Updated for 2021!!

BASICS OF MEDICARE

Let's keep it simple!

LONG VIEW
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INSURANCE & INVESTMENT SOLUTIONS

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Chapter 1

Basics of Medicare

Introduction

What is the difference between this Medicare book and all other Medicare books that are supposed to make it easier to understand the subject? This book is here to explain the books that apparently are written for the public that supposedly make it easier to understand the subject. I'll never understand why the government makes it so difficult to understand how Medicare works, when they are the ones that offer the service!

So, this book is here to walk you through the very basics of Medicare. From signing up through Social Security to enrolling in a supplemental plan, we will cover it all. This book will be structured in a reverse pyramid layout. We will focus on the very basics first and get much more specific as the chapters continue. So without wasting anymore of your time, we got some Medicare to clarify!!

Original Medicare

The very first step in preparing for Medicare is understanding that Original Medicare is administered by the government through the Department of Social Security.

When you turn 65 or are on Social Security Disability for 24 months, you are eligible for Original Medicare. There are only two parts to Original Medicare and there are no variations of these parts. Please remember, right now we are only talking about Original Medicare! As of right now, we are not taking into account any supplemental insurance. The figures you are about to see are for Original Medicare only and change every year. At the time of this writing, I have used the 2021 figures.

The first part, Part A, is your Hospital insurance. When you step foot in the hospital as an inpatient (important distinction!), you will pay a deductible of $1,484 for that hospital visit. This deductible is not an annual one! It is per benefit period, so if you go back in the hospital six months later for a different reason, you will pay another $1,484 for that hospital stay. Which means, you have unlimited exposure to a deductible and therefore, no maximum out of pocket that the government provides you.

The second part, Part B, is any medical service that is considered outpatient. Outpatient services can include anything from doctor visits to outpatient surgeries. Common outpatient surgeries would be cataracts or even knee surgery. I will be discussing the difference between inpatient and outpatient surgeries later on in the book because they are a very important distinction. Part B will also include medications that are administered in the hospital and also Durable Medical Equipment, or DME. In

2021, Part B has a deductible of $203. If you consider how much a specialist visit to a urologist would cost WITHOUT any insurance, $203 is not hard to achieve with even one visit. After the $203 deductible, you pay 20% and Medicare will pick up 80%. That sounds all fine and dandy Uncle Sam, but can you imagine having to pay 20% for a knee surgery and then all the physical therapy as well?

There will be a premium for Part B. Yes, even though you have been paying into Medicare your whole life while working, you still have a premium when you go on Part B. You didn't think it was going to be that easy, did you? This is somewhat complicated to explain but if you enroll in Medicare Part B in 2021, most of the American population will pay $148.50/month if their income is below a certain threshold. Your premium could be more than this if you and/or spouse have annual income above certain limits. Instead of writing those limits out in this paragraph, which I always find monotonous to read, I will provide a chart for you to analyze that will let you know if your premium will be more than $148.50. Bottom line, the more income you have coming in, the more you could be paying for Part B. Awesome!

What you have read so far is strictly for Original Medicare Part A and Part B. It is important for you to understand that Original Medicare is very basic insurance and does not cover everything. In particular, it does not cover Dental, Vision, or Prescription Drug Coverage. This is

why almost everybody who goes on Medicare will choose a supplemental plan of some sort.

Part B Premium Income Related Monthly Adjustment Amount (IRMAA) (2021 Figures)

File Individually	*File Jointly*	*Part B Monthly Premium*
$88,000 or less	$176,000 or less	$ 148.50
Between $88,001 and $111,000	Between $176,001 and $222,000	$ 207.90
Between $111,001 and $138,000	Between $222,001 and $276,000	$ 297.00
Between $138,001 and $165,000	Between $276,001 and $330,000	$ 386.10
Between $165,001 and $499,999	Between $326,001 and $749,999	$ 475.20
Greater than $500,000	Greater than $750,000	$ 504.90

Supplemental Insurance

Up until this point, we have discussed Original Medicare without any supplemental plan. It is also at this point, where most people feel the confusion start to set in. So, I am going to make it as simple as possible. There are only two options when it comes to choosing a supplemental insurance. There are many choices within each, but let's not make it more complicated than it has to be. The first

option is actually called a Medicare Supplement. The second option is called a Medicare Advantage plan. Don't worry about a prescription drug plan quite yet, let's focus on the difference between a Supplement and an Advantage plan first.

All the commercials you see on T.V., all the unwanted mail in the mailbox, and all the complicated Medicare advertisements you are bombarded with when you are about to turn 65 can be split into these two categories. They clearly make it more complicated than it has to be. But if you know the basics of how these supplemental plans work, you can figure out which ones are most beneficial for you.

Medicare Supplement

We will first discuss how Medicare Supplements, also known as Medicare Supplements, function. These Supplemental plans literally fill in the "gap" that Original Medicare does not. There are several different plans to choose from, each labeled with a different letter of the alphabet such Plan "A" or Plan "G". Each one will be slightly different in the coverage that they offer. However, just understand that these plans will pick up all or most of the copays and deductibles you have under Original Medicare.

