DS Medicare Solutions

MEDICARE, MADE SIMPLE

Understanding Medicare

A Complete Plain-English Guide

Everything worth understanding before you choose your coverage - the four parts, your two main paths, when you can enroll, what things cost, and the mistakes that are easiest to avoid.

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Medicare is not complicated because it's difficult. It's complicated because nobody explains it in order. This guide walks through it the way I'd explain it sitting at your kitchen table - one piece at a time, in the order the decisions actually come up.

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PLEASE NOTE

This guide explains how the Medicare program is structured. It does not describe or recommend any specific insurance plan. Program rules and dollar figures change every year, so always confirm current-year numbers before making a decision.

What Medicare actually is

Medicare is the government health insurance program mainly for people 65 and older. It also covers some people under 65 who have certain disabilities, kidney failure, or ALS. It is not the same as Medicaid - that's a separate program, run by your state, for people with limited income. Some people qualify for both.

Who qualifies at 65

- You are a U.S. citizen or a lawful permanent resident who has lived here at least five continuous years.
- You or your spouse worked and paid Medicare payroll taxes for at least 10 years (40 quarters). This is what earns you premium-free Part A.
- If you didn't reach 40 quarters, you can usually still get Part A by paying a monthly premium for it.

The two ways to build your coverage

Once you have Part A and Part B - together called Original Medicare - you choose one of two directions to fill the gaps. Everything else in this guide comes back to that choice.

- Path 1: Original Medicare, plus a Medicare Supplement (Medigap) policy, plus a standalone Part D drug plan.
- Path 2: A Medicare Advantage plan (Part C), which bundles your coverage into one plan, usually including drug coverage.

> **You are not locked in forever. There are set windows each year when you can change your mind - but switching one direction is easier than switching the other. Section 7 explains why.**

2. Part A - Hospital Coverage

Part A covers your care when you are officially admitted to the hospital, plus a few services outside the hospital. Most people pay nothing each month for it.

What Part A covers

- Inpatient hospital stays - your room, meals, nursing care, and hospital services and supplies.
- Short-term care in a skilled nursing facility after a qualifying hospital stay - think recovery and rehab, not permanent nursing home living.
- Hospice care for those who are terminally ill.
- Some home health services, such as intermittent skilled nursing or physical therapy.
- Care in certain religious non-medical facilities.

How Part A costs work

Part A doesn't work like most insurance. Instead of one yearly deductible, it uses something called a benefit period. A benefit period starts the day you're admitted and ends once you've been home (or out of a nursing facility) for 60 days in a row. If you land back in the hospital after that, a new benefit period starts - and you owe the deductible again. That can happen more than once in the same year.

> THE MOST MISUNDERSTOOD POINT IN PART A
>
> **Being kept overnight is not the same as being admitted. If you're under observation status, the stay is billed under Part B, and it may not count toward qualifying you for skilled nursing coverage. Always ask directly whether you have been formally admitted.**

What Part A does not cover

- Long-term nursing home care - everyday help with things like bathing, dressing, or eating, when that is the only care you need.
- A private nurse, or a private room unless your doctor says you need one.

3. Part B - Medical Coverage

Part B covers the care you receive without being admitted, which is most of the health care most people use in a given year.

What Part B covers

- Doctor visits, specialists, and second opinions before surgery.
- Outpatient hospital care, emergency room visits, and outpatient surgery.

- Lab work, X-rays, and diagnostic imaging.
- Medical equipment you use at home - walkers, wheelchairs, oxygen equipment, diabetic supplies.
- Preventive services, including the annual wellness visit, many screenings, and most vaccines.
- Ambulance rides when getting there any other way would put your health at risk.
- Physical, occupational, and speech therapy outside the hospital.
- Mental health services, including outpatient counseling.

How Part B costs work

Part B has a monthly premium that's set each year, plus a yearly deductible. After you meet the deductible, Medicare generally pays 80 percent of the approved cost and you pay 20 percent. Here's the catch: that 20 percent has no yearly limit, so a very expensive year means very expensive bills. Filling that gap is the whole point of the two paths covered later in this guide.

> **IRMAA**
>
> **If your income is above a certain level, you pay extra for Part B and Part D. This extra charge is called IRMAA, and it's based on your tax return from two years ago. If your income has dropped since then - say, because you retired - you can ask Social Security to use your newer, lower income instead.**

4. Part C - Medicare Advantage

Medicare Advantage plans come from private insurance companies that Medicare has approved. When you join one, you still have Medicare - but the private plan handles your Part A and Part B benefits instead of the government, and it sets its own copays and its own list of doctors.

