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Medicare fundamentals:

A guide to planning for healthcare in retirement

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Introduction

Experts point to rising healthcare costs as the biggest challenge to financial security in retirement. Getting the most out of your Medicare benefits will play an important part in your retirement readiness. Retirement readiness requires an approach to Medicare that ensures you get the most out of the benefits to which you are entitled.

This guide provides a Medicare overview for people who are:

- approaching eligibility and seeking to learn, prepare, and consider their options.
- already enrolled and wish to review their options as part of their overall retirement plan.
- assisting loved ones with Medicare enrollment or reviewing their plan elections.

Medicare eligibility and enrollment

Eligibility

In general, Medicare is available for legal U.S. residents who have lived in the U.S. for at least 5 consecutive years who:

- are age 65 or older.
- are younger than age 65 with disabilities.
- have end-stage renal disease or ALS.
- have been on Social Security Disability Insurance (SSDI) for at least two years.

Medicare eligibility and enrollment

Enrollment

You will **automatically be enrolled** in Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) if you:

- are already receiving benefits from Social Security or the Railroad Retirement Board (RRB) when you turn age 65.
- are under age 65 but have already received disability benefits from Social Security or the RRB for 24 months.
- have ALS when your Social Security benefits begin.

If you don't want Part B, you must decline coverage before the date indicated on your coverage card.

Exception: If you reside in Puerto Rico, you will be automatically enrolled in Part A but must also enroll in Part B.

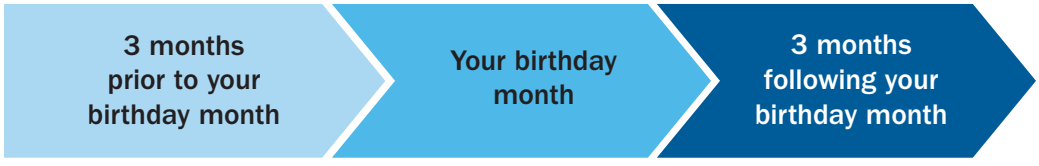
You will **not be automatically enrolled** and must sign up for Part A/Part B if you:

- are approaching age 65 but not receiving Social Security or Railroad Retirement Board benefits. In this case you must sign up during the three-month enrollment window.
- are a resident of Puerto Rico and are receiving benefits from Social Security or the RRB. In this case, you will be automatically enrolled in Part A, but need to sign up for Part B.
- have end-stage renal disease and want Medicare coverage.

Timing synched to birthdate

Enrollment periods are generally within a seven-month window around your 65th birthday, from the first day of the month 3 months before your birthday, through your birthday month, and ending on the last day of the third month after your birthday.

Figure 1: **Enrollment window around your 65th birthday**



Your premium can increase by as much as 10% for each 12-month period within which you could have had Part B, and the penalty increases the longer you go without enrolling.

Failure to sign up during your enrollment period can result in delays and added expenses.

Medicare eligibility and enrollment

Enrollment scenarios

Scenario 1

You are within 3 months of your 65th birthday and not ready to start your monthly Social Security benefits yet.

You can use the online Social Security form at **https://www.ssa.gov/retireonline/** to sign up just for Medicare and apply for your retirement or spouse's benefits later. Usually, no documentation is required. To enroll in Parts C and D, you must first be enrolled in Parts A and B.

Scenario 2

You have medical insurance coverage under a group health plan based on your or your spouse's current employment.

You may not need to apply for Medicare Part B at age 65. You may qualify for a "Special Enrollment Period" that will let you sign up for Part B during:

- any month you remain covered under the group health plan **and** your, or your spouse's, employment continues.
- the eight-month period that begins the month after your group health plan coverage or the employment it is based on ends, whichever comes first.

Scenario 3

You are already enrolled in Medicare and wish to change plans.

During Open Enrollment—from October 15 to December 7—all people with Medicare can change their healthcare plan selections with no penalties. If you are already enrolled in Parts A and B, you can add Parts C and D during Open Enrollment or a "Special Enrollment Period" for circumstances such as:

- Losing employee coverage
- Moving to a new service area
- Being assigned to a Medicare Prescription Drug plan by the government

You can enroll/change plans on the Social Security website **https://www.ssa.gov/benefits/medicare/**.