These plans will have a premium attached to them which will vary greatly depending on the insurance company, the plan type and the state you live in. I will go into more detail on this topic in a later chapter. What I want

you to get out of this section about Supplements is that they do not add any extra benefits that Original Medicare does not offer such as dental, vision or prescriptions. All they do is pick up the part of the bill you are responsible for that Medicare does not pay. You will need to choose and pay for a Prescription Drug Plan (Part D) from a private insurance company. And believe me there are a lot of prescription drug plans to choose from! In this case, more is not always better. Because of how complex the subject of Prescription Drug Plans are, I have dedicated a whole chapter under "Donut Hole".

When you choose a Medicare Supplement, you will continue to have Original Medicare as your insurance. These supplements will then fill in the gap. This means you will continue to have your Original Medicare Part B premium, a Medicare Supplement premium and also a Prescription Drug Plan premium. I know it seems unfair to have to continue paying for Medicare Part B, but Uncle Sam is going to get his money from you somehow. As scary as this may sound, there is a time and place for these plans and they are a vital option for individuals who have high medical costs.

Medicare Advantage

Our next subject will be an introduction to the second option, which is the Medicare Advantage plan. Think of the Medicare Advantage as a "package deal". It is technically referred to as Managed Medicare, but does that

clarify a thing for us? Just like Medicare Supplements, these Advantage plans are also provided through Private Insurance companies. The insurance companies take the roll of Medicare and the government is no longer considered your insurance provider. However, the part of the government that monitors Medicare, CMS, does not just let these insurance companies behave like it's the wild west. They are highly regulated. For example, these plans offered from the insurance company must be as good or better than Original Medicare. Also, these plans MUST have a Maximum Out of Pocket in them. So, if you have a rough year, there is a price limit to what you will be subjected to if you hit that amount.

The important concept to wrap your mind around is that many of these plans will include dental, vision, a Prescription Drug Plan and many other extra benefits. Why? The insurance companies are being subsidized from the government based on a multitude of factors that you don't need to worry about. Just know that you have been paying into Medicare your whole life and now the government owes you. So, the government provides these insurance companies with a certain monetary value each month, per individual who signs up with them. For simplicity sake, let's just say that for each Medicare eligible individual that signs up with a specific insurance company for their respective Advantage plan, the insurance company gets roughly $700/month. Then someone at the insurance agency who is way better at math then I will ever be, figures

out that if they have copays for doctor visits, x-rays, ER visits, etc., they can have extremely low premiums attached to these policies. And with the power of competition, all these insurance companies are trying to get in on the action and start offering all these excellent extra benefits such as your dental, vision and Prescription drug plans. For those of you concerned with dental, this is a good opportunity to take advantage of what they offer because I have yet to find a decent dental plan out there. It's as if when you turned 65, the government decided you no longer need to care for your teeth!

Here is another fun concept to grasp. If you have a Medicare Advantage plan that has prescription drug coverage inside it, you do NOT need to get an additional Prescription Drug Plan (Part D). A very small percentage of Medicare Advantage plans that are offered to the public will not include a Prescription Drug Plan. One of the benefits of a Medicare Advantage plan is the inclusion of the Prescription Drug Plan so it is rare to find a plan without a drug plan that comes along with it. If your Medicare Advantage plan has a Prescription Drug Plan, it is unnecessary to purchase a separate Prescription Drug plan (Part D). In fact, if you do have prescription drug coverage in your Medicare Advantage plan, it is illegal or literally impossible, to have a separate Prescription Drug Plan (Part D).

These Medicare Advantage plans are very similar in nature to the health insurance plans you used to have before you were 65. These plans are PPO's and HMO's, which means you will have a network of doctors and hospitals that you need to go to in order to get the coverage they promise. Also, due to the implementation of Obamacare, there are no pre-existing conditions that will effect your ability to enroll in a Medicare Advantage plan. A big difference between Medicare Advantage and pre-65 health insurance is the insurance companies are able to offer these Medicare Advantage plans for a significantly lower premium and also a significantly lower deductible, if any deductible at all.

Advantage or Supplement??

