Welcome to EasyWay Medicare

Making Medicare Easier

Michael McSwain

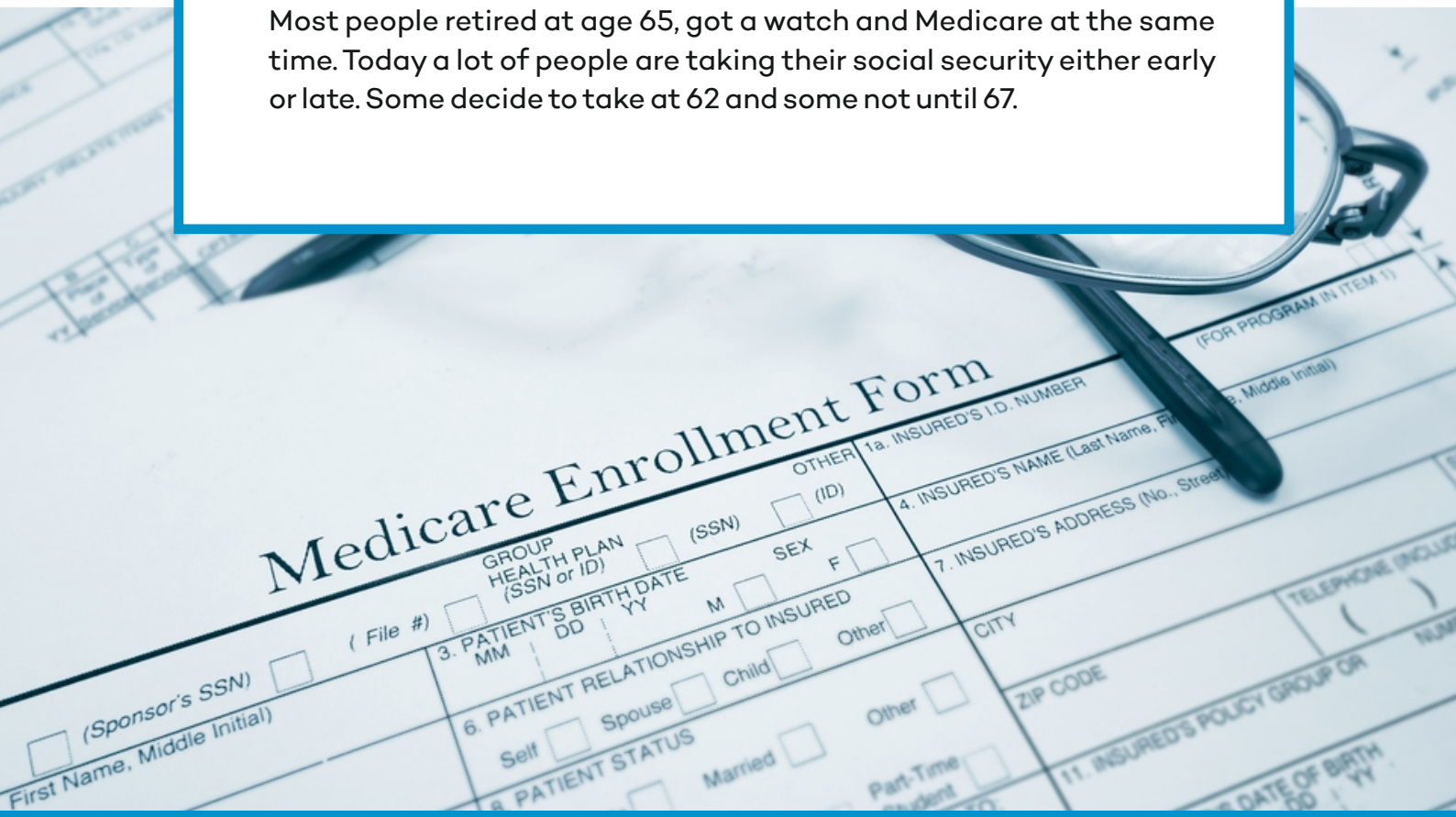
INTRODUCTION

Welcome to EasyWay Medicare. My name is Michael McSwain and I am a licensed insurance agent. Most of my clients describe Medicare as overwhelming and confusing. I work with Medicare insurance every day and I would have to agree. I am writing this guide in an effort to make Medicare a little “easier” which happens to be the mission of my company, Easywaymedicare.

This guide is not designed to answer every question about Medicare, but to hit the highlights that most people want to know. Of course if you ever need help or have questions we would be more than happy to be a resource for you.

HOW AND WHEN TO ENROLL IN MEDICARE

Back in the good ole days Medicare was a bit easier than it is now. Most people retired at age 65, got a watch and Medicare at the same time. Today a lot of people are taking their social security either early or late. Some decide to take at 62 and some not until 67.



