MEDICARE
ENROLLMENT GUIDE
2021

PROVIDED BY

APEX
INSURANCE GROUP

APEX
INSURANCE GROUP

Thank you for utilizing this Medicare Enrollment Guide!

With a significant amount of experience in the Medicare industry, I have encountered quite a few Medicare recipients that weren't fully educated on how Medicare works when they turned 65.

The purpose of this guide is to provide you with the basic knowledge of enrolling into Original Medicare and deciding upon which corresponding health plans may make the most sense for you. This guide covers the most common enrollment types and is for educational purposes only. To complete an application, please contact my office so we can assist you. APEX Insurance is YOUR representative and here to help you in any way that we can. After all, we are the pinnacle for all of your health insurance needs.

I prefer to label myself as an educator and not a salesman, so I will never push one product over another. My goal is to provide you with the most pertinent information so you can make a logical and appropriate choice according to your specific needs. If there is anything you don't understand, please don't hesitate to contact me. I'm YOUR agent, representing YOU, and working for YOU.

After reading this guide, I want you to have a clearer understanding of Medicare, and the choices and decisions appropriate for your particular situation and individual needs. This guide has been written in an easy to understand and straight forward manner. If it doesn't answer your questions or doesn't fit your specific needs, please reach out to me for more information. Every case is unique and they can't all be covered in one short guide.

I either have the answers to your questions in this guide, or I can help you find them!

Thank you again,

Chris Eaton

APEX Insurance Group, LLC.
211 Nokomis Ave S
Venice FL 34285
(941) 221 - 9368
Chris@CoveredByAPEX.com
Website: CoveredByAPEX.com
Website: medicareenrollmentguide.com
Schedule Appointment: APEXCalendar.com

Table of Contents:

I. Who Qualifies for Medicare?
II. How Medicare Works – the basics
III. Medicare Costs
IV. How to Enroll
V. When to Enroll
VI. Advantage and Supplement Plans
VII. Supplement F – what happened to it?
VIII. Supplement G – the next best thing?
IX. Part D
X. The Donut Hole
XI. Penalties
XII. Important Facts to Know Before Enrolling
XIII. Conclusion

I. Who Qualifies for Medicare?

Those turning 65: Essentially, Medicare is designed for those that are aged 65 and older. If you're turning 65 soon and have been a United States legal resident for at least the last 5 years, then you likely qualify for Medicare Parts A and B. Your coverage begins the first of the month in which you turn 65. If your birthday is the first of the month, then your coverage begins the first of the prior month to your 65th birthday.

Example 1: *Sierra turns 65 on September 3, her Medicare begins September 1.*

Example 2: *Matthew turns 65 on December 1, his Medicare begins November 1.*

Those on Social Security Disability Income: If you've been collecting Social Security Disability Income (SSDI) for 24 consecutive months, then you're automatically enrolled in Medicare Parts A and B. You don't have to be aged 65 or older to qualify. Your coverage starts the first day of your 25th month on SSDI.

Example: *Greg has started collecting SSDI on April 1, 2018. His Medicare coverage begins on the first of the 25th month in which he has been enrolled in SSDI, which is April 1, 2020.*

Those over 65 and dis-enrolling from their employer's health plan: If you're currently enrolled in your employer's health plan, you don't have to sign up for Part B of Medicare when you turn 65. Most people sign up for Part A when they turn 65, and keep their employer's plan. When you decide to retire, have been given your notice, can no longer work, or simply are no longer covered on the group policy, you can enroll in Medicare Part B and then choose either a Supplement or an Advantage plan. Your coverage typically begins the first of the month following your loss of coverage from your employer's plan.

Example: *Sean has worked for the local grocery store for over 40 years and is on the company's group health insurance policy. They are covering the majority of his premium. He is now 70 and wishes to retire at the end of the year. He can enroll in Medicare with a January 1 effective date since his last day on the company's health insurance plan is December 31.*

II. How Medicare Works – the basics

Medicare consists of several parts. Each part has its own specific role and may come with a premium. Sometimes an individual may incur a penalty if not enrolled within a certain timeframe. We will cover the very basics of each part individually. There are extensive resources online and government publications regarding the different parts of Medicare. The following will give you a snapshot understanding of how each section works.

Part A: This portion of Medicare is known as hospital insurance. In general, it covers claims related to hospitals, nursing facilities, hospice care, and home health services. If you are hospitalized, this portion of Medicare is going to cover your inpatient care, such as semi-private rooms, meals, nursing services from the facility, medications that are part of your inpatient treatment, and any other services/supplies you receive from the facility you're in.

Part B: This portion of Medicare is known as medical insurance. In general, it covers medical services and supplies that are deemed medically necessary. Services and supplies such as: preventative care, outpatient services, ambulance rides, and durable medical equipment to name a few.

> ***Medicare Parts A and B are known as "Original Medicare" and only cover 80% of your medical expenses.*** **If you elect to keep only Original Medicare and don't enroll in additional coverage, you're responsible for the remaining 20% of your medical costs. There is NO cap on how much you can be responsible for paying for your medical bills. It's highly recommended that you enroll in a Supplement or Advantage plan.**

Part C: Part C of Medicare is a Medicare Advantage Plan. This replaces Original Medicare and is administered by privately owned insurance companies. They are required to cover the same medically necessary services and supplies as Medicare Parts A and B. Instead of a medical office or facility billing Medicare directly, they bill the administrator of the Advantage plan. Some Medicare Advantage plans also include a Prescription Drug benefit. Those plans are referred to as Medicare Advantage Prescription Drug Plans, or MAPD. Advantage Plans are covered in much more detail in section six (6).

Medicare Supplement Plans: This portion of Medicare is known as a "Medigap" policy and picks up where original Medicare ends. These plans cover the 20% of expenses that Original Medicare doesn't cover. A supplement plan will not cover your prescription medications, a Part D plan must be enrolled in for medications to be covered. Medigap/Supplement plans are explained further in section six (6).

