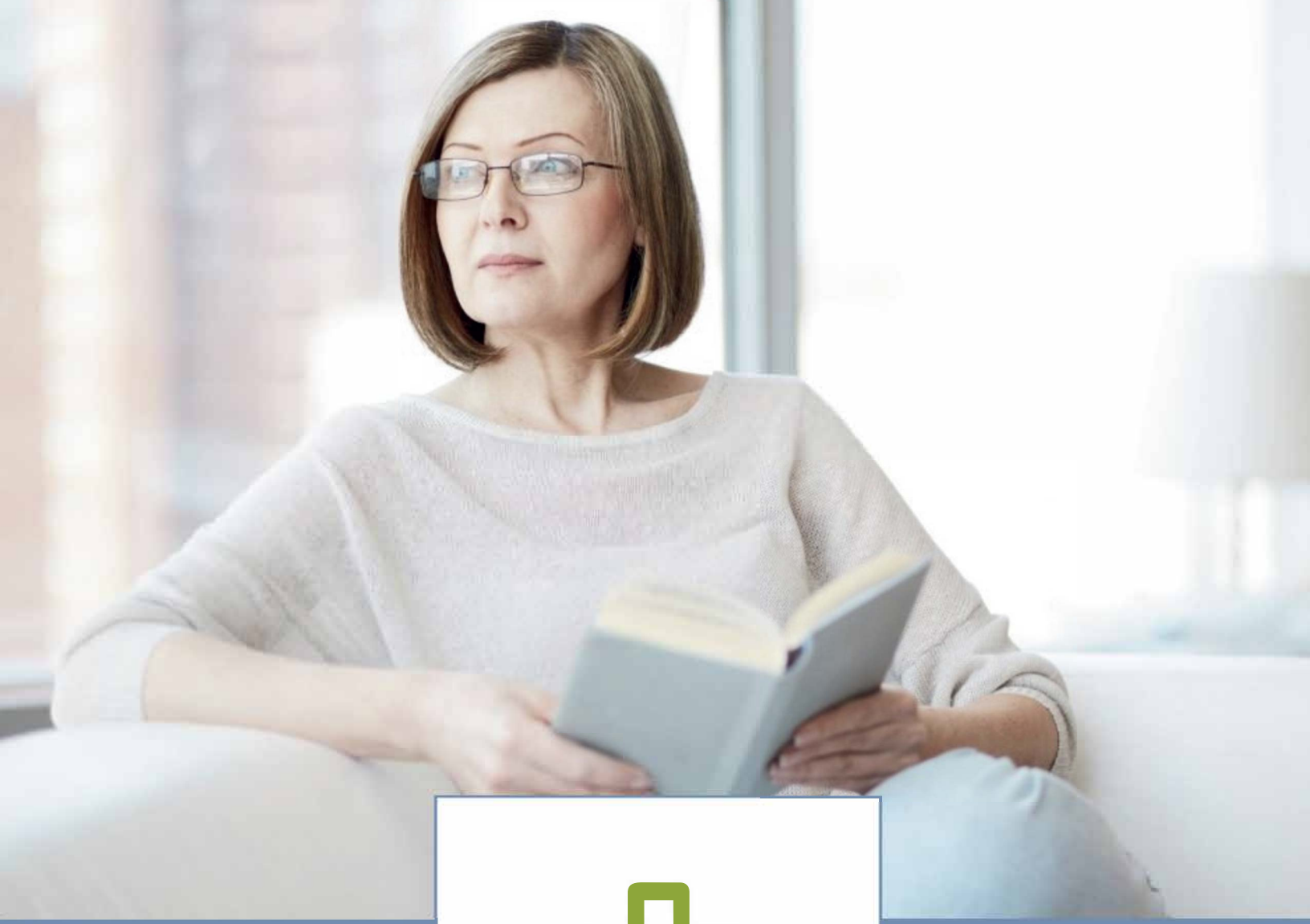


UNDERSTANDING MEDICARE

The Ultimate Guide for Getting the Right Medicare Coverage for You

WH Cornerstone Investments

How to Choose Your Medicare Coverage Submission

This is a big decision. And it will follow you for the rest of your life.

Age 65 is when you can finally transition to Medicare coverage, although you can sign up a bit earlier. (If you're disabled, you don't even have to wait to age 65.) So, if you're nearing age 65, it's time to look into the best Medicare choice for you.

The decisions you make at this time can affect your medical coverage for the rest of your days, and - with few exceptions - at no other time do you have the opportunity to pick any plan you want.

But the yearly barrage of television commercials - and the drip-drip of ads found on flyers, mailers and in your favorite magazines - create nothing but noise. What's worse? They don't show you how to choose what's best for you.

This guide provides you with a clear explanation of the initial decisions you need to make, including:

- ☐ How Medicare parts fit together,
- ☐ what their rough costs are,
- ☐ the pros and cons of each option, and
- ☐ when and how to file.

Once you have made these initial decisions, you can drill down and get more information on your desired options. We are here to be a resource. Let us know how we can help by calling (888) 797-9009 or send us an email at info@whcornerstone.com.