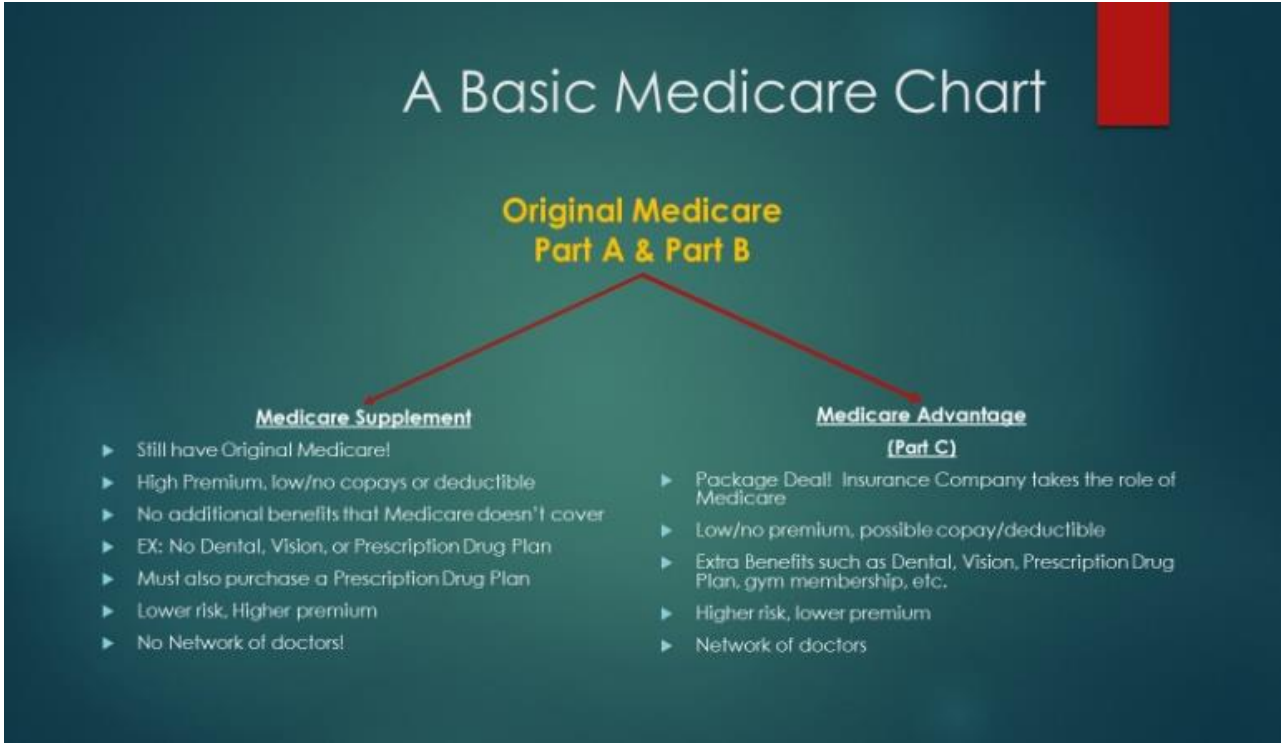
Now that you know the two different options you have as far as choosing a supplemental Medicare plan, the next step is to determine which one is appropriate for you. I can't tell you which one to choose. I can only give you an objective perspective on the issue. People tend to go with an Advantage plan when they are young and healthy and do not have as many doctor visits or prescriptions to take. This way, the premium for the plan is low, a prescription drug plan is already included and they know they have coverage if something did occur and they needed medical assistance. For people who have several health issues and see doctors on a regular and frequent basis, it is common for them to go with a Medicare supplement. The reason

behind this is that the Supplement will cover all of their copays when they go to the doctor or hospital.

We made it through the basics of Medicare! Now that you know the different options offered to you and how to choose each one, the next several chapters will go into more detail about each topic. If you have a specific subject you want more clarification on, just look at the Table of Contents and you should be able to just skip to that section and not have to worry about the rest.

If this hasn't been too confusing already, let's move onto the infamous Prescription Drug Plan Donut Hole!

A Basic Medicare Chart



Chapter 2

The Infamous Donut Hole!

(Prescription Drug Coverage)

Prescription Drug Plans (Part D), is one of the most confusing concepts that I have to explain to people who are entering the world of Medicare. Thankfully, for everyone reading this book, I have spent the past few years trying to find ways to explain this to people in a clear and concise way. The explanation has been a progressive evolution and I think I have finally got it down to the most efficient way for people to not stare at me like I have multiple heads after I get done babbling on to them about the concept of the"Donut Hole".

First and foremost, Prescription Drug Plans, or PDP for short, were established back in 2006 during the Bush administration. Before that, people just paid out of pocket. I'm not sure how that worked exactly, but I somehow doubt the pharmaceutical companies were any more generous than they are today. However, this is what we have to work with and hopefully this chapter will at least ease some of the confusion on how your medications are covered.

Prescription Drug Plans are offered through private insurance companies just like Medicare Supplements and Medicare Advantage plans. Please understand, that you do NOT sign up through Social Security for a Prescription Drug Plan like you do for Part A and Part B. Social Security will help you get on a plan, but typically, from what I have seen with several clients, they put everyone on the same plan. Which is ludicrous because all these Prescription Drug Plans have different formularies. You have to do your homework and determine which PDP is appropriate for you. Also, the formularies change every year so just because all your prescriptions are covered for the current year, it does not mean they will stay that way next year. A good resource to use is Medicare.gov. They have a program where you can input your prescriptions and it will spit out a list of insurance companies in your state that offer Prescription Drug Plans. In my state alone, there are roughly 25 different companies that offer these PDP's.

Now I would like to explain the Coverage Gap, or as it has been nicknamed, the Donut Hole, to everyone. For those of you who have not heard of this, the Donut Hole is exclusive to Medicare Prescription Drug Coverage and it will apply to everyone who is on a Medicare Prescription Drug Plan. It does not matter what plan you have chosen to go on. The figures I am about to give you are the same for every Prescription Drug Plan. It does not matter if you have gone the way of the Medicare Supplement or the way of the Medicare Advantage plan. Every plan must adhere to this

platform I am about to lay out to you. Ok, so take a deep breath, exhale, and let's get started.

There are four different "phases" that someone can enter during the year with their Prescription Drug Plan. The question that I get most often is, how do I skip to the last phase? The only way to move onto the next phase is to spend more money on prescriptions!

