Medicare Primer

Prepared for:
Valued Client

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Medicare Parts A and B

Consider What Medicare Does and Does Not Cover

Medicare is a health insurance program operated by the federal government. Benefits are available to qualifying individuals age 65 or older, certain disabled individuals under age 65, and those suffering from end-stage renal disease. The traditional Medicare program consists of two main parts: Part A, Hospital Insurance and Part B, Medical Insurance. There are clearly defined limits as to what original Medicare will, and will not, pay.

Medicare (Part A) 2025 Hospital Insurance
Covered Services per Benefit Period

Service	Benefit	Medicare Pays	You Pay
Hospitalization: Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic X-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	Medicare pays all covered costs for first 60 days, except the first $1,676. For the 61st through 90th days, it pays all except $419 a day. There are also 60 nonrenewable reserve days that can be used when the 90 days are past. Medicare pays all except the first $838 for each reserve day.		
Post-hospital skilled nursing facility care (in a facility approved by Medicare): You must have been in a hospital for at least three days in a row and enter the facility within 30 days after having been discharged from the hospital.	**First 20 days.**	All costs.	Nothing.
	Next 80 days.	All but $204.00	$209.50 per day
	Medicare and private insurance will not pay for most nursing home care, and you pay for custodial long-term care.		
Home health care: Post-institutional care. You must have been in a hospital for at least three days in a row or have been in a skilled nursing facility following a hospital stay.	Pays the cost of 100 home visits, if made under a physician's treatment plan.	Full cost.	Nothing for services; 20% of approved amount for durable medical equipment.
Hospice care: May exceed the 210 days of care if recertified as terminally ill.	Two 90-day periods and one 30-day period.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
Blood.	Blood.	All but first three pints.	For first three pints.

Medicare (Part B) 2025 Medical Insurance Covered Services per Calendar Year Standard Monthly Premium: $185.00

Service	Benefit	Medicare Pays	You Pay[1]
Medical expense: Doctor's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services in a doctor's office.	80% of approved amount (after $257.00 deductible). 50% of approved charges for most outpatient mental health services.	$257.00 deductible[2] plus 20% of approved amount and limited charges above approved amount. 50% of approved charges for mental health services.
Home health care[3].	Unlimited, if made under a physician's treatment plan.	Full cost.	Nothing for services; 20% of approved amount for durable medical equipment.
Outpatient hospital treatment.	Unlimited if medically necessary.	80% of approved amount (after $257.00 deductible).	$257.00 deductible[1] plus 20% of balance of approved amount.
Blood: Any blood deductibles satisfied under Part B will reduce the blood deductible requirements.	Blood.	80% of approved amount (after first three pints).	$257.00 deductible[1] plus first three pints plus 20% of balance of approved amount.

Note: If the period of hospitalization covers two calendar years, no new deductible is required for the new year. These figures are for 2025 and are subject to change each year.

[1] You pay for charges higher than the amount approved by Medicare, unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for the services rendered. Federal law limits charges for physician services. Source: Centers for Medicare & Medicaid Services (CMS).

[2] Once you have had $257.00 of expense for covered services in 2025, the Part B deductible does not apply to any further covered services you receive the rest of the year. Source: Centers for Medicare & Medicaid Services (CMS).

[3] Home health care is provided under Part B only if not covered under Part A. Source: Centers for Medicare & Medicaid Services (CMS).

Part B Premium for Certain Beneficiaries

Pursuant to one provision of the Bipartisan Budget Act of 2015, certain Medicare beneficiaries will pay a higher Part B premium in 2025. The minimum premium for those in this group will be $185.00. Individuals in this group include:

- Medicare beneficiaries not receiving Social Security benefits.
- Those who enroll in Part B for the first time in 2025.
- Those who have both Medicare and Medicaid, and Medicaid pays the Medicare premiums.
- Those whose income in 2023 exceeded certain limits. The *total* premium for those in this group will also include an income-related monthly adjustment amount. Based on their filing status and income.[1]

The table below shows the 2025 Individual Part B premiums for Medicare beneficiaries.

Unmarried Individuals	Married Filing Jointly	Monthly Premium
Equal to or less than $106,000	Equal to or less than $212,000	$185.00
$106,001 to $133,000	$212,001 to $266,000	$259.00
$133,001 to $167,000	$266,001 to $334,000	$370.00
$167,001 to $200,000	$334,001 to $400,000	$480.90
$200,001 to $499,999	$400,001 to $749,999	$591.90
Greater than or equal to $500,000	Greater than or equal to $750,000	$628.80

Married Filing Separately	Monthly Premium
Equal to or less than $106,000	$185.00
$106,001 to $393,999	$591.90
Greater than or equal to $394,000	$628.80

[1] The measure used is modified adjusted gross income. Generally adjusted gross income plus any tax free interest or any excluded foreign earned income. An appeals process is available in case of a major life change such as the death of a spouse, divorce, or marriage. Source: Centers for Medicare & Medicaid Services (CMS).

