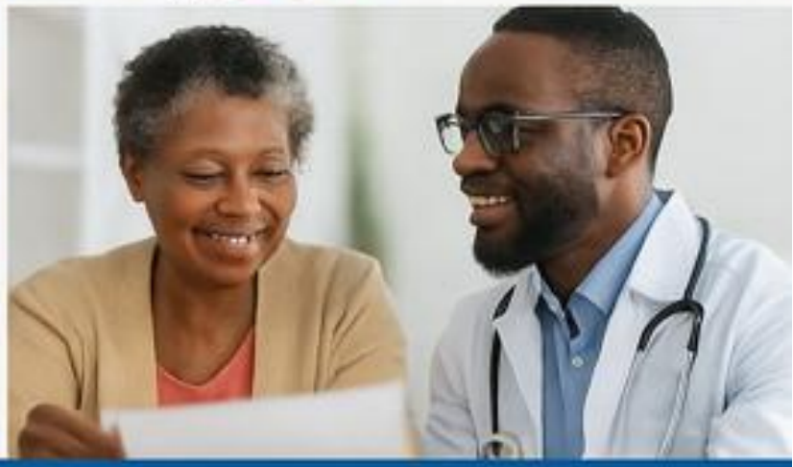
UNDERSTANDING MEDICARE



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Understanding MEDICARE

CHAPTER 1

Chapter 1: What is Medicare?

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Medicare is a federal health insurance program created in 1965 to provide affordable healthcare coverage primarily for people age 65 and older. Over the years, it has expanded to include younger individuals with certain disabilities or those with End-Stage Renal Disease (ESRD).

The idea behind Medicare is simple: help older Americans afford the medical care they need as they age. But the program itself can feel anything but simple. There are multiple "Parts," different enrollment periods, and choices that can have a big impact on your coverage and out-of-pocket costs.

This chapter lays the foundation for everything you need to know about Medicare.

Who Qualifies for Medicare?

You're typically eligible for Medicare if:
- You're age 65 or older and a U.S. citizen or permanent resident
- You're under 65 and have been receiving Social Security Disability Insurance (SSDI) for 24 months
- You have ESRD (permanent kidney failure requiring dialysis or a transplant)
- You have ALS (Amyotrophic Lateral Sclerosis), also known as Lou Gehrig's disease

The Four Parts of Medicare

Medicare is divided into four main parts. Each one plays a unique role in your healthcare coverage.

Part A - Hospital Insurance
Part A helps cover:
- Inpatient hospital stays
- Skilled nursing facility care
- Hospice care
- Some home health care

Most people don't pay a premium for Part A if they or their spouse paid Medicare taxes while working.

Part B - Medical Insurance
Part B covers:

- Doctor visits
- Outpatient care
- Preventive services (like screenings and vaccinations)
- Durable medical equipment (like walkers or wheelchairs)

There is a monthly premium for Part B. In 2025, the standard premium is $185/month, but higher-income individuals may pay more.

Part C - Medicare Advantage
Part C is an alternative to Original Medicare (Parts A & B). These plans are offered by private insurance companies approved by Medicare and often include:
- Coverage for Parts A and B
- Prescription drug coverage (Part D)
- Additional benefits like dental, vision, hearing, gym memberships, and more

Each plan varies, and we'll cover Medicare Advantage in detail in Chapter 4.

Part D - Prescription Drug Coverage
Part D helps pay for the cost of prescription medications. Like Part C, these plans are offered by private insurers. Costs and covered drugs (formularies) vary, so comparing plans is crucial.

Original Medicare vs. Medicare Advantage

Medicare beneficiaries have two primary paths:
1. **Original Medicare (Parts A & B)** with the option to add:
   - A standalone Part D plan
   - A Medigap (Supplement) plan for help with out-of-pocket costs
2. **Medicare Advantage (Part C)** - An all-in-one alternative that bundles hospital, medical, and often drug coverage

Understanding the differences early helps you make confident decisions about which path suits your health, budget, and lifestyle.

Common Misconceptions

- "Medicare is free." Not true-while Part A may be premium-free, Part B has a monthly cost, and Medicare doesn't cover everything.
- "Medicare covers long-term care." It does not. Medicaid is the program that assists with long-term care, which we'll discuss in Chapter 11.
- "I'll be automatically enrolled." Only some people are. Many need to take action to sign up, especially if they're not already receiving Social Security.

Why This Matters

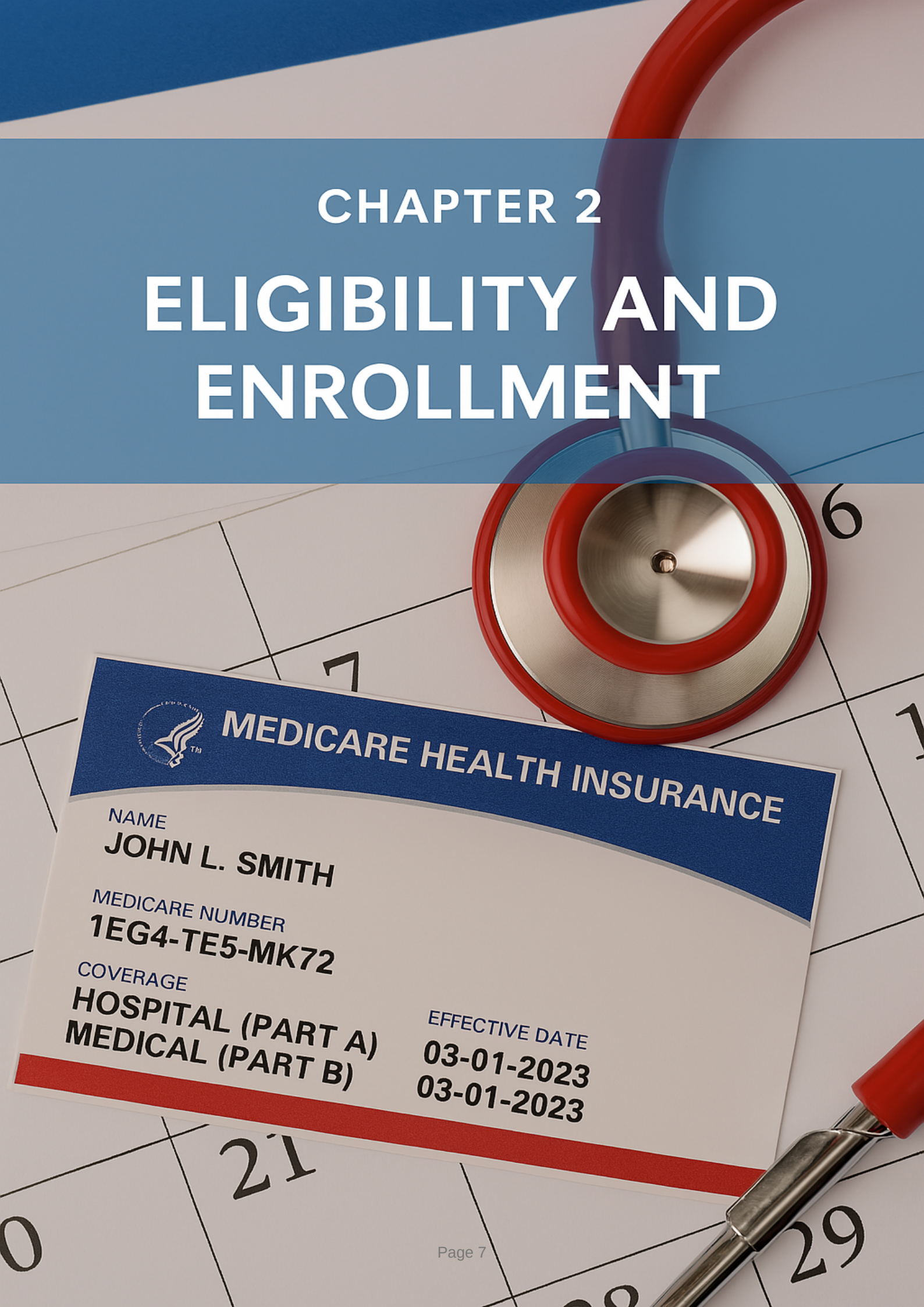
Making the right Medicare decisions early can save you money and reduce stress later. It can impact your access to doctors, specialists, medications, and even how much you pay out of pocket.