What these plans typically include

- Part A and Part B benefits bundled together in one plan.
- Part D prescription drug coverage built in on most plans.
- A yearly limit on what you can be charged out of pocket - something Original Medicare by itself does not have.
- Extras many plans throw in, such as dental, vision, hearing, gym memberships, or a monthly allowance for over-the-counter items.

How networks work

Most Advantage plans are HMOs or PPOs. With an HMO, you generally need to stay with the plan's doctors, and you may need your primary doctor's okay before seeing a specialist. With a PPO, you can go outside the plan's doctor list, but it costs more. These doctor lists are set county by county and can change every year - which is why double-checking that your own doctors are still on the list each fall matters more than any other single step.

Things to weigh honestly

- Plan availability and benefits vary significantly by county. What a friend has in another county may not exist in yours.
- For some services, the plan has to say yes before it will pay - this is called prior authorization.
- You pay less per month, but you pay copays along the way each time you use care.
- If you travel or spend part of the year in another state, check how the plan handles care away from home.

> **A low monthly premium is not the same as a low annual cost. What matters is the total picture: premium, copays, drug costs, and whether your providers are in network.**

5. Part D - Prescription Drug Coverage

Part D helps pay for prescription medications. You can get it as a standalone plan alongside Original Medicare, or as part of a Medicare Advantage plan that includes drug coverage. Part D is offered only through private insurers.

Formularies: why plans differ so much

Every Part D plan has a formulary - simply, its list of covered drugs - sorted into levels called tiers. Drugs on the lower tiers cost you less. Two plans with nearly the same premium can be worlds apart on what your prescriptions cost, because one plan may put your drug on a cheap tier while the other doesn't cover it at all.

THE ONE THING THAT MATTERS MOST

This is why I ask for your medication list with dosages before comparing anything. Choosing a drug plan without running your actual prescriptions is guesswork.

Coverage rules you may encounter

- Prior authorization - the plan has to approve the drug before it will pay for it.
- Step therapy - the plan may ask you to try a cheaper drug first before covering the one your doctor prescribed.
- Quantity limits - a cap on how many pills or doses the plan covers at a time.
- Pharmacy networks - using a preferred pharmacy often costs less than a standard one.

Payment stages

What you pay for drugs changes through the year in stages: first a deductible stage, then a main coverage stage, and finally a stage where your costs drop sharply once you've spent a certain amount. Medicare sets those dollar amounts fresh each year, and the rules have changed recently - so always check this year's numbers instead of going by what used to be true.

6. Medicare Supplement (Medigap)

A Medigap policy works alongside Original Medicare rather than replacing it. Medicare pays its share first, then the Medigap policy pays toward the deductibles, copayments, and coinsurance that Medicare leaves to you.

Standardized plans

Medigap plans are named by letter, and by law every company's version of a letter covers the same things. A Plan G from one company covers exactly what a Plan G from another covers. What's different is the price, how often the company has raised rates over the years, and how they treat their customers - so shopping companies on price and track record is smart, not cutting corners.

How Medigap works in practice

- You can see any provider in the country who accepts Medicare - no networks, no referrals.
- Coverage travels with you anywhere in the United States, which matters if you travel or live part of the year elsewhere.

- Costs are predictable: you pay a monthly premium, and most covered services leave little or nothing else to pay.
- It does not include drug coverage. You add a standalone Part D plan separately.
- Each policy covers one person. Spouses each need their own.

TIMING MATTERS HERE

Medigap has a one-time window that really matters. For six months, starting when you are 65 and enrolled in Part B, you can buy any Medigap policy sold in your state - no health questions, no turning you down. After that window closes, in most cases the company is allowed to ask about your health, charge you more because of it, or say no altogether.

7. Advantage or Medigap: How to Decide

Neither path is simply better. The right answer depends on your doctors, your prescriptions, your budget, how much you travel, and whether you'd rather pay steadily or pay as you go.

Medicare Advantage tends to fit if...

- You want lower monthly costs and are comfortable paying copays as you use care.
- Your doctors are already in the plan's network.
- Extra benefits like dental, vision, and hearing appeal to you.
- You mostly receive care close to home.
- You prefer one plan and one card rather than several.

Medigap tends to fit if...

- You want to know your costs ahead of time, with no surprises at the doctor's office.
- You want any doctor nationwide, without networks or referrals.
- You travel often or live in two states during the year.
- You have ongoing conditions and see specialists regularly.
- You would rather pay the same amount every month than get bills that bounce around.

The question people forget to ask

If you start with a Medicare Advantage plan and later want to move to Medigap, the insurance company can usually ask about your health first - and your answers could affect whether they accept you or what they charge. Going the other direction is much easier. That one-way door is

worth understanding before you choose, not after.

8. When You Can Enroll

Initial Enrollment Period (IEP)

Seven months total: the three months before your 65th birthday month, your birthday month, and the three months after. Enrolling in the three months before your birthday month generally gives you coverage starting the first day of your birthday month.

