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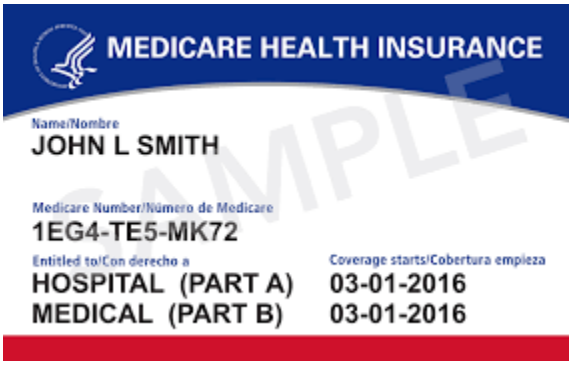
The Definitive Guide to Medicare

Medicare.

It's a recognizable name, a brand name if you will, like Kleenex or Coca Cola. If you ask people what it is, most can tell you it's government health insurance for older people but if you're going to do serious retirement planning you need to know more than that. If you don't know what to do and when to do it, you could miss deadlines that could raise the cost of Medicare for the rest of your life - not to mention the effect it could have on your coverage.



For years, the cost of medical care has been rising much faster than inflation. From 2000 to 2018 the average annual medical care inflation rate was 3.5%, about double the average for the U.S. economy as a whole for the same time period. A medical bill of $1000 in 2000 rose to $1858.91 by 2018. As Americans age, their healthcare requirements increase, the cost of services rise, and so Medicare plays a critical role in the care they receive. Most Americans receive their health insurance through their employer but once they retire, Medicare is the only affordable option for most Senior Citizens.

This handbook will help prepare you for enrolling in Medicare and point out some of the intricacies of the Medicare system.

Medicare History

National health insurance has been talked about since 1912 when Teddy Roosevelt included it in his Progressive Party (popularly known as the "Bull Moose" party) platform. The idea was revived by Harry Truman in 1945 when Harry Truman asked Congress to create a national health insurance fund open to all Americans. But Truman, and later John F. Kennedy who revived the idea, couldn't push national health insurance through a recalcitrant Congress. Lyndon Johnson couldn't either but his Great Society programs, whose ambitious goal was to eliminate poverty and racial injustice, included Medicare, the health insurance program for Americans 65 and older. The impact of many of the Great Society programs are still being debated today but Medicare is widely acknowledged as a success and more than 56 million Americans are currently covered by the program.

Medicare Overview

Initially Medicare had just two parts. Part A—hospital insurance - and Part B - medical insurance. Although Medicare has expanded since then, Parts A and B still exist and are referred to as Original Medicare. Today, there are two additional components - Part C - Medicare Advantage Plans, and Part D - drug coverage. Medicare Supplement Plans are not part of Medicare, but can be an important addition to your overall retirement medical plan.

To be eligible for Medicare you have to be at least 65 years old or have special qualifying conditions or disabilities. The initial enrollment period runs 7 months—3 months before your 65th birthday, the month you turn 65, and 3 months after the month you turn 65. Enrolling for Medicare as soon as you are eligible is often the best option.

Enrollment Periods

There are three enrollment periods:

- Initial Enrollment Period (IEP) described above
- General Enrollment Period. January 1-March 31. The GEP happens every year and allows you to enroll if you missed the IEP.
- Open Enrollment. October 15-December 7. Open enrollment happens every year and is the period when you can switch Medicare Advantage plans, Part D drug plans, etc.

What Medicare Doesn't Cover

There is a misconception that Medicare covers all your medical expenses. Not true. Some of the items Medicare does not cover are out-patient prescription drugs, routine eye exams, glasses, contact lenses or prescription sunglasses, dental expenses, hearing aids, sickness if traveling abroad, and long-term care.

Common Insurance Terms

Insurance terms for Medicare are the same as the ones you find in all health insurance plans:

- Deductible - a set amount you pay out of pocket for covered services each year before Medicare or your plan begins to pay.
- Copay - a fixed amount you pay at the time you receive a covered service. For example, you might pay $20 when you visit the doctor or $4 when you fill a prescription.
- Coinsurance - a percentage of the cost for a covered service you pay at the time service is rendered. For example, Medicare might pay 80% of the covered service and you pay the remaining 20%.