Medicare eligibility and enrollment

Enrollment scenarios (continued)

Scenario 4

You did not sign up during your Initial Enrollment Period.

In most cases, you'll have to pay a late enrollment penalty.

For Part A: If you have to buy Part A, and you didn't buy it when you were first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you didn't sign up.

For Part B: If you didn't get Part B when you're first eligible, your monthly premium may go up 10% for each 12-month period you could've had Part B, but didn't sign up. You'll likely have to pay this penalty each time you pay your premiums for as long as you have Part B; and the penalty increases the longer you go without Part B coverage.

For Part D: The amount of the penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the penalty is calculated by multiplying 1% of the "national base beneficiary premium" by the number of full, uncovered months that you were eligible but didn't enroll and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $0.10 and added to your monthly premium. The "national base beneficiary premium" may increase each year, so the penalty amount may also increase each year. After you enroll in Medicare drug coverage, the plan will tell you if you owe a penalty and what your premium will be.

You may be able to sign up without a late enrollment penalty if you qualify for a **Special Enrollment Period**.

Scenario 5

Your spouse is losing his/her work insurance. Can you add him/her to your Medicare and/or enroll him/her?

The only way your spouse can qualify before age 65 is through disability. Medicare is not like employer group coverage which allows you to add a dependent. However, there is a scenario where your younger spouse can help save you money. In some cases, a younger spouse can help you get Medicare Part A with no monthly premium.

For example, if you have reached age 65, but have not worked long enough to qualify for premium-free Part A, and if your younger spouse has worked a minimum of ten years and paid Medicare taxes, their contribution will enable you to get Part A with no monthly premium.

Medicare eligibility and enrollment

Enrollment scenarios (continued)

Scenario 6

You have an HSA and would like to know how Medicare affects it.

Age doesn't determine HSA-eligibility, but enrollment in Medicare does. You can no longer contribute to an HSA once you have enrolled in any parts of Medicare, but you can withdraw any existing funds at any time.

That said, HSAs can still help you save for retirement health expenses tax free. Once enrolled, you can use an existing HSA balance tax free to pay qualified medical expenses:

- Medical plan deductibles
- Co-pay and co-insurances
- Dental and vision expenses
- Over-the-counter medications and prescriptions
- Medicare Parts A, B and D premiums
- Medicare Part C (Medicare Advantage Plans)

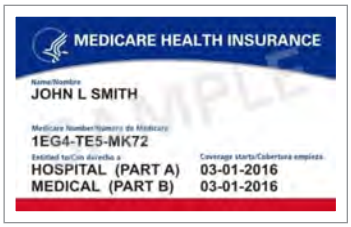
You *cannot* use your HSA to pay premiums for Medicare Supplemental Policies such as Medigap.

The three layers of the HSA tax benefits give you the best of both worlds if you are able to make contributions to the HSA, allow the funds to accumulate, and wait until your retirement years to access. Your contributions go in tax free, funds accumulate tax free and withdrawals for qualifed medical expenses are tax free.

Once you reach age 65, if you want to treat your HSA like a traditional retirement account you can withdraw for non-qualified medical expenses without penalty while paying ordinary income taxes (though no Required Minimum Distributions are required). Depending on where you anticipate your tax brackets will be in different retirement periods, this may be a beneficial strategy.

How Medicare is structured

Medicare Part A and Part B are known as “Original Medicare,” Part C is referred to as “Medicare Advantage,” and Part D refers to the prescription drug plan.

Government Plans		Private Plans		
Medicare Part A	**Medicare Part B**	**Medicare Part C**	**Medicare Part D**	**Medigap Plans**
Helps with hospital costs	**Helps with doctor costs**	**Medicare Advantage plan**	**Private drug plan**	**Medicare supplement**
 When enrolled, you’ll get your Medicare card by mail. Show your card when you need hospital, medical or other health services.		Combines **Parts A and B** in *one* plan Provided by **private health insurers that offer Medicare Advantage**	Helps with prescription costs Provided by **private health insurers**	Helps cover costs not paid for by Medicare Provided by **private health insurers**

Medicare Part A offers premium-free hospital coverage of inpatient hospital stays, skilled nursing facility care, hospice care and home health care.[1]

Medicare Part A (Hospital Insurance)