I TOOK MY SOCIAL SECURITY AT 62

If you took your social security at 62 most likely you will not need to do anything. In my experience, once you have enrolled in Social Security, then you should be AUTOMATICALLY enrolled by Social Security into Medicare at age 65. Your Medicare card will arrive in the mail usually a couple months before your 65th birthday. Word of caution! We are dealing with a large GOVERNMENTAL agency. If you have not received your card a month before your birthday it is worth a phone call to social security. Mistakes HAPPEN. Also, if you have not received your card you can also call my office and I can check with Medicare Health Insurance companies (Anthem, Humana, United Healthcare...) to see if their computer systems show an active date for you. Sometimes it will be in the computer systems but for some reason you just haven't received the card yet.

I TOOK MY SOCIAL SECURITY AT 62, I AM TURNING 65 BUT DON'T WANT MEDICARE PART B.

As mentioned previously, if you signed up for social security at age 62 then you will automatically be enrolled into Medicare at age 65. If for some reason you do not want Part B you can reject the coverage. The directions for rejecting the coverage should be supplied by social security when you receive the card. Most of the time when people reject part B it is because they are covered by an employer plan.

INSIDER TIP FOR VETERANS

Before you reject part B I would seek the advice of a Medicare professional. A Medicare professional can compare Medicare coverage to your employer plan. Health plan decisions are never one size fits all. Everyone's health situation is different. Just because your co-worker rejected B doesn't mean you should too. There are MANY factors that must be considered. If you are planning to reject part B coverage because you are a Veteran and use the Veterans Administration for your healthcare you need to know that it is NOT credible coverage for part B. Rejecting part B may result in stiff penalties and other consequences in you decide to activate part B benefits at a later date.

I AM TURNING 65 AND WANT TO FILE FOR SOCIAL SECURITY AND MEDICARE.

It is a bit confusing but most people think that you file for Medicare separately than social security. Although Medicare itself is a different organization from Social Security, you apply for your Medicare THROUGH Social Security. You can apply for your social security a couple of different ways. First, you can physically visit a social security office (I would recommend getting there first thing in the morning). Second, you can call Social Security (I would recommend getting a speaker phone or headset because many times the hold time is over an hour). Lastly, you can apply online. In my opinion this is the easiest and most efficient method. I do realize that many seniors do not like or are not good with computers. If you fall into this category you can always call our office and I will sit down with you and help you through the process.

I REJECTED PART B AND NOW I WANT TO ACTIVATE IT

There are two categories when we talk about rejecting Part B . One category is if you had “credible coverage". Credible coverage means that you had other health insurance that was primary (pays first) to Medicare. The other category is if you did not have other health insurance (even if you had VA coverage).

HAD CREDIBLE COVERAGE

If you had credible coverage you need to apply to activate your Medicare Part B by contacting the Social Security Administration. See above for specifics. One note, if you go in person bring evidence of your credible coverage. You can get a standardized form from our website, easywaymedicare.com. It is form CMS-L564. This form is what Social Security needs in order to help you avoid potential penalties. You should be able to coordinate your Medicare coverage to begin right after your employer plan ends. In other words you do not have to wait until the General Enrollment Period.

DID NOT HAVE CREDIBLE COVERAGE

If you did not have credible coverage your enrollment process is a bit different. First, you DO have to wait until the General Enrollment Period which is from January 1 to March 31st each year. Once you sign up during this period your Medicare coverage will NOT start until July 1st. Many people who learn this too late are usually very upset and feel as though they are being penalized. THEY ARE! Medicare does not want you to reject the coverage and wait until you need it before signing up so they penalize you if you do this without credible coverage. This is why I stated earlier that it is always good to seek the advice of a Medicare professional before you reject Part B.

YOU'VE SIGNED UP FOR MEDICARE! NOW WHAT?

Congratulations, you have successfully signed up for Original Medicare. You have received your card with effective dates for Parts A and B. Now what? Most people don't realize that they now have multiple options for various types of coverage. At Easyway Medicare it is our mission to help people gain the most comprehensive coverage at a lowest possible price. We do this by providing a no cost consultation and going through ALL of your options while keeping your specific health conditions and prescription drugs in mind.

INSIDER TIP:
NOT ALL INSURANCE AGENTS ARE CREATED EQUAL IN REGARDS TO MEDICARE

Not all insurance agents are the same when it comes to Medicare options.

ANY licensed life/health agent can market and sell Medigap or Medicare Supplement plans. However, in order to market and sell Medicare Advantage plans insurance agents must pay for and complete a considerable amount of Medicare specific training each and every year. This training includes completing courses by American Health Insurance Plans (AHIP) as well as the individual carriers (Aetna, Anthem, Humana, United Healthcare, Wellcare, etc...) Each training course cost around $200 a year and take about 40 hours to complete. I have included this as an insider tip because if an insurance agent does not explain Medicare Advantage plans as an option or disparages them it usually means they are not able to market or sell them because they have not taken the time to complete the proper training.

