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2025 MEDICARE GUIDE

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Important Notice

This report is intended to serve as a basis for further discussion with your other professional advisors. Although great effort has been taken to provide accurate numbers and explanations, the information in this report should not be relied upon for preparing tax returns or making investment decisions.

Assumed rates of return are not in any way to be taken as guaranteed projections of actual returns from any recommended investment opportunity. The actual application of some of these concepts may be the practice of law and is the proper responsibility of your attorney.

Profile

STEPHEN J. SILVERBERG, ESQ., CELA, AEP, CAP

Stephen J. Silverberg is nationally recognized as a leader in the areas of simple and complex estate planning, estate administration, asset protection planning, Elder Law, and Special Needs Planning. He is a past president of the prestigious National Academy of Elder Law Attorneys (NAELA), and a founding member and past president of the New York State chapter of NAELA.

Silverberg was awarded the credential of NAELA Fellow, the highest honor bestowed by NAELA to "attorneys... whose careers concentrate on elder law, and who have distinguished themselves both by making exceptional contributions to meeting the needs of older Americans and by demonstrating a commitment to the Academy." Silverberg is also a founding member of the New York State chapter of NAELA.

He holds the designation of a Certified Elder Law Attorney (CELA), awarded by the National Elder Law Foundation. There are fewer than 520 CELAs throughout the United States.

He has been awarded the Accredited Estate Planner® Designation, by the National Association of Estate Planners & Councils. The AEP designation is the only graduate-level designation in estate planning. The designation is administered and is awarded only to estate planning professionals who meet special requirements of education, experience, knowledge, professional reputation, and character.

Martindale-Hubbell® has rated Silverberg an AV® Preeminent 5.0 out of 5.0 attorney for 2020, the highest possible designation from Martindale-Hubbell. Super Lawyers has named Silverberg to its select list of attorneys for eighteen consecutive years, from 2007 to 2024.

He has served as an active member of the Nassau County Bar Association's Elder Law, Social Services and Health Advocacy Committees and is a long-standing member of the Estate Planning Council of Nassau County. Silverberg is a past President of the Pension Council of Long Island. For eleven years, Silverberg has been an active member of the IRS District Directors Liaison Group. He is also an author of the Elder Law module of the Interactive Legal Document Systems, the preeminent document drafting program for attorneys.

Silverberg is frequently invited as a keynote speaker before national conferences, bar associations, universities, and legal and financial organizations on topics including estate planning, Elder Law, and tax planning matters. He has published in many legal and scholarly journals, including Trusts and Estates Magazine, The New York State Bar Monthly News, and is a widely quoted source for the news media on issues concerning estate and Elder Law.

Silverberg is a graduate of Hartwick College (B.A., 1973) and Brooklyn Law School (J.D., 1976). He is admitted to practice in New York and Florida.

In 2009, Stephen was profiled in "How Can I Help?" in NAELA News. The article captures his unique personality, interests, and dedication to NAELA and Elder Law. The "Little Known Steve Facts" are a fun complement to the seriousness of the work he does.

SCOTT B. SILVERBERG, ESQ.

Scott B. Silverberg focuses his practice on estate planning, Elder Law, and Special Needs Planning

He is a Past President of the New York Chapter of the Board of Directors of the New York chapter of the National Academy of Elder Law Attorneys (NAELA), a current member of the Board of Directors of the NY chapter of NAELA and the Elder Law Practicum of NAELA National.

As a member of the New York State Bar Association, Scott serves as Vice-Chair of the Practice Management Committee of the Elder Law and Special Needs Section Executive Committee. Previously, he chaired the Technology Committee.

He is also a member of the Nassau County Bar Association.

In early 2020, Scott was accepted into the L.L.M. in Elder Law program at the prestigious Stetson University School of Law. This rigorous online program is offered only to Elder Law practitioners who have provided legal services in elder law matters in highly specific areas of the law. Stetson's L.L.M. Elder Law program faculty comprises many leading attorneys in Elder Law. His acceptance into this program is an indication of his dedication to the field of Elder Law and the quality of his practice.

Scott is a graduate of Fordham Law School (J.D., 2013) and holds a Bachelor of Science degree from Cornell University's School of Industrial and Labor Relations, a highly competitive program that prepares students for leadership positions in law, government, public policy, and business.

