41ST EDITION

2024 Medicare

What you need to know about Medicare in simple, practical terms.

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Introduction

Are You Missing Out?

Medicare, the nation's largest health insurance program, is the primary health insurance for the vast majority of people age 65 and over and for many disabled people. Today's Medicare has new health plan choices and is more complicated than it was only a few years ago.

This booklet explains what you need to know about Medicare in simple, practical terms. It includes a description of today's Medicare health plan choices: Original Medicare and Medicare Advantage. This booklet also outlines:

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What Is Medicare?

Medicare is a federal health insurance program for people age 65 and over and for many disabled people. Medicare is sometimes confused with Medicaid (page 31), which is a joint federal-state medical assistance program for people with low income and limited assets.

If you are a Medicare beneficiary, you can receive healthcare services under the Original Medicare Plan (pages 5-21), or you can choose to join a Medicare Advantage (MA) plan (pages 26-28) if one is available in your area.

Medicare has four parts.

Part A (Hospital Insurance) pays some of the costs of hospitalization, limited skilled nursing home care, and hospice care.

Part B (Medical Insurance) primarily covers doctors' fees, most hospital outpatient services, and certain related services. Both Parts A and B cover many home health services. Medicare does not currently cover long-term nursing home care.

Part C, Medicare Advantage (MA) plans, include Health Maintenance Organization plans (page 27), Preferred Provider Organization plans (page 28), Private Fee-for-Service plans (page 28), and Special Needs plans (page 28).

Part D (Outpatient Prescription Drug Plans) is voluntary prescription drug coverage (page 29).

Some of the payroll taxes that you pay while working finance the Part A program. The tax rate paid on all earnings is typically 1.45%. Your employer pays a matching tax. The self-employed pay 2.90%. Some government employees who are not covered by Social Security pay the Medicare tax and receive credits toward Part A coverage. Part A is premium-free for nearly all Medicare beneficiaries.

An additional Medicare payroll tax of 0.9% applies to high-income employees when annual earnings exceed $200,000 ($250,000 for married filing jointly and $125,000 for married filing separately). The employer does not pay this additional tax. Examples: If a single employee earns $220,000, the employer would withhold an additional 0.9% on $20,000. For a two-earner married couple that earns $125,000 and $200,000, no additional Medicare FICA tax would be withheld from their wages, but they would have to pay the additional 0.9% Medicare tax when filing Form 1040 for 2024.

A portion of Part B and Part D is financed by monthly premiums from enrollees (pages 11 and 29), and the rest comes from general federal revenues.

The Original Medicare Plan

When you enroll in Medicare, you are automatically in the Original Medicare Plan unless you choose to join a Medicare Advantage plan (page 26). Original Medicare is a fee-for-service plan offered by the federal government. It is available anywhere in the U.S. Under Original Medicare, you can go to any doctor or hospital that accepts Medicare patients. **Original Medicare generally does not cover prescription drug costs**. You may want to buy a Medicare stand-alone prescription drug plan to help with drug costs (page 29).

Many Medicare beneficiaries in the Original Plan have supplemental coverage from an employer- or union-sponsored retiree plan or from one of the standard Medigap Plans (pages 22-25) to help pay deductibles and coinsurance and to fill in the gaps in coverage.

Part A (Hospital Insurance) Eligibility and Enrollment

You are eligible for **premium-free** Medicare Part A Hospital Insurance if you are age 65 or over and are eligible for any type of monthly Social Security benefit. It is available on the first day of the month that you attain age 65, and your enrollment is automatic if you are already receiving a Social Security or Railroad Retirement benefit. Your Medicare card will be mailed to you about three months before your 65th birthday. You establish your entitlement with the Social Security Administration. Your eligibility can be retroactive for up to six months.

IMPORTANT

The full retirement age for Social Security is gradually rising to age 67, but the Medicare eligibility age is not scheduled to increase, so you will still need to apply for Medicare three months before your 65th birthday.

If your **spouse, widow(er), or divorced spouse** does not qualify for Medicare based on his or her own work history, he or she can qualify for premium-free Part A at age 65 based on your work record. You must be at least age 62 and eligible for monthly Social Security benefits (even if you are still working and haven't applied yet) or receiving Social Security disability benefits.

You and your spouse may be eligible for Medicare based on your government employment on which you paid the Medicare payroll tax.

Entitlement to "totalization benefits" (Social Security and/or foreign pension system benefits payable based on recognizing work credits earned by working in the U.S. and one or more countries under international agreements) does not establish entitlement to Medicare benefits.

If you are **disabled**, you may be eligible for Medicare before age 65. You must be entitled to disability benefits from the Social Security program (not Supplemental Security Income "SSI") for two years as a worker, widow(er), or adult child. Enrollment in such cases is automatic. The two-year waiting period is waived for people with amyotrophic lateral sclerosis (Lou Gehrig's Disease).

If you are **disabled and return to work**, you can continue to have premium-free Part A for at least 93 months after completion of the disability trial work period. After that, you can purchase it in the same way as uninsured people age 65 or over (see below).

If you are under age 65 and have **end-stage renal disease** (kidney failure) and require dialysis or a transplant, you are eligible for Medicare if you are a worker insured by Social Security or Railroad Retirement or the spouse or dependent child of an insured worker. The social service staff at the hospital or dialysis center where you receive treatment will usually assist you in applying for Medicare.

If you are at least age 65 but not eligible for premium-free Part A under the regular rules, you may purchase Part A coverage by paying substantial premiums. You must be a U.S. resident and either a U.S. citizen or a lawfully admitted permanent resident living in the U.S. continuously for the preceding five years. You can also enroll in Part B and pay that premium (page 11), or you may choose to enroll only in Part B. In 2024, the standard Part A monthly premium for people who are not eligible for premium-free Part A is **$505**. It is reduced to **$278** for uninsured people and their spouses with at least 30 Social Security credits.

Part A Benefits

In addition to the basic benefits for inpatient hospital care, **Part A** provides limited benefits for skilled nursing facility care, home health services (also covered under Part B), and hospice care. In most cases, you pay part of the costs of covered services. The amounts you and/or your supplemental insurance pay change each year depending on national increases in hospital costs. The following information is based on 2024 amounts which increase each year.