In the next chapter, we'll break down the different **parts** of Medicare even further-and explain how they work together (or sometimes, overlap) in real life.

And if any of this sounds overwhelming-don't worry. I work with hundreds of clients just like you to simplify Medicare and make sure you get the coverage that fits your needs.

CHAPTER 2

ELIGIBILITY AND ENROLLMENT



Chapter 2: How Medicare Works

Chapter 2: How Medicare Works

Now that you know what Medicare is, let's look at how it actually works in practice-how it's structured, how you access care, how much it might cost, and how the different pieces fit together.

Understanding this framework is key to making confident choices when it's time to enroll or update your plan.

Original Medicare: Parts A and B

Original Medicare is the traditional Medicare program managed by the federal government. When most people talk about "Medicare," they're referring to this setup.

You can use any doctor or hospital in the U.S. that accepts Medicare. There's no provider network, and no referrals are needed to see a specialist.

Here's how it works:

- **Part A (Hospital Insurance)** covers inpatient care in hospitals, skilled nursing facility stays, hospice care, and some home health services.
  - You usually won't pay a monthly premium for Part A if you've worked and paid Medicare taxes for at least 10 years.
  - There is, however, a deductible each time you're admitted to the hospital (in 2025, this is $1,632 per benefit period).

- **Part B (Medical Insurance)** covers doctor visits, outpatient services, preventive screenings, mental health services, durable medical equipment, and lab work.
  - The monthly premium in 2025 is $185, and there is an annual deductible (currently $240), after which you typically pay 20% of Medicare-approved amounts for services.

Keep in mind: **There is no out-of-pocket maximum** under Original Medicare. That means your costs could keep adding up with no cap if you have serious or ongoing medical needs.

What's Not Covered by Original Medicare?

- Most dental, vision, and hearing services
- Long-term custodial care
- Prescription drugs (you'd need a Part D plan)
- Routine foot care, acupuncture, cosmetic surgery, and more

To fill in these gaps, many people choose to add:
- A **Medicare Supplement (Medigap)** plan to help with out-of-pocket costs
- A **Part D plan** for prescriptions

Medicare Advantage: Part C

This is a bundled alternative to Original Medicare offered by private insurance companies. You still have to enroll in Parts A and B to get a Medicare Advantage plan, but you'll receive your benefits through the private insurer instead of the federal government.

These plans often include:
- All Part A and B coverage
- Part D (drug coverage)
- Extra benefits like dental, vision, hearing, fitness memberships, and more

You'll likely need to use the plan's provider network (like an HMO or PPO), and you may need referrals to see specialists. But most plans have **an annual out-of-pocket maximum**, which provides a safety net.

Example:

Let's say Mary has diabetes and needs frequent doctor visits, prescriptions, and routine screenings. She enrolls in a Medicare Advantage plan with:
- $0 monthly premium
- $35 copay to see a specialist
- Prescription coverage included
- $4,500 maximum out-of-pocket limit

This gives her predictable costs and built-in medication coverage. But she must use the plan's network providers.

Prescription Drug Plans: Part D

If you're on Original Medicare, you'll need a separate Part D plan to get prescription drug coverage. These plans vary by provider and region, and it's important to choose one that covers your specific medications.

Part D plans typically include:
- A monthly premium
- An annual deductible (sometimes waived)
- Copays or coinsurance for medications

Plans group drugs into "tiers" (e.g., generic, preferred brand, specialty), and your costs depend on which tier your medication falls into.

How All the Parts Work Together

Here's a simple example:

Sarah chooses Original Medicare:
- She signs up for Parts A and B.
- She adds a standalone Part D plan for her medications.
- She buys a Medigap plan to reduce her out-of-pocket costs.

James chooses Medicare Advantage:
- He signs up for a Part C plan that includes A, B, and D benefits.
- He pays one premium and uses in-network providers.

Your choice depends on your health needs, budget, and preferred level of flexibility.

Coordinating Coverage

Whether you're choosing between Original Medicare or Medicare Advantage, it's important to consider:
- Which doctors and hospitals you want to use
- What prescription drugs you take
- Your travel habits (Advantage plans may have limited networks)
- Whether you want extras like dental or vision

Remember: You can only change your Medicare coverage during specific times of year (we'll cover this in Chapter 5).

Still Have Questions?

Don't worry. This is where I come in. I help clients compare plans, estimate their costs, and enroll in the coverage that best fits their needs and preferences.

You don't have to figure this all out alone.

CHAPTER 3

Medicare Eligibility and Enrollment

Chapter 3: Enrollment Periods and Deadlines

Chapter 3: Enrollment Periods and Deadlines

When it comes to Medicare, timing matters-a lot.

Whether you're brand new to Medicare or looking to make changes to your current coverage, you need to understand the various enrollment periods. Missing a deadline can lead to late penalties, gaps in coverage, or limited plan options.

Let's break it all down clearly.

1. Initial Enrollment Period (IEP)

Your Initial Enrollment Period is a 7-month window that begins:
- 3 months before the month you turn 65
- Includes the month of your 65th birthday
- Ends 3 months after your birthday month

Example:
If your birthday is July 10th:
- Your IEP runs from April 1st to October 31st

What you can do:
- Enroll in Part A and/or Part B
- Join a Medicare Advantage Plan (Part C)
- Sign up for a Part D prescription drug plan

Tip: If you sign up in the 3 months before your birthday, your coverage starts the first day of your birthday month.

2. General Enrollment Period (GEP)

If you missed your Initial Enrollment Period, you can sign up for Medicare Part A and/or B between:
- **January 1st - March 31st** each year

Coverage begins the following month after enrollment.