He is admitted to practice in New York State.

Original Medicare vs. Medicare Advantage

Ther are significant differences between Original Medicare (Medicare Part A and Part B) and Medicare Advantage plans (Medicare Part C). The table below compares and contrasts a few of the key differences between these two choices.

Item	Original Medicare	Medicare Advantage
Choice of doctor and hospital	Any doctor or hospital in the United States that accepts Medicare payment.	Typically restricted to doctors and hospitals within the plan's network and service area.
Services covered	Covers most medically necessary services and supplies. Typically, does not cover extra benefits such as dental care, eye exams, or hearing aids.	Plans must cover the same medically necessary services covered by Original Medicare. These plans may also cover extra benefits such as dental care, eye exams, or hearing aids.
Costs	• Enrollees pay a monthly premium for Part B. Co-payments and deductibles apply to covered services and supplies. • There is no annual limit on what an enrollee may have to pay out-of-pocket. • An enrollee may choose to buy a separate Medigap policy, to help pay remaining out-of-pocket costs. • Enrollees generally have to pay for a separate Medicare Part D prescription medication policy.	• 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. • Plans typically have an annual limit on what an enrollee pays out-of-pocket. Once the annual out-of-pocket limit is reached, there are no further charges for covered services and supplies. • You don't need (and cannot buy) a Medigap policy. • Many plans include Part D prescription drug coverage.
Referral to a specialist	Generally, no referral is required.	A referral may be required to see a specialist.

Original Medicare vs. Medicare Advantage

Item	Original Medicare	Medicare Advantage
Coverage outside the U.S.	Original Medicare doesn't cover medical care outside the U.S. Some Medigap policies provide for emergency care outside the U.S.	Generally, Medicare Advantage plans do not cover medical care outside the U.S. Some plans may offer a supplemental benefit that covers emergency medical care when traveling outside the U.S.

Resources

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*.

Business Responsibilities Under the PPACA

The Patient Protection and Affordable Care Act (PPACA) has several goals, including increasing access to health insurance coverage, expanding federal private health insurance market requirements, and providing for the creation of health insurance exchanges to provide individuals and small employers with access to qualified health insurance.[1]

For employers, the PPACA includes a requirement (the "employer mandate") for certain "large" employers to provide health insurance to their employees. The law includes a penalty (the "shared responsibility" payment) if a large employer either does not offer health insurance to almost all (95%) of its full-time employees, or offers health insurance that does not meet certain standards. The PPACA sets out two elements for determining penalties. First, which firms are considered to be "large" employers, and thus potentially subject to the penalty, and second, for which employees within a firm the penalty is applied.

Who is a "Large" Employer?

In general terms, the PPACA defines a "large" employer as an employer who employed an average of at least 50 full-time equivalent employees (FTEs) on business days during the preceding calendar year. For example, an employer will use information (the number of employees and their hours of service) from 2023 to determine whether or not the employer will be considered a "large" employer in 2024. Both full-time and part-time employees are included in this calculation.

- Full-time employee: An employee who works on average at least 30 hours per week. 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours per week.
- Part-time employees: Part-time employees (less than 30 hours per week) are converted into FTEs. All hours worked by all part-time employees (no more than 120 hours per employee) are added up and the total is divided by 120.

[1] The discussion here concerns federal law. State or local law may differ.

Example: Assume a firm has 35 full-time employees (30 or more hours per week) and 20 part-time employees, each of whom works 24 hours per week (96 hours per month). The 20 part-time employees equate to 16 full-time equivalents (FTEs), calculated as follows;

20 employees x 96 hours = 1920 total hours 1920 ÷ 120 = 16 **F**ull-**T**ime **E**quivalent**s**

With 35 full-time employees and 16 FTEs, the employer would be considered a "large" employer because there is a total FTE count of 51.

- Employee: The PPACA definition of an employee (as contrasted with an "independent contractor") is based on a common law standard under which an employer-employee relationship exists if the employer controls both what and how the work is to be done.
- Seasonal employees: Seasonal employees are generally defined as those who work for up to 120 days a year. Full-time seasonal employees who work 120 days per year or less are excluded from the calculation to determine large employer status.
- Control group rules: The PPACA follows the control group rules of IRC Sec. 414. Thus, if an individual or organization owns all or a substantial part of several other business (for example, a group of fast-food restaurants), all of the business are considered to be one entity. For purposes of the 50-FTE rule, the employees in each business must be aggregated to determine the total.
- Temporary agency employees: For purposes of determining who is a large employer, "temp" (or "leased") employees are generally counted as employees of the temporary agency.