Hospital Benefits. When you are first admitted as an inpatient to a hospital in a benefit period, you will have to pay an initial deductible of **$1,632** for a visit lasting up to 60 days. For the 61st through the 90th day of your hospital stay, you will have to pay **$408** per day in coinsurance. After the 90th day, you can choose to pay **$816** per day for as many as 60 non-renewable lifetime reserve days (or else pay the full charges yourself). A benefit period ends 60 days after your discharge from the hospital or skilled nursing facility. If another hospital admission occurs after those 60 days expire, a new benefit period begins with that admission, and you will have to pay another Part A deductible, as well as the other coinsurance amounts. Devices such as pacemakers and artificial limbs that are permanently installed while in the hospital are covered without further cost sharing.

Skilled Nursing Facility (SNF) Benefits. You may qualify for limited benefits at an SNF if both the facility and your diagnosis and treatment plan meet Medicare's strict standards. Daily skilled nursing or rehabilitation services must be medically required and available to you. Solely custodial care is not covered. SNF benefits are available only if the SNF follows your hospital stay of at least three days and begins within 30 days after discharge from the hospital.

If you qualify for SNF benefits, you pay nothing for the first 20 days except for any charges that Medicare does not allow. For the next 80 days, you pay charges up to **$204** per day, and Medicare pays all remaining allowable charges. No benefits are available after 100 days of care in a "benefit period."

Home Health Services Benefits. Home health services, such as part-time or intermittent skilled nursing care, physical therapy, medical social services, medical supplies, and some rehabilitation equipment may be paid for in full by Medicare when you are confined at home, as long as the services are prescribed by a doctor. Even if you only have Part A or Part B, all covered services will be paid by Medicare if provided by a participating home health agency but with 20% coinsurance for equipment.

Hospice Benefits. A hospice is an organization that furnishes a coordinated program of inpatient, outpatient, and home care for terminally ill patients. Emphasis is on pain-reduction control and counseling, not curative treatment. To qualify for hospice benefits, your doctor must certify that you are terminally ill and probably have less than six months to live. You can receive a one-time hospice counseling session for pain and symptom management if you have not yet elected the hospice benefit. Because hospice benefits will cover some services and medical expenses not usually covered by Medicare, when you choose hospice benefits, nearly all other Medicare benefits stop. Physician services and treatment of conditions not related to the terminal illness are still covered.

You pay up to **$5** for each outpatient prescription drug for symptom management and pain relief.

Inpatient respite care is up to five consecutive days of care in a Medicare-approved facility to allow your usual caregiver to rest. You pay 5% of the Medicare-approved amount for the inpatient respite care.

Psychiatric Hospitals. Part A will pay for up to a lifetime limit of 190 days of inpatient psychiatric care. Restrictions apply to people who are already hospitalized for psychiatric care when they first become covered by Medicare (a 150-day maximum applies).

Blood. If the provider has to buy blood for you, you must pay the cost of the first three pints of blood furnished in a year or have it donated by you or someone else.

Part A Hospital Payments

To avoid excessive hospital stays, Medicare pays fixed amounts to hospitals for inpatient care, according to diagnosis, called diagnosis related groups (DRGs). However, doctors still decide when you are ready to be discharged.

Part B (Medical Insurance) Eligibility

When you enroll in Part A of Medicare, you automatically enroll in Part B unless you decline it. Even if you are not eligible for premium-free Part A, you can almost always enroll in Part B at age 65. Most people living in the U.S. who are eligible for Part B will want to enroll when first eligible **unless** they have primary coverage based on current employment under an employer- or union-sponsored plan.

Part B Enrollment Periods

People attaining age 65 are often uncertain when they should enroll in Part B. There are three enrollment periods: the **Initial Enrollment Period**, **Special Enrollment Period**, and **General Enrollment Period**.

Initial Enrollment Period (IEP). Your IEP is a seven-month period that starts on the first day of the third month before the month you attain age 65 and ends on the last day of the third month after the month you attain age 65. If you are entitled to Social Security benefits in the month before your IEP, you are **automatically enrolled** (except residents of Puerto Rico and foreign residents) in the first month of the IEP with Medicare coverage effective the first day of the month you attain age 65.

You will get an advance notice explaining this and your right to decline it. If you are not automatically enrolled in Part B and wish to enroll during your IEP, you apply with the Social Security Administration.

As outlined in the table below, if you reach age 65 and wait until that month or later to apply, your Part B coverage will begin the following month. Part A, however, can be retroactive for up to six months.

IEP Eligibility (Age 65)	Month of Enrollment	Date Part B Coverage Begins
April	January – March	April 1
April	April	May 1
April	May	June 1
April	June	July 1
April	July	August 1

Normally, if you are retired and do not have group health plan coverage based on your own or your spouse's current employment, you will want to accept the automatic enrollment, even if you have supplemental coverage under a retiree plan, since Medicare is the primary payer. Part B enrollment is also necessary to join a Medicare Advantage plan (page 26) or to enroll in a Medigap plan (page 22).

Special Enrollment Period (SEP). If you are eligible for Medicare at age 65 and have group health plan coverage based on your or your spouse's current employment (with an employer of 20 or more employees), you will normally not want to enroll in Part B until the employer plan coverage based on current employment ends. The first reason is the employer-sponsored group health plan is the primary payer. You may receive little, if any, additional coverage from Part B. **Small employers** (with fewer than 20 employees) may qualify for an **exception** if they participate in a multiple employer Group Health Plan (GHP) and would apply with the Benefits Coordination & Recovery Center (BCRC). A second reason is the **six-month open enrollment period** for the standard Medigap (Medicare supplement) plans begins with the first month that you are 65 or older and enrolled in Part B. If you enroll in Part B more than six months before you enroll in a Medigap plan, you might not be able to get the Medigap coverage you want.

You can enroll in Part B during an **SEP** at any time while still covered under the group plan based on current employment or up to eight months after your employment or coverage ends (whichever happens first). If you enroll during the first month of the eight-month period, your coverage can be effective the first day of that month. If you enroll in one of the remaining seven months, your coverage starts the first day of the month following the month you enroll.

