MY BENEFIT ADVISOR



FAQs: Medicare

Eligibility and Enrollment

Will I need to apply for Medicare or am I automatically enrolled?

Individuals are eligible for Medicare either when they turn 65 or after they have been collecting Social Security Disability benefits for 24 months. Enrollment is only automatic if you are already collecting Social Security; either retirement benefits or disability benefits.

If you are not collecting Social Security when you become eligible for Medicare, you must enroll through Social Security; either by phone, via the Social Security website or in person at their local Social Security office.

Whether you are automatically enrolled or do so yourself, it only applies to Medicare Parts A and B. If Part D (prescription drug coverage) is desired, you must enroll yourself.

When Should I apply for Medicare?

You should apply for Medicare during your Initial Enrollment Period (IEP), which is a seven-month period surrounding your 65th birthday. It begins 3 months before you turn 65, includes the month you turn 65 and continues for the following 3 months. Some circumstances may allow you to waive Medicare and enroll later, penalty free.

You can also apply during a Special Enrollment Period (SEP) if you did not enroll during your Initial Enrollment Period (IEP). Losing employer coverage is the most common reason for an SEP, but there may be other circumstances allowing enrollment outside of your Initial Enrollment Period.

When does my Medicare coverage begin?

The best way to know when your Original Medicare begins is by referring to the letter you received from the Social Security Administration or the Railroad Retirement Board. Alternatively, you can look for the date on the lower right corner of your Medicare card. The effective dates for other programs,

like Medicare Advantage or Medicare Part D (Prescription Drug Coverage) vary depending on when you enroll and which election period you qualify for.

When can I change plans?

There may be a time when your health care needs change and you may want to change Medicare plans. When can you do this? Changes in plans can take place at different times, depending on the change you want to make:

During the Annual Election Period - from October 15 through December 7 each year (AEP) you can change Medicare Advantage or Medicare Part D Prescription Drug plans. Your new coverage will begin on January 1 of the new year.

During the Medicare Advantage Open Enrollment Period - If you're enrolled in a Medicare Advantage Plan and would like to change back to Original Medicare, Parts A and B, you are permitted to do so during the OEP, which runs from January 1 through March 31 each year. Additionally, you may be able to enroll in a stand-alone Prescription Drug (Part D) coverage during this period. The effective date of the Part D coverage would be the first day of the month after the new plan receives your enrollment form.

During a Special Election Period - Medicare recognizes that special circumstances may occur that could necessitate a need to change your plans. As such, you may be able to change plans if:

- You lose your current coverage
- You move to a new address
- You qualify for other coverage, such as an employer-based program, Medicaid or a State Pharmaceutical Assistance Program

The dates and types of changes that can be made vary so be sure to check for details.

What is Medical underwriting and when is it required?

Medical underwriting is the concept that describes a process where an insurance company reviews your past medical history to determine your level of medical risk. If you are enrolled in Original Medicare and would like to add a Supplement (Medigap) plan, medical underwriting may be required, depending on when you enroll. The private insurance companies that provide Medigap Plans cannot require medical underwriting if you enroll during your six-month Medigap Open Enrollment Period. This means you are guaranteed acceptance into the program.

However, if you apply for a Medigap Plan outside your Open Enrollment Period, the insurance carrier may require medical underwriting. As a result of the information obtained through the underwriting process, the carrier can decide if they would like to offer you coverage, the premium they will charge you and whether they want to cover your pre-existing conditions.

General Information

How can I find out if my physician accepts Medicare?

Most people going on to Medicare would prefer to keep the doctor they've been using, especially if they have a long history with that doctor. However not all doctors accept Medicare assignment, so it is important to find out whether or not they do. Using a doctor that accepts Medicare assignment will generally save you out-of-pocket expenses.

Medicare.gov has a physician compare tool that you can use to find out if your doctor accepts Medicare assignment. Also, if you are looking for a new doctor that accepts Medicare assignment, you can use this tool to find a doctor in your area.

What are the advantages of using a doctor that accepts Medicare assignment?

Generally speaking, your out-of-pocket expenses will be less if your doctor accepts Medicare assignment. Situations regarding Medicare assignment generally fall into one of the following categories:

- **You use a participating doctor** - These doctors accept Medicare assignment, meaning they accept the amount Medicare has approved for the services they have provided.
- **You use a non-participating doctor** - These physicians can choose to either accept or not accept Medicare assignment. If they choose not to accept the assignment, you might be required to pay an additional 15% charge above the approved amount. This is referred to as a Medicare Part B excess charge. Combined with the 20% co-insurance, your total requirement could be 35%.
- **You use a doctor who has opted out of Medicare** - These doctors can charge you anything they find appropriate for the services and supplies they have provided you. You would be responsible for the full cost of benefits.

Are the premiums I pay for Medicare Tax Deductible?

Medicare premiums are tax deductible as a portion of your medical expenses. If the total of your medical expenses in any given year exceeds 10% of your gross income, you can deduct them. Always consult with a tax professional for guidance, however, before deducting any medical expenses.

Is there financial assistance available for any Medicare programs?

Low-income individuals can receive some assistance with out-of-pocket expenses if they qualify for one of four Medicare Savings Programs. The four types of programs are:

1. The Qualified Medicare Beneficiary (QMB) Program
2. The Specified Low-Income Medicare Beneficiary (SLMB) Program
3. The Qualifying Individual (QI) Program
4. The Qualified Disabled and Working Individuals (QDWI) Program

Benefits of each program vary, but all of them except the QDWI Program help pay for Medicare Part B premiums. Additionally, eligibility for some of these programs also automatically qualifies you for the Extra Help Program, which helps enrollees save on the cost of prescription drugs.

