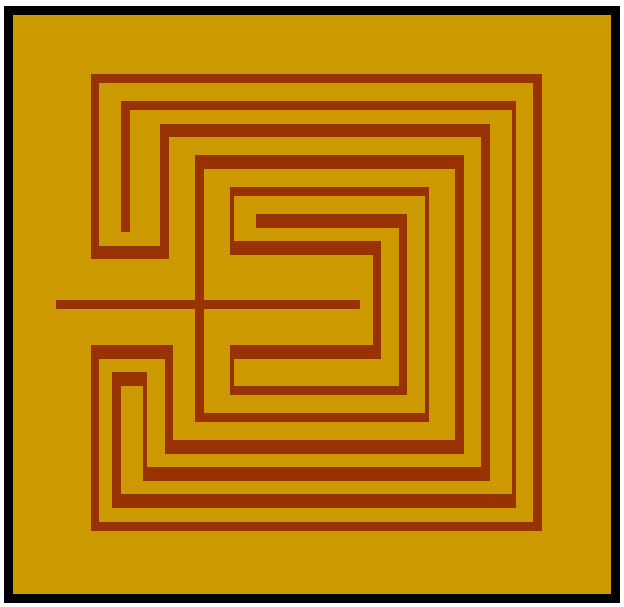
The Definitive Three Step

Approach to

Choosing the Best Medicare Plan

(for you)

While Avoiding the Pitfalls



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INTRODUCTION

Medicare has dozens if not hundreds if not thousands of publications containing millions if not billions if not trillions of pages of information. I have tried to boil it all down to a few pages and three simple steps. However, depending on your situation there is much more information that you may need to know. Visit my website or give me a call and we'll discuss your issue. There is no obligation or cost on your part.

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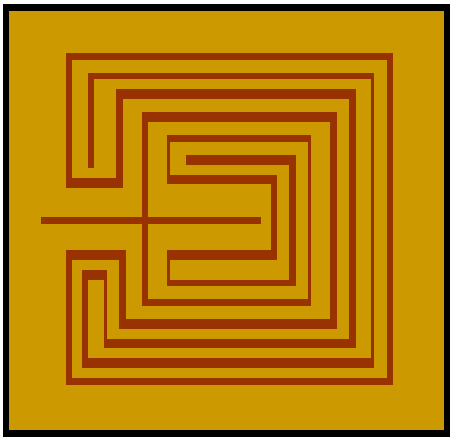


"Your guide through the Medicare Maze"™

Do you find Medicare to be confusing?
Most people do.

Before you decide which plan to purchase you must arm yourself with as much knowledge as possible about what types of plans are available, such as what are the different types of plans and how does each type operate.

The first confusing item — Am I eligible for Medicare?

But first, a little bit about Medicare. You need to be on Medicare before you can sign up with a Medicare plan. I get many questions about when and how to sign up for Medicare, and when can Medicare coverage be delayed.

You are eligible if you are age 65 or older and:

- You collect or qualify to collect Social Security or Railroad Retirement benefits OR
- You are a current U.S. resident and either a U.S. citizen or a permanent U.S. resident having lived in the United States for 5 continuous years.

If you are under age 65 you qualify for Medicare if:

You have been getting Social Security Disability Insurance (SSDI) or Railroad Disability Annuity Checks for at least 24 months.

You have Amyotrophic Lateral Sclerosis (ALS) and receive Social Security Disability Insurance (SSDI) or Railroad Disability Annuity checks, or

You have end-stage renal disease (ESRD) and you, your spouse, or your parent have paid Medicare taxes for a sufficient period of time.

THE FOUR PARTS OF MEDICARE

Part A coverage is for Inpatient hospital charges (up to 90 days per benefit period plus 60 lifetime reserve days), Skilled Nursing facility charges (up to 100 days but only if Medicare thinks you'll get better), some Home Health charges, and Hospice.

Part B coverage is for outpatient procedures, such as physical services, outpatient hospital care and surgeries, some home health visits not covered by Part A. It also covers durable medical equipment, such as wheelchairs and walkers; certain preventive services and screening tests, such as mammograms and prostate cancer screenings; outpatient therapies; laboratory and diagnostic test, such as X-rays and blood tests; outpatient mental health care; and ambulances services.

