Presenter Notes

This training module explains Medicare Program basics including Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), Medicare Supplement Insurance (Medigap), Medicare Advantage, Medicare drug coverage, the Health Insurance Marketplace®, Medicaid, other programs to help people with limited income and resources, and related resources.

Disclaimer

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace®.

The information in this module was correct as of **May 2023**. To check for an updated version, visit CMSnationaltrainingprogram.cms.gov.

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CMS Disclaimer

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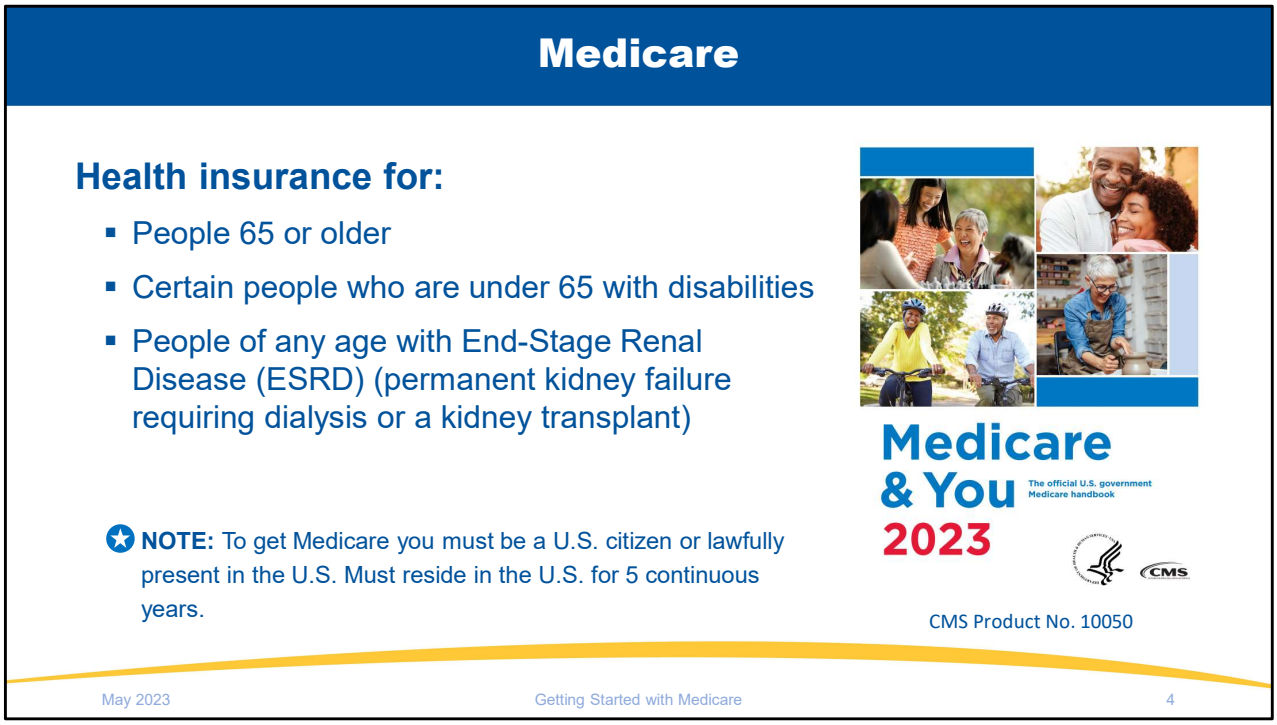
Presenter Notes

Lesson 1 explains the parts of Medicare, coverage options, automatic enrollment, and enrollment periods.



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Presenter Notes

Medicare is health insurance for:

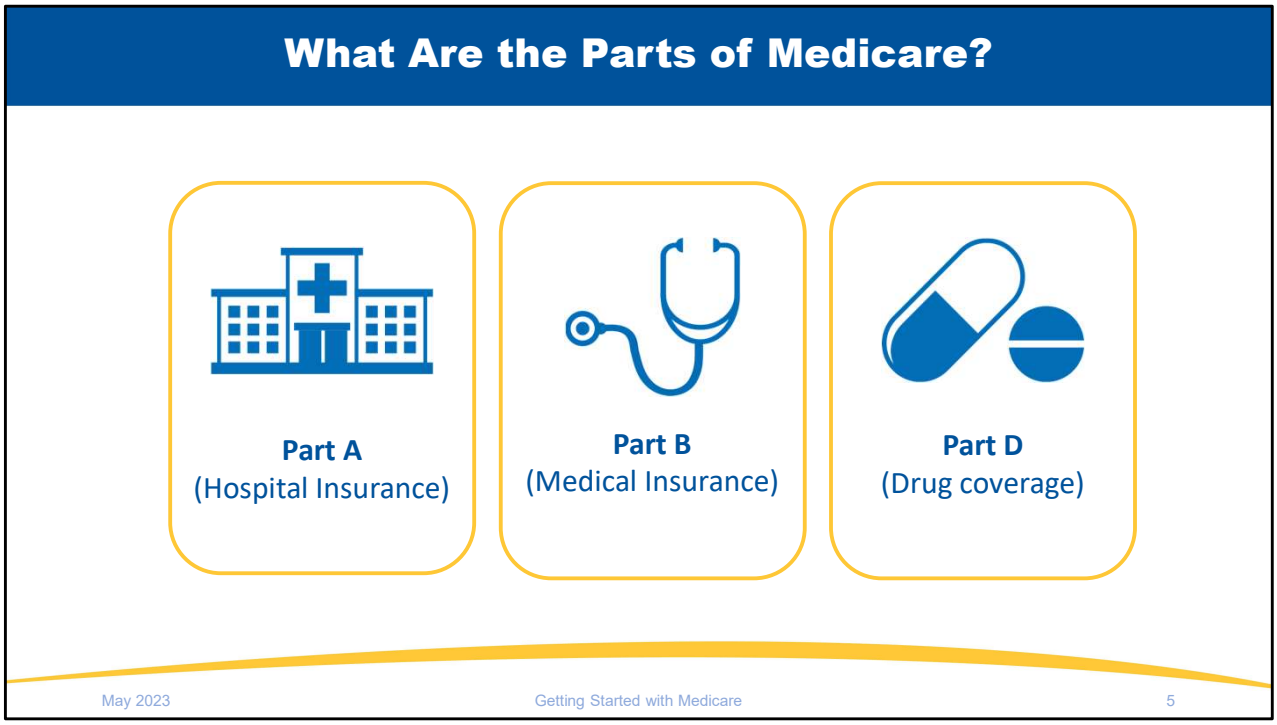
- People 65 or older.
- Certain people who are under 65 with disabilities who've been getting Social Security Disability Insurance (SSDI) benefits for 24 months. Individuals with ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) who get SSDI benefits don't have a 24-month waiting period.
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

A very small subset of people with an asbestos-related condition associated with a federally-declared environmental health hazard can also get Medicare. Currently, this only applies to people affected by a hazard in Libby, Montana.

People who immigrate to the U.S. may qualify for Medicare if they're in a lawful status. Generally, they must have resided in the U.S. for 5 continuous years to get Medicare.

CMS mails the "Medicare & You" handbook (CMS Product No. 10050) pictured on the slide to all new Medicare beneficiaries at the time they enroll, and to every household each year in the fall. Visit Medicare.gov/medicare-and-you to view and download it electronically. The handbook explains Medicare and provides information on Medicare health and drug plans.

For general Medicare enrollment information, visit CMS.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html. For more information on options for people with disabilities, visit CMSnationaltrainingprogram.cms.gov to review the "Medicare & Other Programs for People with Disabilities" training module.



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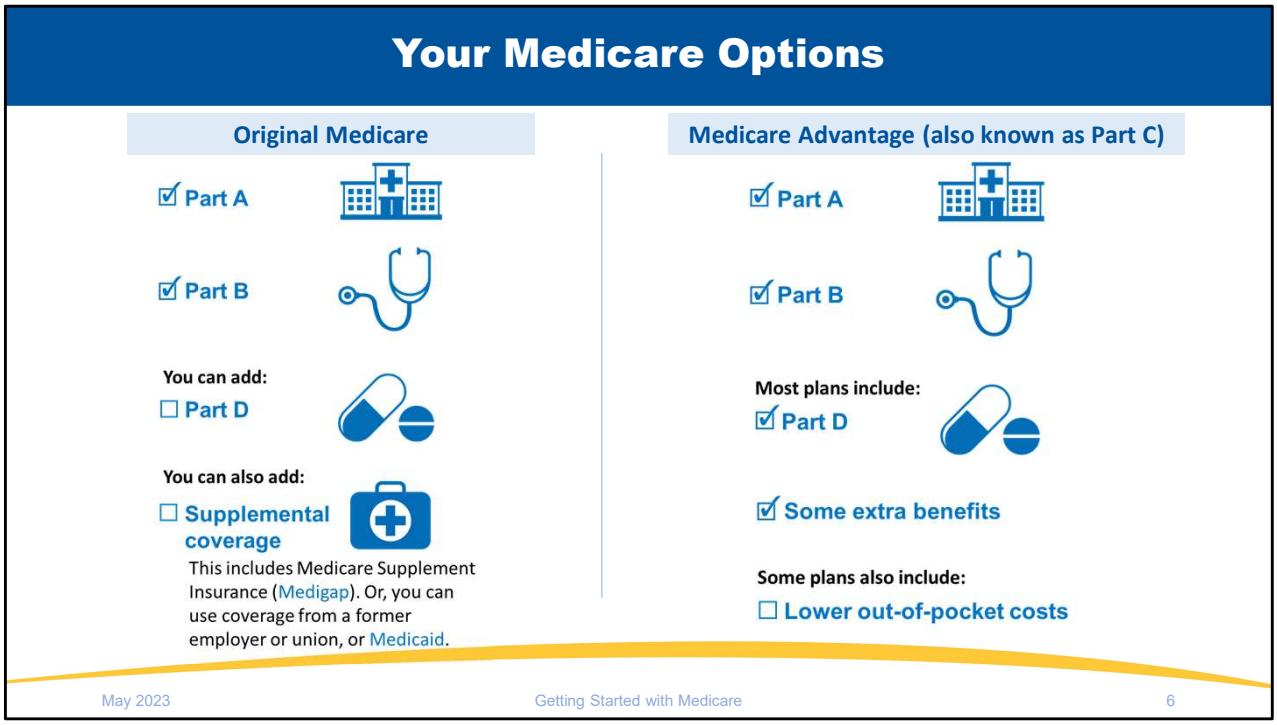
Presenter Option: You may click on the URL to play the "Learn About the Parts of Medicare" video: Medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare for participants.

Presenter Notes

The parts of Medicare include:

- **Part A** (Hospital Insurance)
- **Part B** (Medical Insurance)
- **Part D** (Medicare drug coverage)

More details about Part A, Part B, and Part D are in Lesson 2.



Presenter Option: You may click on the URL to play the "Explore Your Medicare Coverage Options" video: https://www.youtube.com/watch?v=2ikOdAeZboY.

Presenter Notes

When you first sign up for 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
- Medicare Advantage (also known as Part C)

Original Medicare

- Coverage includes Part A and Part B.
- 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. This includes Medicare Supplement Insurance (Medigap) policies, which only work with Original Medicare. Or, you can use coverage from a former employer or union, or Medicaid. Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. It also offers benefits that Medicare doesn't normally cover, like nursing home care and personal care services. The coinsurance is 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.

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 can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- 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. See Lesson 5 for more information on Medicare Advantage including supplemental benefits available in some Medicare Advantage Plans.

Original Medicare vs. Medicare Advantage: Doctor & Hospital Choice

Original Medicare	Medicare Advantage (Part C)
You can use **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you can only use **doctors and other providers who are in the plan's network and service area** (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
In most cases, you **don't need** a referral to use a specialist.	You **may need** to get a referral to use a specialist.

Presenter Notes

The chart lets you compare Original Medicare and Medicare Advantage Plans side-by-side. Let's compare doctor and hospital choice:

Original Medicare

- You can use **any doctor or hospital that takes Medicare, anywhere in the U.S.**
- In most cases, you **don't need** a referral to use a specialist.

Medicare Advantage Plans

- In many cases, you can only use **doctors and other providers who are in the plan's network and service area** (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
- You **may need** to get a referral to use a specialist.

Original Medicare vs. Medicare Advantage: Cost

Original Medicare	Medicare Advantage (Part C)
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible. This amount is called your coinsurance.	**Out-of-pocket costs vary**—plans may have lower or higher out-of-pocket costs for certain services.
You **pay a premium (monthly payment) for Part B**. If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap).	Plans have a **yearly** limit on what you pay out of pocket for services Medicare Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B cover for the rest of the year.
You **can get Medigap** to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.	You **can't buy and don't need Medigap**.

Presenter Notes

Let's compare costs:

Original Medicare

- For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible. This amount is called your coinsurance. The deductible is 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. You **pay a premium (monthly payment) for Part B**. If you choose to join a Medicare drug plan, you'll pay a separate premium for your drug coverage (Part D).
- There's **no yearly limit** on what you pay out of pocket, unless you have supplemental coverage—like Medigap.
- You **can get** Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage Plans

Out-of-pocket costs vary—plans may have lower or higher out-of-pocket costs for certain services.

- You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include drug coverage (Part D).
- Plans have a **yearly limit** on what you pay out of pocket for services Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B cover for the rest of the year.
- You **can't buy and don't need** Medigap.

Original Medicare vs. Medicare Advantage: Coverage

Original Medicare	Medicare Advantage (Part C)
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.	Plans must cover all medically necessary services that Original Medicare covers. Plans may also offer some **extra benefits that Original Medicare doesn't cover**—like vision, hearing, and dental services.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans**. In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.
In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.	In many cases, you have to get a service or supply approved ahead of time for the plan to cover it.

Presenter Notes

Let's compare coverage:

Original Medicare

- Covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.
- You can join a **separate drug plan** to get drug coverage (Part D).
- In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.

Medicare Advantage Plans

- Plans must cover all medically necessary services that Original Medicare covers. Plans may also offer some **extra benefits that Original Medicare doesn't cover**—like vision, hearing, and dental services.
- **Drug coverage (Part D) is included in most plans**. In most types of Medicare Advantage Plans, you can't join a separate drug plan.
- In many cases, you have to get a service or supply approved ahead of time for the plan to cover it.

NOTE: Medicare doesn't pay for your hospital or medical bills if you aren't lawfully present in the U.S. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated. If you're in the hospital as an outpatient and then are admitted as an inpatient, Part A coverage can be retroactive up to 3 days.

Original Medicare vs. Medicare Advantage: Foreign Travel

Original Medicare	Medicare Advantage (Part C)
Original Medicare generally **doesn't cover medical care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally **don't cover care outside the U.S.** Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.

Presenter Notes

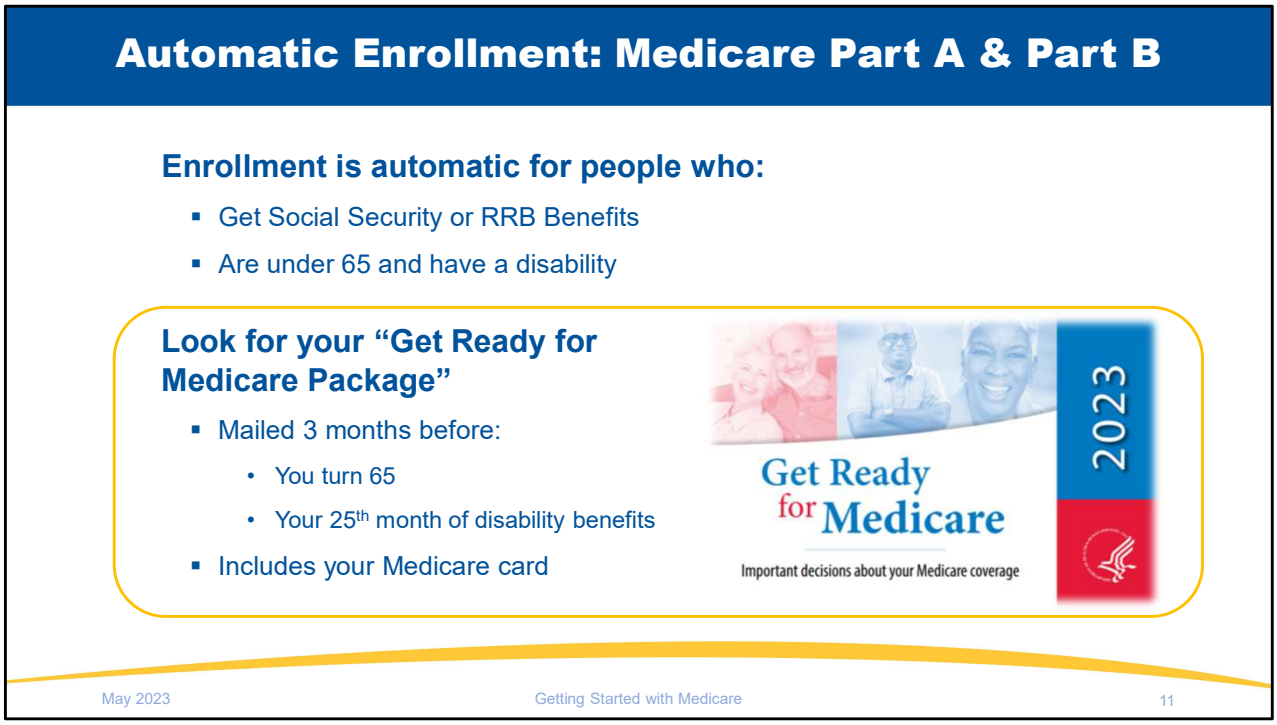
Let's compare foreign travel:

- **Original Medicare** generally **doesn't cover medical care outside the U.S**. You may be able to buy a Medigap policy that covers emergency care outside the U.S. The 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are considered part of the U.S. Anywhere else is considered outside the U.S.
- **Medicare Advantage Plans** generally **don't cover care outside the U.S**. Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.

Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.
- There are also some cases where Part B may pay for services that you get on board a ship within the territorial waters adjoining the land areas of the U.S.

Source: Medicare.gov/coverage/travel



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Presenter Notes

- **If you're already getting Social Security or RRB benefits during your Initial Enrollment Period (IEP)** (for example, you get retirement benefits at least 4 months before you turn 65), you'll be automatically enrolled in Part A and Part B. You'll get your Get Ready for Medicare package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the 1st day of the month you turn 65).

  NOTE: If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the 1st day of the month you turn 65, or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Visit SSA.gov or RRB.gov for help.

- **If you're under 65 and have a disability,** you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. You'll get your Get Ready for Medicare package, which includes your Medicare card and other information, about 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits). If you have ALS, you'll automatically get Part A and Part B the month your Social Security disability benefits begin.

"Get Ready for Medicare," is pictured on this page. Visit Medicare.gov/basics/forms-publications-mailings/mailings/signing-up/get-ready-for-medicare-package to get a copy.

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Presenter Notes

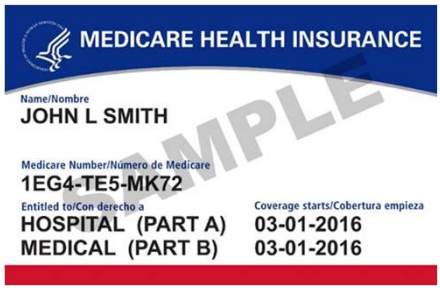
- If you aren't getting Social Security or RRB benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A (even if you're eligible to get Part A premium free (don't need to pay a premium)) and Part B. To avoid a delay in coverage, you should contact Social Security to apply for Medicare 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up. You don't have to be retired to get Medicare.
- You can sign up online at SSA.gov , or call 1-800-722-1213; TTY: 1-800-325-0778, or make an appointment at your local Social Security office. To find your local office, visit secure.SSA.gov/ICON/main.jsp. You can sign up for and get Social Security retirement benefits as early as 62, but the benefit amount will be lower than your full retirement benefit amount. Your benefit amount will be reduced based on the number of months you get benefits before you reach your full retirement age.
- The full retirement age for Social Security benefits is increasing. For many years, the full retirement age was 65. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959. You can calculate your age for collecting **full** Social Security retirement benefits at SSA.gov/retirement/ageincrease.htm.
- For more information, visit SSA.gov/pubs/EN-05-10035.pdf
- **NOTE:** If you sign up for Part A and Part B, CMS will send you a "Welcome to Medicare" package—about 2 weeks after you apply. The package includes a "Welcome to Medicare" cover letter and a "Welcome to Medicare" booklet (CMS Product No. 12020). The package will also provide your coverage start date (which is on the enclosed Medicare card as well). The cover letter and booklet both explain important decisions you need to make.

"Welcome to Medicare," is pictured on this page. Visit Medicare.gov/basics/forms-publications-mailings/mailings/signing-up/welcome-to-medicare-package to get a copy.

Source: SSA.gov/benefits/retirement/planner/applying2.html

Your Medicare Card

- Shows you have Medicare Part A (listed as HOSPITAL), Part B (listed as MEDICAL) or both, and the date your coverage begins
- To accept Part B, keep your card (and carry it when you're away from home)
- To refuse Part B, follow the instructions in the "Get Ready for Medicare" package



Need a replacement card?

- **Visit Medicare.gov/account** to log into your secure Medicare account and print an official copy
- **Call 1-800-MEDICARE** (1-800-633-4227); TTY 1-877-486-2048

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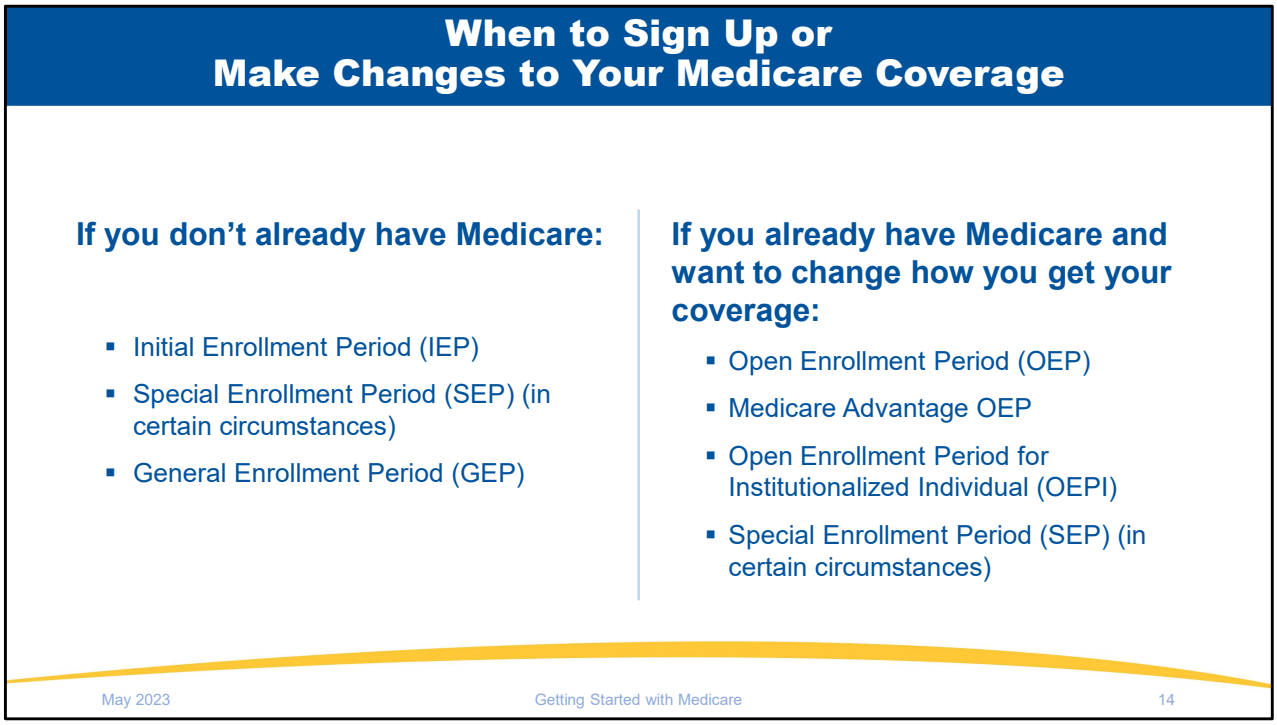
Presenter Notes

- **If you're in Original Medicare,** you use your red, white, and blue Medicare card when you get health care services. **If you join a Medicare Advantage Plan**, your plan may give you a different card to use when you get health care services and supplies. Your Medicare Advantage Plan ID card is your main card for Medicare. However, you may also be asked to show your Medicare card, so you should carry this card too.
- **Your Medicare card** shows you have Medicare Part A (listed as HOSPITAL), Part B (listed as MEDICAL), or both. It also lists the date your coverage begins. Your card has a Medicare Number that's unique to you—it's not your Social Security Number. It's a unique combination of letters and numbers—the letters S, L, O, I, B, and Z are never used. This helps to protect your identity.
- **If you get your Medicare card and don't want Part B,** follow the directions in the "Get Ready for Medicare" package and return the card. Medicare will send you another card that shows you only have Part A coverage.
- **Only give your Medicare Number to doctors, pharmacists, other health care providers, your insurers, or people you trust** to work with Medicare on your behalf. If you forget your card, you, your doctor, or other health care provider may be able to use the secure Medicare Administrative Contractor (MAC) portal to look up your Medicare Number online. If you have a Medicare account, you can get your Medicare Number, print an official copy of your Medicare card, or order an official copy of your Medicare card by logging into it at Medicare.gov/account. You can also call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048 to request a replacement.