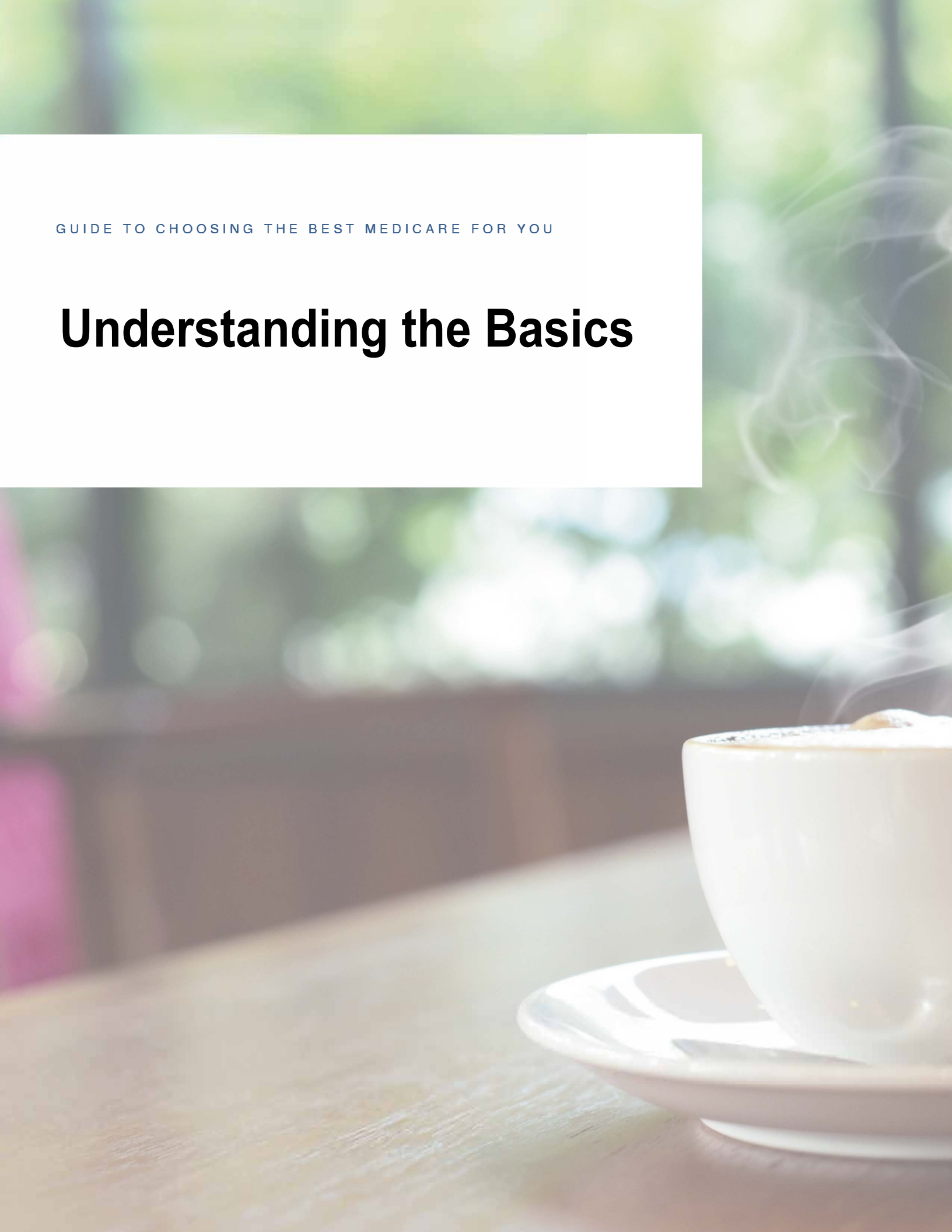
In health,

Bill Paula

WHCornerstone Investments

GUIDE TO CHOOSING THE BEST MEDICARE FOR YOU

Understanding the Basics



Where do you start the selection process?

Your first decision will be this:

Do you want to stay within the government's traditional Original Medicare system or opt for the private Medicare Advantage system?

The government's Original Medicare is the fee-for-service program offered by the U.S. Department of Health and Human Services (HHS) and its Centers for Medicare & Medicaid Services (CMS). Medicare Advantage plans, on the other hand, are government-vetted alternative plans offered by private insurance companies.

To make that decision, you need to know more.

Here's a bird's-eye view of the two alternatives. In a moment, we'll look at all the parts that make up each one.

What are the basic differences between Original Medicare and Medicare Advantage?

An overview of Original Medicare

Of the two systems, Original Medicare can cost more. But you have greater flexibility: you're free to choose your doctors (yes, you can keep your doctor) and you don't need referrals to see specialists. You can see any doctor anywhere in the U.S., not just those listed in an insurer's network. As long as the doctor accepts "Medicare assignment" (and most do), you can make an appointment and your covered costs will be paid by Medicare.

The downside is that your out-of-pocket costs are open-ended, with no upper limit. However, you can bridge as much of the coverage gap as you want by buying one of various government-defined, standalone policies from a private insurer. As of year end 2025, about 50% of beneficiaries had chosen Original Medicare.

Where to start (Continued)

An overview of Medicare Advantage

Medicare Advantage, on the other hand, combines or "bundles" various coverages together. Its plans look more like traditional private insurance coverage: HMOs and PPOs. The upside is that your out-of-pocket costs are capped. (You will spend out-of-pocket for deductibles, coinsurance and copayments, according to the plan you choose.) Although available services may be limited geographically, additional cost-sharing benefits toward dental, hearing, vision and fitness may be included in your package.

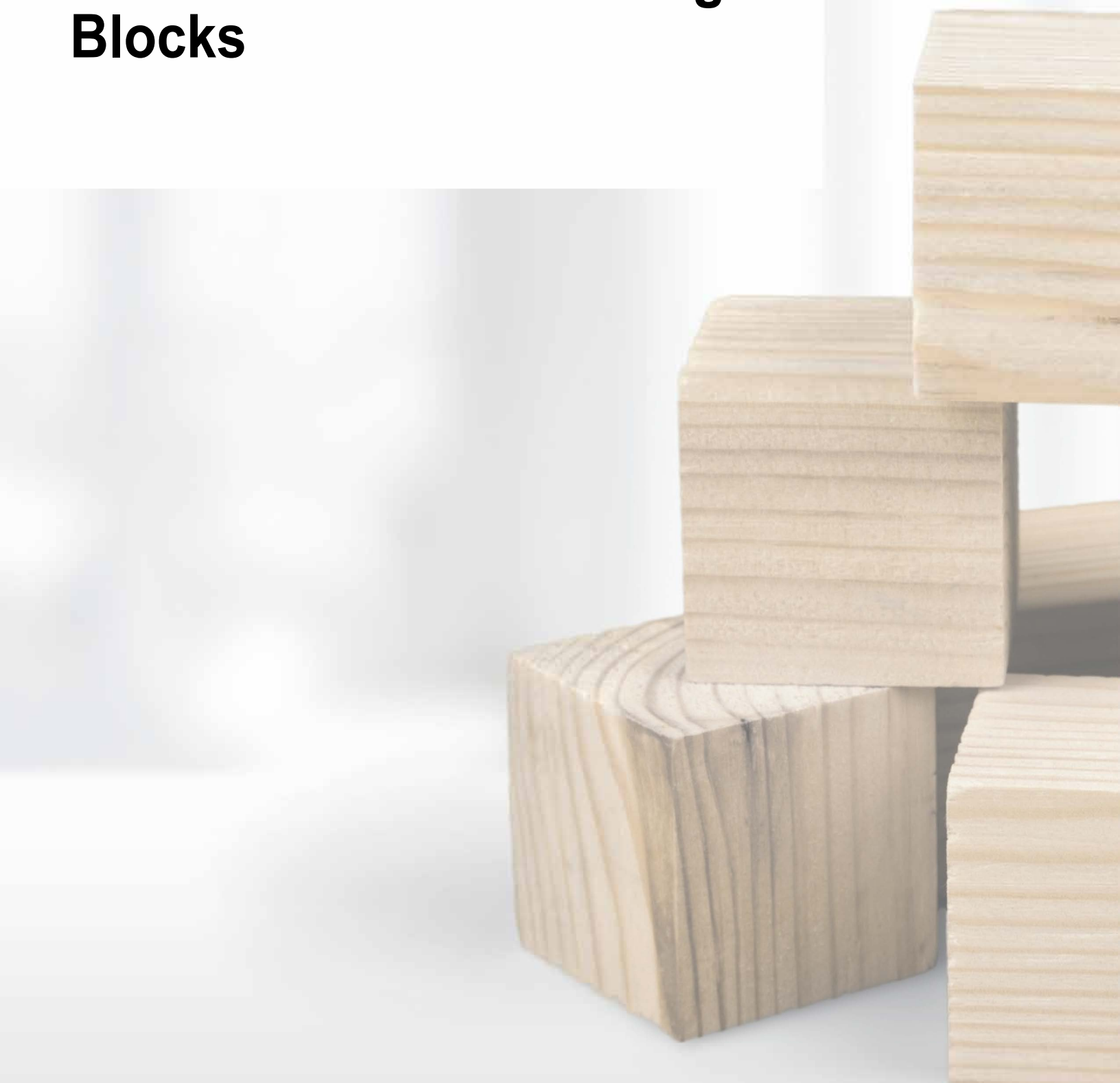
The downside to these substitute packages to Medicare is that they are one-year contracts. That means they can be changed or canceled each year. We are seeing a significant disruption in the Medicare Advantage marketplace, starting in 2024, and continuing for the foreseeable future.