Part C is the Medicare Advantage Plan program, which we'll go into more detail about later.

Part D is the Prescription Drug program and we'll go into more detail about these plans later as well.

Medicare does not cover long term care. It does not pay for home or community-based care, assisted living facilities, or nursing homes. Medicare does not cover routine eye or dental exams nor does it cover most eyeglasses or hearing aids.

MEDICARE (AND PLAN) COSTS

Part A does not have a premium for most people because they (or their spouse or even an ex-spouse) has worked and paid Medicare taxes for at least 40 quarters. If your work history has between 30 and 39 quarters your 2018 Part A premium will be $227 per month. If you have less than 30 quarters your premium will be $413 per month. You might qualify for a Medicare Savings Program which can pay this premium if you have a low income and are under the asset resource limit.

Part B does have a premium for most people in 2018 of $134 per month. If you've been on Social Security and Medicare in previous years your premium might be less ($130 on average) because of the "hold harmless" regulation. This regulation does not allow your Part B premium to increase unless your monthly Social Security check also increases.

You might qualify for a Medicare Savings Program which can pay the Part B premium if you have a low income and are under the asset resource limit.

If you make a higher income your Part B premium could be as high as $428.60 per month. This Income Related Monthly Adjustment Amount (IRMAA) is an extra charge based on income from 2 years ago. Your income can increase because of selling assets such as a home or a business so make sure you speak with your tax professional before doing anything that might increase your income.

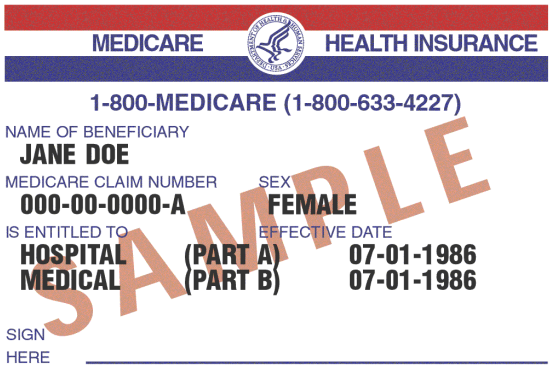
Part C premium will vary by location and plan type. In many locations you can find Part C plans with a $0 premium. For 2018 Arizona Part C plans range from $0 to $190 per month. Your agent can explain the costs and how they can be so low. Some plans that have premiums might be less if you qualify for a Medicare Savings Program.

Part D premium will also vary by location and what you get. For 2018 in Arizona plans can be as low as $12.70 per month. Some plans might be less if you qualify for a Medicare Savings Program.

Medicare Supplement premiums will vary greatly by location, plan type, company, gender, and smoking status. Many companies will also have a variety of discounts available. Your agent can help you find the best for your situation and budget.

HOW AND WHEN TO ENROLL IN MEDICARE

If you qualify for Medicare because you are age 65:


MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE

SAMPLE

In general, if you are receiving Social Security or Railroad Retirement Board retirement benefits when you turn 65 you will automatically be enrolled in both Part A and Part B. You'll receive your Medicare card about 3 months prior to your birth month. If you are not receiving Social Security or Railroad Retirement Board retirement benefits you will need to apply for Medicare at a Social Security office or online at http://ssa.gov/ during your Initial Enrollment Period. This enrollment period is the seven month period that includes the three months prior to your birth month, your birth month, and the three months after your birth month.

If you qualify for Medicare because you are disabled:

After receiving SSDI for 24 months you'll automatically be enrolled. You'll receive your Medicare card about 3 months prior to the 24th month.

WHEN CAN I DELAY ENROLLING?

Most people are happy to be able to enroll in Medicare when first eligible. However, that is not always the case. If you are still employed when you turn 65 you may want to keep your current group policy through an employer. You can do that as long as the employer group policy has 20 or more people enrolled because the group policy is then primary and Medicare is secondary and you can delay enrolling in Part B. If there are fewer than 20 on your group policy you can remain on that policy but Medicare is primary, the group is secondary, and you cannot delay enrolling in Part B.

