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Course 1:

Medicare Basics

— Part A and Part B, What You Need to Know

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What's Covered?

STEP 1 SIGN UP FOR ORIGINAL MEDICARE

Part A
Federal Government
Inpatient Hospital Care

Part B
Federal Government
Outpatient Care & Doctor Visits

STEP 2 SELECT AN OPTION FOR ADDITIONAL COVERAGE

OPTION 1

MEDICARE SUPPLEMENT
Private Insurance Company
Secondary coverage for
Out-of-Pocket Medicare costs

MEDICARE PART D PLAN
Private Insurance Company
Prescription Drug Coverage

OR

OPTION 2

MEDICARE ADVANTAGE
Private Insurance Company

Part C
Combination of Part A
& Part B coverage

Part D
Some plans include
prescription drug coverage

May offer benefits not
covered by Original Medicare

2026 Part A Deductible

Medicare Part A projected deductible is $1,736 per benefit period

The Centers for Medicare & Medicaid Services (CMS) release new premiums, deductibles, and coinsurance for Part A, Part B, and Medicare Part D income-related monthly adjustments every fall. (↑ +$60.00 vs. 2025)

Deductible — A deductible is the amount you pay for certain medical expenses or prescription drugs before your insurance plan starts paying any of the costs

Benefit Period — A benefit period begins the day you're admitted to a hospital/skilled nursing facility and ends when you haven't spent the night in one of them for 60 consecutive days. If you're admitted to a hospital/skilled nursing facility after one benefit period has ended, then a new one begins. You will pay another deductible.

Inpatient Hospital Care

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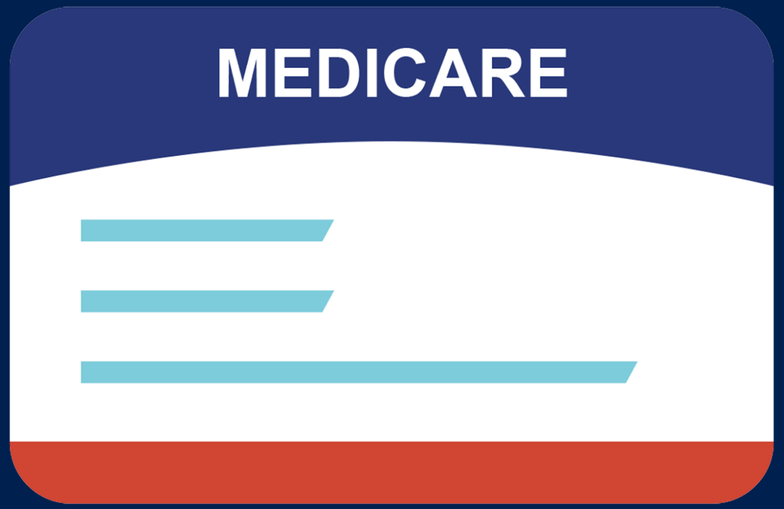
WHAT'S THAT YOU SAY?

2026 Medicare Part B Deductible



Medicare Part B deductible is $283 before Original Medicare starts to pay.

You pay this deductible once each year.

(↑ +$26.00 vs. 2025)

The Centers for Medicare & Medicaid Services (CMS) release new premiums, deductibles, and coinsurance for Part A, Part B, and Medicare Part D income-related monthly adjustments every fall.

