



MEDICARE | LONG TERM CARE

Roadmap to Medicare

Presented by:

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Who is HTA?

We **HELP** simplify and solve complex insurance decisions

Roadmap Consultation

Medicare A & B Enrollment Instruction

Assistance Understanding and Choosing Plans

Questions

VIP SUPPORT*

Annual Review

Billing & Claims Help

***Exclusively available to those that OnBoard through HTA**

MEDICARE ONBOARDING SERVICES



What makes HTA different?

No unwanted phone calls

No pushy sales agents

We are on your team!

We Simplify Medicare

- Unlimited professional support
- Specializing in Medicare for over 20 years
- Access to over 35 insurance companies
- Provide assistance Nationwide
- Salaried Advisors
- Not commissioned based
- Unbiased Advice
- NO pressure to buy

This is a complimentary service!

NO COST to YOU, FAMILY or FRIENDS

Anyone who needs help OnBoarding into Medicare call HTA

Our Only Request...

Please allow us to help with your paperwork!

- HTA is paid by the insurance companies -

You do not pay a higher premium by enrolling through us
rather than directly with the insurance company



What is Medicare?

Original Medicare is “health insurance” for

- **Age 65 and over**
- Under 65 on SSDI for 24 months
- End Stage Renal Disease (ESRD)- permanent kidney failure requiring dialysis or a kidney transplant

**Has nothing to do with
“Normal Retirement Age”**

Medicare Benefits & Costs



Choosing your Medicare insurance

Must enroll in Both



Original Medicare

Enroll through Social Security Administration



Then choose



Medicare Advantage

OR

Medicare Supplement Insurance

Enroll through HTA



Prescription Drug Plan

Enroll through HTA

Medicare Advantage:

- Advertised as an all in one plan alternative to Original Medicare.
- May include Rx, Dental, Vision and other preventive services.

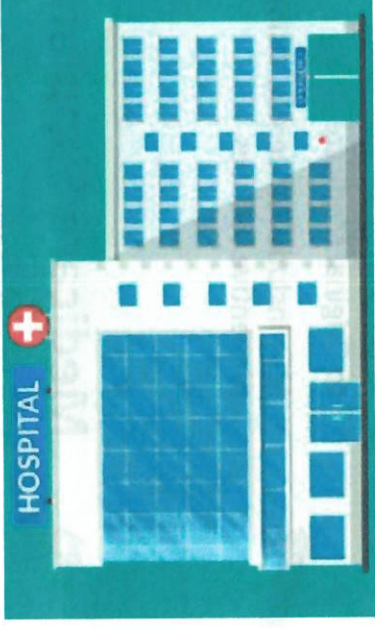
Medicare Supplement:

- A la carte option which allows you to choose your benefits.
- Purchase separately as individual plans: Rx, Dental and/or Vision.



Medicare Part A

- **Generally no cost** (provided you or your spouse have worked a minimum of 40 quarters)
- Hospital Admission
- Helps cover
 - Inpatient care in hospitals
 - Skilled nursing facility care (limited)
 - Hospice
 - Home health services (limited)





Medicare Part B

- **Part A = Hospital = Inpatient**
- **Part B = Medical = Outpatient**
 - **Doctors & Specialists**
 - **Diagnostic Testing - Labs, X-rays & MRIs**
 - **Outpatient Procedures - Surgery & Chemotherapy**
 - **Non-Inpatient hospital - ER & Hospital Observation**
 - **Durable medical equipment**
 - **Some preventive services**



2023 Base Premium = \$164.90/month

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Part B Premiums by Income- 2023

Single		Joint	Married Filed Separately	Part B Premium	Monthly/Person
Up to \$97,000	Up to \$194,000	Up to \$97,000	Up to \$97,000	\$164.90	Same for each Spouse
\$97,001 - \$123,000	\$194,001 - \$246,000	NA	NA	\$230.80	Based on MAGI
\$123,001 - \$153,000	\$246,001 - \$306,000	NA	NA	\$329.70	Tax Return from 2 years ago
\$153,001 - \$183,000	\$306,001 - \$366,000	NA	NA	\$428.60	
\$183,001 - \$499,999	\$366,001 - \$749,999	\$97,001 - \$403,000	\$97,001 - \$403,000	\$527.50	
\$500,000 +	\$750,000 +	\$403,001 +	\$403,001 +	\$560.50	



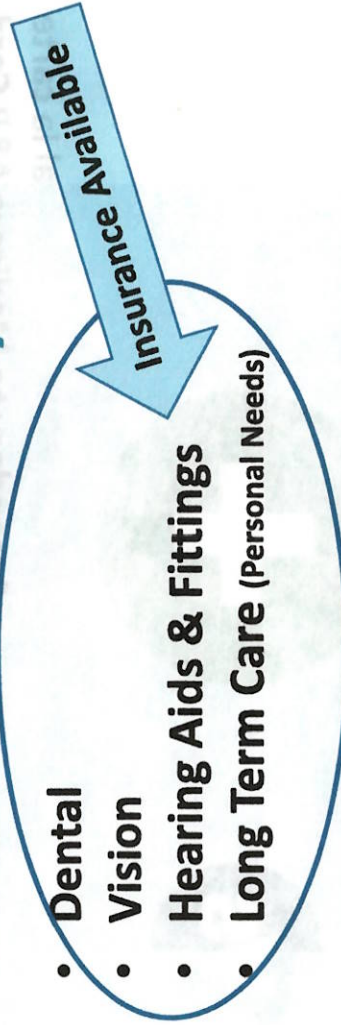
Medicare Out of Pocket Expenses

Outpatient Inpatient

Part A Deductible <i>Per benefit period-similar to per admittance</i>	\$1,600
Part A Hospital Copay Days 61-90 (per day) Days 91+ (60 Reserve Days) 365 Lifetime Days	\$400 \$800 100%
Skilled Nursing Facility Copay Days 0-20 (per day) Days 21-100 (per day) Days 101+	\$0 \$200 100%
Part B Deductible <i>Per calendar year</i>	\$226
Part B Coinsurance <i>No Cap on Out of Pocket Risk</i>	20%
Part B Excess Charges <i>No Cap on Out of Pocket Risk</i>	15%
Foreign travel emergency	100%
Out of Pocket Maximum	no cap

What is not Covered by Medicare?

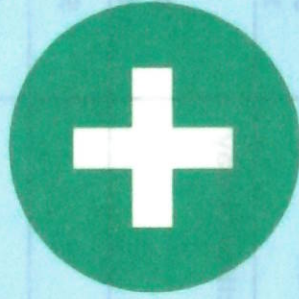
- Dental
- Vision
- Hearing Aids & Fittings
- Long Term Care (Personal Needs)
- Routine Foot Care
- Cosmetic Surgery



*Acupuncture is now covered by Medicare but only for chronic back pain -- limits apply.



MEDICARE ADVANTAGE



All in One
Replaces Medicare A&B Card
Must pay Medicare Part B premium

Vs

MEDICARE SUPPLEMENT



al la carte
Secondary to Medicare A&B Card
Must pay Medicare Part B premium

OR

“Part C”

“MediGap”

Comparing the Differences

Extra Benefits

Dental, Vision, Hearing & Extras
Some benefits that may be included in MA plans:
Gym Memberships, Meal Programs, OTC Benefits
May be Included

Premium & Benefit Cost

Lower Premiums
(typically \$0-\$150/month)
Rx Benefits Included
Higher Out of Pocket
(up to \$8,300/year in network)

Access to Care

Networks
PPO, HMO, PFFS
Managed Care
Prior Authorizations, Limits

Medical Underwriting

1st Eligible
No medical questions
Annual Enrollment
Change plans any year between 10/15 and 12/7 with no medical questions

Dental, Vision, Hearing & Extras
Value Added Discount programs may be available with a limited amount of carriers. Original Medicare does not cover these services.
Separate Plans available

Higher Premiums
(typically \$100-\$250/month)
Purchase Rx Benefits Separately
Lower Out of Pocket
(typically under \$300/year)

No Networks
Use any Doctor that accepts Medicare (99% of all non pediatric doctors participate with Medicare in 2020)
No Managed Care
You and your doctor choose your most appropriate care

1st Eligible
No medical questions
6 months+ after Part B
In most states you will require medical underwriting to purchase or change a MS plan

Medicare Advantage

Medicare Supplements

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How does MA Work?

Copays for all covered services until you hit plan maximum out of pocket.

Rx costs do not count toward maximum out of pocket

*Chemotherapy copay on many plans is 20%

Approximate Monthly Premiums

\$0 \$45 \$0

Medical coverage ^②	\$0.00	\$0.00	\$0.00	\$0.00
Medical Deductible ^②	\$6,900.00	\$7,550.00	\$0.00	\$0.00
Medical out of pocket maximum ^③	In-Network: \$0 copay per visit	In-Network: \$0 copay per visit	In-Network: \$0 copay per visit	In-Network: \$0 copay per visit
Doctor Office Visit ^②	In-Network: \$30 copay per visit	In-Network: \$35 copay per visit	In-Network: \$35 copay per visit	In-Network: \$45
Specialist Office Visit ^②	In-Network: \$95 copay per visit	In-Network: \$95 copay per visit	In-Network: \$95 copay per visit	In-Network: \$95 If you are admitted to the hospital within 24 hours your cost share may be waived, for more information see the Evidence of Coverage
Emergency Room ^②	In-Network: \$225 copay per day for days 1-7, \$0 copay per day for days 8-90.	In-Network: \$250 copay per day for days 1-7	In-Network: \$250 copay per day for days 1-7	In-Network: \$195 per day, days 1-7; \$0 per day, days 8-90
Hospital Inpatient Stay ^②				



Some MA plans include EXTRAS

Part D = Choose an MA plan that INCLUDES Part D (Drug) Benefits

(cannot purchase separately)

(network restrictions may apply)

• **Dental**

- If offered, typically \$250-\$3000/year in benefits

• **Gym Memberships**

- If offered, typically free memberships at participating gyms

• **Grocery Allowance**

- If offered, typically has restrictions for certain diagnosis

• **Routine Vision**

- If offered, typically \$100-\$200/year in benefits

• **Over the Counter Benefits**

- If offered, typically \$25-\$100/quarter website or prepaid debit card

• **Money toward Part B Premiums**

- If offered, typically \$2-\$60/month in benefits



How does MS Work?

Inpatient

Outpatient

	Medicare A & B Only	Plan F	Plan G	Plan HDG/F High Deductible	Plan N
Part A Deductible <i>Per benefit period-similar to per admittance</i>	\$1,600	\$0	\$0	\$1,600	\$0
Part A Hospital Copay Days 61-90 (per day) Days 91+ (60 Reserve Days) 365 Lifetime Days	\$400 \$800 100%	\$0	\$0	\$400 \$800 100%	\$0
Skilled Nursing Facility Copay Days 0-20 (per day) Days 21-100 (per day)	\$0 \$200	\$0 \$0	\$0 \$0	\$0 \$200	\$0 \$0
Part B Deductible <i>Per calendar year</i>	\$226	\$0	\$226	\$226	\$226
Part B Coinsurance <i>No Cap on Out of Pocket Risk</i>	20%	\$0	\$0	20%	\$20 Doc & \$50 ER copay
Part B Excess Charges <i>No Cap on Out of Pocket Risk</i>	15%	0%	0%	15%	15%
Out of Pocket Maximum	no cap	\$0	\$226	\$2,700	no cap

Approximate Monthly Premiums

Based on Suburban and Metro Mid-Atlantic Areas (Phila, Baltimore, DC, NJ)

Please ask for a quote based on your age, gender and zip code.

