Atrium Health

Medicare Resource

2025 Medicare Options Guidebook

MULTI–PLAN_SEmgb1125_M

Table of Contents

Glossary of Terminology 3
Understanding Medicare 4
Medicare Basics 7
Your Medicare Coverages Choices..........8
Medigap: Understanding Your Options 9
NC: Available Medigap Plan Types..........10
SC: Available Medigap Plan Types.......... 11
GA: Available Medigap Plan Types..........12
Part D: Prescription Drug Coverage..........13
Understanding Medicare Advantage..........16
Original Medicare & Medicare Advantage Comparison 19
Enrollment Periods 22
Signing Up for Medicare..........23
Initial Enrollment Period..........24
Special Enrollment Period..........25
Making Changes to Your Coverage 26
Tips & Resources 27

This guidebook is designed to help you understand the basics of Medicare and Medicare insurance. No single Medicare plan is right for everyone.

Use this guidebook to help identify your Medicare insurance needs and select the plan most suitable for you.

Glossary of Terminology

Common terms used within this booklet

Term	Definition
Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
Deductible	The amount you must pay for healthcare or prescriptions before Original Medicare, your Medicare Advantage plan, your Medicare drug plan, or your other insurance begins to pay.
Dependent	Any individual, either spouse or child, who is covered by the primary insured customer's plan.
In-Network Provider	A healthcare professional, hospital or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services.
Medigap Plans	Plans offered by private insurance companies to help fill the "gaps" in Medicare coverage.
Network	The group of doctors, hospitals and other healthcare providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.
Out-of-Network Provider	A healthcare professional, hospital or pharmacy that is not part of a health plan's network of providers. You will generally pay more for services received from out-of-network providers.
Out-of-Pocket Maximum	The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.
Payer	The health insurance company (also known as a carrier) whose plan pays to help cover the cost of your care.
Premium	The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.
Provider	Any person (e.g., doctor, nurse, dentist) or institution (e.g., hospital or clinic) that provides medical care.

Understanding Medicare

Classifications of Medicare insurance

This information represents the most common classifications of Medicare insurance:

- Original Medicare
- Medigap
- Medicare Advantage plan
- Company-Sponsored Medicare
- Medicare/Medicaid

Original Medicare

Original Medicare includes Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). Original Medicare pays for most, but not all, costs for covered health services and supplies. To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can shop for and buy a Medigap plan. If you want drug coverage, you can shop for and buy a separate Part D plan.

Medigap

Medigap policies are sold by private companies and can help pay some of the remaining healthcare costs for covered services and supplies. Medigap provides coverage that is secondary to Medicare (Part A and Part B), meaning Medicare pays first and Medigap plan pays second. See pages 11-14 for more information on Medigap.

Medicare Advantage plan

Also referred to as Medicare Part C, a Medicare Advantage plan incorporates your Part A, Part B and often Part D prescription drug coverage into one plan. See pages 18-20 for more information on Medicare Advantage plans.

Understanding Medicare
(continued)

Classifications of Medicare insurance

This information represents the most common classifications of Medicare insurance:

- Original Medicare
- Medigap
- Medicare Advantage plan
- Company-Sponsored Medicare
- Medicare/Medicaid

Employer-Sponsored Medicare Plan

Employer-sponsored Medicare plans are available to those who receive some form of Medicare insurance from a current or former employer (or their spouse's employer). This category includes corporate Medicare plans, union member plans, military plans (TRICARE for Life) and Medicare plans offered to federal, state and municipal retirees. This type of insurance may be a plan that works secondarily to Medicare, or it may function as a Medicare Advantage plan. Employer-sponsored Medicare plans often feature premiums that include drug coverage and may be more expensive than comparable individual Medicare plans available to the general Medicare population. If you are considering canceling an employer-sponsored Medicare plan and joining a regular Medigap or Medicare Advantage plan, be sure to carefully consider your options, as employers often will not allow retirees to return to the plan after canceling coverage.

Medicare/Medicaid

Medicare and Medicaid are available to those who qualify for both Original Medicare and Medicaid benefits simultaneously. Often referred to as being "dual-eligible," Medicare/Medicaid beneficiaries meet state-specific income requirements for Medicaid eligibility, in addition to being qualified for Original Medicare. In basic terms, these individuals have Medicare as their primary insurance and Medicaid as secondary insurance.

Source: medicare.gov/basics/costs/help/medicaid

Understanding Medicare
(continued)

Medicare is a federal government program that offers health insurance to:

- Individuals age 65 and older or those under age 65 who are disabled and on Social Security for 24 months.
- Individuals of any age with end-stage renal disease or ALS (amyotrophic lateral sclerosis).
- U.S. citizens or permanent legal residents age 65 and older who have lived in the U.S. for a minimum of five consecutive years, including the five years prior to applying for Medicare.

Medicare is managed by the Centers for Medicare & Medicaid Services (CMS).

