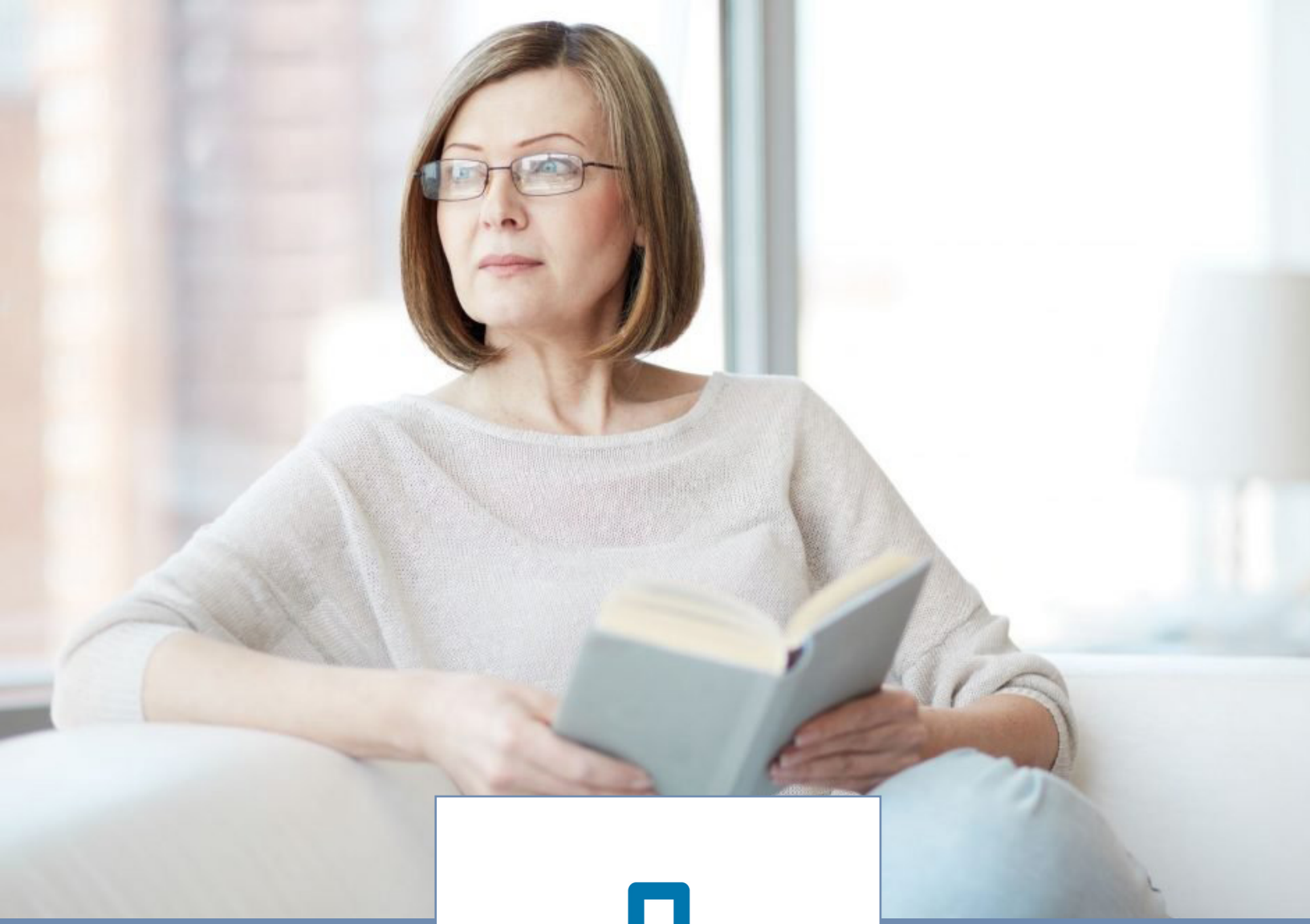


UNDERSTANDING MEDICARE

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 options 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.