- 2021 deductible: $1,484
- Coinsurance: 20% of Medicare-approved amount after deductible is met
- Out-of-pocket expense: no yearly limit
- Doctors: Any in the U.S., usually no referral/preapproval required
- Can add supplemental coverage, e.g., Medigap or coverage from previous employer, credit union, etc.
- Medigap can help cover out-of-pocket costs

Part A does not cover:

- Private nursing
- Private room (unless medically necessary)
- Television and phone
- Long-term care

[1] Some exceptions may apply

How Medicare is structured

Medicare Part B (Medical Insurance)

Medicare Part B offers premium-based medical coverage for:

- Medically necessary services needed to diagnose/treat your medical condition
- Preventive services to detect or defend against illness

Coverage includes doctors and other providers, outpatient care, ambulance services, home health care, durable medical equipment, diagnostic tests, x-rays, and preventive services including mental health and addiction. It does not provide coverage outside of the U.S.

- 2021 premium: $148.50
- 2021 deductible: $203
- Coinsurance: 20% of Medicare-approved amount after deductible is met

Your Part B premium will automatically be deducted from your payment if you receive benefits from Social Security, the Railroad Retirement Board, or the Office of Personnel Management. Otherwise, you will receive a bill.

Addressing current issues

Medicare Part B also covers certain telehealth services. You'll pay the same amount for most telehealth services that you would have paid had they been in person.

Medicare Part B covers most COVID-19-related expenses:

- COVID-19 testing
- COVID-19 antibody testing if you were diagnosed with or suspected of having had COVID-19
- Monoclonal antibody treatments for COVID-19
- COVID-19 vaccines

Medicare Part A covers hospitalizations, including if you are diagnosed with COVID-19 and would otherwise have been discharged but must stay for quarantine. Hospital deductibles, copays and coinsurances apply.

How Medicare is structured

Medicare Part B (Medical Insurance) (continued)

Income-Related Monthly Adjustment Amount

If the modified adjusted gross income on your IRS tax return from two years prior to enrollment exceeds a certain amount, an Income-Related Monthly Adjusted Amount (IRMAA) will be charged in addition to your premium.

The standard Part B premium amount in 2021 is $148.50. Please refer to the chart below for a description of IRMAA adjustments.

Yearly income in 2019			You pay each month (in 2021)
File individual tax return	File joint tax return	File married & separate tax returns	
$88,000 or less	$176,000 or less	$88,000 or less	$148.50
above $88,000 up to $111,000	above $176,000 up to $222,000	Not applicable	$207.90
above $111,000 up to $138,000	above $222,000 up to $276,000	Not applicable	$297.00
above $138,000 up to $165,000	above $276,000 up to $330,000	Not applicable	$386.10
above $165,000 and less than $500,000	above $330,000 and less than $750,000	above $88,000 and less than $412,000	$475.20
$500,000 and above	$750,000 and above	$412,000 and above	$504.90

If you are newly retired, you may wish to request a reevaluation of your IRMAA. Work reduction/stoppage is considered a “life event” that warrants reevaluation.

If you are enrolled in Part B/Part D, Social Security will notify you if any IRMAA criteria apply to you. The amount you pay may change each year. If you receive an IRMAA notice, you should keep it for your records. The notice will include information about your appeal rights. If you disagree with the notice, you can appeal by following the instructions to contact Social Security.

Should you get Part A and Part B?

According to the government, most people should enroll in Part A and Part B when they become eligible. However, you may choose to postpone Part B, depending on the type of health coverage you have.

How Medicare is structured

Additional enrollment scenarios

Scenario 7

You are currently working and have coverage through your job.

If your employer has fewer than 20 employees, you should sign up when you become first eligible because Medicare pays before your other coverage. If your employer employs more than 20 employees, you may be able to postpone Part A and Part B without paying a penalty if you enroll later. Consult your benefits administrator for your employee plan details. Once you're eligible for Medicare, you can enroll in Part A at any time. Your Part A coverage will go back retroactively 6 months from when you sign up, but no earlier than the first month you're eligible.

When your employment coverage ends, you may be eligible for COBRA coverage, which extends your coverage in your employer's plan but at additional cost to you. You have 8 months to sign up for Part B without a penalty, whether you choose COBRA or not. If you don't enroll in Part B within the eight-month window, you may need to wait until January 1, and coverage may not begin until July of that year. Before you elect COBRA, Medicare recommends that you talk with your State Health Insurance Program (SHIP) about Part B and Medigap.