Part D: This portion of Medicare is known as the prescription drug portion. This is what helps cover the cost of your prescription medications that you receive from a pharmacy. This does not cover the medications you received in and administered through a doctor's office; those are covered under Part B of Medicare.

III. Medicare Costs

Part A: Most enrollees don't pay a monthly premium for Part A. If you or your spouse paid Medicare taxes for at least 40 quarters while working, you don't have a Part A premium. This is commonly referred to as "premium-free Part A."

Note: *The 40 quarters do not have to be consecutive.*

At age 65, you can obtain premium-free Part A if:

- You are collecting retirement income from Social Security or the Railroad Retirement Board.
- Are eligible for retirement benefits from Social Security or the Railroad Retirement Board but haven't filed for them yet.
- You or your spouse had Medicare-covered government employment.

Below age 65, you can obtain premium-free Part A if:

- You have collected Social Security Disability Income, or Railroad Retirement Board disability income for 24 months.
- You have End-Stage Renal Disease (ESRD) AND meet certain requirements

For those who don't qualify for premium-free Part A, the premium breakdown is as follows:

Medicare Taxes Paid:	Premium:
< 30 quarters	$471
30 – 39 quarters	$259

Part B: Your Part B premium is determined by your income, and tax filing status from **two years prior** to the current year. The premium is adjusted every year, based on this information. That means, your 2021 Part B premium is determined by your 2019 income, your 2022 premium by your 2020 income, etc. The chart below illustrates this. If you wish to enroll in either a Medicare Supplement Plan, or a Medicare Advantage Plan, then you must pay your Part B premium and remain enrolled no matter which product you choose. These premiums are per person and not discounted even if your spouse enrolls in Medicare as well.

Use your income and filing status from 2019 to determine your 2021 part B monthly premium		
Individual Tax Return	Joint Tax Return	Your Part B premium
$88,000 or less	$176,000 or less	$148.50
$88,000 to $111,000	$176,000 to $222,000	$207.90
$111,000 to $138000	$222,000 to $276,000	$297.00
$138,000 to $165,000	$276,000 to $330,000	$386.10
$165,000 to $500,000	$330,000 to $750,000	$475.20
$500,000 +	$750,000 +	$504.90

IV. How to Enroll

If you are turning 65 and <u>not</u> collecting Social Security income: You can either enroll at your local Social Security office in person, or you can go directly to Medicare.gov and follow the directions below.

1. Go to Medicare.gov
2. Scroll down to the section labeled "Resources"
3. Click "Apply for Medicare"
4. Scroll down to the section labeled "How to Apply Online for Just Medicare"
5. Click the light blue button "Apply for Medicare Only"
6. Read through their terms and conditions
7. Check the box agreeing to the above statements
8. Click "Next"
9. Click "Start a New Application" under "Apply & Complete"

Important Notes:

- You will need your MySocialSecurity account information in order to apply for Medicare.
    - If you don't have a MySocialSecurity account, you will create one when applying for Medicare online.
- If you are over 65 and enrolling in Part B for the first time, you'll need to visit your local Social Security office, or call the Social Security hotline at 1-800-772-1213.
- You are not required to take Part B if you or your spouse is actively working for your/their employer and on the company health insurance plan. Keep in mind there is a penalty for signing up late for Part B if you haven't had "minimum Essential Coverage." We will discuss this further in later sections.
- There is an option to enroll in cash benefits. Be sure <u>not</u> to select it if you don't want to enroll in Social Security income!

V. When to Enroll

Turning 65: For those that are turning 65 and enrolling in Medicare for the first time, you have a 7-month window in which to enroll. This window consists of the three months before the month of your 65th birthday, the month of your 65th birthday, and three months after the month of your 65th birthday. The picture on the following page is an example of Sierra, born on September 3. This is called your "Initial Enrollment Period." I always recommend enrolling in Original Medicare at the beginning of this window. That way, you have plenty of time to receive your ID card and verify coverage begins when it should. This also gives you enough time to choose additional coverages, such as a Supplement or Advantage plan.

Initial Enrollment Period Example:

Sierra turns 65 on September 3. She is NOT collecting Social Security and wishes to enroll in both Original Medicare, and a Medicare Advantage Prescription Drug plan. She is eligible to sign up as early as June 1, and as late as December 31. If she enrolls during June, July, or August, then her Medicare effective date is September 1. If she enrolls in September, or the three months after she turns 65, her Part B coverage will be delayed and this could cause a lapse in her coverage.

- **If you are not collecting Social Security retirement income:** You'll need to enroll yourself into Medicare using the instructions provided and do so during your Initial Enrollment Period.
- **If you are collecting Social Security retirement income:** You will be automatically enrolled in both Parts A and B. If you don't want Part B because you have other coverage, then you can respond to the letter the Social Security office mails you with your Medicare ID card and decline enrollment into Part B. If they don't hear back from you, then your enrollment is automatic.

Collecting Social Security Disability Income: You will be automatically enrolled in both parts A and B. You should receive your letter of enrollment and your ID card two to three months prior to your 25th month on disability.

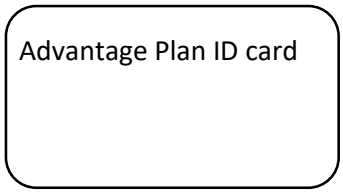
VI. Advantage and Supplement Plans

As discussed previously, when enrolling in Medicare, you purchase part A and B directly from Medicare, then you choose either an Advantage plan, **or** a Supplement plan to pay for claims that Medicare doesn't cover. No matter which one you choose, you must pay your Part A and B premium. Advantage and Supplement plans are very different from one another. I want you to understand the difference between the two so you can make an enrollment decision based on your opinion and comfort.