For more information about these programs or to apply, contact your state Medicaid office, visit Medicare.gov or call Medicare at **1-800-MEDICARE (1-800-633-4227)**.

Medigap and Medicare Advantage Plans

What's the difference between Medigap and Medicare Advantage?

Medicare Parts A and B won't cover all your medical expenses and as a result, many people might desire additional coverage to fill in the gaps. Both Medigap and Medicare Advantage are good options offered by private companies but it's important to understand the differences.

Medigap (also known as Medicare Supplement) Plans are designed in a sense to "wrap" around Original Medicare. This means that the Medigap Plan will pay after Medicare Parts A and/or B pays, picking up any applicable copays and deductibles based on the plan you purchase.

Medicare Advantage, on the other hand, is often looked at as a replacement to Original Medicare. If you choose to enroll in Medicare Advantage, you will receive your benefits directly from the plan chosen, not Medicare. Most of these plans will require you to utilize the plan's network of providers, except for emergency medical situations. Copays may apply to various aspects of the benefit plan.

How many different Medigap plans are there?

Currently, there are 8 standard Medigap plans offered to new enrollees, labeled plan A, B, D, G, K, L, M and N. In 1990, Medicare established guidelines that required all plans of the same letter include the same benefits regardless which insurance company is offering them. This holds true for 47 of our 50 U.S. states, as Massachusetts, Minnesota and Wisconsin provide their own standardized plans. Please note, however, that insurance companies are not required to offer all the plans and premiums are not standardized, so the price you pay for Plan G, for instance, could vary from one insurance company to another.

How many different Medicare Advantage plans are there?

Many people find it difficult to decide between enrolling in Original Medicare and perhaps a supplement versus Medicare Advantage. It might be helpful to take a look at the pros and cons of a Medicare Advantage plan:

Pros:

1. Often, the coverage provided under Medicare Advantage enhances what is provided through Medicare Parts A and B. Companies are required to provide at least what Medicare parts A and B provide but are permitted to provide additional benefits like dental, vision and prescription drug coverage, for instance.

2. Although you must continue to pay your Part B premium in addition to the premium charged by the insurance company for the Advantage plan, your total out-of-pocket expenses with an Advantage plan can be lower than if you enrolled just in Medicare Part A and B. That's because most Advantage Plans limit your out-of-pocket liability and include coverage for prescription drugs.

3. Medicare Advantage Plans provide more coordinated care, providing you with a valuable and convenient advantage. Typically consisting of managed care programs, these plans often utilize a primary care physician to coordinate your care across the varies networks of doctors and hospitals.

Cons:

1. The same provider networks that are described above can also be considered a disadvantage, as they restrict your access to doctors that are in the network. If you want to go outside the network for care, the plan may either not cover your medical expenses or your out-of-pocket costs may be greater. The plan may also require prior authorizations for certain services.
2. Most plans have networks consisting of providers within a certain local geographic region, which may not be good for people who travel often or have a second home located in a different area.

Questions Relating to Employer Coverage

Can my employer require me to terminate my group coverage and take Medicare when I turn 65?

You can choose to leave your group health plan and enroll in Medicare but your employer cannot require you to do so. Be sure to ask your employer about the consequences of leaving the group health plan before doing so. For instance, can your spouse remain on the plan? Or, will you lose the ability to contribute to a HSA?

What would happen if after retired, I decide to go back to work?

If you take a job after retirement and would like to take advantage of employer-based coverage, you can cancel your Medicare Part B coverage. If you later retire again, you will be able to obtain Part B coverage again using a Special enrollment period due to loss of employer coverage.

How does Medicare coordinate with COBRA?

To avoid being imposed with penalties, it is important to understand how Medicare coordinates with COBRA, as it works differently than with active employer coverage.

While you are actively at work with a large employer (20 or more employees), your group insurance is primary and Medicare is secondary. With COBRA, Medicare is primary and COBRA is secondary.

As a result, if you are on COBRA coverage through an employer and then become eligible for Medicare, you must enroll in Part A and B during your Initial Enrollment Period (IEP). Your COBRA coverage will usually end when your Medicare coverage begins. If you don't enroll during your IEP

you may incur a lifelong penalty. (This will not affect any dependents you may have, as they can continue on COBRA for up to 3 years provided they are not yet 65 or otherwise eligible for Medicare.)

If you are actively at work past the age of 65 and decide to retire at some point, you would be permitted to enroll in COBRA coverage, but you must also enroll in Parts A and B no later than your 8th month on COBRA coverage. This is true even if your COBRA coverage continues beyond that since Medicare will be primary and COBRA secondary. If you don't enroll in Medicare you can incur a permanent late enrollment penalty for Part B. Perhaps even more importantly, it could delay your Medicare Part B coverage until July of the following year.

An exception exists for anyone with End-Stage Renal Disease. In this scenario, your COBRA coverage will be primary during a special 30-month coordination period between Medicare and COBRA.

Where can I find more information about Medicare?

You can find more information about Medicare by visiting the Medicare website at www.Medicare.gov, or by contacting us at www.mybenefitadvisor.com/medicare.

My Benefit Advisor is a licensed health insurance agency and is not affiliated with or endorsed by the government or Federal Medicare Program. We do not offer every plan in your area. Provide a zip code for the number of organizations and products we represent in your area. Please contact www.medicare.gov or 1-800-MEDICARE to get information on all of your options. CA Insurance License #0G33244.