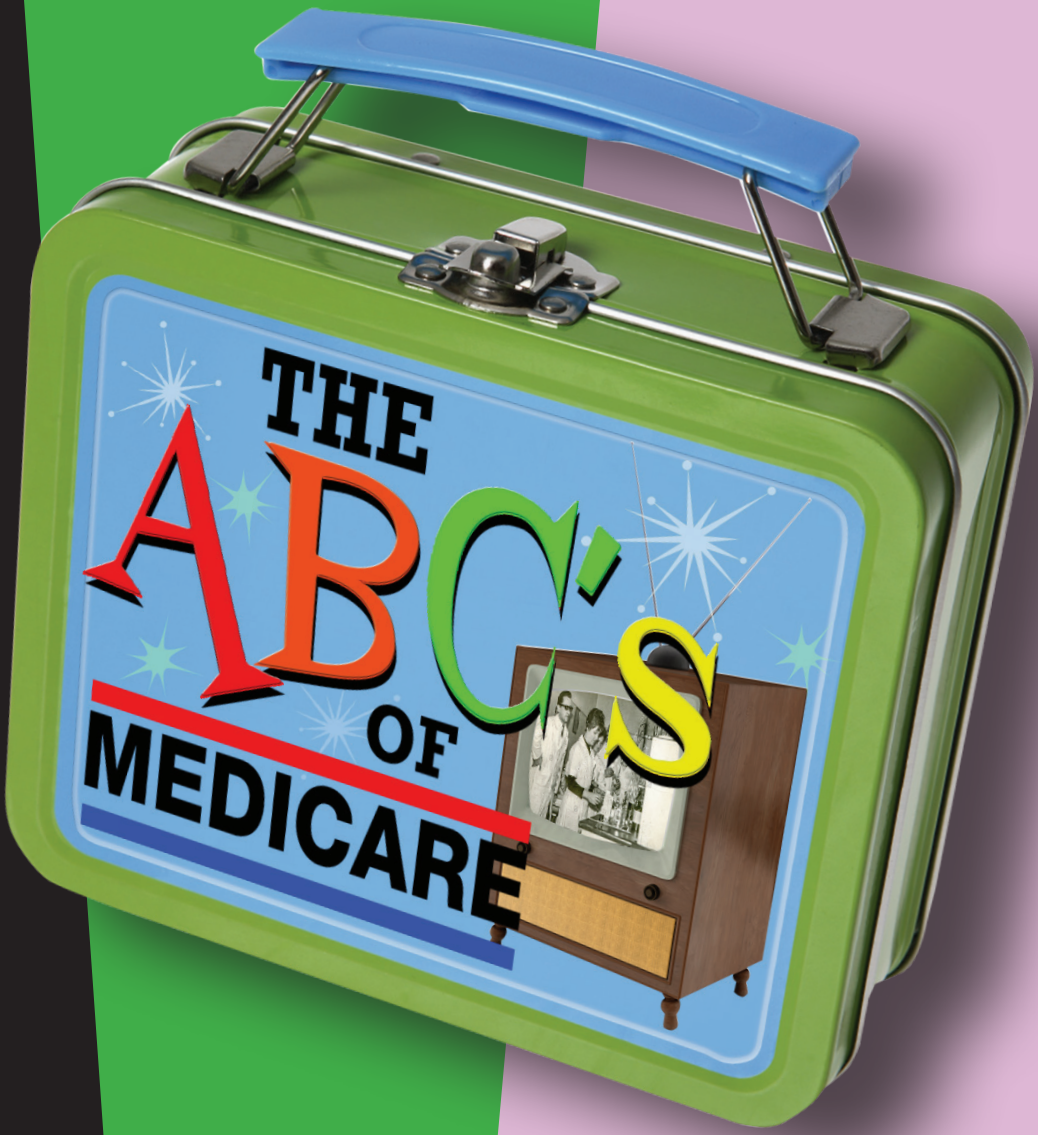

By

Bob Garrison

The pre-eminent guide to Medicare.

Contents

I believe you should get all you deserve from the Medicare system. After all, you earned it!

Introduction

Hi. I'm Bob Garrison. I wrote this book, and I want to tell you why.

Many years ago, way before I started my own insurance agency, I assisted my parents with their insurance needs. I ultimately became the care provider for my father. At the time, I had no idea how Medicare worked. And for sure, I didn't know what Part A and Part B or the rest of the alphabet menu of options were, or if you even needed them. I had a lot to learn and, as it turns out, I was not alone.

Medicare can be bewildering, to say the least. For over a decade now, I have been helping people navigate its mysteries. In my experience, nearly 100% of the folks I talk with are confused by Medicare. They become even more confused by reading the advertising mailers they receive and the TV commercials being broadcast.

Most folks are skeptical of Medicare and think the health insurance they got through their employer or by personal purchase is better. In the majority of cases, that is simply not true. Pairing Medicare with the correct supplement plan and drug plan can provide exceptional insurance coverage. But you MUST make TIMELY decisions or face the potential of poor coverage and a lifetime of penalties.

An all-too common story with an ending you don't want

One of my newer clients told me that, as he got closer to retirement, he spent a bunch of time reading about Medicare from both brochures and on line. He thought he understood most of the concepts.

When he turned 65, he was automatically signed up for Medicare Part A. But because he was still working, and had decided to retire at 66, he put off signing up for Part B until he was past the deadline. When he eventually signed up for Part B, he was slapped

with a 10% late penalty because he did not have an employer health plan. And that penalty was not for just the first year, but annually for the rest of his life!

Sadly, this is a common mistake made by many new retirees. If he had sought my help before he was 65, he could have saved himself from a long list of hassles, as well as unnecessarily spending serious money.

Why I wrote this book

My objective in writing this book is to help people fully understand how Medicare works. I took existing information about Medicare that is often confusing or worse, and made it easier to understand.

That said, this book also covers the most common rules and regulations, using real life examples of how Medicare can work to your advantage. Do I cover every possible scenario? No. Specific cases can be complex, and should be discussed with a qualified Medicare advisor. But I do present enough information for you to make good Medicare choices.

Chapter One

Medicare History, Eligibility, Parts and Pieces

The story of enacting Medicare is one of persistent political struggle and 11th hour compromise. There was growing recognition in the late 1950s and early 1960s of the need for federal action to help ease the high cost of healthcare for the nation's elderly. But there were sharply different views about how to do it.

After months of deliberations, Congress struck a compromise that created Medicare in two parts. Part A of Medicare was a hospital insurance program. Part B covered outpatient physician services through a supplementary program that embodied the principle of voluntary participation by doctors and patients. Today, these two parts (A and B) are called "Original Medicare." (Congress also created a program for means-tested assistance that became the blueprint for the Medicaid program for low-income families with children, as well as the aged, blind and disabled.) President Johnson signed the bill into law on July 30, 1965.

Over the years, Congress made changes to Medicare and more people became eligible. In 1972, Medicare was expanded to cover the disabled, people with End-Stage Renal Disease (ESRD) requiring dialysis or a kidney transplant, and people under 65 who are on Social Security disability.