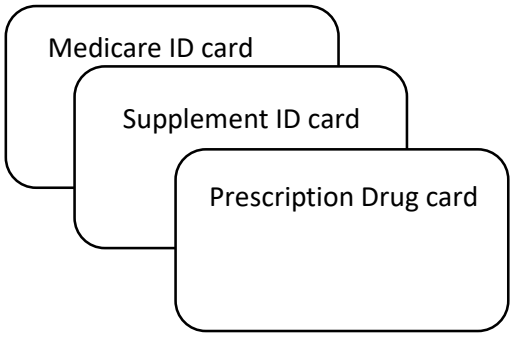
Medicare Advantage plans are also known as part C of Medicare. They replace your Original Medicare, which means Medicare isn't paying any portion of your medical bills, you share the cost with your Advantage plan. Supplement plans require you to pay your Part B Deductible, then Original Medicare to cover up to 80%, then the plan pays a portion, or all, of the remaining 20%.

Here's an easier way of looking at it. When utilizing your policy, with a Medicare Advantage plan, you present just the card provided by the carrier. When utilizing a Medicare Supplement plan, or Prescription Drug Plan, you present three cards.

Medicare Advantage:

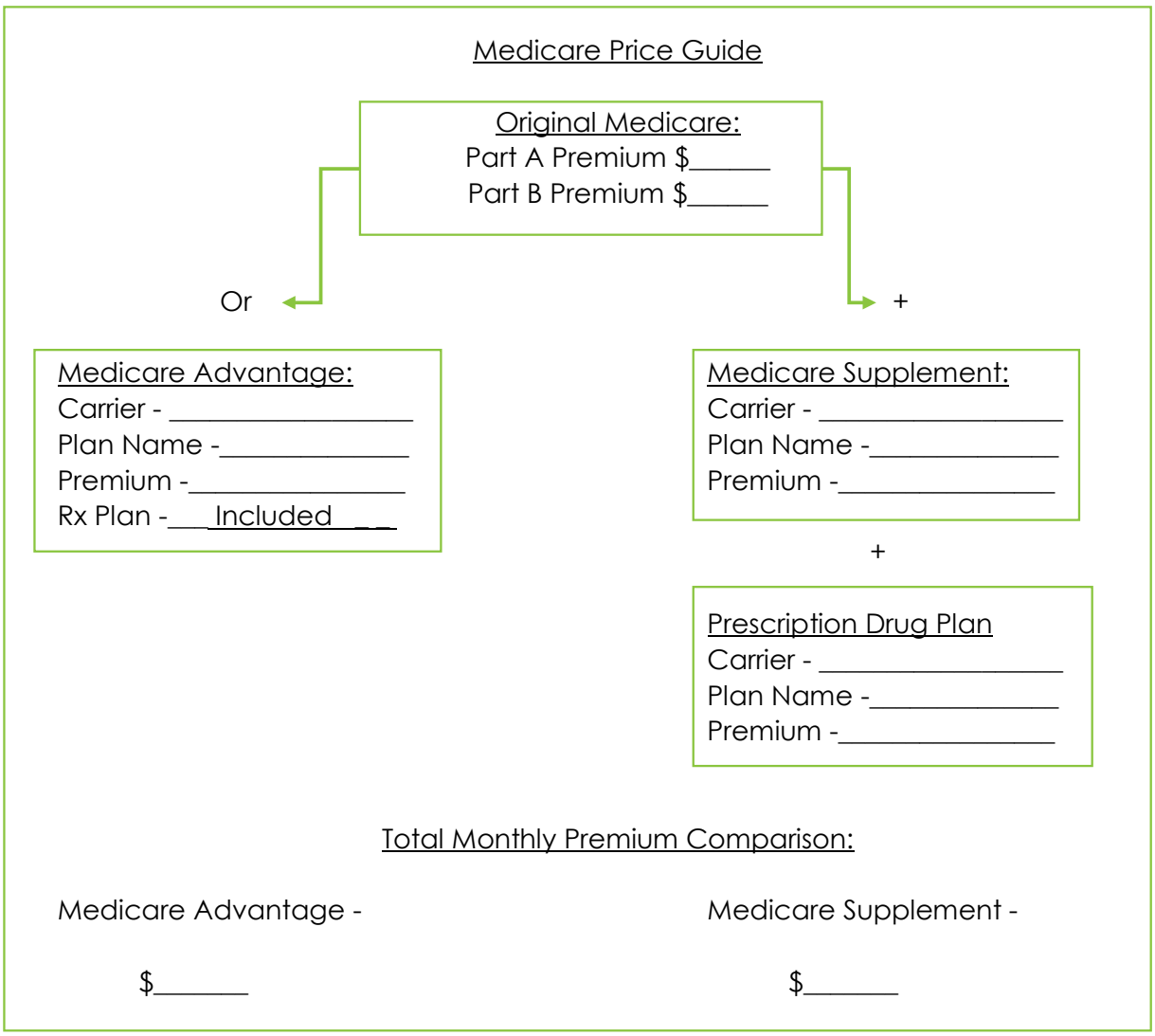


Medicare Supplement:



The enrollment option you make when you turn 65 may be the decision that you continue with for the rest of your life. It isn't always easy to switch plans if you decide your current one isn't performing like you had hoped. During the first six months of being enrolled in Part B of Medicare, you can get into a Supplement plan with no medical questions asked. Outside of that period, medical questions apply. I will cover this in more detail later.

Here is a flow chart that may give a better example of how choosing a plan works. You can use this in our meeting to write down the prices specific to the plan we select together.



Advantage Plans

Advantage plans are offered directly from an insurance carrier that is not government operated but is approved by the Centers for Medicare and Medicaid Services. Each Advantage plan is different, and each company is different. The county I live and work in has about 30 different plans to offer. Each year, agents are required to undergo training on each and every plan they are appointed with. I personally evaluate each plan, note the pros and cons, and determine which plan I think is the best for the new year. I can't state the name of it for 2021 in this book, but we can discuss it further in our meeting. The rest of this section is going to cover the basics of how Advantage plans work, the pros and cons, and what you need to know prior to enrolling.