Identifying "Full-Time" Employees

The IRS's final regulations provide two methods for determining whether an employee has sufficient hours of service to be considered a "full-time" employee:

- Monthly measurement method: Under this approach, an employer simply records an employee's hours of service each month. Once the number of hours of service are known, the rules previously discussed (30 hours per week or 130 hours per calendar month) are applied to determine if an employee is considered to be full-time or not. This method may be used to determine if an employer is a "large" employer as well as for calculating any "shared responsibility" payment.

- **Look-back measurement method:** Under the "look-back" method, an employer determines the status of an employee as full-time during a *future* period (the "stability" period) based upon the hours of service in a *prior* period (the "measurement" period). As with the monthly measurement method, the "30 hours per week or 130 hours per month" rules are applied to determine an employee's status as either full or part-time. The look-back method is available only for computing an employer's "shared responsibility" payment and not for determining if the employer is a "large" employer. The following table outlines this approach:

	Measurement Period	Administrative Period	Stability Period
Description	A period of time during which an employer measures the average hours an employee worked per week.	At the employer's option, a period of time during which full-time employees are identified and enrolled in a health plan.	During the stability period, the employee is treated as full-time regardless of how many hours are worked. This is also the period in which a penalty payment may be due.
On-going employees	From three to 12 months.[1] Uses data from a preceding year.	Up to 90 days.	At least six consecutive calendar months, but cannot be shorter in duration than the measurement period.
New employees, hired as full-time	Not applicable.	Up to 90 days to enroll.	Not applicable.
New variable-hour, part-time, and seasonal employees	From three to 12 months.[2]	Up to 90 days. Measurement period and administrative period cannot exceed 13 months.	Three to 12 months, but cannot be longer than the measurement period.

Minimum Essential Health Insurance

If an employer is determined to be a "large" employer, and, in order to avoid a potential penalty, the employer must offer "minimum essential health coverage" to all full-time employees. The health insurance must also be both affordable and provide adequate coverage to employees and their dependents.

[1] For on-going employees, this is referred to as the "standard" measurement period.

[2] For new employees, this is referred to as the "initial" measurement period.

Business Responsibilities Under the PPACA

- Minimum Essential Health Coverage: The PPACA lists the types of services that must be included to be considered "minimum essential health coverage", including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including vision and oral care.

- Coverage must be "affordable": Coverage under an employer-sponsored plan is "affordable" if the employee's required contribution to the plan does not exceed 8.39% of the employee's household income for the taxable year.[1]

- Affordability "safe-harbors": As a practical matter, most employers will not know the family's household income. To overcome this, three, alternative "safe-harbor" tests have been proposed. Under the first safe-harbor, the annualized, required contribution must not exceed 8.39% of the employee's earnings from the employer, as shown in Box 1 of the employee's W-2 Tax and Wage statement. Under the second safe harbor, the 8.39% affordability test is applied to the employee's hourly rate of pay for a month, multiplied by 130. Finally, if the employee's required contribution is less than 8.39% of the federal poverty level for a single individual, the coverage is treated as affordable. A plan can meet any one of these tests to comply with the affordability requirement.

- "Adequate" coverage: For PPACA purposes, a plan is considered to provide adequate coverage (also called "minimum value") if the plan's actuarial value (i.e. share of the total allowed costs the plan is expected to cover) is at least 60%. Under the PPACA, the health insurance plans offered through the health insurance exchanges will generally be available at four "levels" or price points. Each level covers a specified percentage of the actuarial value of the benefits provided by the plan. These levels are: Bronze – 60%; Silver – 70%; Gold – 80%; and Platinum – 90%.