Male Age 68
Female Age 68

\$200
\$170

\$165
\$145

\$50
\$45

\$120
\$105

Household Discounts may be available



How does MS Work?

Inpatient

Outpatient

	Medicare A & B Only	Plan F	Plan G	Plan HDG/F High Deductible	Plan N			
Part A Deductible <i>Per benefit period—similar to per admittance</i>	\$1,600	NOT AVAILABLE IF FIRST MEDICARE ELIGIBLE AFTER 1/1/2020						
Part A Hospital Copay Days 61-90 (per day) Days 91+ (60 Reserve Days) 365 Lifetime Days	\$400 \$800 100%							
Skilled Nursing Facility Copay Days 0-20 (per day) Days 21-100 (per day)	\$0 \$200							
Part B Deductible <i>Per calendar year</i>	\$226							
Part B Coinsurance <i>No Cap on Out of Pocket Risk</i>	20%							
Part B Excess Charges <i>No Cap on Out of Pocket Risk</i>	15%							
Out of Pocket Maximum	no cap							
						\$0	\$1,600	\$0
						\$0	\$400 \$800 100%	\$0
						\$0 \$0	\$0 \$200	\$0 \$0
		\$226	\$226	\$226				
		\$0	20%	\$20 Doc & \$50 ER copay				
		0%	15%	15%				
		\$226	\$2,700	no cap				
		\$165	\$50	\$120				
		\$145	\$45	\$105				

Approximate Monthly Premiums

Based on Suburban and Metro Mid-Atlantic Areas (Phila, Baltimore, DC, NJ)
Please ask for a quote based on your age, gender and zip code.

Male Age 68
Female Age 68

Household Discounts may be available

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Medicare Supplement = MediGap

Same benefits

No networks

Any Doctor that accepts Medicare

Same claims process

Throughout USA

Shop Premiums





\$129.56 /mo	Cigna Health And Life Insurance Company Parent: Cigna Hhh Grp AM Best Rating: A (Outlook Under Review - Developing) Rate Type: Attained age	Plan: G S&P Rating: n/a Rating Class: n/a	Years in Market: 1 Effective Date: 07/14/2016 Rating Class: n/a
\$130.86 /mo	Aetna Health And Life Insurance Company Parent: Aetna Grp AM Best Rating: A (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: AA- Rating Class: n/a	Years in Market: 4 Effective Date: 05/01/2016 Rating Class: n/a
\$134.00 /mo	Transamerica Premier Life Insurance Company Parent: Aegon Us Holding Grp Rate Type: Attained age	Plan: G AM Best Rating: AA- Rating Class: n/a	Years in Market: 2 Effective Date: 02/01/2016
\$135.42 /mo	The Manhattan Life Insurance Company Parent: Harris Ins Holdings Grp Rate Type: Attained age	Plan: G AM Best Rating: B+ (Outlook Stable) Rating Class: n/a	Years in Market: 34 Effective Date: 10/01/2016
\$139.28 /mo	Amerko Financial Life And Annuity Insurance Company Parent: Financial Holdings Grp Rate Type: Attained age	Plan: G AM Best Rating: A (Outlook Stable) Rating Class: n/a	Years in Market: 2 Effective Date: 09/01/2016
\$145.59 /mo	American Retirement Life Insurance Company Parent: Cigna Hhh Grp AM Best Rating: A- (Outlook Under Review - Developing) Rate Type: Attained age	Plan: G S&P Rating: n/a Rating Class: n/a	Years in Market: 4 Effective Date: 02/01/2017 Rating Class: n/a
\$148.83 /mo	CSI Life Insurance Company Parent: Berkshire Hathaway Grp Rate Type: Attained age	Plan: G AM Best Rating: A+ (Outlook Stable) Rating Class: n/a	Years in Market: 2 Effective Date: 11/15/2015
\$149.81 /mo	Mutual Of Omaha Insurance Company Parent: Mutual Of Omaha Grp AM Best Rating: A+ (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: n/a Rating Class: n/a	Years in Market: 51 Effective Date: 07/23/2016

\$150.08 /mo	Central States Indemnity Co. Of Omaha Parent: Berkshire Hathaway Grp Rate Type: Attained age	Plan: G AM Best Rating: A+ (Outlook Stable) Rating Class: n/a	Years in Market: 6 Effective Date: 11/01/2016
\$150.67 /mo	Equitable Life & Casualty Insurance Company Parent: n/a AM Best Rating: B (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: B Rating Class: n/a	Years in Market: 48 Effective Date: 04/15/2016 Rating Class: UR Prem
\$152.89 /mo	Medico Corp Life Insurance Company Parent: American Enterprise Mut Grp Rate Type: Attained age	Plan: G AM Best Rating: A- (Outlook Stable) Rating Class: n/a	Years in Market: 11 Effective Date: 07/01/2015
\$153.82 /mo	Combined Insurance Company Of America Parent: Ace Ltd Grp AM Best Rating: A+ (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: AA- Rating Class: n/a	Years in Market: 29 Effective Date: 09/01/2016
\$160.18 /mo	Amerko Financial Life And Annuity Insurance Company Parent: Financial Holdings Grp Rate Type: Attained age	Plan: G AM Best Rating: A (Outlook Stable) Rating Class: Class 1	Years in Market: 2 Effective Date: 09/01/2016
\$200.92 /mo	Equitable Life & Casualty Insurance Company Parent: n/a AM Best Rating: B (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: B Rating Class: n/a	Years in Market: 48 Effective Date: 04/15/2016 Rating Class: Sld Prem
\$213.05 /mo	Garber Life Insurance Company Parent: Nestle Sa Grp AM Best Rating: A (Outlook Stable) Rate Type: Attained age	Plan: G S&P Rating: BBB Rating Class: n/a	Years in Market: 8 Effective Date: 11/01/2016



EXTRAS with MS can be limited

Part D = Purchase Standalone Part D (Drug) Benefits at extra cost *(separate plan – Typically \$10-\$50/month extra premium)*

(network restrictions may apply)

- **Dental**
 - Separate plan available at extra cost. Limited MS plans may have a discount available at certain dental providers – Typically **\$20-\$60/month extra premium**
- **Gym Memberships**
 - Limited MS plans may have a either a discount available or free memberships
- **Grocery Allowance**
 - Not Available
- **Routine Vision**
 - Separate plan available at extra cost. Limited MS plans may have a discount available at certain dental providers – Typically **\$10-\$15/month extra premium**
- **Over the Counter Benefits**
 - Not Available
- **Money toward Part B Premiums**
 - Not Available

Medicare Advantage Plans

Medicare Supplement Plans

Pros	Cons	Pros	Cons
<ul style="list-style-type: none"> • Low monthly premiums • Additional benefits (drugs, dental, vision, gym, OTC, groceries, etc.) • All-in-one plan • Many plan options available • Can shop annually with no medical questions 	<ul style="list-style-type: none"> • Higher maximum-out-of-pocket costs (up to \$8,300 in network) • Doctor networks • Networks are regionally based • Managed care • Medical underwriting to change to Medicare Supplement later 	<ul style="list-style-type: none"> • Low out-of-pocket costs • No doctor networks • Nationwide coverage • No managed care • Foreign travel emergency coverage on most popular plans • Standardized, easy to understand plan options 	<ul style="list-style-type: none"> • Higher monthly premium • Purchase dental, vision and drug benefits separately • Annual rate increases • Multiple ID cards



Part D Prescription Benefits

MA = Purchase a Medical Plan that INCLUDES Part D benefits

MS = Purchase a Standalone Part D Plan for extra cost

- Deductibles and Copays vary by plan
- Plans cover different medications
- Plans rank medications in different tiers

Average STANDALONE PLAN Premium \$31.50/month

What we need

- List of meds including dosage & frequency
- Name of Pharmacy

What we provide

- Report showing the anticipated monthly cost of your medications
- Annual Review during AEP 10/15-12/7

Questions

VIP SUPPORT*

Annual Review

Billing & Claims Help

***Exclusively available to those that OnBoard through HTA**

HTA Understanding Part D

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2023

Total Cost of Medications

Up to \$505

Stage 1:
Deductible

Member Pays

Total Retail Drug Cost

<\$4,660
*based on retail costs

Stage 2:
Before Gap

Initial Coverage Level

Copay or Coinsurance

<\$7,400
*based on Tro-op

Stage 3:
Coverage Gap

25%

>\$7,400
*based on Tro-op

Stage 4:
After Gap

Catastrophic

5%



Medicare Part D IRMAA- 2023

Single	Joint	Married Filed Separately	Part B Premium	Part D IRMAA	Monthly/Person
Up to \$97,000	Up to \$194,000	Up to \$97,000	\$164.90	Premium Only	Same for each Spouse
\$97,001 - \$123,000	\$194,001 - \$246,000	NA	\$230.80	Premium + \$12.20	
\$123,001 - \$153,000	\$246,001 - \$306,000	NA	\$329.70	Premium + \$31.50	Based on MAGI
\$153,001 - \$183,000	\$306,001 - \$366,000	NA	\$428.60	Premium + \$50.70	
\$183,001 - \$499,999	\$366,001 - \$749,999	\$97,001 - \$403,000	\$527.50	Premium + \$70.00	Tax Return from 2 years ago
\$500,000 +	\$750,000 +	\$403,001 +	\$560.50	Premium + \$76.40	

Base
Income Bracket
(Under \$97K/\$194K)

Approx.
\$165-\$350

Add \$100 per
Income Bracket

Must enroll in Both:



Original Medicare

Enroll through Social Security Administration. Premiums are drafted from SSI if collecting, otherwise billed quarterly.

Medicare Part A Estimate

Inpatient Coverage

To qualify for Part A for Premium-Free, you or a spouse must have paid a minimum of 40 quarters of Medicare Taxes

Part A \$0.00

Medicare Part B Estimate

Outpatient Medical Coverage

You may pay more for Part B if you are in a Higher Income Bracket.

Part B \$164.90

Part D IRMAA \$0.00

Choose one:

Medicare Supplement (MediGap) OR

Medicare Advantage (HMO/PPO)



Medicare Advantage

OR

Medicare Supplement Insurance

Enroll through HTA

Medicare Supplement premiums can be drafted from bank or billed. In addition, Medicare Advantage plans have option to draft from SSI.

MS Plan G \$145.00

Estimated Premium

Max Out of Pocket: \$226 on Medicare Eligible Services

Max Out of Pocket does not apply to prescriptions, dental, vision, hearing or other non-covered services.

MA PPO \$0.00

Estimated Premium

Max Out of Pocket: \$7,550 in network/\$13,200 total in & out

Max Out of Pocket does not apply to prescriptions, dental, vision, hearing or other non-covered services.

Accepted by all doctors and facilities that accept Medicare. No referrals required. No managed care.

Doctors & facilities must accept your specific carrier and plan. Medicare Advantage plans are managed care plans: Referrals, Prior Authorizations and/or Quantity Limits on services may apply.



Prescription Drug Plan

Enroll through HTA

Premiums can be drafted from bank or SSI or billed. IRMAA is drafted from SSI if collecting.

\$12.00

Estimated Premium

\$0.00

Included in Medicare Advantage Plan

You will be responsible for Plan Deductibles, Copays, and Coverage Gap Expenses. Prescription Drug Programs and the 4 stages of coverage

Total Monthly Premiums

With a Medicare Supplement

\$321.90

With a Medicare Advantage

\$164.90

Highest
Income Bracket
(Over \$500k/\$750K)

Approx.
\$640-\$850

Must enroll in Both:

A&B Original Medicare

Enroll through Social Security Administration. Premiums are drafted from SSI if collecting, otherwise billed quarterly.

