What are the parts of Medicare?

Part A (Hospital Insurance)

Helps cover:

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

Part B (Medical Insurance)

Helps cover:

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

Part D (Drug coverage)

Helps cover the cost of Prescription drugs (including many recommended shots or vaccines).

Plans that offer Medicare drug coverage (Part D) are run by Private insurance companies that follow rules set by Medicare.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

How do I compare Medigap plans?

The chart below shows basic information about the different benefits that Medicare Supplement Insurance (Medigap) plans cover for 2023. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

Benefits	Medigap plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	100%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-procket limit in 2023..			
							$6.940	$3.470		

- Plans F and G also offer a high-deductible plan in some states. With this option, you to the ay for Medicare-covered costs (coinsurance, copayments and deductibles) upfo the deductible amount of $2,700 in 2023 before your Policy pays anything. (You Cant buy Plans C and F if you were new to Medicare on or aftor January 1, 2020. See previous page for more information.)
- Bor Flans K and L. after you meet your out-of-pocket yearly limit and your yearly {mt 8 deductible ($226 in 2023), the Medigap plan pays lon tr covered services for the rest of the calendar year.
- Plan N pays 100% of the Part B coinsurance. You must Pay a copayment of up to $20 for some office visits and up to a $50 copayment fay emergency room visits that don't Fesult in an inpatient admission.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

What's an "Advance Beneficiary Notice of Non-coverage" (ABN)?

If you have Original Medicare, your doctor, other health care provider, or Supplier may give you a written notice if they think Medicare won't pay for the items or services you'll get. This notice is called an "Advance BeneficioryNotice of Non-coverage," or ABN. The ABN lists the items or services that your doctor or health care provider expects Medicare will not pay for, along with an estimate of the costs for the items and services and the reasons why Medicare may not pay.

What happens if I get an ABN?

- You'll be asked to choose whether to get the items or services listed on the notice.
- If you choose to get the items or services listed on the notice, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the notice to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you a notice for services that Medicare never covers. See page 55.
- An ABN isn't an official denial of coverage by Medicare. If Medicare denies payment, you can still file an appeal once you get the "Medicare Summary Notice" (MSN) showing the item or service in question. However, you'll have to pay for the items or services if Medicare decides that the items or services aren't covered (and no other insurer is responsible for payment).

Can I get an ABN for other reasons?

- You may get a "Skilled Nursing Facility ABN" when the facility believes Medicare will no longer cover your stay or other items and services.
- You may get an ABN if you're getting an off-the-shelf back or knee brace that's included in the DMEPOS Competitive Bidding Program and the supplier isn't a contract supplier. Visit the "Competitive areas & items" page at **Medicare.gov** for more information.

What if I didn't get an ABN?

If your provider was required to give you this notice but didn't, in most Cases, your provider must give you a refund for what you paid for the item or service.

Where can I get more information about ABNs?

Visit **Medicare.gov/basics/your-medicare-rights/your-protections** to learn more about the different types of ABNs and what to do if you get one

Note: If you're in a **Medicare Advantage Plan,** you have the right to ask the plan in advance if it covers a certain service, drug, or supply. Contact your plan to request and submit a pre-service organization determination. The plan's response will include instructions to file a timely appeal, if you want one. You also may get plan directed care. This is when a plan provider refers you for a service or to a provider outside the network without getting an organization determination in advance. See page 65.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

What if I need help paying for my Medicare health care costs?

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

1. **Qualified Medicare Beneficiary (QMB) Program:** If you're eligible, the QMB Program helps pay for Part A and/or Part B **premiums.** In addition, Medicare providers aren't allowed to bill you for services and items Medicare covers, including **deductibles, coinsurance, and copayments.** If you get a bill for these charges, tell your provider or the debt collector that you're in the QMB Program and can't be charged for Medicare deductibles, coinsurance, and copayments. If you've already made payments on a bill for services and items Medicare covers, you have the right to a refund. If you're in a **Medicare Advantage Plan,** you should also contact the plan to ask them to stop the charges. In some cases, you may be billed a small copayment through **Medicaid,** if one applies.

   Note: To make sure your provider knows you're in the QMB Program, show both your Medicare and Medicaid or QMB card each time you get care. If you have Original Medicare, you can also give your provider a copy of your "Medicare Summary Notice" (MSN). Your MSN will show you're in the QMB Program and shouldn't be billed. Log into (or create) your secure Medicare account at **Medicare.gov** to sign up to get your MSNs electronically. If your provider won't stop billing you, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. We can also confirm that you're in the QMB Program.
2. **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums only.
3. **Qualifying Individual (QI) Program:** Helps pay Part B premiums only. Applications are granted on a first come, first-served basis.
4. **Qualified Disabled and Working Individuals (QDW1) Program:** Helps pay Part A premiums only. You may qualify for this program if you have a disability, you're working, and you lost your Social Security disability benefits and premium-free Part A because you returned to work.

If you sign up for the immunosuppressive drug benefit (see page 53) and have limited income and resources, you may qualify for help paying the costs through a QMB, SLMB, or QI Program. Contact your state to apply. If you qualify for a QMB, SLMB, or QI Program, you automatically Qualify to get **Extra Help** paying for Medicare drug coverage (Part D). see pages 91-93.

Important! The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico or the U.S. Virgin Islands.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

Key Benefit Terms[1,2]

Out-of-Pocket (OOP) Costs
Costs a patient has to pay that are not covered by the patient's insurance plan.

Premium
A fixed amount that a patient has to pay to participate in a plan; usually a monthly payment.

Cost Sharing
Patient contributions to the cost of care (insurance contributes, but typically does not pay for all of it).

Deductible
A preset, fixed amount that the patient is required to pay before insurance starts to pay.

Coinsurance
An amount (usually a percentage) that a patient pays as the patient's share of the cost. Typically this is paid after the patient's deductible.

OOP Maximum
A maximum amount that a patient pays out-of-pocket their share of the cost.

Co-pay
A preset fixed amount that a patient pays for a service (ie, office visit) or prescription drug (ie, biologic injection). Once a co-pay is paid, an insurer typically covers the balance of the covered expenses.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

GO 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. See page 55.	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.

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 medical 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.

This handbook explains these topics in more detail:

- **Original Medicare:** See Section 3 (starting on page 7)
- **Medicare Advantage:** See Section 4 (starting on page 61).
- **Medicare Supplement Insurance (Medigap):** See Section 5 (starting on page 75).
- **Medicare drug coverage (Part D):** See Section 6 (starting on page 79).

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf

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 heed to geta referral to use a specialist.

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 joina 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.

CMS Document. From Medicare & You 2023 Handbook. Accessed February 8, 2023
https://www.Medicare.gov/pubs/pdf/10050-Medicare-and-you.pdf