ORIGINAL MEDICARE

Option one would be Original Medicare. With Original Medicare the one main advantage is you can use any doctor in America that accepts Medicare. Original Medicare covers hospital (Part A) and doctor visits (Part B). Under Part b most people know that Medicare pays 80 percent of the bill and your responsibility is 20 percent. What most people don't know is that there is never a cap on the 20 percent. In other words, a person can technically have an unlimited amount of risk if they were to fall upon poor health. Also, most people do not realize that under Part A (hospital) there are deductibles. . For example, if you get admitted into the hospital you OWE $1364.00 for each benefit period. In addition to these costs there are a number of other health related items that Original Medicare doesn't cover at all. These include hearing, dental, vision, over-the-counter, transportation, fitness, and PRESCRIPTION DRUGS! That's right, Medicare does not cover prescription drugs (Part D). See the Prescription drug coverage section in this brochure for a more detailed analysis for prescription drugs. For this section you just need to know that prescription drugs are not covered by Medicare and that it represents an additional cost to you.

MEDICARE SUPPLEMENTS OR MEDIGAP

If you ever watch TV you would be hard pressed to have not heard of a Medicare Supplement plan or Medigap plan. They are the same thing. Just two different names that describe the same product. For our discussion here I am going to use both terms. Due to the costs described earlier,, many people decide to buy additional insurance to SUPPLEMENT Original Medicare. The first thing to note is that it supplements Original Medicare. It helps pay for what Medicare covers but doesn't pay in full. It DOES NOT cover things that Original Medicare doesn't cover. Let me repeat that a different way because it is IMPORTANT. It will help pay for things like the 20% you owe for doctor bills and hospital co-pays. It will NOT pay for things that Medicare doesn't cover like hearing aids or dental. So if Medicare covers it your Supplement could cover it. If Medicare doesn't cover it your supplement will not add any extra coverage.

COVERAGE OPTIONS

In order to help a consumer shop around for Medicare Supplement insurance the plans are given a letter to represent what they cover. In other words Humana's plan F has the same exact medical coverage as Anthem plan F which has the same coverage as Cigna's plan F, this allows consumers to comparison shop.

OPEN ENROLLMENT

Most people have heard the term "Open Enrollment" as it relates to Medicare. However, MOST people do not know that it has two different and IMPORTANT meanings. There is Medigap open enrollment and then there is Medicare Advantage Annual Election Period. Many people refer to the Annual Election period as open enrollment. Medigap Open enrollment refers to your initial 6 month period from the time your Medicare part B becomes active and you are age 65 or above. Medicare Advantage Annual Election period between October 15th and December 7th is the time when you can "elect" a new plan for the following year.

MEDIGAP/SUPPLEMENT OPEN ENROLLMENT

Underwriting is a very important topic when looking at a Medicare Supplement plan. VERY IMPORTANT! A Medigap policy MAY or MAY NOT require medical underwriting depending on how long your Part B has been active. The general rule is that you have 6 months after your Part B becomes effective (assuming you are 65) to purchase a Medigap plan that does not require medical underwriting. If you have chronic or semi-serious health conditions this is a BIG DEAL. If you apply during this 6 month period the carrier will NOT ask ANY medical questions. If you apply after this 6 month period you will have to answer medical questions and depending upon the condition MAY or MAY NOT be able to get a Medigap plan. Also, if you have medical conditions and apply outside of this 6 month window you may get rated by the insurance company and have to pay more in premium.

PROS AND CONS OF MEDIGAP/SUPPLEMENT POLICIES

As with many insurance products there are pros and cons to each. Let's take a closer look at how a Medigap policy works. For illustration purposes let's consider Bob who is turning 65 and buys a plan F that pays 100% in all the major categories. See coverage chart. Let's assume that plan F cost 150 dollars a month for Bob. With this coverage if Bob goes to the doctor, hospital, or does anything that Medicare covers he is not going to owe any money for medical bills. The Medicare Supplement is going to pay everything that Original Medicare didn't pay. So if Bob has a stroke, heart attack, brain tumor, cancer, gets hit by a train, he is not going to owe for medical bills that Medicare covered. This is obviously a PRO that with a Medicare Supplement you have very comprehensive medical protection for a reasonable price. So the main pros are that you have a fixed and predictable cost, comprehensive medical protection, you can use any doctor that accepts Original Medicare.

Now you know the pros what about the cons. The first con is the first pro. Confused? The first pro was fixed and predictable cost. Having a fixed cost is good when you have many or serious health conditions, but not so good if you don't. In the previous example, Bob is paying 1800 a year(150 x 12) to have coverage. Bob would also most likely have a part D plan. These are usually about 30 dollars a month or 360 a year(30 x 12). So now Bob is paying 2,160 (1800 + 360) for additional protection. If Bob goes to the doctor twice in a year he is paying over $1000 for a doctor visit (2160 fixed cost/2). So this can be considered a con if someone is NOT a heavy user of the medical system. Con number two is that the rate for a Medicare Supplement is typically going to go up year after year. Over time these plans can become expensive. It is not uncommon for seniors in their late 70's and early 80's to be paying over $300 a month per person. So for a husband and wife household they could be spending $600 a month and as healthcare costs continue to rise so will the premiums. You also will still NEED to purchase a part D drug plan. This increases a person's monthly cost under this structure. Also, the cost of your drugs and deductible can be higher with a stand alone prescription drug plan compared to a Medicare Advantage Plan.