Medicare Part A Estimate
Inpatient Coverage

To qualify for Part A for Premium-Free, you or a spouse must have paid a minimum of 40 quarters of Medicare Taxes

Part A \$0.00

Medicare Part B Estimate
Outpatient Medical Coverage

You may pay more for Part B if you are in a Higher Income Bracket.

Part B \$560.50

Part D IRMAA \$76.40

Choose one:

C Medicare Advantage

Enroll through HTA. Medicare Supplement Insurance. Premiums can be drafted from bank or billed. In addition, Medicare Advantage plans have option to draft from SSI.

Medicare Supplement (MediGap) OR

MS Plan G \$145.00

Estimated Premium
Max Out of Pocket: \$226 on Medicare Eligible Services
Max Out of Pocket does not apply to prescriptions, dental, vision, hearing or other non covered services.

MA PPO \$0.00

Estimated Premium
Max Out of Pocket: \$7,550 in network/\$13,200 total in & out
Max Out of Pocket does not apply to prescriptions, dental, vision, hearing or other non covered services.

D Prescription Drug Plan

Enroll through HTA. Premiums can be drafted from bank or SSI or billed. IRMAA is drafted from SSI if collecting.

Standalone Part D

\$12.00

Estimated Premium

Advantage Part D

\$0.00

Included in Medicare Advantage Plan

You will be responsible for Plan Deductibles, Copays, and Coverage Gap Expenses. Prescription Drug Programs and the 4 stages of coverage

Total Monthly Premiums

With a Medicare Supplement

\$793.90

With a Medicare Advantage

\$636.90

Medicare Confusion!!

Do I have to go on Medicare when I turn 65?

What if I am not ready to retire?

What are my Medicare Options?

Can I defer Medicare Parts A or B?

Get advice when you turn **64**

Know what to expect



Is Medicare Automatic?

Collecting Social Security?

Enrollment is Automatic

Valid reason to Defer = Return Part B

NOT Collecting Social Security?

Enrollment is not Automatic

Valid reason to Defer = Do Nothing



Possible consequences by not signing up

Penalties

- **Part A** – No Penalties as long as you are eligible for \$0 premium
- **Part B** – 10% for every 12 months added to Part B premium for life
- **Part D** – 1% for each month you go with out creditable drug coverage after age 65

Gaps in Coverage

- Sometimes at age 65 Medicare becomes your **Primary Insurance**
- If you don't enroll, you may have to pay any bills Medicare would have been responsible for (approximately 80% of your medical care)

Deadlines

- **Initial Enrollment Period** = 7 months surrounding 65th Birthday
- **Special Enrollment Period** = 8 months following creditable coverage
- **General Enrollment Period** = once a year Jan 1st to Mar 31st

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Do I have creditable coverage?

Group Health Coverage
Based on Current Active Employment
of the Primary Insured

Who is your Primary Insured?

Non Creditable Coverage

- Individual Plans – ACA, Obamacare
- Group Plans not based on Current Active Employment – Cobra, Retiree, Severance

www.HTA-insurance.com/individuals

MEDICARE | LONG TERM CARE

610-430-6650, option 1

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Creditable Coverage

Will I receive a penalty if I don't enroll now?

No. You will not receive a late enrollment penalty provided you remain covered under the group creditable coverage and your primary insured remains actively at work at the employer that provides your benefits.

+

Medicare Rules and Guidelines

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Creditable Coverage

Will I receive a penalty if I don't enroll?
No. You will not receive a late enrollment penalty under the group creditable coverage and at work at the employer that provides you

+

Medicare Rules and Guidelines

— Medicare Rules and Guidelines

Part A: If you are eligible for Premium-Free Part A (you or your spouse has paid 40 quarters of Medicare taxes), you **WILL NOT** receive a [Part A Penalty](#) for enrolling after age 65.

- Since Part A is Premium-Free for many people, they commonly enroll in Part A even if not necessary (special considerations apply if you have an HSA account).

Part B: You will receive a [Part B Late Enrollment Penalty](#) if you do not have creditable coverage after age 65.

- **Creditable coverage** is group health insurance coverage while the Primary Insured is actively working for the employer providing the **Group Health Plan**.
 - Severance, COBRA and/or Retiree Plans are not creditable for avoiding the penalty.

A 10% penalty added for every 12 months you go without creditable coverage. Months need not be consecutive. See [Details](#) on how the penalty is calculated.

- The penalty will be assessed on the **Base Medicare Premium** for as long as you are enrolled in Medicare.

Part D: You will receive a [Part D Late Enrollment Penalty](#) if you do not have creditable prescription coverage after age 65.

- **Creditable prescription coverage** is drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

A 1% penalty added for every 1 month you go without creditable prescription coverage. Months need not be consecutive.

- The penalty will be assessed on the **Average Medicare Part D Premium** for as long as you are enrolled in Medicare Part D.



Creditable Coverage

What is my deadline to enroll?

You can enroll anytime after age 65 up to 8 months after your group coverage or the employment that it is based on ends.

Valid times to waive off Group Health Plan

Turning Age 65

Medical Open Enrollment Period

Retirement

And maybe – ANY TIME you decide to enroll in Medicare

ASK HUMAN RESOURCES

Is “Enrollment in Medicare” a valid reason to opt out of group insurance mid year?

Am I required to Enroll in Medicare A or B?

NO

Creditable

Primary Insured Actively Working & On Group Creditable Coverage & **Over 20** Employees

MAYBE

Creditable

Primary Insured Actively Working & On Group Creditable Coverage & **Under 20** Employees

YES

Not Creditable

Not Working
Individual Coverage
No Coverage
Retiree Coverage
COBRA, Severance



Over 20 Employees

Do I need Medicare to have full coverage?

No. Your group coverage should remain primary insurance as long as the employment that it is based on continues.

+ Medicare Rules and Guidelines

Choice =

Keep Group Health Plan and don't pay for Medicare

OR

Enroll in Medicare (all Parts) and don't pay for Group Health Plan



Over 20 Employees-Should I consider Medicare?

Look at

Group Health

Costs and Benefits

Premium +

Out of Pocket Expenses

(copays, deductibles, not Rx's)

Breakeven Analysis

\$3,600/year

(more if high income)

Group costs lower?

Group plan is more cost effective.

Group costs higher?

Possibly consider Medicare.

Dependent spouses

may have higher costs
making Medicare attractive



Do I defer both Parts A & B (or Part B only)?

Enroll in PART A at ANY time **WITHOUT PENALTY OR DEADLINE**
(As long as you qualify for **PREMIUM FREE Part A**)



Deposit = NO
Use Funds = YES

Use Savings For...

- Medicare Parts A, B, C (Medicare Advantage), D
- Out of Pocket Medical Expenses

Cannot Use Savings For...

- Medicare Supplement Insurance



Over 20 Employees



Customized Roadmap Report

Click on the image to download your 1 page Roadmap



Your Roadmap is based on....

- Your Primary Insured intends to remain **ACTIVELY WORKING** (at the employer providing your benefits)
- You **ARE** covered under the Group Health Insurance Plan
- The employer providing health insurance has **MORE THAN 20** employees

Recommendation Summary

Since you have creditable coverage (group coverage based on current active employment), you are **NOT** required to enroll in Medicare at this time. However, if you do not have a Health Savings Account, we recommend that you enroll in Medicare Part A and defer your Part B.

If you do not enroll in Medicare A and/or B at this time, you will not accrue a penalty. You will have a Special Enrollment Period (SEP) when your group coverage and/or your employment end to enroll in Medicare. You will need to show proof of creditable coverage when you go to enroll later (it is not necessary at the time you defer).

HTA

Enrolling after Age 65 – time to prove creditable coverage

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (

1. Employer's Name

3. Employer's Address

City

4. Applicant's Name

6. Employee's Name

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? Yes No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)

3. Has the coverage ended? Yes No

4. If yes, give the date the coverage ended. (mm/yyyy)

5. When did the employee work for your company?

From: (mm/yyyy) / To: (mm/yyyy)

Take to HR to have them complete and sign.
--one for each spouse--

Must show:

- You have been covered
- Employee has been employed continuously since 65th birthday.

May need multiple forms if you have multiple jobs after age 65



Under 20 Employees



Your Roadmap is based on...

- Your Primary Insured intends to remain **ACTIVELY WORKING** (at the employer providing your benefits)
- You **ARE** covered under the Group Health Insurance Plan
- The employer providing health insurance has **LESS THAN 20** employees

Do I need Medicare to have full coverage?

Yes/Likely. Once you turn 65, it is likely that your group coverage will become secondary coverage and Medicare will become the primary insurance. If you do not enroll in Medicare, you may not have full coverage.

Choice =

Keep Group Health Plan as Secondary and enroll in Medicare A & B only

OR

Enroll in Medicare (all Parts) and don't pay for Group Health Plan



Under 20 Employees

Questions to verify with your Employer:

- Will my group health plan remain primary payer now that I am turning age 65 (or do I need Medicare to be primary)?
- If Medicare is needed as primary, will my premiums change since the group plan is only paying secondary?
 - Is there a "Group Medicare Supplement" option available to roll into on the group plan that is lower cost (and then would allow my spouse to maintain dependent benefits)?
- Can my spouse stay on the group plan (or get COBRA) if I come off the plan and go into Medicare?
 - How long can he/she keep the group plan and/or COBRA?
 - What would the premium be for him/her only if I come off the plan?

If you wish to defer enrollment in Medicare A and/or B, please confirm from your Group Health insurance carrier (in writing recommended) that they will remain the primary payer or you could have significant gaps in your coverage.



Under 20 Employees-Should I consider Medicare?

Most plans will require you to have

Medicare A & B

Even if you want to keep your group plan.

This will be an added expense to you.

Breakeven Analysis

Dependent spouses

may have higher costs making Medicare attractive

\$2,400/year
(more if high income)

Group costs lower?

Group plan is more cost effective.

Group costs higher?

Possibly consider Medicare.

What about my under Age 65 Spouse?

Am I required to Enroll in Medicare A or B?

NO

Creditable
Primary Insured Actively Working & On Group Creditable Coverage & **Over 20** Employees

MAYBE

Creditable
Primary Insured Actively Working & On Group Creditable Coverage & **Under 20** Employees

YES

Not Creditable
Not Working
Individual Coverage
No Coverage
Retiree Coverage
COBRA, Severance



Non Creditable Coverage

Examples: ACA, Obamacare, COBRA, Retiree, Severance

Will I receive a penalty if I don't enroll in Medicare?

YES

Will Medicare be my Primary Insurance?

YES

Choice =

Keep Current Health Plan as Secondary and enroll in Medicare A & B only

OR

Enroll in Medicare (all Parts) and don't pay for Current Health Plan



When to Enroll

- **Already on non creditable coverage** before turning age 65 and 3 months
 - *Example: You retired prior to age 65 and are on individual coverage, COBRA, retiree or severance when you turn age 65.*

IEP

= 3 months before, the month of, 3 months after your 65th birthday

- **Getting on non creditable coverage** after age 65 and 3 months
 - *Example: You retire when you are over age 65 and your employer offers you COBRA, retiree or severance coverage.*

SEP

= 8 months after coming off coverage or leaving employment

Am I required to Enroll in Medicare A or B?