- Dependent: Although employers are encouraged to offer health coverage to an employee and all dependents, under IRS regulations, the term "dependent" has a narrow meaning. For PPACA purposes, a "dependent" is a child of an employee who has not yet attained age 26. The term does not include a spouse or others (such as parents) that an employee might claim as a dependent on his or her federal income

[1] This is the percentage for 2024; for 2023 this value was 9.12%. This percentage is subject to adjustment in future years.

tax return[1]. Thus, in order to meet the letter of the law, an employer must offer health insurance that covers only the employee and his or her children under the age of 26.

What Triggers the Penalty?

Regardless of whether or not a "large" employer offers health coverage, it will be liable for a penalty only if at least one of its full-time employees obtains coverage through a health insurance exchange and receives a premium assistance tax credit or cost-sharing subsidy.

One part of the PPACA calls for the creation of health insurance exchanges. These exchanges are intended to provide an online marketplace where individuals and small businesses can shop for qualified health insurance coverage. Individuals who purchase health insurance through a health insurance exchange may receive help in paying for the coverage in several ways:

- Premium assistance tax credit: A low-income individual[2] who purchases health insurance through a health insurance exchange may be eligible to receive a refundable "premium assistance" tax credit. The U.S. Treasury pays the premium assistance credit amount directly to the health insurance company, with the individual being responsible for paying any remaining premium.
- Cost-sharing subsidy: An individual may also qualify for a "cost-sharing" subsidy, available through the health insurance exchange. The subsidy reduces the dollar amount of "out-of-pocket" expenses (deductibles or co-payments) that the individual might otherwise pay. This subsidy is generally limited to low-income individuals[3] and is only available for those months when the individual qualifies for a premium assistance tax credit.

Calculating the Employer Penalty

Assuming that an employer is a "large" employer, and at least one full-time employee has obtained health insurance coverage through a health insurance exchange, with either a

[1] For 2018-2025, the Tax Cuts and Jobs Act of 2017 temporarily suspends the deduction for personal and dependent exemptions.

[2] Generally, someone earning from 100% up to 400% of the federal poverty level (FPL) for the family size involved. For 2024, in the continental U.S., 100% of the FPL for a family of one is $14,580; for a family of four it is $30,000; for a family of eight it is $50,560.

[3] Generally, those earning less than 250% of the federal poverty level (FPL), for the family size involved.

premium tax credit or a cost-sharing subsidy, the method used to calculate the employer's "shared responsibility" payment will vary:

- Large employer not offering health insurance: For 2024, the monthly penalty assessed to an employer who does not offer health insurance to at least 95% of its full-time employees will be equal to the number of full-time[1] employees minus 30 (the penalty is waived for the first 30 employees), multiplied by one-twelfth of $2,970.[2]

Example: In 2024, Employer X does not offer minimum essential health coverage and has 100 full-time employees, 10 of whom receive a premium assistance tax credit for the year. For each employee over the 30-employee threshold (100 - 30 = 70), the monthly penalty amount for Employer X is $17,325, (70 x ($2,970 ÷ 12)) or (70 x $24.75).

- Large employers offering coverage: Even though an employer may offer health insurance coverage, the coverage may not be "affordable" or it may not be "adequate." In this situation, for 2024, the monthly penalty assessed to an employer for each full-time employee who receives a premium tax credit or cost-sharing subsidy will be one-twelfth of $4,460.[2] However, the monthly penalty will be capped at an amount equal to the total number of full-time employees during the month (regardless of the number of employees receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of $2,970.

Example: In 2024, Employer Z offers health coverage and has 100 full-time employees, 20 of whom receive a premium tax credit or cost-sharing subsidy for the year. For these 20 employees, Employer Z employer owes a penalty of $7,433.33 per month (20 x ($4,460 ÷ 12)) or (20 x $371.67). The maximum monthly penalty for is capped at the amount that would have been assessed for a failure to provide coverage, or $17,325 ((100-30) x ($2,970 ÷12)) or (70 x $24.75). Since the calculated penalty of $7,433.33 for the 20 employees receiving a premium tax credit or cost-sharing subsidy is less than the maximum amount of $17,325 Employer Z will pay the $7,433.33 monthly penalty.

[1] Part-time employees are not included in the penalty calculations. Part-time employees <u>are</u> included in determining whether or not an employer is a "large" employer.

[2] The $2,970 and $4,460 amounts apply to 2024. For 2023 they were $2,880 and $4,320. These values are subject to adjustment for inflation in future years.