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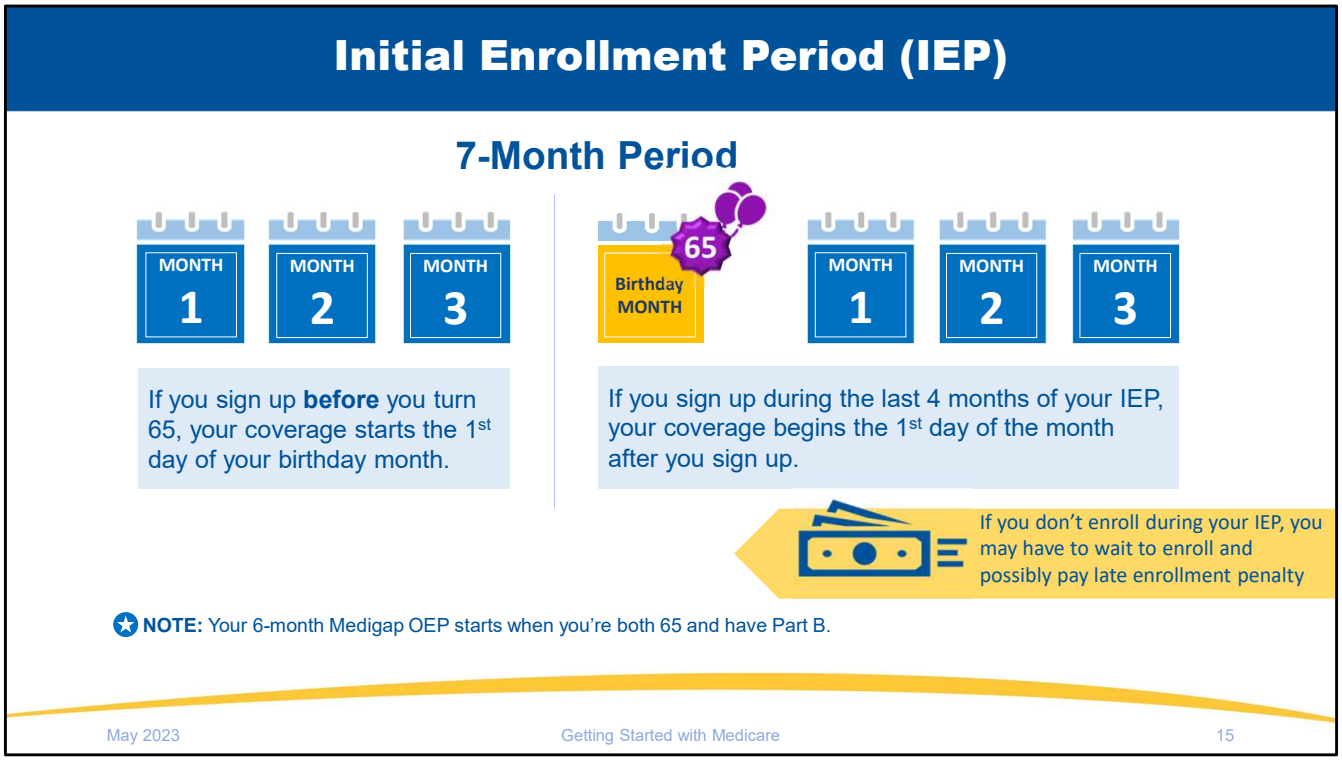
Presenter Notes

- If you don't have Medicare and you qualify for premium-free Part A, you can sign up for Part A anytime. Your coverage will begin up to 6 months before the date you applied, but it won't start earlier than the date you first qualify for Medicare. If you have to buy Part A, you can only sign up during specific enrollment periods.
- Generally, your first opportunity to sign up for Medicare Part A and Part B is during your IEP. If you don't sign up for Part B during your IEP, you have to wait until the next General Enrollment Period (GEP), or you may have a chance to sign up for Medicare during a Special Enrollment Period (SEP).
- If you already have Medicare, you can make changes to your coverage during the Open Enrollment Period (OEP), the Medicare Advantage OEP for individuals enrolled in Medicare Advantage Plans, Open Enrollment Period for Institutionalized Individuals (OEPI), or in certain circumstances, an SEP.
- Signing up for Medicare or changing how you get your Medicare are important decisions. These actions must be done timely to avoid late enrollment penalties and to be sure you get the coverage you need, when you need it. Enrollment periods are explained on the following slides.



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Presenter Option: You may click on the URLs below to play the two videos:

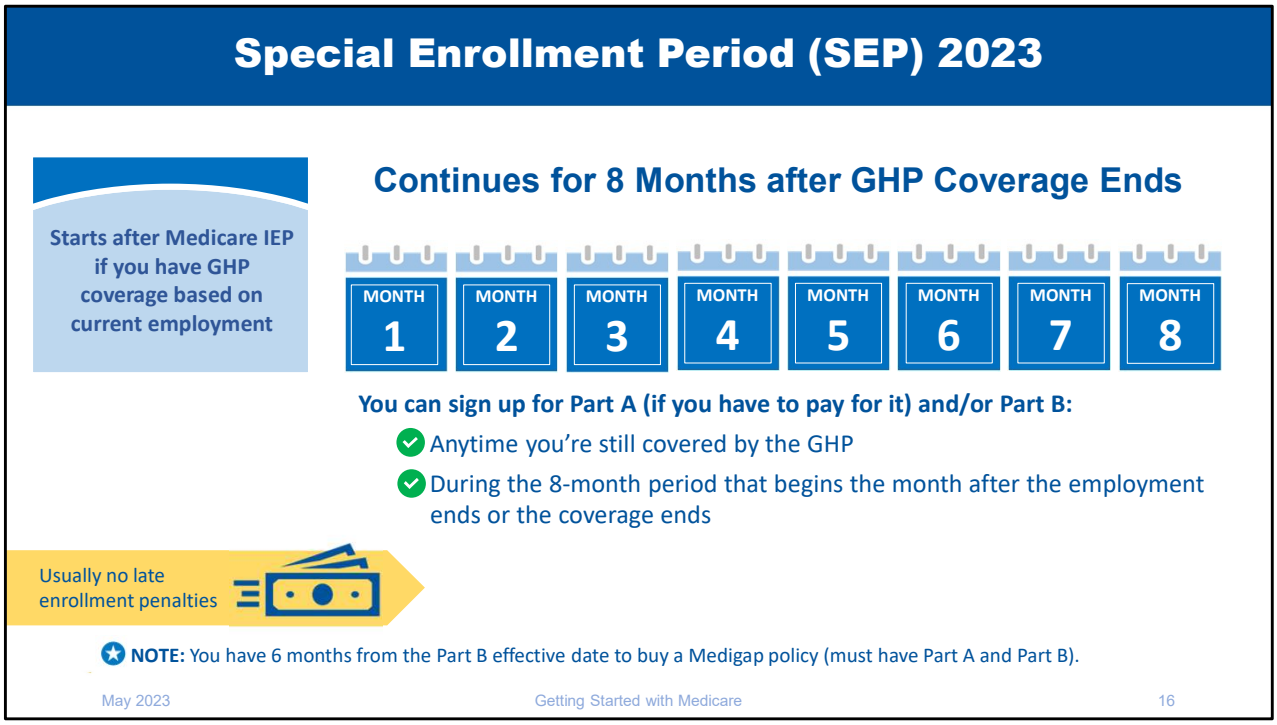
1. "Understanding Your Medicare Initial Enrollment Period" Medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start
2. "Explaining the Medicare Part B Late Enrollment Penalty" Medicare.gov/basics/costs/medicare-costs/avoid-penalties

Presenter Notes

If you aren't getting Social Security or RRB benefits at least 4 months before your turn 65, you'll need to sign up for Part A and Part B.

- You can first sign up for Part A and/or Part B during your IEP. This is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- If you sign up for Part A and/or Part B during the first 3 months of your IEP, in most cases, your coverage begins the 1st day of your birthday month. However, if your birthday is on the 1st day of the month, your coverage starts the 1st day of the prior month.
- **NEW:** If you sign up and are paying for Part A and/or Part B the month you turn 65 or during the last 3 months of your IEP, your coverage starts the 1st day of the month after you sign up.
- If you're eligible for premium-free Part A, you can sign up for Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you have to buy Part A, you can only sign up during a valid enrollment period.
- If you don't sign up for Part B (or Part A if you have to buy it) during your IEP, you may have to pay a late enrollment penalty if you sign up later. For Part B, it's a lifetime penalty.

NOTE: Your 6-month Medigap OEP starts when you're both 65 and have Part B. Medigap is covered in more detail in Lesson 3.



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Presenter Notes

- If you or your spouse are still working, have a group health plan (GHP) (a health plan offered by an employer or employee organization that provides health coverage to employees and their families), and didn't sign up for Part B (or Part A if you have to pay for it) during your IEP, you may be able to sign up during an SEP. A SEP allows you to sign up after your IEP and not wait for the GEP. If eligible, you usually won't have to pay a late enrollment penalty, but this SEP is limited.
- If you're 65 or older, your GHP coverage must be based on your own or your spouse's current employment. If you have Medicare based on disability, you can also have GHP coverage based on a family member's current employment.
  NOTE: If you have a disability, and the GHP coverage is based on a family member's current employment (other than your spouse), the employer offering the GHP must have 100 or more employees for you to get a SEP. It's important to note that COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, coverage through a retiree health plan, Veterans Affairs (VA) coverage, and individual health coverage (like through the Health Insurance Marketplace®) aren't considered coverage based on current employment.

You can sign up for Part A (if you have to pay for it) and/or Part B:

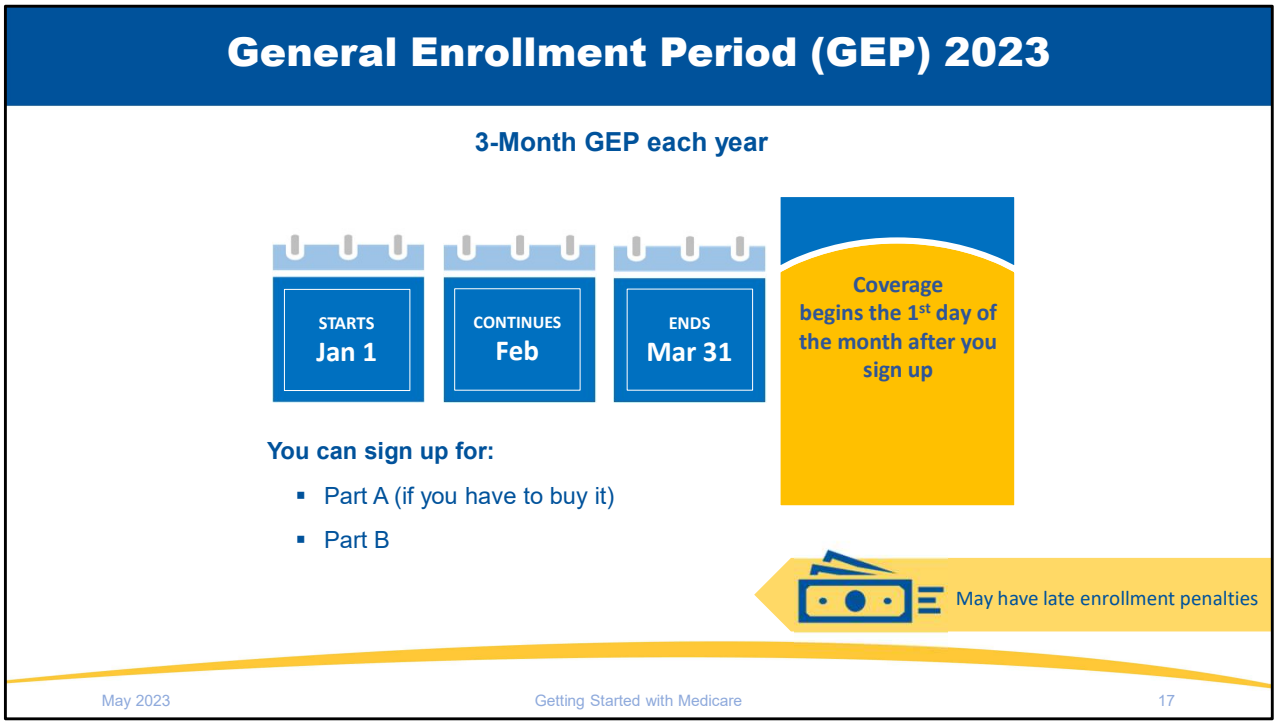
- Anytime you're still covered by the GHP.
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first.

If you sign up for Medicare during your SEP, you can join a Medicare Advantage Plan (must have Part A and Part B) and a drug plan (if you have Part A and/or Part B).

If you don't sign up for Medicare during the SEP, you'll have to wait until the next GEP to sign up, you'll have a gap in your coverage, and you may have to pay a penalty. If you're entitled to "premium-free" Part A, you can sign up any time after you qualify for Medicare.

This SEP doesn't apply if you qualify for Medicare based on ESRD, or you're still in your IEP.

If you have Part A, but delayed getting Part B, your Medigap OEP starts when your Part B coverage starts. You can buy a Medigap policy during the 6 months after your Part B effective date. You must have both Part A and Part B to buy a Medigap policy.



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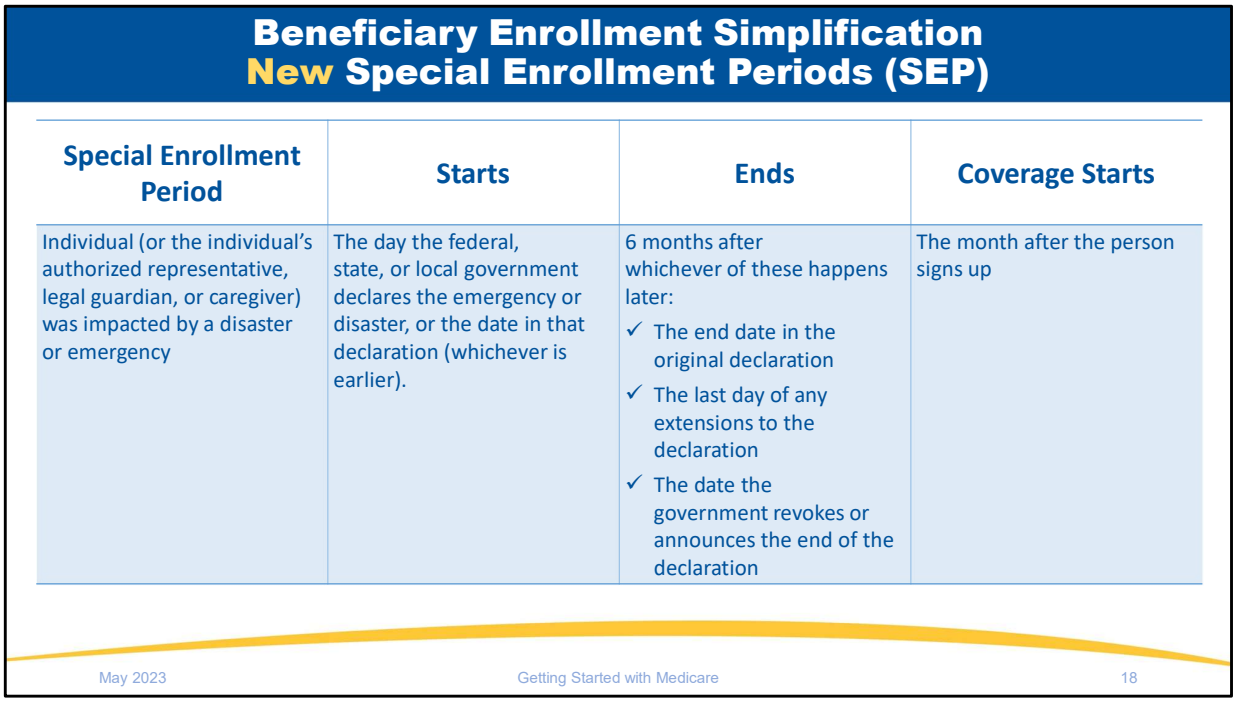
Presenter Notes

- If you didn't sign up for **Part B (or Part A if you have to buy it)** during your IEP, and you don't qualify for a SEP, you can sign up during the GEP from January 1–March 31 each year. Your coverage starts the 1st day of the month after you sign up. You may have to pay a higher Part A and/or Part B premium for late enrollment. For most people who don't sign up during their IEP or SEP, this is their only chance to sign up. In addition, if more than 12 months have passed since you qualified for Part B (or Part A, if you have to buy it), you'll likely have to pay a late enrollment penalty that's added to your monthly Part B premium (or Part A, if you have to buy it). In most cases, you'll have to pay this penalty for as long as you have Part B. However, if you delayed Part B (or Part A, if you have to buy it) because you or your spouse were still working and had GHP coverage, you won't have a late enrollment penalty and you may be able to sign up during a SEP. The SEP special circumstances will be discussed in more detail later in this lesson.
- If you delayed your enrollment in Part B, you must complete the "Application for Enrollment in Medicare Part B (Medical Insurance)" form (Form CMS-40B, CMS.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf) and submit it to your local Social Security office. If you sign up during a SEP, include the "Request for Employment Information" form (Form CMS-L564, CMS.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf) with your Part B application. You must complete Section A, and your employer must complete Section B on the form.
- CMS sends the "Sign Up for Part B" GEP package (Medicare.gov/basics/forms-publications-mailings/mailings/signing-up/sign-up-for-part-b-package) to those who didn't sign up for, dropped, or lost Part B in the past year. The package notifies people of the chance to sign up for Part B during the GEP. It includes a letter and booklet. The package explains how to sign up for Part B, the risks for delaying enrollment, and describes other decisions you may need to make about your Medicare coverage.
- If you have Part A and sign up for Part B during a GEP, you can join a Medicare Advantage Plan (with or without drug coverage) 3 months immediately before you're first entitled to get Part A and Part B until the last day of the month before your entitlement to both Part A and Part B. Your coverage will start the same day as when your Part B coverage starts.



Presenter Notes

Specifically, CMS established the following SEPs:

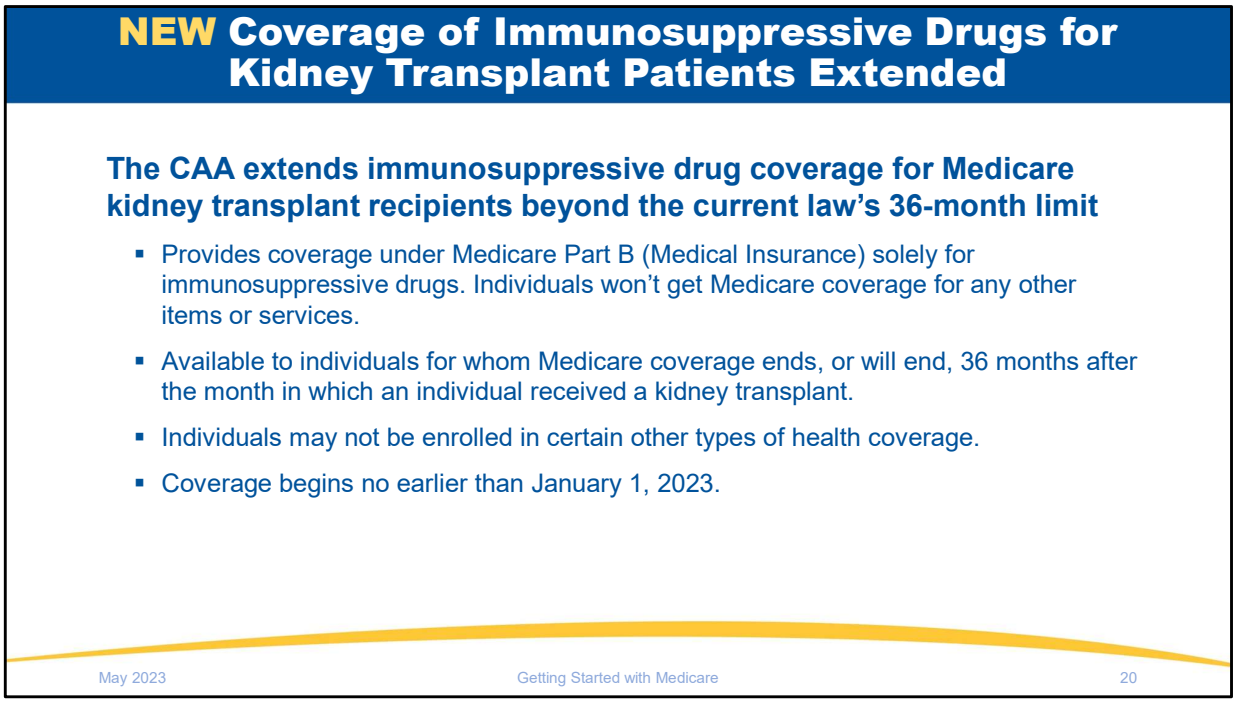
- A **SEP for people impacted by an emergency or disaster:** For people who miss a chance to sign up because they were impacted by a natural disaster or an emergency that's declared or started on or after January 1, 2023.
- The SEP also applies if the disaster or emergency takes place where the individual's authorized representative, legal guardian, or person who makes health care decisions on their behalf resides. Coverage beginning the month after the month of enrollment.
- The SEP starts the day the federal, state, or local government declares the emergency or disaster, or the date in that declaration (whichever is earlier).
- The SEP ends 6 months after whichever of these happens later:
  - The end date in the original declaration.
  - The last day of any extensions to the declaration.
  - The date the government revokes or announces the end of the declaration.

Beneficiary Enrollment Simplification
New Special Enrollment Periods (continued)

Special Enrollment Period	Starts	Ends	Coverage Starts
Health Plan or Employer Error	The day the person notifies Social Security that their health plan or employer misrepresented or provided incorrect information	6 months after the person notifies Social Security	The month after the person signs up
Formerly Incarcerated	The day the person is released from custody	The last day of the 12th month after the month the person is released	The month after the person signs up or, the person can choose retroactive back to their release date (not to exceed 6 months)
Termination of Medicaid Coverage	The day the person is notified that Medicaid coverage is ending	6 months after Medicaid coverage ends	The month after the person signs up, unless the person elects a start date of the first day of the month they lost Medicaid and agrees to pay all prior premiums
Other exceptional conditions	Once Social Security decides whether the person qualifies for a SEP	Minimum 6-month duration	The month after the person signs up

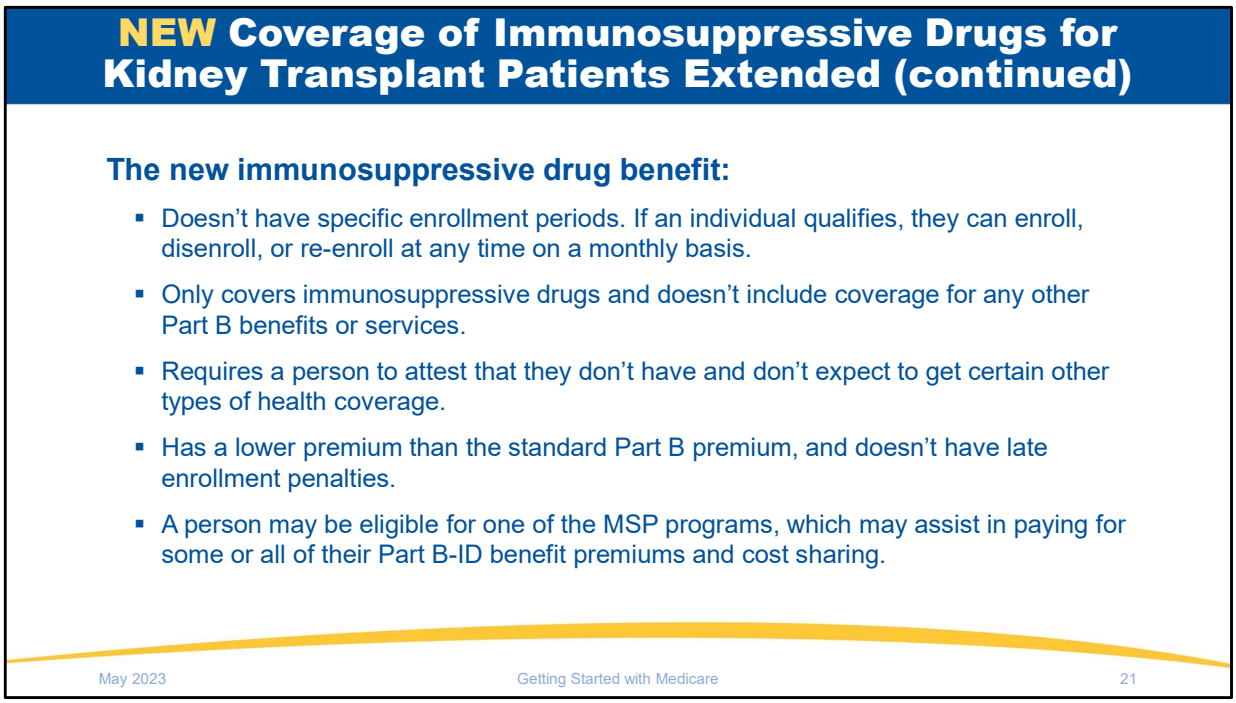
Presenter Notes

- A **SEP for health plan or employer error –** This SEP is for people who missed a chance to sign up because they got inaccurate or misleading information from their health plan or employer on or after January 1, 2023. The SEP lasts for 6 months after the person notifies Social Security that they got inaccurate or misleading information. If the beneficiary doesn't have documentation of the misinformation, they can submit a written attestation. Coverage starts the month after the person signs up.
- A **SEP for people who were formerly incarcerated –** This SEP allows people to sign up after they're released from incarceration. This SEP starts the day the person is released from custody and ends the last day of the 12th month after they're released. Coverage starts the month after the person signs up. In some cases, the person can choose to begin coverage up to 6 months in the past. If they choose to start coverage in the past, they must pay Medicare premiums back to their coverage start date.
- A **SEP for people who lose Medicaid Coverage –** This SEP allows people to sign up if they lose Medicaid on or after January 1, 2023. The SEP starts the day the person is notified their Medicaid coverage is ending, and lasts for 6 months after their Medicaid coverage ends. Coverage starts the month after the person signs up, or the date their Medicaid coverage ends, whichever they choose. If someone chooses to start coverage in the past, they must pay Medicare premiums back to their coverage start date.
- A **SEP for other exceptional conditions –** On a case-by-case basis, this SEP allows people to sign up when circumstances beyond their control prevented them from signing up during the IEP, GEP, or other SEPs. The SEP begins when Social Security decides the person qualifies, and ends at least 6 months later. Coverage starts the month after the person signs up.
- These changes will expand Medicare enrollment opportunities and reduce multi-month coverage gaps in Medicare.
- To view a fact sheet on the final rule, visit: CMS.gov/newsroom/fact-sheets/implementing-certain-provisions-consolidated-appropriations-act-2021-and-other-revisions-medicare-2
- To view the final rule, visit: federalregister.gov/public-inspection/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and