Note: You may be subject to late enrollment penalties-especially for Part B and Part D. These penalties can last a lifetime.

3. Special Enrollment Periods (SEPs)

You may qualify for a SEP if you delayed Medicare because you were still working and had employer coverage, or due to other qualifying life events.

Common SEP reasons include:
- Losing employer coverage
- Moving to a new service area
- Becoming eligible for Medicaid
- Gaining or losing eligibility for a Special Needs Plan

Example:
You retire at age 67 and lose employer health coverage. You have 8 months from that point to enroll in Part B without penalty.

Important: COBRA and retiree coverage do not count as "creditable coverage" to delay Part B without penalty.

4. Medicare Advantage & Part D Open Enrollment (AEP)

Every year, you can review and change your Medicare Advantage or Part D plan during the **Annual Enrollment Period** (AEP):
- **October 15th - December 7th**

What you can do:
- Switch from Original Medicare to a Medicare Advantage plan (or vice versa)
- Change from one Advantage plan to another
- Join, drop, or change a Part D prescription plan

New coverage starts **January 1st** of the following year.

5. Medicare Advantage Open Enrollment Period (MA-OEP)

If you're already enrolled in a Medicare Advantage plan, you have a one-time opportunity to switch to another Advantage plan or back to Original Medicare between:
- **January 1st - March 31st**

You cannot switch from Original Medicare to Advantage during this window-only if you're already in Advantage.

Common Mistakes to Avoid

Missing your IEP and assuming you can sign up at any time
Thinking COBRA delays Part B penalties-it does not
Letting AEP pass without reviewing your Part D plan (formularies change yearly)
Not updating your plan when you move to a new ZIP code

Working with a licensed Medicare specialist helps ensure you stay on track and don't miss critical deadlines.

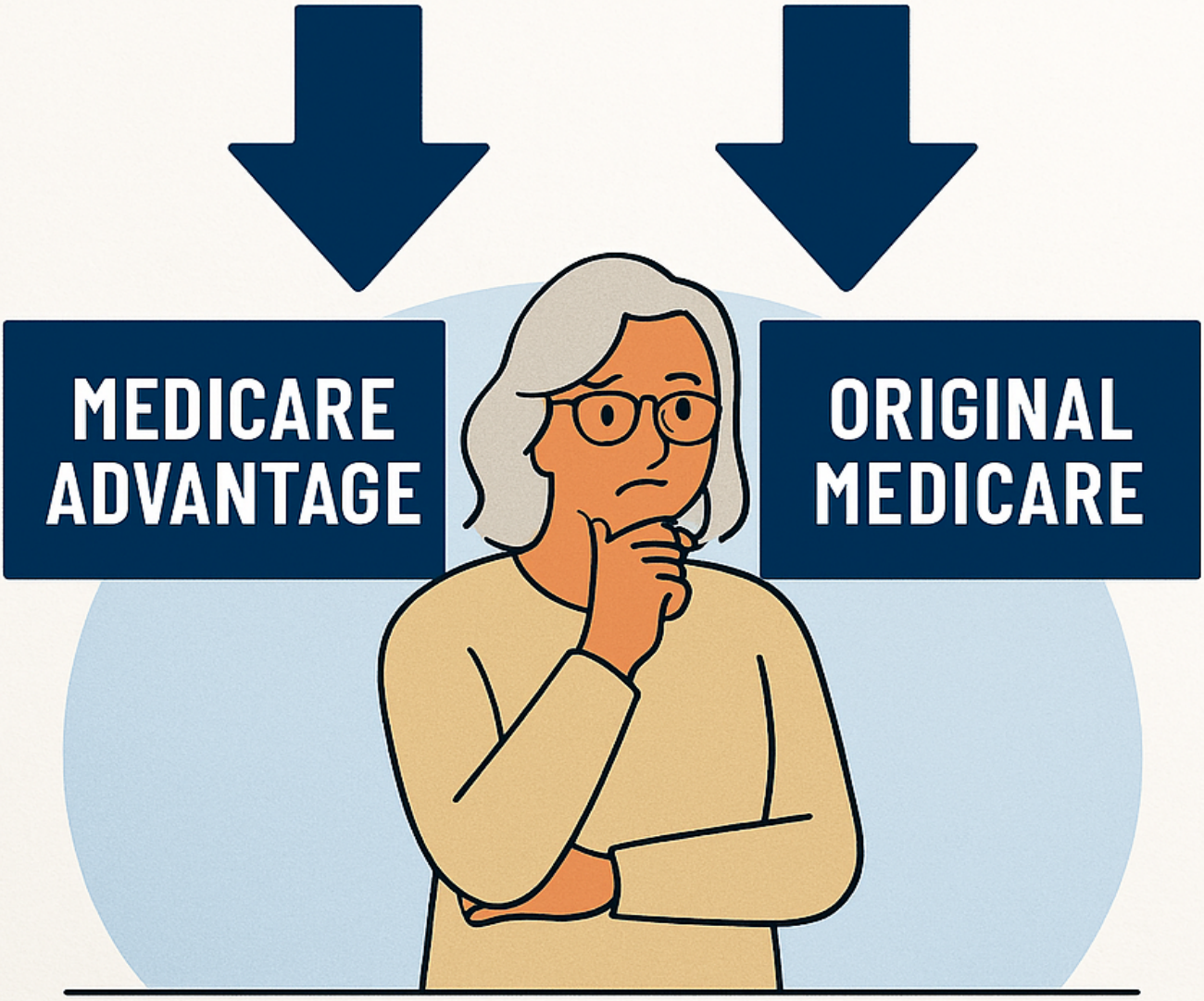
How I Help

I assist clients by:
- Keeping track of important enrollment dates
- Helping them compare plans during AEP
- Ensuring penalties are avoided
- Guiding late enrollees through GEP and SEPs
- Managing transitions from employer coverage to Medicare

Medicare doesn't need to be confusing. The key is understanding your window-and having someone in your corner to walk you through it.

CHAPTER 4

Medicare Advantage vs. Original Medicare



Chapter 4: Medicare Advantage Plans (Part C)

Chapter 4: Medicare Advantage Plans (Part C)

Medicare Advantage, also known as Medicare Part C, is an all-in-one alternative to Original Medicare. These plans are offered by private insurance companies approved by Medicare and must provide at least the same coverage as Parts A and B.

But Medicare Advantage plans usually go well beyond that.

They often bundle hospital, medical, and prescription coverage together-and include extra benefits not offered by Original Medicare. This can make them an attractive choice for many Medicare-eligible individuals.

Let's take a closer look.

What's Included in a Medicare Advantage Plan?

All Medicare Advantage (MA) plans must include:
- Hospital coverage (Part A)
- Medical coverage (Part B)

Most also include:
- Prescription drug coverage (Part D)
- Extra benefits like dental, vision, hearing, and fitness programs
- Telehealth services
- Transportation to doctor visits
- Over-the-counter (OTC) allowances for health-related products

How Do These Plans Work?

