PART A (Hospitals)

Qualifications

- 65(+)
- Disability for 2(+) yrs
- ESRD

Cost

- Generally Free if you pay in 40 quarters
- Can be drawn from someone else for Free
- If it cost, it is based on several factors (In General $441 a month + 10% penalty)

HOSPITAL CARE

Inpatient Hospital Care

Medicare Part A (Hospital Insurance) covers hospital services, including semi-private rooms, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. This includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care.

What's not covered

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone in your room (if there's a separate charge for these items)
- Personal care items, like razors or slipper socks

Cost

- Days 1–60: $1,184 deductible for each benefit period in 2013.
- Days 61–90: $296 coinsurance per day of each benefit period in 2013.
- Days 91 and beyond: $592 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) in 2013.
- Beyond lifetime reserve days: all costs.

SKILLED NURSING CARE

Medicare-covered services include, but aren't limited to:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Physical and occupational therapy*
- Speech-language pathology services*
- Medical social services
- Medications
- Medical supplies and equipment used in the facility

- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the SNF
- Dietary counseling

*Medicare covers these services if they're needed to meet your health goal.

Cost

- Days 1–20: $0 for each benefit period in 2013.
- Days 21–100: $148 coinsurance per day of each benefit period in 2013.
- Days 101 and beyond: all costs.

LONG-TERM CARE HOSPITALS

Medicare Part A (Hospital Insurance) covers care in a long-term care hospital (LTCH). LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

Cost

Generally, you won't pay more for care in a long-term care hospital than in an acute care hospital. Under Medicare, you're only responsible for one deductible for any benefit period. This applies whether you're in an acute care hospital or a long-term care hospital (LTCH).

You don't have to pay a second deductible for your care in a LTCH if:

- You're transferred to a LTCH directly from an acute care hospital
- You're admitted to a LTCH within 60 days of being discharged from an inpatient hospital stay

If you're admitted directly to the LTCH more than 60 days after any previous hospital stay, you pay the same deductibles and coinsurance as you would if you were being admitted to an acute care hospital.

HOSPICE CARE

Hospice care is usually given in your home and includes these services when your doctor includes them in the plan of care for palliative care (for comfort) for your terminal illness and related condition(s):

- Doctor services
- Nursing care
- Medical equipment (like wheelchairs or walkers)
- Medical supplies and durable medical equipment
- Drugs for symptom control or pain relief
- Hospice aide and homemaker services
- Physical and occupational therapy
- Speech-language pathology services
- Social work services
- Dietary counseling

- Grief and loss counseling for you and your family
- Short-term inpatient care (for pain and symptom management)
- Short term respite care: respite care is inpatient care given to a hospice patient so that the usual caregiver can rest. You can stay in a Medicare-approved facility, like a hospice facility, hospital, or nursing home, up to 5 days each time you get respite care.
- Any other Medicare-covered services needed to manage your pain and other symptoms related to your terminal illness, as recommended by your hospice team

When you choose hospice care, you've decided that you no longer want care to cure your terminal illness and/or your doctor has determined that efforts to cure your illness aren't working.

Once you choose hospice care, Medicare **won't** cover:

- **Treatment intended to cure your terminal illness.** Talk with your doctor if you're thinking about getting treatment to cure your illness. As a hospice patient, you always have the right to stop hospice care at any time.
- **Prescription drugs to cure your illness** (rather than for symptom control or pain relief).
- **Care from any hospice provider that wasn't set up by the hospice medical team.** You must get hospice care from the hospice provider you chose. All care that you get for your terminal illness must be given by or arranged by the hospice team. You can't get the same type of hospice care from a different provider, unless you change your hospice provider. However, you can still see your regular doctor if you've chosen him or her to be the attending medical professional who helps supervise your hospice care.
- **Room and board.** Medicare doesn't cover room and board if you get hospice care in your home or if you live in a nursing home or a hospice inpatient facility. If the hospice team determines that you need short-term inpatient or respite care services that they arrange, Medicare will cover your stay in the facility. You may have to pay a small copayment for the respite stay.
- **Care in an emergency room, inpatient facility care, or ambulance transportation,** unless it's either arranged by your hospice team or is unrelated to your terminal illness**.**

Who's eligible?