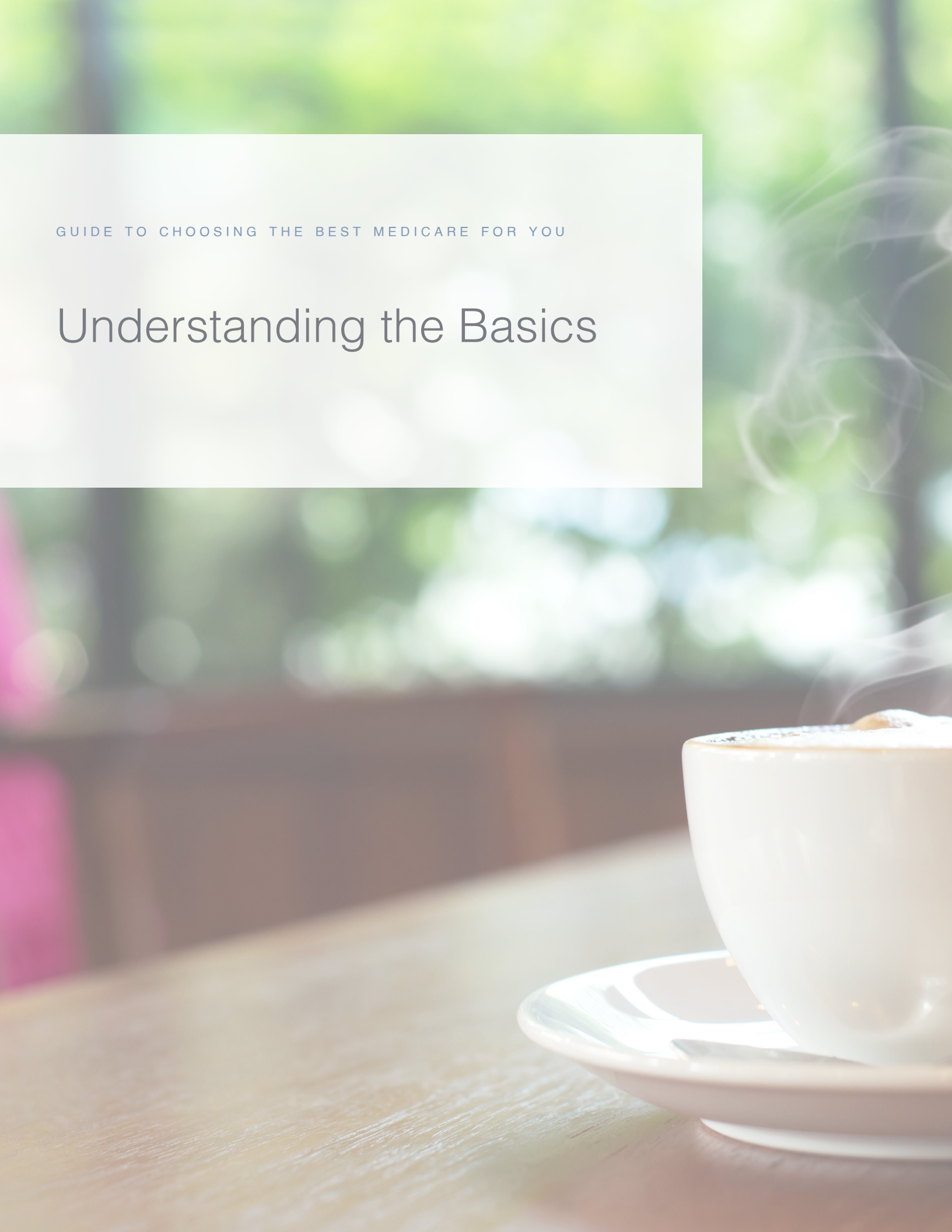
In health,

Bill Paula

WH Cornerstone 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 may cost a bit 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'll get the prescribed coverage.

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. In August 2022, about 54% 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.) Additional benefits such as hearing, vision and fitness may be included in your package, but services available to you may be limited geographically.

The most obvious downside is that you may have to stay within a network of providers and may need to get referrals from the insurer or a primary care physician to see specialists. It depends on the plan you choose: the more flexibility you have, the higher the plan’s premium. In August 2022, nearly 46% 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. This care is provided and processed by the federal government.