You do want to compare the costs of the group policy with the costs associated with getting on Medicare. Often, you'll find one is much more cost effective than the other. This sometimes takes a little homework and guesswork to figure which is best.

You may also want to delay enrolling if your spouse has a group policy that you can keep. That policy must have 100 employees or more.

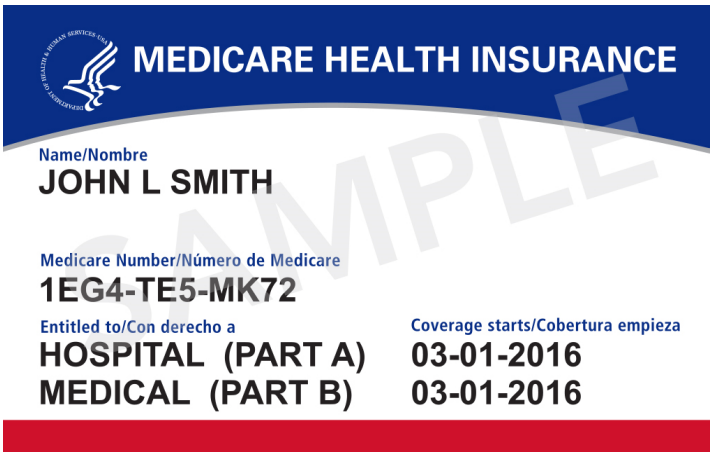
If you are living oversees you cannot enroll in Medicare, so you can delay until and when you move back to the U.S. without penalty.

Another reason is if you are disabled or qualify for Medicare because of an illness. If you have a regular health insurance policy for those under age 65 and you want to keep it because your doctor doesn't accept Medicare, or for any other reason, you can delay Part B. *Be aware that if you have an individual policy and you are receiving a subsidy through the ACA rules and regulations you'll no longer qualify for the subsidy once you become eligible for Medicare.*

If you are an active-duty service member you do not have to enroll to keep your TRICARE coverage, though you will have to enroll prior to retiring to keep your TRICARE for life.

If you have Veteran's benefits you may decide to delay enrolling in Part B. However, Part B may provide you with additional service and location options, and you may have to pay a late enrollment penalty in the future.

NEW MEDICARE CARDS AND SCAMS



Medicare will be issuing new Medicare cards starting in April 2018 and going through April 2019. The new cards will no longer display a Social Security number and will no longer have other identifiable information but will instead have a randomly generated 11 digit Medicare Beneficiary Identifier (MBI). The MBI will have certain positions always a numeric value, certain positions always an alphabetic value (minus S, L, O, I. B, Z), and certain positions alpha-numeric values.

The new cards will be issued in a state by state basis in 7 "waves" as shown below. Wave 1 and 2 will occur May through June 2018. The other waves will start sometime after June 2018, but as of this writing the exact months were not released. Also, be aware that you might receive your card at a different time than your spouse or your neighbor receives theirs.

Wave 1: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Wave 2: Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon

Wave 3: Arkansas, Illinois, Indiana, Iowa, Kansas,

Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin

Wave 4: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont

Wave 5: Alabama, Florida, Georgia, North Carolina, South Carolina

Wave 6: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming

Wave 7: Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands

Those newly eligible for Medicare will receive the new card starting April, 2018.

Of course, any time there is a change there is the "opportunity" for SCAMS. Rip-off artists are now calling claiming to be from Medicare. The most common SCAMS are:

— the SCAMMERS asking you to pay for your card. The new card is free so HANG UP!

—They are asking for your Medicare number, effective dates, and bank information so you can get your new card. HANG UP!

—You're told you'll lose your Medicare benefits if you don't give them money or personal information right now. HANG UP! Your card will be sent to you automatically.

WHEN CAN MEDICARE PART A BE EFFECTIVE?*

Medicare Part A is always effective the first day of a month as long as you have 40 quarters of work history to your credit. You are eligible even if you do not officially sign up for Medicare.