Costs

If you meet the Medicare requirements, there is no cost to you for Part A. But there is a monthly premium for Part B that increases almost every year. And if you don't sign up for part B when you're eligible you run the risk of paying a hefty, ongoing late enrollment penalty that lasts for the rest of your life. There can also be a penalty for late enrollment in Medicare Part D, the prescription drug benefit.

One exception to the rule is for those who continue working past the age of 65 and who have health insurance through a current employer. They can delay enrolling in Medicare, penalty-free, for up to eight months after their job or group insurance ends.

If you have medical coverage through a current or former employer, don't make any decisions until you understand how your current coverage works with Medicare. Doing your homework will eliminate surprises that could cost time, money, and a lot of red tape.

How to Enroll

When you're ready to enroll in Medicare you have three options:

- Online - www.socialsecurity.gov/medicare/apply.html
- Visit your local Social Security Office
- Call Social Security - 1-800-772-1213

More detailed information about the various parts of Medicare is below.

Medicare Part A

Medicare Part A is one of the original components of the Federal health insurance program for Americans age 65 and older. It's the element that provides hospital insurance. In broad categories Part A covers:

- Hospital Care
- Skilled nursing facility care
- Nursing home care (as long as custodial care is not the only care you need)
- Hospice
- Home health services.

Part A also covers services like lab tests, surgeries, and doctor visits as well as supplies such as wheelchairs and walkers if they're considered medically necessary.

If you're in a Medicare Advantage Plan or other Medicare plan, there may be different rules, but your plan is required to provide at least the same coverage as Original Medicare.

Some of the things Medicare Part A **does not** cover include:

- Long-term care
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care

It's always a good idea to talk to your doctor or health care provider to make sure what you need is covered by Medicare.

Generally, there is no cost for Medicare Part A, sometimes called premium-free Part A. However, it doesn't mean you incur no costs. There is an inpatient deductible as well as coinsurance. If you have a hospital stay:

- There is a deductible for each benefit period

According to Medicare, *a benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.*

Besides the deductible, coinsurance can be involved. For example, in 2019:

- You pay $0 coinsurance days 1-60 for each benefit period
- You pay $341/day coinsurance days 61-90 for each benefit period
- You pay $682/day coinsurance days 91 and beyond for each "lifetime reserve day" after

day 90 for each benefit period. (Medicare defines lifetime reserve days as *additional days Medicare will pay for when you're in a hospital more than 90 days. You have 60 reserve days that can be used during your lifetime. For those days, Medicare pays all covered costs except for daily coinsurance.)*
- You pay all costs when you exhaust your lifetime reserve days.

You're eligible to sign up for Part A Medicare when you turn 65. The seven-month initial enrollment period (IEP) begins three months before your 65th birthday, the month you turn 65, and the three months after the month you turn 65. For example, if your birthday is in June, you can sign up for Part A beginning in March before your birthday through the September immediately after your birthday. If you wait until the month you turn 65 (or the 3 months after you turn 65) to enroll, your Part B coverage will be delayed. This could cause a gap in your coverage.

If you didn't enroll during the IEP you can enroll in Medicare Part A and Part B during the General Enrollment Period (GEP) which happens every year from January 1 to March 31. You may also choose to join a Medicare Advantage plan (Part C) or a prescription drug plan (Part D) from April 1 to June 30 the same year. Your coverage will start July 1.

To confirm your eligibility and other important information check out the Medicare calculator. https://www.medicare.gov/eligibilitypremiumcalc

Medicare Part B

Medicare Part B is the other original component of the Federal health insurance program for Americans age 65 and older. It's the element that provides routine health insurance and covers things like outpatient services and doctors' fees. Part B covers 2 types of services:

- Medically-necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- Preventive services: Healthcare to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

It also covers supplies necessary to diagnose or treat a medical condition that meets accepted standards of medical practice as well as preventive services.