NO

Creditable

Primary Insured Actively Working & On Group Creditable Coverage & **Over 20** Employees

MAYBE

Creditable

Primary Insured Actively Working & On Group Creditable Coverage & **Under 20** Employees

YES

Not Creditable

Not Working

Individual Coverage

No Coverage

Retiree Coverage

COBRA, Severance

HTA How to take action

We provide customized instruction and timeline on how to defer or enroll
Deferring both Part A & B – Deferring Part B Only
Enrolling at age 65 - Enrolling after age 65 - Enrolling in Part A only - Enrolling in Part B only

Not Enrolling in Medicare Parts A and B

Since you have **group creditable coverage** (see video on right), you can wait to enroll in Medicare Later. You have the option to not enroll (defer) both Medicare A and B, or you can enroll in premium free Part A, and defer Part B which has a cost.

If you do not have a Health Savings Account, we recommend that you enroll in Part A to get your Medicare number established. It is not required, but does not cost you anything. Please visit our [HTA web page](#) for more details.

However, if you have an HSA (Health Savings Account) on your group health plan, you should not enroll in either Medicare Parts A or B.

Deferring is easy but will depend on if you are already collecting social security income:

- + Not Collecting Social Security Income
- + Already Collecting Social Security Income



HTA

MEDICARE
LONG TERM CARE

Home Services Products Education Testimonials Schedule an Appointment

Enrolling in Medicare B (already enrolled in Part A)

Since you did not enroll in Part B when you enrolled in Part A, you will have to submit documentation to show you had creditable coverage from your 65th birthday or your Part A start date (whichever is earlier). You will need the [Request for Employment Information](#) to apply for Part B.

- Send this to your employer first for completion. See more information below about completing this form.
- Once you receive the completed copy back from your employer, you can apply for Part B.

- + Apply Online
- + Apply by Fax
- + Apply by Mail
- + Apply in Person

www.HTA-insurance.com/individuals

MEDICARE



Questions?



Schedule Online:
www.hta-insurance.com/schedule

610-430-6650, option 1

Medicare@HTA-insurance.com

Request a consultation



2022

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare



This official government guide has important information about:

- Medicare Supplement Insurance (Medigap)
- What Medigap policies cover
- Your rights to buy a Medigap policy
- How to buy a Medigap policy



Developed jointly by the Centers for Medicare & Medicaid Services (CMS)
and the National Association of Insurance Commissioners (NAIC)

Who should read this guide?

If you're thinking about buying a Medicare Supplement Insurance (Medigap) policy or you already have one, this guide can help you understand how it works.

Important information about this guide

The information in this guide describes the Medicare Program at the time this guide was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“2022 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

This product was produced at U.S. taxpayer expense.

Section 1: Medicare Basics	5
What's Medicare?	6
The different parts of Medicare	6
Your Medicare coverage options	7
Medicare and the Health Insurance Marketplace™	8
Find more information about Medicare	8
Section 2: Medigap Basics	9
What's a Medigap policy?	9
What Medigap policies cover	10
What Medigap policies don't cover.	12
Types of coverage that are NOT Medigap policies	12
What types of Medigap policies can insurance companies sell?	12
What do I need to know if I want to buy a Medigap policy?	13
When's the best time to buy a Medigap policy?	14
Why is it important to buy a Medigap policy when I'm first eligible?	16
How do insurance companies set prices for Medigap policies?	17
What this pricing may mean for you	18
Comparing Medigap costs	19
What's Medicare SELECT?	20
How does Medigap help pay my Medicare Part B costs?	20
Section 3: Your Right to Buy a Medigap Policy	21
What are guaranteed issue rights?	21
When do I have guaranteed issue rights?	21
Can I buy a Medigap policy if I lose my health coverage?	24
Section 4: Steps to Buying a Medigap Policy	25
Step-by-step guide to buying a Medigap policy	25
Section 5: If You Already Have a Medigap Policy	31
Switching Medigap policies	32
Losing Medigap coverage	36
Medigap policies and Medicare drug coverage	36

Section 6: Medigap Policies for People with a Disability or ESRD	39
Information for people under 65	39
Section 7: Medigap Coverage in Massachusetts, Minnesota, and Wisconsin	41
Massachusetts benefits	42
Minnesota benefits	43
Wisconsin benefits	44
Section 8: For More Information	45
Where to get more information	45
How to get help with Medicare and Medigap questions	46
State Health Insurance Assistance Program (SHIP) and State Insurance Department	47
Section 9: Definitions	49

SECTION

Medicare Basics



Words in blue
are defined on
pages 49–50.

What's Medicare?

Medicare is health insurance for people 65 or older, certain people under 65 with disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

The different parts of Medicare

The different parts of Medicare help cover specific services.



Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care



Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)



Part D (Drug coverage)

Helps cover:

- Cost of prescription drugs (including many recommended shots or vaccines)

Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

Your Medicare coverage options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare.

Original Medicare

- Includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.

Part A



Part B



You can add:

Part D



You can also add:

Supplemental coverage



This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

- A Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you'll need to use doctors who are in the plan's network.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover - like vision, hearing, and dental services.

Part A



Part B



Most plans include:

Part D



Some extra benefits

Some plans also include:

Lower out-of-pocket-costs

Medicare and the Health Insurance Marketplace®

If you have coverage through an individual Marketplace plan (not through an employer), you should enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty. For most people, their Initial Enrollment period is the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.

You can keep your Marketplace plan without penalty until your Medicare coverage starts. Once you're considered eligible for premium-free Part A, you won't qualify for help paying your Marketplace plan **premiums** or other costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back some or all of the help you got when you file your taxes.

Visit [HealthCare.gov](https://www.healthcare.gov) to find your state's Marketplace, or learn how to end your Marketplace financial help or plan to avoid a gap in coverage. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Note: Medicare isn't part of the Marketplace. The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies, **Medicare Advantage Plans**, or Medicare drug coverage (Part D).

Find more information about Medicare

To learn more about Medicare:

- Visit [Medicare.gov](https://www.Medicare.gov).
- Look at your "Medicare & You" handbook.
- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP). (See pages 47– 48.)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Find and compare health and drug plans at [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare).

Health Insurance Marketplace™ is a registered service mark of the U.S. Department of Health & Human Services.

SECTION

Medigap Basics

2

What's a Medigap policy?

A Medigap policy is an insurance policy that helps fill "gaps" in Original Medicare and is sold by private companies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medigap policies are sold by private companies, and can help pay for some of the costs that Original Medicare doesn't, like **copayments**, **coinsurance**, and **deductibles**.

Some Medigap policies also cover certain benefits Original Medicare doesn't cover, like emergency foreign travel expenses. Medigap policies don't cover your share of the costs under other types of health coverage, including **Medicare Advantage Plans**, stand-alone **Medicare drug plans**, employer/union group health coverage, **Medicaid**, or TRICARE.

If you have Original Medicare and a Medigap policy, Medicare will pay its share of the **Medicare-approved amounts** for covered health care costs. Then, your Medigap policy pays its share. Medicare doesn't pay any of the costs of buying a Medigap policy.

A Medigap policy is different from a Medicare Advantage Plan because those plans are another way to get your Part A and Part B benefits, while a Medigap policy only helps pay for the costs that Original Medicare doesn't cover. Insurance companies generally can't sell you a Medigap policy if you have coverage through a Medicare Advantage Plan or Medicaid.

All Medigap policies must follow federal and state laws designed to protect you, and policies must be clearly identified as "Medicare Supplement Insurance." Medigap policies are standardized, and in most states are named by letters, Plans A–N. Each standardized Medigap policy under the same plan letter must offer the same basic benefits, no matter which insurance company sells it.

Words in **blue** are defined on pages 49–50.

Cost is usually the only difference between Medigap policies with the same plan letter sold by different insurance companies.

What Medigap policies cover

The chart on page 11 gives you a quick look at the standardized Medigap plans available. For more information to help find a policy that works for you, visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.Medicare.gov/medigap-supplemental-insurance-plans). If you need help comparing and choosing a policy, call your [State Health Insurance Assistance Program \(SHIP\)](#) for help. See pages 47–48 for your state’s phone number.

- Every insurance company selling Medigap policies must offer Plan A. If they want to offer policies in addition to Plan A, they must also offer either Plan C or Plan F to individuals who aren't new to Medicare and either Plan D or Plan G to individuals who are new to Medicare. Not all types of Medigap policies may be available in your state.
- Plans D and G with coverage starting on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- **Plans E, H, I, and J are no longer sold**, but if you already have one, you can generally keep it.
- Since January 1, 2020, Medigap plans sold to people new to Medicare aren't allowed to cover the Part B **deductible**. Because of this, **Plans C and F are no longer available to people new to Medicare on or after January 1, 2020**.
 - If you already have either of these two plans (or the high deductible version of Plan F) or you were covered by one of these plans before January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.
 - For this situation, people new to Medicare are people who turned 65 on or after January 1, 2020, and people who get Medicare Part A (Hospital Insurance) on or after January 1, 2020.

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. (See pages 42–44.) In some states, you may be able to buy another type of Medigap policy called **Medicare SELECT**. Medicare SELECT are standardized plans that may require you to see certain providers and may cost less than other Medigap plans. (See page 20.)

This chart shows basic information about the different benefits that Medigap plans cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest. If a box is blank, the plan doesn't cover that benefit.

Benefits	Medicare Supplement Insurance (Medigap) Plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charge					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2022**			
							\$6,620	\$3,310		

* Plans F and G also offer a high-deductible plan in some states (Plan F isn't available to people new to Medicare on or after January 1, 2020.) If you get the high-deductible option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,490 in 2022 before your policy pays anything, and you must also pay a separate deductible (\$250 per year) for foreign travel emergency services.

**Plans K and L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and your Part B deductible (\$233 in 2022). After you meet these amounts, the plan will pay 100% of your costs for approved services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

What Medigap policies don't cover

Generally, Medigap policies don't cover:

- long-term care (like non-skilled care you get in a nursing home)
- vision or dental services
- hearing aids
- eyeglasses
- private-duty nursing

Types of coverage that are NOT Medigap policies

- [Medicare Advantage Plans \(also known as Part C\)](#)
- [Medicare drug plan \(Part D\)](#)
- [Medicaid](#)
- Employer or union plans, including the Federal Employees Health Benefits Program (FEHBP)
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans
- Qualified Health Plans sold in the Health Insurance Marketplace*

What types of Medigap policies can insurance companies sell?

In most cases, Medigap insurance companies can sell you only a standardized Medigap policy. All Medigap policies must have specific benefits, so you can compare them easily. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

Insurance companies that sell Medigap policies don't have to offer every Medigap plan. Each insurance company decides which Medigap plans it wants to sell, although federal and state laws might affect which ones they can offer.

In some cases, an insurance company must sell you a Medigap policy if you want one, even if you have health problems. You're guaranteed the right to buy a Medigap policy during certain times:

- When you're in your [Medigap Open Enrollment Period](#). (See pages 14–15.)
- If you have a [guaranteed issue right](#). (See pages 21–23.)

You may be able to buy a Medigap policy at other times, but the insurance company can deny you a Medigap policy based on your health. Also, in some cases, it may be illegal for the insurance company to sell you a Medigap policy (like if you already have Medicaid or a Medicare Advantage Plan).

What do I need to know if I want to buy a Medigap policy?

