**Medicare Supplement Insurance**

Medicare supplement insurance fills in the gaps between what original Medicare pays and what you must pay out-of-pocket for deductibles, coinsurance, and copayments.

Medicare supplement policies only pay for services that Medicare says are medically necessary, and payments are generally based on the Medicare-approved charge. Some plans offer benefits that Medicare doesn’t offer, such as emergency care outside the United States.

Medicare supplement policies are sold by private insurance companies that are licensed and regulated by TDI. Medicare supplement benefits, however, are set by the federal government.

It’s best to buy Medicare supplement insurance during your six-month open enrollment period. Your open enrollment period begins when you enroll in Medicare Part B at age 65 or older. During this time, companies can’t refuse to sell you a policy because of your health history or condition. If you wait until after your open enrollment period, you might not be able to buy a policy if you have a preexisting condition.

**Note:** Your Medicare supplement policy is renewed automatically each year to ensure you have continuous coverage. If you drop your Medicare supplement policy, you may not be able to get it back, or you might not be able to buy a new policy.

**Medicare Select**

Medicare Select is a type of Medicare supplement policy that usually requires you to use doctors and hospitals in the plan’s network for your routine care. If you use out-of-network hospitals -- other than in an emergency -- you’ll have to pay more of the cost.

If you move out of the plan’s service area, you have the right to buy a Medicare supplement policy that offers the same or fewer benefits as your current policy. You must buy the plan from the same company that provides your Select coverage. If you’ve had your Medicare Select policy for more than six months, you won’t have to answer medical questions.

**The 10 Standard Medicare Supplement Insurance Plans**

There are 10 Medicare supplement insurance plans. Each plan is labeled with a letter of the alphabet and has a different combination of benefits. Plan F has a high-deductible option. Plans K, L, M, and N have a different cost-sharing component.

Every company must offer Plan A. If they offer other plans, they must offer Plan C or Plan F.

**Basic Benefits**

The 10 Medicare supplement plans (plans A, B, C, D, F, G, K, L, M, and N) provide these benefits:

* **Hospitalization:**
	+ Pays your daily copayments for hospitalization expenses from the 61st through the 90th day of the Medicare benefit period.
	+ Pays the Medicare Part A copayments for any hospital confinement beyond the 90th day in a benefit period, up to an additional 60 days during your lifetime. (These are your inpatient reserve days. You may use these days when you require more than 90 days in the hospital during a benefit period. When you use a reserve day, it is subtracted from your lifetime total and can’t be used again.)
	+ Pays the Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
	+ Pays the skilled nursing facility care coinsurance.
* **Hospice:** Pays the copayment for outpatient pain medications and the coinsurance for inpatient respite care. Plans K and L pay this cost at a different rate. You must meet Medicare’s requirements, including getting a doctor’s certification of terminal illness.
* **Medical expenses:** After you’ve met your Part B deductible, pays your portion of the 20 percent Part B coinsurance for doctor bills, hospital or home health care, and some other Medicare-eligible expenses. Plans K, L, and N require you to pay part of the 20 percent Part B coinsurance.
* **Blood:** Pays for the first three pints of blood each year under Medicare parts A and B.

In addition:

* **Plans B, C, D, F, G, and N** pay the entire Part A deductible. Plans K, L, and M pay a percentage of the Part A deductible. Out-of-pocket limits apply to plans K and L.
* **Plan N** requires a $20 copayment for most office visits and $50 for emergency room visits.
* **Plans C and F** pay the Part B deductible.
* **Plans C, D, F, G, M, and N** pay for skilled nursing facility care copayments from the 21st day through the 100th day in a benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A. This is not custodial care. Plans K and L pay a portion of the cost until you meet the annual out-of-pocket limits. The plan will then pay 100 percent.
* **Plans C, D, F, G, M and N** pay for emergency care while traveling outside the United States. They pay 80 percent of the charges that Medicare would pay if you were in the United States. Care must begin during your first 60 days outside the United States. The calendar year deductible is $250. The lifetime maximum benefit is $50,000.
* **Plans F and G** pay Medicare Part B excess doctor charges that Medicare doesn’t pay.  They pay 100 percent of the excess fees, which are limited to 15 percent above the Medicare-approved amount.

***This chart summarizes the benefits provided by each plan:***[***Standard Medicare Supplement Insurance Plans***](https://www.tdi.texas.gov/consumer/documents/cpmedsupplan.pdf)***.***

**Keeping Your Coverage if You Move**

If you are moving to another county or state, make sure your Medicare plan will still be in effect after you move.

If you have original Medicare, federal rules usually allow you to keep your Medicare supplement policy. There are exceptions to this if you have a Medicare Select plan or if you have a plan that includes added benefits, such as vision coverage or discounts that were available only where you bought the plan.

If you have a Medicare Advantage plan, ask the plan whether it’s available in your new ZIP code. If the plan isn’t available, you’ll have to get a new one. You can switch to another Medicare Advantage plan in your new area or to original Medicare.