There is no premium increase if you enroll during the SEP and had employer-sponsored coverage based on current employment continuously since age 65. If the SEP overlaps with the IEP (page 9), your enrollment will be processed under the rules of the IEP. For example, if you enroll in the last month of your IEP and that is also the first month of the SEP, your coverage does not begin until the first day of the month following the month you enroll.

Starting in 2023, new SEPs will be available to cover exceptional circumstances, such as missing an enrollment period due to a natural disaster or other emergency, health plan or employer error, incarceration, termination of Medicaid coverage, or other exceptional circumstances on a case-by-case basis.

There is a one-time enrollment right for disabled military retirees. Certain TRICARE beneficiaries (and spouses, surviving spouses, and dependent

children) have a 12-month period after the end of the IEP to enroll in Part B which applies only once during their lifetime.

General Enrollment Period (GEP). The GEP is available if you did not enroll during your IEP, an SEP, or if you dropped Part B and wish to re-enroll. The GEP is from January 1 through March 31 every year. If you enroll in the GEP, your coverage starts the first day of the month following the month you enroll. **There is a permanent 10% premium increase for each full 12 months that you could have been, but were not, enrolled in Part B**. Months in which you were age 65 or over and covered by an employer health plan based on your or your spouse's current employment are not counted in calculating the increase.

What Do You Pay for Part B (Medical Insurance)?

The **standard Part B monthly premium is $174.70** in 2024 for current, new, and high-income Medicare beneficiaries and for people whose Medicare premiums are paid by Medicaid. The income-related premium (see the table below) applies to roughly 8% of the current Part B enrollees and is based on your 2022 federal income tax return filing status and adjusted gross income.

The high-income thresholds are indexed for inflation. If your income has gone down, you will need to contact Social Security and submit form SSA-44 with documentation verifying the income.

Annual Income for Most Unmarried Filing Individually	Annual Income for Married Filing Jointly	2024 Monthly Part B Premium
$0 to $103,000	$0 to $206,000	$174.70
$103,001 to $129,000	$206,001 to $258,000	$244.60
$129,001 to $161,000	$258,001 to $322,000	$349.40
$161,001 to $193,000	$322,001 to $386,000	$454.20
$193,001 to $499,999	$386,001 to $749,999	$559.00
$500,000 or more	$750,000 or more	$594.00

The premium is deducted from your monthly Social Security benefit; otherwise, the government bills you quarterly in advance. If you enroll late, or if you drop out and enroll again, you may have to pay a higher premium (page 10). However, in most cases, there is no premium surcharge when late enrollment occurs during a special enrollment period (page 10).

Part B Benefits

In 2024, you or your supplemental insurance pay an **annual deductible** which is the first **$240** of charges allowable by Medicare for covered medical services provided to you in a calendar year. This deductible may change each year. After that, you or your other insurance will generally pay **20% coinsurance** for covered expenses (which may not exceed the charges allowed by Medicare) plus any additional amount that the physician or other Part B covered service provider is allowed to charge (pages 17-19). There are special provisions for hospital outpatient services (pages 15-16).

Other covered items and services include:

- acupuncture up to 12 visits in 90 days for defined chronic low-back pain with a maximum of 20 visits in a 12-month period
- ambulance services when necessary
- artificial body replacements for parts of the body (may be covered by Part A)
- bariatric surgery for certain conditions related to morbid obesity
- behavioral health integration services

- blood for transfusions after the first three pints per year
- braces for arm, leg, back, or neck
- cardiac and pulmonary rehabilitation programs
- chiropractic services (limited), for manipulation of the spine to correct a subluxation
- chronic care, principal care, and transitional care management
- chronic pain management and treatment services
- clinical laboratory services
- cognitive assessment and care plan services
- coronavirus disease 2019 (COVID-19) vaccines, tests, and treatments
- diagnostic tests such as X-ray, MRI, CT scans, and EKG/ECGs
- many doctor services and supplies
- durable medical equipment rental (and sometimes purchase) for use in the home, including oxygen tanks, hospital beds, and wheelchairs; beneficiaries may need to get certain equipment or supplies from specified suppliers
- home health services (page 7)
- home infusion therapy services and supplies
- kidney dialysis and kidney disease education services
- lymphedema compression treatment items
- medical supplies, such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies
- opioid use disorder treatment services, including medication counseling, drug testing, therapy, intake, and periodic assessment
- certain oral drugs for cancer, immunosuppressive drugs used after organ transplant, and certain injectable drugs
- outpatient mental healthcare, including marriage & family therapists, mental health counselors, and intensive outpatient program services
- certain prosthetic and orthotic devices
- routine costs in approved clinical trials
- second surgical opinions (in some cases)
- speech, physical, and occupational therapy
- telehealth (limited) for select services from an eligible provider and for specific locations depending on the health issue
- therapeutic shoes for people with diabetes (in some cases)

- transplants – heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions)
- non-routine vision services by a qualified optometrist if they would be covered when performed by a physician

Preventive Services

Part B covers some preventive services at no cost to you if your doctor accepts assignment, but you may have to pay coinsurance and the Part B deductible for the office visit. Covered preventive services include:

- **abdominal aortic aneurysm screening** one screening for people at risk with a doctor's referral
- **alcohol misuse screening and counseling** one screening and up to four counseling sessions each year
- **bone mass measurements** once every 24 months (more often if medically necessary) for people at high risk for losing bone mass
- **cardiovascular disease screening** blood tests once every 5 years and an annual risk reduction visit with your primary care physician
- **colorectal cancer screening tests** for people age 45 and over with no minimum age limit for colonoscopy (frequency varies); 15% coinsurance applies if a polyp or tissue is removed
- **depression screening** once a year
- **diabetes prevention program** with weekly core sessions over 6 months and 6 monthly follow-up sessions
- **diabetes screening tests** twice a year for people at risk
- **diabetes self–management training** to help manage diabetes (Part B coinsurance and deductible applies)
- **glaucoma screening** once a year for high-risk patients including people with diabetes or a family history of glaucoma (Part B coinsurance and deductible applies)
- **Hepatitis B virus screening** once a year for high-risk patients and at certain times during pregnancy
- **Hepatitis C screening** one screening for people with certain conditions and yearly screenings for people at high risk
- **HIV screening** once a year if at risk or up to 3 times if pregnant
- **lung cancer screening** once a year for people with certain conditions