Presenter Notes

- The CAA was signed into law on December 27, 2020. Section 402 of the Act extended coverage of immunosuppressive drugs for kidney transplant patients.
- Most individuals with ESRD qualify for Medicare, regardless of age. When someone with ESRD gets a kidney transplant, Medicare coverage ends 36 months after the transplant (unless the person still qualifies for Medicare based on age or disability). Because of the changes enacted by the CAA, a person who loses their Part A coverage 36 months after a kidney transplant and who doesn't have certain other types of health coverage may be able to sign up for Part B immunosuppressive drug coverage. This benefit only covers immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage. CMS refers to this benefit as the immunosuppressive drug benefit, or the Part B-ID benefit. People who qualify for the new benefit can sign up any time after their Part A coverage ends. To sign up, call Social Security at 1-877-465-0355; TTY: 1-800-325-0788.
- Under the CAA, Medicare Savings Programs (MSPs) can now pay the immunosuppressive drug benefit premiums and, in some cases, the deductible and coinsurance amounts for certain people with low incomes. These changes mean that people with low incomes who have Medicare through the Part B immunosuppressive drug benefit may also qualify for the Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Medicare Beneficiary (SLMB) program, or Qualifying Individual (QI) program. These programs help pay for some or all of their Part B–ID benefit premiums and cost sharing.
- To view a fact sheet on the final rule, visit: CMS.gov/newsroom/fact-sheets/implementing-certain-provisions-consolidated-appropriations-act-2021-and-other-revisions-medicare-2
- To view the final rule, visit: federalregister.gov/public-inspection/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and



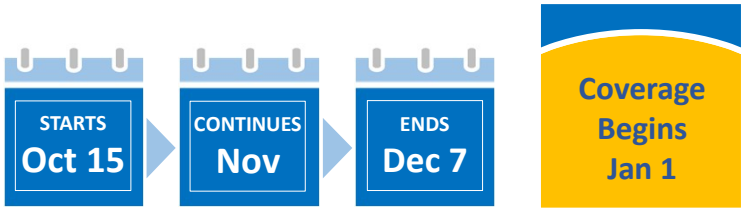
Presenter Notes

The new immunosuppressive drug benefit:

- Doesn't have specific enrollment periods. If an individual qualifies, they can enroll, disenroll, or re-enroll at any time on a monthly basis. Coverage will start (or end) the month after the individual contacts Social Security.
- Only covers immunosuppressive drugs and doesn't include coverage for any other Part B benefits or services.
- Requires a person to attest that they don't have and don't expect to get certain other types of health coverage (like a GHP, TRICARE, or Medicaid that covers immunosuppressive drugs), and that they'll notify Social Security within 60 days if they sign up for such other coverage (thereby ending their enrollment in Medicare).
- Has a lower premium than the standard Part B premium, and doesn't have late enrollment penalties. The premium in 2023 is $97.10.
- A person may be eligible for one of the MSP programs, which may assist in paying for some or all of their Part B-ID benefit premiums and cost sharing.
- To view a fact sheet on the final rule, visit: CMS.gov/newsroom/fact-sheets/implementing-certain-provisions-consolidated-appropriations-act-2021-and-other-revisions-medicare-2
- To view the final rule, visit: federalregister.gov/public-inspection/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and

Yearly Open Enrollment Period (OEP) for People with Medicare

7-Week Period



- 7-week period each year where you can sign up for, disenroll, or switch Medicare Advantage Plans or Medicare drug plans
- This is a time to review health and drug plan choices

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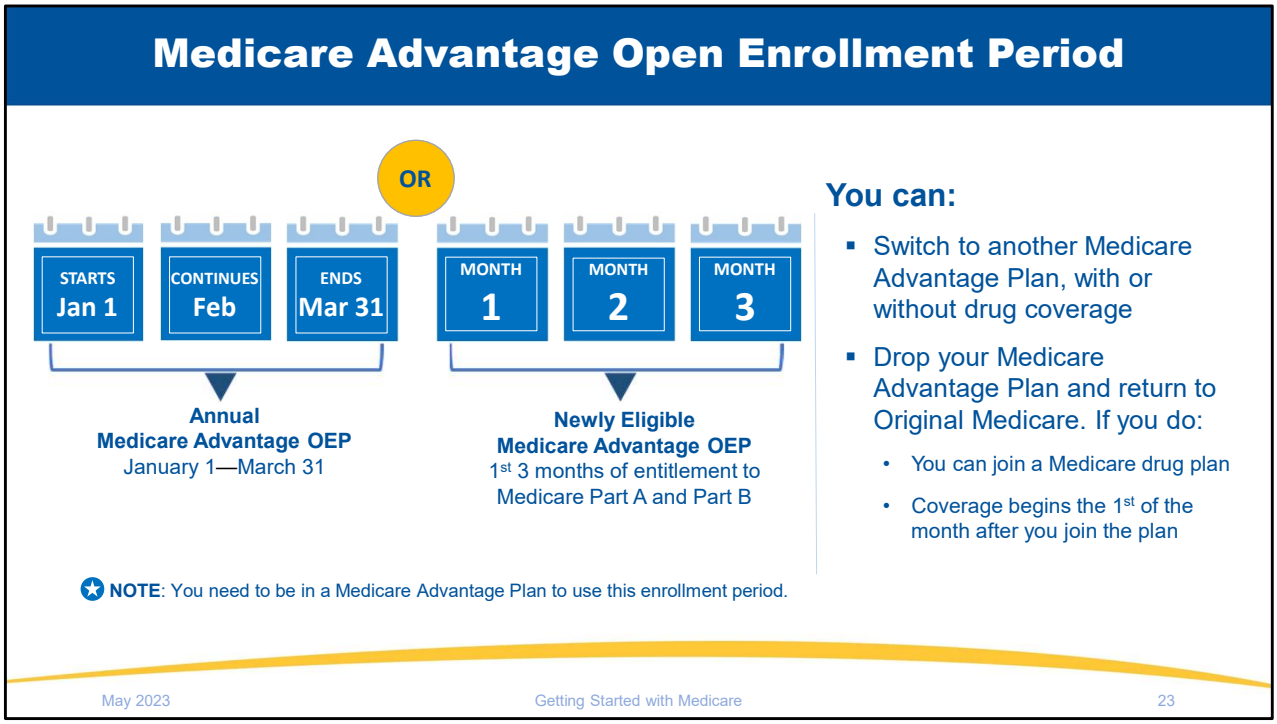
Presenter Notes

- If you already have Medicare, the OEP allows you the opportunity to review your choices and pick the Medicare health and/or drug plan that works best for you.
- Open Enrollment starts on October 15 and ends December 7 each year.
- This gives you a full 7 weeks to compare and make decisions, and helps ensure that you'll have essential plan materials and membership cards in hand on January 1, when your new coverage starts.



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Presenter Notes

The Medicare Advantage Open Enrollment Period (OEP) is from January 1–March 31 each year. Your coverage begins the 1st day of the month after you join a plan. You must be enrolled in a Medicare Advantage Plan (at any time) during the first 3 months of the year to use this enrollment period.

Between January 1–March 31 each year, you can make these changes during the Medicare Advantage OEP:

- If you're in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage).
- You can drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a drug plan. (There's a coordinating Part D SEP).

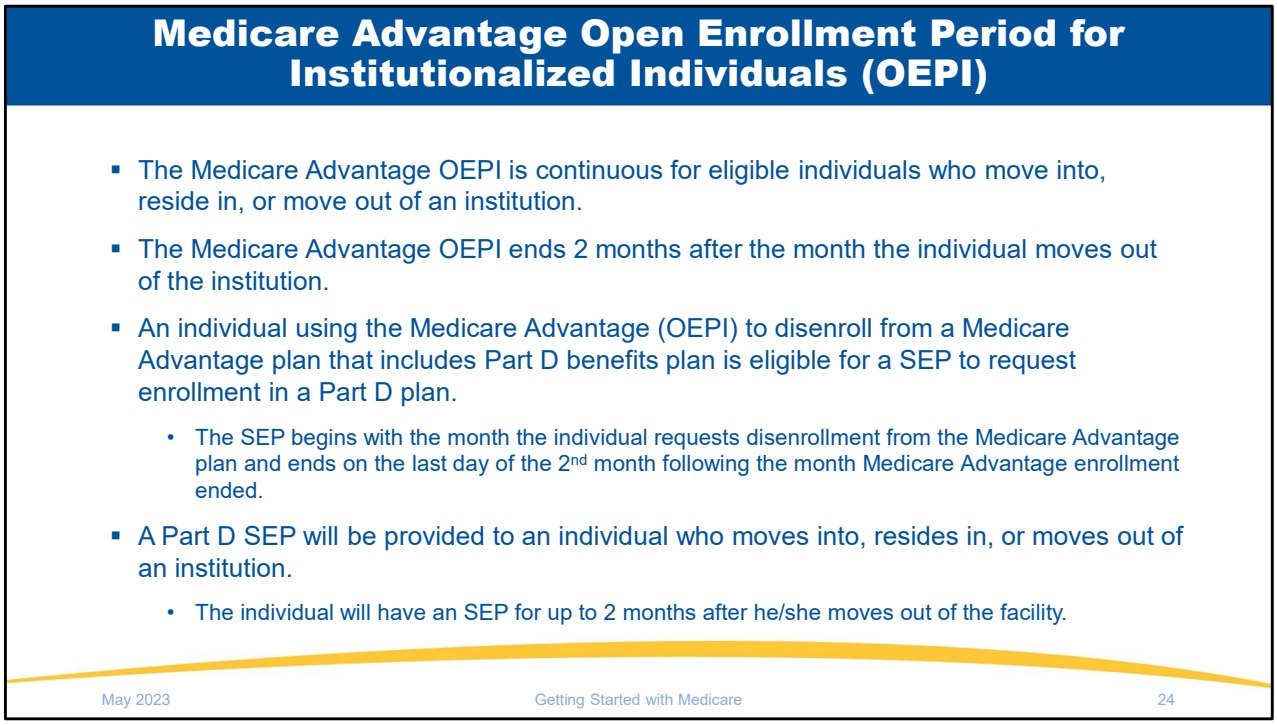
During this period, you **can't**:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a drug plan if you're in Original Medicare.
- Switch from one drug plan to another if you're in Original Medicare.

You can only make one change during the Medicare Advantage OEP, and any changes you make will be effective the 1st of the month after the plan gets your request.

You can also use the Medicare Advantage OEP if you have Part A and Part B for the first time and you're enrolled in a Medicare Advantage Plan during the first 3 months of becoming eligible. The Medicare Advantage OEP starts when you first get Part A and Part B and ends on the last day of the 3rd month of your Medicare coverage.

If you're returning to Original Medicare and joining a drug plan, you don't need to contact your Medicare Advantage Plan to disenroll. You'll be automatically disenrolled when you join the drug plan.

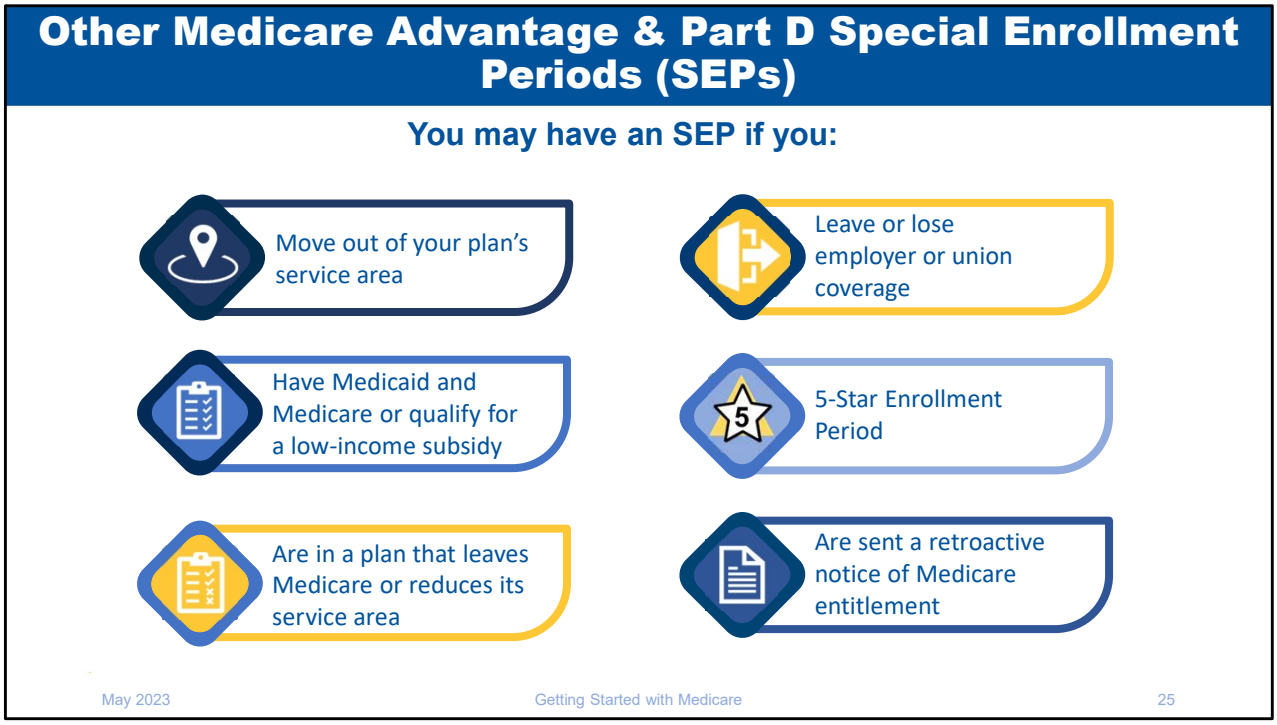


- The Open Enrollment Period for Institutionalized Individuals (OEPI) is continuous for eligible individuals. An institutionalized individual is an individual who moves into, resides in, or moves out of an institution. Your chance to join, switch, or drop coverage lasts as long as you live in the institution and for 2 full months after the month you leave the institution.
- Special Note for SNP enrollment: In addition, the OEPI is available for individuals who meet the definition of "institutionalized" to enroll in or disenroll from an Medicare Advantage SNP for institutionalized individuals.
- A Medicare Advantage eligible institutionalized individual can make an unlimited number of Medicare Advantage enrollment requests during the OEPI. A Medicare Advantage organization is not required to accept requests to enroll into its plan during the OEPI, but if it is open for these enrollment requests, it must accept all OEPI requests to enroll into the plan.
- Since the OEPI is continuous for eligible individuals, Original Medicare is also open continuously. Therefore, Medicare Advantage organizations must accept requests for disenrollment from their Medicare Advantage plans during the OEPI whether or not the Medicare Advantage plan is open to accept enrollment. Please note the definition of "institution" here differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.
- An individual using the Medicare Advantage OEPI to disenroll from a Medicare Advantage plan that includes Part D benefits plan is eligible for a SEP to request enrollment in a Part D plan. The SEP begins with the month the individual requests disenrollment from the Medicare Advantage plan and ends on the last day of the 2nd month following the month Medicare Advantage enrollment ended.
- A Part D SEP will be provided to an individual who moves into, resides in, or moves out of an institution. The individual will have an SEP for up to 2 months after he/she moves out of the facility. This SEP permits an individual to enroll in, or disenroll from, a Part D plan. The effective date is the 1st day of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

42 CFR 422.62(a)(4): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-B#p-422.62(a)(4)

Source: 42 CFR 423.38(c)(15): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-B#p-423.38(c)(15)

42 CFR 423.38(c)(25): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-B#p-423.38(c)(25)



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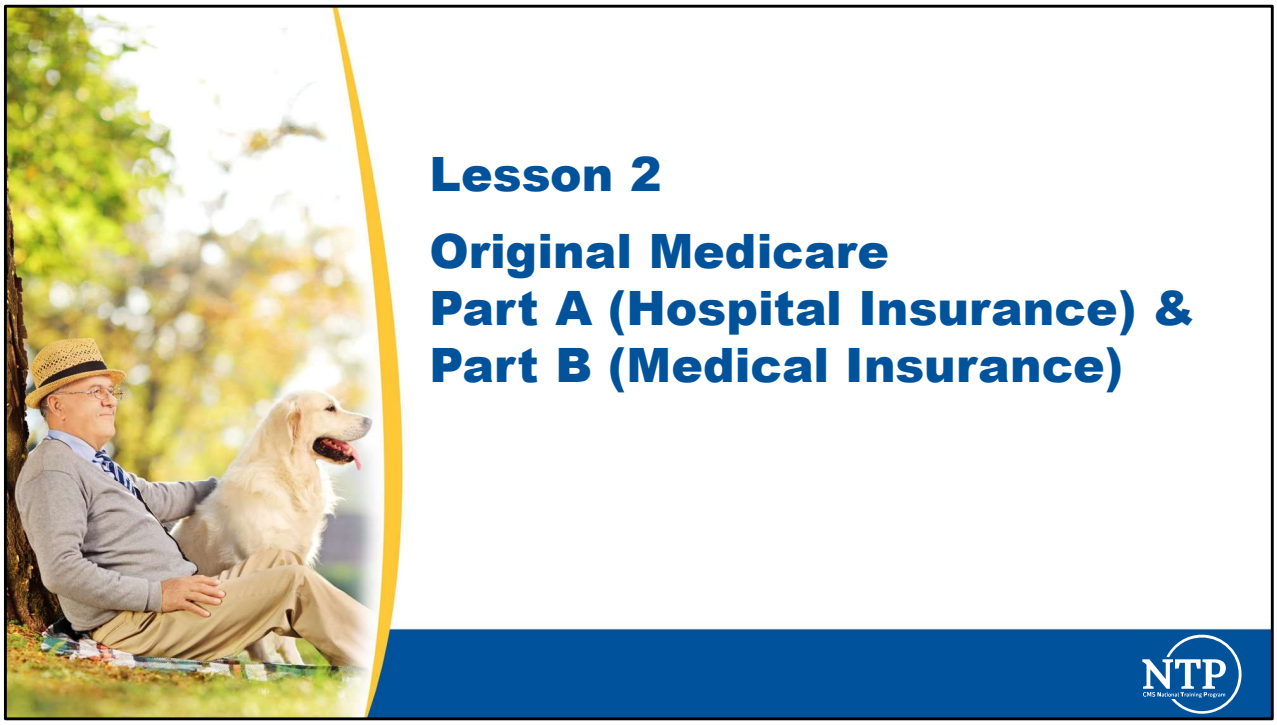
Presenter Notes

You may be able to join or switch plans outside of Open Enrollment if any of these special circumstances apply to you.

- You move out of your plan's service area.
- You have Medicare and Medicaid (sometimes called dual eligible), or if you qualify for a low-income subsidy (LIS), also called "Extra Help," (but don't get Medicaid benefits). You can only change plans one time per calendar quarter in the first 3 quarters (9 months) of the year. In the 4th quarter, you can change plans using the OEP. If you're a dual/LIS eligible who's considered "potentially at-risk" or "at-risk" for misuse of opioids and other frequently abused medications, you won't be able to use the dual/LIS SEP (1x per calendar quarter SEP) to change plans. This quarterly SEP is the only SEP that "potentially at-risk" or "at-risk" individuals can't use. Also, you'll have 2 other SEPs available if you're a dual eligible:
  - You can make a change within 3 months after a gain, loss, or change to Medicaid or LIS eligibility, or notification of such a change, whichever is later.
  - You can make a change within 3 months after CMS or state-initiated enrollment action or the notification of that action, whichever is later.
- You're enrolled in a plan that decides to leave Medicare or reduce its service area.
- You leave or lose employer or union coverage.
- You live in the service area of one or more Medicare Advantage Plans or drug plans with an overall quality rating of 5 stars. You can use the 5-star Special Enrollment Period to join a Medicare Advantage Plan, Medicare Cost Plan, or drug plan with an overall quality rating of 5 stars. You can use this SEP only once between December 8 and November 30 the following year. If you move from a Medicare Advantage Plan that includes drug coverage to a stand-alone drug plan, you'll be disenrolled from your Medicare Advantage Plan, including the health benefit. You'll be returned to Original Medicare for coverage of your health services. If you move from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't, you may lose your drug coverage. You'll have to wait until your next enrollment opportunity to get drug coverage, and you may have to pay a Part D late enrollment penalty.
- You get notice of retroactive Medicare entitlement.
- Other exceptional circumstances, like you weren't properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).

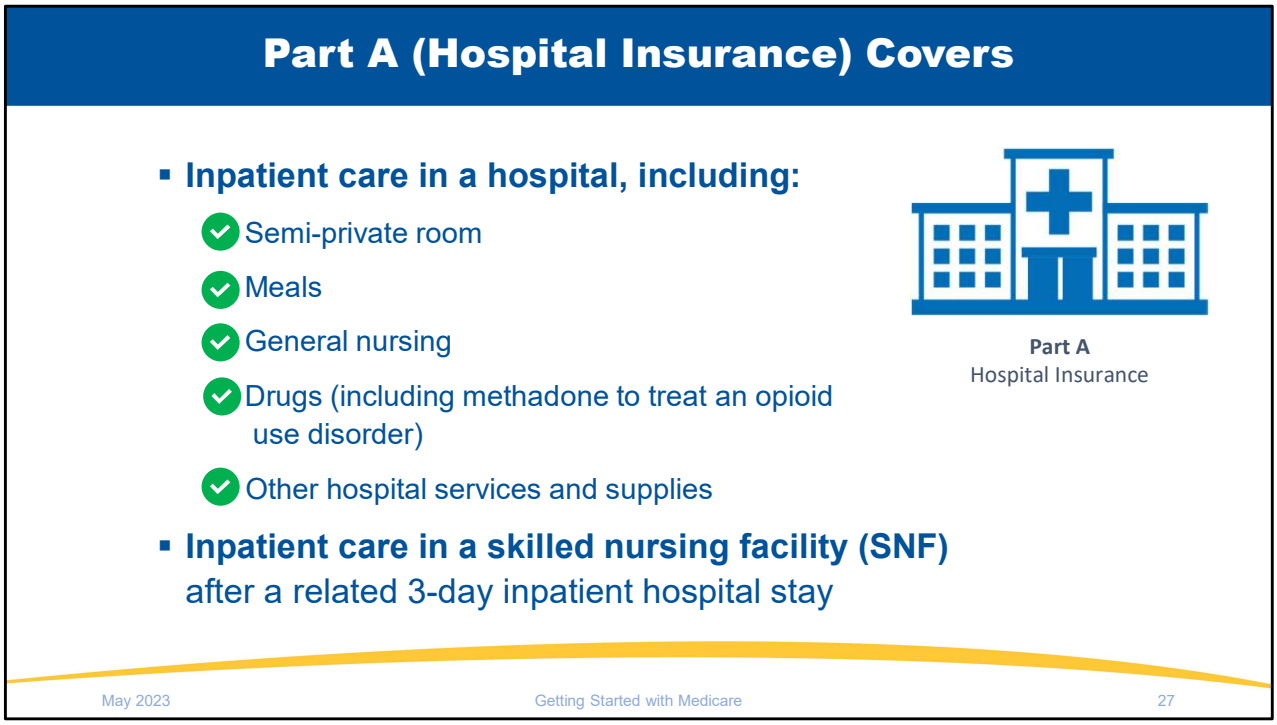
NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4, at CMS.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf.

Source: Medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods.



Presenter Notes

Lesson 2 explains the parts of Medicare, and the coverage and costs of Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).



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Presenter Notes

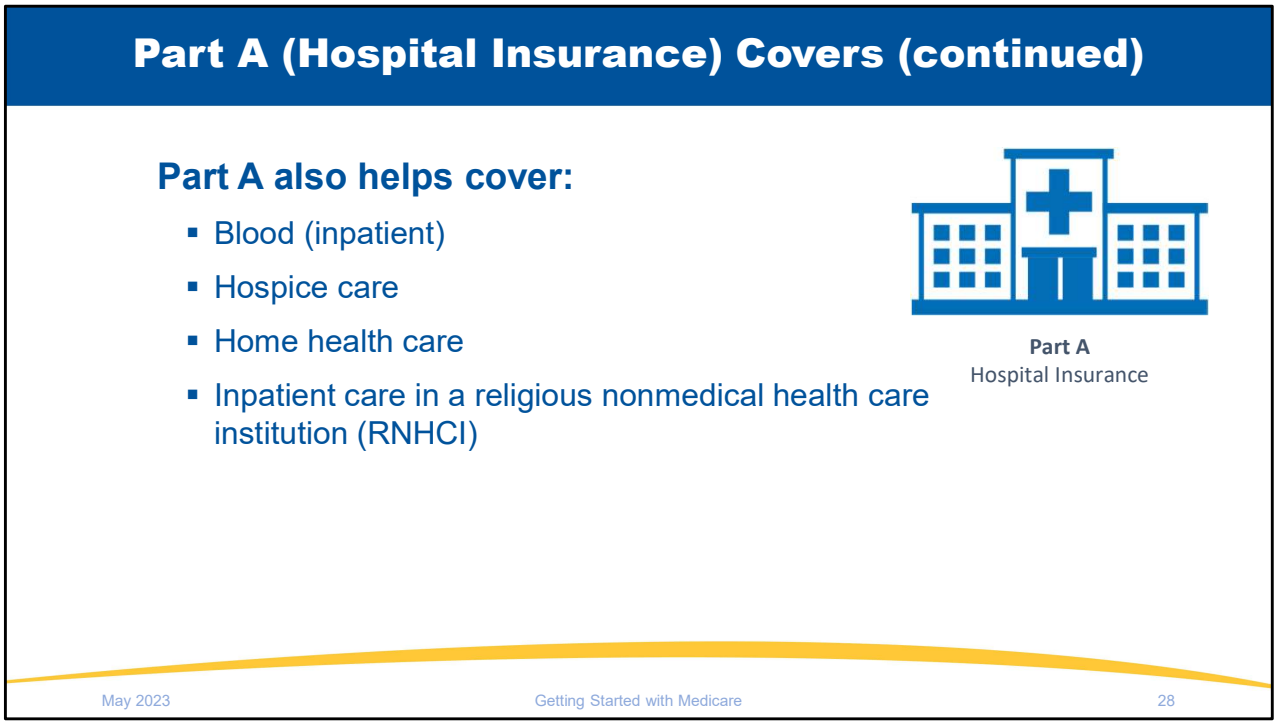
Part A helps cover medically necessary inpatient services.