In 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act. This act updated Medicare to include a prescription drug plan called Part D, and Part C, which are Medicare Advantage plans. Medicare Parts C and D will be explained in detail later in this book.

In the coming months and years, Congress will no doubt make changes to Medicare and Medicaid to address many issues such as premiums, deductibles and how to handle the enrollment of many millions of retiring Baby Boomers (those born approximately 1946 through 1964). As a health insurance professional, one of my jobs is to notify my clients of those changes and adjust coverage, if necessary.

Who is eligible for Medicare?

- Medicare is health insurance for...
- people 65 or older;
- people under 65 with certain disabilities;
- people of any age with End-Stage Renal Disease (ESRD) and those who are on Social Security disability.

What does Medicare cover?

Medicare is different from your traditional health insurance (employer provided or personally purchased) because it comes in many parts and pieces. Each is designed to address specific health-care needs.

If you had experience with the Affordable Care Act (ACA also known as Obamacare), you may have seen higher premiums and higher deductibles than were initially projected. As you transition from ACA or another plan to Medicare, you will discover that, when done right and paired with a good supplement and Part D drug plan, you can get better coverage at lower cost.

Part A helps cover inpatient care in hospitals, and also includes skilled nursing facility (SNF) care, hospice care and home health care.

Hospitalization—It covers the first 90 days of an inpatient hospital stay with a deductible of $1316.00 (effective in 2017) for each individual hospital stay. Therefore, an additional hospital stay

would result in an additional $1316.00 deductible. Beginning day 61 through day 90 of a hospital stay, a co-pay of $329.00 per day is required. After 90 days the co-pay increases to $658 per day for a maximum of 60 lifetime reserve days.

Skilled Nursing—There is a fairly complex formula as to what and for how long skilled nursing coverage is available. A Medicare advisor can be a big help here. But, basically, after a required minimum three-day hospital stay, Medicare will cover up to 20 days of skilled nursing care at 100% coverage at a Medicare approved nursing home. After the 20 days, the coverage level is reduced and ends at 100 days.

Part B helps cover services from doctors and other health care providers, outpatient care, home health care, durable medical equipment and some preventive services. Part B accounts for the majority of all Medicare spending.

Part D is the plan that helps pay for prescription drugs. These plans can be complicated because there are coverage gaps and deductibles and specific formularies. I am going to talk more about Part D later in this book. You can also go to Medicare.gov and find a list of the Part D plans available in your area.

Part C refers to Medicare Advantage plans offered by private insurance companies that contract with Medicare to provide you with all your Part A and Part B benefits. About 35% of the nearly 50 million people currently on Medicare have enrolled in an ad-vantage plan and the numbers are growing.

Medicare Advantage plans may offer extra coverage, like vision, hearing, dental, and/or health and wellness programs. However, many people are surprised to learn that Medicare does not cov-er long-term care for people who need to go into nursing homes indefinitely because they are disabled or can no longer take care of themselves. Medicare also does not cover daily custodial care, such as assistance with eating, bathing and dressing.

What are the gaps in coverage?

Original Medicare (Parts A and B) without a supplement has a number of gaps where the coverage does not apply, or applies only to a portion of the cost. These gaps can be quite costly for people without additional coverage such as a Medicare Advantage plan or Medigap supplement.

I explain Medicare Advantage (Part C) and Medigap plans in Chapter 4.

Does your doctor accept Medicare?

Medicare officials say the number of doctors who don't accept Medicare is very small. According to their figures, only about 4% of U.S. doctors don't participate and most beneficiaries (as patients are called in Medicare lingo) can see the doctors they want.

Still, a report by the Medicare Payment Advisory Commission, an independent congressional agency, shows that 28% of beneficiaries seeking a new primary-care physician last year had trouble finding one who accepted Medicare from new patients. For example, while nearly 80% of the Texas Medical Association's doctors were taking new Medicare patients in 2000, fewer than 60% in 2016 were. It seems there are pockets of the country, primarily in wealthier urban areas, where a growing percentage of doctors no longer takes any insurance, regardless of their patients' ages.

Chapter Two

When and How to Get Basic Medicare

Medicare eligibility for most Americans begins at 65.

During your turning 65 open enrollment, you can enroll in person at your local Social Security office, by phone or better yet, enroll online. Simply go to SSA.gov and click on menu, select Medicare and go to the bottom and click on Apply for Medicare only. This process takes less than 10 minutes and you can sign up for Part A and or Part A and B.

If you did not enroll during the initial open enrollment period, you need to call or visit a local Social Security office. If you are enrolling in Part B using a special enrollment period because you have lost employer group coverage you are not subject to a late enrollment penalty but you are required to provide a Medicare enrollment application and a request for employment verification form. This form is proof of group health coverage by your employer.

Your current work situation, and whether or not you are covered by an existing work-provided plan, generally dictate when and how you sign up. You may find your situation in the examples that follow.

Example 1

If you are working and are currently receiving Social Security benefits, the first of the month you turn 65 you will automatically be enrolled in Medicare Part A and Part B, and you should receive your Medicare card in the mail three months prior to your birthday. The premium for Medicare Part B will be automatically deducted from your Social Security check.

However, if you are working and are enrolled in a group health plan and want to continue receiving benefits from that plan, you must contact Medicare to cancel your Part B, assuming you do not want to pay the Part B premium.

Example 2

If you are working, turning 65, enrolled in a group health plan at work, and are not receiving Social Security benefits, you can defer Medicare Part B if you wish. But we do recommend you sign up for Part A (as there is usually no cost for part A). You can call Social Security directly at 1-800-772-1213 to set up an appointment to visit your local office. Or, the best solution I've found, is using the online enrollment system. Go to www.socialsecurity.gov and follow the enrollment links.

Example 3

If you are not receiving Social Security benefits or insurance at work, and want to sign up for both Part A and Part B, I again recommend you use the online enrollment process at www.socialsecurity.gov. The process takes about 10 minutes and you can enroll three months prior to your 65th birthday.

Example 4

If you want to enroll in Medicare Part A and Plan B but do not have the work credits and are going to use your spousal benefit, you will need to visit your local Social Security office. They will require proof of marriage to process the Medicare application. If your spouse is at least 62 and has worked at least 10 years in Medicare-covered employment, you can get Part A and Part B at 65. If your spouse is not yet 62 when you turn 65, you won't be eligible for premium-free Part A until your spouse reaches their 62nd birthday. In this case, you should still apply for Part B at 65, so you can avoid paying a higher Part B premium.

Example 5

If you are turning 65 and still working and enrolled in a group health plan, you may or may not want to apply for Medicare Part B. Here are some common scenarios.

1. Jim is 65 and still working and is on his employer's group health plan. After checking with his Human Resources department, Jim discovers that his company has fewer than 20 employees and his current health plan would pay after Medicare pays. Jim elects to enroll in Part B to receive the full benefits offered by Medicare.