Getting Help Deciding

A number of resources are available to help Medicare beneficiaries answer questions about Medicare, including:

- **Medicare:** Medicare can be reached online at https://www.medicare.gov/ By phone, Medicare can be reached at (800) 633-4227. TTY users can call (877) 486-2048. An individual can also write to Medicare at PO Box 1270, Lawrence KS 66044.
- **State Health Insurance Assistance Programs (SHIP):** SHIPS are state-run programs that receive money from the federal government to provide free, personalized counseling. The telephone number and website for a state's SHIP program can be found on the web at https://www.shiphelp.org and also in the Medicare publication, *Medicare and You 2024*.

Medicare Part C – Medicare Advantage

Medicare Part C – also known as Medicare Advantage - is an alternative to Original Medicare, made up of Medicare Part A and Part B. Medicare Advantage plans are Medicare-approved programs offered by private companies, following rules set by Medicare. Medicare Part C plans generally take an "all-in-one" or "bundled" approach to providing medical care, as contrasted with the "fee-for-service" nature of Original Medicare. A few key differences:

- **Limited choice of doctor and hospital:** Medicare Advantage plans typically require plan enrollees to use doctors and hospitals within the plan's network and service area.
- **Services covered:** Medicare Advantage plans must cover the same medically necessary services covered by Original Medicare. They may also cover extra benefits such as dental care, eye exams, or hearing aids, not covered by Original Medicare.
- **Costs:** Enrollees pay a monthly premium for Part B and may also have to pay a plan's premium. Co-payments typically apply to covered services and supplies. Medicare Part C plans generally have an annual limit on the total amount an enrollee pays; once that annual limit is reached, there are no further charges for covered services and supplies for the year.
- **Prescription Medication:** Unlike Original Medicare, many (but not all) Medicare Advantage plans include Part D prescription medication coverage. In those Medicare Advantage plans that do not offer prescription drug coverage, an enrollee will have to purchase (and pay for) a separate Medicare Part D prescription drug plan.

Types of Medicare Advantage Plans

There are a number of different types of Medicare Advantage Plans, including:

- **Health Maintenance Organization (HMO):** Enrollees must generally receive their care and services from hospitals and health care providers in the plan's network.
- **HMO Point-of-Service:** Similar to an HMO. However, enrollees may receive some services out-of-network for a higher co-payment or co-insurance.

- **Medical Savings Account (MSA) Plans:** MSA plans typically don't have a network of doctors or hospitals. Instead, the plan deposits money into a special savings account to pay for health care expenses. Enrollees may receive covered services from any Medicare provider in the U.S.
- **Preferred Provider Organization (PPO) Plan:** PPO plans have a network of doctors and other health care providers an enrollee may use. Out-of-network providers may also be used, usually for a higher cost.
- **Private Fee-for-Service (PFFS) Plan:** An enrollee can go to any doctor, hospital, or other health care provider that accepts the plan's payment terms, agrees to treat the enrollee, and hasn't opted out of Medicare. An enrollee who chooses an out-of-network provider may pay more.
- **Special Needs Plan (SNP):** A SNP provides benefits and services to people with specific diseases or certain health needs, or who may also be on Medicaid. SNP plans tailor their care and benefits to best meet the needs of the groups they serve.

Joining a Medicare Advantage Plan

1. **Initial Medicare eligibility:** An individual may enroll in a Medicare Advantage plan when he or she first becomes eligible for Medicare. Such an individual may change to another Medicare Advantage Plan or change to Original Medicare within the first three months of having Medicare.
2. **Annual open enrollment:** Annual open enrollment takes place each fall, from October 15 through December 7. Elections made during this period take effect on January 1st of the following year.
3. **General enrollment period:** From January 1 to March 31, if a beneficiary has only Part A coverage, and then gets Part B coverage, the individual has the option to join a Medicare Advantage plan, with coverage generally beginning July 1.
4. **Medicare Advantage open enrollment period:** Between January 1 to March 31 of each year, an enrollee may make certain changes: (1) switch from one Medicare

Advantage plan to another Medicare Advantage plan; (2) or dis-enroll from a Medicare Advantage plan and return to Original Medicare. If an enrollee choses this second option, he or she will be able to joint a Medicare Part D prescription drug plan. However, the enrollee may NOT be able to buy a Medigap policy.

5. **Special enrollment periods:** An enrollee may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period. Examples of these are: (1) an enrollee moves out of a plan's service area; (2) the enrollee has (or loses) Medicaid coverage; (3 an enrollee qualifies for (or loses) Extra Help in paying certain expenses; and (4) the enrollee moves into an institution such as a nursing home.
6. **5-Star special enrollment period:** An enrollee may change to a Medicare Advantage plan that has five stars for its overall rating from December 8 to November 30 of the following year. An enrollee may only use this Special Enrollment right once during this timeframe.