Scenario 8

You have coverage through your spouse's job.

If your spouse's employer has fewer than 20 employees, you should sign up when you become first eligible because Medicare pays before your other coverage. If your spouse's employer employs more than 20 employees, you may be able to postpone Part A and Part B without paying a penalty if you enroll later. Consult the benefits administrator for specific employee plan details.

You can delay your coverage, depending on your circumstances:

- If you'll be getting benefits from Social Security or the Railroad Retirement Board (RRB) at least 4 months before you turn age 65, you'll automatically get Part A and Part B. If you don't want Part B, follow the instructions that come with your Medicare card in the mail 3 months before your 65th birthday and send the card back so you won't pay Part B premiums.
- If you **won't** be getting benefits from Social Security or the RRB at least 4 months before you turn 65, you don't need to do anything when you turn age 65.

When your spouse's employment coverage ends, the same options regarding COBRA and Medicare apply as in Scenario 4 on the previous page.

How Medicare is structured

Additional enrollment scenarios (continued)

Understanding other scenarios

Scenario	Solution
You have retiree coverage from your/your spouse's former employer.	You should sign up for Part A and Part B when you are first eligible because Medicare pays before your other coverage.
You have Marketplace or other private insurance.	You should sign up for Part A and Part B when you are first eligible. If you have a Marketplace plan for individuals or families, you should drop it so that it stops when your Medicare starts.
You have Veteran benefits.	If you have only Veteran benefits, you should sign up for Part A and Part B when you are first eligible.
You have CHAMPVA, TRICARE, or you have End-Stage Renal Disease (ESRD).	Please visit **Medicare.gov** for detailed information.

If you don't want Part B

If your Medicare hasn't started yet, there are two options:

1. If you were automatically enrolled in Part A and Part B and received your Medicare card, follow the instructions on the card and send the card back.
2. If you signed up for Medicare through Social Security, contact Social Security.

If your Medicare has already started and you want to drop Part B, contact Social Security for instructions on how to submit a signed request.

How Medicare is structured

Medicare Part C (Medicare Advantage)

With Medicare Advantage, you have one medical card. You visit your doctor, present the card, make your co-payment, and the healthcare provider submits the claim to your insurer. The insurer makes all remaining payments according to the plan benefits.

Medicare Part C—also known as Medicare Advantage—combines Parts A and B and can also include Part D (drug coverage). Medicare Advantage plans are offered by private health insurers that are approved by Medicare and required to cover all Medicare-approved services.

You may need to use health care providers who participate in the plan's network and service area for the lowest costs. These plans set a limit on your out-of-pocket expenses each year for covered services, to help protect you from unexpected costs. Each plan can have a different limit, and the limit can change each year—something to consider when choosing a plan. Some plans may offer out-of-network coverage, but at a higher cost. Similarly, some may offer coverage outside the U.S. but, again, at a higher cost.

Medicare pays a fixed amount each month to the health insurers offering Medicare Advantage plans to cover your care. These health insurers must follow rules set by Medicare, but each Medicare Advantage plan can charge different out-of-pocket costs. They can also have different rules for how you get services, and rules can change each year, so it's a good idea to review your elections prior to each Open Enrollment or qualifying enrollment period.

Out-of-pocket costs in a Part C plan depend on:

- Whether the plan charges a premium
- Whether the plan pays another part of your Part B premium
- Whether the plan has any deductibles
- How much you pay for a copayment/coinsurance for each visit/service
- The type and frequency of the services you need
- Whether you go in/out of network and follow other plan rules
- Whether you need extra benefits and whether the plan charges for them
- The plan's limit on out-of-pocket costs
- Whether you have Medicaid or get help from your state programs

While Part C can be less expensive than Parts A and B, it may require you to choose an in-network, in-region provider, and may require referrals. It may also include Part D plus extras like dental, vision, hearing and fitness coverage. It does not provide coverage while outside the U.S.

How Medicare is structured

Medicare Part D (Prescription drug coverage)

A plan's list of covered drugs is called a "formulary;" each plan has its own formulary.