People with Medicare who meet all of these conditions are covered:

- You're eligible for Medicare Part A (Hospital Insurance).
- Your doctor certifies that you're terminally ill and are expected to have 6 months or less to live.*
- You accept palliative care (for comfort) instead of care to cure your illness.
- You sign a statement choosing hospice care instead of routine Medicare-covered benefits for your terminal illness.

*In a Medicare-approved hospice, nurse practitioners aren't permitted to certify the patient's terminal illness, but after a doctor certifies the illness, the nurse practitioner can serve in place of an attending doctor. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies every 6 months that you continue to be terminally ill.

Cost

- $0 for hospice care.
- You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control.
- You may need to pay 5% of the Medicare-approved amount for inpatient respite care. Your cost for respite care may range from $5-$12 per day.
- Your usual Part B deductible and coinsurance for your doctor’s services (if your attending doctor isn't employed by the hospice).
- Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
- If you pay out-of-pocket for an item or service your doctor ordered, but the hospice refuses to give you, you can file a claim with Medicare. If your claim is denied, you may file an appeal.

Part B (Doctors)

Qualifications

- 65(+)
- Disability for 2(+) yrs
- ESRD

Cost

- Cost $104.90 a month
- Rate changes every year
- $147.00 Deductible each year
- 20% Co-Insurance Medicare Approved Amounts

What's covered?

Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition. If you're in a Medicare Advantage Plan or other Medicare plan, you may have different rules, but your plan must give you at least the same coverage as Original Medicare. Some services may only be covered in certain settings or for patients with certain conditions.

Part B covers 2 types of services

- **Medically necessary services:** Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- **Preventive services:** Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

You pay nothing for most preventive services if you get the services from a health care provider who accepts assignment.

Part B covers things like:

- Clinical research
- Ambulance services
- Durable medical equipment (DME)
- Mental health
- Inpatient
- Outpatient
- Partial hospitalization
- Getting a second opinion before surgery
- Limited outpatient prescription drugs

Medicare doesn't cover everything. If you need certain services that Medicare doesn't cover, you'll have to pay for them yourself unless you have other insurance or you're in a Medicare health plan that covers these services.

Even if Medicare covers a service or item, you generally have to pay your deductible, coinsurance, and copayments.

Some of the items and services that Medicare doesn't cover include:

- Long-term care (also called custodial care)
- Routine dental or eye care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care

PART C – Med. Advantage Plan (Private A&B combined)

- Usually cost $0 in addition to Part B
- A few will pay your Part B Premium
- Some have a small cost associated as premiums (Vary by company)
- Provides for predictable co-pays & deductibles
- Varies by company & area

Includes Special Needs Plans (SNP) for:

- Dual Eligible (Medicare & Medicaid)
- Chronic Illnesses such as Diabetes, Congestive Heart Failure, COPD, etc.
- Confined to a nursing home

PART D Prescription Drugs(RX Coverage)

- Cost an additional premium usually between $20 & $60 a month
- Deductible on RX
- Co-payments or Co-insurance
- Drugs usually cost according to Tier (Tier 1 is preferred generic, Tier 2 is non-preferred generic, Tier 3 is preferred brand, Tier 4 is non-preferred brand, Tier 5 is Specialty).
- Each company will use a formulary of what they cover & what they do not cover.
- The formulary will provide the cost of each medication
- Varies by company & area

The Coverage GAP (Also known as the “Donut Hole”) is the amount you pay once your total cost for RX reaches $2,970.00 in a benefit year. Once you are in the “Donut Hole” you pay 47.5% of the cost of brand name drugs. You will pay 69% of the cost for generics. The percentage you pay for generics will decrease every year you reach the “Donut Hole”, until you only pay 25% in year 2020.