NOTE: Your (or your spouse's) work history affects Medicare premiums, but not eligibility.

A divorced spouse can apply for Medicare benefits on the work record of their former spouse if married a minimum of 10 years. (Certain rules apply.)

- Social Security processes your application for Original Medicare (Part A and Part B) and can give you general information about the Medicare program.
- Other parts of Medicare are run by private insurance companies that follow rules set by Medicare.

Source: medicare.gov/basics/costs/help/medicaid

Medicare Basics

Original Medicare is composed of **Part A** and **Part B** and is available directly through the federal government.

PART A — HOSPITAL INSURANCE

Medicare Part A helps pay for:
- Hospital Care
- Skilled Nursing Facility Care
- Home Healthcare
- Hospice Care

In most cases, you will usually have a $0 Medicare Part A premium if you or your spouse paid Medicare taxes long enough while working – generally at least 10 years.

You are first eligible for Part A at age 65, or earlier if you have been entitled to Social Security due to disability for 24 months.

PART B — MEDICAL INSURANCE

Medicare Part B helps pay for:
- Physician Services
- Outpatient Services
- Durable Medical Equipment
- Other Medical Services

You are first eligible for Part B at age 65, or earlier if you have been drawing Social Security due to disability for 24 months.

PART C — MEDICARE ADVANTAGE PLAN

Part C, or Medicare Advantage plan, is an all-in-one alternative to Original Medicare and often includes Part D prescription drug coverage.

For these plans, Medicare pays a private insurance company to provide your healthcare coverage with a Medicare Advantage plan. These plans must, at minimum, provide the same level of coverage as Original Medicare, and may include a monthly plan premium. Medicare Advantage plans often include additional benefits not offered by Original Medicare. You must have Part A and Part B to be eligible to

PART D — PRESCRIPTION DRUG COVERAGE

Part D refers to Medicare prescription drug coverage. People with Original Medicare and Medigap will need to purchase a Medicare Part D prescription plan separately.

For people considering a Medicare Advantage Plan, in addition to Medicare Part A and B, they often include Medicare Part D prescription coverage.
Note: if you decide to enroll late for Part D prescription drug coverage, a penalty may be assessed.

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium.

For Medicare costs and estimates, visit medicare.gov/basics/costs/medicare-costs

Additional resource: The "Medicare & You" book published annually by the Centers for Medicare & Medicaid Services includes additional information pertaining to Parts A, B, C and D. To request a copy, call 800-MEDICARE (800-633-4227), TTY/TDD 877-486-2048, or download at medicare.gov/medicare-and-you

Your Medicare Coverage Choices

There are 2 main ways to get your Medicare coverage:

1. Part A + Part B with the option of adding Part D and a Medigap Policy
2. A Medicare Advantage plan

You must be enrolled in Part A and Part B to sign up for a Medicare Advantage plan.

Use these steps to help you understand your coverage choices.

STEP 1

Decide how you want to get your coverage

Original Medicare

Part A
Hospital Insurance

Part B
Medical Insurance

STEP 2

Decide if you need to add drug coverage

Part D
Prescription Drug Coverage

STEP 3

Decide if you need to add supplemental coverage

Medigap Policy

END

OR

STEP 1

Decide how you want to get your coverage

Medicare Advantage Plan

Part C (like HMO* or PPO**)

Part C
Part A + Part B and usually Part D

STEP 2

Decide if you need to add drug coverage

Part D
Prescription Drug Coverage
Most Medicare Advantage plans cover prescription drugs. You may be able to add drug coverage to some plan types if not already included

END

If you join a Medicare Advantage plan, you can't use and can't be sold a Medigap policy.

*HMO = Health Maintenance Organization
**PPO = Preferred Provider Organization

Medigap: Understanding Your Options

Medigap always functions secondarily to Medicare. This means Medicare will pay its portion of the healthcare claim first, and the Medigap will pay second.

Useful facts about Medigap

The federal government has authorized 10 different standardized Medigap plan designs, named with letters from A to N for all states except Wisconsin, Minnesota and Massachusetts, which are considered waiver states and have a different set of standardized plans. Every policy must follow federal and state laws designed to protect you. Note: These letters have no relationship to the Medicare Part A, B, C and D designations.

All Medigap policies with the same letter offer the same benefits, regardless of the insurance company selling the policy. Some policies offer additional benefits, so select the one that suits your needs.

Medigap is sold by private insurance companies and does not include Part D prescription drug coverage.

Premiums for Medigap can vary greatly by company and plan. Medigap plans provide coverage nationwide.

Medigap may require the prospective policyholder to answer a series of health-related questions to qualify for coverage if purchased outside the guaranteed-issue period. This is called medical underwriting.

Medigap open enrollment period (OEP) for guaranteed issue is a one-time, 6-month window after a person first enrolls in Part B.