- **Inpatient hospital care**—semi-private room, meals, general nursing, drugs (including methadone to treat an opioid use disorder), and other hospital services and supplies as part of your inpatient treatment. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, psychiatric care in inpatient psychiatric facilities (lifetime 190-day limit in a freestanding psychiatric hospital), and inpatient care for a qualifying clinical research study. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), personal care items (like razors or slipper socks), and a private room, unless medically necessary.
  - Medicare doesn't pay for your hospital or medical bills if you aren't lawfully present in the U.S. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated. **NOTE**: If you're in the hospital as an outpatient and then are admitted as an inpatient, Part A coverage can be retroactive up to 3 days.
  - **All people with Part A are covered for inpatient hospital care when all of these are true:**
    - You're admitted to the hospital as an inpatient after an official doctor's order, which says you need inpatient hospital care to treat your illness or injury
    - The hospital accepts Medicare

    NOTE: In certain cases, Part A also covers inpatient hospital care if the hospital's Utilization Review Committee approves your stay while you're admitted.
- **Inpatient Skilled Nursing Facility (SNF) care** (not custodial or long-term care) **if you meet certain criteria**. Skilled care involves safe and effective care given by skilled nursing or rehabilitative staff. Skilled nursing and therapy staff include registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists. You must first have a related 3-day* inpatient hospital stay. This doesn't include the day you're discharged.

*If your doctor is participating in an Accountable Care Organization (or other type of Medicare initiative) that's approved for a SNF 3-Day Rule Waiver, you may not need to have a 3-day inpatient hospital stay before getting coverage.

Source: Medicare.gov/publications/10116-your-medicare-benefits.pdf



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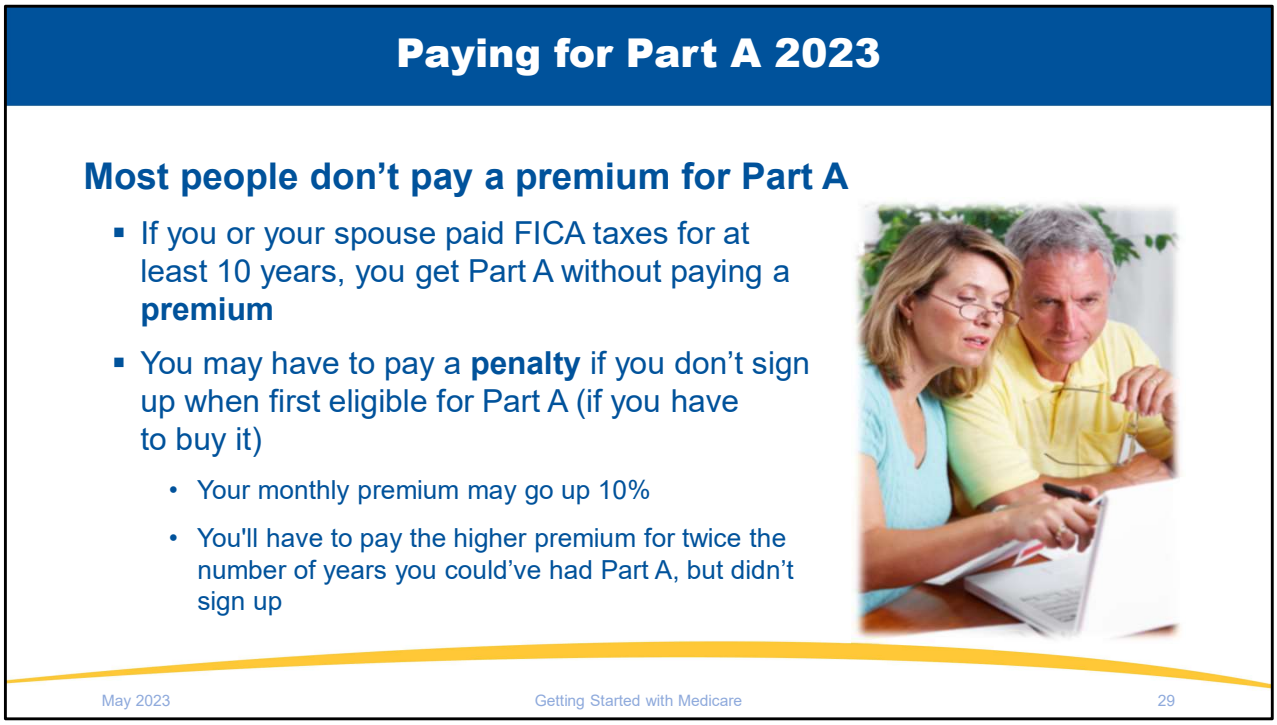
Presenter Notes

Here's more detail about what's covered under Part A:

- Blood – If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or you or someone else can donate the blood.
- Hospice care – To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. When you agree to hospice care, you're agreeing to comfort care (palliative care) instead of care to cure your terminal illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:
  - All items and services needed for pain relief and symptom management
  - Medical, nursing, and social services
  - Drugs for pain management
  - Durable medical equipment (DME) for pain relief and symptom management
  - Aide and homemaker services
  - Other covered services you need to manage your pain and other symptoms, as well as spiritual and grief counseling for you and your family.
- Home health care – Medicare covers home health services under Part A and/or Part B. Medicare covers home health services as long as you need part-time or intermittent skilled services and as long as you're "homebound," which means:
  - You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
  - Leaving your home isn't recommended because of your condition.
  - You're normally unable to leave your home because it's a major effort.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs) – Medicare will only cover the inpatient non-religious, non-medical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.



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Presenter Notes

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid enough Medicare taxes while working. This is sometimes called premium-free Part A. Federal Insurance Contributions Act (FICA) tax is a U.S. federal payroll (or employment) tax imposed on both employees and employers to fund Social Security and Medicare.

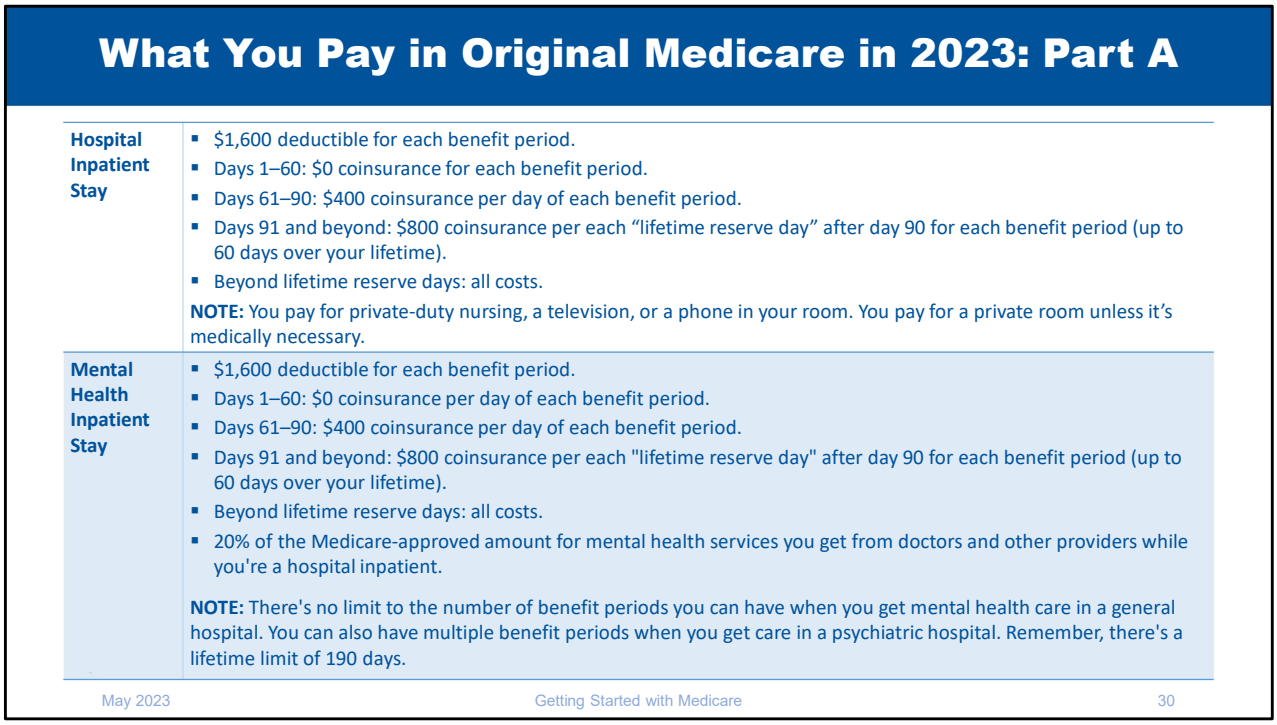
About 99% of people with Medicare don't pay a Part A premium since they've worked at least 40 quarters (10 years) of Medicare-covered employment. Enrollees 65 and over and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium to get coverage under Part A unless they can get benefits through a spouse or family member's record.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you're:

- 65 or older, and you've signed up for (or are enrolling in) Part B, and meet the citizenship and 5-year residency requirements.
- Under 65, have a disability, and your premium-free Part A coverage ended because you returned to work. If you're under 65 and have a disability, you may continue to get premium-free Part A for up to 8 1/2 years after you return to work.

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. The Part A premium amount depends on how long you or your spouse worked in Medicare-covered employment.

- Social Security determines if you have to pay a monthly premium for Part A. In 2023, the Part A premium for a person who has worked less than 30 quarters of Medicare-covered employment is $506 per month in 2023 . Those who have between 30 and 39 quarters of coverage may buy Part A at a reduced monthly premium rate of $278 for 2023.
- If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.
- If you have limited income and resources, your state may help you pay for Part A and/or Part B (see Lesson 7). Call Social Security at 1-800-772–1213; TTY: 1-800-325-0778 for more information about the Part A premium.



Presenter Notes

The actual dollar amounts are updated yearly. To see the most current amounts, visit Medicare.gov/your-medicare-costs/medicare-costs-at-a-glance. This is what you pay per benefit period (discussed on the next slide) for Part A-covered medically necessary services:

- **Hospital Inpatient Stay**: After you pay the deductible amount of $1,600, you pay no coinsurance for days 1–60; $400 for coinsurance per day for days 61–90; $800 for coinsurance per each “lifetime reserve day” for days 91 and beyond (up to 60 days over your lifetime); all costs for each day beyond lifetime reserve days.
- **Mental Health Inpatient Stay**: After you pay the deductible amount of $1,600, you pay no coinsurance days 1–60; $400 for coinsurance per day for days 61–90; $800 for coinsurance per “lifetime reserve day” after day 90 (up to 60 days over your lifetime); all costs for each day after the lifetime reserve days. You will also pay 20% of the Medicare-approved amount for mental health services you get from doctors and other health care providers while you're a hospital inpatient.

  NOTE: There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital. Remember, if you’re in a psychiatric hospital, Part A only pays for up to 190 days during your lifetime.

What You Pay in Original Medicare in 2023: Part A (continued)

Skilled Nursing Facility (SNF) Stay	▪ Days 1–20: $0 for each benefit period. ▪ Days 21–100: $200 coinsurance per day for each benefit period. ▪ Days 101 and beyond: all costs.
Home Health Care	▪ $0 for home health care services. ▪ 20% of the Medicare-approved amount for durable medical equipment (DME).
Hospice Care	▪ $0 for hospice care. ▪ You may need to pay a copayment of no more than $5 for each drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Medicare drug coverage (Part D). ▪ You may need to pay 5% of the Medicare-approved amount for inpatient respite care. ▪ Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Blood	▪ If hospital gets it from a blood bank at no charge, you have no charge. ▪ If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Presenter Notes

- **SNF Care**: Medicare.gov/coverage/skilled-nursing-facility-snf-care – $0 for the first 20 days of each benefit period; up to $200 coinsurance per day for days 21–100 of each benefit period; all costs after day 100 (see benefit periods on the next page).
- **Home Health Care Services**: Medicare.gov/coverage/home-health-services – $0 for covered home health care services; 20% of the Medicare-approved amount for DME for providers accepting assignment (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).
- **Hospice Care**: $0 for hospice care; a copayment up to $5 per Rx to manage pain and symptoms while at home; 5% of the Medicare-approved amount for inpatient respite care. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home). The copayment is 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 prescription drug. A copayment is usually a set amount, rather than a percentage. F
- **Blood**: If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or you or someone else can donate the blood.

NOTE: If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in Lesson 7.

Benefit Periods in Original Medicare

Benefit periods can span across calendar years

- **Each benefit period:**
  - Begins the day you first get inpatient care in hospital or SNF
  - Ends after being home for 60 days in a row (not in a hospital or skilled care in a SNF)
- You pay Part A deductible for each benefit period
- No limit to number of benefit periods you can have

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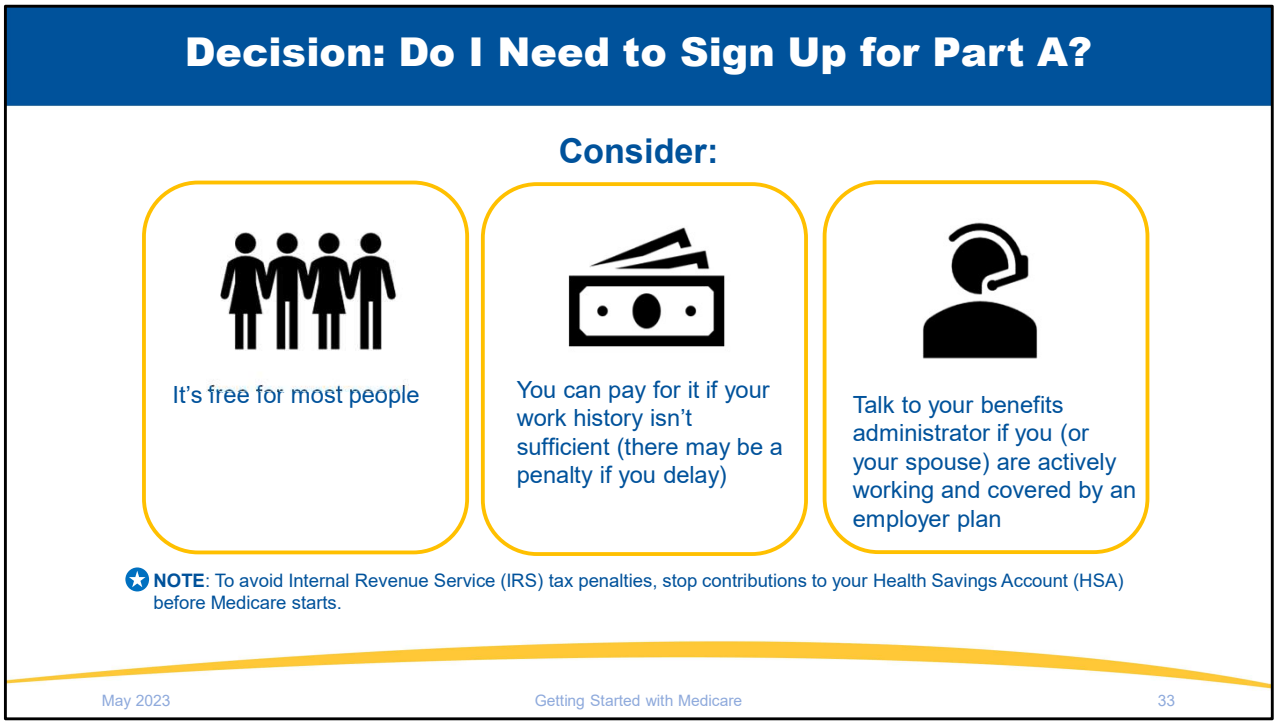
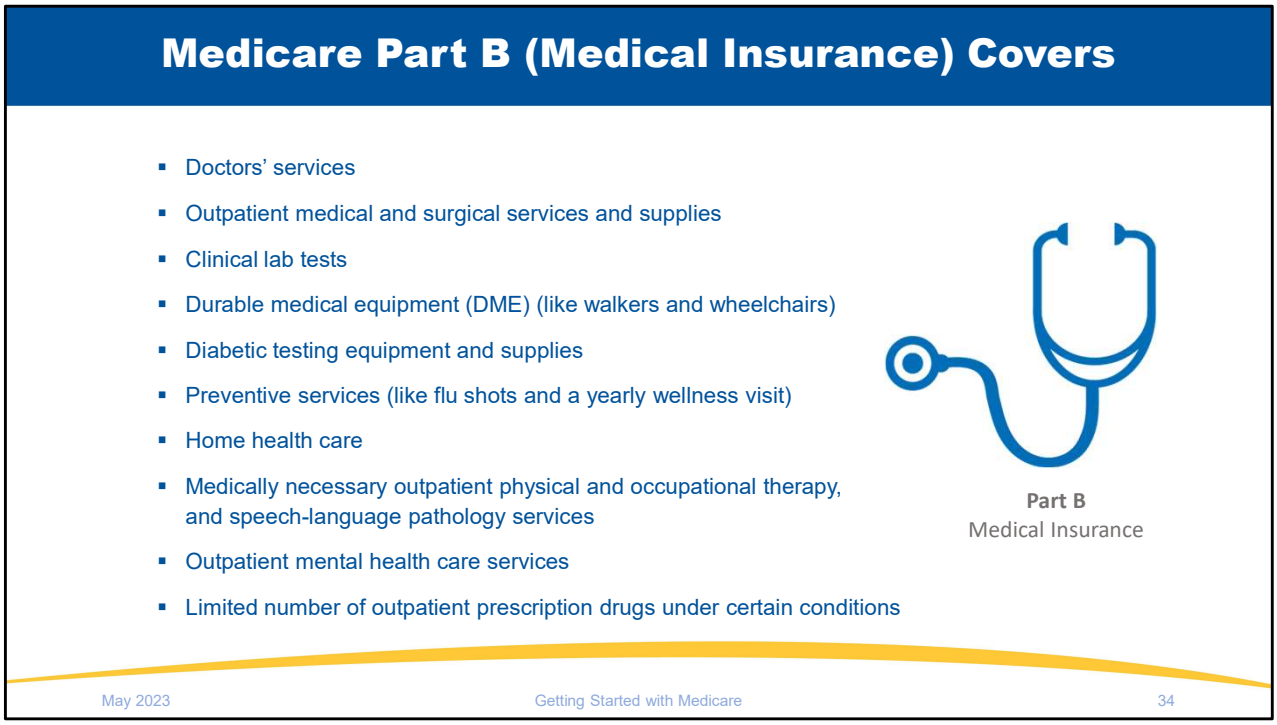
Presenter Notes

- A benefit period refers to the way that Original Medicare measures your use of hospital and SNF care. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new one begins.
- You must pay the Part A inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods you can have. Benefit periods can span across calendar years.



Presenter Notes

- **If you're getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65, you'll be automatically enrolled in premium-free Part A.**
- **If you don't get Part A automatically, you should consider signing up for Part A when you're first eligible** (during your Initial Enrollment Period (IEP)). Most people don't pay a monthly premium for Part A coverage because they or their spouse paid Medicare taxes while working.
- **If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%.** You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up. The Part A late enrollment penalty applies after 12 months have passed from the last day of the IEP to the last date of the enrollment period you used to sign up. In other words, if it's less than 12 months, the penalty won't apply. This penalty also won't apply if you qualify for a Special Enrollment Period (SEP). Remember, you're only eligible for an SEP if, when you first qualify for Medicare, you or your spouse (or family member if you're disabled) is actively working and has a group health plan (GHP) through the employer or union based on that work. You can sign up during any month while you still have the GHP based on current employment, or during the 8-month period that begins the month after the employment ends or the GHP coverage ends, whichever happens first. If you're still working or have coverage through a spouse, talk to your employer benefits coordinator to learn how enrolling in Medicare (or delaying enrollment) will affect your employer coverage.
- **You can no longer contribute to a Health Savings Account (HSA) if you have Medicare.** Talk to your company's benefits administrator about when you should stop contributing to an HSA if you plan to sign up for Medicare. You may have to stop contributing to your HSA up to 6 months before your Medicare starts if you sign up late. Your Part A may be retroactive up to 6 months, but can't be effective earlier than your first month of eligibility. You can withdraw money from your HSA after you sign up for Medicare to help pay for medical expenses (like deductibles, premiums, copayments). If you contribute to your HSA after you have Medicare, you could be subject to a tax penalty by the Internal Revenue Service (IRS). See IRS Publication 969 for more information: IRS.gov/pub/irs-pdf/p969.pdf.



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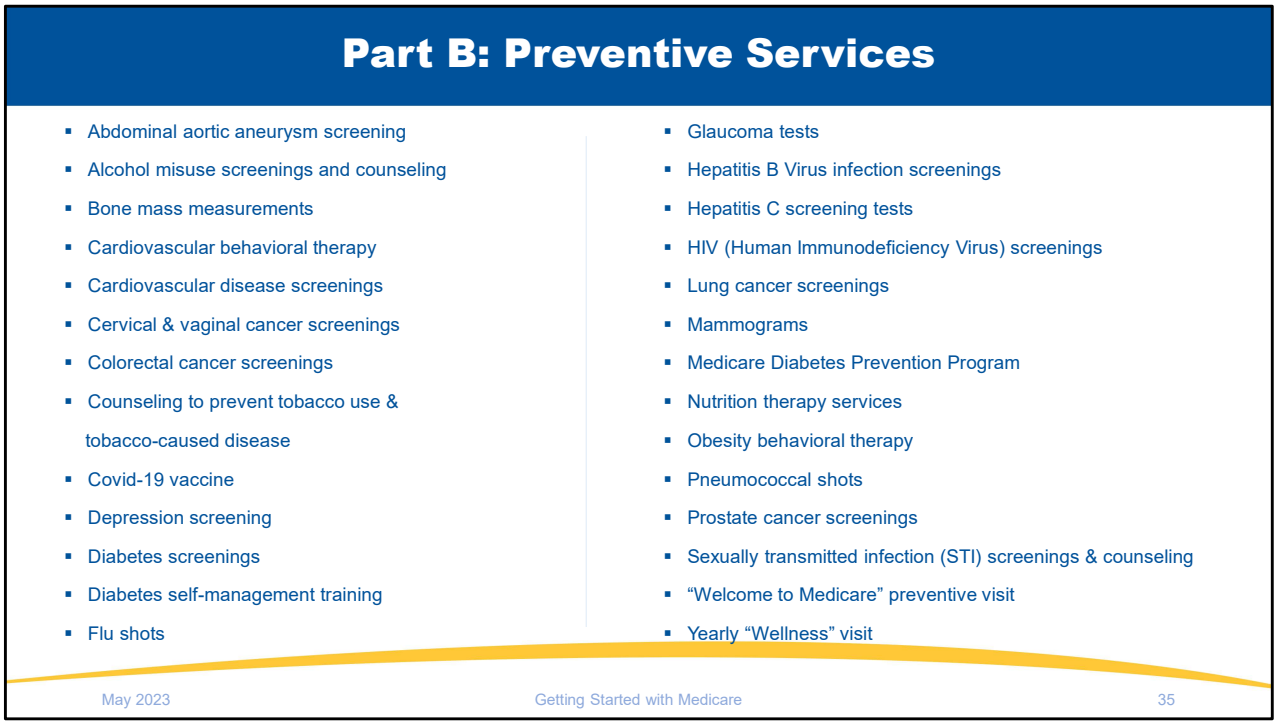
Presenter Notes

Part B helps cover medically necessary:

- Doctors' services – Services that are medically necessary.
- Outpatient medical and surgical services and supplies – For approved procedures like X-rays or stitches.
- Clinical laboratory services – Blood tests, urinalysis, and some screening tests.
- DME – Like walkers, wheelchairs, and canes.
- Diabetic testing equipment and supplies – Blood sugar (glucose) testing monitors, blood sugar test strips, insulin, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes or inserts.
- Preventive services – Many exams, tests, screenings, and some shots to prevent, find, or manage a medical problem (like flu shots and a yearly wellness visit).
- Home health services – You can use your home health benefits under Part A and/or Part B. Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A-covered home health care visits exceed 100. For more information, visit Medicare.gov/publications to review "Medicare and Home Health Care" (CMS Product No. 10969). You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.
- Medically necessary outpatient physical and occupational therapy, and speech-language pathology services.
- Outpatient mental health care services.
- Limited number of outpatient prescription drugs under certain conditions – Usually, Part B covers drugs you wouldn't typically give to yourself, like those you get at a doctor's office or in a hospital outpatient setting. To review some examples of Part B-covered drugs, visit Medicare.gov/coverage/prescription-drugs-outpatient.

See the next slide for a list of preventive services covered by Medicare.

To find out if Medicare covers a service not on this list, visit Medicare.gov/coverage, or call 1-800-MEDICARE (1-800-633-4227): TTY 1-877-486-2048. You can also download the "What's covered" mobile app. The app is available for free on both the App Store and Google Play.



Presenter Notes

- Medicare also covers many preventive services (health care to prevent illness or detect illness at an early stage, when treatment is likely to work best). You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service. Talk to your health care provider about the services that are right for you.
- For more preventive service information, visit Medicare.gov/coverage/preventive-screening-services.