General Enrollment Period (GEP)

January 1 to March 31, for people who missed their Initial Enrollment Period and do not qualify for a Special Enrollment Period. Late enrollment penalties may apply.

Annual Enrollment Period (AEP)

October 15 to December 7 each year. You can join, switch, or drop a Medicare Advantage plan or a Part D plan. Changes take effect January 1. This is the window most people use for their yearly review.

Medicare Advantage Open Enrollment (OEP)

January 1 to March 31. If you are already enrolled in a Medicare Advantage plan, you get one opportunity to switch to a different Advantage plan or return to Original Medicare. It does not apply if you are on Original Medicare.

Special Enrollment Periods (SEP)

These open up when certain life changes happen - like moving out of your plan's coverage area, losing coverage from a job, or moving into or out of a nursing facility. How long you get depends on the event.

Medigap Open Enrollment

Six months, starting the month you are 65 and enrolled in Part B. During this window you can buy any Medigap policy sold in your state with no health questions asked. Unlike the others, this window comes once and does not repeat each year.

> **Mark October 15 through December 7 on your calendar every year, even if you are happy with your plan. Plans change their networks, formularies, and costs annually, and the plan that fit you last year may not be the same plan next year.**

9. Late Enrollment Penalties

Medicare uses permanent penalties to encourage timely enrollment. They are avoidable, but only if you understand them before your window closes.

Part B penalty

If you skip Part B when you're first able to get it - and you don't have health coverage from a job you or your spouse still works at - your premium goes up 10 percent for every full year you waited. And in most cases, that higher price sticks for as long as you have Part B.

Part D penalty

If you go about two months or more without drug coverage that's at least as good as Medicare's, a penalty gets added to your Part D premium. The longer you went without coverage, the bigger the penalty - and it generally stays with you for as long as you have Part D.

Part A penalty

Most people get Part A premium-free and this doesn't apply. If you have to buy Part A and enroll late, a penalty may apply for a limited period.

> **KEEP YOUR PAPERWORK**
>
> **The word to remember is creditable - it simply means coverage at least as good as Medicare's. Many job-based plans count. Each year, your employer or plan sends a letter confirming your coverage is creditable. Save those letters. If Medicare ever questions your timing, they are your proof.**

10. What Medicare Costs

Specific dollar figures change every year, so rather than list numbers that will be out of date, here is the structure of what you will pay - which does not change.

Recurring monthly costs

- Part A premium - $0 for most people who worked 40 quarters.
- Part B premium - a standard amount set annually, higher for upper-income households through IRMAA.
- Part D premium - varies by plan, with an IRMAA adjustment for higher incomes.

- Medicare Advantage plan premium - varies by plan; many are $0, though you still pay your Part B premium.
- Medigap premium - varies by plan letter, carrier, your age, and where you live.

Costs when you use care

- Part A benefit period deductible for inpatient stays.
- Part B annual deductible, then generally 20 percent coinsurance with no cap under Original Medicare alone.
- Copays and coinsurance under a Medicare Advantage plan, up to that plan's annual out-of-pocket maximum.
- Prescription costs, which depend on your plan's formulary tiers and the coverage stage you are in.

> **Compare total expected annual cost, not monthly premium. Add up premiums, likely copays, and your actual drug costs. The cheapest premium and the cheapest year are frequently different plans.**

11. Still Working at 65?

If you or your spouse are still working and covered by an employer group health plan, you may be able to delay Part B without penalty. Whether you should depends on the size of the employer.

- If the company has 20 or more employees, the work plan pays your bills first and Medicare backs it up. Many people in this spot safely wait on Part B.
- If the company has fewer than 20 employees, Medicare pays first - so without Part B, big parts of your bills may not be covered at all.
- COBRA and retiree coverage do not count as job coverage under these rules, even though they come from an employer. This trips people up all the time.
- Once you stop working or the work coverage ends - whichever happens first - you get eight months to sign up for Part B without penalty.

HSA WARNING

If you put money into a Health Savings Account (HSA), you have to stop once you're enrolled in any part of Medicare. And because Medicare enrollment can sometimes be backdated up to six months, it pays to plan the timing before you sign up.

12. Help With Costs

Several programs help people whose income and savings are limited. Far fewer people use them than qualify for them - so ask. There is nothing to be embarrassed about, and the savings can be real.

- Extra Help, also called the Low-Income Subsidy, reduces Part D premiums, deductibles, and prescription costs.
- Medicare Savings Programs, run by the state, can help pay Part B premiums and sometimes other costs.
- Medi-Cal, California's Medicaid program, may cover costs Medicare doesn't for those who qualify.
- Some people qualify for both Medicare and Medi-Cal, and there are specific plans designed for that situation.