Deductible (Phase 1)

The first phase is the Deductible Phase. Each year, the Deductible can increase or decrease, but I'm sure you can imagine how often the government has decided to decrease the amount. Please keep in mind, I have updated these figures to be accurate with the 2021 figures. The maximum deductible amount that an insurance company can have on these prescription drug plans is $445. It is important to understand that the insurance companies can choose the amount of the deductible that the Medicare enrollee will be responsible for, just as long as it does not exceed $445. Furthermore, they can choose what tier the deductible will apply to. For example, you may have a Prescription Drug Plan that has a $200 deductible that you are responsible for, but only applies to Tiers 3, 4, and 5. In other words, the deductible applies to your more expensive drugs like insulin, inhalers and brand name drugs. In some cases, the Prescription Drug Plan may not have a deductible at all. It is important to make sure you know what the

deductible is and what prescriptions you have which may be going towards this deductible.

Initial Coverage (Phase 2)

The second "phase" of the Coverage Gap is known as the Initial Coverage. This is the stage that everyone is used to. This is when you go to the pharmacy and pay $2 for a 30 day supply of a generic drug. Or you may pay $100 for 30 day supply of a brand name drug that is much more expensive. While your portion was the $2 or $100, the retail cost of the drug could be significantly different. There is an imaginary number that Medicare made up and the retail cost of all your prescriptions goes towards this number. Let's pretend the prescription you paid $100 for had a retail cost of $4000. I know that seems extreme, but this is the reality of the situation. It is the retail cost of $4000 that is going towards this imaginary number Medicare made up. In 2021, the imaginary number was $4,130. If the retail cost of all your prescriptions during the year have gone over $4,130, you have graduated past Phase 2 and now entered the Donut Hole and it is not something that you want to be in.

From my own experience helping seniors get on the right Medicare plan, I can tell you the prescriptions that subject people to the Donut Hole most often are insulin medications, asthma inhalers, dermatology creams, eye drops and certain brand name medications such as Crestor. For the most part, you are going to find that your doctor

tries to prescribe medication that falls in the Generic category so it is not as expensive for you to get a 90 day supply. For some people, generics do not work as efficiently or they could even be allergic to the generic version of a particular prescription. In this case, the insurance company uses a method called Step Therapy, that will have you experiment with generic prescriptions and move up towards the brand name until they find a prescription that will work. I understand this is not always the case and some people are forced to take specialty prescriptions out of necessity.

Coverage Gap (Donut Hole) (Phase 3)

Back to this Donut Hole we need to finish discussing. The third stage is the Coverage Gap (Donut Hole). In this stage, you will pay 25% of the retail cost of Brand and Generic prescriptions. You may have read that the "Coverage Gap" was closing by 2020. Over the past several years, since the inception of this Prescription Drug Donut Hole, the percentage of the retail cost that you are responsible for has been getting lower and lower. In 2020 and going forward, they consider it "closed". Yes, you have read that correctly. You are paying 25% for your prescriptions and they consider the Donut Hole "closed". I'm not joking either. This is really their definition of "closing" the Coverage Gap.

Catastrophic Stage (Phase 4)

The last stage is appropriately titled the Catastrophic Stage. You will enter this stage when you have paid out of your own pocket a certain amount. In order to get out of the Donut Hole, you must pay out of your own pocket, $6550 in 2021. The figure typically goes up each year. Once you have spent $6,550 on prescriptions, you are now in the Catastrophic Stage. You will pay significantly less for generic and Brand name prescriptions. You will pay $3.70 and $9.20 for generic and Brand name prescriptions respectively, or (and this is a BIG or) 5% of the retail cost of the prescription, whichever is more. For example, if you have a Brand name drug that has a retail value of $4000, 5% of that is certainly more than $9.20, so you will pay the 5%.

If you are anything like me, I prefer visuals in order to truly understand this process. So, I have provided you with a handy chart that will give more clarification on how this all comes to fruition. The good news is that a very small percentage of seniors enter the "Donut Hole". Since a small percentage ever hit the "Donut Hole", that means an even smaller percentage will go into the Catastrophic Coverage.

Obviously, the easiest way to stay out of the "Donut Hole" is to practice prevention over treatment. The healthier you are, the cheaper it will be for you in the long run. Unfortunately, some people are not so lucky and they have been cursed with medical issues outside their control and will have to pay for it physically as well as financially.

There are a few things you can do to try to limit the amount that comes out of your pocket. First, if it is a brand name drug, I suggest contacting the manufacturer. Many of them have discounts and deals that you can subscribe to that will significantly decrease your copay. Other discount deals include GoodRX. Goodrx is a program that you subscribe to which gives you discounts on generic and brand name drugs. It has a website as well as a smartphone app. The neat part about this program is you can go online and input your prescriptions and it will let you know what pharmacy has the cheapest copay for your particular prescriptions. I know people who go shopping at multiple pharmacies and supermarkets until they find the best deals!

***If you need a deeper explanation into this, you can watch my videos that I have created on Facebook and Youtube. Look up *Long View Wealth Management* and you can access a few different videos on these specific subjects.**

Donut Hole Explained!!

- Donut Hole Explained!!

Chapter 3

What the @#$% is IEP, AEP, SEP and OEP??

This chapter is going to focus on the different types of enrollment periods that you will experience during your lifetime. As complicated as they may have made the Healthcare system, they do give you plenty of opportunities to find a plan that is right for you. Most people realize you sign up for Medicare when you turn 65. However, what happens if you still work? What happens every year between October 15th and December 7th? Now they are telling you that you have the opportunity to change at the beginning of the year too? Who would have thought getting old was so complicated?