Original Medicare (Part A and Part B) doesn't cover most prescription medicines. For prescription drug coverage, you will need to take one of two steps: enroll in a Medicare Part D Prescription Drug Plan (PDP), or enroll in a Medicare Part C (Medicare Advantage) plan that includes Part D benefits.

Medicare Part D covers your prescription drugs. There is no automatic enrollment for Part D, so you will need to elect it during enrollment. Beneficiaries who enroll in Part D typically pay a monthly premium, annual deductible and per-prescription cost-sharing. An Income-Related Monthly Adjusted Amount (IRMAA) may apply.

All plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain protected classes, like drugs to treat cancer or HIV/AIDs. All Medicare prescription plans must be equal to or better than the Defined Standard Benefit.

Understanding defined standard benefit Medicare Part D - 2021

Threshold	Rule
$445 deductible	**Deductible** **Enrollee pays:** $445
$4,130 total cost of drugs initial coverage stage	**Initial coverage** **Enrollee pays:** 25% of prescription drug cost.
	Coverage gap* – also called the "donut hole" **Enrollee pays:** 25% of prescription drug cost for generic or 25% of undiscounted cost for brand name.
$6,550 out-of-pocket threshold	**Catastrophic coverage** **Enrollee pays:** either 5% prescription drug cost, or $9.20 brand name/$3.70 generic, whichever is greater.

* Drug manufacturers absorb 70% of the cost of brand name drugs in the form of a discount. Although not paid by you, the discounted portion of the brand name drug cost does count towards your annual out-of-pocket threshold. But your share of the cost for brand name drugs is based on the undiscounted cost Coverage Gap Percentage Division: You: 25%, Manufacturer Discount(s): 70%, Plan: 5%.

How Medicare is structured

If you are late in signing up for Part D, penalties may apply. Penalty premiums are increased for every month that you delay and this can become very costly.

Medicare Part D (continued)

Medicare drug plans may have the following coverage rules, so examine your plan carefully before choosing to ensure it aligns with your prescription medication needs:

- Opioid pain medication safety checks
- Prior authorization requirements
- Quantity limits
- Step therapy
- Part D vaccine coverage
- Drugs you get in hospital outpatient settings

The donut hole can be avoided altogether by switching to lower-cost medicines (such as generics), using prescription mail order, enrolling in a drug assistance program, or applying for the Low-Income Subsidy (LIS) program (also called "Extra Help").

Mind the "donut hole"

The donut hole is the **coverage gap** between your initial prescription coverage limit and catastrophic coverage. In this gap, you pay higher prices for prescriptions until you reach a predetermined out-of-pocket amount. Not everyone enters this gap.

In 2021, once your Part D plan has spent $4,130 on covered drugs, you would be in the coverage gap. When you have spent $6,550 out of pocket, you would be out of the coverage gap; catastrophic coverage would then ensure you would pay only a small prescription coinsurance/copayment for the rest of the year.

Once you reach the coverage gap, you'll pay no more than 25% of the cost for your plan's covered brand-name prescription drugs. Although you'll pay no more than 25% of the price for the brand-name drug, almost the full price of the drug will count as out-of-pocket costs to help you get out of the coverage gap.

Medicare will pay 75% of the price for generic drugs and you will pay 25% while you are in the coverage gap. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

Even though you'll pay no more than 25% of the full cost for your plan's covered drugs in the donut hole, to help you get out sooner, brand-name drugs will have nearly their full price applied as out-of-pocket costs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

How Medicare is structured

Medicare supplement plans (Medigap)

Medicare supplement plans—sometimes called Medigap plans—are sold by private health insurers and can help pay some of the health care costs that Original Medicare (Parts A and B) won't cover, such as co-payments, co-insurance and deductibles. All policies offer the same basic coverage, but some offer more features and benefits than others. Each health insurer decides which Medigap policies it wants to sell, although state laws may factor into their decisions. Medigap policies in Massachusetts, Minnesota and Wisconsin are standardized in a different way.

Please refer to the chart below for detailed information about the Medicare supplement plans, and the respective benefits they offer.