Most Medigap plans will allow the policyholder to receive care from any Medicare-certified healthcare provider that accepts Original Medicare, but some require the use of a contracted network of providers. Most plans cover a limited dollar amount for foreign travel emergencies.

North Carolina: Available Medigap Plan Types

These Medigap plans in North Carolina are consistent with Medigap plans nationwide. Due to their low out-of-pocket costs and comprehensive coverage, popular Medigap plans include:

MEDIGAP **PLAN F**

Plan F is the most comprehensive plan, but not all Medicare beneficiaries are eligible.

If you received Original Medicare after Jan. 1, 2020, you are eligible for Medigap Plan F. New Medicare beneficiaries do not qualify for Plan F, so they will not have the opportunity to enroll in this coverage.

You are responsible only for your monthly premium when you have Medigap Plan F. All out-of-pocket costs receive 100% coverage from day one with Medigap Plan F.

MEDIGAP **PLAN G**

If you are not eligible for Plan F, but still want comprehensive coverage, Medigap Plan G is the second-most comprehensive policy. It is available to all Medicare beneficiaries, regardless of when they become eligible for Original Medicare coverage.

Additionally, due to Plan G's low monthly premiums, it is quickly growing in popularity among those eligible for Plan F. The only cost Plan G does not cover is the Medicare Part B deductible. So, once the deductible is met, you are covered at 100%.

MEDIGAP **PLAN N**

Plan N is popular for its low rate increases and low premium.

You may have to make occasional $20-$50 copays to the doctor or hospital and also cover excess charges. Excess charges are not allowed in every state, but there may be an additional cost when seeing a doctor who does not accept Medicare.

North Carolina allows excess charges, so you will need to speak with your doctor about Medicare assignment before receiving treatment. If you receive coverage in a state that does not allow excess charges, you will not pay any additional costs. However, these costs are very rare even in the states that do allow them.

Source: medicare.gov/health-drug-plans/medigap

South Carolina: Available Medigap Plan Types

Some of the most popular Medigap plans in South Carolina are:

MEDIGAP **PLAN F**

Medigap Plan F is the most comprehensive plan of the three. Medigap Plan F leaves the beneficiary with no out-of-pocket costs. However, not every Medicare beneficiary is eligible for this plan.

If you received Medicare after Jan. 1, 2020, you are not eligible for Medigap Plan F. This ineligibility is due to a law that was passed to eliminate first-dollar coverage. First-dollar coverage refers to Medigap plans that cover you at 100% from the first dollar.

MEDIGAP **PLAN G**

If you are ineligible for Medigap Plan F, the next-best option for comprehensive coverage may be Medigap Plan G. Medigap Plan G covers all the same benefits as Plan F, except Plan G has a Medicare Part B deductible.

Additionally, Medigap Plan G has a lower premium and rate increase history than Plan F. Thus, Medigap Plan G is quickly becoming one of the most popular Medigap plans in South Carolina.

MEDIGAP **PLAN N**

Medigap Plan N is the lowest level of coverage among the three plans.

When you enroll in Medigap Plan N, you are responsible for the Medicare Part B deductible, $20 copays at the doctor, $50 copays at the emergency room if you are not admitted (the copay is waived if you are admitted), and excess charges if applicable in the state where you receive care.

South Carolina is one of the majority of states that allow excess charges. However, excess charges are not typical, and if you receive care in a state that does not allow them, you will not have to pay them, regardless of your South Carolina residence.

Source: medicare.gov/health-drug-plans/medigap

Georgia: Available Medigap Plan Types

Every standardized type of Medigap plan is offered in Georgia, but Plan F and Plan G offer the most comprehensive coverage and are some of the most popular. Plan F and Plan G also come in high-deductible versions. Here are some highlights and differences among a few plans:

MEDIGAP PLAN F

Most comprehensive

Covers the Part B deductible

Available only to people who were eligible for Medicare before Jan. 2020

MEDIGAP PLAN G

Most comprehensive for newer beneficiaries

Pays for excess Part B charges, so you can see any Medicare provider even if it charges more than the Medicare-approved amount

MEDIGAP PLAN K

One of two plans that have an out-of-pocket limit

After you reach the limit and pay your Part B deductible, your plan pays 100%

MEDIGAP PLAN L

Similar to Plan K, but has a lower out-of-pocket limit, and monthly premiums are higher

MEDIGAP PLAN M

Pays 50% of Part A deductible, so it could cost more if you need inpatient hospitalization

MEDIGAP PLAN N

Growing in popularity, Plan N has lower premiums but charges a copay for doctor and emergency room visits

Source: medicare.gov/health-drug-plans/medigap

PART D

Part D: Medicare Prescription Drug Coverage

MEDICARE PRESCRIPTION DRUG COVERAGE

- Medicare prescription drug coverage is available to everyone with Medicare
- These plans are offered by Medicare-approved private insurance companies
- You must have Part A and/or Part B to enroll in Part D

COVERAGE

- Coverage is available through:
  - Stand-alone Medicare prescription drug plans
  - Most Medicare Advantage plans
- Make sure your prescription drugs are covered before you enroll in a plan
  - The list of covered prescription drugs can change each year
  - Every plan has a tiered drug formulary (a list of prescription drugs covered by a plan)
  - Medicare sets standards for the types of prescription drugs Part D plans must cover

COSTS

- You may join a Medicare-approved Part D plan, which may include deductibles and copayments. Prescription drugs covered vary from plan to plan
- The prescription Part D monthly plan premium varies by plan and may be higher, depending on your income*
- Prescription drug assistance programs are available for Medicare-eligible individuals who meet certain requirements.