PROS AND CONS OF MEDIGAP/SUPPLEMENT POLICIES

Con number 3 is that they are MEDICALLY UNDERWRITTEN. As mentioned earlier if you get a Medicare Supplement outside of your 6 month open enrollment period it will be medically underwritten. This means that it can be difficult or even impossible to change companies or plans based on your medical history. Con number 4 is not so much a Medicare Supplement con and was eluded too in the earlier example. If you use Original Medicare with a supplement you still NEED to purchase a part D drug plan. This increases a person's monthly cost under this structure. Also, the cost of your drugs and deductible can be higher with a stand alone prescription drug plan compared to a Medicare Advantage Plan.

MEDIGAP/SUPPLEMENT RECAP

We have covered a lot of information above and hopefully you have a better understanding of what and how a medigap policy works. Here are generally my recommendations when it comes to a Medigap policy. If someone has chronic or serious health conditions I usually recommend that they consider a Medigap Policy very seriously. If you are wondering what is considered serious health conditions feel free to call my office and I will mail you a blank application that has the medical questions. The applications are also on my website at Easywaymedicare.com under forms. These questions are “KNOCKOUT” questions which means if you answer yes than you are “KNOCKED” out and do not qualify. REMEMBER: If you are in your first 6 months of your Part B coverage you do not have to answer these questions. If a person does not have many health conditions then we also need to talk about Medicare Advantage Plans.

MMEDICARE ADVANTAGE

When we talk about Medicare Advantage Plans there is a lot to talk about.

One way to look at them is that they function differently than a Medicare Supplement plan. Before we get into the specifics I think a little background about how they came about and evolved would be helpful.

BACKGROUND

Medicare Advantage got its roots in the 1970s when people began to have the option to receive their Medicare benefits through private health plans. These were mainly HMO's. The program changed again in 1997 and was renamed "Medicare+Choice". In 2003 it was renamed Medicare Advantage under the Medicare Modernization Act. Just as the name has evolved, so has the final product. In the early days of Medicare Advantage many people were not satisfied with the coverage. Most plans were restrictive HMOs with not the best networks or access to care. However, with time and many improvements, many people are starting to shift towards Medicare

Advantage Plans. At one time only 13% of Medicare recipients chose to have an advantage plan. Now those numbers are up to about 33% and in some states as high as 56%. The numbers for Medicare Advantage are rising steadily. Throughout the rest of the section on Medicare Advantage I am going to try and simplify as much as possible. There is a vast amount of information when it comes to Medicare Advantage programs and again this guide is not intended to describe every detail. It is intended to give you an over view of your options and educate you on the basics. For more comprehensive information you can always schedule a no cost consultation with myself or staff.

ORIGINAL MEDICARE VS MEDICARE ADVANTAGE

One way I might define Medicare Advantage is it means to "specialize" your Medicare. Sometimes people get confused about this. When a person chooses a Medicare Advantage plan they no longer have Original Medicare. They have chosen to have a private company like Anthem, Aetna, Humana, United Healthcare, etc to provide their Medicare benefits. As mentioned earlier in our discussion, Original Medicare has deductibles and coinsurance. Medicare Advantage plans may or may not have deductibles. Each plan is different in that regard. Medicare advantage plans typically have copays and sometimes co-insurance. What this means is that every service is either a set co-pay amount or sometimes a percentage of the bill. For example, many primary care visits are going to be a set co-pay amount. This could range anywhere from $0 to $40.00. With Original Medicare you would owe 20% of the bill. One of the issues with having to pay a percentage is that you usually don't know how much the bill is going to be. With co-pays you know EXACTLY how much the bill is going to be. Another distinction is that most Medicare Advantage plans also offer benefits that Original Medicare does not offer. These include Hearing, Dental, Vision, Over-the-counter items, Transportation, Fitness, AND A PRESCRIPTION DRUG PLAN. Medicare Advantage plans are called PART C (which combines Parts A,B, and D)

INSIDER TIP: MEDICARE ADVANTAGE

One of the common questions I get about Medicare Advantage is how can I get good quality healthcare with a plan that cost $0 a month. The answer is that it doesn't cost $0 a month. It cost the consumer $0 per month. When you select a Medicare Advantage plan Original Medicare then pays a premium to the company you selected. On average that premium is about $10,000 a year.

