and Medicaid eligibility. Approved treatments overseen by your healthcare team have no deductibles or copayments.

- **If your eligibility pertains solely to Medicare**, you'll be required to cover premiums for long-term care and a prescription drug (Part D) premium.
- **For individuals eligible for both Medicare and Medicaid**, there won't be any premium charges for the long-term care component of PACE.
- **In cases where eligibility for Medicare or Medicaid is absent**, you bear responsibility for covering the expenses associated with all PACE treatments.

Covering the Costs of Medicare

Payment for Medicare coverage includes premiums, as well as deductibles, copayments, and coinsurance for specific treatments.

A premium is the fee an insured individual pays to obtain coverage.

A deductible is the out-of-pocket amount that an enrollee pays for covered services before Medicare initiates payment.

A copayment is a predetermined cost borne by the enrollee for services, office visits, or medications, paid out of pocket.

Coinsurance signifies the enrollee's jointly-shared expense for a covered service, involving an agreed-upon out-of-pocket payment, with the remaining cost covered by Medicare.

Covering Costs for Medicare Parts A and B

Premiums are mandatory for Medicare Part B and D, and your specific plan for Medicare Part C may also require premiums. Depending on your work history, you might also need to pay premiums for Medicare Part A. Refer to "Who needs to pay Medicare Part A premiums?" for additional details.

If you receive Social Security or Railroad Retirement Board benefits, your Medicare Part B premiums can be deducted automatically from your Social Security payments.

Four payment options are available for your Medicare Parts A and B premiums:

Access your Medicare account and manually pay your premiums using a credit card, debit card, or bank account by logging in at https://account.mymedicare.gov/.

Establish an online bill payment service through your bank, following their instructions. Provide your Medicare number, list the payee as "CMS Medicare Insurance," and use the address:
Medicare Premium Collection Center
P.O. Box 979098
St. Louis, MO 63197-9000

Enroll in Medicare Easy Pay, which automatically deducts monthly premiums from your checking or savings account. Complete the form at https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/sf5510english.pdf and mail it to:
Medicare Premium Collection Center
P.O. Box 979098
St. Louis, MO 63197-9000

Mail your payment to Medicare via credit card, debit card, check, or money order using the payment coupon from your bill. Send the completed coupon to:
Medicare Premium Collection Center
P.O. Box 979098
St. Louis, MO 63197-9000

Covering Costs for Medicare Part C

If your Medicare Part C plan mandates premiums, you'll directly pay the insurance provider. During enrollment, choose your preferred payment method, which varies among providers but generally includes the following options:

- Pay by check
  - Upon receiving a bill from your Part C provider, mail a check for your premium payment to the specified address.
- Set up automatic debit payments
  - Arrange automatic payments through your bank or credit union, allowing your provider to deduct the premium automatically.
- Use a debit or credit card
  - Enter your debit or credit card details on your provider's website, or follow payment instructions in your premium bill.
- Deduct payments from benefits
  - Some providers may permit deducting your Part C premium from other benefits received through Social Security or the Railroad Retirement Board (RRB).

Note that the listed payment methods may not be available with every Part C plan provider. Contact your provider for more information on submitting payments.

Covering Costs for Medicare Part D

Authorize direct deductions of Part D premiums from your Social Security benefits by contacting your Part D provider. They will also offer alternative methods for monthly premium payments.

If you have to settle a Part D IRMAA payment, make the payment directly to Social Security using the same options outlined for paying Medicare Parts A and B premiums, as detailed in the preceding section.

Paying for a Medigap Plan

For Medigap Plan expenses, payment methods vary by provider, similar to Medicare Part C. If a premium is required, make direct payments to the provider. Consult the “Paying for Medicare Part C” section for accepted payment methods, and reach out to your provider for additional guidance on payment submissions.

The Medicare Savings Program

Low-income residents meeting specific qualifications can receive state assistance with Medicare premiums and costs, including support for deductibles and copayments for Medicare Parts A and B. The following programs cater to these individuals, with the information current as of 2023; details for 2024 are pending.

- **Qualified Medicare Beneficiary (QMB) Program**
  - Individual Monthly Income Limit: $1,153
  - Married Couple Monthly Income Limit: $1,546
  - Individual Resource Limit: $8,400
  - Married Couple Resource Limit: $12,600
  - This program assists with:
    - Part A premiums
    - Part B premiums
    - Deductibles, coinsurance, and copayments

- **Specified Low-Income Medicare Beneficiary (SLMB) Program** — Geared towards low-income individuals with Part A coverage and limited income and resources.
  - Individual Monthly Income Limit: $1,379
  - Married Couple Monthly Income Limit: $1,851
  - Individual Resource Limit: $8,400
  - Married Couple Resource Limit: $12,600
  - This program provides assistance for:
    - Part B premiums

Qualifying Individual (QI) Program — Comparable in intent to the SLMB program, this initiative operates on a first-come, first-serve basis, with preference given to those who received QI benefits the preceding year. Not open to Medicaid recipients.