2. Jane is 65 but not ready to retire. She works for a large corporation with good health benefits, but she is paying over $400 per month in premiums, her health plan has a $3000 deductible and there are co-pays for doctor visits. Jane decides it is much better to enroll in Medicare, pay the Part B cost of $134.00 and purchase a Part D drug plan and a Medicare supplement for an additional $200.00. Her total cost is reduced to $334.00 per month and she has no deductibles or co-pays.

3. Sam works for a company with great health benefits and pays nothing for his medical insurance. Sam decides to waive the part B coverage for now and continue with his group health plan coverage. Sam also has a spouse who is not Medicare eligible currently enrolled in his group health plan at work. If Sam dropped the coverage his spouse would need to seek coverage under Cobra or find individual insurance until he or she was eligible for Medicare.

There's a special enrollment period for those with an employer group health plan.

If you're 65 or older and covered under a group health plan, either from your own or your spouse's current employment, you may have a "special enrollment period" in which to sign up for Medicare Part B. This means that you may delay enrolling in Medicare Part B without having to wait for a general enrollment period and paying the penalty for late enrollment. There are limits, so we strongly advise you to contact a Medicare advisor to help you.

The rules allow you to enroll in Medicare Part B any time while you have a group health plan based on current employment; or enroll in Medicare Part B during the eight-month period that begins the month after the employment ends or the group health coverage ends, whichever happens first. When you enroll in Medicare Part B while you're still in the group health plan, or during the first full month when you are no longer in the plan, your can choose to have coverage begin either on the first day of the month you enroll, or on the first day of any of the following three months.

If you enroll during any of the remaining seven months of the "special enrollment period," your Medicare Part B coverage begins on the first day of the following month. If you don't enroll by the end of the eight-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year. You may also have to pay a late enrollment penalty for as long as you have Part B coverage, as described previously.

Penalties for not enrolling on time

In most cases, if you don't sign up for Part B when you're first eligible, you'll have to pay a late enrollment penalty for as long as you have Part B. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Also, you may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B, and coverage will start July 1 of that year. Usually, you don't pay a late enrollment penalty if you are enrolled in a qualified group health plan. However, Cobra coverage does not count as a qualified group health plan.

Not enrolling in a Part D drug plan also triggers a penalty. Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($35.63 in 2017) times the number of full, uncovered months you didn't have Part D or creditable coverage. The monthly premium is rounded to the nearest $.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.

I know it sounds confusing, and it certainly can be. A Medicare advisor can sort it all out for you.

Chapter Three

Medicare has a price.

Medicare Part A usually does not have an out-of-pocket cost if you or your spouse have worked in the USA and paid Social Security taxes for 10 years or 40 quarters. However, if you have not met that benchmark, Part A will cost you up to $413.00 each month. Fortunately, if you don't qualify based on your own work record, you can still get no-cost Part A if your spouse qualifies, by using your spouse's Social Security history when signing up for Medicare.

Part B costs are a bit more complex as they are tied to earnings. The standard Part B premium is $134.00 per month (or higher depending on your income). If you get Social Security, Railroad Retirement Board, or Office of Personnel Management benefits, your Part B premium will be automatically deducted from your Social Security benefit payment. If you don't get Social Security benefit payments, you'll get a bill which will be explained later in this chapter.

However, if your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you may pay an Income Related Monthly Adjustment Amount (IRMAA), which is an extra charge added to your premium. The chart on the next page provides the rates based on 2015 income amounts.

Selecting a good Part D drug plan can be confusing. I suggest you get help from a qualified Medicare advisor.

If your yearly income in 2015 (for what you pay in 2017) was			You pay each month (in 2017)
File individual tax return	File joint tax return	File married & separate tax return	
$85,000 or less	$170,000 or less	$85,000 or less	$134.00
above $85,000 up to $107,000	above $170,000 up to $214,000	Not applicable	$187.50
above $107,000 up to $160,000	above $214,000 up to $320,000	Not applicable	$267.90
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 and up to $129,000	$348.30
above $214,000	above $428,000	above $129,000	$428.00

How to pay for Medicare Part B

If you get a Social Security or Civil Service benefit, the cost of Part B will be deducted from your benefit payment. If you don't get these benefit payments and you sign up for Part B, you'll get a bill called a "Notice of Medicare Premium Payment Due" (CMS-500). If you are not receiving Social Security benefits you must pay for Medicare Part B each month or each quarter when Social Security mails you an invoice.

After a yearly deductible of $183.00 (effective in 2017), part B covers about 80% of all the costs, and the insured person is responsible for the remaining 20%.

Part B has a monthly cost of $134.00 that is automatically deducted from your Social Security check. The $134.00 per month deduction is based on your past income, and the monthly premium could be higher if your income is higher. The actual cost is determined when you apply for Medicare.

Part B covers preventive health services free of charge during your first 12 months of enrollment. After the first 12 months Part B offers annual wellness check-ups every calendar year afterward. The annual preventive care includes physicals and some tests like bone mass measurements and breast cancer screenings.

How to pay for Medicare Part D

Part D helps cover the cost of prescription drugs. All Part D drug plans are offered by independent insurance companies and the average premium is $34.00 per month with a deductible of $400.00 per year.

Medicare Advantage and Medigap are not at all similar products and, in fact, should be viewed as apples and oranges.

If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain

limit, you may pay a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA) in addition to your monthly plan premium. This extra amount is paid directly to Medicare, not to your plan. The chart below lists the extra premium levels by income. Social Security will contact you if you have to pay Part D-IRMAA, based on your income. The amount you pay can change each year.

If your filing status and yearly income in 2014 was			
File individual tax return	File joint tax return	File married & separate tax return	You pay (in 2017)
$85,000 or less	$170,000 or less	$85,000 or less	your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$13.30 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	not applicable	$34.20 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$55.70 + your plan premium
above $214,000	above $428,000	above $129,000	$76.20 + your plan premium

4 ways to pay

- Through your bank's online bill pay system
- Through Medicare Easy Pay, a free service that automatically deducts your premium payments from your savings or checking account each month. Forms are available for auto draft at www.ICUSA-tx.com
- Mail a check or money order to Medicare Premium Collection Center, P.O. Box 790355, St. Louis, MO 63179-0355
- Pay by credit card or debit card. To set up credit or debit payments, follow the directions and complete the bottom portion of the payment coupon on your Medicare bill.

Chapter Four

Closing the Gaps

Now that you have signed up for Medicare Part A and Part B (referred to as Original Medicare), is this all you need to do to have great health coverage?

For most people, the answer is "No!" As I explained earlier, Medicare works on a fee-for-service basis. Medicare pays a portion of the costs to providers, usually about 80%, and you pay the remaining 20%, plus the deductibles.

The problem is the 20% does not have a ceiling. In other words, 20% of $100.00 is affordable, but 20% of $100,000.00 is serious money. You can cover this gap (20% difference) if you have access to retirement health benefits from your employer. But these days, fewer people than ever have retirement health benefits, so the options are purchasing a Medicare supplement (also known as a Medigap plan) or you can choose a Medicare Advantage plan.