- **mammogram screening** one baseline between ages 35-39, once every 12 months at age 40 and over, and diagnostic mammography when medically necessary (Part B coinsurance and deductible applies)
- **medical nutritional therapy services** for patients with diabetes or renal disease
- **obesity screening and counseling** for people with a body mass index (BMI) of 30 or more
- **pap smears and pelvic examination** the frequency varies
- **physical exam** within 12 months of the day you enroll in Part B (one-time initial preventive physical exam with education and screening referrals); thereafter, a yearly wellness exam to recommend preventive services and screenings; Part B coinsurance and deductible may apply for additional tests or services
- **prostate cancer screening** once a year for men age 50 and over (Part B coinsurance and deductible applies to certain services)
- **sexually transmitted infections screening and counseling** once a year for high-risk people or at certain times during pregnancy
- **tobacco use cessation counseling** for up to 8 visits every 12 months
- **vaccinations** for flu, pneumonia, Hepatitis B (if you are at medium to high risk), and coronavirus

Outpatient Services

Medicare has a complex Outpatient Prospective Payment System to determine what Medicare pays hospitals, outpatient clinics, and community mental health centers for many of the services and items received by Medicare beneficiaries. This payment system **applies only** to the Original Medicare Plan. It does not apply to Medicare Advantage plans.

Medicare decides how much the outpatient provider will be paid for each set of services you receive. The Medicare payment rates vary from one geographic area to another. They are based upon Ambulatory Payment Classifications (APCs) that take into account differences in wage levels and the types of services provided.

Medicare determines set payment amounts for each service the hospital provides. Each payment amount is subject to your $240 annual Part B deductible (if not already met). Your coinsurance or copayment amounts are also set by Medicare for **each** service and cannot be more than the Part A inpatient deductible (**$1,632** in 2024). If you have supplemental coverage from an employer or union plan, or a Medigap plan, it may cover some or all of these amounts.

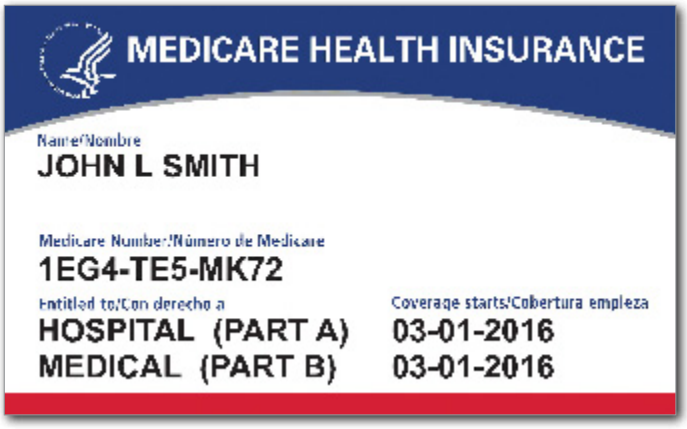
Medicare **will not pay** for some outpatient procedures and surgeries, so you will have to pay the full charge for the service. You should ask your doctor or the hospital if Medicare will pay for the outpatient procedure. If the procedure is not covered, ask if you can be admitted as an inpatient and have the procedure covered under Part A.

Medicare pays for some outpatient services under separate Medicare payment systems. These include:

- ambulance services
- clinical diagnostic laboratory services
- dialysis for permanent kidney failure (end-stage renal disease)
- orthotics, non-implantable prosthetics, or durable medical equipment
- outpatient hospital services at "critical access hospitals" (small facilities in rural areas with limited services to people)
- outpatient services you get in any hospital in the **State of Maryland** (hospitals are paid under Maryland's all-payer hospital payment system)
- physical therapy, speech-language therapy, or occupational therapy services

Original Medicare Plan Card

You will receive a Medicare Health Insurance Card with your name, Medicare number, and the effective dates of your coverage for Parts A and B. If you are in the Original Medicare Plan, you will need to present your Medicare card when you receive medical services. If you are in a Medicare Advantage plan or a Medicare Part D prescription drug plan, the plan will give you a membership card.



How Claims Are Paid

Claims are processed by fiscal intermediaries and carriers – look at your Medicare Summary Notice or Explanation of Medicare Benefits for the contact name and address. These are insurance companies or other organizations under contract to the government.

Doctors and suppliers of covered medical services may submit charges directly to the Medicare carrier by accepting **assignment**. Doctors and suppliers who always accept assignment (**participating providers**) accept Medicare's reimbursement, plus any applicable deductible or coinsurance, as payment in full. Your doctor will be paid the portion covered by Medicare and will bill you for any part of your $240 annual deductible not already met and the 20% coinsurance payment. A few states either require all physicians to accept assignment or prohibit "non-participating" physicians (who do not always accept assignment) and other healthcare providers from balance billing Medicare patients more than the Medicare-allowed charge. You can call your State Health Insurance Assistance Program (page 32) to find out if special rules apply in your state.

Non-participating physicians may choose to accept assignment on a case-by-case basis. Whether the doctor accepts assignment or not, the doctor still sends the claim to the Medicare carrier for you. If the doctor does not accept assignment, you pay the doctor's bill directly at the time of your visit or treatment, and Medicare will reimburse you for the amount of the bill it covers. Because Medicare's benefit payment to you will be based on the

allowable charge, not the doctor's billed charges, you may have to pay the doctor an amount that exceeds what Medicare allows. However, by law, a non-participating doctor may charge a Medicare patient no more than 15% above the Medicare allowable charge for most services and supplies.

Some doctors do not participate in Medicare at all (except for emergency or urgent care). They are called private contract doctors. If you enter into a private contract arrangement with such a doctor, Medicare will not pay the doctor or you for the services you receive, and there is no limit to what the doctor may charge. Medigap plans (pages 22-25) and many other insurance plans will not pay for these services either.

Example of How Medicare Pays for Physician Visits

Mr. Allen, age 72, has acute arthritis and visits his physician, Dr. Williams, every two months for his condition and for review of the effect of the drugs he is taking. Dr. Williams is a **participating physician (always takes assignment)** and sends the bills to the Medicare carrier that processes Part B claims. Dr. Williams usually charges $250 for office visits plus varying amounts for outside laboratory tests.