	Medigap Plans									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	•	•	•	•	•	•	•	•	•	•
Part B coinsurance or copayment	•	•	•	•	•	•	50%	75%	•	•***
Blood (first 3 pints)	•	•	•	•	•	•	50%	75%	•	•
Part A hospice care coinsurance or copayment	•	•	•	•	•	•	50%	75%	•	•
Skilled nursing facility care coinsurance			•	•	•	•	50%	75%	•	•
Part A deductible		•	•	•	•	•	50%	75%	50%	•
Part B deductible			•		•					
Part B excess charge					•	•				
Foreign travel exchange (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$5,880 for 2020 $6,220 for 2021	$2,940 for 2020 $3,110 for 2021	N/A	N/A

Source: www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies

* Plans F and G also offer a high-deductible plan. With this option, you must pay for Medicare-covered costs (coinsurance, copayments and deductibles) up to the deductible amount of $2,340 in 2020 ($2,370 in 2021) before your Medigap plan pays anything.

** For Plans K and L, 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 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.

As of January 1, 2020, Medigap plans sold to new people with Medicare aren't allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare as of January 1, 2020. If you already have either of these two plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, you were able to keep your plan. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans.

How Medicare is structured

Medicare supplement plans (Medigap) (continued)

There are several reasons why you might choose a Medicare supplement plan:

- Choice of plans to meet your needs
- Choice of any licensed doctor or hospital that is eligible to receive reimbursement from Medicare
- Plans are portable
- Applications are accepted throughout the year if you are eligible
- Plans are available that cover you for emergency care when travelling outside the U.S.
- Claims are submitted electronically by the original Medicare processor for Parts A and B:
  - One step for you
  - One ID card for medical and pharmacy
  - One explanation of benefits

As with all the above-mentioned plans, the timing of your enrollment is important.

If you delay enrollment in a Medicare supplement plan, you may be denied coverage due to a pre-existing condition, whereas you cannot be denied if you enroll during Open Enrollment.

Long-term care

Medicare doesn't cover long-term care if that is the only care one needs.

Long-term or "custodial" care comprises an array of services and support for personal care needs that are not medically related, such as bathing, dressing, and other activities of daily life. Most nursing home care is custodial care. You pay 100% for noncovered services, which include most long-term care.

To qualify for long-term care paid for by Medicaid, a senior must meet strict financial and functional requirements administered by each state. In addition to the financial threshold, an applicant must need a nursing-home level of care as determined by a medical specialist.

Medicare savings programs

If you need help paying for your Medicare benefits, there are options available to you.

A Low-Income Subsidy (LIS), in the form of "Extra Help" from the federal government, helps members afford their plan's monthly premium, deductible, and prescription co-payments if they qualify based on predetermined income levels.