Medicare Advantage and Medigap are not at all similar products and, in fact, should be viewed as apples and oranges.

I can't emphasize strongly enough that the decision to go with a Medigap or Advantage plan is not an easy one to make. You should definitely consider asking an insurance professional with Medicare

experience to assist you and reduce the chance of making what could turn out to be a very expensive choice.

All about Medigap

Again, you need to understand that original Medicare does not cover all medical costs and has no out-of-pocket ceiling on how much you have to pay for health services. Medigap plans pick up those uncovered charges. Medicare supplements (designated A through N) are federally standardized and have a standard plan design. All supplement plans are issued by private insurance companies and every one of the plans, regardless of the insurance company, has the same benefits. Example: A Medicare Plan F from Blue Cross Blue Shield is exactly the same as a Plan F from Aetna.

What is different is the price you pay for the plan and how the insurance company calculates the rate either based on a community rating schedule or age-based pricing structures. Your claim history and health status will not affect your rate or single you out for cancellation.

Medigap plans do not use provider networks. They cover you anywhere in the USA. That means you can use any provider you would like as long as they accept original Medicare. Most Medigap plans have coverage for foreign travel, also.

The chart on the following page shows the Medigap plans that are available and the coverage.

Medigap Plans										
Medicare Supplement Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance hospital costs up to an additional 365 days after Medicare benefits are exhausted	X	X	X	X	X	X	X	X	X	X
Medicare Part B copayment or coinsurance coverage	X	X	X	X	X	X	50%	75%	X	X***
First 3 pints of blood	X	X	X	X	X	X	50%	75%	X	X
Part A hospice care coinsurance or copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility (SNF) care coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B deductible			X		X					
Medicare Part B 'excess charges'					X	X				
Foreign travel emergency coverage (up to plan limits)			80%	80%	80%	80%			80%	80%
Medicare Part B preventive care coinsurance	X	X	X	X	X	X	X	X	X	X

** Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of $2,180.00 in 2016 before your Medigap plan pays anything.*

*** After you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.*

**** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20.00 for some office visits and up to a $50.00 copayment for emergency room visits that don't result in inpatient admission.*

Which Medigap plan is the best for you?

The best plan is the one that provides you with the benefits you need for the best price. However, not all insurance companies are the same and you should be aware of the average premium rate increases for each of the companies. If you review the historical rate trends for the various insurance companies (ask your insurance agent) you will find a select group of generally larger companies that have a premium rate trend averaging an increase of less than 5% a year. Those are the companies you should consider. I always suggest selecting a Medigap plan that you can keep for life.

Plan F or Plan G?

Plan F is scheduled to be eliminated in 2020 and the changes coming are a result of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. You may have heard it referred to as the "doc fix" law. After 2020, Medigap plans can still cover the Part A hospital deductible, but as of 2020, the plans can no longer cover the Part B deductible for new enrollees.

Currently (2017) this deductible is $183.00 per year. Since Plan F covers that deductible, it is going to be phased out for new enrollees. If you sign up for a Plan F prior to 2020, you will be able to keep your plan. The goal of this measure, in the view of Congress, is to make Medicare beneficiaries put a little more "skin in the game." So the big question is will Plan F increase in price for existing customers more rapidly after 2020? No one can answer that question with certainty; however, it is important for you to know the differences between F and G.

Many people don't know which plan to select, or even understand they are different. This is easy to explain because there's only one benefit difference between Plan G and F: Plan F covers the Medicare Part B deductible and Plan G doesn't. That would suggest if the price for Plan G is less than $183.00 per year over plan F, then Plan G could be a better value. One other caveat to

consider is anyone who is applying during a Medigap Special Enrollment Period (SEP). Plan F has guaranteed issuance status during SEP where Plan G may not have this status for every insurance company.

Medicare Advantage Plans (Medicare Part C)

Medicare Advantage plans, sometimes called Part C plans, are a type of Medicare health plan offered by private companies that contract with Medicare to provide you with all your Part A and Part B benefits. They are Medicare replacement plans.

Medicare Advantage Plans take over your Medicare benefits and require provider networks as defined by the insurance company offering the plan. These include HMO, PPO and Private Fee-for-Service Plans. If you're enrolled in a Medicare Advantage Plan, all Medicare services are covered through the plan but claims are not paid for by Medicare, but by the Advantage plan. Most Medicare Advantage Plans include prescription drug coverage.

Rates for Medicare Advantage plans are relatively low but you still must have Part A and pay for Part B before you can purchase a Medicare Advantage plan.

Friends and clients who have turned 65 all tell me the same story. They were inundated with advertising letters, postcards and even phone calls promoting the virtues of Medicare Advan-

tage plans. No one is happier about our upcoming 65th birthdays it seems, than the private insurers who sell Medicare Advantage plans and Part D drug plans.

Advantage plans are marketed and sold aggressively because they are very profitable to insurance companies that sell them. The average insurance company will get roughly $10,000.00 from Medicare for each person who buys an Advantage plan. Most of the Advantage plans require members to use only the health care providers within the plan's network, and the insurance company picks the doctors and other providers you can use. If your doctor is in the network, then the Advantage plans may offer you great coverage for less money, but if you need to visit providers outside of the network, it can be very costly.

How do Medicare Advantage plans work?

Advantage plan premiums

Premiums are usually very low. In fact, the rates range from $0 for some HMO plans to just over $100.00 per month. Rates and plan designs vary for each state and county, so finding the best plans in your county requires research. (That's where your insurance agent or Medicare advisor can help.)

Benefits

Advantage plans do not pay 100% of your medical costs, but you are not usually subject to paying the 20% that Medicare Part B does not pay for most services. Instead you pay copays and coinsurance for most services. Copays can range from $5.00 for a primary care doctor visit to $400.00 a day for a hospital visit. Each plan will have specific copay amounts for every medical service and those plans and benefits must be approved by Medicare.

Out-of-pocket maximums

One of the strongest selling points for Advantage plans is they place a cap on how much you can spend on covered health expenses during a year. Those out-of-pocket amounts vary by plan, but the maximum is (in 2017) $6,700.00 per year. Having an Advantage plan with a maximum out-of-pocket limit is far better than original Medicare.

Chapter 5

More Rules of Enrollment

The initial Medicare enrollment is a piece of cake. You turn 65, retire and sign up for Social Security benefits, Medicare Part A and Part B, and you are all set. Right? Well, not so fast.

The Social Security Administration has the responsibility to administer the Medicare enrollment process, and in days past it made sense. Unfortunately, changes to the retirement age have tossed a wrench into the machinery, and the result is anything but simplicity. I added this chapter to the book to expand on the enrollment information in Chapter 2.