- Individual Monthly Income Limit: $1,549
- Married Couple Monthly Income Limit: $2,080
- Individual Resource Limit: $8,400
- Married Couple Resource Limit: $12,600
- This program assists with:
  - Part B premiums

- **Qualified Disabled and Working Individuals (QDWI) Program —** Geared towards assisting with Part A premiums, this program is applicable to the following categories:
- Working disabled individuals under 65
- Individuals who lost premium-free Part A upon returning to work
- Individuals not receiving medical assistance from the state
- Individuals meeting state income and resource limits
- Limits: Individual Monthly Income Limit: $4,615
    - Married Couple Monthly Income Limit: $6,189
    - Individual Resource Limit: $4,000
    - Married Couple Resource Limit: $6,00
    - This program provides support for
        - Part A premiums

Note:
Income limits are slightly higher in Alaska and Hawaii. In Alaska, the limits remain consistent for each type of MSP. It's important to acknowledge that income and resource limits for 2024 were not available during the research. The most recent income and resource limits for Alaska, valid for FY 2021, are detailed below:

- *Individual Monthly Income Limit: $1,831*
- *Married Couple Monthly Income Limit: $2,470*
- *Individual Resource Limit: $7,970*
- *Married Couple Resource Limit: $11,960*

Hawaii income limit information was not accessible during the research. However, the following resource limits are applicable:

- *Individual Resource Limit for QMB, SLMB, and QI: $6,600 plus $500 per dependent*
- *Married Couple Resource Limit for QMB, SLMB, and QI: $9,910 plus $500 per dependent*
    - *Individual Resource Limit for QDWI: $4,000 plus $500 per dependent*
- *Married Couple Resource Limit for QDWI: $6,000 plus $500 per dependent*

How to Apply for Medicare

You can enroll in Medicare through three different methods:

- Online
- By phone
- In person

Depending on the specific Medicare plan you wish to join, your available enrollment methods may vary among those mentioned earlier. Enrollment in Medicare can occur automatically or manually, and the determination of your enrollment process is influenced by the following factors:

- Receiving benefits from Social Security or the Railroad Retirement Board (RRB) at least four months before reaching the age of 65.
- Being under the age of 65 and having a disability.
- Having End Stage Renal Disease (ESRD).
- Having ALS (Lou Gehrig's Disease).

For further details on how to initiate your Medicare application, explore the sections below. These sections provide insights into your enrollment choices and the timing of eligibility for benefit application.

Required Information and Documentation for Application

When applying for Medicare, it is essential to furnish specific information and documents to confirm your eligibility for the program.

To initiate the application for Medicare Parts A and B, the following information is necessary:

- Your date and place of birth
- Medicaid number and start date, if applicable
- Current details of your health insurance

If you are applying for Medicare Parts A or B as the spouse of an eligible Medicare beneficiary, you will also be required to furnish the following details:

- Information related to your marriage and divorce
  - Name of your current spouse
  - Name of any previous spouse, particularly if the previous marriage lasted for over 10 years or ended in death
  - Date(s) of birth and Social Security Number(s) of your spouse or spouses
  - Start and end dates of your marriage(s)
  - Location(s) of your marriage(s)
- Names and birthdates of children who became disabled before turning 22, those under 18 and unmarried, or those aged 18 or 19 attending school full time
- U.S. military service history, including:
  - Branch served in
  - Position held
  - Start and end dates
- Employment details for the last three years, if not self-employed, including:
  - Employer name
  - Start and end dates
- Self-employment details for the last three years, if self-employed, including:
  - Business type
  - Total net income
- Bank account information for direct deposit.

To enroll in Medicare Parts C or D, you are required to furnish the following details from your Medicare card:

- Your Medicare number

The date(s) when your Medicare Parts A and/or B coverage commenced

You have the option to enroll in Medicare Parts A or B through the following methods:

- Online
- By phone
- In person

Apply Online for Parts A and B

Follow the steps provided below to submit your application online:

1. Visit the Social Security website at https://www.socialsecurity.gov/medicare/apply.html.
2. Scroll down and choose the option "Apply for Medicare Only."
3. You will be directed to the "Apply for Benefits" online portal on the Social Security website.
   - Input all the necessary information, as detailed in the "Information and Documents Needed to Apply" section.
   - The application process typically takes between 10 and 30 minutes.
4. Click on "Submit Now."

