



A, B, C, Ds of Medicare

What you need to know for 2022

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Introduction to Medicare

Medicare is a federal government program that provides healthcare insurance if you are 65+, under 65 and receiving Social Security Disability Insurance (SSDI), or under 65 and with end-stage renal disease (ESRD). The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs Medicare.

Medicare provides an excellent foundation for healthcare coverage, but it is unlikely to meet all of your medical needs. It is important that you understand how Medicare operates and what choices you have.



Original Medicare is the traditional fee-for-service healthcare coverage provided through Medicare Part A (inpatient hospital coverage) and Medicare Part B (outpatient medical coverage). Original Medicare is administered by CMS.



Medicare Part C or Medicare Advantage plans are offered by a private insurer that contracts with CMS. Medicare Advantage plans must provide all of the benefits of Original Medicare (Parts A and B) and some Medicare Advantage plans provide additional benefits.



Medicare Part D is insurance that covers most outpatient prescription drugs and is offered by private insurers that contract with CMS.

The purpose of this booklet is to help you understand what the different parts of Medicare do and do not cover, and what your share of Medicare costs may be.

Medicare eligibility and enrollment

If you have been paying into Medicare through FICA payroll taxes during your working years and are age 65, you are probably eligible for Medicare.

Medicare's enrollment guidelines:

- If you are applying for or are already receiving Social Security benefits, you will be automatically enrolled in Part A and Part B at age 65.
- If you plan to keep working and you have health coverage through your employer, it may be advantageous to delay Medicare, particularly Medicare Part B. You should discuss this with your benefits manager.
- If you're under 65 and disabled for 24 months, you'll automatically get Part A and Part B after you get disability benefits from Social Security.
- You may also be eligible if your spouse/deceased spouse has/had Medicare.
- You are also eligible if you have end-stage renal disease (ESRD).

LEARN MORE ABOUT MEDICARE

Call or go online to obtain
additional resources.

Call 800-MEDICARE (**800-633-4227**) or visit
medicare.gov, where you can download the Medicare
publication, *Medicare and You*.

Medicare Part A | Hospital

Inpatient care in a hospital and skilled nursing facility, hospice care, home healthcare and some other benefits

There is no monthly premium for enrollment in Medicare Part A if you have made sufficient FICA contributions during your working years. You should receive information from Medicare about Part A enrollment several months before your 65th birthday. The chart below illustrates the major types of coverages and benefit period or lifetime limits for Medicare Part A for 2021.

Part A coverage	You pay ¹
Hospital deductible	\$1,556
Hospitalization	Days 1-60: ¹ \$0 coinsurance Days 61-90: ¹ \$389 coinsurance per day Days 91-150: ¹ \$778 coinsurance per each lifetime reserve day after day 90 for each benefit period. Up to 60 days over your lifetime. After lifetime reserve days are exhausted, you pay 100%.
Skilled nursing	Days 1-20: ¹ \$0 Days 21-100: ¹ \$194.50 per day Beyond 100 days: ¹ You pay 100%.
Home healthcare	\$0 for medically necessary care 20% of approved amount for durable medical equipment
Hospice care	\$0 if you meet certain requirements. You pay up to a \$5 copay for prescription drugs for pain management. You pay 5% for inpatient respite care.
Mental health	Days 1-90 lifetime: Same cost sharing as inpatient hospitalization Days 91 and beyond: You pay \$778 per each lifetime reserve day. There's no limit to the number of benefit periods you can have when you get mental healthcare in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital. Remember, there's a lifetime limit of 190 days.

Medicare Part B | Medical

Physician visits, diagnostic testing and durable medical equipment (Part B also covers many preventive services.)

You should enroll when you are first eligible or you will pay a penalty of 10% for each full 12-month period that you were eligible but did not enroll. You do not pay this penalty if you do not sign up for Part B because you are covered under an employer's active group plan or enrolled under a spouse/partner's health plan. Just be sure to sign up shortly after that coverage ends.

Your monthly premium for Medicare Part B is deducted from your monthly Social Security. Premiums are based on your annual taxable income on a phased-in basis. If your modified adjusted gross income is above a certain amount, you may pay an income-related monthly adjustment amount (IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from two years ago.