If you choose an HMO plan, you must stay within a specified network of facilities and physicians. You will need a primary care physician and referrals to see specialists and get certain prescriptions. If you choose a PPO, you may be able to go outside the network, but you'll generally pay more. And you'll need to contact the non-network provider in advance to see if they will accept your insurance plan. Otherwise, you are responsible for full payment.

You may find plans with $0 monthly premiums, but they are generally HMOs. More flexible PPOs typically have higher plan premiums. At year end 2025, about 50% of beneficiaries were enrolled in Medicare Advantage plans.

GUIDE TO CHOOSING THE BEST MEDICARE FOR YOU

Medicare's Main Building Blocks



Examining Medicare's Main Building Blocks: Parts A, B, D and C

Before we start building the ideal Medicare solution for you, let's look at each building block that can make up Medicare.

Medicare Part A

Part A concerns your "hospital insurance" and helps pay for different forms of inpatient care.

Part A cover

- Inpatient care in a hospital
- Skilled nursing facility care (up to 100 days)
- Nursing home care (up to 100 day inpatient care in a skilled nursing facility not custodial or LTC)
- Hospice care
- Home health care (after an approved, inpatient stay at a hospital)

Medicare does not cover custodial care, assisted living or long-term care.

Everyone who has Medicare has to have Part A. And, virtually everyone (99%) qualifies for Part A with no premium to pay because that person (or a spouse) has worked enough over their life and paid into FICA to be eligible. Others have to pay a monthly fee.

Medicare Part A is designed to cover most of your costs while in the hospital or skilled nursing care. But, you will first pay a deductible, and then daily rates if you need a long stay.

Your share of Part A costs can be covered under a Medigap plan (more information follows).

Medicare Part B

Part B deals with your "medical insurance". It helps pay for medically necessary and preventive services in an outpatient environment. Part B typically covers 80% of the costs for approved services, leaving you with a significant 20% coinsurance exposure, which has no cap or limit.

However, if you choose a Medigap plan with Part B's coinsurance coverage, you will not pay the 20%. Instead, the insurer will pay your share of Part B posts, and you'll pay a monthly premium to the insurer (more information on Medigap plans follows).

Building Blocks (Continued)

Part B covers

- Physicians, specialists, other healthcare professionals
- Outpatient services
- Ambulance ground transportation (only if medically necessary)
- Clinical approved clinical research or trials
- Durable medical equipment (DME)
- Outpatient mental health services
- Certain outpatient prescription drugs

Medicare does not cover eyeglasses, dentures, hearing aids or related services.

Medicare Part B is technically a voluntary part of this insurance program. However, there are generally no other options to get your doctors and outpatient costs covered without Part B after age 65. If you are still working for a large company and covered on the company plan, you can delay applying for Part B.

If you miss your one opportunity to apply for Part B on time, you can enter during the first three months of the year, but you will pay a **permanent penalty**.

Medicare Part D

As we age, paying for needed drugs can become a burden. A private prescription drug plan (Part D) can be added to your Medicare coverage. While private insurers provide such standalone plans, the plans must meet federal guidelines. Each plan has a list of drugs that it covers, called a formulary, and it includes both brand-name and generic drugs. Part D coverage is technically optional. But you'll only have one chance to get into a Part D plan on time. Late entries can only be made during the annual Open Enrollment Period (10/15 - 12/7) and you will be assessed a permanent penalty.

Further, note that your Part D plan is a one-year contract. These plans can change significantly every year-premiums, the drugs covered, and even if the plan will continue to be offered in your zip code. Because these are private plans, the monthly premium can vary significantly from one plan to another.

Building Blocks (Continued)

Medicare rates the available Part D plans on a 1-5 scale that reflects customer service, care quality and member satisfaction. Ratings of 4 stars and above indicate better service and coverage.

Medicare Part C (Medicare Advantage)

Part C is not a separate benefit. Instead, it's a substitute or alternative to Medicare. Once you are enrolled in both Medicare Parts A and B, you can choose to have your insurance coverage through Medicare-approved, private-sector health plans called Medicare Advantage instead of from Original Medicare.

Each plan will bundle together the services of Part A and Part B, and will often add other benefits. For example, in 2024, 97% of beneficiaries were in plans with prescription drug coverage. As for other extra benefits, in 2024, beneficiaries in Medicare Advantage plans received the following help: eye exams and/or glasses (99%), dental care (98%) hearing exams and/or aids (96%) and fitness club discounts (95%).