Upon submission, you will receive a receipt along with an application number, which should be retained for future reference. The Social Security Administration (SSA) will review your application and send you their decision by mail.

Apply by Phone for Parts A and B

Enroll in Medicare Parts A and B by dialing 1-800-772-1213.

Apply in Person for Parts A and B

Enroll in Medicare Parts A and B by visiting a nearby Social Security office. Locate an office in your vicinity using the locator tool available here: https://secure.ssa.gov/ICON/main.jsp

What if I initially declined Part B coverage but now wish to apply?

If you initially declined Part B coverage upon eligibility and now desire to apply, you can enroll through the following methods:

- Online
  - Access your mySocialSecurity account at https://www.ssa.gov/myaccount/
  - Complete the online application and click "submit."

By mail

Download, print, and fill out the "Application For Enrollment in Medicare Part B" form (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf) and mail it to your local Social Security office. Locate an office nearby using the tool here: https://secure.ssa.gov/ICON/main.jsp

Note:As PACE is not a federally administered initiative, its availability varies by state. Rather than being universally accessible, distinct PACE programs cater to specific geographical regions. Presently, there are 146 PACE programs operating through 273 centers in 32 states.

How to Enroll in Medicare Part C

Given that Medicare Part C plans are provided by private insurance companies rather than the federal government, the enrollment methods may vary. Depending on your provider, you can consider the following options:

- Online:
  - Check your **provider's website** for the availability of an online application.
- By Phone:
  - Contact your provider directly to apply or to gather more information about application procedures.
  - You can also call the national Medicare line at **1-800-633-4227.**
- By Mail or In Person:
  - Every Medicare Part C plan is required to offer a **paper enrollment form**. Some providers permit mail-in applications, while others may necessitate in-person form submissions. Please contact your plan for specific details.

Before enrolling in a Medicare Part C plan, it is crucial to identify a plan that operates in your location. Utilize the plan finder at this link: Medicare Plan Finder

How to Enroll in Medicare Part D

Before signing up for a Medicare Part D plan, it's essential to locate a plan available in your area. Utilize the plan finder at this link: Medicare Plan Finder. Once you identify a suitable Part D plan, you can enroll through the following methods:

- Online:
  - Apply on your provider's website or directly on the Medicare.gov website at this address: Medicare Plan Compare.
- By Phone:
  - Contact your provider directly to apply or to gather more information about application procedures.
  - You can also call the national Medicare line at **1-800-633-4227.**
- By Mail or In Person:

Medicare Part D plans offer a **paper enrollment form**, and submission methods vary. Some allow mail-in applications, while others require in-person submissions. Contact your plan for details.

How to Enroll in a Medigap Plan

To enroll in a Medigap program, compare options in your state, choose a plan, and find a local insurance company offering that policy. Use these methods to locate insurers:

- Visit the following link and enter your ZIP code: Medigap Supplemental Insurance Plans
- Seek assistance from your State Insurance Department by visiting: State Insurance Department Contacts
- Conduct an online search for information on insurance companies providing Medigap coverage in your area.

Once you have pinpointed the Medigap policy you wish to enroll in, follow the steps outlined by the insurer to complete the enrollment process.

How to Enroll in the Program of All-Inclusive Care for the Elderly (PACE)

PACE programs vary in their application processes by state and plan. To apply, visit the website of your local PACE plan or contact them directly. Find contact details using the PACEfinder tool.

When to Apply for Medicare

Medicare applications are only accepted during specific timeframes known as enrollment periods. There are three distinct types of enrollment periods for Medicare applicants:

- Initial Enrollment Period (IEP)
- Special Enrollment Period (SEP)
- General Enrollment Period (GEP)

Not applying for Medicare Parts A, B, or D initially may incur a late enrollment fee upon later application. Find details about these fees in the "Penalties for Missing Medicare Deadlines" section.

The Initial Enrollment Period (IEP) is applicable to those newly eligible for Medicare due to age or disability. It spans seven months around the applicant's 65th birthday (for age-based eligibility) or the 24 months when the applicant receives Social Security or Railroad Retirement Board (RRB) benefits (for disability-based eligibility).