Once a plan has been chosen, that choice will remain in effect until the enrollee changes it or the plan no longer serves the area in which the enrollee lives.[1] If an individual fails to make an election, he or she will remain in the Original Medicare fee-for-service program.

Getting Help Deciding

A number of resources are available to help Medicare beneficiaries answer questions about Medicare, including:

- **Medicare:** Medicare can be reached online at https://www.medicare.gov/ By phone, Medicare can be reached at (800) 633-4227. TTY users can call (877) 486-2048. An individual can also write to Medicare at PO Box 1270, Lawrence KS 66044.
- **State Health Insurance Assistance Programs (SHIP):** SHIPS are state-run programs that receive money from the federal government to provide free, personalized counseling. The telephone number and website for a state's SHIP program can be found on the web at https://www.shiphelp.org and also in the Medicare publication, Medicare and You 2025.

[1] Not all Medicare Advantage options are available in all geographic areas.

Medicare Part D – Prescription Drug Coverage

In the original Medicare program (Part A and/or Part B), there is no coverage for prescription medications. To address this gap, Medicare Part D provides insurance coverage for prescription drugs. Under this program, insurance companies and other private firms contract with Medicare (Medicare pays most of the premium) to provide prescription drug benefits to Medicare beneficiaries.

Each eligible Medicare beneficiary must select a drug plan and pay a monthly premium to receive the drug coverage. All drug plans (the choice varies by state) must provide coverage at least as good as the standard coverage specified by Medicare. Some plans may offer extra benefits such as no deductible, higher coverage limits, or cover additional drugs, in exchange for a higher monthly premium. Individuals with limited income and resources may qualify for help in paying for drug coverage.

Making a Choice

There are a number of factors to consider in making a choice about drug plans, including:

- **Initial enrollment:** A new Medicare beneficiary may enroll in a prescription drug plan during the seven-month period beginning three months before he or she turns age 65 until three months after reaching age 65. An individual who has lost "creditable coverage" (prescription drug coverage from some other source that is at least as good as the standard Medicare prescription coverage) has 63 days to select and join a Medicare prescription drug plan. An eligible beneficiary who does not enroll in a prescription drug plan within the prescribed time limits faces a penalty for late enrollment.
- **Open enrollment period:** Individuals who delay joining a Medicare prescription drug plan beyond their initial eligibility face a monthly premium that will increase by at least 1% per month for each month of delay. This increased premium applies for as long as the individual is enrolled in a Medicare drug plan.

- **Changing plans:** Each year, from October 15 to December 7, a beneficiary can change to a different prescription drug plan.
- **Current prescription coverage:** Individuals who currently have prescription drug coverage from another source may not wish to enroll in a Medicare prescription drug program. In some cases the benefits provided under these other plans are better than those provided under the standard Medicare prescription drug plan.
- **Medication coverage:** Consider what medications are needed. Compare the needed medications with those covered by each plan. Each plan will have a list (termed a "formulary") showing the drugs (generic and brand-name) the plan will pay for.
- **Out-of-pocket cost:** A prescription drug plan can vary in how much it charges and how much coverage is provided. Issues such as the monthly premium, yearly deductible, any co-insurance or co-payments, and coverage limits must all be considered. Beginning in 2025, out-of-pocket drug costs will be capped at $2,000.
- **Pharmacy convenience:** Not all pharmacies will be contracted with all plans. Some plans will allow a beneficiary to receive prescriptions by mail.
- **Future health changes:** Even though an individual takes few or no medications now, joining a prescription drug plan now means paying the lowest possible monthly premium. Future health changes may require increased use of prescription drugs.

Paying for Prescription Medication

Beginning in 2025, once an enrollee reaches $2,000 in out-of-pocket expenses, he or she will face no further copayment or coinsurance payments for Part D drugs for the remainder of the year.

The **Medicare Prescription Payment Plan** is new for 2025. This plan works with your existing drug plan to help manage the out-of-pocket costs for drugs by providing the ability to spread the out-of-pocket costs evenly throughout the year. This option is available to anyone with a Medicare drug plan or Medicare health plan and there is no cost to participate. This option is available for all plans and participation is voluntary. If this option is selected, the health or drug plan will send a bill each month to pay for the prescription drugs. No payment is made to the pharmacy.