ENROLLMENT

- Coverage is not automatic; you must enroll in a Part D plan during the appropriate enrollment period
- You must live in the service area of the Part D drug plan you want to join
- Penalties may apply if you enroll late

Source: medicare.gov/drug-coverage-part-d

PART D Part D: Medicare Prescription Drug Coverage (continued)

DO YOU HAVE CREDITABLE DRUG COVERAGE?

How does your coverage compare to Medicare's?

- For example, you may have coverage through an employer group plan, when you are still employed
- No penalty if you have creditable drug coverage and delay enrolling in a Medicare drug plan

Compare current drug costs on your current creditable plan vs. premium and drug costs of Medicare Part D plans.

WITHOUT CREDITABLE COVERAGE

You may pay a late-enrollment penalty if you do not sign up when first eligible or if you go without drug coverage for more than 63 consecutive days.

Insulin savings through the Part D Senior Savings Model

INSULIN BENEFIT: The cost of a one-month supply of each Part D-covered insulin is capped at $35 and you don't have to pay a deductible. If you get a 60- or 90-day supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin.

To search for participating plans in your area, go to medicare.gov/plan-compare

You can filter and compare participating plans to help you find the one that's right for you. For frequently asked questions on this program, visit medicare.gov/coverage/insulin

Help with Drug costs: Extra Help program

"Extra Help" is a Medicare program to help people with limited income and resources pay Medicare drug coverage (Part D) premiums, deductibles, coinsurance, and other costs.

For more information on Extra Help, call Social Security at 800-772-1213 TTY:800-325-0778 or contact your local SHIP (Senior Health Insurance Program) certified counselors at 877-839-2675 or visit shiphelp.org.

medicare.gov/basics/costs/help/drug-costs

PART D

How is the Medicare Part D Benefit Changing in 2025?

Out-of-pocket drug spending will be capped at $2,000

Beginning in 2025, Part D enrollees' out-of-pocket drug costs will be capped at $2,000. This amount will be indexed to rise each year after 2025 at the rate of growth in per capita Part D costs. (This cap does not apply to out-of-pocket spending on Part B drugs.)

The coverage gap phase will be eliminated

This means that Part D enrollees will no longer face a change in their cost sharing for a given drug when they move from the initial coverage phase to the coverage gap phase, which is the case in most Part D plans today, since most plans charge varying cost-sharing amounts, rather than the standard 25% coinsurance, in the initial coverage phase.

Part D plans and drug manufacturers will pay a larger share of costs for catastrophic coverage, and Medicare will pay a smaller share

Medicare's share of total costs in the catastrophic phase (reinsurance) will decrease from 80% to 20% for brand-name drugs and from 80% to 40% for generic drugs beginning in 2025.

Part D plans and manufacturers will face changes to their share of total drug costs paid in the initial coverage phase

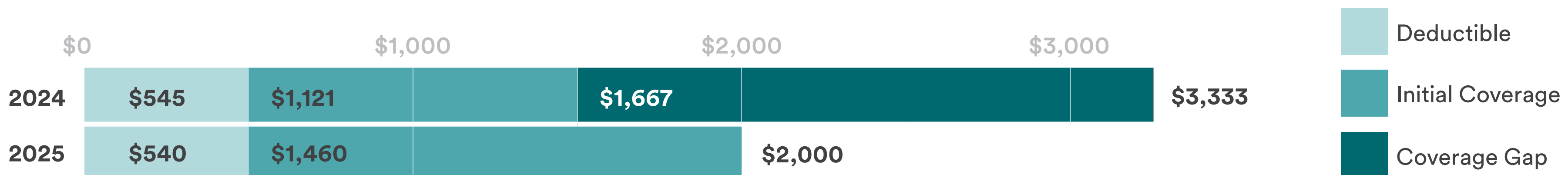
Drug manufacturers will be required to provide a 10% discount on brand-name drugs in the initial coverage phase beginning in 2025, replacing the 70% price discount in the coverage gap phase under the current benefit design. Part D plans will pay 65% of brand-name drug costs.

What Other Changes Are Being Made to Part D?

Starting in 2025, Part D enrollees will have the option of spreading out their out-of-pocket costs over the year rather than face high out-of-pocket costs in any given month.