Medicare approves only $190 for each office visit. Dr. Williams must accept this amount as full payment. The Medicare carrier applies this to Mr. Allen's annual Part B deductible of $240.

After Mr. Allen's second visit in the year, the carrier sends Mr. Allen a statement showing his allowable Part B charges for the year total $380, so that the $240 deductible is met ($190 from the first visit and $50 from the second visit). The carrier sends Dr. Williams a check for $112, which is 80% of $140 ($380 minus $240). For the second visit, Mr. Allen pays $78 ($50 for the Part B deductible and $28 for the 20% coinsurance on $140). For subsequent visits, Medicare pays Dr.Williams $152 (80% of $190), and Mr. Allen pays him the remaining $38.

Participating Physician Visit	Allowable Charge	Medicare Pays	You Pay
1st	$190	$0	$190.00
2nd	$190	$112.00	$78.00
3rd	$190	$152.00	$38.00

The laboratory bills Medicare directly. Mr. Allen receives a notice of the payments made for the services. Medicare pays the allowed amount of the laboratory test bills. This amount is not necessarily what the laboratory would charge a non-Medicare patient but is a rate set by Medicare.

For **non-participating physicians**, Medicare's allowable charges are 5% lower than for participating physicians. If Dr. Williams does not take assignment, the Medicare allowable charge for each visit would be $180.50 (95% of $190). Even though his usual charge is $250, Dr. Williams cannot bill Mr. Allen more than $207.58 (115% of $180.50) for the visit. He would, as required by law, send the bills to the Medicare carrier and bill Mr. Allen what Medicare will allow – $207.58 for each visit. After the first two visits in 2024, the carrier would notify Mr. Allen that the $240 deductible was met because the total allowable charges would be $361. The carrier would send Mr. Allen a check for $96.80 (80% of: $361 minus the $240 deductible). For each future visit, Mr. Allen would pay Dr. Williams $207.58, and Medicare would pay Mr. Allen $144.40 (80% of $180.50).

Non-Participating Physician Visit	115% of Allowable Charge You Pay Doctor	Medicare Pays You	Your Net Cost
1st	$207.58	$0	$207.58
2nd	$207.58	$96.80	$110.78
3rd	$207.58	$144.40	$63.18

If Dr. Williams performs the laboratory tests in his office instead of sending them to an independent laboratory, how Medicare pays for the tests depends on whether Dr. Williams takes assignment for lab tests, regardless of whether he takes assignments for his other services. If Dr. Williams takes assignment for the tests, he submits the bill to the Medicare carrier and is paid a flat fee for the type of test from a Medicare fee schedule. Dr. Williams accepts this as full payment, and Mr. Allen pays nothing. However, if Dr. Williams does not take assignment for such tests, Medicare would not pay anything, and Mr. Allen would have to pay the usual charge.

Medicare as Secondary Payer

If you are age 65 or older and are working for an employer with **20 or more employees**, then you are entitled to the same health benefits your employer offers to younger employees. If you have such health insurance benefits, are working, and are entitled to Medicare, then Medicare is the secondary payer, and it pays only those medical charges not covered by your employer-provided

group health plan. These rules also apply to your Medicare covered spouse age 65 or older if your spouse has coverage under your employer's health plan based on your current employment, regardless of your age.

You can begin your coverage under Part B when your group coverage based on current employment ends. You get an eight-month **special enrollment period** beginning the month after employer-sponsored coverage or current employment status ends, whichever happens first (page 10).

Medicare Secondary Payer rules also apply to disabled Medicare beneficiaries who are under age 65 and are covered by an employer-provided health insurance plan as a currently working employee or as a family member of an employee. However, in this case it applies only if the plan is for an employer with **100 or more employees**.

In those cases where the "employer size" condition is not met, Medicare is the primary payer, and the employer plan is the secondary payer.

If you enroll in Medicare because of **end-stage renal disease (ESRD)** and have group health plan coverage for any reason from an employer of any size, then Medicare is the secondary payer for the first 30 months that you qualify for Medicare because of ESRD, and Medicare is primary thereafter.

Under any of these circumstances, you may choose not to participate in Part B and thus not pay premiums. Or you may choose not to participate in the employer-provided plan and have Medicare coverage only. However, if you decline your employer-provided health plan while you are still working, the employer cannot offer insurance to supplement Medicare but can only provide coverage for services not covered by Medicare.

Medicare is also the secondary payer if medical costs can be paid under any liability policy, such as auto insurance.

What the Original Medicare Plan Does Not Cover

Medicare does not cover all healthcare expenses. A telephone call to the carrier that handles your Medicare claim is the best way to get answers to your questions about specific cases. Some of the items and services **not covered** include:

- most prescription drugs and medicines taken at home (see the Outpatient Drug Plan on page 29, and the limited exceptions on page 13)
- long-term nursing home care
- eye exams and glasses (except one pair after cataract surgery with an intraocular lens)
- hearing aids and exams for fitting them
- dentures and most dental care
- routine foot care and orthopedic shoes, except for diabetics (page 14)
- services or items not reasonable or medically necessary
- services or items that are provided for free
- services or items paid for by a government program or workers' compensation
- services performed by a relative or household member
- services outside the U.S. (except for qualified Canadian and Mexican facilities if nearest to your home in the U.S. or for emergency care while traveling to or from Alaska)
- most chiropractic services (see exception on page 13)
- custodial care
- cosmetic surgery (except after an accident)
- most shots (vaccinations) except those listed on page 15
- first three pints of blood for transfusions (each year)
- meals delivered to your home
- private nurses
- extra charges for a private room (unless medically necessary), telephone, television, and other personal comfort items
- homemaker services (except under hospice provisions)
- services covered by liability or auto insurance

Medigap

Medigap (Medicare Supplement Insurance)

Many Medicare beneficiaries have supplemental retiree coverage from an employer or union. Often, this is sufficient to meet most expenses that are not covered by Medicare. Military retirees and their spouses may be covered by **TRICARE** and do not need additional Medicare supplemental coverage. Many others who are in the Original Medicare Plan purchase a **Medigap** policy (Medicare Supplement Insurance) from private insurance companies, membership organizations, or fraternal orders. Medigap pays for some of the expenses that are not covered by Original Medicare including deductibles and coinsurance.