Part B coverage	You pay ¹
Medicare Part B premium	\$170.10
Medicare Part B deductible	\$233 per benefit period ¹
Physician charges	20%
Clinical laboratory services and diagnostic tests	0% for Medicare-approved services, 20% for covered diagnostic tests and x-rays
Preventive care	Generally you pay nothing if you get your preventive care from a provider that accepts Medicare assignment (mammograms, pap tests, pelvic exams, prostate cancer screenings, other screenings for those at high risk). Not all preventive services are covered every year. Check with Medicare for the coverage provisions for the appropriate service or screening.
Durable medical equipment	20%
Outpatient therapy	20% (may be limits and exceptions)
Home health services	0% for Medicare-approved services
Outpatient hospital services	Coinsurance varies by service

Medicare Part C | Medicare Advantage plans

Also called "Part C" or "MA plans," your Medicare Parts A and B are assigned to a private insurer who provides you with healthcare coverage.

Medicare Advantage plans are sold by private insurance companies. When you buy a Medicare Advantage plan, you must also be enrolled in Medicare Part A and Part B. You continue to pay your Medicare Part B premium in addition to the premium for the Medicare Advantage plan.

With Medicare Advantage plans, CMS pays the health insurer a subsidy to assume all of the benefit coverages defined by Original Medicare (Parts A and B). Medicare Advantage plans must cover all Medicare-approved services. Sometimes the plans offer additional benefits, including preventive services that go beyond Medicare's eligible services.

Medicare Advantage plans may be structured in various ways, with copayment or coinsurance (%) and annual out-of-pocket limits. The amount that Medicare Advantage plans pay for Medicare-eligible expenses may be different from what Original Medicare would pay, but generally speaking, the Medicare Advantage plan must pay at least what Medicare would have paid. In turn, CMS pays the health insurer to provide Medicare Parts A and B coverages. CMS subsidies vary significantly from one geographic area to another.

Some Medicare Advantage plans provide prescription drug coverage and/or certain levels of vision and hearing coverage, but many do not provide these coverages at all. It's important to review plan options carefully.

One type of Medicare Advantage plan is Preferred Provider Organization (PPO) plan.

The PPO plan will provide all of your Medicare Part A (Hospital) and Part B (Medical) coverage. In all types of Medicare Advantage plans, you're always covered for emergency and urgent care.

Medicare Part C | Medicare Advantage plans

Medicare Advantage plans are not supplemental coverage plans; a Medicare Advantage plan becomes your primary insurance. How Medicare Advantage plans work:



**Visit your doctor. Use one ID card (from private health insurer).
Make a copayment or pay coinsurance.**



Your doctor submits a claim to your private insurance provider.



**Your private health insurer makes all remaining payments
according to the Medicare Advantage plan benefits.**

What are the other types of Medicare Advantage plans?

- **Health Maintenance Organization (HMO) plans:** You generally must get your services from doctors, other healthcare providers or hospitals in the plan's network.
- **HMO Point-of-Service (HMOPOS) plans:** These plans may allow you to get some services out-of-network for a higher copayment or coinsurance.
- **Private Fee-for-Service (PFFS) plans:** The private insurer, not Medicare, determines how much it will pay the healthcare provider and how much you pay for a covered health service.
- **Special Needs plans (SNPs):** These plans provide benefits and services to people with specific diseases, certain healthcare needs or limited incomes.

Medicare Part D | Prescription Drug plans

The Medicare Part D prescription drug benefit is designed to help Medicare-eligible retirees manage the increasing costs of prescription drugs.

Medicare Part D prescription drug coverage is provided by Medicare-approved private insurance companies. Medicare drug coverage is available to everyone enrolled in Medicare. You pay an annual premium for the plan. You may also pay a separate Medicare Part D premium directly to Medicare if you are in a higher income bracket.

Enrolling in Part D coverage

It is important to consider enrolling in a Part D drug plan when you are first eligible. A late enrollment penalty will be added to your Part D premium if you don't enroll during your initial enrollment period or if you don't have other creditable prescription drug coverage that pays, on average, at least as much as Medicare's standard prescription benefit. This would permanently increase your premiums by 1% of the "national base beneficiary premium" for each month you did not enroll or did not have creditable coverage. You do not pay the late enrollment penalty if you are eligible for the low-income subsidy program.

You can enroll in only one Part D drug plan at a time. Each year, during the Medicare open enrollment period in the Fall, you can switch to a different private insurer or plan, with coverage becoming effective January 1.

NOTE: Some Medicare Advantage plans bundle prescription drug coverage with the plan.

Income adjustment

Beneficiaries with income above \$85,000 (individual) or \$170,000 (couple) pay an income-related monthly adjustment amount (IRMAA) in addition to the Part D plan premium. Usually, the extra amount will be deducted from your Social Security check.

Medicare Part D | Prescription Drug plans

All Medicare Part D plans are based on the Medicare Part D benefit each year. In order to better understand how Part D drug plans work, it's helpful to review Medicare's Part D foundational design (see diagram below), which reflects the minimum amount of prescription drug coverage that Medicare allows.