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- If you have a **Medicare Advantage Plan** but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurance company can sell it to you as long as you're leaving the Medicare Advantage Plan. Ask that the new Medigap policy start when your Medicare Advantage Plan enrollment ends, so you'll have continuous coverage.
- You pay the private insurance company a **premium** for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, **you each will have to buy separate Medigap policies.**
- When you have your **Medigap Open Enrollment Period**, you can buy a Medigap policy from any insurance company that's licensed in your state.
- Any new Medigap policy issued since 1992 is **guaranteed renewable** even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you stay enrolled and pay the premium.
- Different insurance companies may charge different premiums for the same exact Medigap plan type. As you shop for a policy, be sure you're comparing policies under the same plan type (for example, compare Plan A from one company with Plan A from another company).
- Some states may have laws that may give you additional protections.
- Although some Medigap policies sold in the past covered prescription drugs, Medigap policies sold after January 1, 2006, aren't allowed to include prescription drug coverage. If you want drug coverage, you can join a **Medicare drug plan** offered by private companies approved by Medicare. (See pages 6–7.) To learn about Medicare drug coverage, visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

When's the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your [Medigap Open Enrollment Period](#). This period lasts for 6 months and begins on the first day of the month you're both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods including those for people under 65. If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. (See page 39 for more information.)

During the Medigap Open Enrollment Period, an insurance company can't use [medical underwriting](#) to decide whether to accept your application. This means the insurance company can't do any of these because of your health problems:

- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except as explained below)

While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition.

A pre-existing condition is a health problem you have before the date a new insurance policy starts. In some cases, the Medigap insurance company can refuse to cover your out-of-pocket costs for these pre-existing health problems for up to 6 months. This is called a "pre-existing condition waiting period."

After 6 months, the Medigap policy will cover the pre-existing condition.

Coverage for a pre-existing condition can only be excluded if the condition was treated or diagnosed within 6 months before your Medigap policy coverage starts. This is called the "look-back period." Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't, but you're responsible for the Medicare [coinsurance](#) or [copayment](#).

When's the best time to buy a Medigap policy? (continued)

Creditable coverage

It's possible to avoid or shorten your waiting period for a pre-existing condition if:

- You buy a Medigap policy during your 6-month Medigap **Open Enrollment Period**.
- You're replacing certain kinds of health coverage that counts as "creditable coverage."

Prior creditable coverage is generally any other health coverage you recently had before applying for a Medigap policy. If you've had at least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing conditions.

There are many types of health coverage that may count as creditable coverage for Medigap policies, but they'll only count if you didn't have a break in coverage for more than 63 days.

Your Medigap insurance company can tell you if your previous coverage will count as creditable coverage for this purpose. You can also call your **State Health Insurance Assistance Program (SHIP)**. (See pages 47–48.)

If you buy a Medigap policy when you have a **guaranteed issue right** (also called "Medigap protection"), the insurance company can't use a pre-existing condition waiting period. See pages 21–23 for more information about guaranteed issue rights.

Why is it important to buy a Medigap policy when I'm first eligible?

During your **Medigap Open Enrollment Period**, you have the right to buy any Medigap policy offered in your state. In addition, you generally will get better prices and more choices among policies. If you apply for Medigap coverage **after** your Open Enrollment Period, there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the **medical underwriting** requirements, **unless** you're eligible for **guaranteed issue rights** (Medigap protections) because of one of the situations listed on pages 22–23.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap Open Enrollment Period begins when you enroll in Part B, and it can't be changed or repeated. After your Medigap Open Enrollment Period ends, you may be denied a Medigap policy or charged more for a Medigap policy due to past or present health problems.

In most cases, it makes sense to enroll in Part B and buy a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty and might miss your 6-month Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Employer coverage

If you have group health coverage through an employer or union, because either you or your spouse is currently working, you may want to wait to enroll in Part B. Benefits based on current employment often provide coverage similar to Part B, so you wouldn't want to pay for Part B before you need it, and your Medigap Open Enrollment Period might expire before a Medigap policy would be useful. When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty, which means your Medigap Open Enrollment Period will start when you're ready to take advantage of it. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare. See page 24 for more information.

How do insurance companies set prices for Medigap policies?

Each insurance company decides how it'll set the price, or **premium**, for its Medigap policies. The way they set the price affects how much you pay now and in the future. Each Medigap policy can be priced or "rated" in one of three ways:

1. Community-rated (also called "no-age-rated")
2. Issue-age-rated (also called "entry-age-rated")
3. Attained-age-rated

Each of these ways of pricing Medigap policies is described in the chart on the next page. The examples show how your age affects your premiums, and why it's important to look at how much the Medigap policy will cost you now and in the future. The amounts in the examples aren't actual costs. Other factors like where you live, **medical underwriting**, and discounts can also affect the amount of your premium.

How do insurance companies set prices for Medigap policies? (continued)

Type of pricing	How it's priced	What this pricing may mean for you	Examples
Community-rated (also called “no-age-rated”)	Generally the same premium is charged to everyone who has the Medigap policy, regardless of age or gender.	Your premium isn't based on your age. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Smith is 65. He buys a Medigap policy and pays a \$165 monthly premium.
			Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a \$165 monthly premium.
Issue-age-rated (also called “entry age-rated”)	The premium is based on the age you are when you buy (are “issued”) the Medigap policy.	Premiums are lower for people who buy at a younger age and won't change as you get older. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Han is 65. He buys a Medigap policy and pays a \$145 monthly premium.
			Mrs. Wright is 72. She buys the same Medigap policy as Mr. Han. Since she is older when she buys it, her monthly premium is \$175.
Attained-age-rated	The premium is based on your current age (the age you've “attained”), so your premium goes up as you get older.	Premiums are low for younger buyers but go up as you get older. They may be the least expensive at first, but they can eventually become the most expensive. Premiums may also go up because of inflation and other factors.	Mrs. Anderson is 65. She buys a Medigap policy and pays a \$120 monthly premium. Her premium will go up each year: <ul style="list-style-type: none"> At 66, her premium goes up to \$126. At 67, her premium goes up to \$132.
			Mr. Dodd is 72. He buys the same Medigap policy as Mrs. Anderson. He pays a \$165 monthly premium. His premium is higher than Mrs. Anderson's because it's based on his current age. Mr. Dodd's premium will go up each year: <ul style="list-style-type: none"> At 73, his premium goes up to \$171. At 74, his premium goes up to \$177.

Comparing Medigap costs

As discussed on the previous pages, the cost of Medigap policies can vary widely. **There can be big differences in the premiums that different insurance companies charge for exactly the same coverage.** As you shop for a Medigap policy, be sure to compare Medigap plan types with the same letter, and consider the type of pricing each insurance company uses. (See pages 17–18.) For example, compare Plan G from one company with Plan G from another company. Although this guide **can't** give actual costs of Medigap policies, you can get this information by calling insurance companies or your [State Health Insurance Assistance Program \(SHIP\)](#). (See pages 47–48.)

You can also find out which insurance companies sell Medigap policies in your area by visiting [Medicare.gov/medigap-supplemental-insurance-plans](https://www.medicare.gov/medigap-supplemental-insurance-plans). The cost of your Medigap policy may also depend on whether the insurance company:

- Offers discounts (like discounts for women, non-smokers, or married people; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses [medical underwriting](#), or applies a different premium when you don't have a [guaranteed issue right](#) or aren't in a [Medigap Open Enrollment Period](#).
- Sells [Medicare SELECT](#) policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. (See page 20.)
- Offers a “high-deductible option” for Plans F or G. If you buy Plans F or G with a high-deductible option, you must pay the first \$2,490 of [deductibles](#), [copayments](#), and [coinsurance](#) (in 2022) for covered services not paid by Medicare before the Medigap policy pays anything. You must also pay a separate deductible (\$250 per year) for foreign travel emergency services.

What's Medicare SELECT?

Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be offered as any of the standardized Medigap plans. (See page 11.) These policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT hospital or doctor for non-emergency services, you'll have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

How does Medigap help pay my Medicare Part B costs?

In most Medigap policies, you agree to have the Medigap insurance company get your Part B claim information directly from Medicare. Then, the Medigap insurance company pays the doctor directly whatever amount is owed under your policy. Some Medigap insurance companies also provide this service for Medicare Part A claims.

If your Medigap insurance company **doesn't** provide this service, ask your doctors if they participate in Medicare. Participating providers have agreed to accept **assignment** for all Medicare-covered services. If your doctor participates, the Medigap insurance company is required to pay the doctor directly if you request it. If your doctor doesn't participate but still accepts Medicare, you may be asked to pay the **coinsurance** amount at the time of service. In these cases, your Medigap insurance company may pay you directly according to policy limits. Check with your Medigap policy for more details.

If you have any questions about Medigap claim filing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION

3 Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

Guaranteed issue rights are your rights to buy certain Medigap policies in certain situations outside of your **Medigap Open Enrollment Period**. In these situations, an insurance company must:

- Sell you a Medigap policy
- Cover all your pre-existing health conditions
- Not charge you more for a Medigap policy regardless of past or present health problems

If you live in Massachusetts, Minnesota, or Wisconsin, you have guaranteed issue rights to buy a Medigap policy, but the Medigap policies are different. See pages 42–44 for your Medigap policy choices.

When do I have guaranteed issue rights?

In most cases, you have a guaranteed issue right when you have other health coverage that changes in some way, like when you lose the other health coverage. In other cases, you have a “trial right” to try a **Medicare Advantage Plan** and still buy a Medigap policy if you change your mind. For information on trial rights, see page 23.

Words in **blue** are defined on pages 49–50.

Medigap guaranteed issue right situations

The chart on this page and the next page describes the most common situations, under federal law, that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may offer additional Medigap [guaranteed issue rights](#).

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
<p>You have a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p> <p>You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.</p>	<p>As early as 60 calendar days before the date your Medicare Advantage Plan coverage will end, but no later than 63 calendar days after your coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.</p>
<p>You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.</p> <p>Note: In this situation, you may have additional rights under state law.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p> <p>If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.</p>	<p>No later than 63 calendar days after the latest of these 3 dates:</p> <ol style="list-style-type: none"> 1. Date the coverage ends. 2. Date on the notice you get telling you that coverage is ending (if you get one). 3. Date on a claim denial, if this is the only way you know that your coverage ended.
<p>You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.</p> <p>Call the Medicare SELECT insurance company for more information about your options.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by any insurance company in your state or the state you're moving to.</p>	<p>As early as 60 calendar days before the date your Medicare SELECT coverage will end, but no later than 63 calendar days after your Medicare SELECT coverage ends.</p>

***Note:** Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.

Medigap guaranteed issue right situations (continued)

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
<p>(Trial right) You joined a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.</p>	<p>Any Medigap policy that's sold in your state by any insurance company.*</p>	<p>As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.</p> <p>Note: Your rights may last for an extra 12 months under certain circumstances.</p>
<p>(Trial right) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back.</p>	<p>The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it.</p> <p>If your former Medigap policy isn't available, you can buy Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p>	<p>As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.</p> <p>Note: Your rights may last for an extra 12 months under certain circumstances.</p>
<p>Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p>	<p>No later than 63 calendar days from the date your coverage ends.</p>
<p>You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p>	<p>No later than 63 calendar days from the date your coverage ends.</p>

***Note:** Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.

Can I buy a Medigap policy if I lose my health coverage?

You may have a [guaranteed issue right](#) to buy a Medigap policy if you lose your health coverage, so make sure you keep these:

- A copy of any letters, notices, emails, and/or claim denials that have your name on them as proof of your coverage being terminated.
- The postmarked envelope these papers come in as proof of when it was mailed.

You may need to send a copy of some or all of these papers with your Medigap application to prove you have a guaranteed issue right.