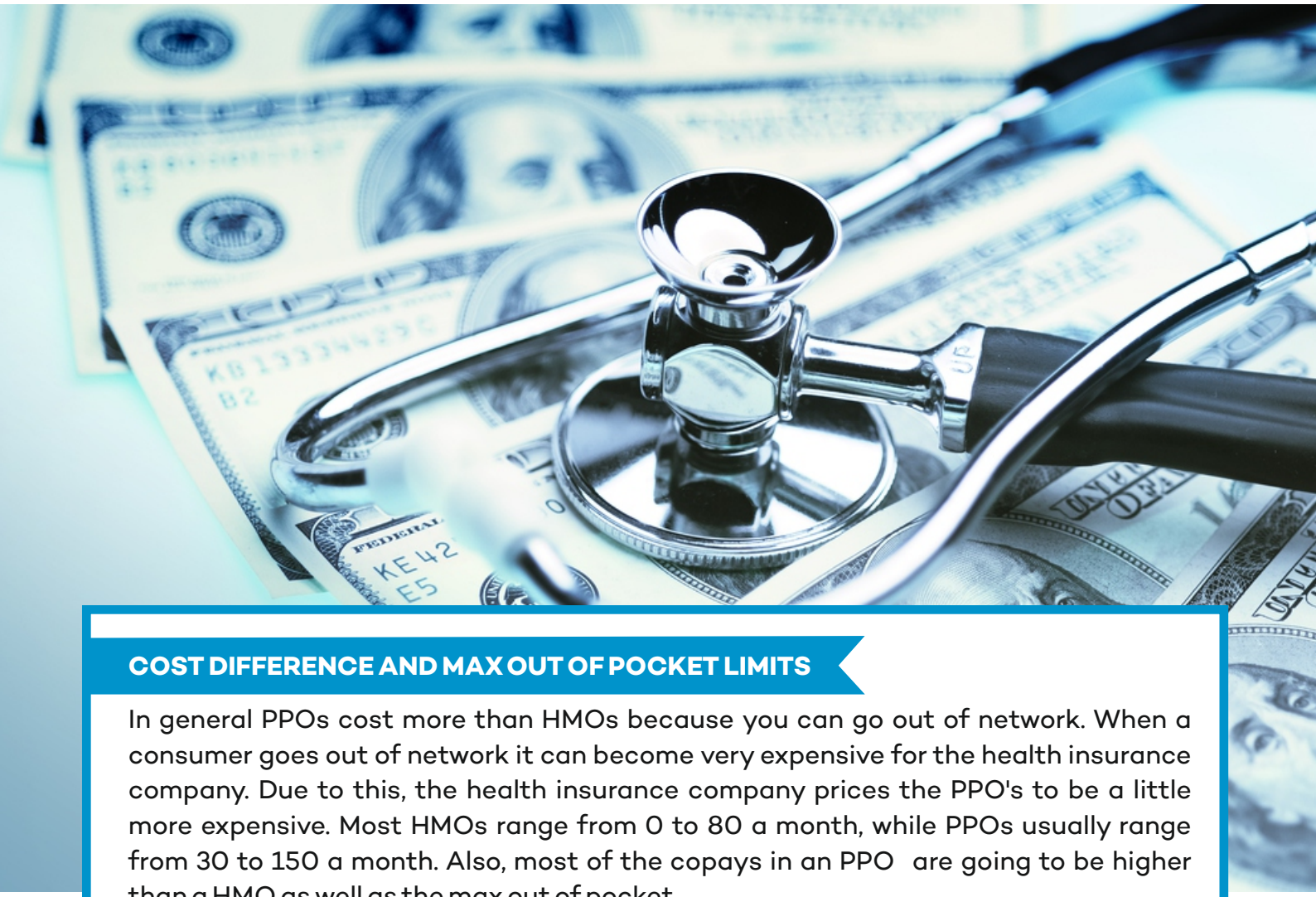
NETWORKS

As opposed to Original Medicare a Medicare Advantage plan uses “networks” for provider care. If you have ever used private health insurance you are probably familiar with networks. Remember, with Original Medicare you can use any provider in the United States that accepts Original Medicare. With a Medicare Advantage plan you will have a network of providers. The network is one way these providers(Aetna, Anthem...can compete with one another. Obviously, it is more attractive to consumers to have a larger network (more accepted providers) than a smaller network. It is VERY IMPORTANT when considering a Medicare Advantage plan that you research ALL of your providers to make sure you will be able to use them. This can be a bit tricky. Most of the providers have an online tool to assist with this process. Also, I would not call your provider as ask “do you take Humana”. Most of the people who work the front desk at doctors' offices do not UNDERSTAND how insurance works and many times mislead consumers by mistake. If you need or want help with this process you can always call myself or staff and we will be happy to look them up for you.

HMO VS PPO

HMO-Stands for health maintenance organization. The two main things you need to understand is that by definition HMOs do not have “out of network” benefits and are usually less expensive than PPOs. What does it mean that it does not have “out of network” benefits? Remember, a network is the providers in a geographic region that accept the health insurance plan. If you want to use a provider that is NOT in this group of providers, then the HMO will NOT pay ANYTHING for you to do so. PRACTICAL EXAMPLE: Let's say you have been having problems with your hip and your start researching hip replacement. You find a surgeon who has an unusually high success rate and you want THAT surgeon to do your operation. Keep in mind your HMO may have hundreds of surgeons that could perform the operation, but you want this particular surgeon. If that surgeon is not in your health plans network then they will NOT pay ANYTHING for you to use that surgeon.