There's no cost to you for most preventive services if you receive them from a health care provider who accepts assignment, meaning the provider agrees to be paid directly by Medicare, accepts the amount Medicare pays, and agrees not to bill you for more than the Medicare deductible and coinsurance. Part B covers things like:

- Clinical research
- Ambulance services
- Durable medical equipment (DME)
- Mental health
- Inpatient
- Outpatient
- Partial hospitalization
- Getting a second opinion before surgery
- Limited outpatient prescription drugs

Unlike premium-free Part A, there is a monthly premium for Part B. If you receive Social Security, the premium is automatically deducted from your benefit payment. If you are not receiving Social Security you will be billed.

Most people pay the standard Part B premium amount. However, if your modified adjusted gross income is above a certain amount, you may pay an Income Related Monthly Adjustment Amount

(IRMAA), which is an extra charge added to the standard premium. Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago. This is the most recent tax return information provided to Social Security by the IRS. The rules are outlined in the SSA publication: *Medicare Premiums: Rules for Higher-Income Beneficiaries*.

If Social Security says you have to pay more but you disagree, you can appeal. Some of the items SSA will consider include:

- An amended return that changes the income Social Security counts
- You got married, divorced, or became widowed
- You or your spouse lost income-producing property because of a disaster or other event beyond your control
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan
- You or your spouse received a settlement from an employer or former employer because of the employer's closure bankruptcy, or reorganization.

If you claim any of these reasons in your appeal SSA will require documentation to verify the event and the reduction of your income. SSA will tell you specifically what proof it needs.

There are two ways to appeal—online at www.socialsecurity.gov/disability/appeal or you can request an appeal in writing. Complete a Request for Reconsideration (Form SSA-561-U2). It can be found at www.socialsecurity.gov/online or requested by phone at 1-800-772-1213.

In addition to the monthly Part B premium, you pay an annual Part B deductible. After paying your deductible you typically pay 20% of the Medicare approved amount for:

- Most doctor services (including most doctor services while you're a hospital inpatient)
- Outpatient therapy
- Durable medical equipment (such as wheel chairs, walkers, or hospital beds ordered by your doctor for in-home use)

Some of the costs not covered by Part B may be paid by Medicare Advantage Plans or supplemental insurance plans which will be discussed later in this handbook.

Just like Part A, you're eligible to sign up for Part B Medicare when you turn 65. The seven-month Initial Enrollment Period (IEP) runs from three months before the month of your 65th birthday, the month you turn 65, and the three months after the month you turn 65. For example, if your birthday is in June, you can sign up for Part B beginning in March before your birthday through the September immediately after your birthday.

Once you sign up for Part B you must pay the premium every month for as long as you have Part B, even if you don't use it.

If you don't sign up for Part B when you're first eligible, in most cases, you'll have to pay a late enrollment penalty when you do enroll. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B. You'll have to pay the late enrollment penalty for as long as you have Part B. Also, you may have to wait until the next General Enrollment Period (GEP),

January 1-March 31, to enroll in Part B coverage that begins July 1 of that year.

If you have Part B, decide to drop it, and then want it back, you won't be able to enroll again until the next General Enrollment Period, January 1-March 31. At re-enrollment you will most likely get hit with the late enrollment penalty, which, again, you will have to pay for as long as you have Part B coverage.

If you continue to work after your 65th birthday and have employer health coverage, or you have coverage through a former employer or a union, it may be to your advantage to delay enrolling in Part B. In some instances, you can sign up for Part B without penalty when your current insurance coverage ends. It's important to understand how your current coverage works with Medicare before making any decisions.

Medicare Part C – Medicare Advantage Plans

Part C Medicare is not a term we hear often, but it's the part of Medicare that outlines Medicare Advantage or MA plans. They include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans (PFFS), Special Needs Plans, and Medicare Medical Savings Accounts (MSA). These plans are offered by private companies approved by Medicare. If you're enrolled in a Medicare Advantage plan most Medicare services are covered through the plan and are not paid by Original Medicare.