Outpatient Care

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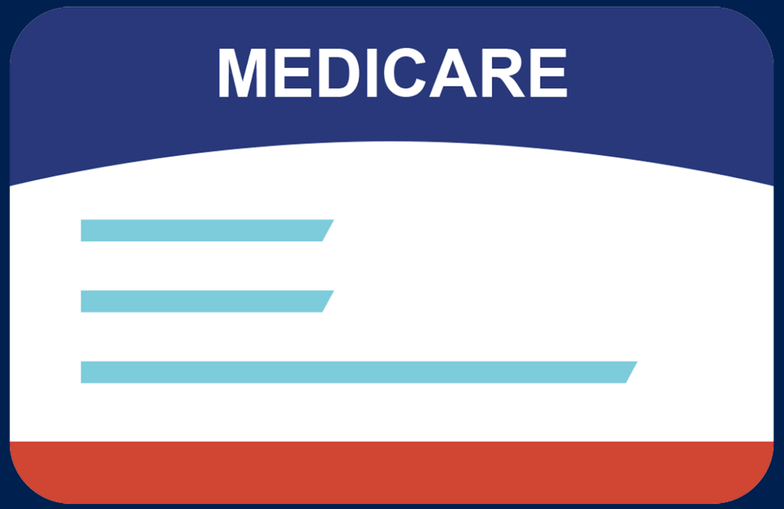
WHAT'S THAT ABOUT? →

2026 Medicare Part B Premium



In 2026, the standard monthly premium for Medicare Part B enrollees is anticipated to be $202.90*

(↑ +$17.90 vs. 2025)

The Centers) for Medicare & Medicaid Services (CMS) release new premiums, deductibles, and coinsurance for Part A, Part B, and Medicare Part D income-related monthly adjustments every fall.

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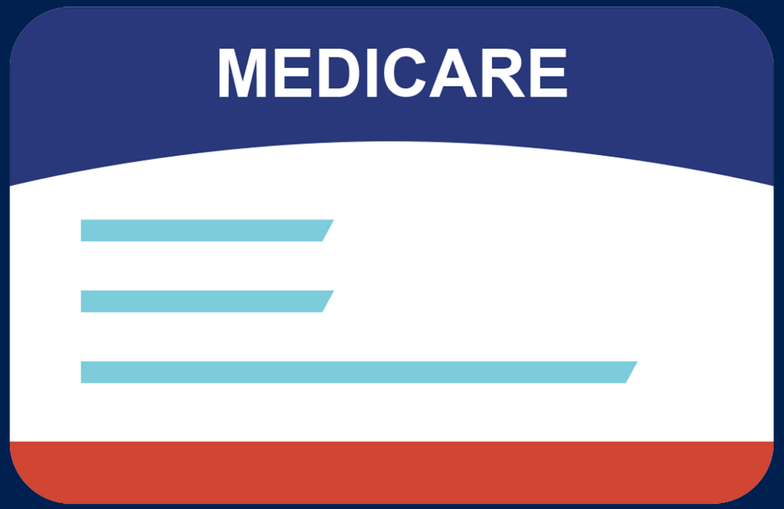
WHAT'S THAT YOU SAY?

2026 Medicare Part B Co-Insurance



After your deductible is met, typically you pay 20% of the Medicare-approved amount for these services.

There is no benefit period for Part B coverage.

The Centers for Medicare & Medicaid Services (CMS) release new premiums, deductibles, and coinsurance for Part A, Part B, and Medicare Part D income-related monthly adjustments every fall.

Outpatient Care

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About the Numbers →

2026 IRMAA Chart

Beneficiaries who file individual tax returns w/modified adjusted gross income	Beneficiaries who file joint tax returns w/modified adjusted gross income	Part B Total Monthly Premium Amount	Part D Total Monthly Premium Amount
Less than or equal to $109,000	Less than or equal to $218,000	$202.90	Premium Varies
Greater than $109,000 and less than or equal to $137,000	Greater than $218,000 and less than or equal to $274,000	$284.10 ($202.90 + $81.20)	Premium + $14.50
Greater than $137,000 and less than or equal to $171,000	Greater than $274,000 and less than or equal to $342,000	$405.80 ($202.90 + $202.90)	Premium + $37.50
Greater than $171,000 and less than or equal to $205,000	Greater than $342,000 and less than or equal to $410,000	$527.90 ($202.90+ $324.60)	Premium + $60.40
Greater than $205,000 and less than or equal to $500,000	Greater than $410,000 and less than $750,000	$649.20 ($202.90 + $446.30)	Premium + $83.80
Greater than $500,000	Greater than or equal to $750,000	$689.90 ($202.90 + $487.00)	Premium + $91.00