However, many insurers have been scaling back benefits or the amount of the discount offered. In 2025, many retirees in Medicare Advantage plans experienced cuts and they are likely to see bigger reductions in the extras going forward.

Two-thirds of those in Medicare Advantage plans pay no premium for their plan beyond their Medicare Part B premium (including any means-testing upcharges).

Medicare Advantage premiums and other costs vary by plan. The private insurer you select to provide your Medicare Advantage plan will set the prices they pay doctors and facilities for the services you use. The insurer first receives a fee per person from the federal government, then the insurer decides how much to pay the providers. And how much you will be responsible to pay.

The implication to each retiree is that each insurer designs and offers multiple plans with varying payment structures. No two insurance companies offer the same plan construction or costs, so you cannot compare them apples to apples. And remember, these plans change every year as they are only one-year contracts.

Building Blocks (Continued)

Beyond any plan premium and the deductibles, you may be responsible for paying flat fees (copayments) or percentages (coinsurance) for services such as:

- Primary care doctor visits
- Specialist visits
- Emergency room use
- Inpatient hospital stays
- Outpatient surgery and rehab
- Ambulance rides
- CT or MRI scans
- Prescription drugs
- And various others

Several types of Medicare Advantage plans exist, but the two most common are:

- Health Maintenance Organization (HMO) Plans (including HMO-Point of Service Option)
- Preferred Provider Organization (PPO) Plans

The less-common Medicare Advantage plans include Private Fee-for-Service (PFFS) plans and Special Needs Plans (SNP). PFFS plans offer broader choices in doctors and hospitals than other Medicare Advantage plans, and SNPs are tailored to people with specific diseases or characteristics.

Medicare.gov compares the coverage of the various plan types here.

Medicare rates the available Medicare Advantage plans on a 1-5 scale that reflects customer service, care quality and member satisfaction. Ratings of 4 stars and above indicate better service and coverage.

Building Blocks (Continued)

Another important Medicare building block: Supplement Insurance/Medigap

Because Medicare Part A and Part B were never designed to offer full coverage, Medicare has authorized private insurers to offer "Medicare Supplement Health Insurance" policies that complement Original Medicare. This Supplement Insurance is commonly known as Medigap, which can be confusing when Medicare insurance is being explained or promoted. (The two names refer to the same thing.)

This coverage is entirely optional. You decide if you want to buy it to limit your exposure to having to pay for the portion of goods and services that Original Medicare doesn't pay. Here is what Medigap covers primarily:

- Part A deductible (or the amounts you must spend on hospitalizations or skilled nursing care before your Medicare begins to pay)
- Part B coinsurance (an amount, usually your 20% share of costs for Part B services percentage, you need to pay after you have met the annual Part B deductible)

Nearly 43% of beneficiaries with Original Medicare chose to supplement it with a Medigap policy, another 44% have other options available through a former employer or Medicaid.

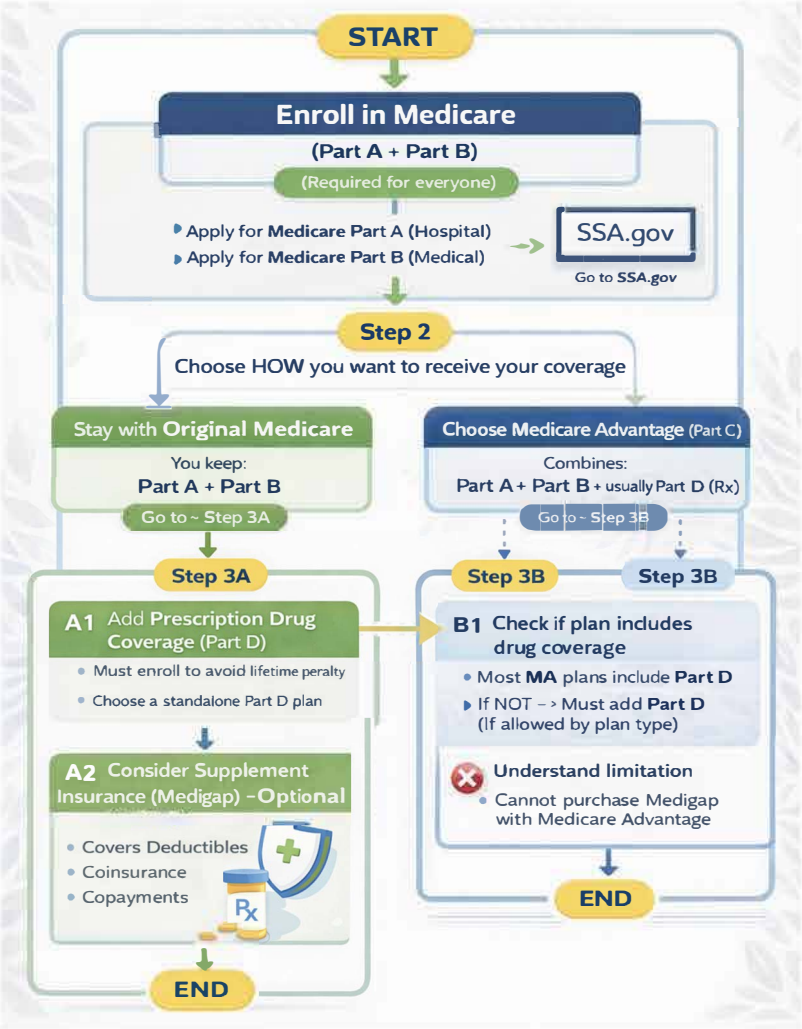
Medigap policies do not cover vision or dental care, hearing aids, eyeglasses, long-term care or private-duty nursing, since these are not costs covered by either Medicare Part A or Part B.

GUIDE TO CHOOSING THE BEST MEDICARE FOR YOU

How to Start Building Your Medicare Coverage

How to Start Building Your Medicare Coverage

Now, let's start putting the pieces together.



Everyone begins by enrolling in Medicare Part A (hospital insurance) and Part B (medical insurance), typically through Social Security. This is the foundation of all Medicare coverage, and you must be enrolled in both before choosing how you want to receive your benefits.

Once enrolled, review the plans available in your area and consider your healthcare needs, including your prescriptions and preferred doctors. At this stage, you'll decide whether to stay with Original Medicare or enroll in a Medicare Advantage plan, based on what best fits your situation.