When investigating Medicare Advantage plans and coverage, it's imperative that you know and understand the terms associated with payments and how the costs are shared. Here's a quick glossary.

Coinsurance
The costs that you and the health insurance plan pay are split on a percentage basis. For example, you might pay 20% of the total allowed cost of a service and the remaining 80% would be paid by the plan.

Copay
The fixed amount you pay at the time you receive a covered service. For example, you might pay $20 when you visit the doctor or $12 when you fill a prescription.

Deductible
A set amount you pay out of pocket for covered services each year before your plan begins to pay.

Out-of-Pocket Maximum
The maximum amount you pay during a policy period (usually a year). This amount does not include your premium or the cost of any services that are not covered by your plan. After you reach your out-of-pocket maximum, your plan pays 100% of the allowed amount of covered services for the rest of the policy period.

Limits on your cost-sharing is one way that Medicare Advantage plans differ from Original Medicare (Part A and Part B). Many Medicare Advantage plans offer a feature that caps your out of-pocket spending (out-of-pocket maximum) for cost-sharing expenses like copays and deductibles in any given year. This provides financial protection in case of catastrophe or medical emergency.

Premium
The fixed amount you pay your health insurance or plan for Medicare coverage. You may pay your premium to Medicare, to a private insurance company or both, depending on your coverage. Most premiums are charged monthly.

Your Share of Medicare Advantage Costs

With Medicare Advantage plans, the company that offers the plan sets the monthly premium and decides on the cost-sharing amounts. Look at the details of each plan you're considering to see what your share of the cost (cost-sharing) could be.

Prescription Drug Coverage Deductibles

Some Medicare Advantage plans have a deductible for prescription drug coverage, while others do not. Look at the specific plan for details.

If you join a Medicare Advantage Plan, you still have Medicare, but your Part A hospital insurance and Part B medical insurance coverage come from the Plan, not from Original Medicare.

While the plans cover all services offered by Original Medicare, they always cover you for emergency and urgently needed care, and may cover you for vision, hearing, dental, and health and wellness programs. Most plans also include Medicare prescription drug coverage (Part D).

Medicare pays a fixed amount for your care each month to the companies offering Medicare Advantage plans, and the plans have to follow rules set by Medicare. However, the cost of Medicare Advantage Plans varies and they can charge different out-of-pocket costs as well as have different rules for obtaining various services. Your out-of-pocket costs depend on:

- Whether the plan charges a monthly premium
- Pays any of your monthly Medicare Part B premium
- Has a yearly deductible or additional deductibles
- The copayment or coinsurance amount you pay for each visit or service
- The type of health care services you need and how often you get them
- If your doctor accepts assignment
- Whether you use network providers
- If you need extra benefits
- The plan's yearly limit on your out-of-pocket costs for all medical services

Once a year Medicare Advantage Plans set the amounts they charge for premiums, deductibles, and services. It is the plan, not Medicare that decides how much you pay for a MA plan. Changes can only occur once a year and they take affect each January 1st.

If you are in a Medicare Advantage plan, review the Evidence of Coverage and Annual Notice of Change announcements. The plan sends these reports each fall. The Evidence of Coverage report gives you details about what the plan covers and how much you'll pay. The Annual Notice of Change includes any changes in coverage, costs, or service area that will take effect the following January.

Generally, Medicare Advantage plans don't pay for services that are not medically necessary. You can ask the plan for a written advance coverage decision to make sure a service is medically necessary and will be covered. If the plan won't pay for a service you think you need, you have to pay all the costs if you didn't ask for an advance coverage decision.

If you're already in a Medicare Advantage Plan and want to switch to another, you want to join the new plan during one of its enrollment periods. You will automatically be dis-enrolled from the old plan when your new coverage begins. If you want to leave your current plan and return to Original Medicare, contact your current plan or call 1-800-MEDICARE.

Unless you have drug coverage, you should carefully consider Medicare Prescription Drug Coverage as part of a Medicare Advantage plan.