Payment of Claims:

Advantage plans replace Original Medicare. When you obtain medical services, the provider does not bill Medicare, they bill you and the plan only. You are still required to pay the Part B premium, which is explained in another section. The company that operates the Medicare Advantage plan is responsible for negotiating charges, paying claims, enforcing copays, etc.

Premium:

It's very common to find plans that offer a $0 monthly premium.

This sounds too good to be true. Simply put, Medicare pays an insurance company for every member that enrolls in that company's Advantage plan. The company is then incentivized to get more enrollees, and thus charges no monthly premium for joining.

The total monthly premium cost of choosing an Advantage plan is very often just the Part B premium, which starts at $148.50.

Network:

Advantage plans have a list of providers that have agreed to accept payment from the plan at a negotiated rate. The doctors and facilities that agree to this payment schedule are considered "in network providers." If you receive services from an in network provider, you typically pay a flat rate, known as a copay. Receiving services outside of the plan's network, you typically pay an out of network deductible, then a copay or a certain percentage of the claim. Some plans offer the same out of network benefits as their in network benefits.

The participating providers may stretch across the entire country, like in most PPO plans, or they may be limited to a specific region in a state, like in some HMO plans. When we discuss Advantage plans, it's important to have your list of providers with you so we can check their network participation.

Deductibles, Copays, and the Maximum out of Pocket (MOOP)

A deductible is the amount you pay for covered healthcare services before your Medicare plan starts to pay. The Advantage plans I like, have $0 deductibles. This means you have a copay for most services rendered. A copay is a flat dollar amount you pay for a service rendered by a physician or medical facility. Amounts such as $5 at your primary care physician's office, $35 at a specialist's office, or $250 for an outpatient surgery. Each copay counts towards your maximum out of pocket, or MOOP. The maximum out of pocket is a financial cap, or financial limit, you have to pay for covered services in the plan year. This financial cap varies. Some plans have a cap of $4,900, whereas others have a cap of $6,700. Medicare plans operate on a calendar year basis. If you have met your deductible, or maximum out of pocket, keep in mind it will restart on January 1 the following year. Medication expenses do not count toward the maximum out of pocket.

Additional Benefits:

Advantage plans commonly offer additional benefits such as dental, vision, hearing, and the Silver Sneakers program. Dental and vision benefits may operate like traditional plans, such as having deductibles, copays, networks, etc. Other Advantage plans have cash reimbursement strategies that allow clients to see any dentist and/or optometrist. Silver Sneakers is a great addition to plans because the program encourages enrollees to participate in physical activities and events to keep them healthy and social. In our meeting, we can cover which plans have all of these benefits, and which don't.

Prescription Drug Plan:

There are two types of Part C (Medicare Advantage) plans, and they both follow the same outline already discussed. The two plans vary in what type of prescription medication coverage they offer. The two plans are:

1. Medicare Advantage Prescription Drug Plan (MAPD): These offer health benefits, as well as prescription drug benefits. That means you don't have to find an additional insurance policy to help offset the costs of your medications.
2. Medicare Advantage Plans (MA): These offer health insurance benefits but no prescription drug benefits at all. An additional plan must be purchased known as a stand-alone prescription drug plan or PDP. A PDP is purchased at an additional cost.

The most common type of plan is an MAPD plan. Be careful when signing up for a plan and be sure you ask if it offers prescription drug coverage.

Advantage Plan Touchpoints:

- Typically offered with no, or low premium, even for MAPD plans.
- There is a list of providers that participate in that plan's network. Seeking out providers in the network grants you access to lower medical expenses.
- Medicare Advantage plans are a "pay as you go" type of insurance. You only pay for the services you need, when you need them. You're not paying a high premium for an additional plan that you're not using.
- You COULD spend over $6,000 in one year by having an Advantage Plan. This would be tough to do though since most plans have copays for the majority of their services.
- Advantage plans offer additional benefits that Supplement plans typically don't offer, like dental, vision, hearing, and the Silver Sneakers program.
- A prescription drug plan is included with some Medicare Advantage plans, and commonly at no additional cost.

Here's a quick example of one scenario I have seen many times:

> *Mike is now 70 and has been on an Advantage Plan for five years. His monthly premium is $0 and he sees three doctors a year. The first, his primary care physician, he visits for his annual physical and lab work. The second, his cardiologist, he visits because heart disease runs in the family. And his third, his dermatologist, because he lives in Florida and frequently visits the beach.*
>
> *At his Primary Care Physician, he pays $0 since it's an annual physical. At the other two visits he pays $35 each. Over a 12 month period Mike has spent only $70 on all of his medical expenses. That includes his Advantage Plan's premiums and doctor visits but excludes any medications he may be taking.*
>
> *If Mike had enrolled in a Medicare Supplement plan, in my area, he would be paying around $175 a month for Supplement Plan G, and $18 a month for a Prescription Drug Plan. That's $2,316 per year in premiums alone for 2021. For Mike's situation, he feels much more comfortable being enrolled in a Medicare Advantage Plan due to his low annual cost and the fact he is healthy. Over five years he would have spent $11,580 in premium!*

The pros of Advantage Plans:

- They're inexpensive! There may be a plan in your area for $0 per month. If a low monthly premium is important to you, then there may be a plan out there you can afford.
- They are widely recognized by providers. You have to choose the right plan of course, but many doctors and facilities participate in the plan networks.
- It would be difficult to reach the out-of-pocket maximum since the copays are relatively affordable.
- They normally offer additional benefits, such as dental, vision, hearing, and the Silver Sneakers program.
- Prescription drug coverage is included, and normally at no additional cost.

The cons:

- Even though they may have a large number of providers that participate in network, some enrollees want to see providers not in the network.
- If you are needing frequent medical services, the copays may become frustrating to pay each visit. But it's important to look at the overall cost compared to what you would pay for a Supplement Plan.
- Depending on the plan, you may need a referral to see a specialist.
- Once you enroll and have a major medical bill, you typically can't switch out of them to a supplement plan. This is covered in more detail in a later section.