If you choose Original Medicare, you will need to enroll in a standalone Part D prescription drug plan to avoid penalties and help manage medication costs. You may also choose to add a Medicare Supplement (Medigap) policy to help cover out-of-pocket expenses. If you choose Medicare Advantage, drug coverage is often included, and supplemental coverage like Medigap is not available.

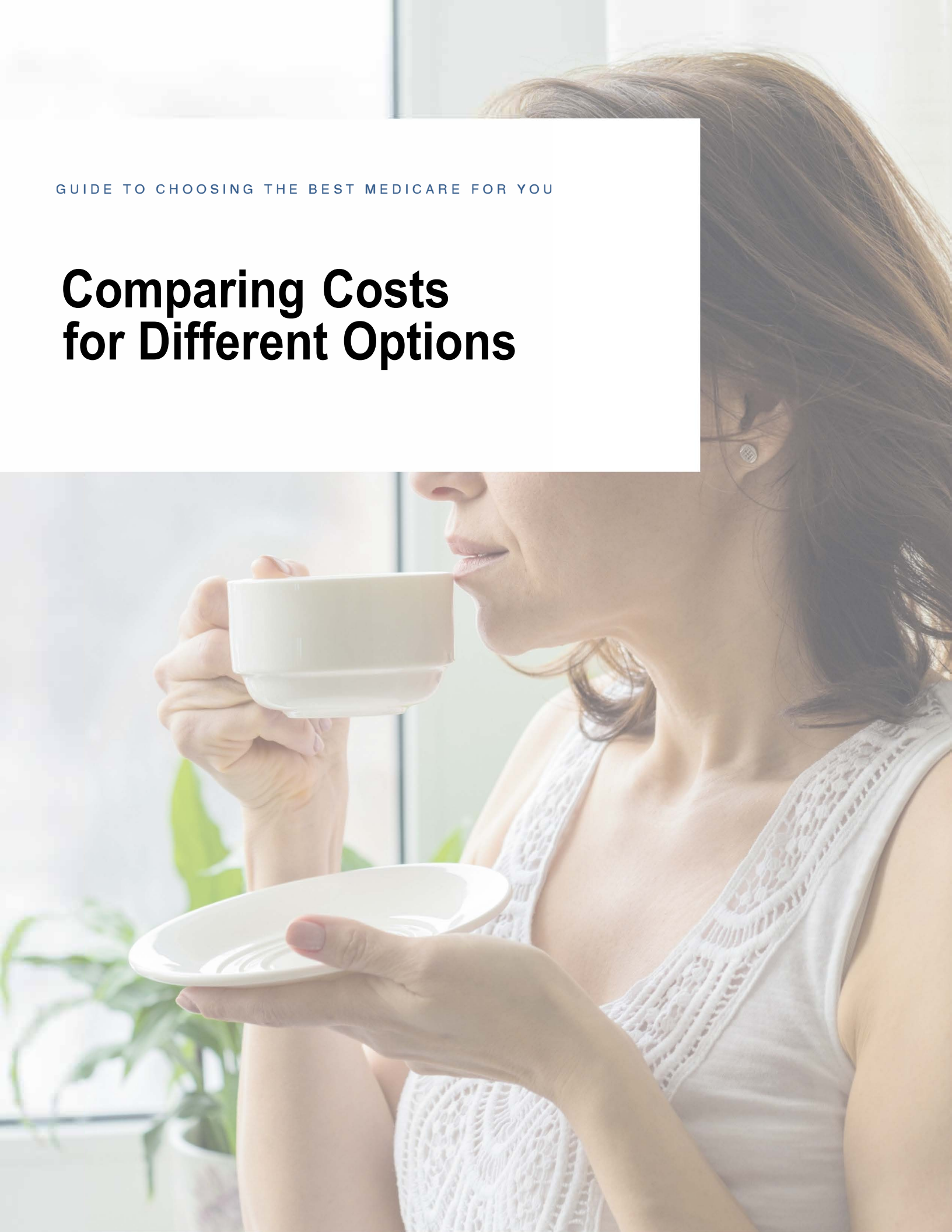
Advantages and Disadvantages of Each Option

Let's compare the coverage offered by the two main options.

Element	Original Medicare with a Medigap	Medicare Advantage
Cost	Medicare A and B have no out-of-pocket limits. Including a Medigap caps your cost to the monthly premium x 12.	The yearly limit is $9,250 for in-network and $13,900 for out-of-network in 2026. Insurers can set a lower limit. Rising annual caps are expected.
Coverage	Most healthcare needs and services are covered under either Part A or B, whether provided in hospitals, doctors' offices or other healthcare locations.	All services offered under Parts A and B must be covered, but many offer some cost-sharing or discounts for additional services.
Prescription Drugs	Failure to buy a Part D when first eligible results in a permanent penalty. Later, you can only buy a plan during the annual **optional enrollment period** (**OEP**).	Most plans include drug coverage; if not, you do not have any prescription drug coverage and will pay a permanent penalty if you want to add drug coverage later.
Supplement Insurance	Medigap policies are available at an added cost to cover out-of-pocket expenses not covered by Parts A and B.	It is not legally permitted to have a Medigap policy with a Medicare Advantage plan. You must cover deductibles, coinsurance, and copayments until reaching the plan's out-of-pocket limit.
Doctor and Hospital Selection	You can go to any doctor in the U.S. and be treated in any hospital or facility that accepts Medicare.	You may need to use the healthcare providers in your plan's network, who are likely in a limited geographic area. Your plan may offer out-of-network coverage but at a higher copayment. Any out-of-network doctor or facility must agree to accept your insurance or you pay the full cost.
Doctor and Hospital Access	You do not need a referral from a primary care doctor to see a specialist or access a hospital.	You may need referrals from a primary care doctor to see a specialist or to access a hospital. Pre-clearence is needed before seeing anyone outside your network.
Emergency Care	Available anywhere in the U.S. Part B deductibles and copayments may apply. Some Medigaps will cover your costs.	Available anywhere in the U.S., with possible out-of-pocket costs depending on the plan.
Travel Coverage	Parts A and B do not offer coverage outside the U.S., but some Medigap policies do.	Plans operate in limited geographic areas in the U.S. Outside the U.S., some plans may offer some coverage.