For Medicare Part D enrollees who use only brands, out-of pocket drugs costs at the catatrosphic threshold will fall from about $3,300 in 2024 to $2,000 in 2025.

Out of pocket drug costs under the standard benefit for Part D enrollees without low-income subsidies.



NOTE: 2024 out-of-pocket amounts based on Part D benefit parameters from the 2024 Advance Notice. Deductible amount for 2025 is from 2023 Medicare Trustees report, Table V.E2.
SOURCE: KFF estimates based on Part D benefit parameters.
kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/

For a complete list of costs, visit: medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage

Understanding Medicare Advantage

Medicare Advantage facts

- Medicare Advantage/Medicare Part C plans work differently than Original Medicare. They are an alternate way to receive your medical and hospital benefits from a private health insurance company contracted with Medicare.
- In many cases, **you can only use doctors and other providers who are in the plan's net work and service area.** *If you are allowed to go out-of-network for the plan, you may have higher out of pocket costs. Contact the plan for further details.*
- Medicare Advantage plans usually include member coinsurance and copayments.
- A Summary of Benefits and Coverage is an official document from the Medicare Advantage plan, summarizing member cost-sharing requirements and should be reviewed carefully prior to applying for coverage.
- Some Medicare Advantage plans charge a monthly premium, which varies by insurer, plan and market. Medicare Advantage plans cannot adjust plan premiums based on the member's age, health or claims experience.
- Medicare Advantage plans require Part A and Part B of Medicare to be in effect, and you must continue to pay your Part B monthly premium. You also must reside within the county (plan service area) in which the Medicare Advantage plan is offered.

Understanding Medicare Advantage
(continued)

Medicare Advantage facts (continued)

- Medicare Advantage plans may include Part D prescription drug coverage. Medicare Advantage plans must offer emergency and urgent care coverage outside of the plan's service area (but not outside the U.S.). Contact your plan for more information on coverage while out of your plan's service area.

- Some Medicare Advantage plans feature additional plan benefits, such as dental care, vision care, telehealth visits, annual hearing exam, gym membership, transportation for healthcare services and more, that are not included with Original Medicare.

- People who already have a Medicare Advantage plan should receive an Annual Notice of Change (ANOC) letter from their Medicare Advantage plan no later than Sept. 30. The ANOC letter indicates how their Medicare Advantage benefits will change for the upcoming plan year. Medicare Advantage members are strongly encouraged to carefully review their ANOC letter.

- All Medicare Advantage plans are required to set maximum out-of-pocket costs for health-related services each year. Many Medicare Advantage plans have lower maximum out-of-pocket limits. Contact your Medicare Advantage plan provider for more information on coverage limits. *You cannot be enrolled in a Medicare Advantage and Medicare Supplement plan at the same time.*

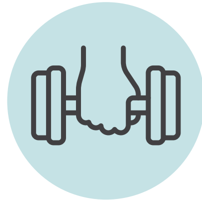
Source: medicare.gov/health-drug-plans/health-plans/your-health-plan-options

Understanding Medicare Advantage (continued)

Medicare Advantage extra benefits

Many Medicare Advantage plans have some of the following extra benefits included. Review plans, in the county in which you reside, for specific benefit details.

Telehealth



Fitness

Dental

Eye Exams and Glasses

Hearing Aids

Over-the-Counter Prescriptions

Meals

Transportation

Bathroom Safety

Home Healthcare & Caregiver Support

FLEX ALLOWANCE
Some MA (Part C) plans offer additional dollars on a pre-paid card that can be used towards plan identified services

Original Medicare & Medicare Advantage Comparison

Doctor & Hospital Choice

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you can **only use doctors and other providers who are in the plan's network and service area** (for non-emergency care).
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible. This amount is called your coinsurance.	**Out-of-pocket costs vary.** Plans may have different out-of-pocket costs for certain services.
You **pay the monthly premium** for Part B. If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly **Part B premium** and may also have to **pay the plan's premium.** Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out-of-pocket, unless you have supplemental coverage – like Medigap, Medicaid, employer, retiree, or union coverage.	Plans have a **yearly limit** on what you pay for covered Part A and Part B services (with different limits for in-network and out-of-network services). Once you reach your plan's limit, you'll pay nothing for covered services for the rest of the year.
You **can choose to buy** Medigap to help pay your out-of-pocket costs that Medicare doesn't cover (like your 20% coinsurance). Or, you can use coverage from a current or former employer or union, or Medicaid.	You **can't buy** Medigap to cover your out-of-pocket costs.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

Original Medicare & Medicare Advantage Comparison (continued)

Coverage

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some services, like routine physical exams, eye exams, and most dental care.	Plans must cover all medically necessary services that Original Medicare covers. For some services, plans may use their own coverage criteria to determine medical necessity. Plans may also offer some extra benefits that Original Medicare doesn't cover.
In most cases, you **don't need approval** (prior authorization) for Original Medicare to cover your services or supplies.	In many cases, you may need to **get approval** (prior authorization) from your plan before it covers certain services or supplies.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans.** In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.