13. What Medicare Doesn't Cover

Understanding the gaps prevents unpleasant surprises. Original Medicare generally does not cover:

- Long-term nursing home care - the ongoing, everyday help with things like bathing and dressing that most people picture when they think of a nursing home.
- Most dental care, including cleanings, fillings, extractions, and dentures.
- Routine vision exams and eyeglasses, apart from specific exceptions after cataract surgery.
- Hearing exams for fitting hearing aids, and hearing aids themselves.
- Most care received outside the United States.
- Cosmetic surgery, and most alternative therapies.

Some Medicare Advantage plans include dental, vision, and hearing benefits, though the scope

and annual limits vary widely between plans. Separate standalone policies are another route.

14. Six Common Mistakes

Assuming enrollment is automatic

If you are already receiving Social Security before 65, you may be enrolled automatically. If you are not, you generally have to take action yourself.

Choosing on premium alone

The lowest monthly premium often produces the highest annual cost once copays and drug costs are counted.

Not checking the drug formulary

Plans cover different drugs at different prices. The plan that fit perfectly last year may not cover a prescription you started this year.

Skipping the annual review

Doctor lists, drug lists, and costs change every year. Doing nothing is still a choice - and sometimes an expensive one.

Missing the Medigap window

Six months at 65. Afterward, health underwriting may apply in most situations.

Trusting the mail

You will get a mountain of Medicare mail, and a lot of it is made to look official. If something pressures you to act right now, slow down and check it out first.

15. Questions to Ask Before You Choose

Whether you work with me or with anyone else, these are the questions that lead to a good decision:

- Are all of my doctors and my preferred hospital in this plan's network?
- Is every one of my prescriptions on the plan's drug list, and how much will each one cost me?
- What is my total expected cost for the year - premiums plus likely copays plus drugs?
- What is the annual out-of-pocket maximum, and what counts toward it?
- For the care I get regularly, does the plan need to approve it first, or do I need a referral?

- How does this plan handle care when I am traveling or out of the area?
- If my health changes, what are my options to switch later, and would underwriting apply?
- How many carriers did you compare, and why did you land on this recommendation?

16. Your Turning-65 Checklist

6 months before

Decide whether you'll keep working and stay on your job's health plan. If so, ask HR two things: does the coverage count as creditable, and how does it work alongside Medicare?

4 months before

Write down your doctors, your hospital preference, and every prescription with its dosage. This list drives every comparison that follows.

3 months before

Your Initial Enrollment Period opens. Enroll in Part A and, unless you are delaying it for employer coverage, Part B.

2 to 3 months before

Compare your two paths - Advantage, or Medigap plus Part D - against your actual doctors and medications.

1 month before

Finish enrolling so your coverage starts on day one. Make sure you've actually received a confirmation - submitting an application is not the same thing.

Every October after

Review your plan during Annual Enrollment. Check that your doctors and drugs are still covered for the coming year.

Beneficiary A person enrolled in Medicare.

Benefit period How Part A counts hospital coverage. It starts when you're admitted and ends after you've been out of the hospital or nursing facility for 60 days in a row.

Coinsurance Your share of a bill, as a percentage - for example, the 20 percent you typically pay under Part B.

Copayment A fixed dollar amount you pay for a service, common in Medicare Advantage plans.

Creditable coverage Coverage at least as good as Medicare's. Having it protects you from late sign-up penalties.

Deductible What you pay before your coverage begins paying its share.

Formulary A plan's list of covered drugs, sorted into price levels called tiers.

Guaranteed issue Times when a company must sell you a Medigap policy no matter what your health looks like.

IRMAA An extra charge added to Part B and Part D premiums for people with higher incomes.

Medical underwriting When an insurance company looks at your health history to decide whether to cover you and what to charge.

Network The doctors and hospitals a plan has agreements with. Staying inside the network usually costs less.

Original Medicare Part A and Part B together, administered directly by the federal government.

Out-of-pocket maximum The most you can be charged for covered care in a year. Medicare Advantage plans have this limit; Original Medicare by itself does not.

Premium What you pay each month to keep your coverage, whether or not you use it.

Prior authorization The plan's required okay before it will pay for certain services.

SHIP State Health Insurance Assistance Program - free help from trained counselors, available in every state, with no sales involved.

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Required disclosures

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We do not offer every plan available in your area. Currently we represent 7 organizations which offer 44 products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.

How we're paid

There is no cost to you for our services. We may be compensated by insurance carriers if you choose to enroll in a plan. Your premium is the same whether you enroll through an agent or directly with the carrier.

For official Medicare information

Visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, seven days a week.

Let's talk about your situation

I'll compare your options against your actual doctors and prescriptions, in plain English - no pressure, no obligation, and no cost to you for my services.

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