Supplement Plans

Supplement plans are offered directly from an insurance carrier that is not governmentally operated but is approved by the Centers for Medicare and Medicaid Services. The different Supplement Plans, however, are designed and regulated by the federal government. Each Supplement Plan is slightly different, but plan designs are exactly the same amongst the different carriers. No carrier can change the plan design. Plan G from one carrier, is the exact same design and benefit structure as Plan G from all of the other carriers. The rest of this section is going to cover the basics of how they work, the pros and cons, and what you need to know prior to enrolling.

Payment of Claims:

Once your Part B deductible has been met, $203 for 2021, Original Medicare pays 80% of the Medicare-approved amount, while your Supplement Plan may cover all, or some, of the other 20%. You would have three different ID cards, one for Original Medicare, one for your Supplement, and one for your Part D plan.

Premium:

Even though each plan must be offered in the exact same way between different carriers, the premiums vary. Premium isn't the only important factor though. Carriers can add additional benefits and track the performance of your medical care. Others have brand awareness and attract members by that alone.

The total monthly premium cost of choosing a Supplement plan is the Original Medicare premium, plus the supplement premium, plus a stand-alone prescription drug plan.

Network:

Supplement plans do not have a specific list of providers. Any doctor, or facility that accepts Original Medicare, will accept your Medicare Supplement plan. The Medicare-approved amount is the amount providers receive as reimbursement for their services. The carrier that administers your plan has absolutely nothing to do with what providers you can be treated by. This is true across the entire county and for all insurance carriers.

Deductibles, Copays, and the Maximum out of Pocket (MOOP)

Since Supplement Plans vary, refer to the following chart for a better description of each plan. All require the Part B deductible, some require $20 copays at a doctor's office, and some don't cover the Part B Excess Charges.

Q: What are Part B Excess charges?

A: A doctor can legally charge up to 15% above the Medicare-approved amount. These are the excess charges. If your plan doesn't cover this, then the cost is yours to bear.

Additional Benefits:

Supplement plans don't typically offer additional benefits such as dental, vision, or hearing. There are some carriers that do offer the Silver Sneakers program at no additional cost, however.

Supplement Plan Touchpoints:

- Premiums vary amongst carriers, but all plan designs are the same.
- You can receive care from any provider that accepts the Medicare-approved amount.
- You pay a much higher premium compared to an Advantage plan, but your fees for services are much lower over the calendar year.
- One plan has a maximum out of pocket of $198, whereas some plans may not have a maximum.
- Only a few carriers offer the Silver Sneakers program, whereas most don't offer any additional benefits.

Here's a quick example of another scenario I have seen many times:

> *Tyler is now 70 and has been on a Supplement Plan for five years. His total cost for his Supplement, and Prescription Drug Plan, is about $200 per month. He sees the doctor regularly due to certain medical concerns. On average, he visits a doctor once a week, has one hospital stay per year, and has a history of high medical bills.*
>
> *He chose a Medicare Supplement Plan that requires him to pay the Part B deductible one time per year. His total medical expenses for 2021 will not exceed $203 since he always visits providers that accept Medicare. His medication expenses are separate of course.*
>
> *If Tyler had enrolled in a Medicare Advantage plan, he would be constantly paying for his services. His monthly medical bills may exceed the $200 that he is paying as a premium for his Supplement and drug plans. For Tyler's scenario, it makes more sense financially to have a Supplement plan.*

To choose a Supplement Plan over an Advantage Plan does not have to be due to the expectation of high medical claims. Many of my clients are already paying a very high premium with their individual insurance and save hundreds a month when they turn 65 and choose a Supplement Plan. These clients still see it as a savings, even if they only visit their doctor a couple times a year.

Switching to a new supplement plan:

Let's assume you've been enrolled in Medicare and have an additional plan, Supplement or Advantage, it doesn't matter. At some point in the future, you decide that switching to a new supplement plan is the best option for you. Whether you have an Advantage plan and don't like it, or have a Supplement plan that has become too expensive, whatever the reason, you want a new Supplement plan. If you signed up for Medicare Part B within the last six months, you can get into a new Supplement plan without having to answer medical questions.

This is called Guaranteed Issue Rights.

The pros of Supplement Plans:

- It's easier to budget monthly since your expenses are relatively fixed.
- There are many providers across the country that accept Medicare. Finding a provider is extremely easy.
- The costs for medical services are very low when enrolled in the proper plan.

The cons:

- Some of my clients can't afford the monthly premium of Original Medicare, a Supplement, AND a Prescription Drug Plan. This is the most common reason I see when a client doesn't choose a Supplement.
- They typically don't offer additional benefits.

VII. Supplement F – what happened to it?

You may have heard about this wonderful Supplement Plan, called Plan F. Enrollees love this plan because they don't experience medical bills for any Medicare approved services. It was the most enrolled in Supplement Plan amongst my clients over the last six years. But it can no longer be enrolled in for those turning 65. Why? What happened?

To make a long story short, the federal government passed a law in 2015 that stopped Medicare recipients from enrolling in "first dollar" Supplement Plans. Those are plans C and F. This law took effect on January 1, 2020. If you were born in 1954 or sooner, you can still enroll in one of these plans. If you were born after 1954, you are not eligible for these plans. I believe that the Medicare agency recognized these two plans were being abused by enrollees since the enrollee doesn't have any financial obligation when seeking Medicare approved medical care. The enrollee may have been using the plan even when not truly necessary. Over a nationwide scale, this was costing billions of dollars to Medicare.

All Supplement plans offered require the enrollee to pay the Part B deductible. This deductible is the first $203 of your medical care in 2021. Having the enrollee pay this deductible saves Medicare billions of dollars per year.

Q: If I currently have Plan C or F, should I switch?

A: If the premium of the new plan and paying your Part B deductible is less than your total premium now, then it may be a good idea to switch.