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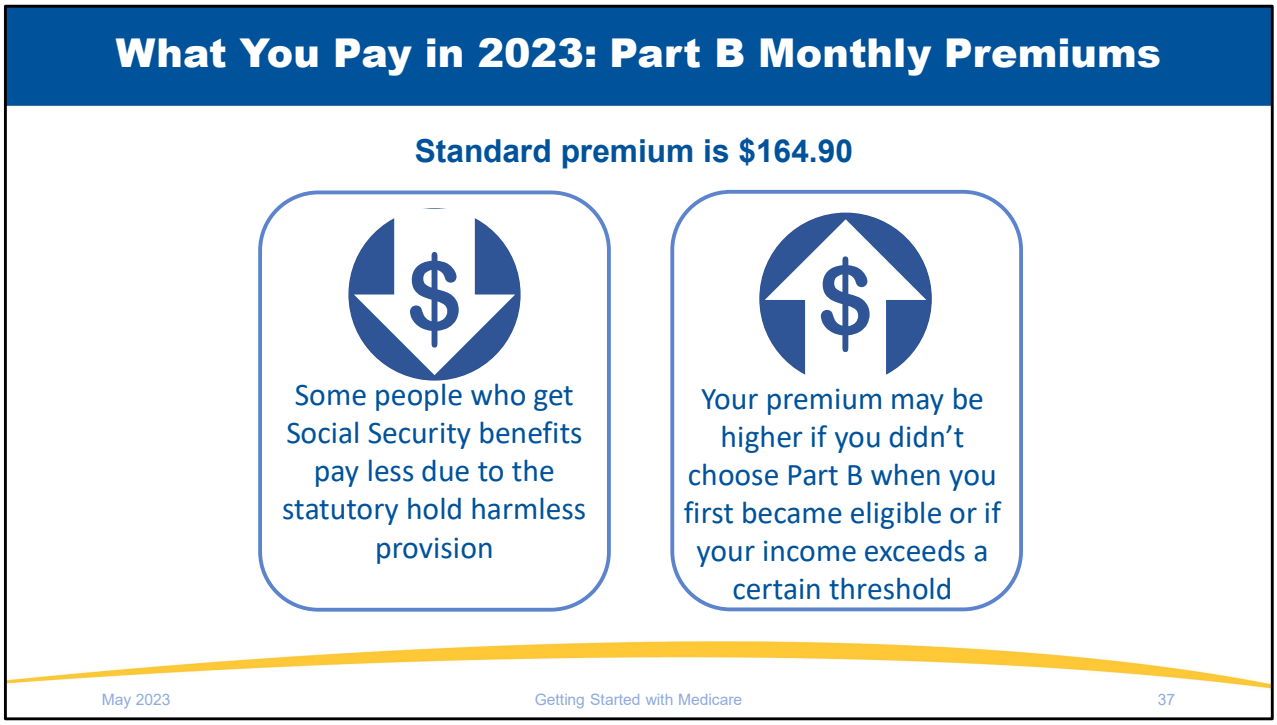
Presenter Notes

Medicare doesn't cover everything. If you need certain services that aren't covered under Part A or Part B, you'll have to pay for them yourself unless:

- You have other coverage (including Medicaid) to cover the costs
- You're in a Medicare Advantage Plan that covers these services

Some of the items and services that Original Medicare doesn't cover include:

- Most dental care.
- Vision (for prescription glasses).
- Dentures.
- Cosmetic surgery.
- Massage therapy.
- Routine physical exams.
- Hearing aids and exams for fitting them.
- Long-term care.
- Concierge care.
- Covered items or services you get from an "opt-out" doctor or other provider. These are doctors or providers who don't want to work with the Medicare program. Medicare won't pay for items or services you get from provider that opts out, except in emergencies. Providers opt out for a minimum of 2 years. Every 2 years, the provider can choose to keep their opt-out status, accept Medicare-approved amounts on a case-by-case basis ("non-participating"), or accept assignment.



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Presenter Notes

- When your coverage starts, the monthly Part B premium will be deducted from your Social Security benefit payment. If your Social Security benefits aren't enough to cover the whole Part B premium or you're no longer getting Social Security benefits, you'll get a bill for your Part B premium every 3 months. The monthly Part B standard premium is $164.90 in 2023.
- Some people with Medicare pay less than the full Part B standard monthly premium amount due to the statutory "hold harmless" provision. This provision limits an increase in their Part B premium to be no greater than the increase in their Social Security benefits.

REMEMBER: This premium may be higher if you didn't sign up for Part B when you first qualified for it. The cost of Part B may go up 10% for each 12-month period that you could've had Part B but didn't sign up for it. In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare coverage in the future (in some cases over a year), and you may have to pay a late enrollment penalty for as long as you have Part B.

You'll pay the standard premium $164.90 (or higher) in 2023 if you:

- Sign up for Part B for the first time in 2023.
- Don't get Social Security benefits.
- Are directly billed for your Part B premiums.
- Have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $164.90 in 2023).
- Had a modified adjusted gross income (MAGI) as reported on your IRS tax return from 2 years ago above a certain amount. If so, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium (see next slide).

Monthly Part B Standard Premium—Income-Related Monthly Adjustment Amount (IRMAA) for 2023

If your yearly income in 2021 (for what you pay in 2023) was:

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	You pay each month (in 2023)
$97,000 or less	$194,000 or less	$97,000 or less	$164.90
Above $97,000 up to $123,000	Above $194,000 up to $246,000	Not applicable	$230.80
Above $123,000 up to $153,000	Above $246,000 up to $306,000	Not applicable	$329.70
Above $153,000 up to $183,000	Above $306,000 up to $366,000	Not applicable	$428.60
Above $183,000 and less than $500,000	Above $366,000 and less than $750,000	Above $97,000 and less than $403,000	$527.50
$500,000 or above	$750,000 or above	$403,000 or above	$560.50

Presenter Notes

Most people will pay the standard premium amount. If your modified adjusted gross income is above a certain amount, you may pay an IRMAA. Roughly 7% of people with Medicare pay an IRMAA. The total Part B premiums for people with higher income for 2023 are shown below.

For people whose income is:

- $97,000 or less and file an individual tax return; file a joint tax return with a combined yearly income of $194,000 or less; the Part B premium is $164.90 per month
- Above $97,000–$123,000 and file an individual tax return; file a joint tax return with a combined yearly income above $194,000 and less than $246,000; the Part B premium is $230.80 per month
- Above $123,000–$153,000 and file an individual tax return; file a joint tax return with a yearly income of above $246,000 and less than $306,000; the Part B premium is $329.70 per month
- Above $153,000–$183,000 and file an individual tax return; file a joint tax return with a combined income above $306,000 up to $366,000; the Part B premium is $428.60 per month
- Above $183,000 and less than $500,000 and file an individual tax return; file a joint tax return with a combined income above $366,000 and less than $750,000; the Part B premium is $527.50 per month
- $500,000 or above and file an individual tax return; file a joint tax return with a combined income above $750,000, the Part B premium is $560.50 per month

For people with Medicare who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouse's, whose income is:

- $97,000 or less, the Part B premium is $164.90 per month
- Above $97,000 and less than $403,000, the Part B premium is $527.50 per month
- Above $403,000 the Part B premium is $560.50 per month

If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213; TTY: 1-800-325-0778.

NOTE: You may pay more than these amounts if you also pay a Part B late enrollment penalty.

What You Pay in Original Medicare in 2023: Part B

Yearly Deductible	$226
Coinsurance for Part B Services	▪ 20% for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for most preventive services ▪ 20% for outpatient mental health services, and copayments for hospital outpatient services

NOTE: If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in Lesson 7.

Presenter Notes

In addition to premiums, there are other costs you pay in Original Medicare. This is what you pay in 2023 for Part B-covered medically necessary services, which are services or supplies you need to diagnose or treat your medical condition and that meet accepted standards of medical practice:

- **The annual Part B deductible is $226 in 2023.** If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. This means that you must pay the first $226 of your Medicare-approved medical bills in 2023 before Part B starts to pay for your care.
- **After you meet the annual deductible, you pay coinsurance for Part B services.** In general, it's 20% for most covered services for providers accepting assignment. If the provider doesn't accept assignment, they can charge you up to 15% above the approved amount (called the "limiting charge"), and you may have to pay the entire amount up front.
- **Most preventive services have no coinsurance, and the Part B deductible doesn't apply as long as the provider accepts assignment.** You pay 20% for outpatient mental health services (visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions, or outpatient treatment of your condition (like counseling or psychotherapy) for providers accepting assignment).
- **If you can't afford to pay these costs, there are programs that may help.** These programs are discussed later in Lesson 7.

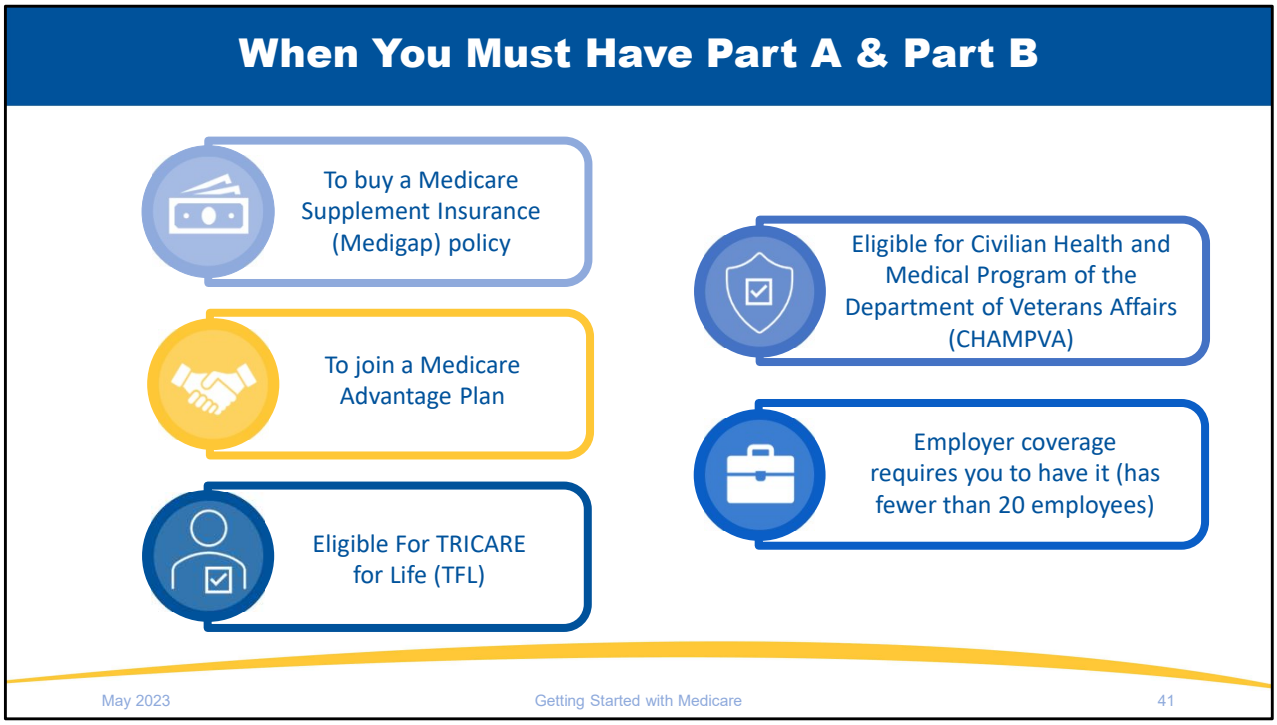
Decision: Should I Keep/Sign Up for Part B?

Consider:

- Most people pay a monthly premium
  - Usually deducted from Social Security/RRB benefits
  - Amount depends on income
- You can delay enrollment if you have GHP coverage based on your current employment, or the employment of a spouse or a family member if you're disabled.
- You can apply for Part B at any time while working and continue for 8-months after employment ends or GHP ends, whichever comes first
- Sometimes, you must have Part B

Presenter Notes

- The Part B premium usually gets deducted from monthly Social Security, Railroad Retirement, or federal retirement payments. The amount depends on your income and when you sign up for Part B. If you signed up late, you may have to pay a lifetime penalty, which is added to your monthly Part B premium.
- People who don't get a retirement payment, or whose payment isn't enough to cover the premium, get a bill from Medicare for their Part B premiums. You can pay your bill through Medicare's Easy Pay, your bank's online bill payment service from your checking or savings account; or by check, money order, credit card, or debit card (Medicare.gov/basics/costs/pay-premiums)
- If you or your spouse are still working, have a group health plan (GHP) (a health plan offered by an employer or employee organization that provides health coverage to employees and their families), and didn't sign up for Part B (or Part A if you have to pay for it) during your IEP, you may be able to sign up during an SEP. An SEP allows you to sign up after your IEP and not wait for the GEP. If eligible, you usually won't have to pay a late enrollment penalty, but this SEP is limited. You can sign up for Part A (if you have to pay for it) and/or Part B at anytime you're still covered by the GHP and continue for an 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first.
- You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if you should sign up for Part B during your IEP.
- There are situations where you must have Part B. See the next slide for those situations.



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Presenter Notes

You must have Part A and Part B if:

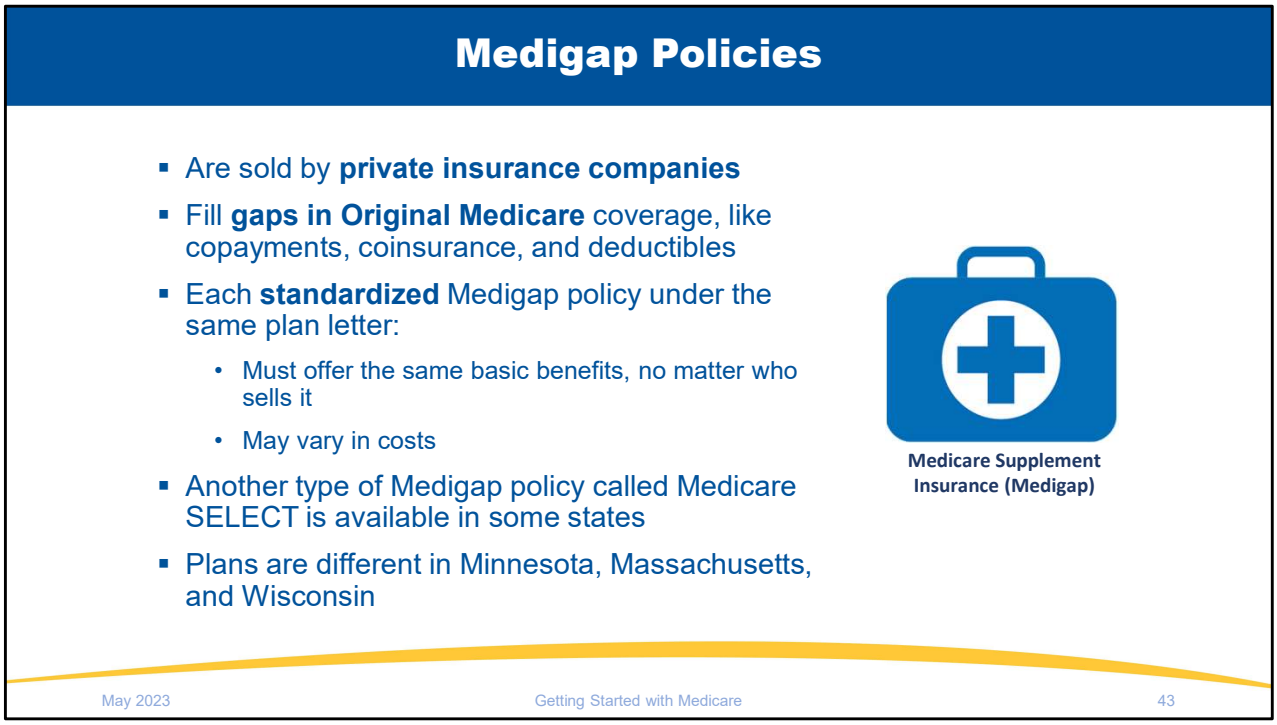
- You want to buy a Medicare Supplement Insurance (Medigap) policy.
- You want to join a Medicare Advantage Plan.
- You're eligible for TRICARE For Life (TFL). TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. However, if you're an active-duty service member, or the spouse or dependent child of an active-duty service member, you may want to sign up for Part A, but you don't have to sign up for Part B to keep your TRICARE coverage. When the active-duty service member retires and coverage changes to TFL, you must sign up for Part A and Part B to keep your TFL coverage. For more information, visit tricare.mil/mybenefit.
- You're eligible for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Your employer coverage requires you or your spouse/family member to have it because the company has fewer than 20 employees (talk to your employer or union benefits administrator).

NOTE: If you have (or can get) both Medicare and Veterans' benefits, you can get treatment under either program. However, Medicare is never the secondary payer after the Department of Veterans Affairs (VA). Each time you get health care or see a doctor, you must choose which benefits to use. Medicare can't pay for the same service that your Veterans' benefits covered, and your Veterans' benefits can't pay for the same service that Medicare covered.

If you have other coverage, view or download "Medicare and Other Health Benefits: Your Guide to Who Pays First" (CMS Product No. 02179) at Medicare.gov/publications.

Presenter Notes

Lesson 3 talks about searching for and buying Medicare Supplement Insurance coverage that can help with some of the out-of-pocket costs associated with Original Medicare.



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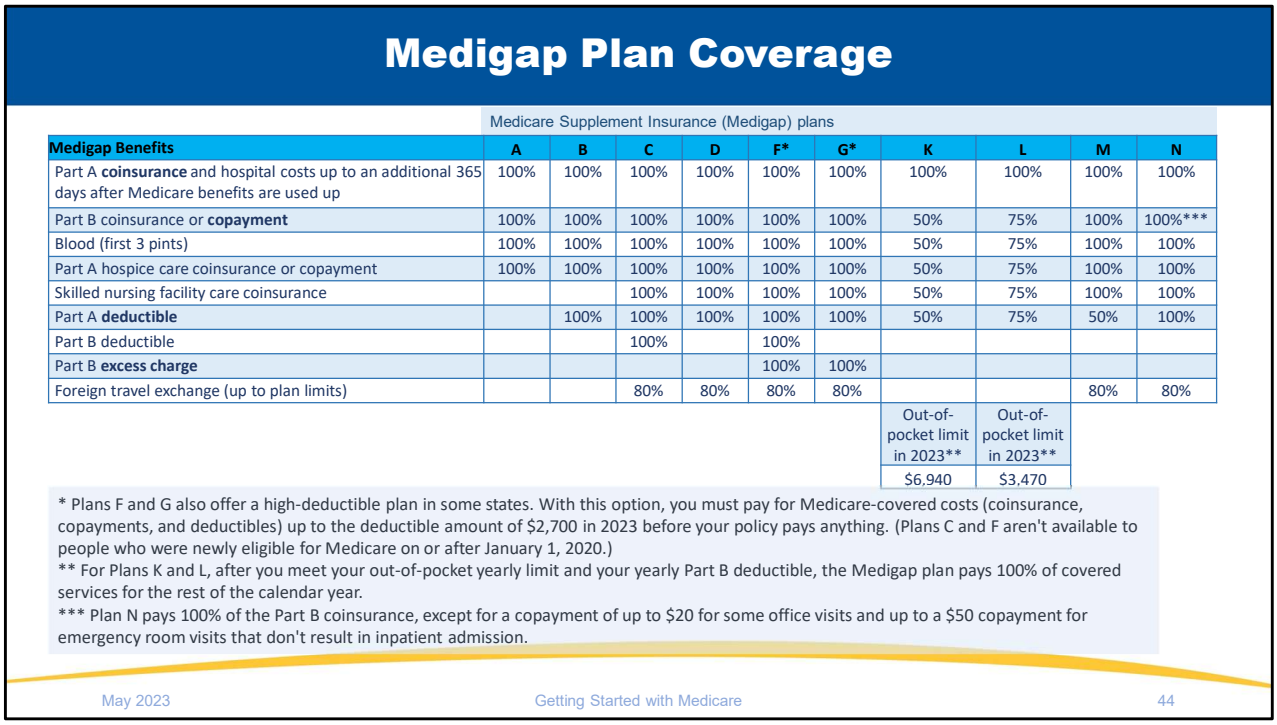
Presenter Notes

- **A Medicare Supplement Insurance (Medigap) policy is an insurance policy that helps fill "gaps" in Original Medicare.** Private companies sell these policies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medigap policies can help pay for some of the costs that Original Medicare doesn't, like copayments, coinsurance, and deductibles.
- **Some Medigap policies also cover 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.
- **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. Cost is usually the only difference between Medigap policies with the same plan letter sold by different insurance companies.
- **In some states, you may be able to buy another type of Medigap policy called Medicare SELECT.** If you buy a Medicare SELECT policy, you have the right to change your mind within 12 months and switch to a standard Medigap policy.
- **In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.**

NOTE: Since January 1, 2020, Medigap plans sold to people new to Medicare aren't allowed to cover the Medicare Part B (Medical Insurance) deductible. Because of this, Plans C and F are no longer available to people who were "new to Medicare" on or after January 1, 2020.

- If you already have either of these 2 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 qualified for Medicare before January 1, 2020 but you haven't signed up yet, you may be able to buy one of these plans.
- For this situation, "new to Medicare" means people who turned 65 on or after January 1, 2020, and people who got Medicare Part A (Hospital Insurance) on or after January 1, 2020.



Medigap Plan Coverage

	Medicare Supplement Insurance (Medigap) plans									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Part A **coinsurance** and hospital costs up to an additional 365 days after Medicare benefits are used up	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
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 exchange (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2023**	Out-of-pocket limit in 2023**		
							$6,940	$3,470		

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,700 in 2023 before your policy pays anything. (Plans C and F aren't available to people who were newly eligible for Medicare on or after January 1, 2020.)
** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered 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 inpatient admission.

Presenter Notes

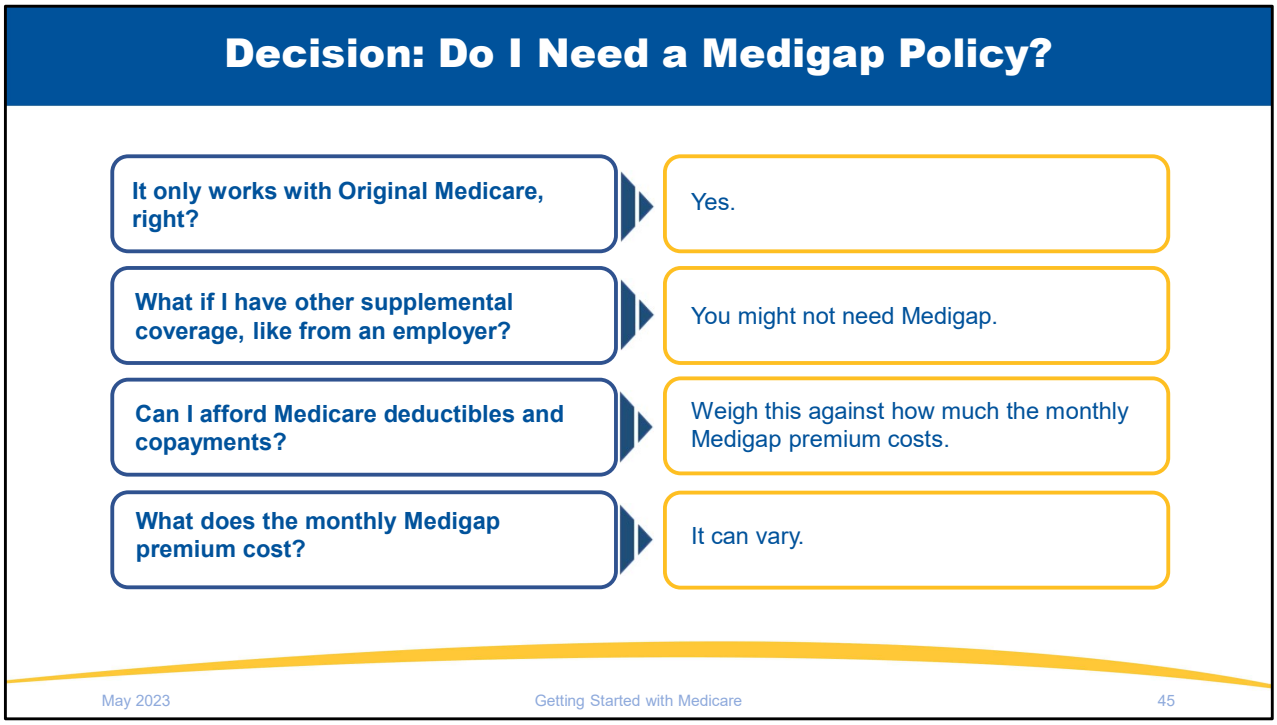
All Medigap policies cover a basic set of benefits, including the following:

- All plans pay 100% of Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used. Plans F and G also offer a high-deductible plan in some states.
- Plans A, B, C, D, F, G, M, and N pay 100% of the Part B coinsurance or copayment. 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. Plan K pays 50% of Part B coinsurance or copayment, with Plan L paying 75% of the Part B coinsurance.
- Plans A, B, C, D, F, G, M, and N pay 100% of blood (first 3 pints). Plan K pays 50%; Plan L pays 75%.
- Plans A, B, C, D, F, G, M, and N pay 100% of Part A hospice care coinsurance or copayment. Plan K pays 50%; Plan L pays 75%.

In addition, each Medigap plan covers different benefits:

- Plans C, D, F, G, M, and N cover 100% of the skilled nursing facility care coinsurance; Plan K covers 50%; Plan L covers 75%.
- Plans B, C, D, F, G, and N cover 100% of the Part A deductible; Plans K and M cover 50%; Plan L covers 75%.
- Plans C and F cover 100% of the Part B deductible. Plans C and F aren’t available to people who qualified for Medicare on or after January 1, 2020.
- Medigap Plans F and G cover 100% of the Part B excess charges.
- Medigap Plans C, D, F, G, M, and N cover 80% of foreign travel emergency costs up to plan limits.
- In 2023, both Plan K and Plan L have out-of-pocket limits of $6,940 and $3,470, respectively.

Source: Medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies



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Presenter Notes

- A Medigap policy only works with Original Medicare; Medigap doesn't work with Medicare Advantage Plans.
- If you have other coverage that supplements Medicare, like retiree coverage, you might not need Medigap.
- Consider whether you can afford Original Medicare's deductibles and copayments and weigh this against how much the monthly Medigap premium costs.

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Presenter Notes

Usually the best time to buy a Medigap policy is during your Medigap Open Enrollment Period (OEP). This period lasts for at least 6 months and begins the 1st day of the month you're both 65 or older and enrolled in Part B. You must also have Part A to have a Medigap policy.

Some states may give you more than 6 months to buy a Medigap policy during your OEP. But once this period starts, you can't delay it or get another one.