Foreign Travel

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Original Medicare generally **doesn't cover medical care outside the U.S.** You may be able to buy a Medigap policy that covers emergency care outside the U.S.	Plans generally **don't cover medical care outside the U.S.** Some plans may offer an extra benefit that covers emergency and urgently needed services when traveling outside the U.S.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

Medicare Advantage Comparison at a Glance

PLAN TYPE	HMO Health Maintenance Organization	PPO Preferred Provider Organization	PFFS Private Fee-for-Service Plan	SNP Special Needs Plan	MSA Medicare Savings Account
Premium Do most plans charge a monthly premium?	**Yes.** Many charge a premium in addition to the monthly Part B premium.	**Yes.** Many charge a premium in addition to the monthly Part B premium.	**Yes.** Many charge a premium in addition to the monthly Part B premium.	**Yes.** Many charge a premium in addition to the monthly Part B premium.	**No.** You won't have to pay a separate monthly premium, but you'll continue to pay your Part B premium.
Drugs Does the plan offer Medicare prescription drug coverage (Part D)?	**Usually.** If you join an HMO plan that doesn't offer drug coverage, you can't get a separate Medi-care drug plan.	**Usually.** If you join a PPO plan that doesn't offer drug coverage, you can't get a separate Medicare drug plan.	**Usually.** If your PFFS Plan that doesn't offer drug coverage, you can get a separate Medi-care drug plan.	**Yes.** All SNPs must provide Medicare drug coverage (Part D).	**No.** You may join a separate Medicare drug plan.
Providers Can I use any doctor or hospital that ac-cepts Medicare for covered services?	**Sometimes.** You generally must get your care and services from doctors, other providers, or hospi-tals in the plan's network (except emergency or urgent care or out-of-area dialysis). In an HMO Point-of-Service (HMOPOS) Plan you may be able to get some ser-vices out of network for a higher copayment or coinsurance.	**Yes.** Each plan has a network of doctors, hospitals, and other providers that you may go to. You may also go out of the plan's network, but your costs may be higher.	**Yes.** You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If the plan has a network, you can use any of the network providers. (If you go to an out-of-network provider that accepts the plan's terms, you may pay more.)	**Sometimes.** If your SNP is an HMO, you must get your care and services from doctors or hospitals in the SNP's network (except for emergency, urgent care, or out-of-area dialysis). However, if your SNP is a PPO, you can get Medicare-covered services out of network.	**Yes.** MSA plans generally don't have network providers. You may go to any Medicare-approved provider for services that Original Medicare covers.
Primary Care Do I need to choose a primary care doctor?	**Usually**	**No**	**No**	**Varies by plan.** Some SNPs require you to choose a pri-mary care doctor and others don't.	**No**
Referrals Do I need a referral from my doctor to use a specialist?	**Yes**	**No**	**No**	**Maybe.** If the SNPs is an HMO, you need a referral. If the SNP is a PPO, you don't need a referral.	No

Source: medicare.gov/health-drug-plans/health-plans/your-coverage-options/compare

Enrollment Periods at a Glance

	PART A AND PART B	PART C	PART D	MEDIGAP
Medicare: initial enrollment period	7 month window, starting 3 months before an individual turns 65, and ending 3 months after the month they turn 65, allowing eligible individuals to enroll into a Medicare plan.	7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up.	7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up.	Guaranteed-issue one-time 6-month window after a person first enrolls in Part B.
Medicare: general enrollment period	3-month window from Jan. 1 - March 31 annually when you can enroll in Medicare Part A and Part B for the first time if you missed signing up when you were first eligible and you are not eligible for a special enrollment period. Coverage begins the following July 1. You may be subject to late penalties.			N/A
Medicare: annual enrollment period	N/A	Oct. 15-Dec. 7	Oct. 15-Dec. 7	N/A
Medicare Advantage: open enrollment period	N/A	One-time change between Jan. 1 - March 31. Must already be enrolled in a Medicare Advantage plan on Jan. 1. Can switch to a different MA plan, with or without drug coverage. Can return to Original Medicare and enroll in Part D. Cannot switch from one prescription drug plan to another. No guaranteed-issue right for Medigap.	N/A	N/A
Medicare: special enrollment period	Granted by Medicare in certain situations.	Granted by Medicare in certain situations.	Granted by Medicare in certain situations.	May have special rights and guaranteed-issue rules.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Signing Up for Medicare