After you have spent a total of $4,700.00 on RX in a calendar year you go into “Catastrophic Coverage”. After that you will only pay a small co-payment or co-insurance for your RX.

Items that count towards the coverage gap

- Your yearly deductible, coinsurance, and copayments
- The discount you get on brand-name drugs in the coverage gap
- What you pay in the coverage gap

Items that don't count towards the coverage gap

- The drug plan premium
- Pharmacy dispensing fee
- What you pay for drugs that aren’t covered

MAPD (Combined Part C & Part D)

- Combines Part C & Part D
- Can include SNPs
- Provides for predictable Co-Pays, Co-Insurance, Deductibles, etc
- Covers premiums for both Part C & Part D for 1 (one) fixed amount

MEDICARE SUPPLEMENT (Medigap) Insurance

A Medicare supplement (Medigap) insurance, sold by private companies, can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

A Medigap policy is different from a Medicare Advantage Plan. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.

8 things to know about Medigap policies

1. You must have Medicare Part A and Part B.
2. If you have a Medicare Advantage Plan, you can apply for a Medigap policy, but make sure you can leave the Medicare Advantage Plan before your Medigap policy begins.
3. You pay the private insurance company a monthly premium for your Medigap policy in addition to the monthly Part B premium that you pay to Medicare.
4. A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you'll each have to buy separate policies.
5. You can buy a Medigap policy from any insurance company that's licensed in your state to sell one.
6. Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you pay the premium.
7. Some Medigap policies sold in the past cover prescription drugs, but Medigap policies sold after January 1, 2006 aren't allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D).
8. It's illegal for anyone to sell you a Medigap policy if you have a Medicare Medical Savings Account (MSA) Plan.

Medigap policies don't cover everything

Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Insurance plans that aren't Medigap

Some types of insurance aren't Medigap plans, they include:

- Medicare Advantage Plans (like an HMO, PPO, or Private Fee-for-Service Plan)
- Medicare Prescription Drug Plans
- Medicaid
- Employer or union plans, including the Federal Employees Health Benefits Program (FEHBP)
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans

Buy a policy when you're first eligible
The best time to buy a Medigap policy is during your 6-month Medigap open enrollment period, because you can buy any Medigap policy sold in your state, even if you have health problems. This period automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.

During open enrollment
Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the Medigap policy. However, if you apply during your Medigap open enrollment period, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health.

Dropping your entire Medigap policy (not just the drug coverage)
If you decide to drop the entire Medigap policy, you need to be careful about the timing. For example, you may want a completely different Medigap policy (not just your old Medigap policy without the prescription drug coverage), or you might decide to switch to a Medicare Advantage Plan that offers prescription drug coverage.

If you drop your entire Medigap policy and the drug coverage wasn't creditable or you go more than 63 days before your new Medicare coverage begins, you have to pay a late enrollment penalty for your Medicare Prescription Drug Plan, if you choose to join one.

Medigap policies are standardized

Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" policy identified in most states by letters.

All policies offer the same basic benefits but some offer additional benefits, so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

Each insurance company decides which Medigap policies it wants to sell, although state laws might affect which ones they offer. Insurance companies that sell Medigap policies:

- Don't have to offer every Medigap plan
- Must offer Medigap Plan A if they offer any Medigap policy
- Must also offer Plan C or Plan F if they offer any plan

Medigap Plans

Note
The Medigap policy covers coinsurance only after you've paid the deductible (unless the Medigap policy also pays the deductible).

Compare Medigap plans side-by-side

The chart below shows basic information about the different benefits Medigap policies cover.
Yes = the plan covers 100% of this benefit
No = the policy doesn't cover that benefit
% = the plan covers that percentage of this benefit
N/A = not applicable

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charges	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes

Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$4,800	$2,400	N/A	N/A

* Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of $2,110 (in 2013) before your Medigap plan pays anything.
** After you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.
*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.