WHEN CAN MEDICARE PART B BE EFFECTIVE?*

If you get Medicare because of age your benefits will start the first day of the month of your birth. So if you were born May 31st your benefits will start May 1st. The one exception to this rule is if you were born on the first day of a month your benefits will start the first day of the preceding month.

If you get Medicare because of disability your Part A and Part B benefits will start the first day of the 25th month of disability qualification.

If you get Medicare after turning 65 because you delayed Medicare because you were working you can pick the day for Medicare to start but it must be no later than 8 months after your retirement date.

If you get Medicare because you delayed Part B but didn't have a good reason you can only sign up between January 1 and March 31 of any year and benefits will be effective July 1 of that same year.

of course, there can be exceptions to the above

THE MAZE BEGINS

Medicare has particular rules and regulations that each plan must follow, but that doesn't mean each company is the same. There can be big differences between plans. To make it even more confusing, the best plan for your spouse or your neighbor isn't necessarily the best plan for you. Many people who say "John Doe next door has XYZ plan. If it's good enough for him it's good enough for me" are doing themselves a great disservice.

This white paper will explain in basic terms and easy to understand language how to select a Medicare plan. In most counties there are dozens of options – we pick the best one for you using the following three step approach.

STEP ONE:

Analyzing your Part D drug coverage.

This step is the most important step as well as the most difficult. It is also the most difficult to explain and understand. This is the first thing I do for my clients and this is the first thing you must do - because drug costs can be one of the biggest differences between plans. This step will eliminate many of the plans that are more expensive or are unsuitable, leaving the more cost effective plans still in the running.

You get drug coverage either through a stand-alone drug plan or through a Medicare Advantage plan with drug coverage. To do an accurate and effective analysis you'll need to go through the following four steps.

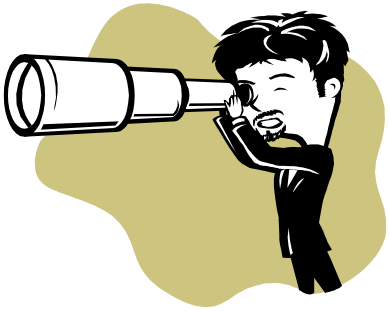
1a. Find out what tier levels your medications are placed with each company. Just because you have a generic doesn't mean that drug is always on Tier 1. I'll explain the tier levels later. To keep your options open you'll want to do this with each plan. So if you live in Maricopa County, Arizona, you'll have to check the 23 drug plans and the 36 Medicare Advantage plans that have drug coverage.

1b. Find out how much your medication will cost each month. Co-pays will be different with each company. This year a generic drug could run from $0 to $20 per month with the different plans. There are also plans that charge a percentage, such as 20% to 50% so to figure your costs you'll need to find out "xx% of what"? Surprisingly, there are some generic medications that are not covered at all.

1c. Find out when you are going to go into the 'donut hole', and what your medications will cost during that time. Your cost will be different with each company because you pay a percentage of what the company pays during this time, and each company will negotiate a different cost for each drug.

1c.1 – here is a quick explanation of the 'donut hole'. A more detailed explanation along with an illustration follows in the next section. As soon as you and your drug company together has paid (in 2018) $3,750 in total drug expenses you go into the donut hole, where you will pay 44% of the negotiated cost of your generic medication and 35% of the cost of your brand name medication.

1d. Find out if and when you'll come out of the 'donut hole', and what they'll cost during the catastrophic coverage. For 2018 you exit the 'donut hole' when your cost total $5,000. With all plans (unless you qualify for Extra Help) you pay the greater of $3.35 for generics, $8.35 for brand, or 5%. Again, you need to know "5% of what".



You can search for all of this information on the Medicare website, on the website of each company, or through your agent. For the websites you'll need to follow the prompts on each separate site. This can be daunting even if you are a computer ace, but can be even more so if your computer experience is low and can take you several days. The websites can also be difficult to navigate and hard to understand.

A good agent who works with all of the major companies will have the experience and know how to get you this information in only an hour or two.