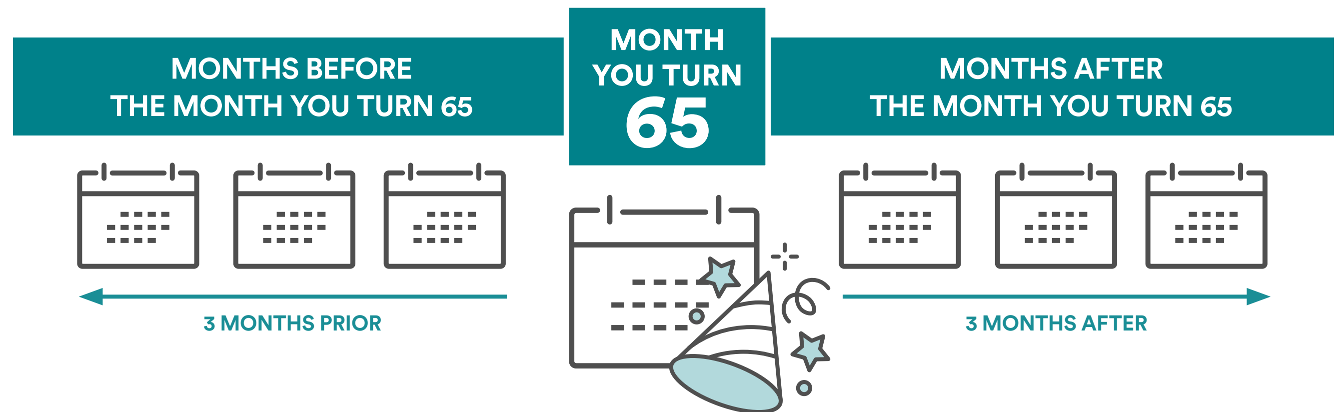
Just turning 65?

Understand the Medicare initial enrollment period and Medigap open enrollment period.

The Medicare initial enrollment period is a 7-month window that begins three months before you turn 65, continues the month you turn 65, and ends the third month after your 65th birthday. To sign up for Medicare Part A and Part B benefits, contact Social Security Administration or visit ssa.gov/benefits/medicare

If you sign up for Medicare Part B during the initial enrollment period, there is no late-enrollment penalty. However, for Part B coverage to start by your 65th birthday, you must sign up during the three months prior to your birthday. Note: If you become eligible for Medicare due to a disability, your eligibility begins on the 25th month of receiving Social Security Disability Insurance.

When you sign up for Medicare Part B, you automatically begin your Medigap open enrollment period. This period lasts for six months after you are enrolled in Medicare Part B. During this time, an insurance company cannot deny you any Medigap policy it sells, make you wait for coverage to start, or deny coverage because of a pre-existing condition.



If you enroll in this month of your initial enrollment period	Your Medicare benefit will begin
1-3 months before you reach age 65	The month you turn 65
The month you reach age 65	1 month after you enroll
1-3 months after you reach age 65	1 month after you enroll

Source: medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Initial Enrollment Period

You are automatically enrolled if:	You are not automatically enrolled if:
• You are collecting Social Security prior to age 65 – Medicare Part A and Part B card mailed 2-3 months prior – Coverage automatically begins the first day of your 65th birthday month • You are under age 65 and disabled – Benefits should begin the 25th month after receiving disability benefits • If you do not want to be enrolled in Medicare Part B, follow instructions on the back of the card and return to delay enrollment in Part B	• Not collecting Social Security before age 65 • You are still working and have creditable employer health insurance • You have coverage through the health insurance marketplace • You can enroll with Social Security – Visit your local office, go to ssa.gov or call 800-772-1213 (TTY 800-325-0778) – If retired from the railroad, enroll with the Railroad Retirement Board; call your local Railroad Retirement Board office or 877-772-5772 (TTY 312-751-4701)

You do not have to be retired to receive your Medicare benefits.

Medicare Enrollment Facts

You can sign up for your Medicare benefit at age 65, but you can choose to delay drawing on your Social Security benefits until later.

To avoid paying a late enrollment penalty for Part B (Medical) and Part D (Prescription Drug), you must have creditable health insurance. Check with your employer or current health insurance company to see if their plan is expected to pay, on average, at least as much as Medicare drug coverage or similar in value to Medicare Part B.

Source: medicare.gov/basics/get-started-with-medicare/medicare-basics/working-past-65
medicare.gov/basics/costs/medicare-costs/avoid-penalties

Special Enrollment Period

What if you're working past 65?

You may be eligible for a special enrollment period

If you or your spouse already has or is eligible for current employer health insurance or union coverage, check with your benefits administrator or insurer and ask how your current plan works with Medicare.

You may be able to apply for Medicare right away during your initial enrollment period or wait on some parts. Note: If you decline your employer's plan, all family members covered by it, including your spouse and children, would also lose their group benefits and would need to find a new plan.

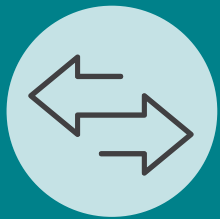
If you choose to wait to enroll in Medicare after age 65 while you continue to work, you will get a special enrollment period to sign up when you retire.