Part A covers:

- ☐ Inpatient care in a hospital
- ☐ Skilled nursing facility care
- ☐ Nursing home care (inpatient care in a skilled nursing facility not custodial or LTC)
- ☐ Hospice care
- ☐ Home health care

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 to be eligible. Others have to pay a monthly fee.

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.

Part B covers:

- ☐ Doctor visits
- ☐ Preventive services
- ☐ Ambulance services
- ☐ Clinical research
- ☐ Durable medical equipment (DME)
- ☐ Inpatient and outpatient mental health
- ☐ Limited outpatient prescription drugs

Building Blocks (Continued)

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

Plan B care may be provided and processed by the federal government. To be covered for Part B, all eligible people have to pay a monthly premium (or have it paid for them). For that reason, not everyone has Part B. (In 2018, 92% did.)

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 optional. Because these are private plans, the monthly premium can vary significantly from one plan to another.

Medicare Part C

Part C is not a separate benefit. Instead, it's an optional program that lets most beneficiaries who are enrolled in both Part A and Part B choose to receive their services 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 2022 87% of beneficiaries are in plans with prescription drug coverage, so you do not need to buy a Part D policy. As for other extra benefits, in 2022, beneficiaries in Medicare Advantage plans received the following help: vision (99%), hearing (98%), fitness (98%), telehealth (98%) and dental (96%).

Yet nearly seven in ten beneficiaries pay no premium for their plan beyond the standard Medicare Part B premium.

Medicare Advantage premiums and other costs vary by plan. The private insurer you select to provide your Medicare Advantage plan will pay doctors and hospitals for the services rendered, not the federal government. That way, each insurer can design and offer multiple plans that have varying deductibles, coinsurance and copayments.

Building Blocks (Continued)

Beyond 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
- ☐ Preferred Provider Organization (PPO) plans

The less-common Medicare Advantage plans include Private Fee-for-Service (PFFS) plans and Special Needs Plans (SNP), neither of which will be detailed here. 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.

Another important Medicare building block: Supplement Insurance

Because Medicare Part A and Part B do not offer full coverage, Medicare has authorized private insurers to offer “Medicare Supplement Health Insurance” policies that complement Original Medicare. This Supplement Insurance is also known as Medigap, which can be confusing when Medicare insurance is being explained or promoted. (The two names refer to the same thing.)

Building Blocks (Continued)

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:

- ☐ Deductibles (or the amounts you must spend on healthcare or prescriptions before your insurance begins to pay)
- ☐ Coinsurance (an amount, usually a percentage, you need to pay after you have met any deductibles)
- ☐ Copayments (a set amount you may need to pay at the time of service)

Nearly 39% of beneficiaries with Original Medicare chose to supplement it with a Medigap policy in 2020.