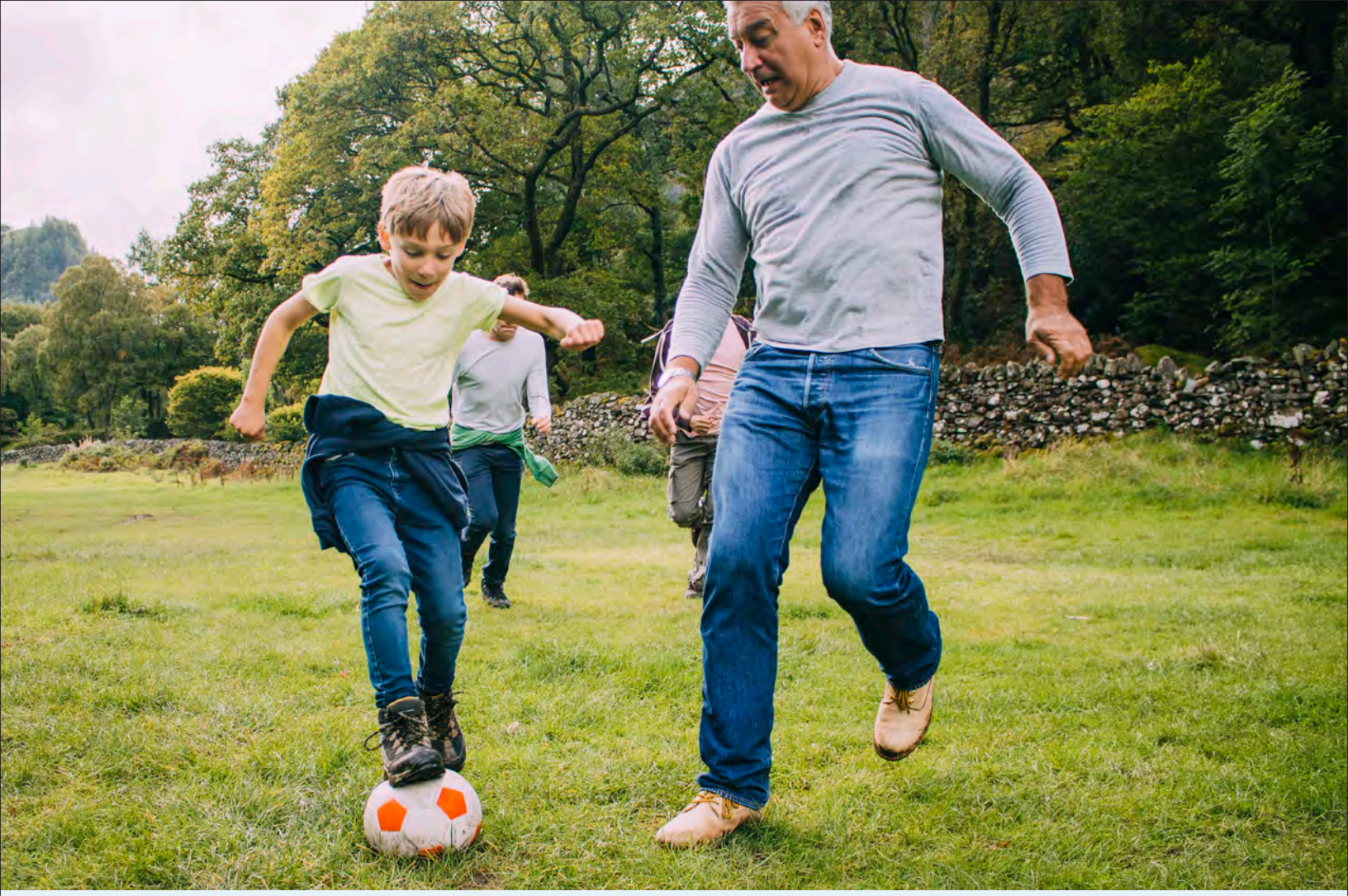
State Medicare Savings Programs, like the ones listed below, can also help. If you have income from working, you may qualify even if your income is higher than the income limits listed for each.

- 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 QMB, SLMB, or QI, you automatically qualify for Extra Help paying for Medicare drug coverage.

Medicaid is a state and federal program that provides health coverage if you have a very low income and limited financial assets. If you are eligible for both Medicare and Medicaid (dually eligible), you can have both. They can work together to provide you with healthcare and help you manage costs. If you qualify for both, it often means no out-of-pocket healthcare costs. If you change residence from one state to another, you will need to reapply for Medicaid, but not for Medicare.

Programs for All-inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet healthcare needs without going to a nursing home or other facility for care.



Information resources

- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.
- Find and compare health and drug plans at **Medicare.gov/plan-compare**.
- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP).

Summary

It is important to understand your Medicare and other financial planning options in the context of your particular healthcare needs, other coverage, and budget to ensure the coverage you choose makes the most of your options and positions you well for continued good health and well-being in retirement. As part of this understanding, it is equally important to sign up in accordance with enrollment windows and criteria to avoid paying stiff penalties.

Points to consider when choosing plans

- Do you take brand-name prescription drugs instead of generics?
- Are there specific doctors and pharmacies that you need to use?
- Do you have additional insurance through an employer, credit union, spouse's/partner's plan?
- What is most important: coverage, cost, access to your network?
- Do you plan to travel?
- Have you been diagnosed with a new illness?
- Will you need to supplement by purchasing private insurance to be fully covered?
- Can you afford your current plan?
- Did you have problems with your plan in the past year?
- Are you confident in your ability to choose the right options, or would you value help?

Once you have enrolled, it is wise to review your coverage regularly to determine whether changes to factors like age, income, status, lifestyle, state of residence, health, etc. would predicate a change in your healthcare coverage plan and/or your ability to afford coverage.

Also, review changes in your coverage to ensure that formularies, plan features and benefits, and other plan-related elements have not changed in ways that would make it prudent for you to consider another plan.

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