When you enroll in a Medicare Advantage plan, you're still in the Medicare program-but your coverage is managed by the private insurance company, not directly by the government.

That company pays for your care instead of Medicare. You'll generally need to follow plan rules for getting services, such as:
- Using network providers
- Getting prior authorizations for some services
- Paying structured copays and coinsurance

Types of Medicare Advantage Plans

Not all plans are created equal. Here are the most common types:

1. HMO (Health Maintenance Organization)
- You must use network doctors and hospitals
- Referrals required to see specialists
- Usually lowest cost structure

2. PPO (Preferred Provider Organization)
- You can see out-of-network providers at a higher cost
- No referrals needed
- More flexibility, but often higher premiums or out-of-pocket limits

3. PFFS (Private Fee-for-Service)
- You can see any provider who agrees to the plan's terms
- Less common today
- Offers some provider freedom

4. SNP (Special Needs Plans) - Covered in Chapter 10
- Designed for people with chronic conditions or dual Medicare/Medicaid eligibility

Costs and Coverage

Many Advantage plans offer:
- $0 monthly premiums
- Low or fixed copays (e.g., $0 for a primary doctor visit)
- An annual **maximum out-of-pocket (MOOP)** limit for covered services (something Original Medicare does not offer)

Example:
Jane joins a local HMO Medicare Advantage plan:
- $0 monthly premium
- $0 primary care visits
- $40 specialist visits
- $4,500 out-of-pocket max

She gets dental, vision, hearing, gym membership, and drug coverage-without needing to buy extra policies.

Prescription Drugs and Formularies

Most Advantage plans include drug coverage, but each plan has a **formulary**-a list of covered medications.

Drugs are grouped into "tiers," and your costs depend on the tier your medication falls into. It's important to check that your prescriptions are covered before enrolling.

Why People Choose Medicare Advantage

Convenience: One plan, one card, one premium
Predictable costs with copays and limits
Extra benefits like dental and vision
Drug coverage built in
Care coordination, especially in HMOs

Why Some Prefer Original Medicare

Freedom to see any provider that accepts Medicare
No need for referrals
Easier access to specialists in some cases
Can add Medigap for predictable out-of-pocket costs

Things to Watch Out For

- Plans may change their benefits, networks, or drug lists each year
- You may need referrals and prior approvals
- Not all doctors accept Medicare Advantage plans
- If you travel frequently, network restrictions may limit access to care

Working with a Medicare Advisor

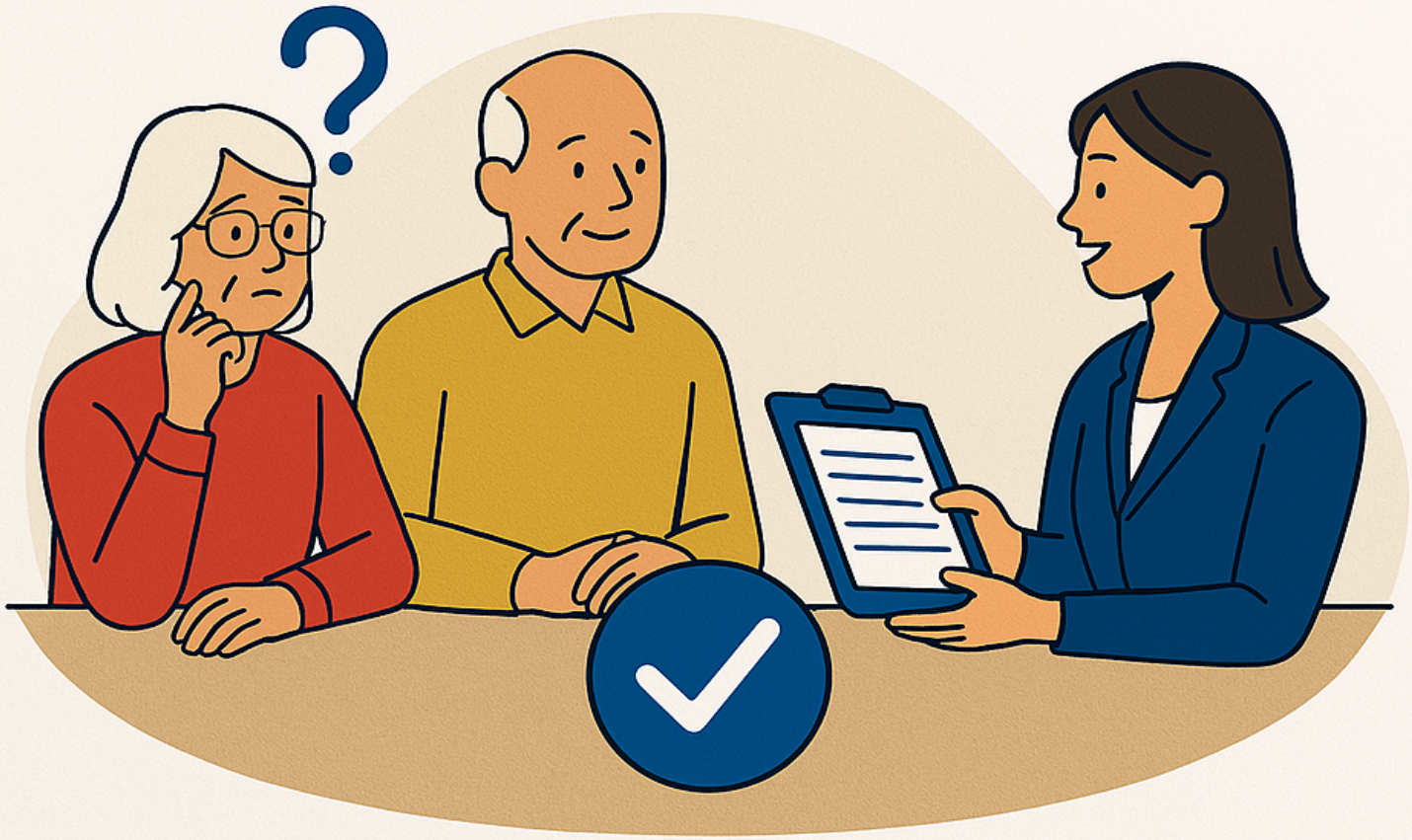
Choosing a Medicare Advantage plan is a personal decision. I help clients:
- Compare plans side-by-side
- Check provider networks and drug coverage
- Estimate costs and benefits
- Enroll during the correct window

The right Medicare Advantage plan can give you solid coverage and peace of mind-if it's matched to your health needs and preferences.

We'll dive deeper into comparing Advantage vs. Supplement plans in Chapter 6.

CHAPTER 5

CHOOSING THE RIGHT MEDICARE PLAN



Chapter 5: Medicare Supplement (Medigap) Plans

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If you choose Original Medicare (Parts A and B), you're responsible for deductibles, copayments, and 20% coinsurance-with no annual limit. That's where a Medicare Supplement plan (also known as Medigap) comes in.