During your Medigap OEP, companies can't:

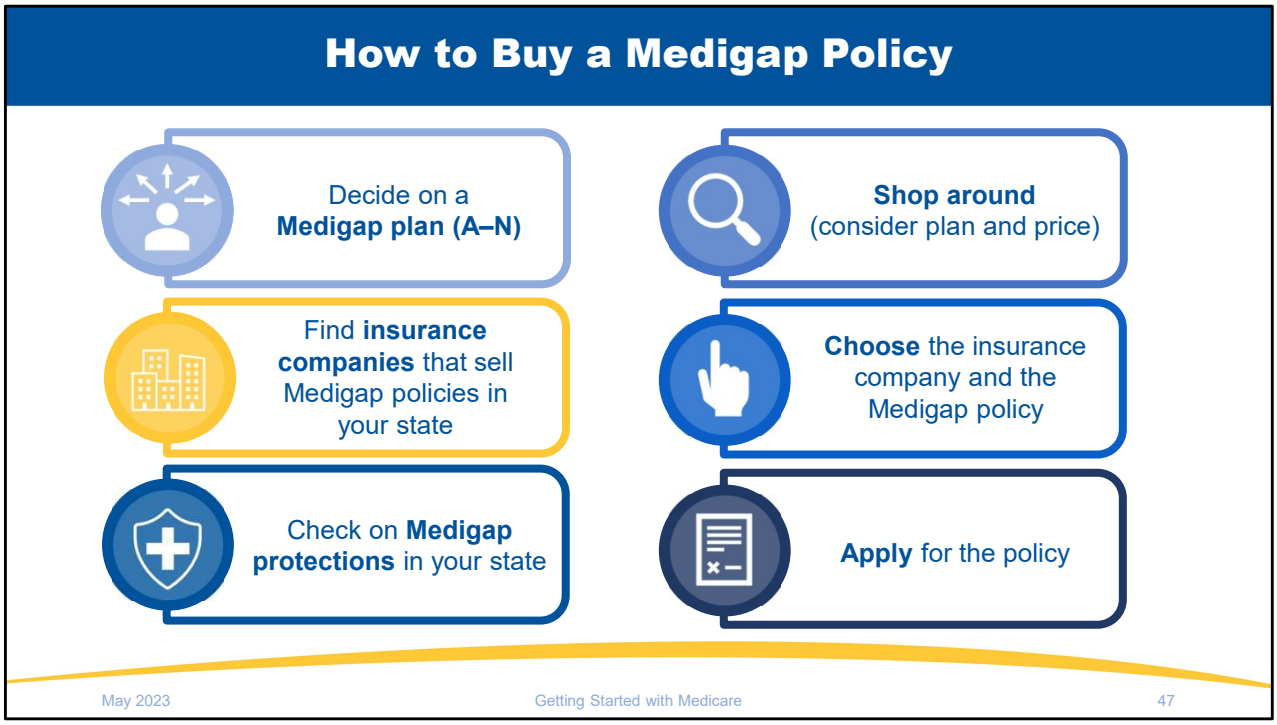
- Refuse to sell you any Medigap policy they offer because you have a disability or other health problem.
- Make you wait for coverage to start (there can be a waiting period for coverage of pre-existing conditions that are treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy if you don't have creditable coverage—previous health insurance coverage that can be used to shorten the waiting period for coverage of a pre-existing condition under Medigap policy—before the OEP).
- Charge you more for a Medigap policy because you have a past or present health problem.

To avoid a gap in coverage, you may want to apply for a Medigap policy before your Medigap OEP starts if your current health insurance ends the month you qualify for Medicare, or the month you turn 65.

NOTE: After your Medigap OEP ends, companies can refuse to sell you Medigap policy or charge you more for a policy because of past or present health problems. However, there are exceptions if you have employer coverage.

You can also buy a Medigap policy whenever a company agrees to sell you one. However, there may be restrictions, like medical underwriting or a waiting period for pre-existing conditions.

Insurance companies use the medical underwriting process to determine your health status when you're applying for health insurance, whether to offer you coverage, the price of your coverage, and any exclusions or limits.



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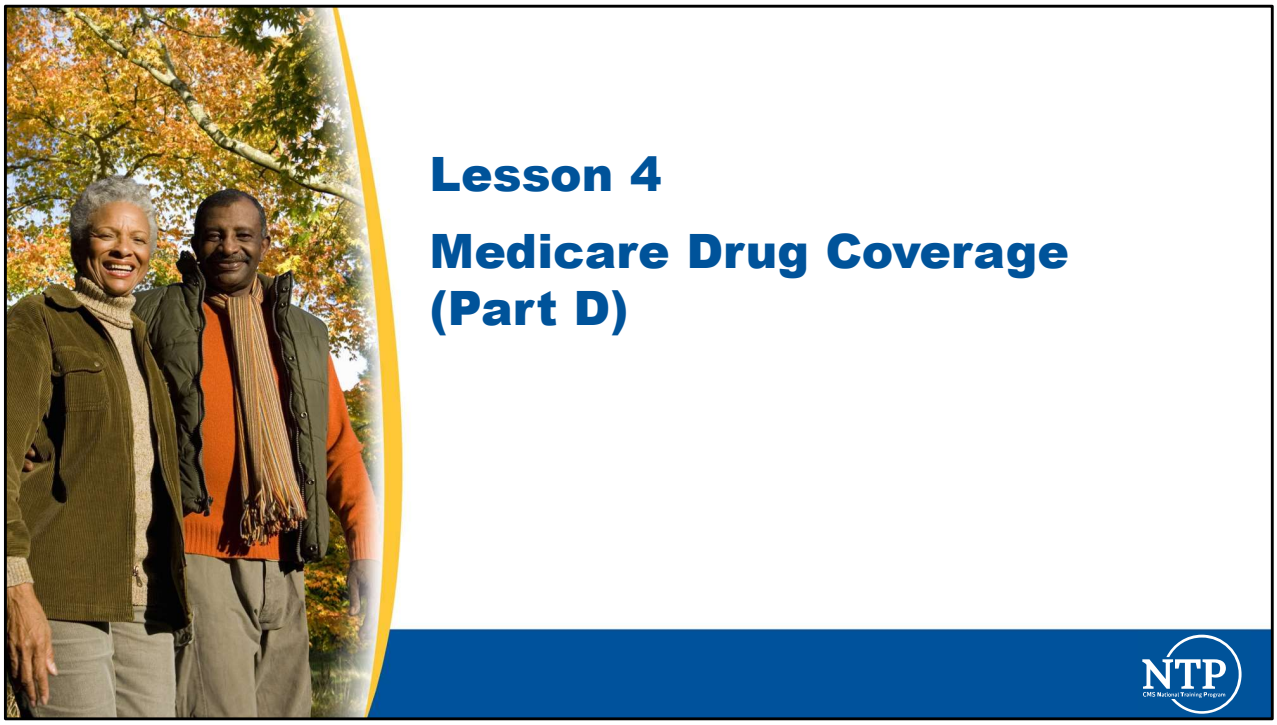
Presenter Notes

To buy a Medigap policy, follow these steps:

- Decide which Medigap policy (A–N) has the benefits you need. You can use the Medigap comparison tool on Medicare.gov/medigap-supplemental-insurance-plans to compare plans. You can also call 1-800-MEDICARE (1-800-633-4227) for help; TTY: 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP) to find out which insurance companies sell Medigap policies in your state. To find contact information for your local SHIP, visit shiphelp.org or visit Medicare.gov/medigap-supplemental-insurance-plans.
- Check on Medigap protections in your state. People who have Medicare because of a disability don't get the same federal Medigap protections. Contact your State Insurance Department to find out if your state offers protections to people under 65.
- Call the insurance companies and shop around for the best policy at a price you can afford.
- Once you choose a Medigap policy, apply for it. The insurance company must give you a clearly worded summary of your Medigap policy when you apply.

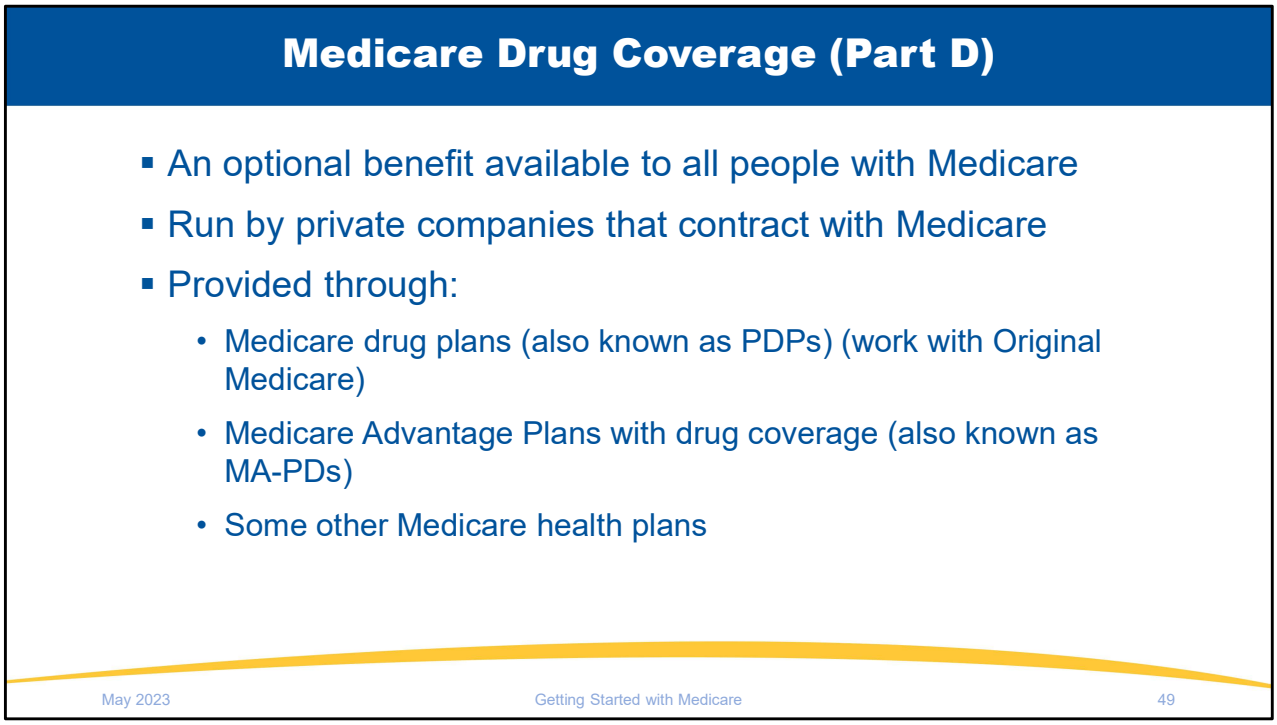
For more Medigap information:

- View the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" (CMS Product No. 02110) at Medicare.gov/publications.
- Call your State Insurance Department. Visit shiphelp.org, or call 1-800-MEDICARE (1-800-633-4227); TTY 1-877-486-2048, to get the phone number.
- See Module 3 in the Training Library at CMSnationaltrainingprogram.cms.gov/?q=global-search&search=Medigap+policies&combine=Medigap+policies.
- Visit Medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies.



Presenter Notes

Lesson 4 explains Medicare drug coverage, associated costs, and how to choose and join a plan.



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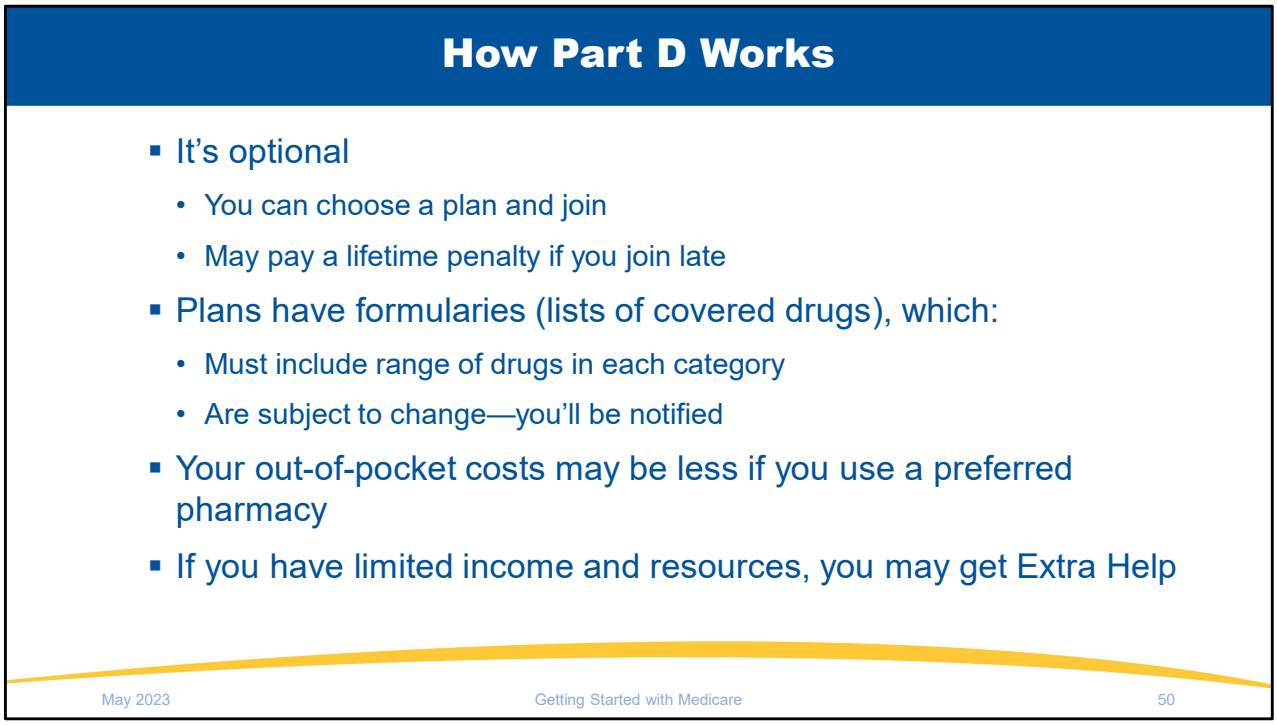
Presenter Notes

- **Part D is Medicare drug coverage.** It's an optional benefit available to all people with Medicare. If you sign up for Original Medicare and you want drug coverage, you must join a Medicare drug plan (also known as PDPs). You usually pay a monthly premium for the drug plan.
- **These plans are run by private companies** that contract with Medicare.
- You can get Part D through Medicare drug plans and Medicare Advantage Plans with drug coverage (also known as MA-PDs).
- You can also get Part D coverage through other Medicare health plans, like the Programs of All-inclusive Care for the Elderly (PACE). However, each plan type has special rules and exceptions. Contact the plans you're interested in for more details.
- **For help choosing a Part D plan,** visit Medicare.gov/plan-compare, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048. You can also contact your local State Health Insurance Assistance Program (SHIP) for free help comparing Medicare drug plans. To find information for your local SHIP, visit shiphelp.org.



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Presenter Notes

- **Medicare contracts with private insurance companies that offer drug plans to people with Medicare.** Everyone with Medicare can get drug coverage by joining a drug plan (Part D). If you don't get Part D when you're first eligible and you don't have other creditable coverage, you may have to pay a penalty for as long as you have a drug plan. You can also get drug coverage from a Medicare Advantage Plan (with drug coverage), but to join one you must have both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Each plan has a formulary, or list of covered drugs.** Each plan's formulary must include a range of drugs in the most commonly prescribed categories. This ensures that people with different medical conditions can get the treatment they need. All drug plans generally must cover at least 2 drugs in each drug category, but plans can choose which specific drugs they cover.

All plans must cover a wide range of drugs that people with Medicare take, including most drugs in certain protected classes, which include:

1. Cancer drugs
2. HIV/AIDS drugs
3. Antidepressants
4. Antipsychotics
5. Anticonvulsants
6. Immunosuppressants for organ transplants

Also, drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the COVID-19, flu and pneumococcal shots). People with drug coverage pay nothing out of pocket for even more vaccines that are recommended by the Advisory Committee on Immunization Practices. You or your health care provider can contact your drug plan for more information about vaccine coverage. View the Code of Federal Regulations' Access to covered Part D drugs, *§423.120(d),* ecfr.gov/cgi-bin/text-idx?SID=7805cfe316ca233ff673e2e02b0e6b74&mc=true&node=se42.3.423_1120&rgn=div8.

Your plan can change its formulary at any time. They'll notify you if any formulary changes impact drugs you're taking. Also, plans may have preferred pharmacies. If you use a preferred pharmacy, your out-of-pocket costs may be lower.

People with limited income and resources may be able to get Extra Help paying for their Medicare drug costs. "Extra Help" is discussed in further detail later in the presentation.

Medicare Drug Plan Costs: What You Pay in 2023

Most people will pay:

- A monthly **premium** (varies by plan and income)
- A yearly **deductible** (if applicable)
- **Copayments or coinsurance**
- **Out-of-pocket** costs
  - A **percentage** of the cost while in the coverage gap,which begins at $4,660 for out-of-pocket spending in 2023
  - **Very little** after spending $7,400 out of pocket in 2023—will automatically get catastrophic coverage

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Presenter Notes

Costs vary by plan.

Most people will pay:

- A monthly premium (varies by plan and income)
- A yearly deductible (if applicable)
- Copayments or coinsurance
- A percentage of the cost while in the coverage gap, begins at $4,600 for out-of-pocket spending in 2023
- Very little after spending $7,400 out of pocket in 2023—will automatically get catastrophic coverage

If you have limited income and resources, you may qualify for Extra Help to pay for your drug coverage (see Lesson 7).

Resources:

- Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap
- Medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/catastrophic-coverage

Income-Related Monthly Adjustment Amount (IRMAA): Part D Premium for 2023

If your filing status and yearly income in 2021 was:

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	You pay each month (in 2023)
$97,000 or less	$194,000 or less	$97,000 or less	Your plan premium (YPP)
Above $97,000 up to $123,000	Above $194,000 up to $246,000	Not applicable	$12.20 + YPP
Above $123,000 up to $153,000	Above $246,000 up to $306,000	Not applicable	$31.50 + YPP
Above $153,000 up to $183,000	Above $306,000 up to $366,000	Not applicable	$50.70 + YPP
Above $183,000 and less than $500,000	Above $366,000 and less than $750,000	Above $97,000 and less than $403,000	$70.00 + YPP
$500,000 or above	$750,000 or above	$403,000 or above	$76.40 + YPP

Presenter Notes

Most people will pay the standard premium amount for drug coverage. If your modified adjusted gross income (MAGI) is above a certain amount, you may also pay an Income-Related Monthly Adjustment Amount (IRMAA). Roughly 7% of people with Medicare pay an IRMAA. The total 2023 Part D premiums for people with higher income are shown below.

The Bipartisan Budget Act of 2018 changed the income-related premium policy and adjusted the income thresholds for determining IRMAA. IRMAA is adjusted each year. It's calculated on the national base beneficiary premium.

For 2023:

- You pay only your plan premium if your yearly income in 2021 was $97,000 or less for an individual, or $194,000 or less for a married couple.
- If you reported a MAGI of more than $97,000 (individual) or $194,000 (married individuals filing jointly) on your 2021 tax return (the most recent tax return information provided by the Internal Revenue Service (IRS) to Social Security), you'll have to pay the Part D IRMAA in addition to your plan premium (YPP).
- If you reported a MAGI above $183,000 and up to $500,000, and file an individual tax return, or file a joint tax return with an income above $366,000 and up to $750,000, you pay your plan premium and your IRMAA of $70.00 per month.
- If you reported a MAGI of $500,000 or above, and file an individual tax return, or file a joint tax return with an income above $750,000, you pay your plan premium and your IRMAA of $76.40 per month.

NOTE: If you're married filing separately, but you lived with your spouse at any time during the taxable year, and your income is from $97,000 to $403,000, you pay YPP and IRMAA of $70.00 each month.

If your income changes for certain reasons, like divorce or retirement, you may be able to reduce your IRMAA. Visit SSA.gov/forms/ssa-44.pdf to view and print a copy of the "Medicare Income-Related Monthly Adjustment Amount – Life-Changing Event form.

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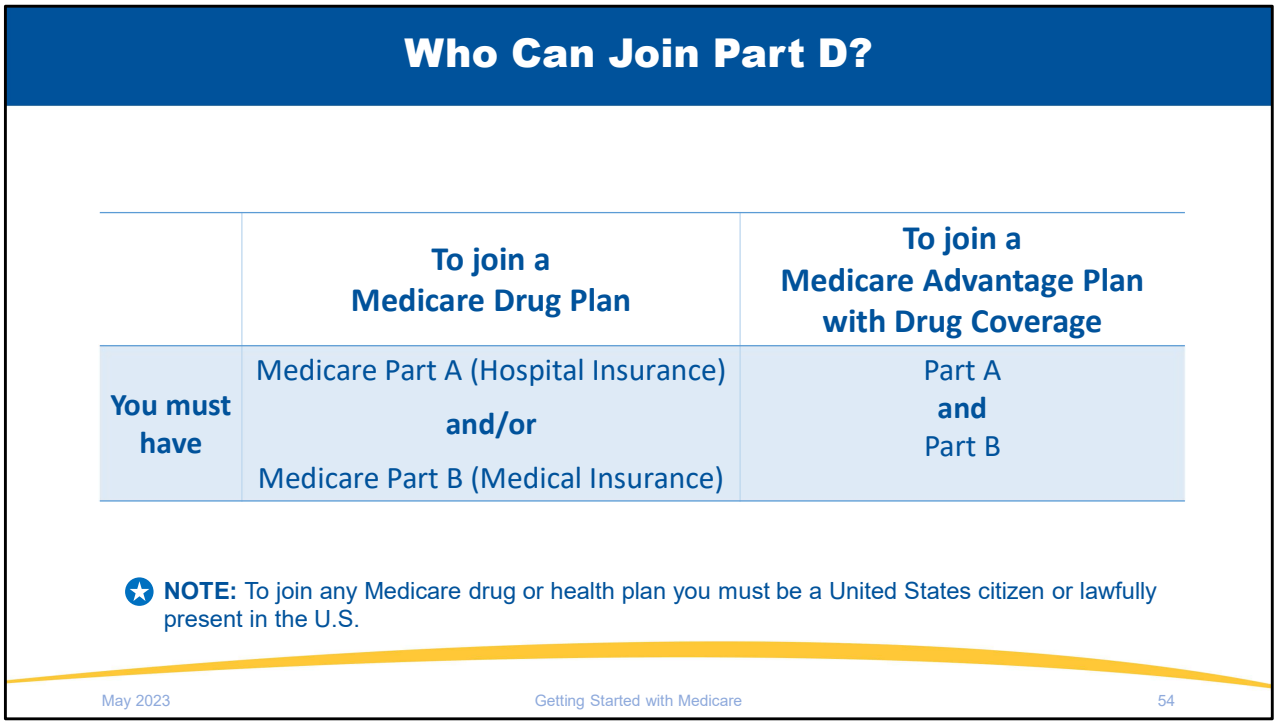
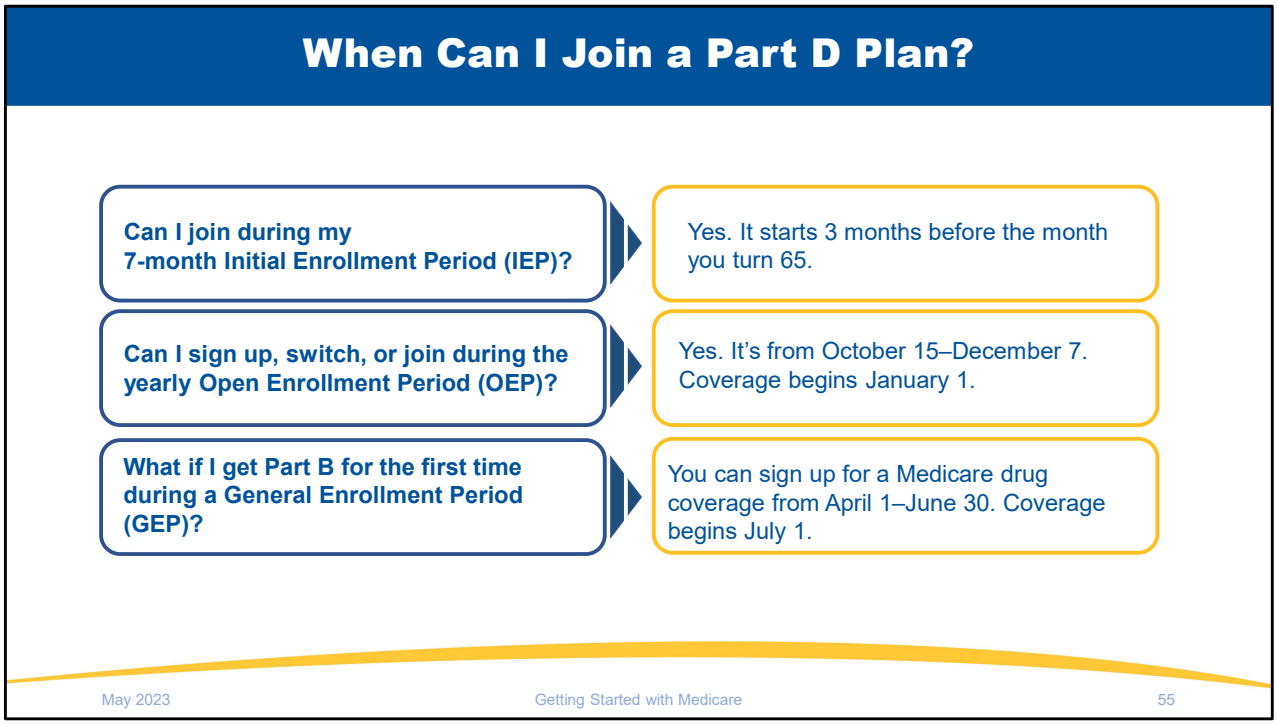
Presenter Notes

- **You may owe a late enrollment penalty (in addition to your regular monthly premium) if you don't join a drug plan during your Initial Enrollment Period (IEP), and you go for at least 63 days in a row without Part D or other creditable drug coverage.** Creditable drug coverage (for example, from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage) that's expected to pay, on average, at least as much as Medicare's standard drug coverage. Your plan must tell you each year if your non-Medicare drug coverage is creditable coverage. The amount of the late enrollment penalty depends on how long you went without creditable drug coverage. If you had other creditable drug coverage or if you qualify for Extra Help, you won't have to pay a late enrollment penalty.
- **Medicare calculates the late enrollment penalty** by multiplying 1% times the number of full, uncovered months you didn't have drug coverage (once you qualified) or other creditable drug coverage (coverage from an employer or union that's expected to pay, on average, at least as much as Medicare's standard drug coverage) times the current "national base beneficiary premium" ($32.74 in 2023). The final amount is rounded to the nearest $.10 and added to your plan's monthly premium. The national base beneficiary premium may change each year, so the penalty amount may also change each year. You may have to pay this penalty for as long as you have a drug plan.
- **Your Medicare plan is required to tell you if you owe a penalty, and what your payment will be.** The late enrollment penalty goes to the Medicare Trust Fund, not the plan. If you don't agree with your late enrollment penalty, you can ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to send proof that supports your case.
- **For more information,** visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf.