Pitfalls To Avoid:

Is your medication on the formulary? Most people think that a medication not being covered is a bad thing. However, if the drug is not covered the cost is not applied toward the donut hole, which can be a good thing. This information is revealed to you when you analyze your medications. Sometimes, a drug not being on the formulary, while costing more in the beginning, will keep you from going into the donut hole. Going into the donut hole will cause all of your other medications to be more expensive.

Are there quantity limits? If you are taking 2 pills per day but the insurance company will only pay for 1 you may have a problem.

Is there step therapy? Step therapy means the insurance company will require you to try a lower cost medication first before they'll cover the higher cost drug.

Is there pre-authorization needed? This means you must ask your insurance company to cover the cost before you start taking the drug. This can be a big pain, especially if you are already taking that drug when you sign up for the plan.

Exceptions can be made. In general, you have 30 days after the policy effective date to ask the company for an exception to the above limitations. As a rule, though, exceptions are seldom granted. When they are, the plan will cover based on the Tier 4 co-pay amount.

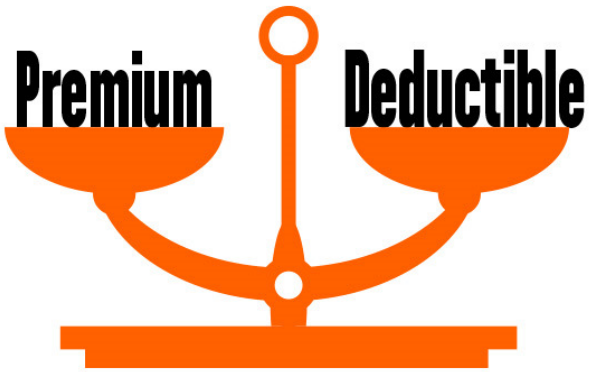
The difference in medication costs that YOU would pay between companies in a year can be as little as a few dollars to over $40,000 in extreme cases.

A plan with a higher premium does not necessarily mean that your drug costs will be lower than a plan with a lower premium.

A plan with a higher premium does not mean you get better coverage than a plan with a lower premium of the same company, it just means you have different coverage and the plan is set up differently. For example, one of your medications may be in the formulary with one plan while with another plan from the same company your medication may not be on the formulary. So don't assume your meds are covered until you've checked each plan available.

Do not be afraid of plans with deductibles. Many times your total costs over the course of a year will be less even paying the deductible. The reason why is once you get through the deductible the co-pays for your drugs may be significantly lower than on those plans without a deductible. Also, with some plans the deductible doesn't apply with certain tier levels.

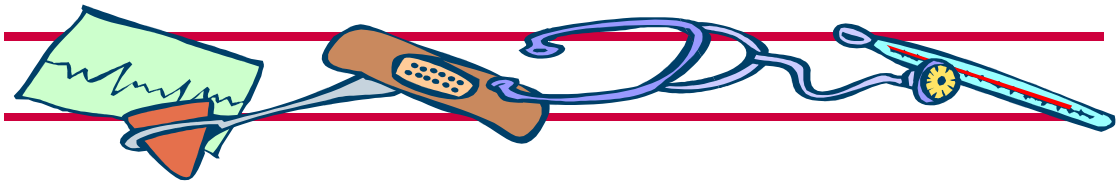
You need to balance the premium with the deductible with the co-pays with the drug formulary with the……



If you neglect this balancing act you may end up paying much more than you need to be paying for your medications.

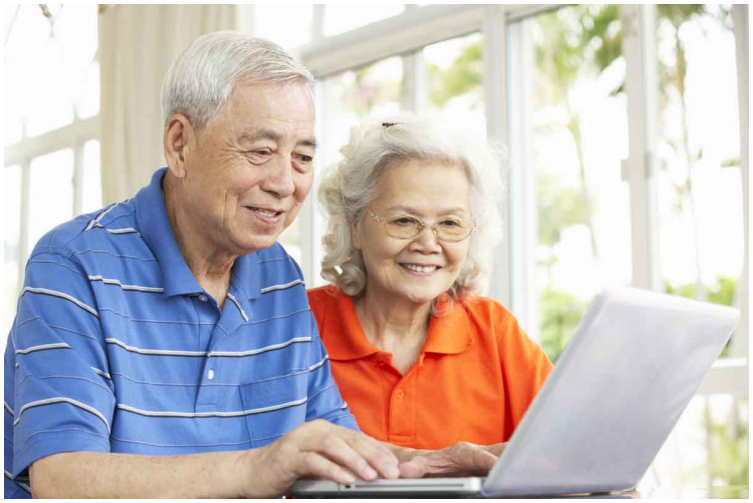
If you don't get Part D coverage when first eligible you may have penalties in the future.