Other Requirements

- **Information reporting requirements:** Large employers subject to the employer shared-responsibility requirement are required to report certain health insurance coverage information to both its full-time employees and to the IRS. An employer who fails to comply with these reporting requirements is subject to certain penalties. Additionally, information reporting requirements apply to insurers, self-insuring employers, and certain other providers of minimum essential health coverage.

Seek Professional Guidance

The foregoing is a simplified, high-level summary of a complex piece of legislation. The guidance of knowledgeable income tax, health insurance, and other financial professionals is highly recommended.

Income-Related Monthly Adjustment Amount - IRMAA

Medicare enrollees whose modified adjusted gross income (MAGI)[1] exceeds certain dollar amounts are required to pay an additional amount (beyond the standard monthly premium) toward certain parts of their Medicare health insurance coverage. This additional amount is termed the "**I**ncome-**R**elated **M**onthly **A**djustment **A**mount," or **IRMAA**.

For 2024, the "threshold" amounts (based on federal income tax filing status) are (1) Married Filing Jointly: $206,000; and (2) All Others: $103,000.

The IRMAA can apply in one of four situations:

An individual is enrolled in Medicare Part B; or

The individual is enrolled in Medicare Part B and a Medicare Advantage Plan (Medicare Part C) with prescription drug coverage; or

The individual is enrolled in Medicare Part B and a Medicare Part D prescription drug plan; or

The individual is enrolled in a Medicare Part D prescription drug plan.

If an individual who is subject to IRMAA is enrolled in *both* Medicare Part B and either a Part D prescription drug plan or a Part C plan with drug coverage, he or she will be subject to *two* additional IRMAA amounts; one for Medicare Part B and a second for the prescription drug coverage.

Computing the IRMAA

An individual's IRMAA is computed by the Social Security Administration (SSA) using tax information provided by the Internal Revenue Service (IRS). Generally, the MAGI used to calculate the IRMAA is the most recent that the IRS is able to provide. In most cases this is two years prior to the current year. For example, IRMAA amounts for 2024 would generally be calculated using tax information from 2022. In some cases, tax data from three years prior may be used. If data from two or three years prior is not available for an individual, or if MAGI

[1] MAGI for this purpose is defined as the enrollees Adjusted Gross Income (AGI) as shown on line 11 of IRS Form 1040, increased by any tax-exempt interest shown on line 2a of Form 1040.

Income-Related Monthly Adjustment Amount-IRMAA

Computing the IRMAA (continued)

is at or below the threshold, an IRMAA will not be imposed. This process is an ongoing one, involving an initial determination, followed by annual re-determinations each subsequent year. Once the amount of the IRMAA is determined, the SSA sends a notice to the individual involved advising them of the IRMAA, the information used to calculate the IRMAA, and how to appeal if the enrollee disagrees with the determination. A notice will also provide information about what an enrollee should do if their income or circumstances have changed.

Appealing an IRMAA Determination

A Medicare enrollee can request an appeal within 60 days of receipt of an IRMAA determination notice. Generally, an appeal is filed when the income used by the SSA to calculate the IRMAA is based on incorrect or incomplete information.

Incorrect income tax information: Such as an amended income tax return, incorrect IRS information, or use of two-year old tax data when the SSA used IRS information from three years prior.

A change in living arrangements: Usually, when the tax filing status is "Married Filing Separately," and the individuals lived apart all year.

A Life Changing Event: Life changing events include:

- Death of a spouse
- Marriage
- Divorce or annulment
- Work reduction or stoppage
- Loss of income producing property
- Loss or reduction of pension income
- Receipt of employer settlement payment

Income-Related Monthly Adjustment Amount-IRMAA

IRMAA Tables for 2024

The tables below show the IRMAA amounts for 2024 for both Medicare Part B and for the Medicare Part D Prescription Drug Benefit. As MAGI rises, so does the IRMAA.