If you have a [Medicare Advantage Plan](#) but you're planning to return to Original Medicare, you can apply for a Medigap policy before your plan coverage ends. The Medigap insurance company can sell it to you as long as you're leaving the Medicare Advantage Plan. Ask that the new policy take effect when your Medicare Advantage enrollment ends, so you'll have continuous health coverage.

For more information about Medigap rights

If you have any questions or want to learn about any additional Medigap rights in your state, you can:

- Call your [State Health Insurance Assistance Program \(SHIP\)](#) to make sure that you qualify for any of these guaranteed issue rights. (See pages 47–48.)
- Call your [State Insurance Department](#) if you're denied Medigap coverage in any of these situations. (See pages 47–48.)

Important: The guaranteed issue rights in this section are from federal law. These rights apply to Medigap and [Medicare SELECT](#) policies. Many states provide additional Medigap rights.

There may be times when more than one of the situations in the chart on pages 22–23 applies to you. When this happens, you can choose the guaranteed issue right that gives you the best choice.

Some of the situations listed include loss of coverage under Program of All-inclusive Care for the Elderly (PACE). PACE combines medical, social, and long-term care services, and prescription drug coverage for frail older adults who need nursing home services but are capable of living in the community. To be eligible for PACE, you must meet certain conditions. PACE may be available in states that have chosen it as an optional [Medicaid](#) benefit. If you have Medicaid, an insurance company can sell you a Medigap policy **only** in certain situations. To find a PACE plan in your area, visit [Medicare.gov/plan-compare/#/pace](https://www.Medicare.gov/plan-compare/#/pace). For more information about PACE, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION

Steps to Buying a Medigap Policy

4

Step-by-step guide to buying a Medigap policy

Buying a **Medigap policy** is an important decision. Only you can decide if a Medigap policy is the way for you to supplement your Original Medicare coverage and which Medigap policy to choose. Shop carefully. Compare available Medigap policies to see which one meets your needs. As you shop for a Medigap policy, keep in mind that different insurance companies may charge different amounts for exactly the same Medigap policy, and not all insurance companies offer all of the Medigap plans.

Below is a step-by-step guide to help you buy a Medigap policy. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

STEP 1: Decide which plan you want. Medigap policies are standardized, and in most states are named by letters, Plans A–N. Compare the benefits each plan helps pay for and choose a plan that covers what you need.

STEP 2: Pick your policy. Find policies in your area. Price is the only difference between policies with the same letter sold by different companies.

STEP 3: Contact the company. Get an official quote from the company. Prices can change at any time based on when you buy, your health conditions, and more. When you're ready to buy a policy, contact the company.

Words in blue
are defined on
pages 49–50.

STEP 1: Decide which plan you want.

Think about your current and future health care needs when deciding which benefits you want because you might not be able to switch Medigap policies later. Decide which benefits you need, and select the Medigap policy that will work best for you. See the chart on page 11 for an overview of each Medigap plan's benefits.

STEP 2: Pick your policy.

To find out which insurance companies sell Medigap policies in your state:

- Call your [State Health Insurance Assistance Program \(SHIP\)](#). (See pages 47–48.) Ask if they have a “Medigap rate comparison shopping guide” for your state. This guide usually lists companies that sell Medigap policies in your state and their costs.
- Call your [State Insurance Department](#). (See pages 47–48.)
- Visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.Medicare.gov/medigap-supplemental-insurance-plans) to find information on your coverage options, including the Medigap policies in your area.

You can also get information on:

- ✓ How to contact the insurance companies that sell Medigap policies in your state.
- ✓ What each Medigap policy covers.
- ✓ How insurance companies decide what to charge you for a Medigap policy [premium](#).

If you don't have a computer, your local library or senior center may be able to help you find this information. You can also call 1-800-MEDICARE (1-800-633-4227). A customer service representative will help you get information on all your coverage options including the Medigap policies in your area. TTY users can call 1-877-486-2048.

STEP 2: (continued)

Since costs can vary between companies, plan to call more than one insurance company that sells Medigap policies in your state. Before you call, check the companies to be sure they're honest and reliable by:

- Calling your **State Insurance Department**. Ask if they keep a record of complaints against insurance companies that can be shared with you. When deciding which Medigap policy is right for you, consider these complaints, if any.
- Calling your **State Health Insurance Assistance Program (SHIP)**. These programs can give you help with choosing a Medigap policy at no cost to you.
- Going to your local public library for help with:
 - Getting information on an insurance company's financial strength from independent rating services like weissratings.com, A.M. Best, and Standard & Poor's.
 - Looking at information about the insurance company online.
- Talking to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy from the same insurance company.

Before you call any insurance companies, figure out if you're in your **Medigap Open Enrollment Period** or if you have a **guaranteed issue right**. Read pages 14–15 and 22–23 carefully. If you have questions, call your **State Health Insurance Assistance Program (SHIP)**. (See pages 47–48.)

STEP 3: Contact the company.

When you're ready to contact insurance companies, use this chart to help you keep track of the information you get.

Ask each insurance company...	Company 1	Company 2
<p>“Are you licensed in ___?” (Say the name of your state.) Note: If the answer is NO, STOP here, and try another company.</p>		
<p>“Do you sell Medigap Plan ___?” (Say the letter of the Medigap Plan you're interested in.) Note: Insurance companies usually offer some, but not all, Medigap policies. Make sure the company sells the plan you want. Also, if you're interested in a Medicare SELECT or high-deductible Medigap policy, tell them.</p>		
<p>“Do you use medical underwriting for this Medigap policy?” Note: If the answer is NO, go to step 4 on page 30. If the answer is YES, but you know you're in your Medigap Open Enrollment Period or have a guaranteed issue right to buy that Medigap policy, go to step 4. Otherwise, you can ask, “Can you tell me if I'm likely to qualify for the Medigap policy?”</p>		
<p>“Do you have a waiting period for pre-existing conditions?” Note: If the answer is YES, ask how long the waiting period is and write it in the box.</p>		
<p>“Do you price this Medigap policy by using community-rating, issue-age-rating, or attained-age-rating?” (See page 18.) Note: Circle the one that applies for that insurance company.</p>	<p>Community Issue-age Attained-age</p>	<p>Community Issue-age Attained-age</p>
<p>“I'm ___ years old. What would my premium be under this Medigap policy?” Note: If it's attained-age, ask, “How frequently does the premium increase due to my age?”</p>		
<p>“Has the premium for this Medigap policy increased in the last 3 years due to inflation or other reasons?” Note: If the answer is YES, ask how much it has increased, and write it in the box.</p>		
<p>“Do you offer any discounts or additional benefits?” (See page 19.)</p>		

STEP 3: (continued)**Watch out for illegal practices**

It's illegal for anyone to:

- Pressure you into buying a Medigap policy, or lie to or mislead you to switch from one company or policy to another.
- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have **Medicaid**, except in certain situations.
- Sell you a Medigap policy if they know you're in a **Medicare Advantage Plan**, unless your coverage under the Medicare Advantage Plan will end before the effective date of the Medigap policy.
- Claim that a Medigap policy is a part of Medicare or any other federal program. Medigap is private health insurance.
- Claim that a Medicare Advantage Plan is a Medigap policy.
- Sell you a Medigap policy that can't legally be sold in your state. Check with your **State Insurance Department** (see pages 47–48) to make sure that the Medigap policy you're interested in can be sold in your state.
- Misuse the names, letters, or symbols of the U.S. Department of Health & Human Services (HHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare. (For example, they can't suggest the Medigap policy has been approved or recommended by the federal government.)
- Claim to be a Medicare representative if they work for a Medigap insurance company.
- Sell you a Medicare Advantage Plan when you say you want to stay in Original Medicare and buy a Medigap policy. A Medicare Advantage Plan isn't the same as Original Medicare. (See page 7.) If you enroll in a Medicare Advantage Plan, you can't use a Medigap policy.

If you believe that a federal law has been broken, call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users can call 1-800-377-4950. Your State Insurance Department can help you with other insurance-related problems.

STEP 4: Buying your Medigap policy

Once you decide on the insurance company and the Medigap policy you want to buy, apply. The insurance company must give you a clearly worded summary of your Medigap policy. Read it carefully. If you don't understand it, ask questions. Remember these when you buy your Medigap policy:

- **Filling out your application.**

Fill out the application carefully and completely, including medical questions. The answers you give will determine your eligibility for a [Medigap Open Enrollment Period](#) or [guaranteed issue rights](#). If the insurance agent fills out the application, make sure it's correct. If you buy a Medigap policy during your Medigap Open Enrollment Period or provide evidence that you're entitled to a guaranteed issue right, the insurance company can't use any medical answers you give to deny you a Medigap policy or change the price. The insurance company can't ask you any questions about your family history or require you to take a genetic test.

- **Paying for your Medigap policy.**

Your insurance company will let you know your payment options for your particular policy. Many companies offer electronic funds transfer, which lets you set up a recurring payment to debit automatically from a checking account or credit card. You may also be able to pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. If you buy from an agent, get a receipt with the insurance company's name, address, and phone number for your records.

- **Starting your Medigap policy.**

Ask for your Medigap policy to become effective when you want coverage to start. Generally, Medigap policies begin the first of the month after you apply. If, for any reason, the insurance company won't give you the effective date for the month you want, call your [State Insurance Department](#). (See pages 47–48.)

Note: If you already have a Medigap policy, ask for your new Medigap policy to become effective when your old Medigap policy coverage ends.

- **Getting your Medigap policy.**

If you don't get your Medigap policy (like your Medigap card or proof of insurance) in 30 days, call your insurance company. If you don't get your Medigap policy in 60 days, call your State Insurance Department.

SECTION

If You Already Have a Medigap Policy

5

Read this section if any of these situations apply to you:

- You're thinking about switching to a different Medigap policy. (See pages 32–35.)
- You're losing your Medigap coverage. (See page 36.)
- You have a Medigap policy with Medicare drug coverage. (See pages 36–38.)

If you just want a refresher about Medigap insurance, turn to page 11.

Words in **blue**
are defined on
pages 49–50.

Switching Medigap policies

Can I switch to a different Medigap policy?

In most cases, you won't have a right under federal law to switch Medigap policies, unless you're within your 6-month **Medigap Open Enrollment Period** or are eligible under a specific circumstance for **guaranteed issue rights**. But, if your state has more generous requirements, or the insurance company is willing to sell you a Medigap policy, make sure you compare benefits and **premiums** before switching. If you bought your Medigap policy before 2010, it may offer coverage that isn't available in a newer Medigap policy. On the other hand, Medigap policies bought before 1992 might not be **guaranteed renewable** and might have bigger premium increases than newer, standardized Medigap policies currently being sold.

If you decide to switch, don't cancel your first Medigap policy until you've decided to keep the second Medigap policy. On the application for the new Medigap policy, you'll have to promise that you'll cancel your first Medigap policy. You have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look period." The 30-day free look period starts when you get your new Medigap policy. You'll need to pay both premiums for one month.

Switching Medigap policies (continued)

Do I have to switch Medigap policies if I have a Medigap policy that's no longer sold?

No. But you can't have more than one Medigap policy, so if you buy a new Medigap policy, you have to give up your old policy (except for your 30-day "free look period," described on page 32). Once you cancel the old policy, you can't get it back.

Do I have to wait a certain length of time after I buy my Medigap policy before I can switch to a different Medigap policy?

No, but if you've had your current Medigap policy for less than 6 months, the insurance company offering the new Medigap policy may be able to make you wait up to 6 months before it covers a pre-existing condition.