Presenter Notes

- **To join a drug plan,** you must have Part A and/or Part B.
- **To join a Medicare Advantage Plan with drug coverage,** you must have both Part A and Part B.
- **To join a Medicare Cost Plan with drug coverage,** you must have Part A and Part B, or have Part B only. Cost Plans are a type of Medicare health plan available in certain, limited areas of the country (learn more in Lesson 5).
- **Each plan has its own service area, which you must live in to join.** People living in the U.S. territories, including Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, can join. If you live outside the U.S. and its territories, or if you're incarcerated, you're not eligible to join a plan. This means you can't get drug coverage. You must be lawfully present in the U.S. to join a plan.
- **Most people must join a drug plan to get coverage.** So, while all people with Medicare can have this coverage, you need to take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a drug plan unless you decline coverage or join a plan yourself. You can only have one drug plan at a time (learn more in Lesson 7).



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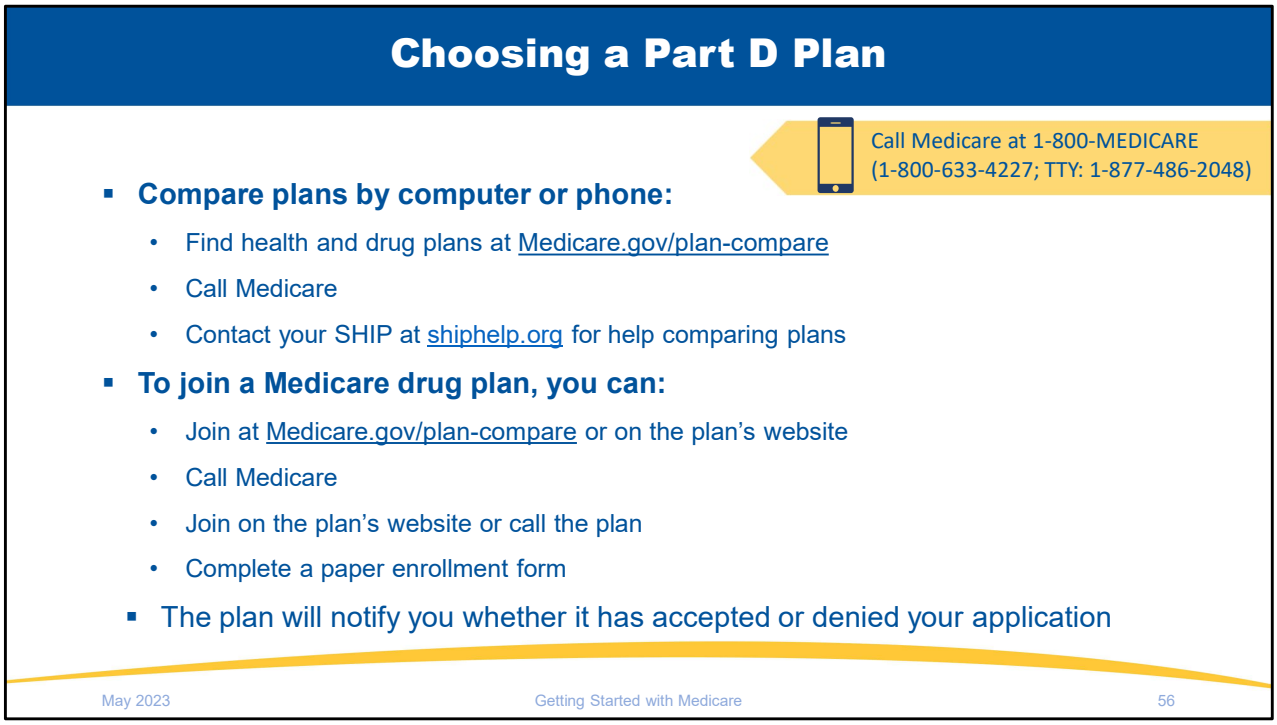
Presenter Notes

- **You can join a drug plan during your 7-month IEP.** Your IEP begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- **If you qualify, you can join, switch, or drop a Medicare drug plan during the yearly Open Enrollment Period (OEP) from October 15–December 7.** If you make a change during the OEP, your coverage starts January 1 (as long as your plan gets your request by December 7). For most people, this is the one time each year that they can make changes.
- **If you have to buy Part A,** and you and sign up for Part B during the Part B General Enrollment Period (GEP) from January 1–March 31, you can join a drug plan from April 1–June 30. Your coverage begins July 1st.



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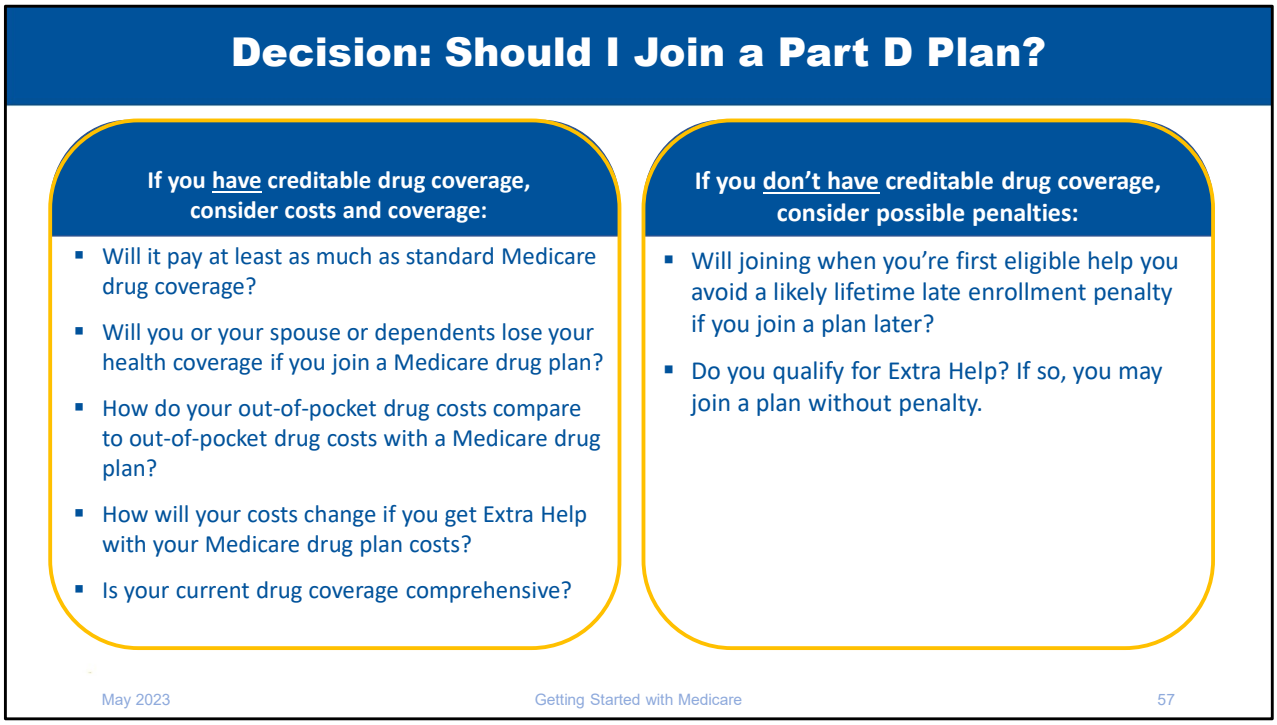
Presenter Notes

- **There's help available to find the drug plan that's right for you.** You can visit Medicare.gov/plan-compare, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048. You can also contact your SHIP for free help comparing drug plans. To find contact information for your local SHIP, visit shiphelp.org.
- **After you pick a plan that meets your needs, call the company offering it and ask how to join.** All plans must offer paper enrollment applications. Also, plans may let you join through their website or over the phone. Most plans also participate and offer enrollment through Medicare.gov/plan-compare. You can also call Medicare to join at 1-800-MEDICARE.
- **Plans must process applications in a timely manner.** After you apply, the plan must tell you if they've accepted or denied your application. Plans aren't allowed to deny your application based on your health condition or the drugs you're taking.



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Presenter Notes

Everyone with Medicare has to make a decision about drug coverage. If you're new to Medicare and already have other drug coverage (like from an employer or union), find out how your employer or union drug coverage works with Medicare, because your coverage may change if you join a drug plan.
Your employer or union (or the plan that administers your drug coverage) will send you a "Creditable Coverage" disclosure each year, letting you know if it's creditable drug coverage and how it compares to drug coverage. If you don't get this information, ask your employer or union for it.

You may have to make choices about your employer/union drug coverage and Medicare drug coverage:

- During your 7-month IEP, when you first qualify for Medicare
- During the OEP, between October 15–December 7 each year
- When your employer/union coverage changes or ends

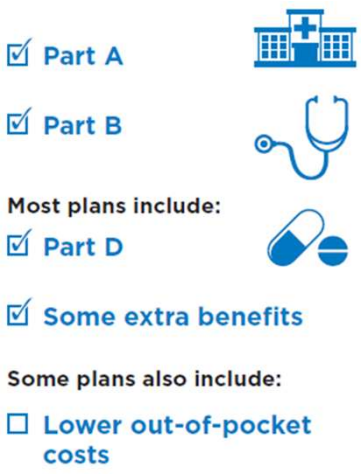
Before making a decision, here are a few things you should consider:

- Is your employer or union drug coverage creditable? If you decide not to join a drug plan when you first qualify, and you don't have other creditable drug coverage for at least 63 days in a row, or you don't get Extra Help, you'll likely pay a lifetime late enrollment penalty if you join a plan later.
- Will you or your spouse or dependents lose all of your employer or union health coverage if you join a drug plan?
- How do your out-of-pocket drug costs with your employer or union drug coverage compare to out-of-pocket drug costs with a drug plan?
- How will your costs change if you get Extra Help with your drug plan costs?
- Is your current drug coverage comprehensive? For example, does your plan cover all your current medications, and are your out-of-pocket costs high? All drug plans and health plans with drug coverage must ensure that their members have access to medically necessary drugs to treat their conditions.

Presenter Notes

Lesson 5 explains Medicare Advantage (Part C), Cost Plans, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Advantage Plans (Part C)



- Another way to get your Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) **coverage**
- Offered by Medicare-approved **private companies** that must follow rules set by Medicare
- Most Medicare Advantage Plans include drug coverage (Part D)
- In most cases, you'll need to use health care providers who participate in the **plan's network** (some plans offer non-emergency coverage out of network, but typically at a higher cost)

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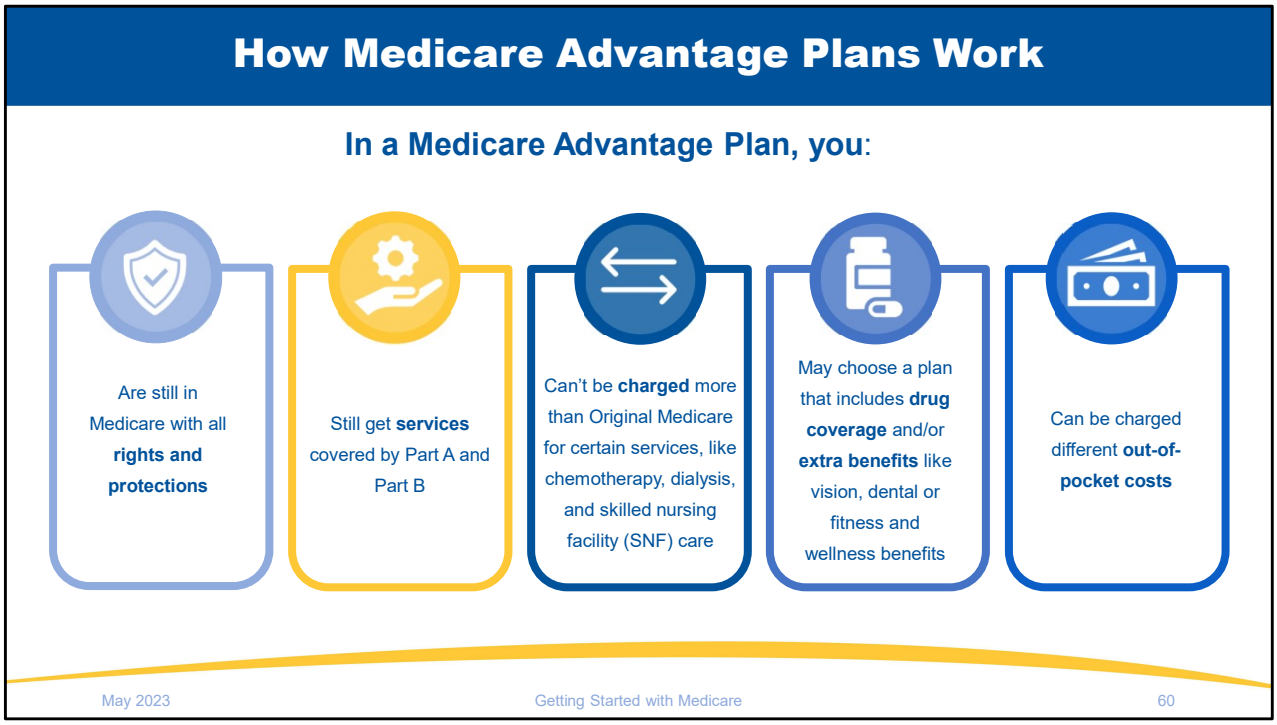
Presenter Notes

- **A Medicare Advantage Plan is another way to get your Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) coverage.** Plans, sometimes called "Part C," are offered by Medicare-approved private companies that must follow rules set by Medicare. If you join a Medicare Advantage Plan, you'll still have Medicare but you'll get your Part A and Part B coverage from the Medicare Advantage Plan, not Original Medicare. Most Medicare Advantage Plans also include drug coverage (Part D). In most cases, you'll need to use health care providers who participate in the plan's network. These plans set a limit on what you'll have to pay out of pocket each year for covered services. Some plans offer non-emergency coverage out of network, but typically at a higher cost. In many cases, you'll need to get approval from your plan before it covers certain drugs or services.
- **If you join a Medicare Advantage Plan, your plan may give you a card to use when you get health care services and supplies.** Your Medicare Advantage Plan ID card is your main card for Medicare. However, you also may be asked to show your Original Medicare card, so you should carry that card too.



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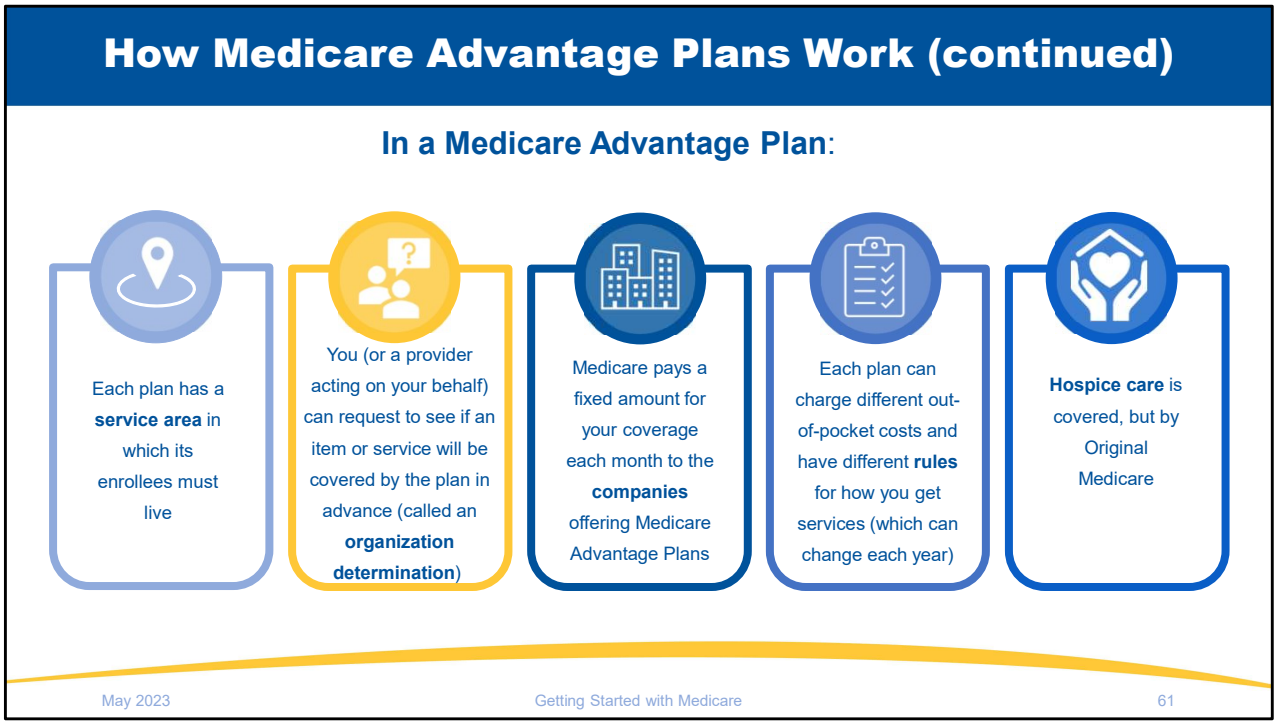
Presenter Notes

In a Medicare Advantage Plan, you:

- Are still in Medicare with all rights and protections
- Still get services covered by Part A and Part B, but the Medicare Advantage Plan covers those services instead of Original Medicare (you must have both Part A and Part B to join a Medicare Advantage Plan)
- Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility (SNF) care
- May choose a plan that includes drug coverage
- May choose a plan that includes extra benefits Medicare doesn't cover, like vision, dental, or fitness and wellness benefits
- Your out of pocket costs may vary depending on the plan
- Have a yearly limit on your out-of-pocket costs

Note: Medicare Advantage Plans can cover more extra benefits than they have in the past, including transportation to doctor visits, over-the-counter prescription drugs, adult day-care services, and other services that promote your health and wellness. Plans can also tailor their plan offerings to people with certain chronic health conditions. You can get more details about these benefits from the plan materials. For CMS to approve an extra benefit, the benefit must focus directly on an enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one. Visit CMSnationaltrainingprogram.cms.gov/?q=global-search&combine=classroom%20modules to review "Medicare Advantage and Other Health Plans" for more information about expanded health-related extra benefits.



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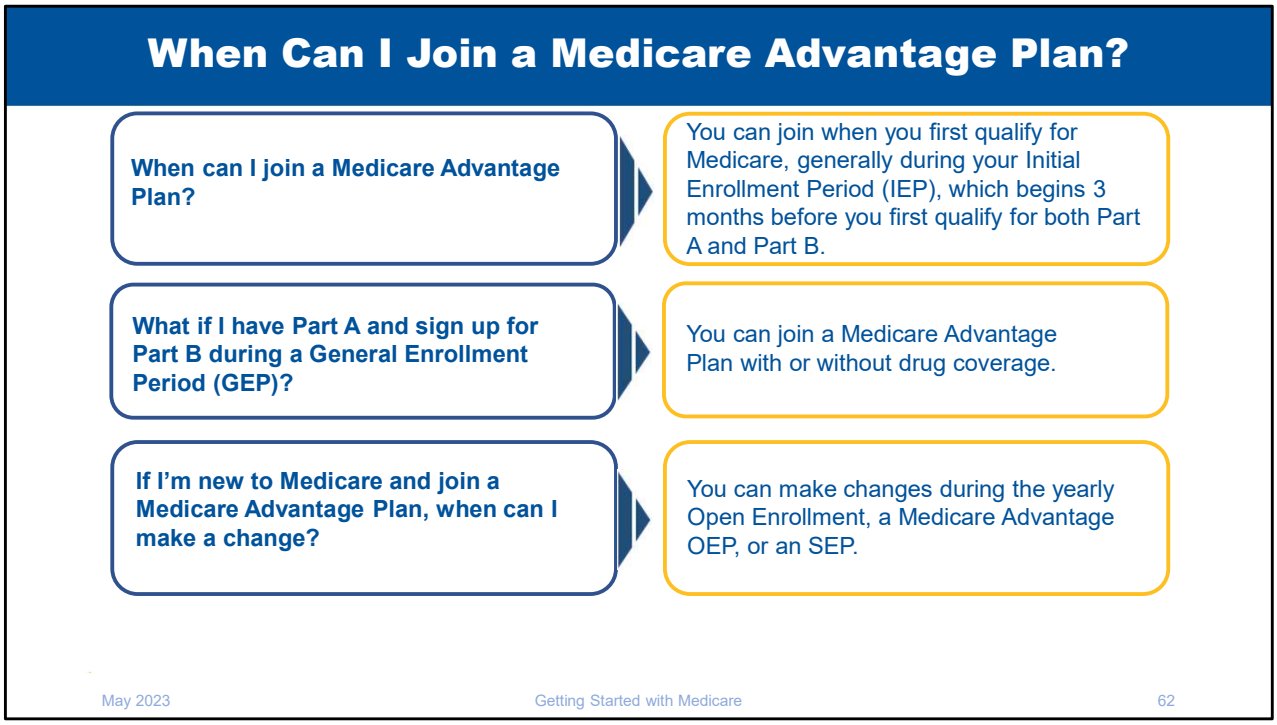
Presenter Notes

- Each plan has a service area in which its enrollees must live.
- You (or a provider acting on your behalf) can ask in advance if the plan covers an item or service. Sometimes you must do this for the service to be covered. This is called an "organization determination." Contact your plan for more information.
- Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans.
- Each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like if you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year.
- Original Medicare covers hospice care, some new Medicare benefits, and some costs for clinical research studies even if you have a Medicare Advantage Plan.

Sources:

- Medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/things-to-know-about-medicare-advantage-plans
- Medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work
- Medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services.



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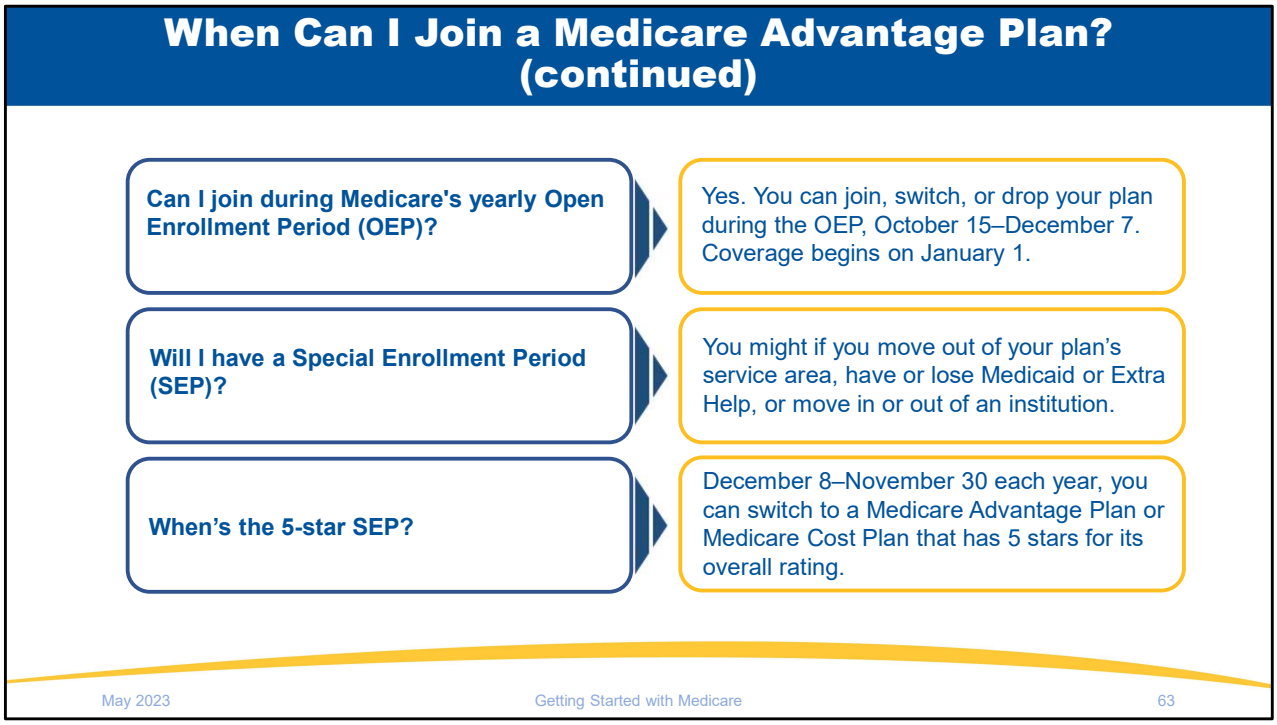
Presenter Notes

- You can join a Medicare Advantage Plan when you first qualify for Medicare, generally during your Initial Enrollment Period (IEP), which begins the 3 months before you first qualify for both Part A and Part B.
- If you have Part A and sign up for Part B during a General Enrollment Period (GEP), you can join a Medicare Advantage Plan with or without drug coverage 3 months immediately before you're first entitled to get Part A and Part B until the last day of the month before your entitlement to both Part A and Part B. Your coverage will start the same day as when your Part B coverage starts.
- After you enroll in a Medicare Advantage Plan, you can only make changes during the yearly Open Enrollment period, which starts on October 15 and ends on December 7 each year. During your Medicare Advantage Open Enrollment Period (Medicare Advantage OEP), which runs from January 1-March every year, or if you have Part A and Part B for the first time and enrolled in a Medicare Advantage Plan during the first 3 months of becoming eligible, during the first 3 months of having Part A and B. During an SEP.
- **Source:** Medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan



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Presenter Notes

- Each year, you have the chance to review your Medicare coverage and join, switch, or drop your plan during the OEP from October 15 – December 7. Coverage changes you make during the OEP start January 1, as long as the plan had your request by December 7.
- You may qualify for a Special Enrollment Period (SEP) in certain circumstances, like if you:
  - Move out of your plan's service area
  - Have or lose Medicaid or Extra Help
  - Move in or out of an institution (like a SNF or long-term care hospital)
- 5-star SEP information:
  - You can switch to a Medicare Advantage Plan or Medicare Cost Plan that has 5 stars for its overall star rating
  - You can switch to a Medicare Advantage Plan with drug coverage that has 5 stars for its overall star rating from December 8–November 30 each year. You can only use this SEP once during this timeframe.