Simple math example:

Plan F premium = $200 per month, $2,400 annually.

Plan G premium = $175 per month, $2,100 annually.

Plan G requires the enrollee to pay the $203 Part B deductible.

$2,100 + $203 = $2,303.

Since $2,303 is less than $2,400, it may make more sense for an enrollee to switch.

(This scenario is for example purposes only. The deductible may change annually. Rates change annually, and all rates are subject to underwriting approval.)

Plan Name	A	B	D	F	G	K	L	M	N
Basic Benefits	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	50%	75%	✓	Copay
Skilled Nursing			✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible				✓					
Part B Excess				✓	✓				
Foreign Travel Emergency			✓	✓	✓			✓	✓
Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓

VIII. Supplement G – the next best thing?

Since Supplement Plan F is not available to everyone, I discuss Plan G with my clients as the next best plan option. If you're going to enroll in a Supplement Plan, why not choose one that you're going to get your monies worth out of? A Supplement Plan's premium is much higher than typical Advantage Plans (in my area), which is why I see it fit to enroll in the plan that gives you the best bang for your buck. Supplement Plan G is just that.

The only difference, as you can see from the chart, between Supplement Plan F and Supplement Plan G, is the Part B deductible. Plan G requires you to pay this deductible each year. For 2021, the Part B Deductible is $203, up $5 from 2020.

This amount is your financial responsibility only once per year. As soon as you have paid the first $203 for your medical treatment, Medicare and your Supplement plan will pay the remainder of your medical bills as long as they are medically necessary, and Medicare approved.

IX. Part D

"Part D" is the prescription drug portion of Medicare. This is the type of coverage that helps you pay for your medications prescribed by a doctor's office. This portion does not normally cover the injections administered in a doctor's office. It is designed for the medications delivered through a pharmacy.

As discussed in other sections, depending on which type of health plan you choose will determine whether you are, or need to enroll in Part D. A Medicare Advantage Prescription Drug Plan has Part D included in it, so no other plan needs to be purchased. But a Medicare Supplement Plan does not include Part D, so a separate Part D plan should be enrolled in. If you choose one carrier for your Supplement Plan, you do not have to choose that same carrier for your Part D Plan.

A useful tool for choosing a Part D plan is on Medicare.gov. I walk all of my clients through a calculator to find the plan that best fits their needs. You may find a plan offered in your county for $17.40, as an example. Even though it's the most affordable plan you found, it may not cover your medications at an affordable rate or may have a high deductible.

Tiers: Every carrier is required to organize medications into different "tiers." A tier 1 medication is generic. As the tier number increases, so does the cost of the medication. Plans will have either a 5-tier, or a 6-tier formulary. Your medications may fall under a different tier with different companies. I can show you what your medication costs will be during our meeting.

Deductible: Most plans will have a "deductible." This is the amount that you pay first, before the plan pays any portion of your medication. With some plans, a tier 1 and tier 2 medication are not subject to the deductible.

Copays: A copay is a flat dollar amount that you pay for that specific item/service. If your plan document says "$5 copay" next to a specific tier, then you pay $5 for any medication that falls under that tier.

Enrolling in Part D is optional, just like Part B. However, there is a late enrollment penalty once you do sign up for a prescription drug plan at a date later than when you initially become eligible. The penalty is 1% of the national average for a drug plan, times the number of months you've been without coverage.

Late enrollment penalty example:

Cory turned 65 in February of 2017. He chose NOT to enroll in a Part D plan since he wasn't taking any expensive medications at the time. It is now October 2019 and he wishes to enroll in a Part D plan. Enrolling in a plan during the annual enrollment period results in coverage beginning January 1. This means, Cory will have been without Part D coverage for 35 months.

The penalty is the number of months you've been without coverage, times the "national base beneficiary premium." That amount is $32.74 for 2020. This penalty is paid monthly and lasts the entire time you're enrolled in a Part D plan. It is also rounded to the nearest $0.10. The penalty is recalculated every year. Cory's penalty calculation is as follows:

35 months x 1% per month = 35%

35% x $32.74 = $11.46

$11.46 rounds to $11.50

This means Cory will pay $11.50 per month for all of 2020. The penalty is adjusted each year as the national base beneficiary premium changes. If Cory continues coverage for the rest of his life, then the Part D penalty will never go away for him.

X. The Donut Hole

The infamous donut hole! It's important to note that not all Medicare enrollees will experience the donut hole. But it is good for everyone to know the basics and understand what the donut hole is.

There are different phases of prescription drug coverage. This is true for both Medicare Advantage Prescription Drug plans, and stand-alone drug plans. The donut hole is a coverage "gap" that occurs once the insured and the insurance carrier have paid a certain amount towards covered drugs. We are talking about the total cost of the medications. If your copay is $5, and the carrier pays $20, then we are discussing the full cost of $25.

Phase 1: Deductible phase

Some plans have a prescription drug deductible, which is a flat dollar amount. You pay for 100% of the cost of your medication until the deductible has been met. If you have a $450 deductible, and a $500 medication, you pay the first $450, then a certain copay, or a percentage of the remaining amount. The total cost of all of your medications count towards the deductible.

Example: Cindy is prescribed a $1,000, tier 5 medication. Her plan has a $445 deductible, and a 30% fee for tier 5 medications. At the pharmacy, she pays $445, then 30% of the remaining cost, which is $166.50. Her cost for this medication is $611.50. The total cost for this medication is still $1,000.

Phase 2: Initial Coverage Stage

After you've paid your plan's deductible, you will enter the initial coverage stage. During this period, you pay a copay (flat dollar amount), or coinsurance (percentage of total cost), for your medications. Once the total cost of all of your medications, including the cost during your deductible stage, total $4,130, you will enter stage 3.

Example Continued: Cindy's tier 5 medication, in total, costs $1,000. During this stage, she only pays the coinsurance of 30%. Which is $300. Once she fills this medication enough times, so the total cost has reached $4,130, even though she's only paid $300 for the last refills, she enters the donut hole.