GUIDE TO CHOOSING THE BEST MEDICARE FOR YOU

Comparing Costs for Different Options



How Do Costs Compare for the Different Options?

First, we looked at the benefits offered by each part. Now let's look at the costs.

Part A and Part B

It's important to understand that most retirees only pay a small portion of the total costs of the healthcare they use. The total Medicare Part B premium in 2026 is approximately $9,740. That's the average cost per retiree. Most pay only 25% of the total premium, or $202.90 per person per month. Higher income retirees pay a larger percentage of the Part B premium.

But you should plan to pay significantly more than your Part B premium each year. Your total "Medicare" costs include monthly premiums for Medigaps or Medicare Advantage plans. Plus, your prescription drug, Part D coverage.

One surprise cost for retirees in many states is a Part B excess charge. If your doctors or other healthcare facilities do not accept "Medicare assignment" they can charge 15% more than Medicare will pay for and you can be responsible for paying it out-of-pocket unless you have a Supplement Insurance plan that covers it (two of the Medigap plans do). Other costs to plan for include dental, eyeglasses, hearing aids, podiatry, acupuncture, and general over-the-counter supplies. Medicare A and B have always been cost-sharing insurance plans; they do not cover everything.

Part D

Premiums in 2026 range from $0 to over $100 per month per person, not counting for adjustments such as late enrollment penalties. For some, it will also include an income-based upcharge, called a Part D IRMAA, if your modified adjusted gross income is above a certain amount. Besides the premiums for Part D, these plans come with deductibles, coinsurance and copayments.

Starting in 2025, all Medicare Part D plans will include a $2,000 cap on out-of-pocket spending on the prescription drugs covered by your plan in a preferred or in-network pharmacy. This cap will be indexed for inflation each year. In 2026, the cap is $2,100. This includes any deductible your plan might have (up to a maximum of $615 in 2026), plus coinsurance up to a total of $2,100. Once you reach that limit, you pay no further copayments or coinsurance for covered drugs for the rest of the year.

Also starting in 2025, all plans must offer the Medicare Prescription Payment Plan that lets you spread your out-of-pocket drug costs throughout the year. Doing so can help smooth out irregular, high costs across the year. This payment plan doesn't save you any money, but it doesn't cost you anything either.

Recent legislation has lowered the cost of insulin which, depending on the delivery mechanism, is covered either by Medicare Part D or Part B. Regardless, the cost is capped at $35/mo per insulin product. Many people use multiple types of insulin, so it is important to note per product or $105 for three months. You don't pay an additional deductible for covered insulin products.

Part C

Medicare Advantage plans, known as Part C, are required to limit your annual out-of-pocket spending for in-network Parts A and B services. In 2026, the maximum is $9,250 for in-network healthcare and $13,900 for in and out of network healthcare. Medicare Advantage companies can choose to offer lower out-of-pocket maximums, and many plans do. But you must plan for the years when you'll reach the cap and have sufficient assets to pay out-of-pocket.

Comparing Medicare Advantage plans can be complicated. Your out-of-pocket costs depend on multiple factors:

- Whether the plan charges a monthly premium
- How much the plan charges for the first 5-to-7 days in a hospital
- Whether the plan has any yearly deductibles
- How much you pay for each visit or service if in-network or out-of-network (copayment or coinsurance)
- Whether your plan's yearly out-of-pocket limit is lower than the maximum
- If you go outside the plan's rules, follow the plan's rules, use network providers, or go out-of-network
- If you're in a PPO or PFFS plan, whether your doctors or suppliers accept your Medicare Advantage insurance at all
- What type of health services you need, and how often you need them
- Whether you need extra benefits and if the plan charges for it
- Whether you have Medicaid or other help from your state

Each Medicare Advantage plan will provide you with a Summary of Benefits that lists the copays and coinsurance it charges for services. For example, $250 for an MRI, $10 for lab work and $50 for a specialist visit.

Each plan is free to charge its own premium, but 67% of the people on Medicare Advantage plans in 2026 paid no premiums in addition to Medicare Part B. 4% of those in a Part C plan pay a premium of less than $20/mo, and 6% pay $100 or more per month, on top of the monthly premium they pay for Part B (which in 2026 is $202.90). However, premiums for the same policy can vary from state-to-state and from county to county within a state.

A wake-up call as to what things cost- According to the most recent data from the U.S. Centers for Medicare & Medicaid Services, from 2023, the average cost (paid by Medicare and the beneficiary, combined) was $17,125 for an inpatient hospital stay and $1,202 for an outpatient emergency room visit. A doctor's visit averaged $110 and a 30-day prescription, $94.

Costs under Medicare Advantage plans are the hardest to examine because they are so variable and dependent on the structure of the plan itself. Still, it can be useful to go a little deeper to understand the various expenses involved in each aspect of Medicare.

Cost Comparison (Continued)

Projecting at age 65 what your health insurance needs will be for the rest of your life is a challenge. However, looking at each part of Medicare as you start making your choice of which system and which plan will give you an idea of your possible financial exposure.

Part	Notes
Part A Premium	Most people (99%) don't pay a Part A Premium because they qualified for it through Medicare taxes paid through work.
Part A Hospital Inpatient Deductible and Coinsurance	Deductibles are based on 'benefit periods.' A benefit period is defined as starting the day you are admitted as an inpatient in a facility and ending after 60 consecutive days of no inpatient care. You can have several benefit periods in a single year.
Part B Premium	Part B premium is "means tested," and increases with your income level. Most beneficiaries pay the standard premium which is expected to increase annually. The extra charge, based on your modified adjusted gross income calculated from your income tax returns from two years ago, affects about 8% of people with Part B. The charge above the standard premium is called an Income Related Monthly Adjustment Amount (IRMAA).
Part B Deductible and Coinsurance	In Original Medicare, you pay an annual Part B deductible plus 20% of all Part B charges if no Medigap.
Part C Premium	To compare costs in your zip code and county, start with the Medicare plan finder toll, then check each Medicare Advantage Insurance company's website.
Part D Premium	If you have high income in retirement and have a Part B IRMMA, you generally have a Part D IRMAA as well. When your modified adjusted income from 2 years back exceeds certain income thresholds, you'll pay a separate upcharge for Part D plans. This amount gets paid to Medicare and is in addition to your Part D plan premium. To find the latest IRMAA upcharges, go to this table.

What role do Supplement Insurance plans play, and what do they cost?