The most common enrollment period most people are aware of, is when you turn 65. This is your Initial Enrollment Period (IEP). You have a seven-month window when you are eligible to sign up for Original Medicare. Three months prior, the month of and three months after the month in which you turn 65. It is most common and most beneficial to sign up for Medicare somewhere between those three months prior to the month in which you turn 65.

It is also important to know that Medicare coverage will begin on the 1st day of the month that you sign up. So if you turn 65 in the middle of July, your Medicare coverage will begin July 1st. The only exception to this, is when your birthday falls on the first of the month. Then Medicare coverage will begin the month before the month you turn 65. So, if your birthday was July 1st, then you could go on Medicare June 1st.

What happens if you do not need to sign up for Medicare when you first turn 65? NOTE: There is an entire chapter dedicated to explaining this very complicated scenario!! The next Enrollment period you need to be familiar with is the Special Enrollment Period, or SEP. There are several reasons you may qualify for a SEP, however, I am going to talk about the most common that people experience. An SEP occurs when an event happens in your life that requires you to enroll/change the current Medicare Advantage or Prescription Drug Plan you are on. A common scenario that would institute an SEP would be if you moved out of the area that offered the specific Medicare Advantage plan you are on. Remember, these Medicare Advantage plans are HMO and PPO's which means you can only sign up for the plans that are offered in your specific geographical location. If you move, you must choose a plan that is offered in the new area that you have moved to. Luckily, your SEP will kick in and you will be given typically 60 days to switch to another plan. Here is a little piece of advice, free of charge. The 60 days refers to the new plan

you are changing to, not the current plan you are on. So if you tell your current Medicare Advantage plan that you have moved, they will kick you off by the end of the month, regardless of whether you have chosen another Medicare Advantage or Prescription Drug plan. Yea, I know, I can hear your cursing from here.

This is just one example of a whole list of events that will constitute an SEP. There is a web page that offers a good explanation of all SEP events through the Medicare.gov site. The most common and therefore, the most important for you to understand is when you finally choose to retire. Like I mentioned before, this requires a whole chapter to explain. So, if this situation applies to you, I definitely suggest reading the chapter titled "What if I'm Still Working?"

The next Enrollment Period we will discuss is the Annual Enrollment Period or AEP. This is my favorite time of year!! It's like tax season for Medicare Advisors. Tis the season for us to help you get on the most appropriate Medicare Advantage or Prescription Drug Plan. You have the opportunity to switch your current plan every year between October 15th and December 7th. If you choose to continue on the plan you are on, then no action is needed on your part and you will roll your coverage over without having to sign or authorize any documents. Your current plan will send you an Annual Notice of Change, or ANOC, which will explain the changes that are occurring for the

following year. It is very important you take initiative and read these changes to understand how your plan is changing. The ANOC usually arrives late September or early October and is currently delivered by mail.

The last Enrollment period I will explain is the Open Enrollment Period, or OEP, which runs from January 1st till March 31st. This time period gives you the opportunity to change from your current Medicare Advantage plan to Original Medicare with a Prescription Drug Plan or to another Medicare Advantage plan. I want to be clear; this only applies if you are currently on a Medicare Advantage plan. If you are on a Prescription Drug Plan, then you may not change. Also, this is a one-time opportunity, so please take the time to do your research in order to make sure all your doctors are in the directory and all your prescriptions are in the formulary.

Chapter 4

What if I'm Still Working?!?!

By far the most common concern I get from people entering retirement is how and when to apply for Medicare if they are continuing to work past age 65. In its most basic element, Medicare is meant for people who have turned the ripe old age of 65 and DO NOT have creditable coverage through an employer. The problem with this simplistic explanation is that it does not account for the numerous variables people encounter when it comes to your concerns with health insurance. So, this chapter will attempt to give you a broad understanding of the idiosyncratic rules Medicare has implemented to confuse you when trying to decide how and when to apply for Medicare.

Part B and Part D Late Enrollment Penalties

There is a penalty for not going on Medicare Part B and Part D when you first turn 65. Don't feel like you are the only one who has been kept out of the loop with this information. There is just not enough reliable education out there for seniors to trust. To put it simply, when you

turn 65, you must enroll in Original Medicare Part B, or you could incur a late enrollment penalty which lasts for the rest of your life. Granted, it is a small penalty but it can accumulate over time and be rather large. For every year you go without Part B, your Part B premium will increase by 10%. And it never goes away!! The percentage the penalty is based on will be the base Part B premium, which is $148.50 for 2021. This will be the case even if you are the lucky recipient of an increased Part B premium due to your higher income.

Let's discuss how you can prevent this Part B penalty from happening to you. The exact definition set by Medicare states that if you are 65 or older and are continuing to work with Creditable Coverage in place, then you must enroll in Medicare Part B within 8 months of retiring or losing the Credible Coverage, whichever one comes first. So, if your employer has decided to provide you with health insurance coverage for a year after you retire, the timer for enrolling in Original Medicare Part B starts the day you retire, not when you lose your group insurance a year later. This creates a lot of confusion for people and has resulted in very unnecessary penalties for people who thought they were law abiding citizens.