IRMAA = Income-Related Monthly Adjustment Amount

- **Two-Year Lookback**: Your 2024 tax return (filed in 2025) determines your 2026 IRMAA.
- **MAGI**: IRMAA applies if your Modified Adjusted Gross Income exceeds the baseline thresholds.
- **Appeals**: You can appeal if your income has significantly decreased due to specific life events (like job loss, divorce, or death of a spouse).

Source: https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles

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SHOW MORE!

Types of Medicare Plans

OOH NICE!

HEALTH MAINTENANCE ORGANIZATIONS (HMO)*

Have their own network of doctors, hospitals and other healthcare providers who provide their services for a specific payment, which allows the HeMO to maintain costs for its members. Cost and choice are the 2 features that set HMOS apart from other healthcare plans.
**Referrals are required.*

PREFERRED PROVIDER ORGANIZATIONS (PPO)

Offer a network of healthcare providers to use for your medical care at a certain rate. Unlike HMO, a PPO offers you the freedom to receive care from any healthcare provider—in or out of your network.

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What's the difference?!!!

HMO vs. PPO

Questions	HMO Health Maintenance Organization	PPO Preferred Provider Organization
How much will this plan cost?	**Lower cost** HMO plans typically have lower monthly premiums. You can also expect to pay less out of pocket.	**Higher cost** PPOs tend to have higher monthly premiums in exchange for the flexibility to use providers both in and out of network without a referral. Out-of-pocket medical costs can also run higher with a PPO plan.
Do I have to use a primary care physician (PCP)?	**Yes** With most HMO plans, all of your healthcare services are coordinated by your designated PCP.	**No** PPO plans do not require referrals for any services.
Do I have to get referrals to use another doctor?	**Yes** With an HMO, you must first schedule an appointment with your PCP and they will provide a referral to an in-network specialist.	**No** PPO plans do not require referrals for any services.
If I have a doctor or a specialist who is out of network, will I still be able to see him or her and have the costs covered?	**No** HMOs don't offer coverage for care from out-of-network healthcare providers. The only exception is for true medical emergencies.	**Yes** With a PPO, you have the flexibility to visit providers outside of your network. However, visiting an out-of-network provider will include a higher fee and a separate deductible.
Will I need to file claims?	**No** Since HMOs only allow you to visit in-network providers, it's likely you'll never have to file a claim. This is because your insurance company pays the provider directly.	**Yes** In some cases, you will have to pay a doctor for services directly and then file a claim to get reimbursed. This is most common when you seek services from out-of-network providers.

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Special Needs Programs (SNP)

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. Individuals may have specific diseases, certain health care needs, or who also have Medicaid.

A SNP has all the benefits of a Medicare Advantage plan (including a prescription drug plan) and also has extra services specific to the type of plan.

There are three different types of SNPs:

1. Chronic Condition SNP (C-SNP)
2. Dual Eligible SNP (D-SNP)
3. Institutional SNP (I-SNP)

Special Needs Programs

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HOW?!!

To be Eligible for a Special Needs Plan (SNP)

You must

1. Have Medicare Part A (hospital insurance) and Part B (medical insurance)
2. Live in the plan's service area
3. Meet the eligibility requirements for the SNP

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WHAT HEALTH CONDITIONS APPLY? →

Chronic Condition SNP

C-SNP Eligibility Requirements:

- You must have both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Be a U.S. citizen or a lawful permanent resident.
- You must reside in a county where a specific C-SNP plan is offered.
- Your doctor must verify you have one or more of the chronic conditions covered by the specific C-SNP plan you choose.
  - Chronic alcohol and other dependence
  - Certain autoimmune disorders
  - Cancer (excluding pre-cancer conditions)
  - Certain cardiovascular disorders
  - Chronic heart failure
  - Dementia
  - Diabetes mellitus
  - End-stage liver disease
  - End-Stage Renal Disease (ESRD) requiring dialysis (any mode of dialysis)
  - Certain severe hematologic disorders
  - HIV/AIDS
  - Certain chronic lung disorders
  - Certain chronic and disabling mental health conditions
  - Certain neurologic disorders
  - Stroke

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D-SNP Eligibility Requirements

- Be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Qualify for your state's Medicaid program, which covers low-income individuals.
- Be a U.S. citizen or a lawful permanent resident.
- Live in an area where D-SNPs are offered.

D-SNPs contract with your state Medicaid program to help coordinate your Medicare and Medicaid benefits, depending on the state and your eligibility

Dual Eligible SNP

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I-SNP Eligibility Requirements:

- Be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- Be a U.S. citizen or a lawful permanent resident.
- Live in an area where I-SNPs are offered.
- **Institutional Setting:** Live in a participating long-term care facility or qualify for the institutional level of care at home (IE-SNP).
- **Duration:** Have been, or are expected to be, in this setting for at least 90 days.

  - Nursing home
  - Intermediate care facility
  - Skilled nursing facility
  - Rehabilitation hospital
  - Long-term care hospital
  - Swing-bed hospital
  - Psychiatric hospital
  - Other facility that offers similar long-term, health care services and whose residents have similar needs and health care status as residents of the facilities listed above

Institutional SNP

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When? →

Election Periods

SPECIAL ENROLLMENT PERIODS (SEP) —

You can make changes to your Medicare Advantage and Medicare drug coverage when certain events happen in your life, like if you move or you lose other coverage. The types of changes you can make and the timing depend upon your life event.

GOT IT!!!!

GENERAL ENROLLMENT PERIOD (GEP) —

If you don't sign up for Part A (if you have to buy it) and/or Part B when you're first eligible, and you don't qualify for a Special Enrollment Period, you may have to wait until the Medicare General Enrollment Period (from January–March 31) to enroll and coverage will start the 1st of the following month.

In most cases, you'll have to pay a late enrollment penalty for as long as you have Part B if you sign up during the General Enrollment Period.

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When? →

Annual Election Period

ANNUAL ELECTION PERIOD (AEP)

AEP pertains to Medicare beneficiaries looking to change their current coverage
Timing: **October 15 to December 7**.
Effective as of January 1st. Dis-enrollments effective December 31st.

STILL GOT IT!!!!

YOU CAN MAKE THE FOLLOWING CHANGES:

1. Change from a Medicare Advantage plan back to Original Medicare
2. Change from Original Medicare to a Medicare Advantage plan
3. Switch from one Medicare Advantage plan to another Medicare Advantage plan (with or without prescription drug coverage)
4. Join, drop, or switch a Medicare Part D (prescription drug) plan

If more than one application is submitted for a consumer during AEP, the last application received is the one that will be valid.

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When? →

Open Enrollment Period

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MA OEP)

MA OEP pertains to Medicare Advantage beneficiaries looking to change their current coverage.

Timing: January 1 – March 31 with an effective date the 1st of the following month after receipt of the enrollment request

ONLY ONCE?

You can make these changes to the way you receive your Medicare benefits:

1. Switch to a different Medicare Advantage plan
2. Switch to Original Medicare (Medicare Part A and Part B) and add a Medicare Part D (prescription drug) plan if desired (with or without prescription drug coverage)

KEEP IN MIND:

- If you have Original Medicare with or without Medicare Part D coverage, you **CANNOT** make any changes to your Medicare coverage during MA OEP.
- You can **only make a single change** during the MA OEP.