Medicare Part D - Prescription Drug Coverage

Income Related Monthly Adjustment Amount (IRMAA)

In addition to the normal Part D premium, enrollees whose incomes exceed certain limits are also required to pay an "Income Related Monthly Adjustment Amount," or IRMAA. The regular plan premium is paid to their Part D plan and the IRMAA is paid to Medicare. The 2025 Part D IRMAA amounts are as follows:

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Equal to or less than $106,000	Equal to or less than $212,000	$0.00
$106,001 to $133,000	$212,001 to $266,000	$13.70
$133,001 to $167,000	$266,001 to $334,000	$35.30
$167,001 to $200,000	$334,001 to $400,000	$57.00
$200,001 to $499,999	$400,001 to $749,999	$78.60
Greater than or equal to $500,000	Greater than or equal to $750,000	$85.80

Married Filing Separately	Monthly Adjustment Amount
Equal to or less than $106,000	$0.00
$106,001 to $396,999	$78.60
Greater than or equal to $397,000	$85.80

For Those Who Currently Have Prescription Drug Coverage

Some retirees may already have prescription drug coverage. For these individuals a key step is to compare the current coverage with that provided through a Medicare plan. The benefits administrator or insurance carrier can provide additional information.

- **Coverage provided by employer or union:** If the drug coverage provided by an employer or union is, on average, at least as good as the standard Medicare coverage, the individual may choose to keep the current plan for as long as it is offered. If the plan is discontinued in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

Medicare Part D - Prescription Drug Coverage

- **Medicare Advantage or other Medicare health plan:** Some Medicare Advantage or other Medicare health plans cover prescription drugs. If a plan does not offer prescription drug coverage, an individual may wish to switch to another Medicare Advantage or other Medicare health plan that does cover prescription drugs, or change to the original Medicare plan and join a Medicare prescription drug plan.

- **Other government insurance:** Generally, the prescription drug benefits provided by TRICARE, the Department of Veterans Affairs (VA), Federal Employee's Health Benefits Program (FEHB), or Indian Health Services are as good as the standard Medicare prescription drug plan. In most cases it will be to the individual's advantage to keep the current plan. If coverage is lost in the future, the individual can join a Medicare drug plan without penalty within 63 days of the coverage ending.

- **Drug price negotiations:** Under this provision, the Act requires CMS to negotiate maximum prices for brand-name drugs that do not have other generic equivalents and that account for the greatest Medicare spending. CMS must negotiate the price of 10 drugs in 2026, 15 drugs in 2027 and 2028, and 20 drugs in 2029 and later.

- **Medicare Part D improvements and maximum out-of-pocket caps:** Beginning in 2023, the Act eliminated beneficiary cost-sharing above the annual out-of-pocket spending threshold (for "Catastrophic" Coverage), as well as expanding eligibility for the Part D low-income subsidy. For the period 2024-2029, the new law limits Part D premium increases to no more than 6% per year. In 2025, the Act caps an enrollee's personal annual out-of-pocket spending at $2,000 per year, (with annual adjustments thereafter) as well as creating a program under which drug manufacturers provide discounts to enrollees who have incurred costs above the annual deductible. Additionally in 2025, the new law establishes a process through which certain beneficiaries can have their personal out-of-pocket monthly costs capped and paid in even monthly installments.

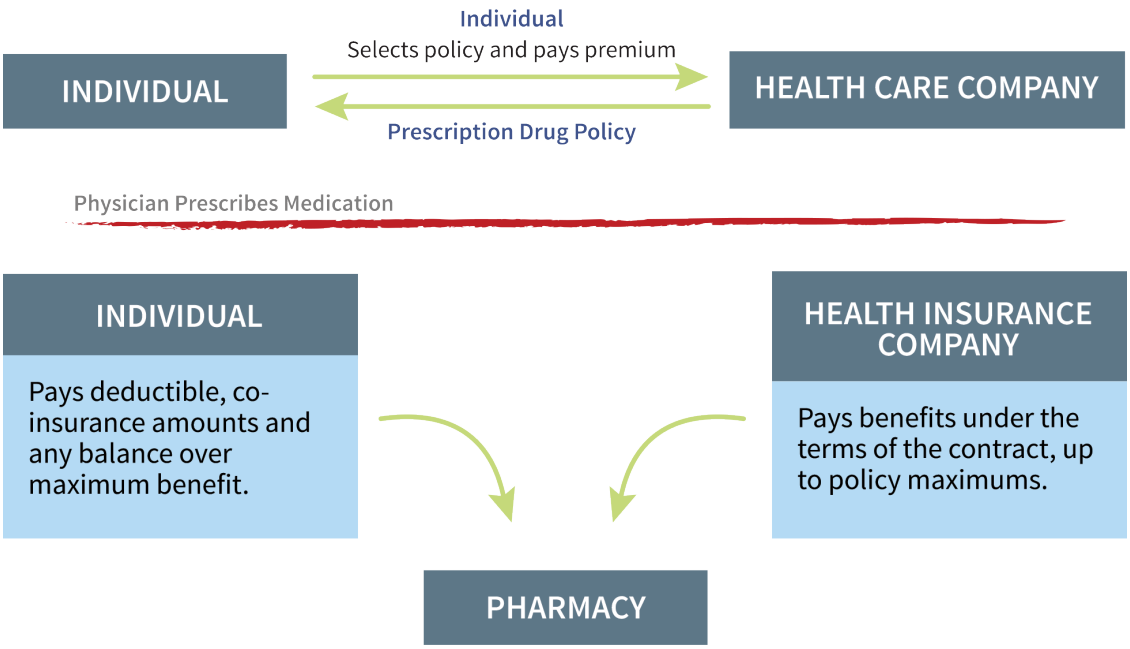
- **Other miscellaneous changes:** Also beginning in 2023, IRA-2022 eliminated any cost-sharing for recommended adult vaccines, thus making them free of cost. In addition, the bill capped cost-sharing for a month's supply of covered insulin products at (1) for 2023 through 2025, $35; and (2) beginning in 2026, $35, 25% of the government's negotiated price, or 25% of the plan's negotiated price, whichever is less.