For someone who opts for Original Medicare, Medicare Supplement Insurance (Medigap) reduces the exposure to the uncapped out-of-pocket expenses for the deductibles, coinsurance and copayments that Medicare Parts A and B do not pay. (Part B coinsurance exposure is typically 20% of the full cost for the physician or outpatient services.) These Medigap policies are sold by private insurance companies. Premiums vary considerably based on factors including, your zip code, county, and state; and the benefits you select to have covered.

Furthermore, depending on your state of residence, Medigap premiums use one, two, or three approved pricing models: attained age, issue age, or community pricing. Each model can use your age, gender, and whether you are a smoker or not to set premiums.

When you incur a medical charge, Medicare pays its portion of approved services first, based on the negotiated rate for that service. Then, your Medigap policy will automatically pay its share. Only then will you get a bill for anything left unpaid. The portion picked up by Medigap depends on the plan you select. For some, such as Plan G, your exposure is virtually limited to the Part B annual deductible.

Original Medicare beneficiaries use various programs to protect against the charges not picked up by Parts A and B. According to the latest available statistics, 43% of beneficiaries use Medigap, 29% use employer-sponsored insurance, and 14% use Medicaid or something else. And 13% had no supplemental coverage at all.

Let's look at how the Medigap plans are set up.

Authorized insurance companies must offer you a "standardized" Medigap policy that follows federal and state laws. The policies are named with letters from A to N. Plan G from one insurer must cover the exact same benefits as Plan G offered by another insurer. Therefore, you are shopping on quality of the insurer and monthly premium. Plan N in one state must cover the same as a Plan N in another state. (Medigap plans in MA, MN, and WI follow a different, approved structure.)

Private insurance companies are free to decide which Supplement Insurance plans they want to offer in what states, if at all. However, if an insurer wants to offer Medigaps, they must offer Plan A. The insurer can also decide what premium to charge. What cannot vary are the benefits covered. Then they can offer all or some of the other lettered plans.

This chart shows precisely what each 'letter' plan covers. If no percentage is shown, the plan does not pay for that item. Coinsurance is only paid once you have met the deductible (unless the deductible is also covered). As of January 1, 2020, no new policies are being written that cover the Medicare Part B deductible (that is, Plans C and F can no longer be purchased).

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs, up to 365 additional days after Medicare benefits are used up	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B coinsurace or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurace or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charge ****					100%	100%				
Foreign travel exchance (up to plan limits)			80%	80%	80%	80%			80%	80%
Out of pocket limit In 2026**	N/A	N/A	N/A	N/A	N/A	N/A	$8,000	$4,000	N/A	N/A

Source: *https://www.medicare.gov/health-drug-plans/medig_ap/basics/compare-plan-benefits*

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments and deductibles) up to the deductible amount of $2,950 in 2026 before your policy pays anything.

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($283 in 2026), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment for some office visits and some emergency room visits that don't result in an inpatient admission.

****Excess charges occur when one of your doctors does not accept Medicare assignment and has the right to charge up to 15% more than the Medicare-approved price for the service. You are responsible for these charges unless your Medigap plan covers it, which Plans F and G do.

Cost Comparison (Continued)

Once you decide what plan interests you, check to see what plans are available in your state here. Premiums will vary widely state-by-state. You can buy a policy from any insurance company that is licensed to sell Medigap in your state.

Your ultimate selection will depend on the premium the company quotes and the reputation you feel the company has for excellent customer service. Once you make your decision, you will contact the insurance company directly to enroll.

When Can You Enroll in Medicare?

Most people become eligible for Medicare on the first day of the month containing their 65th birthday. However, if their birthday falls on the 1st of any month, Medicare starts on the 1st of the prior month. You may also become eligible younger than age 65 due to specific health reasons (for example, a qualifying disability, end-stage renal disease or ALS).

You will proactively enroll in Medicare depending on your employment situation after age 65, your current marital status, and whether you claimed Social Security benefits before age 65. Most people who are not working or who work for a small employer (fewer than 20 employees) as they approach age 65 must sign up for Medicare during their Initial Enrollment Period. If you are still working at 65 and enrolled in the large employer group health insurance plan, there is no need to sign up for Medicare. You will have a Special Enrollment Period when you stop working and leave the group plan.

If you applied for Social Security before age 64 and 8 months, you will be automatically enrolled in Medicare Parts A and B starting the first of month containing your 65th birthday. You must keep Part A, but if you are also still working for a large company, you can request to delayPart B and proactively start it later when you retire.

Let's look how these enrollment periods work.

Your Initial Enrollment Period - The first period in which you can apply for Medicare is called your Initial Enrollment Period (IEP). It is seven months long: the three months before you turn 65, the month of of your 65th birthday and the three months after it. If your birthday falls on the first of a month, your IEP starts four months before your birthday month and ends two months after. The date you apply will affect the start date of your coverage.

Enrollment (Continued)

If you sign up during the three months before the month of your birth, your Part A and Part B coverage will be active on the first day of the month of your birth. Say your birthday is September 14; if you applied during June, July or August, your coverage would be active on September 1. If your birthday is September 1, you sign up May, June, or July to start on time August 1st.

If you apply during your birthday month or in the three (or two) months after, your Medicare Part B starts the first month following your application. Part A is retroactive to your 65th birthday month.

A Special Enrollment Period (SEP) - You avoid penalties for enrolling late and qualify for a Special Enrollment Period by meeting two requirements: you or your spouse is still working when you turn 65, and you are covered by a health insurance plan offered by a large employer (one with 20 or more employees) or most union plans.

About 3 months before you lose coverage from your large employer health insurance-usually due to retirement or loss of a job-make sure to proactively apply for Medicare. You want to coordinate your entry into Medicare with the ending of the large employer group coverage.

If you miss this timeline, the SEP allows you to apply for Medicare Part B within 8 months of losing group coverage. However, if you apply during the SEP, you will not have any primary health insurance until Part B is in effect.

The General Enrollment Period (GEP) - If you didn't sign up when you were first eligible and don't have health insurance elsewhere (generally from a large employer group health plan), you would have to wait until the next General Enrollment Period. The GEP runs each year from January 1 through March 31.

Your coverage will be active the month after you apply, and **you will have to pay a permanent late enrollment penalty on your Part B premium for the duration of your retirement years.** The penalty increases your Part B standard premium by 10% for every full 12-month period that you were not enrolled.