Now, for those who'd like a better understanding of Medicare drug coverage please read the next few paragraphs. For everyone else you can proceed to step two.



THIS IS A MORE DETAILED EXPLANATION OF PRESCRIPTION DRUG COVERAGE

Medicare requires you to have a Part D drug plan or face future monetary penalties and other restrictions. The penalty is you will pay 1% of the national premium average ($35.02 in 2018) for *each month* (rounded to the nearest $.10) you were eligible for drug coverage but did not have such coverage. This does not sound like much, but the penalty will be added on to the monthly premium when you finally do get on a plan, and is payable **FOREVER!** Also, if you don't get the coverage when first eligible the only time you can purchase coverage is during open enrollment, which has become standardized at from October 15 – December 7 for a January 1 effective date. However, this is always subject to change so always ask your agent.



Medicare has standard guidelines concerning drug coverage. Medicare states each drug plan must cover at least the standard benefit "or its actuarial equivalent". The "actuarial equivalent" is one place where companies

differ. Each insurance company will have a basic plan that offers at least the standard benefit. However, the insurance companies can and do offer additional plans that have enhanced coverage that is "better" than standard for a higher premium. What is better, though, will depend upon what medications you are currently taking.

The Medicare guidelines allow for plans to have a deductible, which can increase each year. In 2018 the deductible is $405. Plans can choose to have a deductible lower than $405 (some will have a deductible of $0) and can choose to have certain drug tiers not subject to the deductible.

After you pay the deductible (if there is a deductible on your plan) you go into what is called the "INITIAL COVERAGE" period, where you pay approximately 25% of the cost and the insurance company pays 75%. This coverage period will last until both you and the insurance company has paid $3,750. Your dollar share during this period, including deductible, is approximately $925.00. The actual percentage will vary depending on the company and your specific drugs but must actuarially average to 75% and 25%.

Part D Stage	Drug Type	Insurance Percent	Pharmaceutical Discount	Your Co-Pay
CATASTROPHIC COVERAGE	ALL	95%	N/A	5%
COVERAGE GAP	Brand Drug	15%	50%	35%
	Generic Drug	56%	N/A	44%
INITIAL COVERAGE	ALL	~75%	N/A	~25%
DEDUCTIBLE	Selected or All	(up to $405)		

You then go into the coverage gap, which is commonly known as the “donut hole”.

During this time, you are paying 44% of the *negotiated* cost of your generic medication and the insurance company is paying 56%. For brand name drugs you are paying 35% of the *negotiated* cost, the insurance company is paying 15%, and the pharmaceutical companies are “discounting” the medication 50%. Now it really gets confusing. When your total out of pocket cost of your medications reach $4,950 you come out of the donut hole. This amount includes the 50% discount you receive from the pharmaceutical companies but not the amount the insurance company pays. It also includes your percentage of any “dispensing fee” your pharmacy might have. It does not include the insurance company’s share of the drug cost nor the insurance company’s share of the dispensing fee.

After the donut hole you go into catastrophic coverage where you pay $3.35 for generics and $8.35 for brand name drugs, or 5% (whichever is greater).

TIER LEVELS

Drug plans use co-pay tiers, which is a set amount for each prescription. The "set amount" can be either a flat dollar amount or a percentage, and any one plan may have both. Plans can have anywhere from three to six tier levels. Here is a common example for 2017:

- Tier 1: Preferred Generic drugs
- Tier 2: Generic drugs
- Tier 3: Preferred Brand drugs
- Tier 4: Non-Preferred drugs
- Tier 5: Specialty tier, including injectables and some generics

Drug plans use a formulary, which is a list of drugs covered by the plan. They can also require you to try lower cost drugs in some cases. They may require you to get prior authorization before the plan will cover a drug. They may have a limit on the quantity that you can use daily. What makes it more difficult is any particular drug may be treated differently with each company, i.e a brand name drug might be on tier 1 with one company and tier 3 with another.