Seek Professional Guidance

The process of making decisions concerning health care insurance can be confusing and complex. The advice and counsel of trained advisers is strongly recommended. Additional information is also available from:

- **On the web:** www.medicare.gov
- **By telephone:** Contact Medicare at 1-(800) 633-4227 (TTY users: 1-(877) 486-2048)

How Medicare Prescription Drug Coverage Works



Medigap Policies

Medigap policies are supplemental health insurance policies sold by private insurers, designed to fill some of the "gaps" in health coverage provided by Original Medicare. Although Original Medicare covers many health care costs, you still have to pay certain coinsurance and deductible amounts, as well as paying from your own pocket for services that Medicare does not cover.

Who Can Buy a Medigap Policy?

Generally, you must be enrolled in the original Medicare Parts A and B before you're able to purchase a Medigap insurance policy. Other types of health insurance coverage, such as Medicare Advantage, other Medicare health plans, Medicaid, or employer-provided health insurance, do not work with Medigap policies.

Standardized Policies

Under federal regulations, private insurers may only sell "standardized" Medigap policies, identified as plans A, B, C, D, F, G, K, L, M, and N. The various policies differ in the benefits they provide and in their cost.

These standardized policies allow you to compare "apples with apples." For example, a Plan F policy will provide the same benefits, no matter which insurance company it is purchased from. However, a plan C policy will provide different coverage than a plan D policy. All Medigap policies must provide certain "core" benefits.

Through May 31, 2010, there were 12 standardized Medigap policies, plans A, B, C, D, E, F, G, H, I, J, K, and L. Effective June 1, 2010, plans E, H, I, and J could no longer be sold, and Plans M and N were added. Individuals who had purchased a plan E, H, I, or J before June 1, 2010 were allowed to keep those plans.

Beginning January 1, 2020, Medigap plans sold to those new to Medicare were no longer allowed to cover the Part B deductible. Thus, Plans C and F (including the high deductible version of Plan F) could no longer be sold to people new to Medicare as of that date. An individual who already had one of these plans, or who was covered by one of these plans prior to January 1, 2020, will be allowed to keep the plan. Someone eligible for Medicare before January 1,2020, but who had not yet enrolled, may still be able to buy one of these plans.

Medigap Policies

These standardized plans are not available to those living in Massachusetts, Minnesota, or Wisconsin; there are separate Medigap policies available for residents of these states.

Choosing a Policy

There are two primary factors to consider when choosing a Medigap policy.

- **Needed benefits:** Carefully consider what benefits you are most likely to need; you may not need the most comprehensive plan. However, each individual must have his or her own Medigap policy.
- **Cost:** Once you have decided which benefits you will need, shop for the policy that provides those benefits at the lowest cost.

Policy Costs Can Differ

- **Discounts:** Some insurers may offer discounts to certain classes of people, such as women, non-smokers, or married couples.
- **Medical underwriting:** An insurance company may require you to fill out a detailed questionnaire on your health. The information you provide is used to determine whether or not a policy will be issued, or what premium to charge.
- **Pre-existing conditions:** If you have a "pre-existing condition," a known health problem, before you apply for a Medigap policy, you may have to wait up to six months before that problem is covered.
- **High deductible:** Plans F and G have two options: (1) a standard option and (2) in some states, a "high deductible" option. Choosing the high deductible option means that you must pay more of the costs before the policy begins to provide benefits. Monthly premiums for high deductible policies are typically less.
- **Medicare SELECT:** Medicare SELECT policies are sold in a few states by a few insurers. Except for emergencies, these policies require you to use pre-selected hospitals and physicians.

- **Guaranteed renewable:** Medigap policies issued after 1992 are generally guaranteed renewable. This means that as long as you pay the premiums, are honest about health issues, and the insurance company doesn't go bankrupt, the insurer can't drop your coverage. In some states, policies issued before 1992 may not be guaranteed renewable.
- **Insurer pricing methods:** The table below shows three common methods by which an insurance company will price its Medigap policies:

Pricing Method	Payment	Other Issues
Community (No-Age)	Each insured pays the same premium, regardless of age.	Premiums may increase due to inflation.
Issue-Age	Policy premium is based on your age when you purchase the policy.	Younger buyers pay lower premiums. Premiums may increase due to inflation.
Attained-Age	Premiums are based on your age each year, thus premiums increase annually.	Younger buyers pay lower premiums. Premiums can increase each year. Premiums may also increase due to inflation.