- Your new Medigap policy must subtract the time you had your old Medigap policy from the time it makes you wait before it must cover your pre-existing condition. For example, if you had your old Medigap policy for 4 months, the new policy must subtract 4 months from how long it waits before covering your pre-existing condition. In this example, you'd wait up to 2 months before the new policy covers your pre-existing condition.
- If the new Medigap policy has a benefit that isn't in your current Medigap policy, you may still have to wait up to 6 months before that benefit will be covered, regardless of how long you've had your current Medigap policy.
- If you've had your current Medigap policy longer than 6 months and want to replace it with a new one with the same benefits and the insurance company agrees to issue the new policy, they can't write pre-existing conditions, waiting periods, elimination periods, or probationary periods into the replacement policy.

Switching Medigap policies (continued)

Why would I want to switch to a different Medigap policy?

Some reasons for switching may include:

- You're paying for benefits you don't need.
- You need more benefits than you needed before.
- Your current Medigap policy has the right benefits, but you want to change your insurance company.
- Your current Medigap policy has the right benefits, but you want to find a policy that's less expensive.

It's important to compare the benefits in your current Medigap policy to the benefits listed on page 11. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44. To help you compare benefits and decide which Medigap policy you want, follow the “**Steps to Buying a Medigap Policy**” in Section 4. If you decide to change insurance companies, you can call the new insurance company and apply for your new Medigap policy. If your application is accepted, call your current insurance company, and ask to have your coverage end. The insurance company can tell you how to submit a request to end your coverage.

As explained on page 32, make sure your old Medigap policy coverage ends **after** you have the new Medigap policy for 30 days. Remember, this is your 30-day “free look period.” You'll need to pay both **premiums** for one month.

Can I keep my current Medigap policy (or Medicare SELECT policy) or switch to a different Medigap policy if I move out-of-state?

In general, you can keep your current Medigap policy regardless of where you live as long as you still have Original Medicare. If you want to switch to a different Medigap policy, you'll have to check with your current or the new insurance company to see if they'll offer you a different Medigap policy.

You may have to pay more for your new Medigap policy and answer some medical questions if you're buying a Medigap policy outside of your **Medigap Open Enrollment Period**. (See pages 14–16.)

Switching Medigap policies (continued)

If you have a [Medicare SELECT](#) policy and you move out of the policy's area, you can:

- Buy a standardized Medigap policy from your current Medigap insurance company that offers the same or fewer benefits than your current Medicare SELECT policy. If you've had your Medicare SELECT policy for more than 6 months, you won't have to answer any medical questions.
- Use your [guaranteed issue right](#) to buy any Plan A, B, C, D, F, G, K, or L that's sold in most states by any insurance company.

Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.

Your state may provide additional Medigap rights. Call your [State Health Insurance Assistance Program \(SHIP\)](#) or [State Department of Insurance](#) for more information. See pages 47–78 for their phone numbers.

What happens to my Medigap policy if I join a Medicare Advantage Plan?

Medigap policies can't work with [Medicare Advantage Plans](#). If you decide to keep your Medigap policy, you'll have to pay your Medigap policy [premium](#), but the Medigap policy can't pay any [deductibles](#), [copayments](#), [coinsurance](#), or premiums under a Medicare Advantage Plan. So, if you join a Medicare Advantage Plan, you may want to drop your Medigap policy. Contact your Medigap insurance company to find out how to end your coverage. However, if you leave the Medicare Advantage Plan you might not be able to get the same Medigap policy back, or in some cases, any Medigap policy unless you have a "trial right." (See page 23.) Your rights to buy a Medigap policy may vary by state. You always have a legal right to keep the Medigap policy after you join a Medicare Advantage Plan. However, because you have a Medicare Advantage Plan, the Medigap policy would no longer provide benefits that supplement Medicare.

Losing Medigap coverage

Can my Medigap insurance company drop me?

If you bought your Medigap policy **after 1992**, in most cases the Medigap insurance company can't drop you because the Medigap policy is **guaranteed renewable**. This means your insurance company can't drop you unless one of these happens:

- You stop paying your **premium**.
- You weren't truthful on the Medigap policy application.
- The insurance company becomes bankrupt or insolvent.

If you bought your Medigap policy **before 1992**, it might not be guaranteed renewable. This means the Medigap insurance company can refuse to renew your Medigap policy, as long as it gets the state's approval to cancel your policy. However, if this does happen, you have the right to buy another Medigap policy. See examples of **guaranteed issue right** situations on page 22.

Medigap policies and Medicare drug coverage

What if I bought a Medigap policy before January 1, 2006, and it already has prescription drug coverage?

Medicare offers prescription drug coverage for everyone with Medicare. If you have a Medigap policy with prescription drug coverage, that means you chose not to join a **Medicare drug plan** when you were first eligible. However, you can still join a Medicare drug plan. Your situation may have changed in ways that make a Medicare drug plan fit your needs better than the drug coverage in your Medigap policy. It's a good idea to review your coverage each fall, because you can join a Medicare drug plan between October 15–December 7. Your new coverage will begin on January 1.

Medigap policies and Medicare drug coverage (continued)

What if I change my mind and join a Medicare drug plan?

If your Medigap **premium** or your prescription drug needs were very low when you had your first chance to join a **Medicare drug plan**, your Medigap drug coverage may have met your needs. However, if your Medigap premium has gone up or you've started taking more prescription drugs recently, a Medicare drug plan might now be a better choice for you.

In a Medicare drug plan, you may have to pay a monthly premium. There are no yearly maximum coverage amounts like with Medigap drug benefits in old Plans H, I, and J, which are no longer sold. However, a Medicare drug plan might only cover certain prescription drugs (on its “formulary” or “drug list”). It's important that you check whether your current prescription drugs are on the Medicare drug plan's list of covered prescription drugs before you join.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now?

If you bought a Medigap policy before January 1, 2006, that includes prescription drug coverage, you may have to pay a late enrollment penalty if the policy does not include “creditable prescription drug coverage.” Having creditable coverage means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard drug coverage and gives the same value for your prescriptions as Medicare drug coverage (Part D).

If your Medigap policy's drug coverage **isn't** creditable coverage, and you join a Medicare drug plan now, you'll probably pay a higher premium (a penalty added to your monthly premium) than if you had joined when you were first eligible. Each month that you wait to join a Medicare drug plan will make your late enrollment penalty higher. Your Medigap insurance company must send you a notice each year telling you if the drug coverage in your Medigap policy is creditable or if the drug coverage in your Medigap policy changes so that it's no longer creditable. Keep these notices in case you decide later to join a Medicare drug plan. Also consider that your prescription drug needs could increase as you get older.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now? (continued)

If your Medigap policy includes creditable prescription drug coverage or if you get a notice from your Medigap insurance company that your Medigap drug coverage will no longer be creditable, and you decide to join a [Medicare drug plan](#), you won't have to pay a late enrollment penalty as long as you don't go 63 or more days in a row without creditable prescription drug coverage. Don't drop the drug coverage from your Medigap policy **before** you join the Medicare drug plan and the coverage starts. In general, you can only join a Medicare drug plan between October 15–December 7. However, if you lose your Medigap policy entirely (for example, your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own), you may be able to join a Medicare drug plan.

Some people with Medicare qualify for Extra Help, a program to help people with limited income and resources pay for Medicare prescription drug program costs, like [premiums](#), [deductibles](#), and [coinsurance](#). If you qualify for Extra Help, you won't pay a late enrollment penalty when you join a Medicare drug plan.

Can I join a Medicare drug plan and have a Medigap policy with prescription drug coverage?

No. If your Medigap policy covers prescription drugs, you must tell your Medigap insurance company when you join a Medicare drug plan so it can remove the prescription drug coverage from your Medigap policy and adjust your premium. Once the drug coverage is removed, you can't get that coverage back even though you didn't change Medigap policies.

What if I decide to drop my entire Medigap policy (not just the drug coverage) and join a Medicare Advantage Plan that offers drug coverage?

In general, you can only join a Medicare drug plan or [Medicare Advantage Plan](#) with drug coverage during the Medicare Open Enrollment Period between October 15–December 7. If you join during Open Enrollment, your coverage will begin on January 1. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back, so pay careful attention to the timing.

SECTION

6 Medigap Policies for People with a Disability or ESRD

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD)

You may have Medicare before turning 65 due to a disability or End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

If you're under 65 and have Medicare because of a disability or ESRD, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65. These states are listed on the next page.

Important: This section provides information on the minimum federal standards. For your state requirements, call your [State Insurance Department](#) or [State Health Insurance Assistance Program \(SHIP\)](#). (See pages 47–48.)

Words in blue are defined on pages 49–50.

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD) (continued)

At the time of printing this guide, these states required insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65:

- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- 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
- Wisconsin

Note: Some states provide these rights to all people with Medicare under 65, while others only extend them to people eligible for Medicare because of disability or only to people with ESRD. Check with your [State Insurance Department](#) about what rights you might have under state law.

Even if your state isn't listed above, some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can probably use [medical underwriting](#). Also, some of the federal guaranteed rights are available to people with Medicare under 65. (See pages 21–24.) Check with your State Insurance Department about what additional rights you might have under state law.

Remember, if you already have Medicare Part B (Medical Insurance), you'll get a [Medigap Open Enrollment Period](#) when you turn 65. You'll probably have more Medigap policy options and be able to get a lower [premium](#) at that time. During the Medigap Open Enrollment Period, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare (Part A and/or Part B) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have to wait through a pre-existing condition waiting period for coverage you bought during the Medigap Open Enrollment Period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, see pages 4–5. If you have questions, call your [State Health Insurance Assistance Program \(SHIP\)](#). (See pages 47–48.)

Words in [blue](#) are defined on pages 49–50.

SECTION

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Massachusetts benefits	42
Minnesota benefits	43
Wisconsin benefits.....	44

Words in **blue**
are defined on
pages 49–50.

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

- **Inpatient hospital costs:** Covers the Medicare Part A **coinsurance** plus coverage for 365 additional days after Medicare coverage ends
- **Medical costs:** Covers the Medicare Part B coinsurance (generally 20% of the **Medicare-approved amount**)
- **Blood:** Covers the first 3 pints of blood each year
- Part A hospice coinsurance or **copayment**

Note: Supplement 1 Plan (which includes coverage of the Part B **deductible**) is no longer available to people new to Medicare on or after January 1, 2020. These people can buy Supplement 1A Plan. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Supplement Plan 1.

The check marks in this chart mean the benefit is covered.

Medigap benefits	Core plan	Supplement 1 Plan	Supplement 1A Plan
Basic benefits	✓	✓	✓
Part A inpatient hospital deductible		✓	✓
Part A skilled nursing facility (SNF) coinsurance		✓	✓
Part B deductible		✓	
Foreign travel emergency		✓	✓
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
State-mandated benefits (yearly Pap tests and mammograms—check with the plan for other state-mandated benefits)	✓	✓	✓

Visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.Medicare.gov/medigap-supplemental-insurance-plans) or call your **State Insurance Department** for more information on these Medigap policies. See pages 47–48 for the phone number of your local State Insurance Department.