EXTRA HELP FOR DRUG COSTS

If you have limited income and resources you may qualify for Extra Help with your prescription drug costs.

If you have Full Extra Help your deductible will be $0 and for most people your premium will be $0. If you have Partial Extra Help your deductible will be the lesser of $82 or the plan's standard deductible.

If you have Full Extra Help you will pay no more than $3.35 for generic drugs and $8.35 for brand name drugs in most cases. If you have Partial Extra Help you'll pay 15% of the cost of each prescription or your plan's standard co-insurance (whichever is cheaper). In addition, you will not go into the donut hole if you have Extra Help. After your total drug costs reach $7,425 (your actual drug costs, not your out of pocket costs) you'll go into catastrophic coverage and will pay $0 for each drug.

To qualify in 2018, you must have an annual income of less than $18,210 ($24,690 if married) and resources of up to $14,100 ($28,150 if married). When counting up your resources do not count the home you live in, furniture, one car, personal items, burial plots, irrevocable burial contracts, or back payments from Social Security or Supplemental Security Income (SSI).

To see if you qualify ask your agent or you can call:

- Medicare at 1-800-MEDICARE (1-800-633-4227)
- Social Security Administration at 1-800-772-1213
- online at: http://www.socialsecurity.gov/medicare/prescriptionhelp/
-or use the form provided by each company when you enroll

You might also have automatically received a notice from Medicare or Social Security stating you qualify. You'll receive these notices if you have Medicaid, are in a Medicare Savings program, or get SSI benefits.

If you automatically get a notice you might also automatically be placed on a drug plan unless you get one yourself. The problem here is the drug plan they place you on might not cover your particular medication.

Step Two: 👣

Finding out what plans your Doctor or Pharmacy accepts.

This is usually the easiest step. First, you need to make sure your doctor accepts Medicare. Many do, but not all. Then, you can either ask your doctor which companies they accept or you can look on the website provider list of each company.

Pitfalls To Avoid:

The doctor may stop taking that plan in the future. They can go on and off network plans with little notice. They can go on and off of Medicare. Since the Medicare reimbursement rates are not keeping up with medical inflation some doctors are either limiting new Medicare patients or are dropping out of the program entirely.

If you do call your doctor make sure the person you speak with really knows. In many cases you are connected to a 'newbie' that doesn't know all of the plans. Also, many companies have multiple plans and doctors may or may not take all plans in a company. Therefore, even if your doctor takes "XYZ" company that doesn't mean they take all plans by that company. When the 'newbie' tells you "yes, we take XYZ" but you find out YOUR plan is not accepted you'll be might upset. And the kicker is it is your responsibility to know, not the doctor's office personnel.

You'll also need to make sure your pharmacy is a preferred provider of the plan and not just an in-network provider.

Step Three:

Deciding upon which type of health plan to purchase.

You have three options.

1. Original Medicare
2. Medicare Supplement
3. Medicare Advantage

Option 1 - Original Medicare. You can visit any doctor that accepts Medicare anywhere in the U.S.

Pitfalls with Option 1:

You will be responsible for paying the $1340 Part A per occurrence deductible, the daily hospital co-pay for days 61 to 90 of $335, the daily hospital co-pay for 60 lifetime reserve days of $670, 100% of hospital charges after lifetime reserve days are used up, the $183 Part B annual deductible, and the 20% co-insurance (for most procedures). Also, if your doctor doesn't accept assignment you'll be responsible for the 15% Part B excess. There is no cap to your costs. One big example is the Mayo Clinic. If you have a $100,000 medical bill there you could be responsible for up to $35,000.

Medicare has limits of coverage. For example, Medicare does not cover long term care, it does not pay for home or community-based care, assisted living facilities, or nursing homes. Medicare does not cover routine eye or dental exams nor does it cover most eyeglasses or hearing aids

Medicare does not cover prescription drugs, except for some drugs administered in a medical provider setting (considered Part B drugs) so you'll need to purchase a separate stand alone Part D prescription drug plan.