Enrolling in Medicare Part A and Part B

You will sign up for Medicare Part A and Part B through the Social Security website or by scheduling an appointment at a Social Security office. Everyone needs to be enrolled in A and B before they can add other parts of Medicare: Medigap plus a standalone Part D; or Medicare Part C. However, to receive Medicare, you don't have to be receiving Social Security benefits yet. (For example, you may be delaying Social Security benefits to age 70 to increase your monthly checks, but need to get into Medicare at age 65.) Once you are fully enrolled in both programs - Medicare Part Band Social Security - your Social Security payments will be automatically reduced to pay your Part B premiums plus any IRMAA upcharges.

If you're keeping Original Medicare

If you are keeping Original Medicare Parts A and B, you will need to add two additional insurance plans: Medigap and Part D.

You have a one-time 6-month initial enrollment window beginning the month your Part B begins to choose any Medigap offered in your zip code. Ideally, you want to apply for the plan you've selected one month prior to your Part B starting date. That way, you have no gaps in your coverage.

Within those six months, insurers cannot make you undergo underwriting or alter premiums due to pre-existing or present health problems. However, after that period, insurers in most states can deny coverage or increase your premiums based on any past or present condition they find during underwriting.

Part D requires a faster timeline. You need to have your standalone Part D plan in place within 63 days of losing other creditable coverage. Again, it is ideal to apply for your Part D plan the month just prior to your Part Bstart date. This way, all 4 necessary parts to your Medicare "package" will be in place on time and you have no gaps in coverage or exposure to expensive costs.

If you decide on Medicare Part C (Advantage)

To enroll in a Medicare Advantage plan, you have to be enrolled in Part A and Part B and paying your Part B premiums. Because most Part C plans also include your prescription drug coverage, you only have 63 days to get into a a Part C plan when you first apply for Medicare. Make sure you've researched your choices and are ready to apply the month prior to your Part B start date. Otherwise, you leave yourself open to some financial risks.

Remember, these plans are only 1-year contracts so it is imperative that you review your plan every year during the annual OEP. The annual OEP is from October 15 - December 7.

Medicare Advantage plans and Part D prescription plans can be changed with relative ease, and without penalties, because those plans change their coverages, costs, providers and pharmacies frequently.

Each fall, your Medicare Advantage insurer will send you two notices:

- Evidence of Coverage, which gives you the details of what the plan covers, how much you pay and more
- Annual Notice of Change, which includes any changes in coverage, costs or service area that will be effective the coming January

You can change your Medicare Advantage plan with prescription drug coverage each year during the Fall Open Enrollment Period from October 15 through December 7. At that time, you can:

- Change your Medicare Advantage plan or insurer
- Enroll or disenroll from a Part D prescription plan
- Change your Part D prescription plan
- Switch from Original Medicare to Medicare Advantage
- Disenroll from Medicare Advantage and return to Original Medicare; however, use caution! You may not be able to buy a Medigap plan after your initial 6-month open enrollment period.

If you have a Medicare Advantage plan, you can also change it each year in the first quarter. This is the Medicare Advantage Special Open Enrollment Period. The additional OEP was needed because many seniors found out early in the year that their plan was no longer accept at their doctor or that it no longer cover their expensive drugs.

Sources:

- https://www.ssa.gov/benefits/medicare/
- https://www.medicare.gov/publications/10050-Medicare-and-You.pdf
- https://www.cms.gov/Outreach-and-Education/Reach-Out/Find-tools-to-help-you-help-others/Medicare-Open-Enrollment

What are the methods for enrolling?

Automatic enrollment- If you are already receiving Social Security, or applied for Social Security BEFORE age 64/8mo (or Railroad Retirement Board) benefits, you do not need to enroll in Medicare. You will be enrolled automatically in Original Medicare Part A and Part B as of the first day of the month you reach age 65. If you are enrolled automatically, you will get a "Welcome to Medicare" packet about three months before your birthday. The packet will include your Medicare card.

You will also find information that explains what to do:

- If you want to keep Part B
- If you do keep Part B, how you want to receive your Medicare coverage
- If you want prescription drug coverage through Part D
- If you want a Medicare Supplement Insurance (Medigap) policy

You have to return the Medicare card if you decide you don't want Part B. If you don't return the card, you will be charged the appropriate Part B premium (based on your income). If you mistakenly keep Part B but are also enrolled in a large employer group health plan, you're essentially paying twice for the same benefit.

Exception: If you live in Puerto Rico, you will only receive Part A coverage automatically. You will have to call Social Security to apply for Part B if you want it.

Proactive enrollment - If you are not receiving Social Security (or Railroad Retirement Board) benefits, enrollment will not be triggered by you approaching age 65. Even if you are eligible for premium-free Part A based on your work record, you will have to apply for Part A and Part B proactive if you want them.

The federal government expects you to know when to enroll. Unless you have current employer-based insurance coverage from a large employer, you will want to apply for Parts A and B during your Initial Enrollment Period. If you don't, you will be charged a Part B late enrollment penalty for as long as you have Part B coverage. And worse, you may be without any health insurance for months or years.

How permanent is your decision?

If you chose Original Medicare and added a Medigap policy, it was probably to remove the unknowns from your future health costs. If you are on a fixed income, you may not want to face the surprises that can come with the 20% coinsurance exposure of Part B medical expenses should your healthcare needs spike later in life. Part A coinsurance is also covered by Medigap, as are hospital costs up to an additional 365 days after Medicare benefits are used up.

If you are considering one Medigap plan to another (such as from Plan N to Plan G, or from one insurer to another) after your initial decision, you need to know one thing: you got the very best terms when you signed up during your 6-month Medigap Open Enrollment Period. Your medical history was not factored into your acceptance or premium at that time. Changes made after the fact can result in denial, exemptions or high premiums, especially if you have accumulated pre-existing conditions in the interim. That is what makes it so essential to get your selection right if you go the Original Medicare/Medigap route.

In the case of Medicare Advantage and Part D prescription plans, it is critical to review your plans each fall during OEP because of the changes the insurers make to pricing and conditions. You want to be sure you still have the coverage you need, that your doctors are still in the network, that your hospital or doctors still accept your plan, and that your prescriptions and pharmacies are still available.

You now have all the tools to make the very best decision - for you - on one of the most essential support structures we have in America as we age.

One thing we know for sure is life throws many curve balls.

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