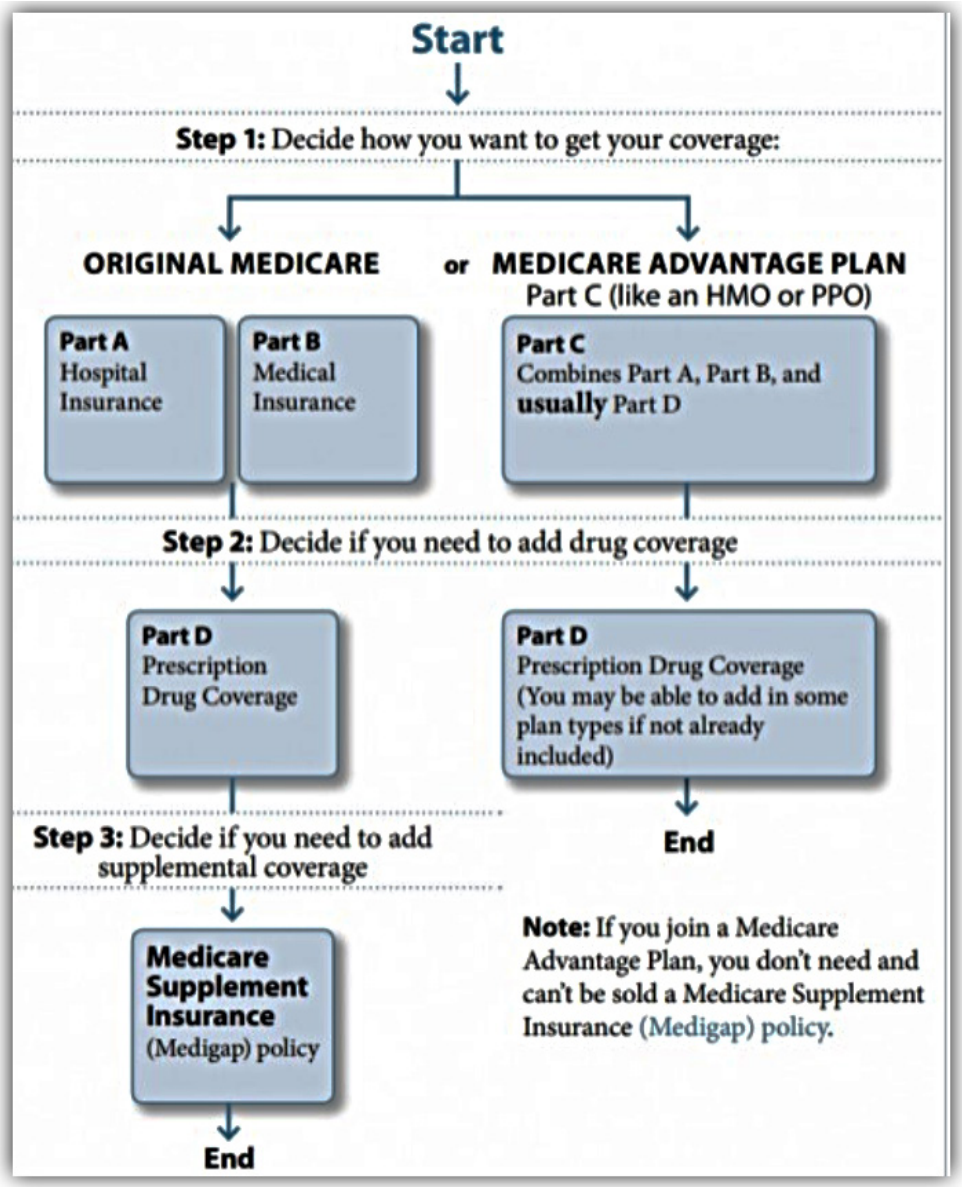
Medigap policies do not cover vision or dental care, hearing aids, eyeglasses, long-term care or private-duty nursing.

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.



The first step: Decide if you want to get your coverage through Original Medicare or Medicare Advantage.

The second step: Decide if you want to add prescription drug coverage. You'll most likely want the coverage if you choose Original Medicare, as prescription drugs can become a costly part of your healthcare needs in your later years. With Medicare Advantage, you will probably already have prescription drug coverage, and you'll only consider adding one if you don't.

The third step: If you've chosen Original Medicare, there is a good chance you will want to look at buying Supplement Insurance, or Medigap, to cover the deductibles, coinsurance and copayments that Part A and Part B do not.

Advantages and Disadvantages of Each Option

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

Element	Original Medicare	Medicare Advantage
Cost	Out-of-pocket costs have no upper limit unless you have a Medigap plan, so your exposure can be high.	Out-of-pocket costs have a yearly limit; once you reach it, you pay nothing more for covered services until the next calendar year.
Coverage	Only medical services and supplies 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 plans offer additional services such as vision, hearing or dental.
Prescription drugs	You may want to buy a standalone Part D prescription drug plan for coverage.	Most plans include drug coverage; if not, a standalone Part D policy may be needed.
Supplement Insurance	Medigap policies are available at an added cost to cover out-of-pocket expenses not covered by Parts A and B.	Because these plans are more all-inclusive, Medigap policies are not available. You will have to cover deductibles, coinsurance and copayments.
Doctor and hospital selection	You can go to any doctor in the U.S. (or its territories) who 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.
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.
Emergency care	Available anywhere in the U.S. Part B deductibles and copayments may apply.	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

In 2016, the last year for which we have data, Original Medicare beneficiaries enrolled in both Parts A and B spent $5,806 on average each year for out-of-pocket healthcare expenditures. Nearly half was for Medicare and Medigap premiums. The rest was for medical and long-term care services not covered by Medicare.