There is another penalty you could incur which is by not having a Prescription Drug Plan or Part D after you turn 65. If you do not have a Part D plan for 63 consecutive days, (such a random number!) you will start to receive a 1%

penalty based on the average premium for a Part D plan throughout the country, for every month you do not have a Part D Prescription Drug Plan. In 2021, the average premium in the United States is $33.06. Let's look at an example. If you turn 65 in June and do not sign up for a Part D when you were eligible, the count down for incurring a penalty will begin 63 days after June 1st because that is when you were eligible to begin Medicare. The next available time you are allowed to start a Prescription Drug Plan would be during Annual Enrollment and you would begin the plan January 1st. That means you went from August to the end of December with no drug plan so you will be penalized. Each month is a $0.33 penalty increase to your Part D premium. Once again, this is not much, but it is important to understand these consequences. I have seen people go without a Part D Prescription Drug Plan for decades. When it comes to the penalty, this can truly add up over time. Also, on a side note, please remember that it is the government, not the insurance company who will be giving you this penalty. Please do not confuse who is giving you the penalty. The insurance company cannot make that decision.

Your first question should be is "What the @#$% is Creditable Coverage?". When you turn 65, the government requires you to have coverage that is on par with Medicare. In other words, if you do not have health insurance that is equal or better to what Original Medicare would provide you, then it is not Creditable Coverage and you must sign up

for Medicare Part A and Part B. The most common type of Creditable Coverage will come from your employer through group insurance. If you are actively employed after you turn 65, and you are taking advantage of the group health insurance they offer, then you do NOT have to sign up for Original Medicare. You can postpone signing up for Original Medicare without the fear of incurring a penalty later on in life when you finally do sign up after retiring or losing the "Creditable Coverage".

I would also like to tell you what is NOT Credible Coverage. COBRA is not considered Creditable Coverage for replacing Medicare. If you are offered COBRA and are over 65 you will still need to enroll in Medicare. Don't worry, though, because I have never run into a situation where COBRA was better or more affordable than what Medicare offers so I would highly suggest you consider signing up for Medicare at that point and going with either a Medicare Supplement or Medicare Advantage plan and cancel COBRA.

Another important consideration involves the veterans of this country and I would like to take this opportunity to thank you for your service. As a fellow veteran, I take great pride in assisting those who served in understanding how Medicare works with VA benefits. VA benefits will be considered Creditable Coverage for Part D Prescription Drug Coverage. However, it will not be considered Creditable Coverage for Original Medicare Part

B. My advice to veterans is to make sure you sign up for Original Medicare Part B when you are first eligible. Even though you go to the VA for coverage, you never know what the future holds and you may need civilian coverage in the future. If you do postpone signing up for Original Medicare Part B and continue to go to the VA, then you will receive a penalty down the road if you ever need to sign up for Original Medicare Part B in the future.

I receive my prescriptions through the VA and I know it takes about a week for them to arrive through the mail. Even though you are going to the VA for healthcare you have earned the right to receive Medicare and you should take advantage of the benefits offered to you. If you have Original Medicare Part B, you have the right to enroll in a Medicare Advantage plan and utilize the benefits they offer you, including the prescription drug coverage, and continue to go to the VA. This comes in handy when you have an emergency situation for an antibiotic and do not have time to wait for the VA to send you prescriptions.

20 or more Employees

What I explained in the above paragraph is a very generic set of rules to abide by when you are determining if and when to go on Medicare. Everyone will have a different situation that will lead to a different set of variables to consider. A good example of this would be the number of employees you have employed at your respective job. If more than 20 are employed, then your group insurance will

be the primary insurance and if you choose to enroll in Original Medicare, Original Medicare would become your secondary insurance. However, if you have less than 20 employees, Medicare will become your primary insurance and your group insurance will become your secondary insurance. In this situation, it is not only beneficial, but essential that you enroll in Medicare Part A and Part B.

If you do have less than 20 employees and your Original Medicare is your primary, it might be a good opportunity to go on a Medicare Supplement or Medicare Advantage plan in order to save on premiums. However, this would require you to do a little number crunching to determine what is going to save you some money.

HSA and Part A

Here is an interesting set of rules that is meant to confuse you. If you are currently contributing to an HSA account, congratulations because Health Savings Account's (HSA's) are a very beneficial financial instrument when it comes to financial planning. However, the moment you go on Original Medicare, you are no longer able to contribute to an HSA. This applies even if you are on your group plan from work and only have Original Medicare Part A. Some people have chosen to postpone Original Medicare Part A and Part B so they can continue to contribute to their HSA and not have to worry about getting a penalty.

This can cause major tax ramifications if not done properly. It is important to understand it is legal to contribute to an HSA as long as you have not enrolled in Medicare even after the age of 65, but the moment you sign up for Medicare Part A, they will retroactively look back six months. If you have been contributing to an HAS during those six months, you will receive a taxable consequence. I leave the tax questions up to the tax preparers and accountants of the world, so you will have to ask them what the specific consequence will be for contributing to an HSA when you are not supposed to. I can't recommend finding out the hard way, so please make sure you are not contributing to the HSA if you are on Medicare!