Other Resources

Professional guidance in dealing with any aspect of a Medigap policy is strongly recommended. Other available resources include:

- **Medicare:** The federal government's Centers for Medicare & Medicaid Services (CMS) has a great deal of information available on their website at www.medicare.gov. You can also reach them by phone at (800) 633-4227. TTY users should call (877) 486-2048.
- **State Health Insurance Assistance Programs:** Many states operate health insurance assistance programs designed to provide assistance and information regarding Medicare, Medigap policies, and long-term care policies.
- **State insurance department:** Each state has an insurance department that regulates the sale of all types of insurance within the state. These state agencies can provide information about Medigap policies.

Medigap Policies Compared

Medigap policies are designed to fill the "gaps" in health insurance provided under original Medicare, Parts A and B. These supplemental policies must provide standardized coverage as specified by the federal government.

The following tables compare and contrast the major components of the different policies. Not all policies are available in all states. The policies shown are not available to residents of the states of Massachusetts, Minnesota, or Wisconsin; there are separate standardized policies for residents of those states.

Medigap Plans Sold On or After June 1, 2010[1]

Plan	Core Benefits	Skilled Nursing	Part A Deductible	Part A Hospice	Part B Deductible	Part B Excess Charges	Emergency Foreign Travel	Preventive Care
A	100%			100%				100%
B	100%		100%	100%				100%
C	100%	100%	100%	100%	100%[2]		80%	100%
D	100%	100%	100%	100%			80%	100%
F[3]	100%	100%	100%	100%	100%[2]	100%	80%	100%
G[3]	100%	100%	100%	100%		100%	80%	100%
K[4]	100%	50%	50%	50%				100%
L[4]	100%	75%	75%	75%				100%
M	100%	100%	50%	100%			80%	100%
N	100%	100%	100%	100%			80%	100%

[1] Through May 31, 2010, 12 standardized Medigap policies could be sold, identified as plans A, B, C, D, E, F, G,H, I, J, K, and L. Effective June 1, 2010, plans E, H, I, and J could no longer be sold, and new plans N and M were added. Individuals who purchased a plan E, H, I, or J before June 1, 2010, may keep those plans.

[2] Beginning January 1, 2020, Medigap plans sold to those new to Medicare were no longer allowed to cover the Part B deductible. Thus, Plans C and F (including the high deductible version of Plan F) could no longer be sold to people new to Medicare as of that date. An individual who already had one of these plans, or who was covered by one of these plans prior to January 1, 2020, will be allowed to keep the plan. Someone eligible for Medicare before January 1,2020, but who had not yet enrolled, may still be able to buy one of these plans. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.

[3] Plans F and G have two options: (1) a standard option and (2) in some states, a "high deductible" option, with a 2025 deductible of $2,870.00.

[4] In 2025, Plan K has an annual out-of-pocket limit of $7,220.00; Plan L has an annual out-of-pocket limit of $3,610.00.

Medigap Policies Compared

What's included?

- **Core benefits:** Plans A-G, M and N - For Part A hospitalization, cover 100% of all copayments except that for days 1-60 of hospitalization ($1,676 in 2025), plus adding 365 lifetime days of hospital coverage after the standard benefit of 150 days is exhausted; 100% of Part B coinsurance amounts[1] after meeting the yearly deductible ($257.00 in 2025); the first three pints of blood. Plans K and L – For Part A hospitalization, cover 100% of all copayments except that for days 1-60 of hospitalization, plus adding 365 lifetime days of hospital coverage after the standard benefit of 150 days is exhausted; for Part B, Plan K pays 50% of the coinsurance amount after the annual deductible is met; Plan L pays 75% of the Part B coinsurance amount after the annual deductible is met; Plan K pays 50% of the cost of the first three pints of blood; Plan L pays 75% of the cost of the first three pints of blood.
- **Part A skilled nursing:** Plans C-G, M and N - Pay 100% of the coinsurance amount Plans C-G, M and N - Pay 100% of the coinsurance amount ($209.50 per day in 2025) for days 21-100 in a skilled nursing facility. Plans K and L – Pay the percentage shown of the coinsurance amount for days 21-100 in a skilled nursing facility.
- **Part A deductible:** Plans B-G, and N – Pay 100% of the Part A deductible ($1,676 in 2025) for the first 60 days of hospitalization. Plans K, L, and M – Pay the percentage shown of the Part A deductible for the first 60 days of hospitalization.
- **Part A hospice:** Plans A-G, M and N – Pay 100% of the Part A hospice copayment. Plans K and L – Pay the percentage shown of the Part A hospice copayment.
- **Part B deductible:** Plans C and F – Pay 100% of the annual Part B deductible ($257.00 in 2025).
- **Part B excess charges:** Plans F and G – Pay 100% of the Part B excess charges.
- **Emergency foreign travel:** Plans C-G, M and N – The insured pays a $250 deductible and then 20% of any remaining costs of emergency health care. This benefit is typically limited to a $50,000 lifetime maximum and the first 60 days of each trip.
- **Part B preventive care:** All plans – Pay 100% of the coinsurance for preventive care.