Until 2008, 65 was the full retirement age for Social Security benefits and also the primary enrollment age for Medicare. That is no longer the case. First of all, the full retirement age for Social Security benefits is moving up. For people born before 1954 the full retirement age is now 66 and will continue to increase for those born after 1954. However, the Medicare enrollment age remains 65 regardless of when you start receiving Social Security benefits. This change is not only a big deal for Social Security but a big deal for Medicare, because it further removes the linkage between the two programs as far as enrollment dates. This traditional retirement date has also been rendered mostly hypothetical due to the number of people continuing to work after their 65th birthday. About 35% of people between the age 65 and 69 are still in the workforce and nearly 25% of those between 70 and 75 are still working. For sure, retirement is not what it used to be.

So when and how do you sign up for Medicare? First, there are several enrollment periods for original Medicare Parts A and B. Secondly, there are different enrollment periods for Medicare Advantage plans and even more variations for Medicare Medigap supplements.

I invite you to grab a Coke or a cup of coffee, and let's dig in.

For those people who are turning 65 and not covered by an employer group health plan, we have seen the process is relatively simple. But slight changes in individual circumstances can make a huge difference in how and when you enroll.

Example 1

For people who need or want Medicare when they turn 65, there is a seven-month enrollment period. The enrollment period runs three months prior to your birthday month, your birthday month and three months afterward. This window applies to Parts A, B and D. It seems easy, but don't assume the Medicare start dates are all the same. The normal effective date is the first day of your birthday month as long as you enroll prior to that date. After the first of your birthday month the enrollment is effective as this example illustrates, using September as the birthday month.

Sign-up Month	**Month Effective**
September	October 1
October	December 1
November	January 1
December	February 1

To avoid gaps in health coverage, make sure you have access to alternative health coverage if you enroll after your birthday month.

If you miss enrolling in Medicare Part A or B during the initial enrollment period discussed above, there is a general enrollment period from January 1- March 31 each year. But waiting for this period could be costly. If you did not have employer sponsored health coverage with creditable drug coverage you could be subject to a late enrollment penalty for Part B of 10% for each year you are late. The Part D is 1% of the national average Rx plan cost for each month you are late. These are cumulative penalties that continue for life!

Example 2

For people turning 65 and covered by an employer group health plan from your employer or your spouse's employer.

This is a much larger group today than in the past. Nearly 20% of Americans age 65 and older report being employed. At 65 if you are a US citizen or not, but have been a resident for at least five years, you are eligible for Medicare. Part A is usually free to people who have worked and paid taxes for at least 40 quarters. Part B however is optional and does have a cost. You are not forced to enroll in part B and if you have employer coverage you are not subject to the Part B late enrollment penalty if you decide to postpone Part B enrollment. Deciding to sign up for Part B or not is somewhat complicated, we will attempt to provide you with some real life situations for enrolling in Part B or not enrolling.

There are an infinite number of real-life scenarios, and I have attempted to address the most common here. As you can see, it is a bunch of 'ifs'—

If you are covered by an employer health plan, you do not need to sign up for Part B or D if that plan has creditable drug coverage. When you retire or lose health coverage you can enroll in Part B as long as you follow the enrollment guidelines, and you will not be subject to a late enrollment penalty. It is normally recommended to enroll in Part A unless you are using a Health Savings Account (HSA). If you are using an HSA and sign up for Medicare, you are no longer eligible to participate in pre-tax contributions to your HSA account. You can enroll in Part A online during open enrollment.

If you are covered by a group health plan and are paying more than a combination of Medicare Part B and a good supplement would cost you, (about $300.00 per month) then you may want to enroll in Medicare Part A, B and D and pay less. Medicare with a good Medicare supplement will pay 100% of Medicare covered health costs with no deductibles or co-insurance.

If you are already receiving Social Security benefits, you will automatically receive Medicare Parts A and B. If you do not wish to enroll in Part B, you must contact Social Security and cancel Part B.

If you are covered by a group health plan, but the employer has fewer than 20 employees, you need to enroll in Medicare Part A and B. Why? Because when the employee is eligible for Medicare, the group plan stops being primary and becomes a secondary payer to Medicare. In other words, your group health plan becomes a Medicare supplement helping pay what Medicare does not pay like deductibles and co-insurance.

Enrollment rules for Medicare Medigap supplements and Advantage plans

The Medigap Window

There is a separate six-month open enrollment period for Medicare supplements (Medigap) which begins when you have enrolled in Part B. This period allows you to purchase a supplement on a guaranteed issue basis, no health questions asked. This guaranteed issue period maybe critical, because if you miss the window, insurance companies are not obligated to sell you a policy or can charge you more based on your health.

If you have original Medicare Parts A and B, but have other creditable coverage like a group health plan and lose that coverage, you have a 63-day window after your coverage ends to purchase a Medigap plan on a guaranteed issue bases.

Medicare Advantage Plan Window

For people turning 65 who enroll in Medicare Parts A and B, you can choose a Medicare Advantage plan and enroll three months before your Part B is active, during the month you turn 65 or for three months after the month you turn 65.

If you are enrolled in Medicare Parts A and B and lose coverage from your employer group health plan, you have two full months

after the month your coverage ends to enroll in a Part D drug plan or Advantage Plan.

If you enroll in an Advantage plan for the first time, you have 12 months to drop the Advantage plan, switch to original Medicare and purchase a Part D drug plan. You also have special rights to purchase a Medicare Medigap supplement on a guaranteed issue basis.

Chapter 6

Prescriptions to Fill

Part D Prescription Plans

Take all the consumer complaints about Medicare, sort them into piles, and I would guess the pile for prescription drug coverage would be the largest by far. Why? Because every drug plan offered by private insurance companies has different formularies for the drugs they offer. The drug coinsurance prices you pay are grouped into tiers with specific generic drugs being on tier 1 or 2 and brand name drugs and specialty drugs on tiers 3, 4 or 5, depending on the plan.

It is important if you have several prescriptions to check each medication for each plan and find out what the tier level (and cost) it is. The best way to do this is to visit www.medicare.gov and enter your list of medications. Medicare will run the list through all the plans offered in your zip code and prepare a report of the three best plans for you based on your current medications.

Rx coverage is by far the most complex part of navigating the Medicare health care system.

Rx coverage is by far the most complex part of navigating the Medicare health care system.

Part D drug plans are voluntary, so you do not have to purchase a plan, but if you do not enroll in a plan you will be subject to the late enrollment penalty I discussed earlier.

Coverage or lack of it

All Part D plans are offered by private insurance companies but they are highly regulated by Medicare, meaning the companies are required to format each drug plan in a similar fashion. That allows for apples-to-apples comparisons.

There is a regulated annual Part D deductible for 2017 of $400.00. Many plans charge less and most have some exclusion for generic tier 1 and 2 medications that are not subject to the deductible. What is different about each plan is the premium they charge and the formulary they offer.

The most important aspect of selecting a Part D plan is making sure your medications are covered and, if so, on what tier are they listed. Medications can be tier 4 on some plans and tier 2 on others, so it pays to do a little research on the plan formularies. Again, the best way to accomplish this is to go to www.medicare.gov and use their plan comparison tool. Or contact a qualified Medicare advisor.