The IEP is split into three periods:

- 3 months before the month the applicant turns 65 OR the month before the 25th month of receiving Social Security or RRB disability benefits
- The month of the applicant's 65th birthday OR the 25th month of receiving Social Security or RRB disability benefits
- The three months after the month the applicant turns 65 OR after the 25th month of receiving Social Security or RRB disability benefits

Applicants can apply for the following types of Medicare in their Initial Enrollment Period:

- Medicare Part A
- Medicare Part B
- Medicare Part C
- Medicare Part D

Open Enrollment Phase

Those who missed enrolling in Medicare Parts A and B during the Initial Enrollment Period (IEP) can now do so in the annual **General Enrollment Period (GEP)** from **January 1 to March 31**. To be eligible for GEP enrollment, applicants must meet specific conditions:

- Missing the Initial Enrollment Period (IEP).
- Ineligibility for a Special Enrollment Period (SEP).

Refer to the next section for Special Enrollment Period eligibility. Enrolling in Medicare Parts A or B during the General Enrollment Period may mean higher premiums. Explore late enrollment penalties in the "Penalties for Missing Medicare Deadlines" section.

Open Enrollment Period – Medicare Parts C and D

If individuals miss enrolling in Medicare Parts C or D during their Initial Enrollment Periods, they cannot sign up for the first time during the General Enrollment Period from January 1 to March 31, unless they already have Medicare Part C and wish to switch back to Parts A and/or B. Instead, they must wait for the **Open Enrollment Period**, which occurs annually from **October 15 to December 7**.

Enrolling in a Medicare Part D plan during this Open Enrollment Period may result in a late enrollment penalty. Discover more about late enrollment penalties in the "Penalties for Missing Medicare Enrollment Deadlines" section of this guide.

Special Enrollment Period (SEP)

Applicants have the option to enroll in Medicare outside their Initial Enrollment Period without penalties during a **Special Enrollment Period (SEP)**. This period is designed to enable those eligible for Medicare to enroll immediately after their other health coverage ends, preventing any gaps in coverage.

SEP Based on Current Employment

Many individuals delay Medicare enrollment because they (or their spouse) are employed and covered by an employer-sponsored (group) health insurance plan. They can enroll in Medicare at any time if they are at least 65 years old and:

- They or their spouse is working, AND
- They are covered by a group health plan through that job.

In the Special Enrollment Period, COBRA and retiree health plans are not classified as group health care plans.

Enrollees joining Medicare while under a group health plan will have coverage starting on the enrollment month or on any of the following three months if preferred.

SEP Based on Recent Employment

Unemployed individuals can enroll in Medicare beyond their Initial Enrollment Period during an eight-month Special Enrollment Period, triggered by the occurrence of either:

- The month after employment concludes
- The month following the termination of the group health plan

Special Enrollment Period for International Volunteers
Volunteers providing service in a foreign country may be eligible for a six-month Special Enrollment Period. To qualify, volunteers must fulfill the following conditions:

- Serve outside the U.S. through a program lasting a minimum of 12 months
  - Participate in a program sponsored by a tax-exempt organization
  - Maintain or have had health insurance coverage during the period while away for volunteer service.

For additional details on this Special Enrollment Period, visit: https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805350.

Automatic Eligibility

Enrollment in Medicare Parts A and B is automatically granted to individuals who fulfill the following conditions:

- Receive Social Security or Railroad Retirement Board (RRB) benefits for at least four months prior to reaching the age of 65.
  - Individuals meeting this criterion will be mailed a Medicare card about three months before their 65th birthday.
- Receive disability benefits from Social Security or the RRB for a continuous period of 24 months.
  - Individuals meeting this criterion will be mailed a Medicare card about three months before their 25th month of receiving disability benefits.

When to Sign Up for a Medigap Plan

The period for enrolling in Medigap starts six months after an individual joins Medicare Part B upon reaching the age of 65. For instance, if someone enrolls in Medicare coverage in June, the open enrollment period for Medigap extends from June to November.

Insurance companies are not mandated by federal law to provide Medigap policies to individuals under the age of 65. However, certain states have enacted laws requiring insurers to offer such policies to this age group. Even if a beneficiary under 65 has Medicare coverage, their ability to enroll in a Medigap policy may be constrained by state regulations.

The following states have implemented laws compelling insurers to make at least one Medigap policy available to individuals under the age of 65:

- Alabama
- Arkansas
- California
- Colorado
- Delaware
- Florida
- Indiana
- Iowa
- Kansas
- Louisiana
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Vermont
- Virginia
- Wisconsin

The following states **do not** require insurers to carry a Medigap policy for individuals younger than 65:

- Alabama
- Alaska
- Arizona
- Iowa
- Nebraska
- Nevada
- New Mexic
- North Dakota
- Ohio
- Rhode Island
- South Carolina
- Utah
- Washington
- West Virginia
- Wyoming

Penalties for Failing to Meet Medicare Enrollment Deadlines

Deadlines for Part A

Individuals who do not sign up for Medicare Part A within their Initial Enrollment Period (IEP) will incur an enrollment penalty only if they are obligated to pay Part A Premiums. For details on who is required to pay premiums, please refer to the "Medicare Part A Premiums" section.