Finally, if you have existing health coverage through your employer, union, or other benefits administrator, talk to them about their rules before you join a Medicare Advantage Plan. In some cases, joining an MA Plan might cause you to lose employer or union coverage for yourself, your spouse or dependents.

In other cases, if you join a MA Plan, you may still be able to use your employer or union coverage along with the plan you join. If you drop employer or union coverage, you may not be able to get it back.

Medicare Supplement (Medigap) Insurance

If you've looked at all the pieces of Medicare you may be pulling your hair out. But let's throw one more item into the mix—Medicare Supplement Insurance, or what the government calls Medigap.

Medicare Supplement Policies are different than Medicare Advantage Plans. In fact, you cannot have a Supplement policy AND a Medicare Advantage Plan. The purpose of MA Plans is to get Medicare benefits. Supplement policies are to help pay some of the health care costs Original Medicare doesn't cover. Things like copayments, coinsurance, and deductibles. If you have Original Medicare and buy a supplement policy, Medicare pays its share of the Medicare-approved amount for covered health care costs. Then, the supplement pays its share.

Here are things to keep in mind when considering Medicare Supplement Policies:

- You must have Medicare Part A and Part B.
- If you have a Medicare Advantage Plan, you can apply for a supplement policy, but make sure you can leave the Medicare Advantage Plan before your supplement policy begins.
- You pay the private insurance company a monthly premium for your supplement policy in addition to the monthly Part B premium you pay Medicare.
- A Supplement policy covers only one person. If both you and your spouse want supplemental coverage, you have to buy separate policies.
- You can buy a supplement policy from any insurance company licensed in your state.
- Any standardized supplement policy is guaranteed renewable even if you have health problems. The insurance company cannot cancel your policy as long as you pay the premium.
- Supplement policies are not allowed to include prescription drug coverage.
- It's illegal for anyone to sell you a Supplement policy if you have a Medicare Medical Savings Account (MSA) Plan.
- Medicare Supplement policies generally do not cover long-term care, vision, dental, hearing aids, eyeglasses, or private-duty nursing.

All Medicare Supplement premiums are not created equal. In fact, insurance companies may charge different premiums for the exact same policy. So, as you shop, be sure you're comparing apples to apples, for example, comparing Plan A from one company with Plan A from another company.

The best time to buy a Supplement policy is during your six-month Medicare open enrollment period. During that time… you can buy any Supplement policy sold in your state, even if you have health problems. The enrollment period automatically starts

the month you turn 65 and are enrolled in Medicare Part B. If you don't sign up for a Medicare Supplement policy during the enrollment period and later change your mind, you could be denied coverage or charged a higher premium based on your health history.

You can find additional information about Medicare Supplement Insurance at www.medicare.gov

Medicare Part D – Drug Coverage

An important part of any health insurance plan for mature Americans is prescription drug coverage. That's where Medicare Part D comes in - the drug plan. Prescription drug coverage is available to everyone who has Medicare, but the type of drug coverage you have depends on how you receive Medicare.

Medicare prescription drug plans, sometimes called PDPs, can be a component added to Original Medicare (Parts A & B). Or drug coverage may be part of a Medicare Advantage plan, which provides Parts A, B and D.

Each Medicare drug plan has its own list of covered drugs, called a formulary. Many plans place drugs into different tiers on their formularies and drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost less than a drug in a higher tier. If your prescriber thinks you need a drug that's on a higher tier, you or your prescriber can ask your plan for an exception to get a lower copayment.

A Medicare drug plan can make changes to its formulary during the year. If a change affects a drug you are taking, the plan must provide you written notice at least 60 days before the change takes effect. Or, at the time you request a refill, you must be given written notice of the change and a 60-day supply of the drug under the same rules as before the change.

Certain rules may apply to Medicare drug plan coverage.

- You or your prescriber must contact the drug plan before certain prescriptions can be filled. Your prescriber may need to show that the drug is medically necessary before the plan will cover it.
- There may be limits to how much medication you can get each time a prescription is filled.
- Some plans require step therapy… which requires you to try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

Except for vaccines covered under Medicare Part B, Medicare drug plans must cover all commercially available vaccines, like the shingles vaccine, when it's medically necessary to prevent illness.