The Donut Hole

Unlike any other insurance coverage you have had in your life, Medicare Part D plans have a coverage gap. You start out every year using your plan which pays a portion of the cost for the medications, then you are responsible for copays based on the tier level of the drug. At some point when the cost of those medications add up to a level of spending that is specified by Medicare which is $3,700.00 for 2017, your coverage simply stops.

You are now in the Coverage Gap, or as it is more commonly called, the Donut Hole. This gap begins once you reach your Medicare Part D plan's initial coverage limit ($3,700.00 in 2017) and ends when you spend a total of $4,950.00 (in 2017).

However, Medicare is attempting to eliminate the coverage gap. In 2017, Part D enrollees will receive a 60% discount on the total cost of their brand-name drugs purchased while in the donut hole. The 50% discount paid by the brand-name drug manufacturer will apply to getting out of the Donut Hole. However, the additional 10% paid by your Medicare Part D plan will not count toward your total out-of-pocket.

For example, if you reach the donut hole and purchase a brand-name medication with a retail cost of $100.00, you will pay $40.00 for the medication, and receive $90.00 credit toward meeting your 2017 total out-of-pocket spending limit.

Enrollees will pay a maximum of 51% copay on generic drugs purchased while in the coverage gap (a 49% discount). For example, if you reach the 2017 Donut Hole, and your generic medication has a retail cost of $100.00, you will pay $51.00. The $51.00 that you spend will count toward your total out-of-pocket.

Year	You'll pay this percentage for brand-name drugs in the coverage gap.	You'll pay this percentage for generic drugs in the coverage gap.
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

*Minimum Cost-sharing in the Catastrophic Coverage portion of the Benefit***

Catastrophic Coverage

When you spend your way out of the Donut Hole, you enter the "Catastrophic Coverage" phase where you pay the greater of 5% or $3.30 for generic drugs and the greater of 5% or $8.25 for brand name drugs.

For more information about the coverage gap we suggest you contact a Medicare advisor to help you navigate the system.

Chapter 7

Employer-based Health Insurance and Medicare

One of the big questions most people have is this: I am getting close to 65, but I am still employed and have insurance through my employer. What do I need to do? Do I need to sign up for Medicare Part A and Part B?

Unfortunately, like Medicare in general, there is no easy answer. Your employer insurance may look exactly the same after you turn 65, but because you are eligible for Medicare, it may work differently.

In most cases, if your employer has fewer than 20 employees, Medicare will become your primary insurer when you are eligible for Medicare and your group plan becomes a secondary payer. In this case you will need to enroll in both Medicare Part A and Part B to make sure your health care bills are covered.

If your company has more than 20 employees, your group plan continues paying first, and Medicare would be your secondary payer. In this case, you should enroll in Part A of Medicare because it is usually premium free. And you can delay enrolling in Part B and save paying the premium which is subject to your earnings as discussed in Chapter 3.

However, if you have a high deductible plan at work and/or are paying a high premium for your group plan, you should look at what Medicare and a supplement would cost as compared to your current group health plan costs. Often, Medicare can be a better deal both in premium costs and benefits.

If you decide to delay Part B and stay with your employer plan, you will not be subject to the Part B late enrollment penalty if you

enroll in Part B within eight months after your group coverage ends. It would behoove you, however, to enroll in Part B before you retire or lose coverage so you can avoid any gaps in your health coverage.

But wait, there's more.

It is still not that clear cut, because if your company health plan offers prescription drug coverage, you need to find out if it is considered "creditable coverage" by Medicare. These days more and more companies are offering Health Savings Account-qualified health plans, and most of those plans may not have drug coverage that Medicare considers creditable coverage. Because of that, you could be subject to a late enrollment penalty for not enrolling in a Medicare Part D drug plan.

If your group employer drug coverage is considered creditable, then you can delay enrolling in a Part D plan until after you retire or lose coverage. In order to avoid paying the Part D penalty at that time, you will need to enroll in a Part D plan within 63 days of losing your group coverage.

Cobra coverage if you are Medicare eligible...a Nightmare Example

John, and his wife Mary, both 68, thought they were doing everything right. When John retired he enrolled in Cobra for both of them. With John's former employer's COBRA health insurance due to run out in May, 2017, he believed he could sign up for Medicare when his Cobra coverage ended and this would require a routine visit to Social Security. He was wrong. They were told they wouldn't be able to get Medicare coverage until July 2018. Suddenly, in their late 60s, they faced the prospect of 13 months without health insurance.

John and his wife had run afoul of an obscure rule that is little understood by Medicare beneficiaries, employers, health insurance companies and even some Social Security and Medicare officials.

COBRA can provide continuation of health insurance for 18 months up to 36 months. It can be a literal lifesaver for people who lose their jobs and health coverage or lose access to group coverage because of a divorce. What it does not do, however, is take the place of employer group coverage in the eyes of Medicare.

An employer plan may excuse someone from needing to sign up for Medicare when they turn 65. However, COBRA does not qualify as group health coverage from an active employer. Even if a person's COBRA coverage is identical to their former group plan, they cannot delay signing up for Medicare when they turn 65 or lose their employer coverage after 65 in the mistaken notion that COBRA qualifies as an employer plan.

So John and Mary, while covered under COBRA, missed the eight month deadline to enroll in Part B after losing his employer plan, and were forced by Medicare to wait for the annual open enrollment period with an effective date of July of the next year. In addition, they both received a late enrollment penalty for not enrolling in Part B within the window. The only good news for John and Mary, was they were not charged a late enrollment penalty for not having creditable drug coverage, since COBRA drug coverage is considered creditable coverage by Medicare!

Quick facts about COBRA and Medicare

- Medicare is always primary to COBRA coverage.
- You should enroll in Part B if eligible.
- You will have to pay a Part B late enrollment penalty if you decide to delay enrolling in Medicare because you had COBRA.
- •Rules are different for people with ESRD.
- Note: COBRA is creditable coverage for Part D
- If you have Medicare first and then are offered COBRA, you can enroll in COBRA.
- Keep your Medicare coverage.
- COBRA may act like a Medigap policy and fill in the gaps not covered by Medicare.

Chapter 8

Medicaid and Medicare combined

Some people who are eligible for both Medicare and Medicaid are called “dual eligibles.” If you have Medicare and full Medicaid coverage, most of your healthcare costs are likely covered. You can get your Medicare coverage through original Medicare or a Medicare Advantage plan. Special Advantage plans exist to coordinate coverage between Medicaid and Medicare.

For people with full Medicaid benefits, the standard Medicare Advantage plans will not work well. You need to check on what Duel SNP plans maybe available in your zip code. If you have Medicare and full Medicaid, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn’t cover.

PACE offers extra help

PACE stands for Programs of All-Inclusive Care for the Elderly. It is a Medicare and joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

PACE is a program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

LIS—Low Income Subsidy Through Medicare

Save on Prescription Drug Costs

If you meet certain income and resource limits, you may qualify for extra help from Medicare to pay the costs of Medicare prescription drug coverage. In 2017, costs are no more than $3.30 for each generic and $8.25 for each brand-name covered drug.