Failing to enroll in Part A results in a heightened premium penalty, where beneficiaries experience a 10 percent increase in their Part A premiums for a duration equal to twice the number of years they could have been covered by Medicare but chose not to enroll.

As an illustration, consider a beneficiary who postponed Part A enrollment by two years. This individual, with a mandated $458 Part A premium based on work credits, will now bear a total payment of $503.80 ($458 + $45.80, reflecting the 10 percent penalty) over a four-year period. This calculation involves multiplying the two years of delayed enrollment by the requisite two-year factor.

Important Information:
Should you meet the criteria for a Special Enrollment Period (SEP), you will be exempt from any late enrollment penalties. For further details on SEPs, please refer to the "Special Enrollment Period" section.

Part B Deadlines

Failure to enroll in Part B during the Initial Enrollment Period (IEP) incurs an enrollment penalty, resulting in elevated premiums. These premiums increase by 10 percent for every 12-month period post-IEP in which enrollment is delayed. For instance, someone postponing enrollment for 27 months faces a 20 percent higher premium. If the standard Part B premium is $170.10, the individual would pay $204.12 ($170.10 + $34.02 penalty) instead. This penalty persists as long as the individual maintains Part B coverage.

Important:
Should you be eligible for a Special Enrollment Period (SEP), you will not be subject to a late enrollment penalty. Further details on SEPs can be found in the "Special Enrollment Period" section of this guide.

Part C Timelines

There is no late enrollment penalty associated with Medicare Part C. Individuals who miss their Initial Enrollment Period must await the Open Enrollment Period, occurring annually between October 15 and December 7.

Part D Timelines

Those who fail to enroll in a Medicare Part D plan during their Initial Enrollment Period (IEP) will incur an enrollment penalty upon later sign-up for Part D coverage, unless they possess comparable drug coverage or qualify for Extra Help (financial assistance for drug costs). This penalty leads to increased premiums, escalating for each month of non-enrollment in Part D while eligible.

The penalty is computed by multiplying 1 percent of the national base beneficiary premium, which represents the average amount insurance companies charge for prescription drug plans nationwide, by the number of complete months the beneficiary did not enroll in Part D while eligible. The result is then rounded to the nearest $0.10.

For the 2024 national base beneficiary premium of $34.70, a beneficiary delaying Part D coverage for 10 months would incur a premium of $38.20 ($34.70 x 1% x 10 = $3.470 →rounded to the nearest $0.10 = $3.50 + $34.70 = $38.20). The penalty remains in effect as long as the individual maintains Part D coverage.

When to Adjust Your Medicare Plan
An elderly man holding a Medicare card is making changes to his Medicare coverage.

Those currently covered by Medicare can make modifications during the following timeframes:

- General Enrollment Period (January 1 – March 31)
- Open Enrollment Period (October 15 – December 7)

During the **General Enrollment Period,** beneficiaries can take these actions:

- Switch from one Medicare Part C plan to another
  - Including choosing a Medicare Part C plan with drug coverage.
- Unenroll from a Medicare Part C plan and return to Medicare Parts A and/or B, simultaneously enrolling in a Medicare Part D plan.
  - Return to Medicare Parts A and/or B within the first 3 months of acquiring Medicare.
  - This applies only to those who initially enrolled in coverage during their Initial Enrollment Period (IEP).

During the Open Enrollment Period, beneficiaries can perform the following actions:

- Change from Medicare Parts A and/or B (with or without a Medicare Prescription Drug Plan) to Medicare Part C.
- Change from Medicare Part C back to Medicare Parts A and/or B (with or without a Medicare drug plan).
- Switch from one Medicare Part C plan to another
  - Including choosing a Medicare Part C plan with drug coverage.

Switch from one Medicare Part D plan to another.
Choose to disenroll from Medicare Part D coverage entirely.

After Enrolling in Medicare

Medicare Card

Upon registration with Medicare, you will receive a card by mail, serving as official documentation of your enrollment. If you are automatically enrolled in Medicare based on meeting age or disability benefit qualifications, the card will be dispatched to you three months before you become eligible..

Distinct cards are provided for Medicare Parts A and B, Part C, and Part D. It is crucial to carry and present the relevant cards depending on the coverage you are seeking.

What constitutes a Medicare card?

Like an insurance card, a Medicare card provides proof of enrollment and coverage, including your name, Medicare ID number (used by providers to verify your identity and enrollment), coverage details for Parts A and B, and the start date of your coverage.