2024 IRMAA Table for Medicare Part B

Unmarried Individuals	Married Filing Jointly	Monthly Premium
Equal to or less than $103,000	Equal to or less than $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
Greater than or equal to $500,000	Greater than or equal to $750,000	$594.00

Married Filing Separately	Monthly Premium
Equal to or less than $103,000	$174.70
$103,001 to $396,999	$559.00
Greater than or equal to $397,000	$594.00

2024 Table for Medicare Part D Prescription Drug Benefit

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Equal to or less than $103,000	Equal to or less than $206,000	$0.00
$103,001 to $129,000	$206,001 to $258,000	$12.90
$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
Greater than or equal to $500,000	Greater than or equal to $750,000	$81.00

Married Filing Separately	Monthly Adjustment Amount
Equal to or less than $103,000	$0.00
$103,001 to $396,999	$74.20
Greater than or equal to $397,000	$81.00

Income-Related Monthly Adjustment Amount-IRMAA

Seek Professional Guidance

Careful planning can sometimes reduce or eliminate the imposition of an IRMAA on a Medicare enrollee's monthly premiums. In this regard, the advice and guidance of trained, experienced tax and planning professionals is highly recommended.

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) 2024 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 $1,632. For the 61st through 90th days, it pays all except $408 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 $816 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	$204.00 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.

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.

Medicare (Part B) 2024 Medical Insurance Covered Services per Calendar Year Standard Monthly Premium: $174.70

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 $240.00 deductible). 50% of approved charges for most outpatient mental health services.	$240.00 deductible[2] plus 20% of approved amount and limited charges above approved amount.[3] 50% of approved charges for mental health services.
Home health care[4].	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 $240.00 deductible).	$240.00 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).	$240.00 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 2024 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 services rendered.

[2] Once you have had $240.00 of expense for covered services in 2024, the Part B deductible does not apply to any further covered services you receive the rest of the year.

[3] Federal law limits charges for physician services.

[4] Home health care is provided under Part B only if not covered under Part A.

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 2024. The minimum premium for those in this group will be $174.70. Individuals in this group include:

- Medicare beneficiaries not receiving Social Security benefits.
- Those who enroll in Part B for the first time in 2024.
- Those who have both Medicare and Medicaid, and Medicaid pays the Medicare premiums.
- Those whose income in 2022 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 2024 Individual Part B premiums for Medicare beneficiaries.

Unmarried Individuals	Married Filing Jointly	Monthly Premium
Equal to or less than $103,000	Equal to or less than $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 $500,000	$386,001 to $750,000	$559.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$594.00

Married Filing Separately	Monthly Premium
Equal to or less than $103,000	$174.70
$103,001 to $397,000	$559.00
Greater than or equal to $397,000	$594.00

[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.

- 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 2024.

[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.

Medicare Part D - Prescription Drug Coverage

- **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.
- **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.

Standard Coverage

The standard coverage for 2024 as set by Medicare is shown in the following table:

	Deductible $545 Deductible	Initial Coverage $546 to $5030	Coverage Gap $5031 Until Out-of-Pocket Totals $8000	Catastrophic Coverage Above $8000 in Out-of-Pocket Costs
Enrollee Pays	$545	25% up to $1121	$743	$0
Others Pay	$0	75% up to $3364	$2,228	All
Total Drug Expense	$545	$4,485	$2,970	No Limit

Medicare Part D - Prescription Drug Coverage

Paying for Prescription Medication (continued)

Once an enrollee reaches the Coverage Gap, he or she will pay no more than 25% of the price of a medication. If a *brand-name medication* is involved, the manufacturer pays 70% of the price, and the Part D plan pays 5% of the cost. The 25% paid by the enrollee, plus the 70% paid by the manufacturer (totaling 95%) count as "out-of-pocket" expense, helping the enrollee quickly leave the Coverage Gap. If a *generic medication* is involved, the enrollee pays 25% of the price and Medicare pays the remaining 75%. In this case, only the 25% paid by the enrollee counts as an out-of-pocket expense toward getting out of the coverage gap.

In 2024, once an enrollee reaches $8,000 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.