Medigap plans are designed to help pay the "gaps" in Medicare coverage-offering predictability, freedom of choice, and peace of mind.

What is a Medigap Plan?

Medigap is private insurance that works alongside Original Medicare. It helps pay for costs like:
- Hospital and medical deductibles
- Copays and coinsurance
- Foreign travel emergency care (in some plans)

You must be enrolled in Medicare Part A and Part B to get a Medigap policy.

Key Features of Medigap Plans:
Use any doctor or hospital that accepts Medicare
No network restrictions-great for travelers or snowbirds
No referrals required
Predictable out-of-pocket costs

Medigap vs. Medicare Advantage

Feature	Medigap + Original Medicare	Medicare Advantage (Part C)
Doctors/Hospitals	Any provider that accepts Medicare	Network-based (HMO/PPO)
Referrals Needed?	No	Sometimes (depending on plan)
Drug Coverage	Not included (add Part D separately)	Usually included
Out-of-Pocket Limit	No limit, but Medigap fills most gaps	Yes, plan sets annual max
Monthly Cost	Typically higher premiums	Often lower premiums or $0
Extra Benefits (Dental, Vision)	Not included	Frequently included

Types of Standard Medigap Plans

There are 10 standardized Medigap plans available in most states (Plans A, B, C, D, F, G, K, L, M, N). Each plan offers a different mix of benefits, but the coverage is standardized-meaning Plan G from one company covers the same as Plan G from another.

Most popular plans:

- **Plan G**: Covers nearly everything except the Part B deductible. Most comprehensive for new enrollees.
- **Plan N**: Lower premiums with small copays for doctor ($20) and ER ($50) visits.
- **Plan F**: Only available to people who were eligible for Medicare before January 1, 2020. Covers all gaps, including Part B deductible.

Example:
David enrolls in Plan G:
- Pays $185/year (2025 Part B deductible)
- No copays or coinsurance afterward
- Predictable healthcare costs with freedom to see any Medicare provider

When Can You Enroll in Medigap?

Your best time is during your **Medigap Open Enrollment Period**:
- Starts the month you're both 65 or older AND enrolled in Part B
- Lasts for 6 months
- During this time, you cannot be denied coverage or charged more due to health conditions

After this period, you may be subject to medical underwriting, which could result in:
- Higher premiums
- Denial of coverage
- Limited plan options

Some states offer guaranteed issue rights or expanded Medigap protections. I help clients understand their options based on where they live.

What Medigap Does NOT Cover

- Prescription drugs (you'll need a separate Part D plan)
- Dental, vision, or hearing services
- Long-term care
- Routine foot care

Who Might Prefer a Medigap Plan?

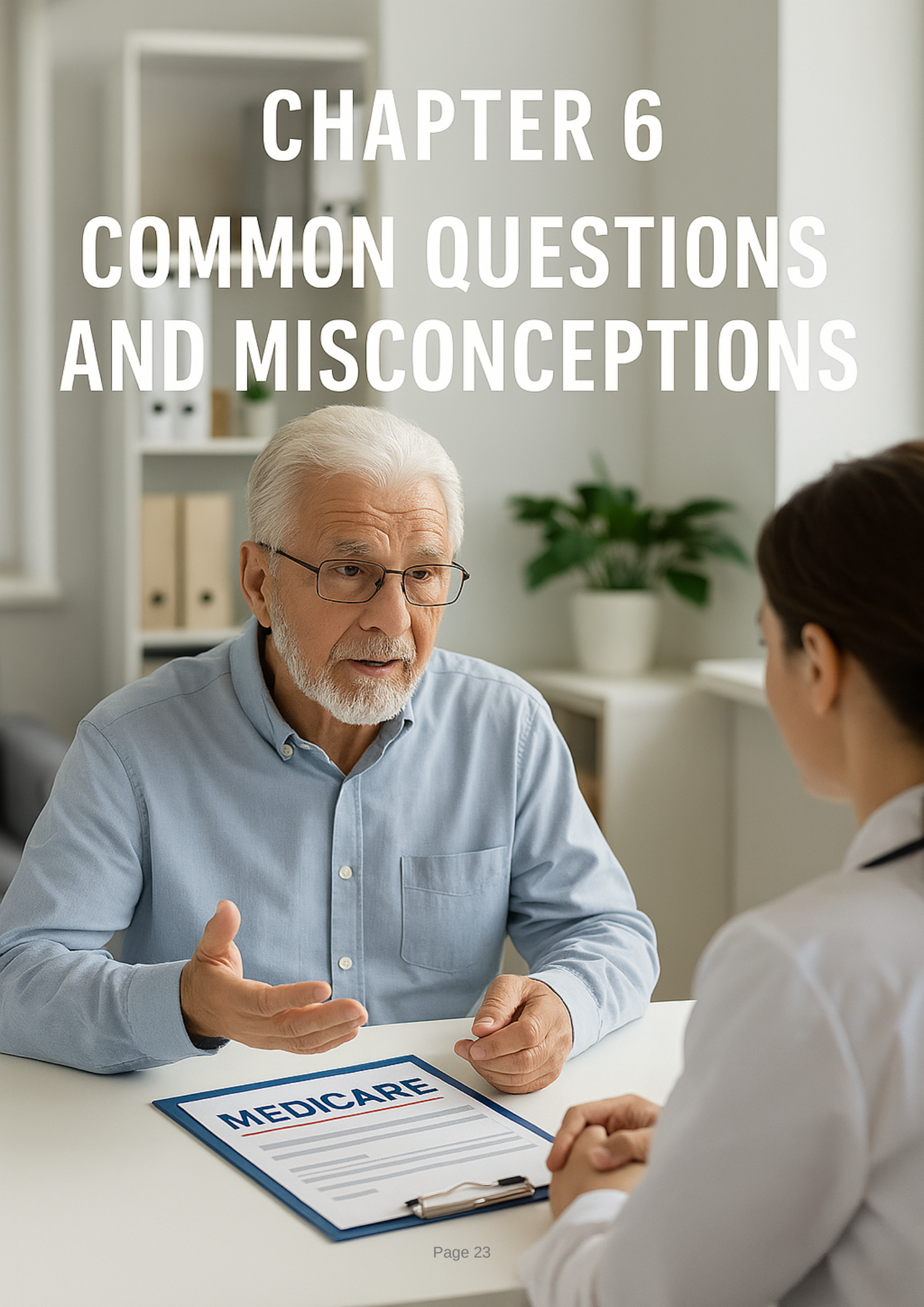
- People who travel frequently or live part-time in another state
- Those who want flexibility to see any doctor
- Individuals who want predictable healthcare costs
- People with chronic conditions who expect frequent visits or procedures

How I Help

I assist clients by:
- Comparing Medigap plan types and rates
- Explaining underwriting requirements and state-specific rules
- Recommending Part D plans to pair with Medigap
- Helping determine whether Medigap or Medicare Advantage is the better fit

Medigap plans are about stability, access, and freedom. If that sounds like the right direction for you, I'll help you evaluate your options clearly and simply.