Other people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level. In 2017, you may qualify if you have up to $18,090 in yearly income ($24,360 for a married couple) and up to $13,820 in resources ($27,600 for a married couple).

Contact Medicare so they can get proof that you qualify. There is a short application to complete. You can expect your request to take anywhere from several days to up to two weeks to process, depending on the circumstances. Call 1-800-MEDICARE (1-800-633-4227).

Medicare Saving Programs

You can get extra help paying your Medicare premiums from your state. In some cases, Medicare Savings Programs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance and copayments if you meet certain conditions. These conditions are listed below under "How do I apply for Medicare Savings Programs?"

Types of Medicare Savings Programs

If you have income from working, you may qualify for one or more of these four programs even if your income is higher than the income limits listed below.

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individuals (QDWI) Program

If you qualify for a QMB, SLMB or QI program, you automatically qualify to get extra help paying for Medicare prescription drug coverage.

Chapter 9

Social Security

If you think Medicare is complicated, our Social Security system is infinitely more complex. I highly recommend visiting with your financial adviser several months prior to becoming eligible for Social Security benefits to make sure you make the correct decisions for your retirement.

In the good old days, it was normal for a person to retire at age 65, and sign up for Social Security benefits and Medicare at the same time. That is no longer the case. Full retirement age is now 66 for most people born after 1943 and will reach 67 for those born after 1960. If you're like most Americans you've worked hard and contributed to the Social Security system for most of your life and should expect to get all of what you have earned with Social Security. Unfortunately the system is complex and it's easy to make the wrong decision about how and when to enroll.

When to enroll to receive Social Security Benefits is an important decision that will impact the income you receive throughout retirement. The decision of when to start benefits can also impact the income and lifestyle of a surviving spouse. To help you make informed decisions, this chapter provides a brief overview of the Social Security system and the choices you should consider. We also suggest you seek the help of a qualified financial planning professional.

How secure is Social Security?

The Social Security system is encountering serious financial issues. According to a government report, by 2017, the amount of benefits paid out will exceed the amount of taxes put into the system and the fund could be exhausted by 2037. Once this happens, benefits would still be paid out but almost certainly be reduced by a significant amount.

While it is very unlikely that the system will be allowed to fail, these numbers are sobering and should serve as a wake-up call to explore all other potential sources of income for retirement in addition to Social Security. The likely result is that retirement ages will be pushed back, benefits reduced, and, while unlikely, even current beneficiaries (that is, those receiving benefits before that date) may have their benefits reduced.

A small fix in the Social Security tax would fix this problem and allow for many years of continued fund checks to be paid. Let's urge our elected officials to make the necessary changes to protect our future retirement.

When should I start collecting SS benefits?

This is the million dollar question, and it is different for every person.

Basically, you have three main options:

1. Collect benefits early. You can start collecting Social Security benefits as early as 62 years of age. However, you will receive about 30% less in income than you will get at full retirement age, which is 66 for most of us.

2. Start collecting at your full retirement age (FRA), and receive 100% of your benefit (Primary Insurance Amount). This option is most often used but adding years before retirement is not always easy. Also, there are other variables to consider.

3. Delay benefits until age 70 and you will receive 32% more income for life. Plus, waiting until 70 could result in a surviving spouse receiving quite a bit more income from Social Security.

Should you start collecting early or wait?

Longevity plays a key role in determining which filing strategy

may be more advantageous for you. Depending on how long you live—and we are all living longer today than our parents—you could potentially receive more in lifetime benefits by waiting until you are 70 to start benefits. The average life expectancy is now 83 for a 65 year old male and 85 for a 65 year old female. One thing for sure, unless you absolutely need the income, enrolling in benefits before your FRA is not a good idea. Collecting Social Security checks at 62 means you will receive 30% less in benefits than waiting for full retirement age, if you live to be age 85 that means thousands of dollars lost as compared to waiting.

Recent Changes to Social Security Rules

The Bipartisan Budget Act of 2015 made some changes to Social Security's laws about claiming retirement and spousal benefits. Section 831 of the law (entitled "Closure of Unintended Loopholes") made several changes to the Social Security Act and closed two complex loopholes that were used primarily by married couples.

What was the loophole? As described above, retirement benefits grow for each month you delay claiming, between full retirement age (currently 66) and 70. A loophole allowed a worker at full retirement age or older to apply for retirement benefits and then voluntarily suspend payment of those retirement benefits, which allowed a spousal benefit to be paid to his or her spouse while the worker was not collecting retirement benefits. The worker would then restart his or her retirement benefits later, for example at age 70, with an increase for every month retirement benefits were suspended.

How is the law changing? Under the new law, you can still voluntarily suspend benefit payments at your full retirement age (currently 66) in order to earn higher benefits for delaying. But during a voluntary suspension, other benefits payable on your record, such as benefits to your spouse, are also suspended. And, if you have suspended your benefits, you cannot continue receiving other benefits (such as spousal benefits) on another person's record.

Spousal benefits and the "file-and-suspend" strategy

If you are married, you are generally eligible to claim the greater of your own benefits or up to 50% of your spouse's full benefit.

The spousal benefit is based on our spouse's benefit at his or her full retirement age. If your spouse waits past the FRA to collect spousal benefits the amounts do not increase the amount of spousal benefit. However, you cannot collect on your spouse's record until your spouse files for benefits. Therefore, if you are waiting to collect your benefits at age 70 and your spouse wants to claim spousal benefits, he or she cannot enroll until you have filed for benefits.

Can I still file a restricted application?

To explain let's use the following example: Sam is 67 and his wife is 66 at (Full Retirement Age) FRA. Sam has elected to wait until 70 to start his Social Security benefits but his wife can enroll at her FRA and start collecting her full benefits. Sam can elect his spousal benefit and collect 50% of his wife's monthly benefit until he is 70, and then switches to his individual full Social Security benefit. The end result is Sam collected Social Security for three years prior to turning 70 at which time he can collect the higher amount.

The new law prevents people born after 1/1/1954 from doing so, but since Sam was born before that date, he can still restrict his application to just his spousal benefit once his wife reaches her FRA. You, of course, still can't do this before FRA, but it's still an option for you at or after your FRA.

Applying for Social Security

If you're approaching retirement age, you may have some idea of when you'd like to start receiving Social Security benefits. However, you may not know how the application process works or when you need to apply in order to start receiving benefits at a specific time. Here's what you need to know about how to apply for

Social Security, what information you'll need to gather, and when to fill out the application.

Three ways to apply

When it comes time to apply for Social Security retirement benefits, you have three options.

1. You can use the Social Security Administration's online enrollment process, which should take no more than 30 minutes as long as you've gathered all of the required information and documentation (more on that in a bit).

2. You can also choose to apply by phone.

3. Enroll at your local Social Security office if you'd rather have someone there to assist with the process. Whichever method you feel most comfortable using, your application will be reviewed and processed as soon as all necessary documentation and information is received. And, the Social Security Administration will notify you if it turns out you could qualify for higher benefits on your spouse's record, or if other family members can receive benefits on your work record.