Medigap policies are regulated by state insurance authorities within guidelines set by the federal government. In most states, there are several standard Medigap plans offering different levels of supplemental coverage (special provisions apply to Medigap plans offered in **Massachusetts**, **Minnesota**, and **Wisconsin**). The premiums for a particular Medigap plan can vary by company and by state.

Within the standard plans, there is another option called **Medicare SELECT** which is a preferred provider arrangement. This type of Medigap policy has lower premiums because the Medicare beneficiary agrees to use the services of particular healthcare providers.

You have a **six-month open-enrollment period** to buy your Medigap policy. It begins with the first month that you are age 65 or over and **also** enrolled in Part B. During this open-enrollment period, you cannot be denied a Medigap policy or charged a higher premium because of your current or past health problems. If you do not enroll during this period, you may not be able to get the policy that you want at a later date, or you may be charged a higher premium. All Medigap plans are guaranteed renewable; once you purchase a policy and continue to pay premiums, your insurer may not drop you regardless of any new health conditions you may develop.

In limited situations, you may buy certain Medigap policies after your open-enrollment period. This exception may apply if you lose your supplemental health coverage (through no fault of your own) under a Medicare managed care plan, Medigap policy (offered by another insurer), or employer retiree coverage. The exception generally applies to enrollment in six types of Medigap policies (A, B, D, G, K, and L) and only if you timely exercise your right.

Starting January 1, 2020, Medigap plans will no longer be allowed to cover the Part B deductible and new Plans C and F will no longer be sold. If you already have Plan C or F (or the high deductible version of Plan F) before January 1, 2020, you will be able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

The benefits included in **Medigap** plans (including Medicare SELECT) follow. A checkmark indicates the Medigap policy covers 100% of the benefit or the percentage is listed.

Medigap Plans[1]

	A	B	D	G	K[2]	L[2]	M	N
Part A coinsurance and hospital costs of 365 extra days during your lifetime after Medicare coverage ends	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	**50%**	**75%**	✓	✓[3]
Blood (first 3 pints)	✓	✓	✓	✓	**50%**	**75%**	✓	✓
Hospice Care coinsurance or copayment	✓	✓	✓	✓	**50%**	**75%**	✓	✓
Skilled Nursing Facility coinsurance			✓	✓	**50%**	**75%**	✓	✓
Part A Deductible		✓	✓	✓	**50%**	**75%**	**50%**	✓
Part B: Excess over Allowable Charge				✓				
Foreign Travel Emergency			**80%**	**80%**			**80%**	**80%**

[1] Plans E, H, I, and J have **not** been sold since May 2010 (but can be renewed). Plans C and F have **not** been sold since January 2020 (but can be renewed).

[2] Plans K and L have out-of-pocket limits (page 25).

[3] Plan N pays 100% of the Part B coinsurance except for copayments up to $20 for office visits and up to $50 for emergency room visits that do not result in an inpatient admission.

Note: The chart does not apply if you live in **Massachusetts**, **Minnesota**, or **Wisconsin**. These states require different plans to be offered with somewhat different benefits.

Medigap plans sold after 2005 do not include prescription drug coverage. If you have prescription drug coverage under Medigap plans H, I, or J that you bought before 2006, you can continue that coverage. Because most Medigap drug benefits are not as good as the standard Medicare drug plan, you will likely pay a higher premium if you later enroll in a Medicare drug plan. The higher premium will apply if you do not enroll when you are first eligible and have no other drug coverage besides that in your Medigap plan.

Medigap plans K and L require you to pay a percentage of the cost-sharing amount of some covered services up to an annual out-of-pocket maximum indicated in the following table. These plans have lower premiums but higher cost-sharing amounts than the other standard Medigap plans. Once you meet the annual limit, the plan pays 100% of the Medicare Part A and B copayments and coinsurance for the rest of the calendar year.

Plan	You Pay	2024 Annual Out-of-pocket Maximum
K	50%	$7,060
L	25%	$3,530

See page 32 on how to get information about the Medigap plans available in your state.

Medicare Advantage (MA)

Part C (Medicare Advantage)

Many Medicare beneficiaries receive healthcare services from a Medicare Advantage (MA) plan rather than the Original Medicare Plan. MA plans include **Health Maintenance Organization plans**, **Preferred Provider Organization plans**, **Private Fee-for-Service plans**, and **Special Needs Plans**. Two less common MA plans include **Medical Savings Accounts** and **HMO Point-of-Service Plans**. When you enroll in Medicare, you are automatically in Original Medicare unless you join an MA plan.

If you join an MA plan, you are still in Medicare and have coverage for all of the medical services covered by Parts A and B. Some MA plans provide coverage for additional items or services such as extra covered days in the hospital or foreign travel. They may charge an additional monthly premium for these extra services. MA plans are available in many areas of the country. The features and costs of plans vary depending on where you live.

MA plans **cannot** charge you more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care. MA plans have an annual cap on how much you pay for Part A and Part B services. This annual maximum out-of-pocket amount can be different between MA plans.

Starting in 2020, MA plans may offer more telehealth benefits than Original Medicare. These benefits will be available no matter where you are located, and you can use them at home instead of going to a healthcare facility. Check with your plan to see what telehealth benefits are offered.

Part C Enrollment

To join an MA plan, you must be enrolled in Medicare Parts A and B, continue to pay the Part B premium, and live in the plan's service area. Special rules apply if you have end-stage renal disease (ESRD or kidney failure).

You can only join or leave an MA plan at certain times. You can generally join during your Part B initial enrollment period (page 9) or during the annual election period from October 15 through December 7 with coverage beginning on the next January 1. If you have ESRD, you can enroll during the annual election period. Some MA plans, however, limit the number of members. You typically must stay in your plan for the year.

Between January 1 and March 31, you can drop your MA plan and switch to Original Medicare. You will have until March 31 to join a Part D prescription drug plan. If your MA plan drops out of the Medicare program, you automatically return to Original Medicare unless you join another MA plan. In these situations, you may have the right to buy a Medigap policy.

Starting on December 8, 2023, you can switch mid-year to a 5-star MA plan but are limited to one such change each year. Plans with 5-star ratings are identified on the **www.medicare.gov** website or by calling **1-800-MEDICARE** (**1-800-633-4227**).