CHAPTER 6
COMMON QUESTIONS AND MISCONCEPTIONS



Chapter 6: Comparing Medicare Advantage and Medigap

Chapter 6: Comparing Medicare Advantage and Medigap

One of the most important decisions you'll make when enrolling in Medicare is whether to choose a Medicare Advantage plan (Part C) or stick with Original Medicare and add a Medigap (Supplement) policy.

There is no "one-size-fits-all" answer-what's best for you depends on your lifestyle, health needs, financial goals, and personal preferences.

This chapter gives you a side-by-side breakdown of the two paths to help you choose with confidence.

The Two Main Coverage Options

Let's quickly review your two main paths under Medicare:

Option 1: Original Medicare + Medigap + Part D
- You enroll in Part A and Part B (Original Medicare)
- Add a standalone Part D plan for drug coverage
- Add a Medigap (Supplement) plan to cover deductibles, copays, and coinsurance

Option 2: Medicare Advantage (Part C)
- You enroll in a Part C plan that includes hospital (Part A) and medical (Part B)
- Most include drug coverage (Part D)
- May include extras like dental, vision, hearing, fitness programs

Comparison Table

Feature	Medicare Advantage	Medigap + Original Medicare
Monthly Premium	Often $0-$70	Typically $100-$250+
Out-of-Pocket Max (MOOP)	Yes (e.g., $3,000-$8,000)	No limit, but Medigap pays most
Referrals Needed	Often yes (HMO); not for PPO	No
Provider Flexibility	In-network (HMO/PPO based)	Any provider that accepts Medicare
Drug Coverage	Included in most plans	Must add a standalone Part D plan
Dental, Vision, Hearing	Often included	Not included
Travel Coverage	Limited to service area	Nationwide (and some foreign

care) |

Example Scenarios

Scenario 1: Jane is healthy and budget-conscious.
- She takes few medications and sees the doctor a few times a year
- She chooses a $0 premium Medicare Advantage HMO plan
- She gets routine dental and vision included
- She stays in-network and has low predictable copays

Scenario 2: Richard has multiple chronic conditions.
- He sees multiple specialists and wants freedom to choose any doctor
- He enrolls in Original Medicare + Plan G Medigap
- He adds a standalone Part D plan for medications
- He pays a higher monthly premium but avoids large out-of-pocket costs

Cost Considerations

- **Medicare Advantage** may have lower premiums, but you'll pay as you go (copays/coinsurance)
- **Medigap** plans have higher monthly premiums, but minimal costs when you receive care

Tip: If you prefer budgeting with fixed costs and want access to any doctor or hospital, Medigap is often the better fit.

Enrollment Timing Matters

- You can switch from Medicare Advantage to Medigap-but you may be subject to underwriting unless you're in your Medigap Open Enrollment Period.
- If you want to go back to Medigap later, you might be denied or charged more based on health.

Key Questions to Ask Yourself

- Do you travel or live in more than one state during the year?
- Is your doctor or specialist in-network for Advantage plans?
- Do you prefer low premiums or low out-of-pocket costs when you need care?
- Are extra benefits like dental, vision, and hearing important to you?

My Role as a Medicare Specialist

I help clients weigh their options and answer questions like:
- Which option gives me better value based on my health?
- What will my actual costs look like with each route?
- Which plan covers my doctors, hospitals, and medications?
- What enrollment rules or deadlines apply?

This decision is one of the most personal-and impactful-parts of Medicare. Let's work together to make sure it's the right one for you.

CHAPTER 7

UNDERSTANDING MEDICARE ENROLLMENT PERIODS

Chapter 7: Medicare Costs and Budgeting

Chapter 7: Medicare Costs and Budgeting

One of the most common questions people ask about Medicare is: "How much will it cost me?"

While Medicare is designed to make healthcare affordable for seniors, it's not free-and the costs can vary widely depending on the type of coverage you choose, how often you need care, and what plans you add.

This chapter breaks down the key Medicare expenses and gives you budgeting tips to help plan ahead.

Basic Medicare Costs

Let's start with the most common baseline costs for 2025:

Part A (Hospital Insurance)
- Premium: $0 for most people (if you or your spouse worked and paid Medicare taxes for 10+ years)
- Hospital deductible: $1,632 per benefit period
- Coinsurance:
  - Days 1-60: $0
  - Days 61-90: $408/day
  - Days 91+: $816/day (up to 60 lifetime reserve days)

Part B (Medical Insurance)
- Premium: $185/month (higher for high-income earners)
- Annual deductible: $240
- Coinsurance: 20% of Medicare-approved costs

Part D (Prescription Drug Plans)
- Premium: Varies (average is $35-$45/month)
- Deductible: Up to $545/year (varies by plan)
- Copays or coinsurance for medications based on tiers

Medigap Plans
- Premium: $100-$250+/month (depending on plan and location)
- Covers most or all of Medicare's out-of-pocket costs
- No network restrictions

Medicare Advantage (Part C)
- Premium: $0-$70/month (many plans have $0 premium)
- Copays: $0-$50 for doctor/specialist visits
- MOOP (Max Out-of-Pocket): Typically $3,000-$8,000/year

Sample Monthly Budget Scenarios

Let's look at how Medicare costs might look in real life.

Scenario 1: Medicare Advantage Plan
- Part B Premium: $185
- Advantage Plan Premium: $0
- Part D: Included
- Copays: $100/month (average for visits, labs, etc.)
- Total Monthly Estimate: $285

Scenario 2: Original Medicare + Medigap + Part D
- Part B Premium: $185
- Medigap Plan G: $180
- Part D Plan: $35
- Total Monthly Estimate: $400

Reducing Medicare Costs

Here are a few strategies to help manage and reduce your Medicare expenses:

Choose a Medicare Advantage plan with low or $0 premiums
Review drug coverage annually to ensure your prescriptions are still covered
Consider switching Medigap plans if your health allows
Apply for Extra Help (LIS) or a Medicare Savings Program if you meet income requirements

Use preferred pharmacies to reduce Part D costs
Take advantage of preventive care and wellness visits

Hidden Costs to Watch Out For

Late Enrollment Penalties
- Part B penalty: 10% for each full year you delay after eligibility
- Part D penalty: 1% per month delayed without creditable coverage

Travel Costs
- Most Advantage plans don't cover care outside your region

- Medigap is ideal for snowbirds and frequent travelers

Out-of-Network Charges
- If you go outside your Advantage plan's network, you may pay more-or the full bill

My Role in Budget Planning

I work with clients to:
- Estimate yearly Medicare costs based on health and usage
- Compare Advantage vs. Medigap for affordability
- Identify drug plans that minimize out-of-pocket costs
- Look for premium savings and subsidies

A little planning can go a long way toward keeping your healthcare both high-quality and affordable.

In the next chapter, we'll talk about how to change or adjust your Medicare coverage if your needs evolve over time.