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Available Election Periods

AVAILABLE ELECTION PERIODS

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Annual Enrollment Period (AEP)	During AEP, consumer can make a new plan choice. Any type of plan can be selected.									**AEP 10/15-12/07**		
Medicare Advantage Open Enrollment Period (MA_OEP)	**MA-OEP 1/1 - 3/31**			During OEP, MA Plan members may have an opportunity from January 1 through March 31 to switch MA plans (with or without drug coverage) or to disenroll from an MA plan and obtain coverage through Original Medicare (with or without a stand-alone PDP). Members enrolled in stand-alone PSP plans are not eligible for the Open Enrollment Period election because the OEP is only available to those enrolled in an MA plan.								
MA-OEP Newly Eligible (MA-OEP NEW)	**MA-OEP NEWLY ELIGIBLE January 1 – March 31st**											
	Newly eligible consumers who enroll in an MA Plan during their IEP/ICEP can use MA-OEP Newly Eligible, but only during the first three months after the start of Part A and Part B.											
Special Enrollment Period (SEP)	**SPECIAL ENROLLMENT PERIODS (SEP) & INSTITUTIONALIZED (OEPI) January 1 – December 31st**											
	Qualifying members can make changes outside of the AEP in accordance with applicable requirements. For example, Dual-eligible or LIS-eligible consumers who are maintaining their status may have a quarterly (not monthly) opportunity to change plans within the first nine months of the calendar year. For DSNP, the change cannot be made during calendar quarter four.											
Newly Eligible (ICEP / IEP)	**January 1 – December 31st**											
	Qualifying members will have 7-month window to enroll: 3 months prior, the month of, and 3-months after the start date of Parts A & B eligibility, or the month they turn 65 (or date of disability, if prior to turning 65). If a qualifying member delays enrollment into Part B they will have only the 3 months prior to their Part B start date.											

NOTE: Members of MA-Only coordinated care plans (HMO, POS, PPO) cannot also enroll in a stand-alone PDP. If they enroll in a stand-alone PDP, they will be disenrolled from their MA-Only coordinated care plan.

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We have answers

FAQ:

Turning 65 and either you or your spouse is still working, and have health coverage through their employer.

You may decline Part B and decide to enroll at a later date, without having to pay a late enrollment penalty as long as you're eligible for and enroll in Part B during a Special Enrollment Period. If you wait to enroll in Part B because you or your spouse are working and have group health coverage through an employer or union based on this current employment, you can enroll during a Special Enrollment Period. You can sign up for Part B during one of these times:

- Any time you're still covered by an employer or union group health plan, through your or your spouse's current or active employment
- During the 8-month period that begins the month after the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

Note: If you're still working and plan to keep your employer's group health coverage, you should talk to your benefits administrator to help you decide when you should enroll in Part B. When you sign up for Part B, you automatically begin your Medigap Open Enrollment Period. Once your Medigap Open Enrollment Period begins, it can't be changed or restarted. For more information on Medigap, visit Medicare.gov/publications to view the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

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We have even more answers

More FAQs:

What is an HSA?

A Health Savings Account is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. HSAs work with HSA-eligible health plans to allow you to pay for qualified medical expenses. HSAs offer triple tax savings:

- You can contribute pre-tax dollars.
- You pay no taxes on earnings.
- You can withdraw the money tax-free now or in retirement to pay for qualified medical expenses.

What do I need to know about Medicare and my HSA?

If you're currently contributing to your HSA and you plan to start your Medicare coverage the month you turn 65: Make sure all HSA contributions end before your 65th birthday month. If your birthday is on the first of the month, make sure you stop your contributions by the beginning of the month before your birthday month.

It’s important to understand the implications of Medicare enrollment for future HAS contributions. You could be subject to tax penalties if you make HSA contributions after you enroll in Medicare or when your Medicare coverage begins.

When you enroll in any form of Medicare, neither you nor your employer should continue contributing to your HSA. If you enroll in Medicare after turning 65, your coverage can become effective up to 6 months earlier. You and your employer will need to end your HAS contributions up to 6 months before enrolling in Medicare since Medicare back dates your Part A coverage from the date you enroll.

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Thank you!