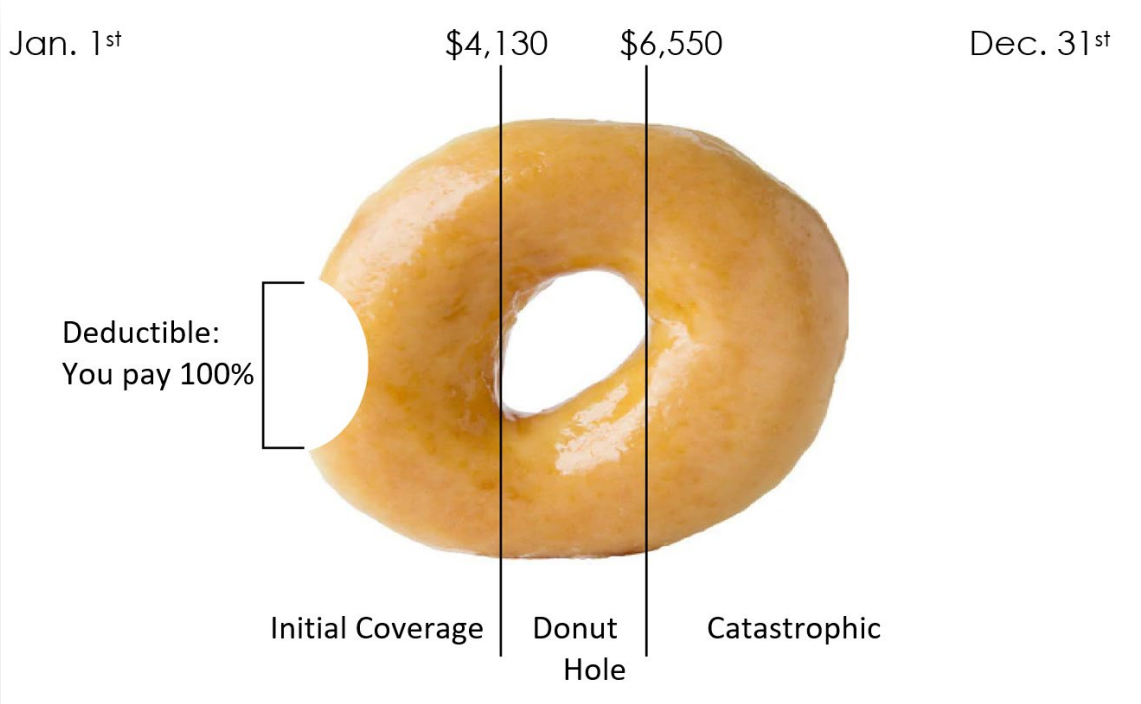
Phase 3: Donut Hole

After the total cost of all of your medications reach $4,130, you will enter the coverage gap, or donut hole. During this stage, you will not pay more than 25% of the cost of any prescribed medications. This is true for both generic, and brand name medications. The amount you pay for a generic medication is the only dollar amount that Medicare counts towards you leaving the donut hole. Whereas with brand-name medications, both your 25% cost, and a discount that the manufacturer provides count towards you leaving the donut hole. 95% of the total cost for a brand-name medication counts towards the total out of pocket costs. Once your total out of pocket costs reach $6,350, you will exit the donut hole.

Example Continued: During the donut hole stage, Cindy will pay no more than 25% of the cost of her medication, which is $250. 95% of the total cost of her medication, which costs $1,000 total, will count toward Cindy leaving the Donut Hole. That means, $950 counts towards the calculation. If Cindy is taking a $10 generic medication, and paid $2.50 for that medication, then only $2.50 counts toward the calculation.

Phase 4: Catastrophic Coverage

Once the total cost of your medications reaches $6,550, you will enter the Catastrophic Coverage phase. During this phase, you pay a small copayment, or coinsurance, for the remainder of the year.



To find out if you will enter the donut hole, I highly recommend going to Medicare.gov and inputting your medications in the "Find Health and Drug Plans" section. You'll need to select a specific plan in order to see if you'll enter the coverage gap. I also complete this calculation when meeting with clients.

XI. Penalties

There are certain penalties that apply if you don't enroll in specific areas of Medicare when you first qualify. All penalties discussed below are paid per month, and for the rest of the time you're enrolled in that plan. There are only two penalties you should be aware of, late enrollment into Part B, and late enrollment into a Part D plan.

Late enrollment into Part B of Medicare:

The Part B Late Enrollment Penalty applies to those individuals that don't sign up for Part B when they're first eligible. The penalty is applied monthly, and for the entire time that you have Part B. In almost all cases, that means for the rest of your life.

The penalty:

Your Part B premiums may go up 10% for every full 12-month period that you could have been enrolled in Part B but didn't apply for it.

How to avoid it:

Have "minimum and essential coverage" when you first turn 65. That means, have a health insurance plan that meets the Medicare guidelines when you first become eligible. Coverage from your or your spouse's employer is the most common type of alternative coverage to have. You'll need to show proof that you have had minimum essential coverage when you do enroll in Part B. Otherwise, to avoid the penalty, you must enroll in Part B during your Initial Enrollment Period, which is when you turn 65.

Important Note:

In order to avoid the Part B Late Enrollment penalty, which applies to those who enroll in Part B after their initial enrollment period, you must answer YES to BOTH of the following questions:

1. Are you enrolled in yours or your spouse's employer health plan?
2. Are you or your spouse actively working for this employer?

Having COBRA coverage does not consider you having minimum and essential coverage. You or your spouse must be actively working to avoid the penalty.