One aspect of Part B that is rarely discussed is if your doctor does not accept "Medicare assignment", which is the Medicare-approved amount for a service. Most do, and it is up to you to ask if they do or don't. (Don't forget to ask lab facilities, home health care companies and all others, too.) When providers don't accept it, they can charge you up to 15% more than the Medicare-approved price for the service. This is called a Part B excess charge, 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.)

Part D

The estimated average premium in 2023 is $31.50, 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 significant deductibles, coinsurance and copayments.

If your prescription drugs are expensive, even with a Part D policy, you can face considerable out-of-pocket expenses. Each calendar year, the first three stages of payment expose you to $7,400 of total drug costs. Then, the 'catastrophic' phase provides a bit of a reprieve, charging you the larger of $10.35 ($4.15 for generics) or 5% of medication costs, whichever is greater, for the remainder of the year. Here there is no maximum or cap.

Cost Comparison (Continued)

Part C

Medicare Advantage plans are required to limit your annual out-of-pocket spending for in-network Parts A and B services. In 2023, the maximum is $8,300. In 2022 the average out-of-pocket limits for in-network services for HMO's and PPO's was $4,972.

Comparing Medicare Advantage plans can be complicated. Just one element – your out-of-pocket costs – can depend on multiple factors:

- ☐ Whether the plan charges a monthly premium
- ☐ Whether the plan pays any part of your monthly Part B premium
- ☐ Whether the plan has any yearly deductibles
- ☐ How much you pay for each visit or service (copayment or coinsurance)
- ☐ Whether your plan's yearly out-of-pocket limit is lower than the $8,300 maximum
- ☐ Whether you follow the plan's rules, like using network providers, or go out-of-network
- ☐ If you're in a PPO or PFFS plan, whether your doctors or suppliers accept Medicare assignment
- ☐ 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 69% of the people on Medicare Advantage plans in 2022 paid no premiums at all. The national average in 2023 is $17.60, on top of the $164.00 monthly premium you pay for Part B. However, premiums for the same policy can vary from state-to-state.

A wake-up call as to what things cost – according to the U.S. Centers for Medicare & Medicaid Services, the average cost (paid by Medicare and the beneficiary, combined) was $15,822 for an inpatient hospital stay and $1,119 for an outpatient emergency room visit. A doctor's visit averaged $99 and a 30-day prescription, $75.

Cost Comparison (Continued)

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.

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	You Pay	Notes
Part A premium	The monthly premium, based on the number of quarters you paid Medicare taxes: • 40 quarters or more: $0 • 30-39 quarters: $278 • Under 30 quarters: $506	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	• Deductible for each benefit period: $1,600 + daily coinsurance • Days 1-60: $0 coinsurance • Days 61-90: $400 coinsurance • Days 91-150: $800 while using your 60 'lifetime reserve days' • Beyond lifetime 'reserve days': all costs	Deductibles are based on 'benefit periods.' A 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 unlimited benefit periods.
Part B premium	For individuals, monthly: • $87,000 or less: $164.90 • Over $97,000 to $123,000: $230.80 • Over $123,000 to $153,000: $329.70 • Over 153,000 to $183,000: $428.60 • Over $183,000 to $500,000: $527.50 • $500,000 or above: $560.50	Part B premium is "means tested," and increases with your income level. 93% of beneficiaries pay the standard $144.60. The extra charge is based on your modified adjusted gross income as reported on your IRS return from two years ago. The charge above the standard premium is called an Income Related Monthly Adjustment Amount (IRMAA). For premiums for married couples, go here on Medicare.gov.
Part B deductible and coinsurance	• Annual deductible is $226.00 • Coinsurance after you've met the deductible is typically 20% of the Medicare-approved cost of services	Applicable to Original Medicare, if no Medigap policy. For Medicare Advantage, Part B costs are folded into each plan's extra payments.