When should you apply?

In order to apply for Social Security benefits, you need to be at least 61 years and nine months old, but you won't begin receiving benefits until you turn 62. Once you've reached the minimum age of eligibility (62), you should be able to apply and start your benefits in the same month, so you really don't need to rush and apply early unless you foresee any delays with documentation or have special circumstances. In general, the Social Security Administration says that you should apply for benefits no more than four months before the date you want your benefits to start.

Bear in mind that Social Security benefits are paid in the month after they are due. So, if you start your benefits on your 62nd birthday, you won't start receiving payments until the following month.

Additionally, if you don't need your Social Security benefits right way, you don't have to do anything in order to increase your monthly disbursements down the road.

Finally, it's also worth noting that even if you decide to wait to claim Social Security benefits, you should still fill out the benefit application to apply for Medicare three months before you turn 65. Delaying your application for Medicare can result in higher premiums, so it's important to do it as soon as possible. Even if you choose not to sign up for Social Security, Medicare is still available and, if nothing else, apply for Part A, as it is free.

What information will you need to supply to sign up for SS?

In order to apply for Social Security benefits, you'll need to be able to document some information about your identity and work history. Specifically, before applying you should have the following information handy:

- Your date and place of birth (which you need to document with an original birth certificate)
- Your Social Security number
- Your spouse's Social Security number and date of birth
- Place of marriage
- Date of divorce or death of your spouse, if applicable
- Names of your unmarried children under 18
- Your bank account information if you want your benefits directly deposited
- The name and address of your employers from this and last year
- The amount of money you earned last year, this year, and your estimated earnings next year (if any)
- A copy of last year's W-2 or self-employment tax return

- Your earnings record (a copy of your Social Security statement has this information)
- Records of any active duty military service before 1968 (documented with a copy of your military service papers)

If you use the online or phone application, you'll be given a list of required documents, as well as instructions of how to submit them.

This is not an exhaustive list, and there are many special circumstances that will require additional documentation. For example, if you have used a different Social Security number at any point in your life, you'll need to document that.

Estimating your Benefits

Your retirement benefit is based on your highest 35 years of earnings and of course your age when you start receiving benefits. If you stop working before you have 35 years of earnings, Social Security will use a zero for each year without earnings when they perform the calculations to determine the amount of benefits you are due.

Depending on how much you earn in wages and other income, you could pay income tax on up to 85% of your Social Security benefits. To find out your benefit amount you can create a account at www.SocialSecurity.gov and discover your estimated benefit amounts. Also available on the Social Security web site are Retirement Estimator calculators you can use to help figure out the best strategy for planning when to enroll and take your benefit payments. One site I recommend is http://bedrockcapital.com/ssanalyze/.

Chapter 10

Acknowledgments

About the Author

Bob Garrison is well into his second decade of helping people by unraveling the mysteries of Medicare. He is president of Insurance Connection USA, a regional insurance brokerage serving clients in Texas, New Mexico and Colorado, and one of the nation's leading experts on health insurance.

Garrison and his team at Insurance Connection USA provide Medicare education and solutions to thousands of retirees. He partners with companies like Mass Mutual, Farmers Insurance, Morgan Stanley and Edward Jones to assist clients in navigating the Medicare system and selecting the best solutions. In addition, he assists retiring employees from companies like American Airlines, Lockheed Martin and many others.

After graduating from the University of Central Washington, Garrison enjoyed a successful career in the media and publishing business, and in senior management positions with major companies.

Garrison is on the board of Dallas Association of Health Underwriters, has served on the Agent Advisory Council for Cigna, and the Advisory Committee for Care N Care, a regional Medicare Advantage Health Plan in Fort Worth. Garrison conducts education seminars on "Navigating Medicare" and also works with individuals consulting on health and Medicare issues.

Acknowledgments

Many thanks to Mike Eiseman who helped me understand some of the complex Medicare rules, Mike solely specializes in Medicare! For four years, he has helped his clients navigate through the ever changing Medicare policies and has continued to educate them on their options. Before he worked in the field, he was looking for Medicare himself. It was not until he needed it that he saw how many common mistakes people made when looking for Medicare. After that, he decided to jump on the opportunity and work side by side with his daughter, Elisa at ICUSA. Outside of the insurance world, he has been married for 47 years, has six children and grandbabies! You can often find him gardening, eating pizza or watching anything with John Wayne.

About ICUSA

The advice offered by Insurance Connection USA (ICUSA) is free. Our mission is to provide timely information so you can make the best decisions for your health care needs. We believe that you should get all you deserve from the Medicare system, because you earned it.

ICUSA represents all Medicare insurance companies. Our Medicare advisors, Mike, Paul, Elisa (and Bob), are available to educate you on all your choices so you can pick the best options.

A major part of that consulting is providing Medicare education and solutions to thousands of retirees. If you are looking for qualified, unbiased assistance, please attend one of our weekly workshops to find out more about your Medicare options. Or give us a call and set up an appointment for an individual meeting.

To contact me and for more information...

visit www.askbobaboutmedicare.com

Medicare and Social Security programs are subject to annual changes, if not more often. For the latest information, contact Social Security, Medicare or ask your advisor.

Chapter 11

Glossary of Common Terms

COBRA

COBRA stands for Consolidated Omnibus Budget Reconciliation Act. This is the federal law that provides many workers with the right to continue coverage in a group health plan. This federal law applies to employers with 20 or more employees, including self-insured employers. It does not apply to group health plans established or maintained by the federal government or to church plans established and maintained by a church that is tax exempt under section 501 of the Internal Revenue Code.

Co-pays and Co-insurance

A co-pay (copayment) is a fixed dollar amount (a partial payment) for a health care expense that is covered by your plan. For example, your insurance may cover all but $35.00 for the cost of a specialist visit. That $35.00 is your co-pay amount.

Unlike a co-pay which is a fixed dollar amount, the coinsurance amount you pay is a percent you have to pay for health care expenses that are covered under your health insurance plan in addition to your fixed dollar co-pay. Someone with an 80-20 co-insurance plan pays 20 percent of the remaining post-deductible balance on qualified treatment.

Deductible

A medical insurance deductible is the amount owed by the policyholder before the plan pays for covered services.

Drug Tiers

Prescription drugs are classified in tiers or levels according to their use. Commonly used, generic drugs may be in Tier 1 or Tier 2. More specialized and brand name drugs, which can be much more expensive, are in higher numbered tiers.

Formularies

A list of medicines covered by an insurance plan.

HSA

A Health Savings Account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan. The funds contributed to an account are not subject to federal income tax at the time of deposit. HSA funds roll over and accumulate year to year if they are not spent. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty.

PACE

PACE stands for Programs of All-Inclusive Care for the Elderly. It is a Medicare and joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

SNF

Skilled nursing facilities, or SNF, offer round-the-clock, in-home skilled care, and are among the most costly types of extensive health care.