PPO-Stands for preferred provider organization. If the above example is upsetting or disturbing to you then you may prefer a PPO. One way to look at a PPO is like an HMO but does have out of network benefits. So in the above example, you could use the surgeon of your choice that accepts Medicare. HOWEVER, it is going to cost you MORE. With a PPO there is a different cost structure when you use an in network provider vs an out of network provider.



COST DIFFERENCE AND MAX OUT OF POCKET LIMITS

In general PPOs cost more than HMOs because you can go out of network. When a consumer goes out of network it can become very expensive for the health insurance company. Due to this, the health insurance company prices the PPO's to be a little more expensive. Most HMOs range from 0 to 80 a month, while PPOs usually range from 30 to 150 a month. Also, most of the copays in an PPO are going to be higher than a HMO as well as the max out of pocket.

What is max out of pocket? The max out of pocket is a protection number to limit or cap the amount of MEDICAL (not drug) expenses a person can have. Another way to say it is that if a person has to spend their own money on various copays the health insurance company keeps track of how much. When you have spent the max out of pocket number the health insurance company kicks in and pays ALL your medical bills for the rest of the year. So the lower the number the better. This number resets every calendar year. The max out of pocket on HMOs range from $3400 to $6700 in the Northern

KY area. With a PPO you have an in network max and an out of network max. The ranges are a bit more complicated because it depends on how much a person is paying for the plan. On average the in network is around 5000 and the out of network is 10000.

INSIDER TIP:

Remember this is a BIG distinction vs Original Medicare. With Original Medicare they NEVER limit or cap how much YOU may have to spend in a year.

MEDICARE ADVANTAGE VS MEDICARE SUPPLEMENT

Earlier we looked at how Medicare Supplement insurance works. Now let's compare that to a Medicare Advantage Plan. Quick note, a person cannot (against the law) have both a Medicare Supplement and Advantage Plan. A Medicare Advantage Plan works almost completely opposite of a Medicare Supplement. A Medicare Advantage plan is a VARIABLE cost plan. This means the more you use it the more it costs and vice versa. When deciding between an Advantage Plan and a supplement I usually look at 4 factors. Health, affordability issues, prescription drugs, and mathematics. Let's take a quick look at each of these.

HEALTH

Health-If someone is in poor health and has known serious or chronic health issues then this leans in favor of a supplement. Many times I ask people to reflect back on the previous year in terms of health. How many times did they go to the doctor? Were they hospitalized in the last 24 months? If so, is there a possibility they may get hospitalized again for the same condition or has it been resolved? Do they have any surgeries coming up? These answers help determine which direction to go. Obviously, if someone is healthy and goes to their primary care physician once a year for a checkup that leans towards an advantage plan.

AFFORDABILITY

Affordability issues-The best insurance in the world is worthless if you can't afford it. I work with people from ALL income levels and the last thing you want to have happen is to take out insurance you can't afford. At some point the policy will most likely lapse. If this happens it can leave a person unprotected and vulnerable. If your budget is fairly tight and the idea of another bill that is going to go up every year is something that there is simply no room for then a Medicare Advantage plan may be a better option.

PRESCRIPTION DRUGS

Prescription Drugs-Most Medicare Advantage Plans include prescription drug benefits. This can save money on prescritption drug deductibles as well as premiums. Many Advantage plans do not have a deductible while most stand- alone plans do but they usually are around 400 a year for certain tiers of drugs. Also, with an Advantage plan there is not an additional premium for the drug plan. It is included. This obviously can save someone additional monies each and every month. Lastly, the drug prices themselves may be different on an Advantage Plan vs a stand-alone drug plan. This topic will be covered a bit more in-depth in the prescription drug section of this brochure.

MATHEMATICS

Mathematics-There are two types of people, those who are good at basic math and those who are not so good. If you fall into the latter category I would suggest you have myself or staff help you with this part. When we do a no cost consultation we look at the mathematics of each scenario as closely as possible. We look at a couple of different scenarios comparing an Advantage Plan to a Supplement. Each person is different because of many different factors. For this discussion there are too many variables to discuss but the general rule if someone can stay healthy for the first two to three years on Medicare the mathematics usually favor the Advantage Plan.

INSIDER TIP

If someone chooses an Advantage Plan we recommend that you PAY YOURSELF the same monthly premium you would have paid to an insurance company. Put the money is a separate bank account. If and when you have to pay a copay on your Advantage Plan pay it out of this account. Keep saving this money until you have your max out of pocket saved. Now you know you are 100% protected for at least a year if you have a bad year medically.

MEDICARE ADVANTAGE ADDITIONAL BENEFITS

Medicare Advantage plans can offer benefits that Original Medicare does not. Each plan is different so make sure you go through the Summary of Benefits and/or Evidence of coverage carefully to determine which benefits are offered and how comprehensive they are. Let's take a quick look at each category.