Obtaining a Replacement for Your Medicare Card

If your Medicare card is lost or damaged, it is advisable to replace it promptly. While your Medicare ID number can be retrieved online by your healthcare provider, having the physical card can expedite the process of seeking treatment.

In the event of a lost or damaged card, you can request a replacement by logging into your account at https://www.mymedicare.gov/ and printing a new copy. Medicare cards are printed on standard paper and do not have any specific requirements for reprinting.

If you suspect that your card has been stolen and there is a risk of fraudulent use of your Medicare ID number, promptly call 1-800-633-4227 to request a change. TTY users can contact 1-877-486-2048.

Commencement Dates for Medicare Coverage

The initiation of your coverage is contingent upon the enrollment date for your chosen Medicare plan. Explore the following sections for insights into the commencement dates for various Medicare plans.

Commencement of Medicare Parts A and B

For those automatically eligible for Medicare Parts A and B, coverage starts one month before their birthday. For instance, if your birthday falls on August

17, your coverage kicks in on July 17. To determine if you qualify for automatic eligibility for Medicare Parts A and B, please refer to the "Automatic Eligibility" section in this guide.

If automatic enrollment doesn't apply to you, and you opt to register for Medicare Parts A and/or B within your Initial Enrollment Period (IEP), the commencement dates for coverage are as follows:

- **Enrolling in the three months preceding your birth month** initiates coverage one month before your birthday.
- **Enrolling during your birth month** results in coverage starting one month after enrollment.
- **Enrolling the month following your birth month** leads to coverage commencing two months after enrollment.
- **Enrolling two or three months after your birth month** means coverage begins three months after enrollment.

If you choose to enroll during the General Enrollment Period (GEP), your coverage starts on July 1.

Medicare Part C

The initiation of coverage for Medicare Part C hinges on the timing of your enrollment in a plan.

- Enrolling in a Medicare Part C plan in any of the three months before turning 65 or before reaching the 25th month of disability benefits results in coverage starting on the first day of the month of turning 65 or the 25th month of benefits.
- Enrolling in a Part C plan during the month of turning 65 or the 25th month of disability benefits leads to coverage commencing on the first day of the subsequent month.
- Enrolling in a Part C plan in any of the three months after turning 65 or after reaching the 25th month of disability benefits initiates coverage on the first day of the following month.
- Enrolling in a Part C plan during the Open Enrollment Period (October 15 – December 7) results in coverage beginning on January 1 of the subsequent year.

Medicare Part D

The commencement date of your Medicare Part D coverage is contingent on the timing of your enrollment in a plan.

- Enrolling in a Part D plan in any of the three months before turning 65 or before reaching the 25th month of disability benefits results in coverage starting on the first day of the month of turning 65 or the 25th month of benefits.
- Enrolling in a Part D plan during the month of turning 65 or the 25th month of disability benefits leads to coverage commencing on the first day of the subsequent month.
- Enrolling in a Part D plan in any of the three months after turning 65 or after reaching the 25th month of disability benefits initiates coverage on the first day of the following month.

Locating Approved Medicare Providers

To access your Medicare benefits, you must visit a provider that accepts Medicare, which is typically the case in most locations in the United States unless you are covered by a Medicare Part C plan.

For those with Original Medicare (Parts A and B), you can find Medicare providers through Medicare's Physician Compare website at https://www.medicare.gov/care-compare/.

Specify the type of provider you are seeking, and you can also conduct searches by name, the body part you need treatment for, the condition you require treatment for, and more.

Medicare Claims

Normally, your healthcare provider takes care of filing a claim when you receive medical treatment. A claim serves as a formal request to your insurance provider to cover the costs of your healthcare. You are only required to file a claim if your physician neglects to do so in a timely manner, and you anticipate that they may miss the deadline for submission.

Claims must be submitted within 12 months or one calendar year from the date of service. If your healthcare provider has not initiated a claim process and the deadline is imminent, it is advisable to personally submit the claim.

To file a claim, you will require the following:

- The completed claim form
- The detailed bill from your provider
- A letter elucidating your rationale for filing the claim
- Any additional supporting documents pertinent to your claim

Access the claim form at this link: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1490s-english.pdf.

Login to your myMedicare account (https://account.mymedicare.gov) and refer to your Medicare Summary Notice for information on the designated address for submitting the claim and accompanying documents.

What constitutes a Medicare Summary Notice?

If you are enrolled in Medicare Part A and/or Part B, a Medicare Summary Notice will be sent to you by mail every quarter. This document serves as a concise overview of all the services covered under your plan, aiding you in monitoring your claims. It includes:

- A list of services and/or supplies that healthcare providers and suppliers billed to Medicare on your behalf during the preceding 3-month period.
- The total payment made by Medicare for those services.
  - The overall maximum amount you may be responsible for paying the provider.