You may enroll (for Part A and/or Part B)

- Anytime while still covered after your 65th birthday
- Within eight months (within two months for Parts C and D) of loss of coverage or current employment, whichever happens first

Note: Retiree and COBRA coverage are not considered active-employment plans.

Additional Resources
Medicare: medicare.gov or 800-MEDICARE (800-633-4227); TTY/TDD 877-486-204



Making Changes to Your Coverage

Medicare Annual Enrollment period (AEP): Oct. 15-Dec. 7 every year

- Join, drop, or switch to another Medicare Advantage Plan (or add or drop drug coverage).
- Switch from Original Medicare to a Medicare Advantage Plan or from a Medicare Advantage Plan to Original Medicare.
- Join, drop, or switch to another Medicare drug plan if you're in Original Medicare.
- Plan is effective January 1 of next year.

Medicare Advantage open enrollment period (OEP)

Runs from Jan. 1 - March 31 every year or within the first 3 months you get Medicare. If you're enrolled in a Medicare Advantage plan, you will have a one-time opportunity to:

- Switch to a different Medicare Advantage plan
- Drop your Medicare Advantage plan and return to Original Medicare and sign up for a stand-alone Medicare Part D prescription drug plan
- Have the new coverage start the first of the month after the plan gets your request.

Special enrollment period (SEP)

Granted by Medicare in certain situations. You may have special rights. If you have employer group health plan coverage based on your (or your spouse's) active current employment, you may enroll (in Part A and/or B) anytime while still covered or within eight months (within two months for Parts C and D) of loss of coverage or current employment, whichever happens first.

To sign up for Part B in a special enrollment period, go to ssa.gov/forms and download two forms: **CMS 40-B** and **CMS L-564**

Trial Period

For those who have joined a Medicare Advantage plan for the first time, you can drop your Medicare Advantage plan and switch to Original Medicare anytime within the first 12 months of plan coverage. You also may have a guaranteed-issue opportunity to purchase a Medigap plan.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Tips & Resources

Determine which Medicare plans are accepted by your physicians, hospital and other healthcare providers

Beneficiaries should review plans that provide them the **benefits they need to address their health coverage needs.** Within the plans that provide the benefits they need, the should review to see which ones are accepted by their provider.

Reflect on your recent health history

Do you have any special healthcare needs, such as receiving outpatient services on a regular basis or a history of frequent hospitalizations? By making a list of healthcare services you've required in the recent past, you will be able to verify that the Medicare plans you're considering will include these important insurance benefits.

Understand the maximum out-of-pocket benefit

Maximum out-of-pocket benefits are included in Medicare Advantage plans; however, the maximum amount will vary by plan. Original Medicare typically covers 80% and has no maximum out-of-pocket benefit. Choosing an optional Medigap plan would help offset this cost.

Consider your prescription medication needs

Compare your medication list against the plan formulary of any Medicare Part D prescription plan of interest, and make sure your prescription medications are covered.

Added benefits may be important

Many Medicare Advantage plans include added benefits such as dental, vision, hearing, telehealth, alternative healthcare, wellness membership and more. Original Medicare and Medigap may not offer these added benefits.

Tips & Resources

NATIONAL

CMS – Centers for Medicare & Medicaid Services: cms.gov or 800-MEDICARE (800-633-4227), TTY/TDD 877-486-2048

Extra Help Prescription Drug Assistance Program (available for those with limited income and resources): 800-772-1213 or socialsecurity.gov/i1020

Medicare: medicare.gov or 800-MEDICARE (800-633-4227), TTY/TDD 877-486-2048

Medicare Benefits Coordination and Recovery Center: 855-798-2627, TTY/TDD 855-797-2627

Medicare Fraud: 800-633-4227, TTY/TDD 877-486-2048. If you are in a Medicare Advantage plan or Medicare drug plan, call the Medicare Drug Integrity Contractor (MEDIC) at 877-772-3379.

Social Security Administration: ssa.gov or 800-772-1213, TTY/TDD 800-325-0778

National SHIP (State Health Insurance Assistance Program) information: shiphelp.org or 877-839-2675

For North Carolina, South Carolina and Georgia, Atrium Health Medicare Information: atriumhealth.org/medicare

NORTH CAROLINA

North Carolina Seniors' Health Insurance Information Program (SHIIP): ncshiip.com or 855-408-1212

North Carolina Department of Aging and Adult Services: ncdhhs.gov/divisions/aging-and-adult-services or 919-855-3400

SOUTH CAROLINA

South Carolina State Health Insurance Assistance Program (SHIP): aging.sc.gov or 800-868-9095

South Carolina Department of Aging: getcaresc.com or 800-868-9095

GEORGIA

Georgia State Health Insurance Assistance Program (SHIP): aging.georgia.gov/georgia-ship or 866-552-4464 (Option 4 to apply via phone)

Georgia Division of Aging: aging.georgia.gov or 404-657-5258 or 866-552-4464

Atrium Health

For more information, visit us online at
AtriumHealth.org/Medicare