2022 Medicare Part D design (non-low-income subsidy eligibles)

Phase 1	Phase 2	Phase 3	Phase 4
Annual deductible	Initial coverage limit	Coverage gap*	Catastrophic coverage
<p>You pay the first \$480 as a deductible.</p> <p>You stay in this phase until you have paid your yearly deductible amount.</p>	<p>You pay part of the cost of your drugs, based on the benefit features of your Rx plan.</p> <p>Your plan pays the rest of the cost until the combined amount (plus deductible) reaches \$4,130.</p>	<p>After your total yearly drug cost reaches \$4,130: You pay 25% of the plan's cost for brand and generic drugs.</p>	<p>After your total covered out-of-pocket costs reach \$6,550: You pay \$3.70 for generic drugs and \$9.20 for brand drugs or 5% of the total cost (whichever is greater).</p>

*The Medicare Coverage Gap Discount Program, available through the Affordable Care Act (ACA), will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving "extra help." A 70% discount on the negotiated price of preferred and non-preferred brand drugs (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount.

Understanding formularies

One of the most important Medicare Part D drug plan provisions is the type of formulary in the plan. A formulary is a listing of covered drugs under the plan. It outlines what tier a drug would be covered under to help you determine your cost share for a specific drug. All Medicare Part D drug plans must comply with CMS requirements. CMS requires that the formulary provides access to an acceptable range of Part D drug choices, and that it includes drug categories and classes that cover all disease states.

Open formularies

An open formulary means that all Part D drugs are available for coverage, although the plan may be designed with lower-member cost sharing for generic and preferred brand drugs.

Closed (or standard) formularies

This type of formulary is a subset of Medicare Part D drugs and requires you to use only those medications that are designated as covered under the private insurer's preferred drug list. If your brand drug is not covered on the closed formulary, you can speak to your doctor about switching to a drug that is on the preferred drug list or your doctor may request a medical exception from the private insurer for the drug to be covered. If you decide to continue taking medications not covered on the closed formulary without obtaining a medical exception, you will pay the full cost and these expenses will not count toward the plan's deductible or out-of-pocket limits.

Part D drug plans may have these coverage rules for certain drugs:

- **Prior authorization:** You and/or your prescriber must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it.
- **Quantity limits:** Limits on how much medication you can get at a time.
- **Step therapy:** In most cases, you must try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.
- **Prescription safety checks at the pharmacy (including opioid pain medications):** Before your prescriptions are filled, your Medicare drug plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages. These safety checks also include checking for possible unsafe amounts of opioids, limiting the days supply of a first prescription for opioids and use of opioids at the same time as benzodiazepines.

Medicare supplement insurance | Medigap plans

Medicare supplement insurance policies sold by private insurers can help cover the "gap" of healthcare costs not covered by Original Medicare.

Medigap insurance policies are standardized.

Medigap plans are sold by private insurance companies to fill the “gaps” in Original Medicare. When you buy a Medigap plan, you must also be enrolled in Medicare Part A and Part B. You continue to pay your Medicare Part B premium in addition to the premium for the Medigap plan.

Every Medigap plan must follow federal and state laws designed to protect you and they must be clearly identified as “Medicare supplement insurance.” Insurance companies can sell you only a “standardized” policy identified in most states by letters A through D, F, G and K through N. All plans offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs.

Starting January 1, 2020, Medigap plans sold to people who are new to Medicare won’t be allowed to cover the Part B deductible. Because of this, **Plans C and F won’t be available to people who are newly eligible for Medicare on or after January 1, 2020.**

New Medigap policies cannot offer prescription drug coverage; you will need to find a separate Part D drug plan if you want prescription drug coverage.

One thing to keep in mind is that once you select a Medigap plan, it could become difficult to switch to a different plan as your needs change each year. Medigap plans require medical underwriting in some states and you may be deemed uninsurable or be required to pay a higher premium by the insurance provider. And if your insurer leaves your local market, you may become part of a closed group with potentially much higher premiums.

Medigap plans are supplemental coverage plans; Medicare is your primary insurance.

The Medigap plan is the secondary insurance.

Medicare may not be enough

Original Medicare (Parts A and B) is a comprehensive framework for health security in retirement but it doesn't cover everything, nor was it ever intended to do so. It's important to understand that there are many health expenses that Medicare doesn't cover completely and where it provides no benefit at all.



Some expenses that Medicare does not cover:

- **Most dental care and dentures**
- **Eye exams (for prescription glasses)**
- **Cosmetic surgery**
- **Massage therapy**
- **Routine physical exams**
- **Hearing aids and exams for fitting them**
- **Long-term care**



¹A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60-day period, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.

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