It's important to note that the Medicare Summary Notice is not a bill. If you owe money to your healthcare provider, a separate bill from them will be issued.

If you did not receive any covered services, treatments, or supplies in a given 3-month period, you will not receive a Medicare Summary Notice. Additionally, if you prefer to receive this notice electronically, you can opt for the eMSN service by logging into your myMedicare account at https://account.mymedicare.gov.

Once you've logged in, navigate to the "My messages" section on the account homepage and select "Get your Medicare Summary Notices (MSNs) electronically." On the "My Communication Preferences" page, locate "Change eMSN preference" and confirm the change by clicking "Yes."

How to Challenge a Denial of Your Medicare Claim

On occasions, Medicare may reject your claim for coverage of a specific treatment or service, reconsider your application.

The appeal process varies slightly depending on the type of Medicare plan under which the initial claim was filed. To understand how to proceed with Medicare appeals for the following plans, read through the sections below:

- Medicare Parts A and B
- Medicare Part C
- Medicare Part D
- Special Needs Program

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

Initiate an Appeal for Medicare Parts A or B

Should you find yourself in disagreement with a decision regarding coverage or payment made by your plan, it is essential to initiate an appeal within 120 days of receiving your Medicare Summary Notice. To commence the process, fill out the Medicare Redetermination Request Form available at this link: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS20027.pdf.

After completing the form, print it and send it by mail to the address specified on the Medicare Summary Notice that you have received.

Claims should be lodged within 12 months or one calendar year from the date of service. In the event that your healthcare provider has not initiated the claims process and the deadline is approaching, it is recommended to personally submit the claim.

For filing a claim, you will need:

- The completed claim form
- The itemized bill from your provider
- A letter detailing your reasons for filing the claim
- Any additional supporting documents relevant to your claim

Access the claim form at the following link: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1490s-english.pdf.

Sign in to your myMedicare account (https://account.mymedicare.gov) and consult your Medicare Summary Notice to find the specified address for submitting the claim and associated documents.

Initiate an Appeal with Medicare Part C

If you are in disagreement with a decision made by your Medicare Part C plan insurance provider, you have the option to file an appeal within 60 days of receiving the initial denial notice. In case you miss the provider's specified appeal deadline, it is essential to provide an explanation for the delay. Each plan has its unique set of general guidelines for appealing a decision, outlined in the initial denial notice from the provider.

Your written appeal should contain the following details:

- Your name, address, and Medicare number
- A description of the items and services for which you are seeking a redetermination
- An explanation of why you believe the items should be covered
- The name of your representative, if applicable
- Any other relevant information

In most instances, you can expect a decision from your provider within 14 days. However, if you are concerned that your health might be adversely affected by a delay, you have the option to request an expedited decision within 72 hours. For additional information, please visit the Medicare website at https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.

Initiate an Appeal with Medicare Part D

You have the option to submit an appeal to your Medicare Part D plan under the following circumstances:

- You desire reimbursement for prescription drugs for which you have already made payments; OR
- You seek coverage for a prescription that is not currently included in your coverage; OR
- You wish to make an expedited request for a prescription you have not yet received.

The appeal must be filed directly with your Medicare Part D plan provider, and the specific requirements depend on the reason for the appeal.

Appeal for Prescription Reimbursement

If you intend to seek reimbursement for prescription drugs you have already purchased, there are two methods to initiate the appeal:

Download and complete the "Model Coverage Determination Request" form available on the Centers for Medicare & Medicaid Services (CMS) webpage:https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminations-.

- Navigate to the bottom of the page.
- Under “Downloads,” select the “Model Coverage Determination Request Form and Instructions (ZIP)” to download the file to your computer.
- Once completed, mail or fax the form to your Medicare Part D plan provider.

Submit a written request for reimbursement directly to your Medicare Part D plan provider.

- Ensure that the letter includes most of the same information required in the Model Coverage Determination Request form:
  - Prescriber’s (i.e., your doctor’s) name, address, and phone number
  - Information regarding your medical condition, diagnosis, and the drugs you currently take
  - Explanation of the reason for your reimbursement request

Requesting a Specific Prescription Benefit

1. If you require a particular prescription drug to address your medical condition, and your Medicare Part D plan does not currently cover it, you have the following options:

- Download and complete the “Model Coverage Determination Request” form available on the Centers for Medicare & Medicaid Services (CMS) webpage: https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminations-.
- Navigate to the bottom of the page.
- Under “Downloads,” select the “Model Coverage Determination Request Form and Instructions (ZIP)” to download the file to your computer.
- Once completed, mail or fax the form to your Medicare Part D plan provider.