DENTAL-Some plans offer basic dental plans that just cover cleanings while others can be more comprehensive. Also, most carriers allow you to purchase more comprehensive dental benefits. One nice thing about these dental plans is that there are typically NO waiting periods for benefit to begin unlike traditional dental insurance.

VISION-Some plans give an allowance for contacts or glasses. These can be anywhere from 50 to 300 a year.

HEARING AIDS-Some plans offer either NO COST, REDUCED COST, or an allowance towards hearing aids.

OVER THE COUNTER ITEMS-Some plans offer a monthly allowance to help offset the cost of pharmacy items. These can be anywhere from about 10 to 50 a month.

TRANSPORTATION-Some plans offer to help get you to and from approved provider facilities like doctor appointments. If you have transportation issues this can be a great benefit.

MEALS-Some plans offer to send pre-packaged meals if you have been discharged from a hospital stay.

PERSONAL EMERGENCY RESPONSE SYSTEM-Some plans offer this service for as little as zero for persons with certain medical conditions. These systems allow you to contact help with a push of a button.

FITNESS-Some plans give their members access to a variety of fitness locations like the YMCA in order to exercise, swim, and stay socially healthy.

INSIDER TIP

It is also a good idea to check the network for these additional services. These networks are usually NOT quite as good as the medical networks. In other words, a company may have a great benefit but you may not be able to FIND a PROVIDER to actually get the benefit.

MEDICARE ADVANTAGE RISKS

In my opinion most Medicare Advantage Plans have 3 areas of risk that should be considered or protected against. These areas are hospital stays, skilled nursing, and cancer.

HOSPITAL STAYS-

With most Medicare Advantage plans the hospital copay is broken up over the course of a few day. Typically around 300 a day, days 1-5. For example, if you were admitted to a hospital and stayed 3 days you are looking at a 900 bill. The days are capped for the benefit period so if you are in the hospital for a long stay of 10 days you only pay for 5. You would still be looking at a 1500.00 hospital bill.

SKILLED NURSING-

Sometimes when someone has had a serious illness they may need additional help to recuperate. Many times that can mean a skilled nursing stay. With most Medicare Advantage plans the co-pay for days 1-20 is ZERO. So that is the good news. However, based on how serious the condition you may need to stay longer. Days 21-100 are usually around 170 dollars A DAY. This can obviously add up and considered a risk.

CANCER-

Unfortunately most people know someone that has been touched by this devastating disease. Not only is this disease destructive to your health but also to the pocketbook. Most Medicare Advantage plans use co-insurance as the amount you have to pay. This means that you will be responsible for 20% of the bill for treatment.

INSIDER TIP

Most people and even some insurance agents don't know that you can protect against these risks for a VERY REASONABLE amount. Read on about the Easyway hybrid option.

HYBRID OPTION

Just like a Medicare Supplement is designed to "supplement" or fill in the gaps of Original Medicare there are insurance products designed to "supplement" or fill in the gaps for a Medicare Advantage plan. I call this a hybrid option because we use two policies to act as one. This creates VERY comprehensive coverage at a VERY affordable cost. The second policy is designed to pick up the cost of the risks listed about. For example, if someone were to be admitted into the hospital or skilled nursing the second policy would pay the co-pays. This means that you, the policy holder, pays ZERO for hospital or skilled nursing. For cancer, the policy would pay a lump sum to help out with the cost. We usually structure the cancer policy to pay at least the max out of pocket amount. That way you know you have a least one years' worth of medical expenses covered. These plans are medically underwritten, but the guidelines are fairly loose compared to a Medicare supplement. The cost varies based on age. Call my office for more details and a rate for your personal situation.

ORIGINAL MEDICARE, MEDICARE SUPPLEMENT, MEDICARE ADVANTAGE RECAP

Hopefully you have learned some things about your Medicare options. Here are the "takeaways" that I would remember. A person can have either

Original Medicare, Original Medicare with a Supplement, a Medicare Advantage Plan, or a Medicare Advantage Plan with the hybrid option. The benefits of Original Medicare is that you can use any doctor in the Unitied States that accepts Medicare. Original Medicare with a Supplement is a fixed cost plan that can give very comprehensive medical coverage. Medicare Advantage plans are a variable cost plan that can provide low monthly cost and fairly comprehensive coverage with a couple of areas of weakness. Medicare Advantage plans with the "hybrid" option can help fill in the weakness areas and provide even more comprehensive coverage for a relatively low price.

PRESCRIPTION DRUG PLANS (PART D)

Depending on where you get the statistics the average Medicare beneficiary is on between 5-10 prescriptions drugs a month. Prescription drug costs have become a VERY REAL concern for persons on Medicare. The trend indicates that every year more and more dollars are being spent on prescription drug cost. Prescription drug plans can be difficult to analyze and compare. Again, we are going to try and give a brief description of the most important topics not necessary a comprehensive guide. We are going to break down some important topics within each drug plan. These include deductibles, formulary, tiers, total costs, and the coverage gap (DONUT HOLE).