CHAPTER 8

Medicaid and Long-Term Care Coverage

Chapter 8: Tips for Saving Money on Medicare

Chapter 8: Tips for Saving Money on Medicare

Medicare provides valuable coverage, but it can still leave you with significant out-of-pocket costs-especially if you don't review your plan options or understand what's available.

The good news is: there are many ways to save money without compromising the quality of your healthcare.

In this chapter, we'll walk through practical ways to reduce your Medicare expenses-whether you're new to the program or a long-time enrollee.

1. Review Your Drug Plan Every Year

Medicare Part D plans and Medicare Advantage plans that include drug coverage change their formularies (list of covered medications) every year. Your premium, copays, and coverage may change too.

What to do:
- Compare plans during the Annual Enrollment Period (Oct 15 - Dec 7)
- Make sure your prescriptions are still covered
- Use the Medicare Plan Finder or contact me for help

Tip: Even if you're happy with your plan, reviewing annually could save you hundreds.

2. Use Preferred Pharmacies and Generics

Many drug plans offer lower copays when you use a "preferred" pharmacy. Ask your pharmacy or check your plan's provider directory.

Also, ask your doctor if a generic alternative is available. Generics can cost up to 85% less than brand-name drugs.

3. Apply for the Extra Help Program

If you have limited income and resources, you may qualify for **Extra Help** (also called LIS-Low Income Subsidy).

This program can reduce:
- Part D premiums
- Deductibles

- Copays for medications

Eligibility in 2025:
- Income below ~$22,000 (single) or ~$30,000 (married)
- Limited assets

Apply through Social Security or your state Medicaid office.

4. Check for Medicare Savings Programs

Medicare Savings Programs (MSPs) help with Part B premiums and may also help with deductibles, coinsurance, and copayments.

There are four types of programs:
- QMB (Qualified Medicare Beneficiary)
- SLMB (Specified Low-Income Medicare Beneficiary)
- QI (Qualifying Individual)
- QDWI (for disabled working individuals)

If you qualify, these programs can cover:
- Your $185/month Part B premium
- Copays and hospital deductibles
- Prescription drug costs (through automatic Extra Help enrollment)

5. Choose a Medicare Advantage Plan with Extra Benefits

Some Medicare Advantage plans offer $0 premiums and extra benefits like:
- Dental, vision, hearing
- Transportation to medical appointments
- Over-the-counter (OTC) monthly allowances
- Fitness and wellness programs

If these are services you already pay for, a plan that includes them could reduce your monthly spending.

6. Avoid Late Enrollment Penalties

Missing your Initial Enrollment Period (IEP) or delaying Part D without creditable coverage can result in lifetime penalties.

What to do:
- Sign up for Part B during your IEP (unless you have employer coverage)

- Make sure you don't go 63+ days without drug coverage

7. Take Advantage of Preventive Services

Medicare covers many preventive services at no cost to you, including:
- Annual wellness visits
- Flu, COVID, and pneumonia vaccines
- Cancer screenings (colon, breast, prostate)
- Diabetes screening and management

These services can catch problems early-and save you money in the long run.

8. Understand Your Plan's Rules

Avoid surprise bills by understanding your plan:
- Stay in-network if on Medicare Advantage HMO
- Get referrals if required
- Use in-network labs and imaging centers
- Know your plan's drug formulary and prior authorization requirements

How I Can Help

As a Medicare specialist, I assist clients with:
- Plan reviews and annual cost comparisons
- Checking eligibility for Extra Help and savings programs
- Avoiding costly penalties
- Identifying plans that match your health and financial needs

Let's work together to make sure you're not paying more than you have to. A few smart choices can lead to thousands in savings over time.

Chapter 9

Tips for Saving Money on Medicare

Chapter 9: Protecting Yourself from Medicare Fraud and Mistakes

Chapter 9: Protecting Yourself from Medicare Fraud and Mistakes

Medicare fraud is a multi-billion dollar problem that affects everyone-especially seniors. Fraud and billing errors can lead to higher healthcare costs, identity theft, and even denial of important medical services.

But the good news is: you can protect yourself with knowledge, vigilance, and the right support.

This chapter will help you recognize common scams, catch billing mistakes, and report suspicious activity before it causes real harm.

What is Medicare Fraud?

Medicare fraud is when a person or company knowingly deceives Medicare to receive unauthorized payments or services.

Examples of Medicare fraud:
- Billing Medicare for services you never received
- Using your Medicare number to bill for false claims
- Offering "free" equipment or screenings in exchange for your Medicare number
- Misrepresenting a diagnosis to justify tests or treatments

Example:
You receive a bill showing charges for a wheelchair you never ordered or received. That's likely fraud.

What is Medicare Abuse?

Medicare abuse happens when providers overcharge or recommend unnecessary services, but without the intent to deceive.

Examples:
- Unbundling lab tests to increase payments
- Charging for a more expensive procedure than was performed
- Ordering duplicate tests or excessive follow-ups

Mistakes vs. Fraud

It's important to note that many errors in billing are just that-mistakes. But you should always

review your records to catch both innocent errors and deliberate fraud.

How to Protect Yourself

Guard Your Medicare Number
- Treat it like a credit card number-only give it to trusted providers
- Don't carry your Medicare card unless you need it
- Never share your number with someone offering free gifts or services

Review Your Medicare Summary Notices (MSN) or Explanation of Benefits (EOB)
- Check dates of service
- Verify provider names
- Look for duplicate charges or services you didn't receive

Beware of These Common Scams:
- "You've won a free genetic test!" (They'll bill Medicare and may steal your identity)
- Callers claiming to be from Medicare asking to confirm your number
- People going door-to-door offering free medical supplies
- Offers of free braces or creams "covered by Medicare"

Don't Sign Blank Forms or Accept Unsolicited Equipment

Report Suspicious Activity

If you think you've spotted fraud or abuse, contact:
- 1-800-MEDICARE (1-800-633-4227)
- Your Medicare Advantage or Part D plan
- Senior Medicare Patrol (SMP): smpresource.org

Reporting fraud helps protect others and strengthens the Medicare system.

What to Do if You've Been Affected

If you think your Medicare number has been misused:
1. Contact Medicare immediately
2. File a report with the Office of the Inspector General (OIG)
3. Inform your healthcare provider or plan if it involves their billing

You'll never be penalized for reporting in good faith-even if it turns out to be a mistake.

How I Support My Clients

I regularly help clients:
- Understand their Summary Notices
- Catch suspicious or incorrect billing
- Get connected to the right reporting channels
- Avoid scams during enrollment and plan changes

Medicare fraud can seem overwhelming, but you're not alone. A few simple habits can keep your identity safe, your wallet protected, and your benefits secure.

In the final chapters, we'll explore specialized plans and Medicaid long-term care for those with additional needs.

CHAPTER 10

SPECIAL NEEDS PLANS: D-SNP AND C-SNP

Special Needs Plans: D-SNP and C-SNP

Chapter 10: Special Needs Plans (D-SNP and C-SNP)

Chapter 10: Special Needs Plans (D-SNP and C-SNP)

Special Needs Plans (SNPs) are a unique type of Medicare Advantage plan designed to provide targeted care and support for people with specific health conditions or financial circumstances.