2. Submit a written reimbursement request to your plan provider,

- The letter should encompass much of the information necessary in the Model Coverage Determination Request form:
  - Prescriber’s details (i.e., your doctor’s) including name, address, and phone number
  - Information regarding your medical condition, diagnosis, and the medications you are currently taking
  - Explanation of the reason for your reimbursement request

3. Submit a request for an exception from your Part D plan provider.

- In cases where the drug is not covered by the plan's formulary, the provider may consider granting an exception based on your medical condition, especially if similar prescriptions are unavailable. Gain a comprehensive understanding of the formulary by referring to the "Medicare Part D" section of this guide.

- Ensure to include a statement from your doctor or medical provider, providing a rationale for the approval of your request. Contact your plan provider to initiate the process.

4. Call your plan provider

Expect a decision within 72 hours, but if a 72-hour wait threatens your health, expedite by checking the box on the Model Coverage Determination Request form for a 24-hour response. Include a prescriber statement justifying urgency.

Note that your Part D plan may still grant an expedited request, even without a prescriber statement, if they determine that waiting 72 hours poses a risk to your life or health after reviewing your information.

These options apply only if you haven't received the drug. If you've already paid for the medication out of pocket, follow the instructions in the "Appeal for Reimbursement" section.

Initiate an Appeal via a Special Needs Plan (SNP) or the Program of All-Inclusive Care for the Elderly (PACE)

Private health insurance companies oversee both the Program for All-Inclusive Care for the Elderly (PACE) and Special Needs Plans (SNPs). Should you disagree with a decision made by your PACE or SNP provider, you have the option to file an appeal directly with the respective provider.

Regarding Coverage from Alternative Health Insurance Plans

What occurs if I currently hold Marketplace coverage?

The federal government operates the Health Insurance Marketplace as an online service in each state, providing a platform for browsing and comparing public health insurance plans. Through the Marketplace, individuals can assess available plans in their state and choose the most suitable option.

If you currently have a health insurance plan obtained via the Marketplace and become eligible for Medicare Part A, it is advisable to cancel your Marketplace coverage. The only exceptions are if you need to purchase Medicare Part A and pay a premium or if you were not automatically enrolled in Medicare and have opted not to enroll. In such cases, you can choose to maintain or acquire Marketplace coverage instead of opting for Medicare.

While you have the flexibility to retain your existing Marketplace coverage upon Medicare eligibility, be aware that you will forfeit any premium tax credits and other savings you were entitled to, potentially resulting in a significant increase in the cost of your Marketplace plan.

What occurs with my Health Savings Account?

Upon enrolling in Medicare, the ability to make contributions to your Health Savings Account (HSA) ceases. Nevertheless, you retain the option to withdraw funds from the HSA to cover medical expenses until the HSA is depleted.

Losing Medicare Coverage

There are limited scenarios in which an individual may lose Medicare coverage once obtained. Individuals facing such circumstances can opt to enroll in an alternative health insurance plan to maintain continuous health care coverage.s.

How might I lose Medicare coverage?

Several factors can lead to the loss of health care coverage for a Medicare beneficiary. Coverage may be lost if:

- Premiums for Medicare Parts A (if required) and B are not paid.
- A premium payment becomes delinquent for more than 90 days, with delinquency occurring after two previous unpaid bills.
- An individual with Medicare based on a disability returns to work.
  - Coverage for working disabled individuals persists for 8.5 years, provided the individual's condition still qualifies as a disability; after 8.5 years, Medicare coverage ceases.
- Premiums, copayments, or coinsurance for Medicare Part C, Part D, or Medigap are not paid as required.

Is it possible to regain Medicare coverage after a loss?

Yes, you can restore Medicare coverage after a lapse due to missed payments, but you must wait for the General Enrollment Period. Re-enrolling may incur late payment penalties for the remaining Medicare duration.

For those who lost Medicare coverage after 8.5 years of returning to work under disability-based Medicare, reinstatement is possible upon qualifying for disability benefits again or upon reaching the age of 65.

Medicare Coverage Limits

While most Medicare coverage has no restrictions, certain benefits do have limitations. For inpatient hospital care, there's a limit of 90 days per benefit period, with an additional 60 lifetime reserve days. Skilled nursing facility (SNF) care is limited to 100 days per benefit period.

When beneficiaries exceed these limits, they may need to pay for additional hospital or SNF days. To manage these costs, consider getting a Medigap policy for up to 365 extra inpatient days after exhausting lifetime reserve days. Check the "Medigap Policies" section in this guide for details on policies, requirements, and availability.