In most MA plans, you must get your prescription drug coverage from that plan if it is offered. An exception is a Private Fee-for-Service (PFFS) plan (page 28) – you can enroll in the PFFS plan and a separate Part D prescription drug plan.

Part C Membership Card

When you join an MA plan, you use the membership card from the insurance company for your healthcare. You will show your card to your healthcare provider at the time of service. In MA plans that include Medicare prescription drug coverage (Part D), your membership card is also used to fill your prescriptions.

Health Maintenance Organization (HMO) Plans

An HMO is a Medicare-approved network of doctors, hospitals, and other healthcare providers that agrees to provide healthcare to Medicare patients in return for a set monthly payment from Medicare. In an HMO, you are limited to using the plan's doctors and hospitals, except for medical emergencies or for urgently needed care when you are out of the plan's service area and can't wait until you return home. Generally, you need a referral from your primary care physician to see a specialist. Some HMOs offer a Point-of-Service option. This may cost more, but it allows you to go to other doctors and hospitals that are not in the plan's network.

An HMO can reduce your out-of-pocket expenses for deductibles and copayments, and it may offer unlimited coverage of some benefits that have limits under Original Medicare. Specific costs to beneficiaries vary from plan to plan.

Preferred Provider Organization (PPO) Plans

Regional PPO plans serve an entire region which may be a single state or a multi-state area – bringing more plan options to people with Medicare. Enrollees in PPOs have a single deductible and a limit on their annual out-of-pocket costs, which vary depending on the plan. PPOs use many of the same rules as HMOs, except you don't need a referral to see a specialist or a provider outside of the plan's network. However, you will likely pay more for such care.

Private Fee-for-Service (PFFS) Plans

PFFS plans are offered by private insurance companies in some areas. Medicare pays the insurance company a set amount of money every month for each Medicare beneficiary covered by the plan.

Some PFFS plans cover prescription drugs; if not, you can join a Part D drug plan. You can go to any Medicare-approved doctor or hospital that accepts the plan's payment. Providers decide case by case whether they will treat you under the PFFS plan's terms – even if you were seen by them before. You will need to check before each service to confirm the provider will accept the plan's payment. The insurance company rather than Medicare decides how much it pays and how much you pay for services.

Special Needs Plan (SNP)

SNPs provide coverage to special needs individuals. You may enroll in an SNP if you are: 1) institutionalized; 2) eligible for Medicare and Medicaid; and/or 3) have a specific chronic or disabling condition. SNPs generally require you to use an approved network of doctors and hospitals. You receive all your Medicare Part A and Part B coverage and Part D prescription drug coverage from the plan.

Medicare Prescription Drug Plan

Part D (Outpatient Prescription Drug Plan)

Medicare helps pay for insurance coverage for outpatient prescription drugs under the voluntary Medicare Part D program (and through some Medicare Advantage plans). Insurance companies and other private businesses are approved by Medicare to sell this coverage.

Part D Enrollment

Your initial enrollment period (IEP) is the same as your IEP for Part B (page 9). Enrollment is voluntary, but you must have Medicare Part A or B to be eligible. You must enroll in a Medicare drug plan within three months after becoming eligible for Medicare or you may pay a penalty. If you are already enrolled in a Medicare prescription drug plan and want to stay in that plan during the new year, you do not need to do anything. If you want to change plans or enroll late, you can do this during the annual election period from October 15 to December 7 with coverage effective January 1 of the new year. Starting on December 8, 2023, you can switch mid-year to a 5-star drug plan but are limited to one such change each year. Plans with 5-star ratings are identified on the **www.medicare.gov** website or by calling **1-800-MEDICARE** (**1-800-633-4227**).

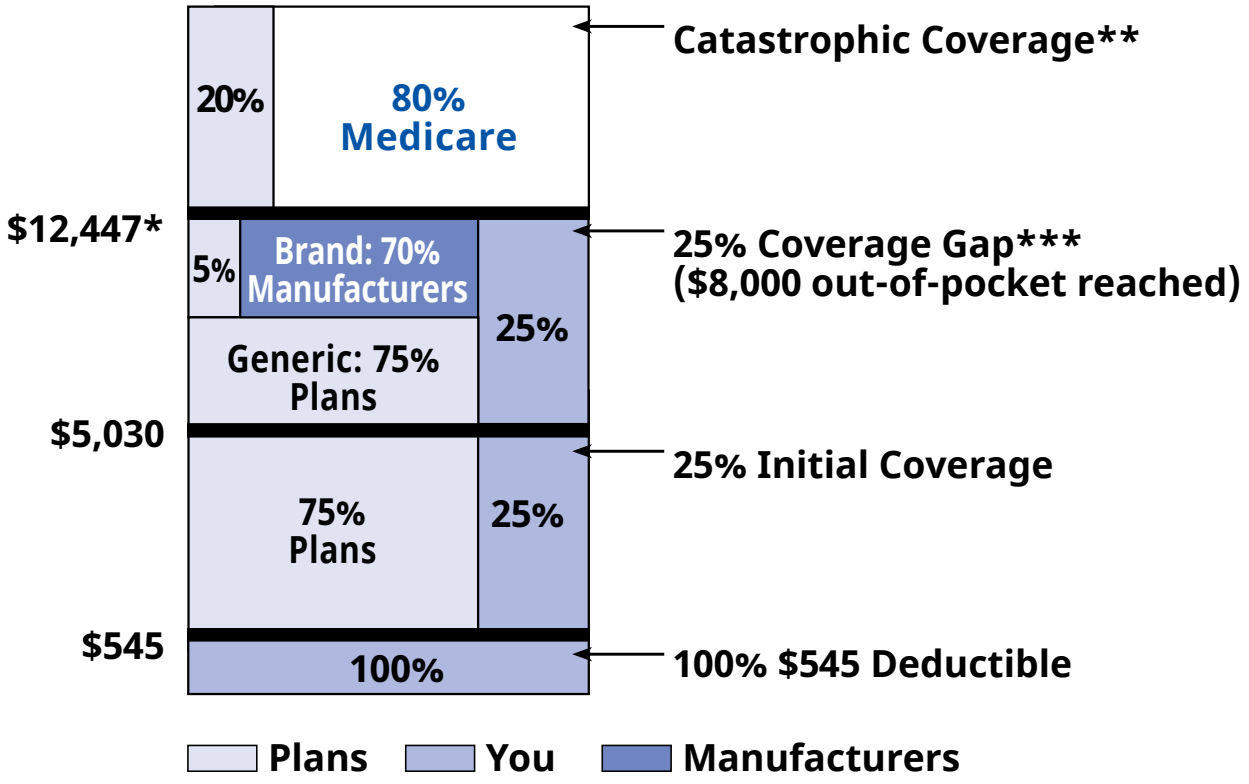
You may have to pay a higher premium if you enroll late. You will not pay the higher premium if you have other creditable drug coverage (as good as the standard Medicare drug plan) without a 63-day break in coverage until the time of your late enrollment. For each month that you did not have other creditable coverage and could have been enrolled in a Medicare drug plan but did not enroll, 1% of the "national base beneficiary premium" ($34.70 in 2024) will be added to your monthly premium. Other drug coverage can include employer- or union-sponsored health plans, but they need to inform you that this coverage meets or exceeds Medicare's standards.