These plans combine the benefits of Medicare Advantage with specialized coverage tailored to those who need it most.

There are three types of SNPs:
- **D-SNP (Dual Eligible Special Needs Plan)** - For people eligible for both Medicare and Medicaid
- **C-SNP (Chronic Condition Special Needs Plan)** - For people with certain chronic health conditions
- **I-SNP (Institutional Special Needs Plan)** - For people living in long-term care facilities (not covered here)

Let's explore how D-SNPs and C-SNPs work, and how they can make a major difference in the care and coverage available to you or a loved one.

What is a D-SNP?

D-SNP stands for **Dual Eligible Special Needs Plan**. These plans are for individuals who qualify for both Medicare and Medicaid.

If you are dual eligible, you may:
- Have low income and assets
- Receive Medicaid through your state
- Be eligible for extra support like transportation, meal delivery, or care coordination

D-SNPs offer:
- Coverage for hospital and doctor visits (Parts A & B)
- Prescription drug coverage (Part D)
- Coordination of Medicare and Medicaid benefits
- Additional benefits like dental, vision, hearing, OTC items, and more
- A care manager to help you navigate appointments, prescriptions, and services

Most D-SNPs have $0 monthly premiums and little or no cost-sharing for covered services.

D-SNP Eligibility

To qualify, you must:
- Be enrolled in Medicare Parts A and B
- Qualify for some level of Medicaid assistance through your state

Levels of Medicaid include:
- QMB, SLMB, QI (explained in Chapter 8)
- Full Medicaid (ALTCS in Arizona, for example)

Example:
Maria is 69, has diabetes, and receives Medicaid due to limited income. A D-SNP gives her a single plan that includes medical, hospital, and drug coverage, plus transportation and case management-all at no cost.

What is a C-SNP?

C-SNP stands for **Chronic Condition Special Needs Plan**. These plans are for individuals with one or more qualifying chronic conditions.

Qualifying conditions may include:
- Diabetes
- Chronic heart failure
- COPD (chronic obstructive pulmonary disease)
- Cardiovascular disease
- End-stage renal disease (ESRD)
- HIV/AIDS
- Dementia or Alzheimer's disease
(Note: Available conditions vary by plan and region)

C-SNPs offer:
- Tailored benefits and formularies for your condition
- Access to specialists and care teams focused on your illness
- Disease management and care coordination
- Additional benefits like meals, transportation, OTC, and fitness

C-SNP Eligibility

To qualify, you must:
- Have Medicare Parts A and B
- Be diagnosed with a qualifying chronic condition
- Be in the plan's service area

Example:
George, age 71, has chronic heart failure. A C-SNP provides a cardiology-focused care network, coverage for specific medications, and a nurse case manager to check in with him regularly.

Enrollment and Coordination

Enrollment for D-SNPs and C-SNPs follows Medicare Advantage rules but also allows for:
- **Special Enrollment Periods (SEPs)** when Medicaid eligibility changes
- Year-round enrollment for some D-SNPs

Plan benefits, availability, and enrollment periods may differ by state and insurer.

How These Plans Differ from Regular Medicare Advantage

Feature	Regular MA Plan	D-SNP or C-SNP Plan
Target Audience	General population	People with Medicaid or chronic conditions
Care Coordination	Limited	Often includes care teams and case managers
Extra Benefits	May include some	Often more robust and condition-specific
Network Access	General providers	Specialists and disease-focused networks

Why Consider an SNP?

Integrated benefits tailored to your needs
Lower or no cost-sharing
Specialized provider networks
Additional support services
Personalized help managing your health

How I Help

I regularly assist clients with:
- Determining if they qualify for a D-SNP or C-SNP
- Comparing plans and benefits in their state
- Enrolling in a plan that supports their specific needs
- Connecting with Medicaid to ensure coordination of benefits

Special Needs Plans can make a world of difference-providing not just healthcare, but care

management and peace of mind.

In the next chapter, we'll explore how state Medicaid programs support long-term care and how that ties into your Medicare strategy.

CHAPTER 11

MEDICAID AND LONG-TERM CARE COVERAGE

Chapter 11: Medicaid and Long-Term Care Coverage

Chapter 11: Medicaid and Long-Term Care Coverage

While Medicare provides critical coverage for hospital, doctor, and prescription services, it offers very limited support for long-term care. That's where Medicaid steps in.

Medicaid is the **primary payer of long-term care services in the United States**-helping millions of seniors and people with disabilities access nursing home care, assisted living, and in-home support.

In this chapter, we'll break down what Medicaid covers, how it differs from Medicare, who qualifies, and how to plan ahead for care needs that may arise later in life.

What's the Difference Between Medicare and Medicaid?

Feature	Medicare	Medicaid
Type	Federal health insurance	Joint federal-state health assistance
Who It's For	People age 65+ or with disabilities	People with low income and assets
Long-Term Care Coverage	Very limited	Extensive, especially nursing home care
Income/Asset Requirements	None for eligibility	Strict income and resource limits

Medicaid and Long-Term Care

Medicaid provides a wide range of **long-term care services**, including:
- Nursing home care (custodial and skilled)
- Assisted living services (in some states)
- Home and Community-Based Services (HCBS)
- In-home caregivers and personal assistance
- Adult day health programs
- Respite care for family caregivers

These services are especially important for seniors who can no longer live independently and require help with **Activities of Daily Living (ADLs)** such as bathing, dressing, and eating.

How to Qualify for Long-Term Care Medicaid

Unlike Medicare, Medicaid eligibility is based on **income and assets**. Each state sets its own guidelines, but most use the following:

In 2025, typical limits include:
- Income: Around $2,829/month (single)
- Assets: $2,000 (not including home, car, and burial plot)

Some states are more flexible and offer **Medically Needy programs** or **spend-down options**, allowing individuals to qualify after covering medical expenses that reduce their income below Medicaid limits.

The Look-Back Period

To prevent people from giving away assets to qualify for Medicaid, there is a **5-year look-back period** in most states.

During this time, Medicaid reviews financial records to ensure no assets were transferred below market value. If improper transfers are found, a **penalty period** may be imposed-delaying eligibility.

Tip: Planning early with a financial advisor or elder law attorney can protect assets while maintaining Medicaid eligibility.

Home and Community-Based Services (HCBS)

Many states offer HCBS waiver programs that allow eligible individuals to receive care **at home** instead of moving into a facility. These services may include:
- In-home health aides
- Meal delivery
- Case management
- Home modifications for safety
- Transportation to medical appointments

Arizona, for example, administers long-term care benefits through the **Arizona Long Term Care System (ALTCS)**. This program provides both nursing home and home-based services for those who qualify medically and financially.

Long-Term Care Planning Tips

Start early: Apply before a crisis occurs
Document assets and income clearly

Know your state's rules and programs
Consider long-term care insurance (while still healthy)
Consult with a qualified elder law attorney or Medicaid planner