To find out which Medicare Advantage Plans are available in your area, visit Medicare.gov/plan-compare, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

For more enrollment period information, visit Medicare.gov/publications to review "Understanding Medicare Advantage & Medicare Drug Plan Enrollment Periods" (CMS Product No. 11219).

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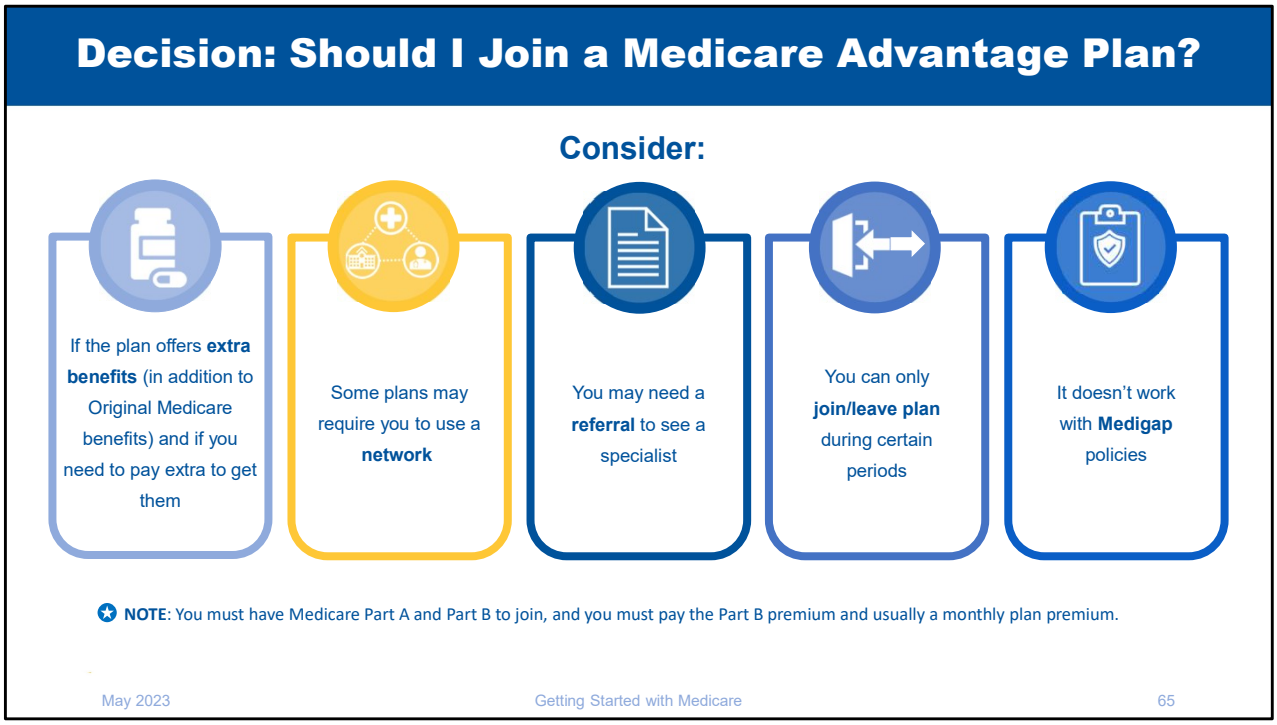
Presenter Notes

Not all Medicare Advantage Plans work the same way. Find and enroll in health and drug plans at Medicare.gov/plan-compare.

Once you understand the plan's rules and costs, here's how to join:

- Visit the plan's website to see if you can join online.
- Fill out a paper enrollment form. Contact the plan to get an enrollment form, fill it out, and return it to the plan. All plans must offer this option.
- Call the plan you want to join. Get your plan's contact information from Medicare.gov/plan-compare.
- Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

Note: Medicare plans aren't allowed to call you to enroll you in a plan, unless you specifically ask for a call. Also, plans should never ask you for financial information, including credit card or bank account numbers, over the phone.



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Presenter Notes

Here are some things to consider when deciding if you want to join a Medicare Advantage Plan:

- You must have Part A and Part B
- In addition to paying the Part B premium, you may have to pay a monthly plan premium
- Does the plan offer extra benefits (in addition to Original Medicare benefits) and do you need to pay extra to get them?
- Some plans may require you to use a network
- You may need a referral to see a specialist
- You can only join/leave the plan during certain periods
- Medicare Advantage Plans don't work with Medigap policies

How Are Medigap Policies & Medicare Advantage Plans Different?

	Medigap Policies	Medicare Advantage Plans
Offered by	Private companies	Private companies
Government oversight	State, but must also follow federal laws	Federal (plans must be approved by Medicare)
Works with	Original Medicare	N/A
Covers	Gaps in Original Medicare coverage, like deductibles, coinsurance, and copayments for Medicare-covered services.	All Part A and Part B covered services and supplies. May also cover things not covered by Original Medicare, like vision and dental coverage. Most Medicare Advantage Plans include Medicare drug coverage.
You must have	Part A and Part B	Part A and Part B
Do you pay a premium?	Yes. You pay a premium for the policy and you pay the Part B premium.	Yes. In addition to paying the Part B premium, you may have to pay a monthly plan premium.

Presenter Notes

This chart displays a side-by-side comparison of Medigap policies and Medicare Advantage Plans.

- Private companies offer both.
- Medigap must follow federal and state laws, but states are responsible for routine day-to-day oversight of standardized Medigap policies. Medicare Advantage Plans must be approved by Medicare.
- Medigap policies only work with Original Medicare. They don't work with Medicare Advantage Plans. If you join a Medicare Advantage Plan, you can't use a Medigap policy to pay for the out-of-pocket costs you have in the Medicare Advantage Plan.
- Original Medicare pays for many, but not all, health care services and supplies. Private insurance companies sell Medigap policies to help pay for some of the out-of-pocket costs ("gaps") that Original Medicare doesn't cover. Medigap policies don't pay your Medicare premiums. Most Medigap policies don't cover out-of-pocket drug expenses. If you want drug coverage, you'll need to consider joining a Part D plan. Some older policies (no longer sold) may have included some drug coverage (Plan I). Medicare Advantage Plans cover Part A- and Part B-covered services, most include Part D, and may offer extra coverage like vision, hearing, dental, and wellness programs.
- In both cases, you must have Part A and Part B.
- You pay a premium for a Medigap policy and you pay the Part B premium. In addition to paying the Part B premium in a Medicare Advantage Plan, you may have to pay a monthly plan premium.
- If you already have a Medicare Advantage Plan, it's illegal for anyone to sell you a Medigap policy unless you drop your Medicare Advantage Plan to go back to Original Medicare.

2023 Minimum Federal Eligibility Requirements for Medicare Savings Programs

Medicare Savings Programs	Individual Monthly Income Limits	Married Couple Income Limits	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,235	$1,663	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,478	$1,992	Part B premiums only
Qualifying Individual (QI)	$1,660	$2,239	Part B premiums only
Qualifying Disabled & Working Individuals (QDWI)	$4,945	$6,659	Part A premiums only

- **Resource limits** for QMB, SLMB, and QI are $9,090 for an individual and $13,630 for a married couple.
- **Resource limits** for QDWI are $4,000 for an individual and $6,000 for a married couple.

Presenter Notes

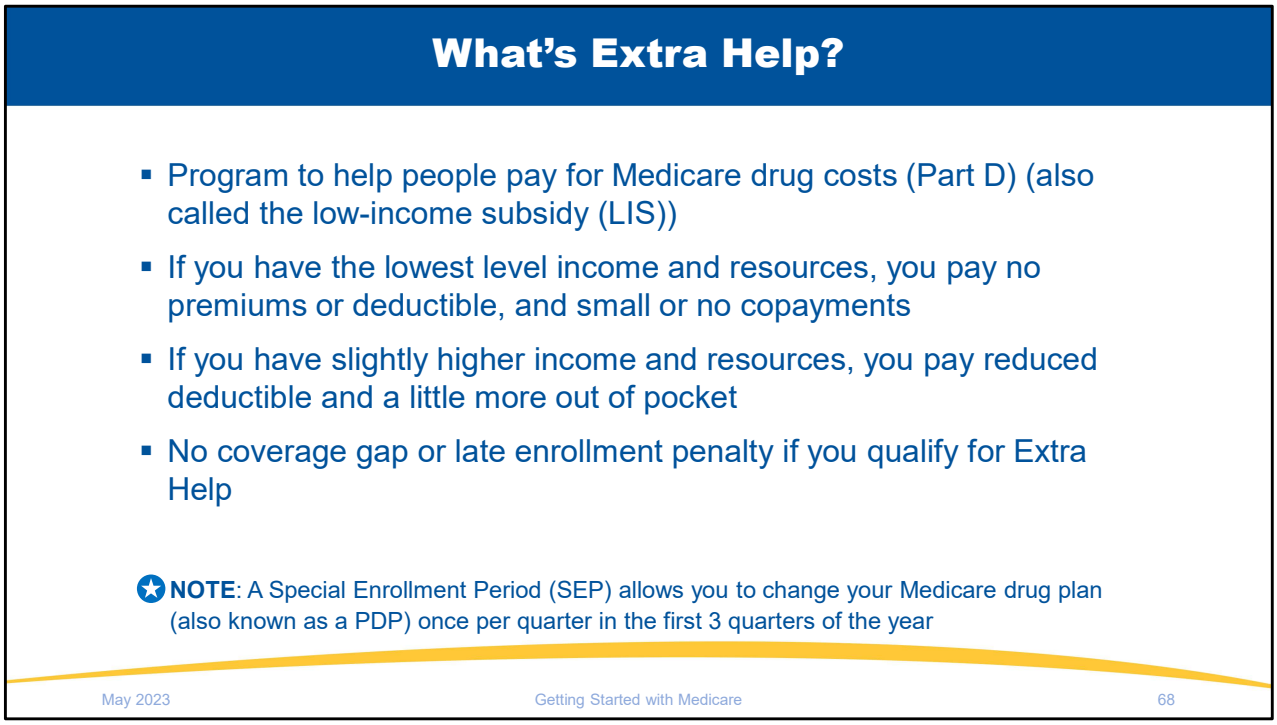
These are the 2023 Medicare Savings Programs (MSP)[1] federal minimum eligibility requirements for the 48 contiguous states. Limits are slightly higher in Alaska and Hawaii.

- **To qualify for the Qualified Medicare Beneficiary (QMB) Program,** you must qualify for Medicare Part A (Hospital Insurance) and have an income that's no more than 100% of the federal poverty level (FPL). Your coverage starts the first month after you meet the QMB eligibility requirements (can't be retroactive).
- **To qualify for the Specified Low-Income Medicare Beneficiary (SLMB) Program,** you must qualify for Part A and have an income that's more than 100% and less than 120% of the FPL.
- **To qualify for the Qualifying Individual (QI) Program,** you must not qualify for any other Medicaid eligibility group. In addition, you must qualify for Part A and have an income that's at least 120% of the FPL and less than 135% of the FPL. You may have to apply every year for QI benefits because funding is limited. If state funds are available, QI applications are granted on a first-come, first-served basis, with priority given to people who got QI benefits the previous year.
- In 2023, the resource limits for the QMB, SLMB, and QI programs are $9,090 for a single person and $13,630 for a married person living with a spouse. Resource limits are adjusted on January 1 of each year, based on the change in the annual consumer price index since September of the previous year (official in April of each year). States can disregard certain income and resources if the Centers for Medicare and Medicaid Services (CMS) approve the changes. Countable resources include money in a checking account or savings account, stocks, and bonds.
- **To qualify for the Qualifying Disabled & Working Individuals (QDWI) Program, you must:**
  - Have a disability
  - Be working
  - Have lost your Social Security disability benefits and Medicare premium-free Part A because you returned to work
  - Have resources worth less than $4,000 for an individual and $6,000 for a married couple, not counting the home where you live, usually one car, and certain insurance in 2023
  - Not already be eligible for Medicaid

States can ask people with incomes between 150% and 200% of the FPL to pay a part of their Part A premium. The resource limits are $4,000 (individual) and $6,000 (married couple).

For more Medicare Savings Programs information, visit Medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs. See Medicare.gov/talk-to-someone to access a state's Medicare Savings Programs website.

States can effectively raise the federal floor for income and resources standards under the authority of section 1902(r)(2) of the Social Security Act, which generally permits state Medicaid agencies to disregard income and/or resources that are counted under certain standard financial eligibility methodologies. Some states have used the authority of section 1902(r)(2) of the Act to eliminate any resource criteria for the MSP groups (CMS.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_DualEligibleDefinition.pdf).



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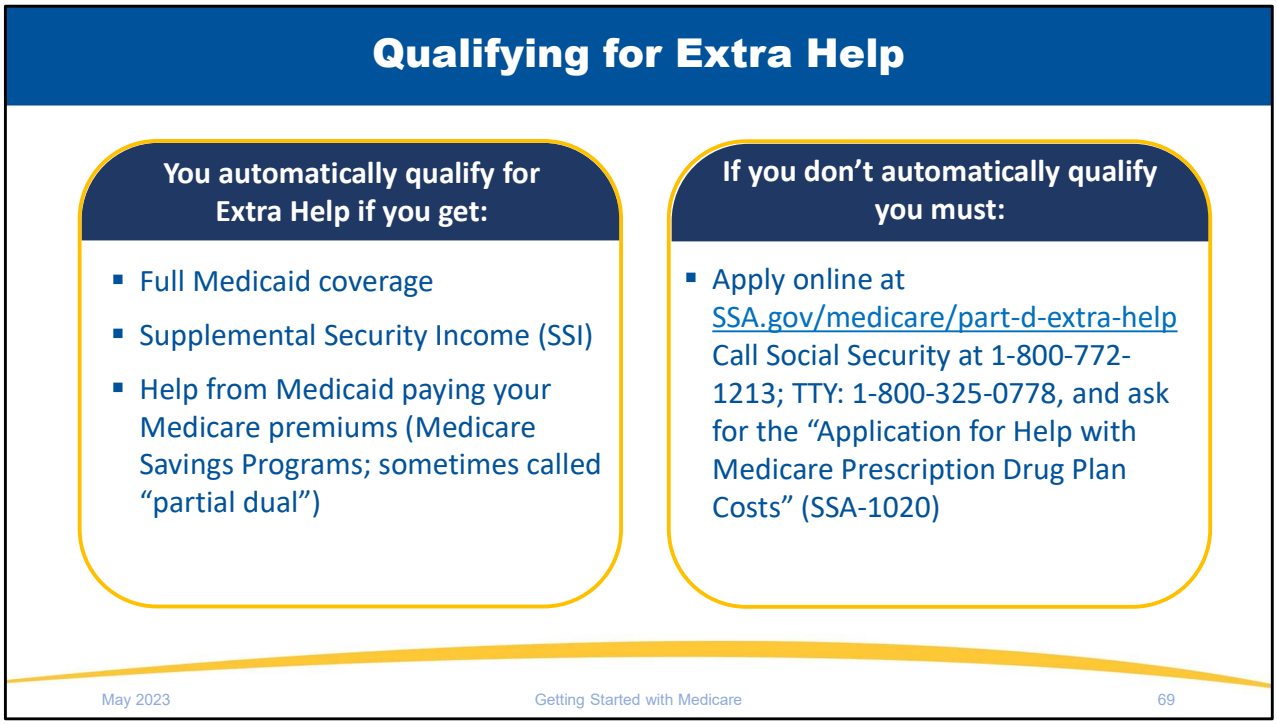
Presenter Notes

Extra Help is a Medicare Program that helps people with limited income and resources pay Medicare drug program costs, like premiums, deductibles, and coinsurance.

- **If you have the lowest level of income and resources,** you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out of pocket.
- **If you qualify for Extra Help,** you won't have a coverage gap or Part D late-enrollment penalty.
- **You can change plans once per calendar quarter in the first 3 quarters of the year.** If you want to change plans in the 4th quarter, you would use the Open Enrollment Period (OEP). To change plans, you just need to join a new plan. That will automatically disenroll you from your old plan.

NOTE: Residents of the U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.

For low-income subsidy information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources.



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You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage (sometimes called "full dual"), Supplemental Security Income (SSI) benefits, or help from Medicaid paying your Medicare Part B (Hospital Insurance) premiums (Medicare Savings Programs; sometimes called "partial dual").

If you don't meet one of these conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your State Medical Assistance (Medicaid) office.

You can apply for Extra Help by:

- Applying online at SSA.gov/medicare/part-d-extra-help Completing a paper application you can get by calling Social Security at 1-800-772-1213; TTY: 1-800-325-0778
- Applying through your Medicaid office
- Working with a local organization, like a State Health Insurance Assistance Program (SHIP)

You can apply yourself, or someone with the authority (like with Power of Attorney) to act on your behalf can file your application, or you can ask someone else to help you apply.

If you apply for Extra Help, Social Security will transmit the data from your application to your State Medicaid office to initiate an application for a Medicare Savings Programs. As mentioned earlier, Medicare Savings Programs can help pay your Medicare premiums.

How Are Medicare & Medicaid Different?

Medicare	Medicaid
National program that's consistent across the country	Statewide programs that vary among states
Administered by the federal government	Administered by state governments within broad federal rules (federal/state partnership)
Health insurance for people 65 and older, people under 65 with certain disabilities, or any age with End-Stage Renal Disease (ESRD)	Health insurance for people based on need—financial and non-financial requirements
Nation's primary payer of inpatient hospital services to the disabled, elderly, and people with ESRD	Nation's primary public payer of acute health care, mental health, and long-term care services

Presenter Notes

Medicare and Medicaid are different in the following ways:

- Medicare is a national program that's consistent across the country. Medicaid consists of statewide programs that vary among states.
- Medicare is administered by the federal government. Medicaid is administered by state governments within broad federal rules (federal/state partnership).
- Medicare is insurance for people 65 and older, people under 65 with certain disabilities, or any age with End-Stage Renal Disease (ESRD). Medicaid is health insurance for people based on need-financial and non-financial requirements.
- Medicare is the nation's primary payer of inpatient hospital services to the disabled, elderly, and people with ESRD. Medicaid is the nation's primary public payer of acute health, mental health, and long-term care services.

Thank you for attending this session with CMS Dallas

- We appreciate your time you have spent with us. We are always trying to improve our level of service to our partners and stakeholders. You can help us do that by providing your feedback on today's session.
- Please take a few moments to complete this brief, voluntary post-engagement evaluation. Just click on the link or use the QR code below. Your answers will help us improve our collaboration with you.
- *Please identify the Name of the CMS Activity you are referring to in your answers by entering:

R6 CMS Dallas – Getting Started with Medicare

https://cmsgov.force.com/act/Evaluation

- Thank you!

- Please use the link or QR code to complete an evaluation survey. You're opinion is very valuable to us.

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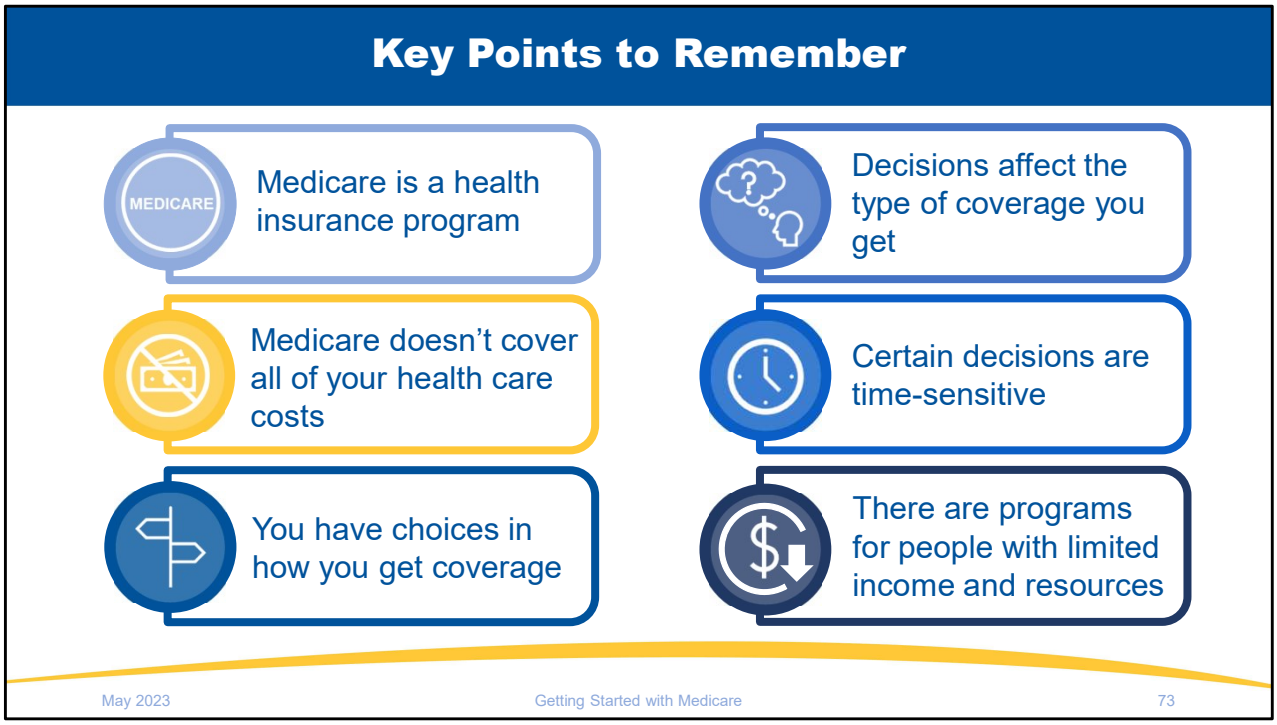
There are a variety of resources available to help you learn more and answer any questions, including:

- Medicare website – Medicare.gov. You can also call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.
- Medicaid website – Medicaid.gov.
- Social Security website – SSA.gov You can also call your local Social Security office.
- Health Insurance Marketplace® website – HealthCare.gov.
- Children's Health Insurance Program website – InsureKidsNow.gov.
- CMS National Training Program website – CMSnationaltrainingprogram.cms.gov.
- SHIPs—you can contact your local SHIP office at – shiphelp.org.



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Presenter Notes

Here are some key points to remember:

- Medicare is a health insurance program.
- It doesn't cover all of your health care costs.
- You have choices in how you get your coverage.
- You have decisions to make. It's important to know when you need to take action. Your decisions affect the type of coverage you get.
- Certain decisions are time-sensitive.
- There are programs for people with limited income and resources.

Acronyms (AB–IR)

ABN Advanced Beneficiary Notice
ADL Activities of Daily Living
ALS Amyotrophic Lateral Sclerosis
ANOC Annual Notice of Change
CHAMPVA Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP Children's Health Insurance Program
CMS Centers for Medicare & Medicaid Services
COBRA Consolidated Omnibus Budget Reconciliation Act
DME Durable Medical Equipment
EOC Evidence of Coverage
ESRD End-Stage Renal Disease
FEHB Federal Employees Health Benefits
FICA Federal Insurance Contributions Act
FMAP Federal Medical Assistance Percentage
FPL Federal Poverty Level
GEP General Enrollment Period
GHP Group Health Plan
HMO Health Maintenance Organization
HSA Health Savings Account
IADL Instrumental Activities of Daily Living
ICEP Initial Coverage Election Period
IEP Initial Enrollment Period
IRMAA Income-Related Monthly Adjustment Amount
IRS Internal Revenue Service

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Acronyms (LI–RN)

LIS Low-income Subsidy
MAC Medicare Administrative Contractor
MA OEP Medicare Advantage Open Enrollment Period
MA-PD Medicare Advantage Plan with Drug Coverage
MACRA Medicare Access and CHIP Reauthorization Act
MAGI Modified Adjusted Gross Income
MEC Minimal Essential Coverage
MSA Medical Savings Account
NTP National Training Program
OEP Open Enrollment Period
OPM Office of Personnel Management
OTC Over the Counter
PACE Programs of All-Inclusive Care for the Elderly
PBP Plan Benefit Package
PDP Prescription Drug Plan
PFFS Private Fee-for-Service
POS Point of Service
PPO Preferred Provider Organization
QDWI Qualifying Disabled & Working Individuals
QHP Qualified Health Plan
QI Qualified Individual
QMB Qualified Medicare Beneficiary
RNHCI Religious Nonmedical Health Care Institutions

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Acronyms (RR–VA)

RRB Railroad Retirement Board

SEP Special Enrollment Period

SHIP State Health Insurance Assistance Program

SHOP Small Business Health Options Program

SLMB Specified Low-income Medicare Beneficiary

SNF Skilled Nursing Facility

SPAP State Pharmaceutical Assistance Programs

SSBCI Special Benefits for the Chronically Ill

SSDI Social Security Disability Insurance

SSI Supplemental Security Income

TFL TRICARE For Life

TTY Teletypewriter/Text Telephone

VA U.S. Department of Veterans Affairs

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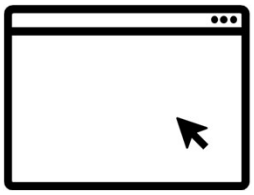
Stay Connected



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