What Do You Pay for Part D?

Medicare prescription drug coverage varies depending on your plan. Most beneficiaries who enroll in Part D at their earliest opportunity pay about a $34.50 monthly premium that varies by plan. In 2024, you may pay a $545 annual deductible before reaching your initial coverage, then you may pay up to 25% of your drug costs and your plan pays 75%. Once you and your plan have spent a combined $5,030 including the deductible, you reach the coverage gap. In the coverage gap, you will pay up to 25% of prescription

drug costs for both brand and generic drugs. Your plan pays 75% of the cost of generic drugs and 5% for brand, and manufacturers pay 70% of the cost of brand drugs. After your out-of-pocket spending (including the 70% of brand drugs paid by the manufacturers) exceeds $8,000 (total spending exceeds $12,447), your plan pays 20%, and Medicare pays 80%.The following chart illustrates these costs. Low-income beneficiaries may be eligible for reduced cost sharing and more generous coverage by Medicare, including paying no more than $11.20 for brand or $4.50 for generic drugs. Starting in 2024, Extra Help under the Low-Income Subsidy Program eligibility has been expanded. For drugs that are not covered by your plan, you pay 100%.

There is an online tool available at **www.medicare.gov** for you to compare the drug plans available in your area. You need your Medicare card information, your preferred pharmacies, and your medications list including the dosages. You can also call **1-800-MEDICARE** (**1-800-633-4227**) for assistance.



*$12,447 is the estimated total covered drug costs to reach catastrophic coverage (your out of pocket costs exceed $8,000)

**Additional changes to total out-of-pocket spending will be implemented in 2025

***Brand: Plans pay 5% Manufacturers pay 70%; Generic: Plans pay 75%

Note: These amounts do not include the monthly premium for your plan.

High-income beneficiaries are charged an adjustment to their Part D premium. The usual monthly plan premium is paid to the Part D plan; the adjustment amount (see the following table) is deducted from the beneficiaries' Social Security benefit or paid directly to Medicare. The income-related premium is based on your 2022 federal income tax return filing status and adjusted gross income. The high-income thresholds are indexed for inflation. If your income has gone down, you will need to contact Social Security and submit Form SSA-44 with documentation verifying the reduction in income.

Annual Income for Most Unmarried Filing Individually	Annual Income for Married Filing Jointly	2024 Monthly Premium Adjustment
$0 to $103,000	$0 to $206,000	$0
$103,001 to $129,000	$206,001 to $258,000	$12.40
$129,001 to $161,000	$258,001 to $322,000	$33.30
$161,001 to $193,000	$322,001 to $386,000	$53.80
$193,001 to $499,999	$386,001 to $749,999	$74.20
$500,000 or more	$750,000 or more	$81.00

Pharmaceutical manufacturers must give Part D plans discounts on covered drugs for beneficiaries in the coverage gap, and may have to pay rebates if drug prices rise faster than inflation. Medicare has started to negotiate directly with manufacturers for lower drug prices. The negotiated prices for the first 10 drugs will go into effect in 2026. Starting January 2023, all Part D plans must limit cost sharing for insulin to $35 per month and must eliminate cost sharing for adult vaccines covered under Part D (such as shingles, whooping cough, Hepatitis A). Deductibles won't apply for insulin products or the adult vaccines covered under Part D. Similar caps on costs apply for insulin used in insulin pumps covered under Part B.

Part D Membership Card

After you enroll in a Medicare Part D drug plan, you will be sent a prescription card to show at your pharmacy. You will have to go to pharmacies that belong to your plan. If you don't, you may have to pay the entire cost of the drug. When you use the card, you will pay the copayment, coinsurance, and/or deductible that is required by your plan. You can contact Medicare if you have limited income to find out if you qualify for assistance in paying for the prescription drug plan.

Helpful Contacts

Social Security Administration (SSA)

Phone: **1-800-772-1213**

TTY: **1-800-325-0778** (for the hearing and speech impaired)

Website: **www.socialsecurity.gov**

You can contact SSA for questions about enrolling in Medicare, replacing a lost Medicare card, and general questions about Medicare or Social Security.

Centers for Medicare & Medicaid Services (CMS)

Phone: **1-800-MEDICARE** (**1-800-633-4227**)

TTY: **1-877-486-2048** (for the hearing and speech impaired)

Website: **www.medicare.gov**

This website includes comparative information on the Medicare Prescription Drug Plans, Medicare health plan choices, hospitals, physicians, home health agencies, nursing homes, and dialysis facilities available in your area. It also provides information on Medigap plans available in your state.

State Health Insurance Assistance Program (SHIP)

Call for help with buying a Medigap policy or long-term care insurance, for help choosing a Medicare health plan, and many other Medicare questions. The telephone numbers are located at **www.medicare.gov/contacts**.

Medicaid

Medicaid is a joint federal and state medical assistance program for individuals and families with low incomes and resources. Medicaid was created in 1965, the same year as Medicare, but it is a separate program. Each state runs its Medicaid program under federal guidelines. For more information on Medicaid, visit **www.medicaid.gov** or look in the blue pages of your telephone book for the Medicaid office in your state. If you need assistance, you can also call the SSA at **1-800-772-1213**.