Why the government decided to implement this six-month lookback rule is beyond me but here is an example to clarify how it would work. If you turn 65 in July and are still working and enrolled in group insurance, you could postpone both Original Medicare Part A and Part B and be eligible to continue contributing to your HSA. Then a few years go by and you are ready to retire in July when you are now 70. So that means you must sign up for Medicare if you lose your group insurance in July. However, since you will be enrolling in Original Medicare in July, the government will look back six months from July to see if you had been contributing to an HSA during that time period. They can be tricky, can't they?

One last thing about HSAs I want to comment on involves what the funds in HSAs can be used for when it comes to Medicare. Do not get confused with the distinction between contributing to and the distribution of the HSA. You cannot contribute to an HSA once you enroll in Medicare, however, the funds that you in your HSA account once you are on Medicare, can be used to pay the medical expenses you incur once you are on Medicare. Just like with pre-65 insurance, you can use the HSA funds to pay for qualified medical expenses. In addition to that, you are allowed to pay the premiums for Part A, Part B, Part D and also the Medicare Advantage Premium if you have one. Please keep in mind, you cannot use the HSA funds to pay the Medicare Supplement premiums. They are not considered qualified.

This is a very brief summary of some of the situations you could encounter when continuing to work and turning 65 at the same time. More and more people will be in this boat, because people are working way past the age of 65 in today's society. If you are not sure how your situation will apply to Medicare, I would definitely reach out to a professional who specializes in the Medicare field.

Chapter 5

FAQ's

1) **Can I sign up for Part A, B, C, and D all at the same time through Social Security?**

   Answer: No, they are all very different segments of Medicare and are offered from different institutions. Part A and B are offered through Social Security. Part C and Part D are offered through the private insurance companies. Keep in mind, you do NOT need a Part D Prescription Drug Plan if you have a Part C Advantage Plan that offers a Prescription Drug Plan in it.

2) **What is the best Medicare plan for me?**

   Answer: This is a very common question I get and it is also the most difficult to answer. What I want everyone to understand is that these Medicare plans, whether it be Supplement or Advantage, are no longer the group insurance you may have been on

when you were still working. In other words, the plan you are on, may not be the best plan for your spouse and vice versa. Unfortunately, I cannot go into detail on plan specifics in consideration of breaking compliance rules, but here are a few things to consider when choosing a plan. The first step is making sure your prescriptions and doctors are in the formulary and network for your respective plan you are considering. Other things to consider would be the deductible you are responsible for and the specific services the deductible applies to. You may also want to consider how the plan will work when traveling outside the state that you reside in. Each plan could be different on how they handle the copayments. Take an interest in the extra benefits these plans may offer. For the most part, Medicare does value prevention over treatment and will provide you with a whole arsenal of benefits to improve your health.

3) **I'm 65 but not ready to start taking Social Security. Can I still go on Medicare?**

   Answer: Yes! Even though you enroll in Medicare through Social Security, it does not mean you need to enroll in both at the same time. Typically, when you enroll in Medicare, the premium for Part B will come out of your Social Security check. If you have chosen not to start taking Social Security until after you have

enrolled in Medicare, your premium will be billed to you quarterly.

4) **I do a lot of traveling. Am I covered out of state? What about internationally?**

   Answer: Great question. You have worked hard your whole life and now it's time to see the world during retirement. Let's look at international coverage first. Original Medicare does not have international coverage, so if you enjoy traveling the world you may want to consider an Advantage or a Supplement to help with that. A Medicare Advantage plan will have an annual coverage limit that will be available to you. For a side note, if you continually hit the maximum coverage every year when your overseas, my recommendation is to get a hobby that has a slightly lower risk factor to it.

   Next, a Medicare Supplement will offer international coverage, but it is a lifetime maximum, not an annual maximum. While this is not as advantageous as an Advantage plan, I would not base my decision on which one to go with because of the international coverage. In fact, I usually recommend getting travel insurance when you travel instead of relying on Medicare Supplements or Medicare Advantage plans to pay for any issues overseas.

While these Medicare Advantage plans are state specific, it is important to understand the government has made it mandatory for these plans to cover Emergency Room and Urgent Care visits anywhere in the country, no matter what state you reside in. In addition, it is important to know the difference between an HMO and PPO. With an HMO, or Health Maintenance Organization, you must go to a doctor that is in network. So, it is most common that the doctors in the network for these plans will be located in the state or surrounding states where the plan is offered. Now, there are insurance companies out there who make the decision to have all their doctors in network, no matter where you are in the country. Typically, the insurance companies who are able to do this are those that are nationally recognized.

PPO plans, or Preferred Provider Organization, will have a network of doctors; however, you have the option of going out of network. It is important to realize you will pay a higher copayment if you go out of network. The important thing in all this is to find someone that specializes in these plans who can give you details on how the plan will apply to your specific situation.

Medicare Supplements are a little easier, actually a lot easier, when it comes to understanding national

coverage. Remember, these plans are not PPO's or HMO's. They do not have a network of doctors so you can go to any doctor that accepts Medicare in the country. I would recommend going to a doctor who graduated medical school, but that is your personal decision…….

5) How do I know how expensive my medications are or if they are even covered?

Answer: Another great question. All prescriptions provided through a Prescription Drug Plan, no matter which insurance company it is being offered through, have been sorted into a series of Tiers. Typically, there are 5 Tiers, however, some plans like to spice things up and add an extra tier or two. However, to keep it simple, most Prescription Drug Plans will have 5 Tiers, starting from Tier 1 through Tier 5. Tier 1 and Tier 2 will fall in the category of Generic prescriptions. Tier 3 and Tier 4 will fall in the category of Brand Name Prescriptions. Tier 5 is reserved for specialty medications and are typically very expensive.