DEDUCTIBLES

What is a deductible? A deductible is an amount the YOU PAY before the insurance company pays for ANYTHING. On part D drug plans most have a deductible for Tiers 3,4, and 5 of around 400 a year. Most, not all. Many people have drug plans where they are paying approximately 400 a year for a deductible maybe unnecessarily.

FORMULARY

The formulary is a list of drugs that are approved by the company. When looking for a drug plan it is IMPORTANT to understand which drugs you are taking will be covered or not covered. If your drugs are not on the formulary then the part D drug company may pay NOTHING towards the cost of your drug. Medicare requires that each company has drugs for each therapeutic category. This means if your drug is not on the list, your drug plan may pay for a different or similar drug. In my experience, most people do not want to switch drugs if they are having success with a particular one so make sure you check to see if your drug is approved. I would recommend when shopping around you use the online tools provided by each company.

These vary in usefulness but they are easier than looking them all up on paper. Also, the paper guides usually do not contain all the drugs. If shopping around and inputting your drug list into each different company's website and comparing results sound overwhelming and confusing you are correct. Feel free to give us a call and we can do it for you. By the way, at NO COST! How easy is that?

TIERS

All part D drug plans rank each drug into a tier group. Typically the tiers are 1-5 with 1 being the cheapest and 5 being the most expensive. The main thing you need to know here is that EACH drug can be given a different tier by each drug plan. Not company, each drug plan. For example, if a company offers 3 different drug plans the tiers may be DIFFERENT for certain drugs even with the SAME company. Not to mention, that the tiers for drugs will be different between companies. This means that the SAME exact DRUG can have DRAMATICALLY different prices between companies and plans.

TOTAL COSTS

When it comes to drug plans everyone has different needs. Just because a particular drug plan works well for a friend or neighbor doesn't mean it is a good fit for you. Many companies offer 3 or more drug plans with different monthly cost for the drugs as well as the monthly premium. Consumers typically pick the lower monthly premium drug plans but this can be a mistake. Sometimes paying more monthly can save on the cost of the drug itself. We recommend that you look at the total cost of the plan which includes the deductible, the monthly premium, and the annual costs of your drugs.

COVERAGE GAP (DONUT HOLE)

No conversation would be complete without addressing the coverage gap or DONUT HOLE. Drug coverage under Medicare has 4 different stages. Deductible,Initial Coverage, Coverage Gap, and Catastrophic Coverage. The deductible is when you are paying 100 percent of the cost of the drug. The initial coverage is when you are mainly paying a copay. The Coverage Gap or donut hole is when you are paying a percentage of the cost or typically more of the cost. The catastrophic coverage is when your drug cost drops way down. The concept here is that a person pays all the costs, then a copay or some of the costs, then pays more of the costs, then pays less of the costs. The donut hole is when you have to pay more of the costs. If you want all of the particulars on the exact calculations on how you move through the different phases feel free to call our office. The main point of this discussion is that a person's drug cost can go up considerably if they go into the coverage gap or donut hole. This is another reason why it is IMPORTANT to shop around. With each carrier a person could go into the donut hole at a different time or not at all. If you know this in advance it could help save you lots of money.

INSIDER TIP

Medicare does not require that all of your drugs are run through your drug plan. At easywaymedicare we have strategies that can help delay or avoid the DONUT HOLE.

CONCLUSION

We started this helpful guide with the statement that most of our clients find Medicare overwhelming and confusing. I hope this guide has helped clear up some of the confusion. I also hope that no matter how you decide to move forward with your Medicare choices that you would consider us for a second opinion. We do this each and every day and many times identify areas you may or may not have considered. Best of luck in your Medicare endeavors and if you ever need help we will be here for you.

A couple of things you need to know before we begin. Many clients ask “how do you get paid”. This is a great question and the answer may surprise you. First, we are an independent insurance broker. This means we are licensed and appointed with various insurance carriers. In Kentucky we are licensed and appointed with approximately 25 Medicare supplement companies and ALL of the Medicare Advantage plans. The insurance companies pay our compensation NOT YOU. This means that you will pay the same price whether you use our expertise or if enroll with a company directly. Additionally, it may also be helpful to know how we are paid. On a Medicare Supplement policy we are paid based on the annual premium. Our Medicare supplement shopping service is designed so you can see the rates of the companies in your area. We then usually recommend the LOWEST RATE possible with a company you are comfortable having. Medicare Advantage plans are regulated by CMS. They all pay the same amount no matter the company or the price. For example, a Medicare Advantage plan from Humana pays EXACTLY the same as a Medicare Advantage plan from Anthem. Also, a Medicare advantage plan that has a ZERO dollar premium pays the same as one that has $155.00 a month premium. ALL plans pay exactly the same so there is no incentive to recommend one over the other. Our Medicare Advantage shopping service is a no cost service designed to help you chose the plan that best fits your needs,

We hope this guide has given you many new insights into Medicare.