Late enrollment into a Part D plan:

This penalty applies to those that do not enroll in a qualified Part D plan nor do they have a health plan with creditable prescription drug coverage. If you don't enroll into a Part D plan, or a Medicare Advantage Plan with Prescription Drug coverage, then you will not experience the penalty until you are enrolled in one of these plans. The Part D Late Enrollment Penalty is calculated once you enroll into a plan with drug coverage. It may be 10 years after you enrolled in Medicare that you're finally choosing a plan with this coverage. At that time, your penalty is applied to your Medicare Part D monthly premium and remains in effect until you disenroll from Part D entirely.

The penalty:

The premium is a somewhat tricky calculation and may be a little confusing. But here is what Medicare.gov states: "The cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($33.06 in 2020) times the number of full, uncovered months you didn't have Part D or creditable coverage. The monthly premium is rounded to the nearest $0.10 and added to your monthly Part D premium. The national base beneficiary premium may increase each year, so your penalty amount may also increase each year."

Example: Bryan signed up for Medicare when he first turned 65 in June of 2017. He enrolled in a supplement plan but did not enroll in a stand-alone prescription drug plan since he wasn't taking any medications and thought it would be financially wise to save the premium. Roughly two years later, during the annual election period of 2019, he decides to enroll in a drug plan since he is now taking expensive medications.

Since Bryan was without creditable prescription drug coverage from June 2017 – December 2019, or 31 months, his penalty in 2021 is 31% of $33.06, or $10.25. However, the penalty is rounded to the nearest $0.10, so he will pay $10.30 per month in 2021.

Here is the calculation:

0.31 (31% penalty) x $33.06 (2021 base beneficiary premium) = $10.25

$10.25 rounded to the nearest $0.10 = $10.30.

XII. Important Facts to Know Before Enrolling

There are some very important factors you should know before enrolling in either an Advantage plan, or a Supplement plan. Your decision may be made pretty quickly depending on your situation. I created a list of the most important things to consider before a final decision is made as your initial decision effects the rest of your Medicare experience.

1) Keeping just Original Medicare and NOT purchasing an Advantage or Supplement plan is NOT a very wise financial decision for most individuals.
    a. As stated previously, Medicare is only going to cover up to 80% of your medical bills. That means YOU are responsible for the other 20% and there isn't a maximum out of pocket on this amount! If you have a $100,000 procedure, you are responsible for $20,000. Sticking with just Original Medicare can be very costly in many circumstances.
    b. If you truly wish to keep your monthly premiums low but don't want to be responsible for 20% of a large medical bill, then you should be able to find an Advantage plan that offers a $0 monthly premium. You may not use your plan, but it's a safety net in case of a major medical claim. Would you rather pay $4,900 with an Advantage plan, or $20,000 with just Original Medicare?
2) You can switch from one Advantage plan to another and from one Prescription Drug plan to another during the Annual Election Period each year.
    a. If you're in one of these plans and want to switch to another plan for any reason, you can do so very easily. Between October 15 and December 7, you can elect to switch to a different plan, even if offered from a different carrier. You can also switch to an Advantage plan from a Supplement plan during this period relatively easily. When enrolling into a new Advantage plan, or a new prescription drug plan, Medicare notifies your previous plan so you don't have to.

3) You should shop your Advantage plan or Prescription Drug plan during the Annual Election Period each year but particularly if any one of the following occurs:
    a. If your medications have changed.
        i. Since every plan is different, your medications will be covered differently on each plan. What was a good plan for you last year, may not be a good plan for you next year. Your new medication may be a tier 3 with your current plan and cost you $40 per refill after a $450 deductible, or it could cost $30 per fill after no deductible on another plan. It doesn't hurt to shop!
    b. If your doctors have changed.
        i. The doctor you prefer to see may be part of a new physicians group which doesn't accept your plan. They may accept another plan that has similar benefits.
    c. If you have moved.
        i. If you move and your plan is not offered in the new area you're in, you are required to switch plans anyway. But if you move within the same county and find that the provider network is not very strong in the new area, it may be wise to switch during the next Annual Election Period.
4) You can switch to a new Supplement plan during any time of the year, but it's not always the easiest to do because it isn't a guaranteed enrollment.
    a. If you enroll in a Supplement plan when you first turn 65 you have what's called guaranteed acceptance. Since you're new to Medicare, you are automatically qualified to enroll in that Supplement plan no matter your health. But if you want to switch in the years to come, you can do so any time, but you must answer the health questions on the new application. (Your carrier may allow you to switch plans within their company without these questions, but not all carriers allow this.)

        These questions may cover health events such as:
        - Are there surgeries that have yet to be performed?
        - Has there been any hospitalization within the last 24 months?
        - Have you been diagnosed with cancer in the last 5 years?

        There are other questions to consider as well. It's very easy to answer yes to some of these questions. **If any answer is yes, then the carrier has the right to deny your application and you must stay with whichever plan you're enrolled in.** Even if you answer no to all questions, you may still be denied enrollment. The insurance carrier verifies your eligibility through their own research. Depending on their findings, you could still be denied. You can switch to an Advantage plan if you wish instead.

XIII. Conclusion

The enrollment process may be challenging. To help summarize the above information, here are the first steps to get started:

1. Highlight or mark any confusing areas/questions you found while reading this guide.

2. Sign up for Medicare **Part A** and **Part B**.

    *Remember, if you are collecting Social Security, this is done automatically.

3. Schedule an initial appointment to discuss and find an enrollment option that fits your specific needs.

    *More than one meeting is routine to ensure the plan chosen is what is best for you.

As you can see, selecting the most appropriate Medicare plan requires some research and information gathering on your part. This guide is intended to provide you with an easy to understand start for your selection process.

For additional information, please contact me at:

Chris Eaton
Agency Owner
APEX Insurance Group
211 Nokomis Ave S
Venice FL 34285
(941) 221 – 9368
Chris@CoveredByAPEX.com

"The pinnacle for all of your health insurance needs!"

If you would like to schedule an appointment to discuss your Medicare enrollment, please visit APEXCalendar.com. You can schedule an in office appointment, phone call, or zoom meeting.

APEX
INSURANCE GROUP