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

- **Inpatient hospital costs:** Covers the Part A [coinsurance](#)
- **Medical costs:** Covers the Part B coinsurance (generally 20% of the [Medicare-approved amount](#))
- **Blood:** Covers the first 3 pints of blood each year
- Part A hospice and respite cost sharing
- Parts A and B home health services and supplies cost sharing

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan	Extended basic plan	Mandatory riders
Basic benefits	✓	✓	Insurance companies can offer 4 additional riders that can be added to a basic plan. You may choose any one or all of these riders to design a Medigap policy that meets your needs: <ol style="list-style-type: none"> 1. Part A inpatient hospital deductible 2. Part B deductible** 3. Usual and customary fees 4. Preventive care Medicare doesn't cover
Part A inpatient hospital deductible		✓	
Part A skilled nursing facility (SNF) coinsurance	✓ (Provides 100 days of SNF care)	✓ (Provides 120 days of SNF care)	
Part B deductible**		✓	
Foreign travel emergency	80%	80%*	
Outpatient mental health	20%	20%	
Usual and customary fees		80%*	
Medicare-covered preventive care	✓	✓	
Physical therapy	20%	20%	
Coverage while in a foreign country		80%*	
State-mandated benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)	✓	✓	

* Pays 100% after you spend \$1,000 in out-of-pocket costs for a calendar year.

**Coverage of the Part B deductible is no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to get this benefit.

Minnesota versions of Medigap Plans K, L, M, and N are available. Minnesota versions of high-deductible F are available to people who had or were eligible for Medicare before January 1, 2020. (See page 10 for details on eligibility.)

Important: The basic and extended basic plans are available when you enroll in Part B, regardless of age or health problems. If you're under 65, return to work and drop Part B to join your employer's health plan, you'll get a 6-month [Medigap Open Enrollment Period](#) after you turn 65 and retire from that employer when you join Part B again.

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

- **Inpatient hospital costs:** Covers the Part A [coinsurance](#)
- **Medical costs:** Covers the Part B coinsurance (generally 20% of the [Medicare-approved amount](#))
- **Blood:** Covers the first 3 pints of blood each year
- Part A hospice coinsurance or [copayment](#)

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan
Basic benefits	✓
Part A skilled nursing facility (SNF) coinsurance	✓
Inpatient mental health coverage	175 days per lifetime in addition to Medicare's benefit
Home health care	40 visits per year in addition to those paid by Medicare
State-mandated benefits	✓

For more information on these Medigap policies, visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.Medicare.gov/medigap-supplemental-insurance-plans) or call your [State Insurance Department](#). See pages 47–48 for the phone number of your local State Insurance Department.

Plans known as “50% and 25% cost-sharing plans” are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan (\$2,490 for 2022) is also available.

Optional riders
Insurance companies are allowed to offer these 7 additional riders to a Medigap policy:
1. Part A deductible
2. Additional home health care (365 visits including those paid by Medicare)
3. Part B deductible*
4. Part B excess charge
5. Foreign travel emergency
6. 50% Part A deductible
7. Part B copayment or coinsurance
*Coverage of the Part B deductible is no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to get this benefit.

SECTION

For More Information

8

Where to get more information

On pages 47–48, you'll find phone numbers for your [State Health Insurance Assistance Program \(SHIP\)](#) and [State Insurance Department](#).

- Call your SHIP for help with:
 - Buying a Medigap policy or long-term care insurance
 - Dealing with payment denials or appeals
 - Medicare rights and protections
 - Choosing a Medicare plan
 - Deciding whether to suspend your Medigap policy
 - Questions about Medicare bills
- Call your State Insurance Department if you have questions about the Medigap policies sold in your area, state issue rights, or any insurance-related problems.

Words in [blue](#) are defined on pages 49–50.

How to get help with Medicare and Medigap questions

If you have questions about Medicare, Medigap, or need updated phone numbers for the contacts listed on pages 47–48:

- **Visit Medicare.gov:**
 - For Medigap policies in your area, visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.medicare.gov/medigap-supplemental-insurance-plans).
 - For updated phone numbers, visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).
- **Call 1-800-MEDICARE (1-800-633-4227):**

Customer service representatives are available 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know the language.

State Health Insurance Assistance Program (SHIP) and State Insurance Department

State	State Health Insurance Assistance Program	State Insurance Department
Alabama	1-800-243-5463	1-800-433-3966
Alaska	1-800-478-6065	1-800-467-8725
American Samoa	Not available	1-684-633-4116
Arizona	1-800-432-4040	1-800-325-2548
Arkansas	1-800-224-6330	1-800-282-9134
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7415	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-3272
Illinois	1-800-252-8966	1-888-473-4858
Indiana	1-800-452-4800	1-800-622-4461
Iowa	1-800-351-4664	1-877-955-1212
Kansas	1-800-860-5260	1-800-432-2484
Kentucky	1-877-293-7447	1-800-595-6053
Louisiana	1-800-259-5300	1-800-259-5301
Maine	1-800-262-2232	1-800-300-5000
Maryland	1-800-243-3425	1-800-492-6116
Massachusetts	1-800-243-4636	1-877-563-4467
Michigan	1-800-803-7174	1-877-999-6442
Minnesota	1-800-333-2433	1-800-657-3602
Mississippi	1-844-822-4622	1-800-562-2957
Missouri	1-800-390-3330	1-800-726-7390
Montana	1-800-551-3191	1-800-332-6148
Nebraska	1-800-234-7119	1-800-234-7119

State	State Health Insurance Assistance Program	State Insurance Department
Nevada	1-800-307-4444	1-800-992-0900
New Hampshire	1-866-634-9412	1-800-852-3416
New Jersey	1-800-792-8820	1-800-446-7467
New Mexico	1-800-432-2080	1-888-427-5772
New York	1-800-701-0501	1-800-342-3736
North Carolina	1-855-408-1212	1-855-408-1212
North Dakota	1-888-575-6611	1-800-247-0560
Northern Mariana Islands	Not available	1-670-664-3064
Ohio	1-800-686-1578	1-800-686-1526
Oklahoma	1-800-763-2828	1-800-522-0071
Oregon	1-800-722-4134	1-888-877-4894
Pennsylvania	1-800-783-7067	1-877-881-6388
Puerto Rico	1-877-725-4300	1-888-722-8686
Rhode Island	1-888-884-8721	1-401-462-9520
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 (St. Croix) 1-340-714-4354 (St. Thomas)	1-340-773-6449 1-340-774-2991
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-727-8370	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION

Definitions

Where words in **BLUE** are defined

Assignment—An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.

Excess charge—If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Guaranteed issue rights (also called "Medigap protections") — Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, like exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed renewable policy—An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical underwriting—The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include: Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for by Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare drug plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare drug plans.

Medicare SELECT—A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medigap Open Enrollment Period—A one-time-only, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Medicare Part B, **and** you're 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional Open Enrollment rights under state law.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Insurance Department—A state agency that regulates insurance and can provide information about Medigap policies and other private health insurance.

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

2. Send us a fax: 1-844-530-3676

3. Send us a letter:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. By phone:

Call 1-800-368-1019. TDD user can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201



**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850

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CMS Product No. 02110

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To get this publication in Braille, Spanish, or large print (English), visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

¿Necesita una copia en español? Visite [Medicare.gov](https://www.Medicare.gov) en el sitio Web. Para saber si esta publicación esta impresa y disponible (en español), llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

MEDICARE & SUPPLEMENT QUICK REFERENCE

Have you enrolled in Medicare A&B?

You can enroll online (turning 65) or in person (after age 65)

It is best to enroll 3 months before your 65th birthday or retirement date

(Amounts provided for 2023)

There may be penalties if enrolling in Medicare Parts A, B or D after age 65 if you do not have a valid Special Enrollment Period

After the initial enrollment period, individuals can only enroll or change plans once a year

This penalty is for life once enrolled, the penalty is added to the monthly premium



Premiums deducted from Social Security Income

If not collecting Social Security, Medicare will bill quarterly

PART A - Hospital Insurance

Premium- \$0 Premium

As long as you or your spouse paid Medicare taxes a minimum of 10 years (40 quarters)

- Part A deductible (\$1,600/occurrence)
- Part A copays (varies for hospital and skilled nursing)

PART B - Medical Insurance

Base Premium- \$170.10/month/person

Based on income. Assumes Income under \$97K single or \$194K household

- Part B deductible (\$226/calendar year)
- Part B coinsurance (20%- no cap)
- Part B Excess (up to 15% over Medicare allowable amount- no cap)



Medicare Advantage

Managed Care Memberships with Doctor Networks

- PPOs, HMOs and Private Fee For Service (PFFS) Plans
- Benefits, Doctor Networks and claims processes differ by carrier

Medicare Supplement Insurance

No Managed Care and No Doctor Networks

Only Plans F, G and HDG cover Part B Excess

PLAN F (only available if you turned 65 before 1/1/20)

- Covers all Medicare A&B Deductibles, Copays & Coinsurances

PLAN G

- Does not cover the Medicare Part B deductible (\$226/calendar year)
- Plan G may save \$250-400/year in premium compared to Plan F

Looking for a lower premium?

Ask about Plans N or High Deductible G (HDG)



- All Prescription Drug Plans are different in which medications they cover, and which tier they rank each drug

4 Stages of Coverage

(amounts may vary by carrier)

- 1. Deductible-**
Until you payout \$0-\$505 (ranges by carrier)
Pay full drug cost
- 2. Initial Coverage (Copay)-**
Until your Total Drug Cost reaches \$4,660
Pay a copay or coinsurance
- 3. Coverage Gap (Donut Hole)-**
Until your True Out of Pocket Cost reaches \$7,400. Pay 25% for Brand and Generic
- 4. Catastrophic-**
Until the end of the calendar year
Pay 5% for Brand or Generic

Dental, Vision and Hearing - Optional

Original Medicare does not cover routine dental, vision and hearing coverage. Please ask about available options



610-430-6650

How you should be treated - A521

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Original Indicators

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PART 2 - Medical Insurance

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Medical Insurance

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- 4. ...



MEDICARE
LONG TERM CARE

Client Tool Kit

VIP Medicare Program

“Your Roadmap to Medicare”





At HTA we feel it is important that our clients receive proper assistance and advice when it comes to their Medicare decisions. We provide a full service package to help you transition to Medicare, acquire appropriate coverage to meet your needs and provide ongoing support

Pre-retirement “Roadmap to Medicare” Consultation

Individual, no cost phone counseling session to prepare and answer questions for all aspects of retirement healthcare

We review:

-  A short fact finder to collect details on the individual’s specific situation as it pertains to planned age for retirement, size of employer group health program and out of pocket medical expenses
-  Personalized information on Medicare related topics
 - Transition from Group Health to Original Medicare and Medicare Supplement Insurance
 - Helpful timeline as to when to contact Social Security and under what circumstances to enroll or defer Medicare Part B
 - What Medicare, Medicare Supplement Insurance, Prescription Drug Plans and Medicare Advantage Plans cover

Tailor-made “Roadmap to Medicare” Report

Specialized report that will give step by step action items to do at specific times leading up to retirement, which will answer questions like:

- Should I enroll or defer my Medicare Part B at age 65?
- How do I defer/enroll?
- Does it make sense to explore Original Medicare and Medicare Supplement Insurance options if I work past age 65?
- When I am ready to research supplements, who do I contact and how does the process work?



Medicare Supplement Insurance, Prescription Drug Plans and Dental & Vision Coverages

HTA provides gentle guidance and support for choosing appropriate coverage to meet your needs. We will compare costs of 30 leading insurance carriers, explain the products and help complete the enrollment. We follow the applications all the way through issue and make sure the individual is comfortable with the policy once received. We continuously remain available for future questions and to offer assistance. There are **NO SALES PITCHES** -- only friendly, undivided and efficiently executed service. HTA is committed to exceeding your expectations

Please call HTA Client Services Team
To set up your phone consultation

610-430-6650