Cost Comparison (Continued)

Part	You Pay	Notes
Part C premium	Varies with each insurer's Medicare Advantage plan. The national average in 2023 is $17.60 per month.	Compare costs for specific Plan C plans
Part D premium	Varies with each plan. The average basic premium is projected at $31.50 in 2023, and the income related upcharge for individuals runs from $0 to $76.40/month for individuals. For individuals, monthly upcharge: • $97,000 or less: $0.00 • Over $97,000 to $123,000: $12.20 • Over $123,000 to $153,000: $31.50 • Over 153,000 to $183,000: $50.70 • Over $183,000 to $500,000: $70.00 • $500,000 or above: $76.40	Part D premium is "means tested," and increases with your income level. The extra charge above the standard premium is based on your modified adjusted gross income as reported on your IRS return from two years ago. It is called an Income Related Monthly Adjustment Amount (IRMAA). For upcharges for married couples compare costs for specific Part D plans.

Source One
Source Two
Source Three

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 can be for 20% of costs, or more.)

These Medigap policies are sold by private insurance companies, with premiums varying by your age, where you live and the coverage you choose. For the popular Plan G, for example, a 65 year-old nonsmoking woman in Des Moines, IA, could pay between $79 and $353. But, if she lives in San Francisco, she could pay $122 to $208, and in Miami, $222 to $359.

Supplemental Insurance (Continued)

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. In 2018, according to the latest available statistics,34% of beneficiaries use Medigap, 29% use employer-sponsored insurance, and 20% use Medicaid. And 17% 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. Except for Massachusetts, Minnesota and Wisconsin, an N plan in one state must cover the same as an N plan in another state.

Private insurance companies are free to decide which Supplement Insurance plans they want to offer in what states, if at all. The insurer can also decide what premium to charge. What cannot vary are the benefits covered.

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 2020, no new policies are being written that cover the Medicare Part B deductible (that is, Plans C and F).

Medigap Plans

Medigap Benefits	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 coinsurance 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 coinsurance 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%	100%	100%
Part B deductible			100%		100%					
Part B excess charge****					100%	100%				
Foreign travel exchange (up to plan limits)			80%	80%	80%	80%				
Out-of-pocket limit in 2023**	N/A	N/A	N/A	N/A	N/A	N/A	$6,940	$3,470	N/A	N/A

Supplemental Insurance (Continued)

* 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 $2,700 in 2023 before your policy pays anything. (Plans C and F aren't available to people who are newly eligible for Medicare on or after January 1, 2020.)

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($226 in 2023), 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 of up to $20 for some office visits and up to a $50 copayment for 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.

Medigap policies are standardized differently for those who live in Massachusetts, Minnesota or Wisconsin.

Once you decide what plan interests you, check to see what plans are available in your state here: https://www.medicare.gov/medigap-supplemental-insurance-plans/. 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?

The day you turn 65, you are automatically eligible to receive Medicare. You decide when you want to apply for Medicare. Your options include three distinct enrollment periods: during your Initial Enrollment Period, the General Enrollment Period and a Special Enrollment Period (when you are getting off employer health insurance). 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).

Let's look at the benefits and consequences of these three main periods.

Your Initial Enrollment Period – The first period in which you can apply for Medicare is called your Initial Enrollment Period. It is seven months long: the three months before you turn 65, the month of your birthday and the three months after it. The date you apply will affect the start date of your coverage.

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. (An exception occurs when your birthday falls on the first of the month. In that case, your effective date moves to the first day of the month before the month of your birth. Say your birthday is March 1; Part A and Part B will be effective on February 1.)

If you sign up during your birth month or the three months after the month of your birth, your Medicare effective date will still be the first day of the month, but the month will be delayed by however many months you delay in signing up.

The General Enrollment Period – If you didn't sign up when you were first eligible and don't have health insurance elsewhere (such as through an employer), you would have to wait until the next General Enrollment Period. These run each year from January 1 through March 31.

Your coverage will be active the month after you enroll, and you will likely have to pay a late enrollment penalty on your Part B premium from that date forward. The premium increases by 10% for every full 12-month period that you were not enrolled. Late penalties are also applied if you choose to add Part D prescription drug coverage after your Initial Enrollment Period.

A Special Enrollment Period – You could avoid penalties for enrolling late and qualify for a Special Enrollment Period by meeting two requirements: you or your spouse are still working when you turn 65, and you are covered by group health insurance from an employer or union.