In most cases, the prescription drugs you get in a hospital outpatient setting, like an emergency department or during observation services, are not covered by Part B. These are sometimes called self-administered drugs that you would normally take on your own. Your Medicare drug plan may cover these drugs under certain circumstances, but you will probably have to pay out-of-pocket for self-administered drugs and submit a claim to your drug plan for reimbursement.

There are also rules governing automatic refill mail-order service for prescription drugs. The bottom line: always check with your Medicare drug plan to find the specific drug coverage rules for you. Medicare puts the responsibility on you and if you fail to investigate, it could end up costing you money that won't be reimbursed.

And then, there's the Donut Hole. Most Medicare drug plans have a coverage gap that begins after you and your drug plan have spent a predetermined amount for covered drugs. The amount may change every year. You can find that amount at www.medicare.gov.

Brand-Name Prescription Drugs

Once you reach the coverage gap, you'll pay no more than 25% of the plan's cost for covered brand-name prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. Some plans may offer higher savings in the coverage gap. The discount will come off the price your plan set with the pharmacy for that specific drug.

Although you'll pay no more than 25% of the price for the brand-name drug 95% of the price—what you pay plus the 70% manufacturer discount payment—will count as out-of-pocket costs which will help you get out of the coverage gap.

These items aren't counted toward your out-of-pocket spending:

- What the drug plan pays toward the drug cost
- What the drug plan pays toward the dispensing fee
- If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the drug's price. The discount for brand-name drugs will apply to the remaining amount that you owe.

Generic Drugs

You'll pay 25% of the cost for generic drugs while you are in the donut hole. Coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap. If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the drug's price.

Items that count towards the coverage gap

- Yearly deductible , coinsurance, and copayments
- The discount you get on brand-name drugs in the coverage gap
- What you pay in the coverage gap

Items that don't count towards the coverage gap

- The drug plan premium
- Pharmacy dispensing fee
- What you pay for drugs that aren't covered

If you think you've reached the coverage gap and you don't get a discount when you pay for your brand-name prescription, review your next "Explanation of Benefits" (EOB). If the discount doesn't appear on the EOB, contact your drug plan to make sure your prescription records are correct and up-to-date. If your drug plan doesn't agree that you're owed a discount, you can file an appeal.

Keep this warning in mind. Joining a Medicare drug plan may affect your Medicare Advantage Plan. Your MA plan will dis-enroll you and send you back to Original Medicare if your MA plan includes prescription drug coverage and you join a Part D plan. You cannot double-dip.

Most Medicare Prescription Drug Plans charge a monthly fee that varies by plan. You pay this in addition to the Medicare Part B premium. If you join a MA Plan or Medicare Cost Plan that includes Medicare prescription drug coverage, the plan's monthly premium may include an amount for drug coverage. Be sure to check.

What's Best for You

Deciding how to structure a Medicare program that's best for you requires investigation, research, and planning. These questions will help you begin the process:

- How often do you go to the doctor?
- What health issues do you have?
- What medications do you take regularly?
- How much can you afford to pay for premiums each month?
- How comfortable are you paying copays and coinsurance for services you receive?
- Are you willing to accept the risk of high out-of-pocket costs?
- Which plans will allow you to go to the doctors, hospitals and pharmacies you want?
- Is it important for you to have healthcare access while you travel?
- Do you have other healthcare coverage through an employer or retiree plan and how will it work in conjunction with Medicare?

For more information about Medicare go to www.medicare.gov or call 1-800-633-4227.

How We Can Help You

Do you have enough to retire? Are you wondering how Medicare will affect your income needs in retirement? If you haven't reviewed your retirement plan recently – or you don't have one – we think we can help.

Give us a call today at 1-888-777-0970 and we'd be happy to arrange for one of our investment professionals to discuss your situation with you – completely complementary. Let's start the conversation today.

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