[1] Plan N pays 100% of the Part B coinsurance except for a co-payment of up to $20 for some office visits and $50 for emergency department visits that do not result in inpatient admission.

Other Resources

Professional guidance in dealing with any aspect of a Medigap policy is strongly recommended.

Other available resources include:

- **Medicare:** The federal government's Centers for Medicare & Medicaid Services (CMS) has a great deal of information available on their website at https://www.medicare.gov/. You can also reach them by phone at (800) 633-4227; TTY users should call (877) 486-2048.
- **State Health Insurance Assistance Programs:** Many states operate health insurance assistance programs designed to provide assistance and information regarding Medicare, Medigap policies, and long-term care policies.
- **State insurance departments:** Each state has an insurance department that regulates the sales of all types of insurance within the state. These state agencies can provide information about Medigap policies.

Medicaid

Medicaid is a jointly-funded, federal-state welfare program which provides medical care to individuals and families with very low resources and income. Each state administers its own program and, within guidelines set by the federal government, establishes its own rules regarding program eligibility and the type, duration, and scope of services provided.

Qualifying For Medicaid

Just being poor is no guarantee that an individual will qualify to receive Medicaid. An individual must belong to one of several specified groups as well as meet certain income and asset limitation tests.

To qualify for federal funds, states must provide care for certain, targeted populations. Included in the mandatory category are persons receiving federally assisted income maintenance payments, such as Supplemental Security Income (SSI), or Aid to Families With Dependent Children (AFDC).

A state may choose to provide healthcare services to certain "categorically needy" populations, individuals and families whose financial situation is similar to those in the mandatory group, but with different qualifying criteria. Medicaid benefits may also be offered to "medically needy" persons, those with incomes too high to qualify under any other category. Such individuals can "spend down" their excess income by incurring medical and/or remedial care expenses, reducing the excess income to a level below the maximum allowed under the state's plan.

What Medical Services Are Provided?

A wide range of services is provided to Medicaid beneficiaries. Some services are mandatory under federal rules, while others are optional. Provided services can include:

- Inpatient hospital services.
- Outpatient hospital services.
- Nursing facility services for beneficiaries age 21 and older.
- Prenatal and delivery services as well as postpartum care.
- Physicians' services and medical and surgical services of a dentist.

- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21, including vaccines.
- Payment of Medicare premiums (Part A and/or Part B) for certain needy elderly or disabled individuals.
- Long-term care (LTC).

Resource and Income Limitations

Generally, a single individual cannot have more than $2,000 in assets and still qualify for Medicaid. In this calculation, certain assets are "exempt" and are not counted:

Asset	Observation
Personal residence	Generally, with no more than $730,000 of equity. A state may raise this limit to $1,097,000.
Cash value life insurance	With a face value of up to $1,500.
Household goods, personal effects	Furniture, appliances, artwork, clothing, jewelry.
Automobile	One car, generally limited to a value of $4,500.
Burial funds	Generally limited to $1,500.
Burial space	Burial plot, grave marker, urn, crypt, mausoleum.
Business assets	Property employed in a trade or business, if essential to self-support.
Jointly owned residence	Exempt if other resident owners would be forced to move if property were sold.

Those applying for Medicaid must also meet certain monthly income limitations, which vary by state. These income limitations generally change from year to year.

Transferring Assets To Qualify For Medicaid

Some individuals, often those needing expensive nursing home care, will attempt to meet Medicaid's asset limitations by gifting or otherwise transferring assets to others for less than

fair market value. However, such transfers can result in a delay in benefit eligibility if made within a "look-back" period of 60 months before the application date.[1]

To avoid a period of ineligibility, an individual who anticipates needing care can either (1) transfer assets more than 60 months before applying for Medicaid benefits; or, (2) keep enough assets to pay for needed care for 60 months, transfer the remainder, and not apply for Medicaid benefits until 60 months have elapsed after the last transfer.

The period of ineligibility is generally determined by dividing the value of the assets transferred by the average monthly cost of nursing home care to a private patient in the local community. Ineligibility begins on the later of: (1) the date of the gift or transfer; or, (2) the date the individual would otherwise have qualified to receive Medicaid benefits.[2]

Example: George lives in a state where the average monthly cost of nursing home care is $6,000 per month. If he transfers property worth $120,000, he will be ineligible for Medicaid benefits for 20 months ($120,000 ÷ $6,000 = 20).