You are free to enroll in Part B at any time that you meet that combination (age 65 and having qualifying coverage). Also, once you lose that coverage, you can enroll penalty-free during the eight months that start the month after you lose the job or coverage, whichever comes first. When you are preparing to move to Medicare from employer insurance, be sure to coordinate with your company's benefits administrator to avoid any conflicts or gaps in coverage.

If you're 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 a Social Security office. 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, if you are receiving Social Security, your Part B premiums will typically be deducted automatically from your monthly check.

If you want Part B coverage, you will want to enroll during your Initial Enrollment Period. If you put off enrolling until later, you will risk paying a late fee that affects premiums for as long as you have Part B coverage. On the other hand, if you have medical insurance coverage from an employer (or your spouse's employer), you can delay applying for Part B with no penalty.

If you're enrolling in Original Medicare

If you want to add Part D prescription drug coverage, you will want to enroll during your Initial Enrollment Period, too. Part D coverage is optional. But, if you only apply for Part D later, it could mean having to pay a lifetime premium penalty. How much the late enrollment penalty costs you depends on how long you go without Part D or creditable prescription drug coverage.

If you want to add a Supplement Insurance (or Medigap) policy, you can do so at any time. However, the only time you can buy any plan being offered in your state is during your 6-month Medigap Open Enrollment Period, even if you have health issues. That period starts the month you turn 65 and are enrolled in Medicare Part B. 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 can deny coverage or increase your premiums based on any past or present condition they find during underwriting.

If you're enrolling in Medicare Advantage

To enroll in a Medicare Advantage plan, you have to be enrolled in Part A and Part B. So, if you are delaying Part B enrollment, you may not be able to enroll in Medicare Advantage in your Initial Enrollment Period.

If you opt to enroll in Part B during the General Enrollment Period (January 1 through March 31), you can enroll in Medicare Advantage then.

To enroll in a Part D prescription plan, the Medicare Advantage plan you select cannot provide that coverage. If it doesn't, you can select a plan just as you would if you had Original Medicare.

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.

When Can You Enroll in Medicare? (Continued)

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 make Medicare Advantage and Part D plan changes 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

What Are the Methods for Enrolling?

You can enroll in Medicare through two methods: automatic enrollment or manual enrollment. Let's look at each option.

Automatic enrollment – If you are already receiving Social Security (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

What Are the Methods for Enrolling? (Continued)

You have to return the Medicare card if you decide you don't want Part B. If you don't, you will be charged the appropriate Part B premium (based on your income) and will have the coverage.

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.

Manual 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 manually if you want them.

The federal government expects you to know when to enroll. Unless you have current employer-based insurance coverage, you will want to apply for Part 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.

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 changing a Medigap plan after your initial decision, you need to know one thing: you got the very best terms when you signed up during your Initial 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.

However, if you find you have the wrong plan for you or are discontent with your insurer, it is worth exploring other alternatives, especially if done before you have added more years to your age or medical conditions to your record. You have a 30-day “free look period” after you buy a Medigap policy to decide if you want to keep it. And you can change anytime within your 6-month Medigap Open Enrollment Period without difficulty.

Just don’t cancel your first Medigap policy until you’ve decided to keep a second Medigap policy. Call the new insurance company, apply for your new Medigap policy and only contact your current insurance company to cancel when you are sure your application has been accepted.

In the case of Medicare Advantage and Part D prescription plans, it is wise to review your plans each fall because of the changes the insurers make to pricing and conditions. You want to be sure you still have the coverage you need.

If you are considering changing an existing Medicare Advantage or Part D drug plan, you can do it during the Medicare Open Enrollment Period, also called the Medicare Annual Enrollment Period. It runs from October 15 through December 7 each year. Changes will take effect on January 1 of the following year.

Changes can also be made during the Medicare Advantage Open Enrollment Period, which runs from January 1 through March 31. You can switch to a different Medicare Advantage plan (with or without drug coverage) or go back to Original Medicare (and pick up a Part D drug plan if needed). Your new coverage will begin the first day of the month after your new plan gets your request for coverage. However, if you go back to Original Medicare outside of your Initial Enrollment Period, you will have to undergo underwriting if you want a Medigap policy.

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