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 2024 Part D IRMAA amounts are as follows:

Unmarried Individuals	Married Filing Jointly	Monthly Adjustment Amount
Equal to or less than $103,000	Equal to or less than $206,000	$0.00
$103,001 to $129,000	$206,001 to $258,000	$12.90
$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 $500,000	$386,001 to $750,000	$74.20
Greater than or equal to $500,000	Greater than or equal to $750,000	$81.00

Married Filing Separately	Monthly Adjustment Amount
Equal to or less than $103,000	$0.00
$103,001 to $397,000	$74.20
Greater than or equal to $397,000	$81.00

Medicare Part D - Prescription Drug Coverage

For Those Who Currently Have Prescription Drug Coverage

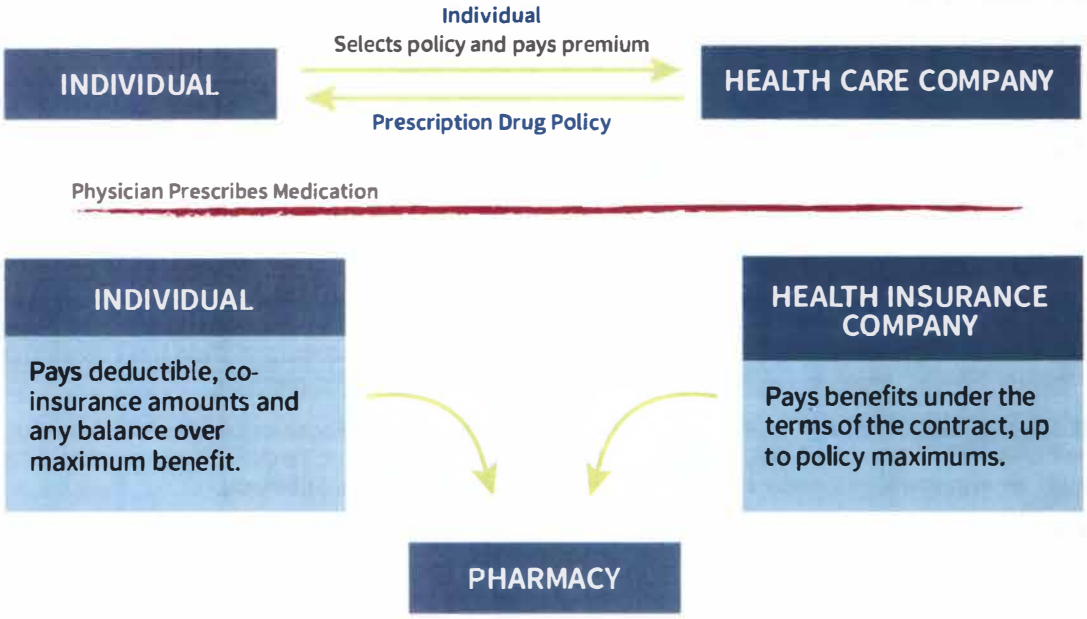
Some retirees may already have prescription drug coverage. For these individuals a key step is to compare the current coverage with that provided through a Medicare plan. The benefits administrator or insurance carrier can provide additional information.

- 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 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.

Inflation Reduction Act of 2022

The Inflation Reduction Act of 2022 (IRA-2022), signed into law by President Joe Biden on August 16, 2022, made significant changes to the prescription drug benefit provided under Part D of the Medicare program. The Medicare program is administered by the federal Centers for Medicare and Medicaid Services (CMS).

How Medicare Prescription Drug Coverage Works



Presented by Stephen Silverberg, Esq., CELA, AEP

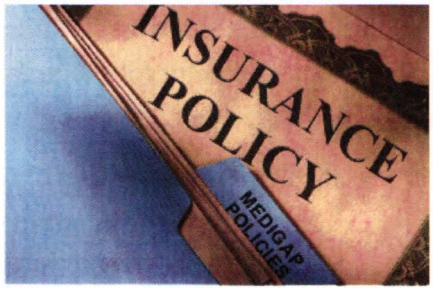
- Drug price negotiations: Under this provision, the Act requires CMS to negotiate maximum prices for brand-name drugs that do not have other generic equivalents and that account for the greatest Medicare spending. CMS must negotiate the price of 10 drugs in 2026, 15 drugs in 2027 and 2028, and 20 drugs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

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 2024 deductible of $2,800.00.

[4] In 2024, Plan K has an annual out-of-pocket limit of $7,060.00; Plan L has an annual out-of-pocket limit of $3,530.00.

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 ($1,632 in 2024), 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 ($240.00 in 2024); 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 ($204.00 per day in 2024) 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 ($1,632 in 2024) 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 ($240.00 in 2024).
- 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.