Each insurance company offering a Prescription Drug Plan will have their own formulary. A Formulary provides a list of prescriptions that are covered and their respective Tiers. This is why it is important to know what Tiers your prescriptions are

for the plans you are researching. When I first meet with someone to help them choose a plan, the first thing we do is ask for a list of current prescriptions they are taking. I have seen situations where one plan has all Tier 1's and another plan has all Tier 3's for the same prescriptions!

Historically, you will find asthma inhalers, diabetic insulin, dermatology creams, and eye drops in the Tier 3 category or above. You will also notice that most, if not all Prescription Drug Plans, will cover generic prescriptions. However, when you start getting into your more expensive prescriptions, you need to do your research on whether or not the prescription is even covered in a particular Prescription Drug Plan. I see this all the time with Insulin prescriptions. Hopefully, this issue will be solved in the near future. However, for now it remains an important step in making sure you are going on the most appropriate plan for your specific circumstance.

6) **Where do I find someone to help me with signing up for Medicare?**

I'm going to take this opportunity to give a step by step process in signing up for Medicare and also who is the best source to help you with each one of these steps.

<u>Step 1</u>: Making the decision to enroll in Medicare when you turn 65. This is easy if you are already retired and do NOT have employer health coverage. In my entire career to date, I have never met someone who preferred to pay $800 per month for a pre-65 health insurance plan instead of going on a Medicare Advantage or Medicare Supplement plan. In fact, it is illegal for you to stay on a pre-65 individual health insurance plan after you turn 65.

It is a little more complicated if you turn 65 and are still employed with group health insurance. You need to determine the cost difference between signing up for Medicare versus staying with the group insurance. Another important factor will be if you have a spouse or children who are on the group health insurance plan as well. When I first consult with someone who is about to turn 65, these are the questions, along with many other scenarios, that we go over in determining if it is time to sign up for Medicare.

<u>Step 2</u>: If you have chosen to enroll in Original Medicare, you must contact the Department of Social Security in order to activate Medicare Part A and Part B. If you are currently receiving Social Security, the government should automatically enroll you in both Part A and Part B. (If you want to postpone Part

B because you are still working, then you must contact Social Security and tell them you want to postpone Part B. If you do not, you will be charged the premium for Part B!) If you are not receiving Social Security, then you will have to contact Social Security and request to be enrolled in Original Medicare Part A and Part B. You can do this by calling a local office, going in person to a local office, or creating an online account and enrolling online.

For those of you who are over 65 and have continued to work with group health insurance, please keep in mind that Social Security will want documentation from your employer that you are losing Creditable Coverage and will require enrollment in Part B. This will be part of the application process and is usually the most frustrating part.

<u>Step 3</u>: Once you have received your Part B confirmation and are officially signed up for both Part A and Part B Original Medicare, you may now sign up for a Medicare Supplement or Medicare Advantage plan. This is when you come to a Medicare Specialist like myself and we work together to determine which plan is right for you.

In my experience, seniors who receive their Original Medicare Part A and Part B confirmation, have already been in contact with me and we have worked

together to get this far in the process. At this point, I would have collected a list of prescriptions and doctors and done my homework to determine the plans we can go into more detail about and the ones that we can discard. This is when we will go into specifics on how each plan works, so as to not allow for any surprises for you six months down the road after signing up.

<u>Step 4</u>: Signing up for a plan. The application process for these Medicare Supplement and Medicare Advantage plans are very simple and the process does not take very long. I have sent in applications the night before enrolling in the plan with no issues. I usually recommend being proactive so we do not have to send the application in the night before, but I also realize there are extenuating circumstances in people's lives.

Conclusion

My fellow confused readers, thank you for investing your time in this short book. I hope you have gotten something out of it. I have always taken great pride in making sure Medicare Beneficiaries understand how Medicare functions and how it applies to you. If you do not know your options then it is impossible for you to make an educated decision on which plan to choose. This is why I give Medicare Educational Seminars all over my area of residence, which is in the State of Connecticut. Due to the recent pandemic we have all unfortunately been exposed to, I have also started putting tutorials on Youtube, Facebook, and Linkedin.

As a former English teacher in South Korea, I learned early on how to take a complex subject and make it as simple as possible. My goal is to do the same for Medicare. I do not want to make Medicare more complicated than it has to be. You all deserve to have the knowledge necessary to make the right choice when it comes to your health. Hopefully I have provided that knowledge to you. Thank you.

About the Author

Kenneth Huffine is a Financial Advisor located in Vernon, Connecticut. During his 20's, he taught English in South Korea for two years and also served in the United State Navy.

After hanging up his Navy hat, he came home to Connecticut and has worked at Long View Wealth Management, LLC, which was founded by his Stepfather, Thomas Hardecker. His dream is to follow in his Stepfather's footsteps and continue to ensure seniors have a smooth transition into retirement.

As a Financial Advisor, he understands how important your health is when looking at your finances. When someone considers retiring, Health Insurance cannot be overlooked and this is what has driven his passion for specializing in the subject of Medicare.

He lives in Manchester with his wife, Christen, and their rescue dog, Honey.

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