Annuities

The purchase of a commercial annuity is considered in the same light as a gift or transfer of assets for less than fair market value, unless certain requirements are met. In general, an annuity is not counted as an asset if it is: (1) irrevocable; (2) non-transferrable; (3) actuarially sound, compared to the beneficiary's life expectancy; and; (4) provides for equal payments during the annuity's term.

Additionally, there can be no payment deferral or balloon payments and the state must be named as the primary remainder beneficiary (in some cases the secondary remainder beneficiary) for the amounts paid by Medicaid for the beneficiary's care.[3]

[1] Under federal rules, some transfers, such as those made for the benefit of a spouse, a blind or disabled child, or a disabled individual under age 65, will not trigger a period of benefit ineligibility.

[2] Under the Deficit Reduction Act of 2005, the 60 month look-back period applies to transfers made on or after February 8, 2006. For transfers before that date, a 36 month look-back period generally applied (60 months in the case of certain trusts).

[3] Annuities purchased before February 8, 2006, the effective date of the Deficit Reduction Act of 2005, were subject to individual state rules.

Trusts

If an individual, or his or her spouse, or anyone acting on the individual's behalf, establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for determining Medicaid eligibility.

In general, payments actually made to or for the benefit of the individual are treated as income to the individual. Amounts that could be paid to or for the benefit of the individual, but are not, are treated as available resources. Amounts that could be paid to or for the benefit of the individual, but are paid to someone else, are treated as transfers for less than fair market value. Amounts that cannot, in any way, be paid to or for the benefit of the individual are also treated as transfers for less than fair market value.[1]

Certain trusts, for disabled or institutionalized individuals, are not counted as being available to the individual. These trusts must provide that the state receives any funds, up to the amount of Medicaid benefits paid on behalf of the individual, remaining in the trust when the individual dies.

Spousal Impoverishment

The high cost of nursing home care can rapidly exhaust the savings of almost anyone. Because of this, Congress has enacted laws to prevent what has been called "spousal impoverishment," which can leave the spouse who is still living at home (the "community spouse") with little or no income or resources. These provisions help ensure that the community spouse will be able to live out his or her life with independence and dignity. These spousal impoverishment rules apply when one member of a couple enters a nursing home or other medical institution and is expected to remain there for at least 30 days.

When the couple applies for Medicaid, an assessment of their combined (regardless of ownership) resources is made. The couple's home, household goods, an auto, and burial funds are not included in the accounting. The result is the couple's combined countable resources. This total is then used to determine a "Protected Resource Amount" (PRA) for the community spouse.[2] After the PRA is subtracted from the couple's combined resources, the

[1] Transfers from trusts for less than fair market value are subject to the same 60-month "look-back" period applicable to other transfers.

[2] The PRA may also be determined by either a court order or by a state hearing officer.

remainder is considered available to the spouse residing in the medical institution as countable resources. If the amount of countable resources is below the state's resource standard, the individual is eligible for Medicaid.

The community spouse's income is not considered available to the spouse who is in the medical facility and the two individuals are not considered a couple for income eligibility purposes. The state uses the income eligibility standard for one person rather than two. If most of the couple's income is in the name of the institutionalized spouse, and the community spouse has insufficient income in his or her own right to live on, a separate calculation is made which allocates a portion of the institutionalized spouse's income to support the community spouse and any other family members living in the household.

Estate Recovery

When a Medicaid beneficiary dies, federal law requires the states to seek recovery of amounts paid by the state for many of the services provided to Medicaid beneficiaries, unless undue hardship would result. Generally, recovery is made from property held in the beneficiary's name only. Some states may seek also recovery from a life estate, assets held in a revocable "living" trust, or jointly held assets. Assets that pass to a surviving spouse are exempt from recovery as long as that spouse is alive.

Long-Term Care Partnership

In a Long-Term Care Partnership, a state government and private health insurers work together to make available to residents of that state LTC insurance policies that are "linked" to Medicaid. If a buyer of a partnership LTC policy later faces long-term care needs that exceed the policy's limits, he or she may apply for assistance from the state's Medicaid program under more relaxed eligibility rules. In what is termed an "asset disregard," the policy owner may keep a larger amount of assets than would normally be allowed under standard Medicaid rules. These relaxed eligibility rules apply only to the amount of assets than an individual can retain; all other normal Medicaid eligibility requirements apply.

Patient Protection and Affordable Care Act (PPACA)

Beginning in 2014, PPACA expanded eligibility for Medicaid to individuals not currently eligible for Medicare (generally, individuals under age 65). This expansion embraced

children, pregnant women, and adults without dependent children, with incomes up to 133% of the federal poverty level (FPL). Coverage is provided through an essential health benefits package purchased through a state's American Health Benefits Exchange.

Seek Professional Guidance

Qualifying for Medicaid services requires meeting complex legal and regulatory requirements. The guidance of trained financial professionals is highly recommended.

See the general information made available by the federal government's Centers for Medicare and Medicaid Services at: https://www.medicaid.gov/.