Option 2 – Medicare Supplement. You can visit any doctor that accepts Medicare, anywhere in the U.S. (except for a few network plans that some companies have available). If you get a comprehensive Supplement plan when you go to the Mayo Clinic in the earlier mentioned example you will have $0 costs for Medicare Approved procedures. There are several different plan options, all with varying coverage. They're known as Plans A, B, C, D, F, G, K, L, M, N. There are also select C, select F, and high deductible F plans available. Not every company has each plan type.

Pitfalls with Option 2:

None of the Medicare Supplements have drug coverage, so you do need to purchase a separate stand-alone Part D drug plan if you want the coverage and to avoid the penalty.

Supplements do not cover anything over and above what original Medicare covers except for an additional 365 hospital days and some foreign travel emergency coverage with some plans.

Premiums can be too much for some people. Premiums may (most likely) increase each year based not only on age but also on inflation, and sometimes you'll see two increases per year.

You'll need to learn about each Plan letter and what they cover. A large percentage of people get Plan F because it is the most comprehensive. However, if you are looking to save premium dollar you can choose one of the other plans that have a lower premium but will require you to pay certain costs when you receive medical care.

These plans are underwritten. That means if you decide you want to change to a different Medicare Supplement in the future you may have to go through the underwriting process of the new company. During underwriting they ask questions about your health and may check your medical records. Certain health conditions may result in you being declined a policy. Your agent will be able to explain and assist you.

As part of the ACA, Congress is trying to cut Medicare cost. One of those proposed recently is Medicare Supplement plans will no longer have “first dollar coverage”.

To explain first dollar coverage — there is no deductible; the insurance company pays everything from the beginning to the end. Starting in the year 2020 all Medicare Supplements will have a deductible you must pay before getting coverage provided by the insurance.

Medicare Supplement Plans C and F do not have deductibles. These plans cannot be sold to anyone that has a Medicare effective date after January 1, 2020. However, the plans will not go away. If you have either Plan C or F before the year 2020 you can remain on that plan, and if your Medicare effective date is December 1, 2019 or earlier you can still purchase either plan.

Option 3 – Medicare Advantage Plan. This option can be very confusing, depending upon your state and county, and you need to learn many acronyms. Here is a listing and a small, incomplete description of each acronym:

HMO – Health Maintenance Organization. There is a network of doctors. You must select a primary care doctor. You cannot go to a doctor that is not in the network unless it is an emergency or urgent care situation. You must get a referral from your primary care doctor to visit a specialist.

PPO – Preferred Provider Organization. This type of plan has a network of doctors, the "preferred providers". However, you can go to any Medicare doctor that is not in the network without a referral. If you do, though, the amount of money you pay will usually be higher. How much higher? That will depend upon the plan and the particular situation.

HMO/POS – an HMO with a Point of Sale option. This plan gives you the option to go to a provider that is out of network for certain procedures. You generally will need to get approval from the plan and referrals to use out of network providers.

PFFS – Private Fee For Service. This is based off of Original Medicare, which is also a Fee For Service. There are non-network PFFS plans and there are network PFFS plans. With the non-network plans you can visit any doctor that accepts Medicare. However, the doctor must be willing to accept the plan and can decide on a case by case basis whether or not to accept each plan. Even if they accept the plan today doesn't mean they'll accept the plan tomorrow. If they accept the plan for you that doesn't mean they'll accept the plan for your spouse. The network plans operate similar to the PPO plans mentioned above. Because of the restrictions and confusion most of the PFFS

plans are going away in all except the very rural areas. If you want my opinion on how Congress messed up with these plans give me a call and I'll be happy to explain.

SNP – Special Needs Plans. These plans are specifically designed for people with certain qualifying illnesses, such as diabetes, chronic heart failure, cardiovascular disease, or chronic lung disorders. They can be set up either as an HMO or a PPO. They will give you special benefits that are helpful with your particular health condition. Most plans offer you some basic transportation to approved locations, such as a doctor's office or pharmacy.

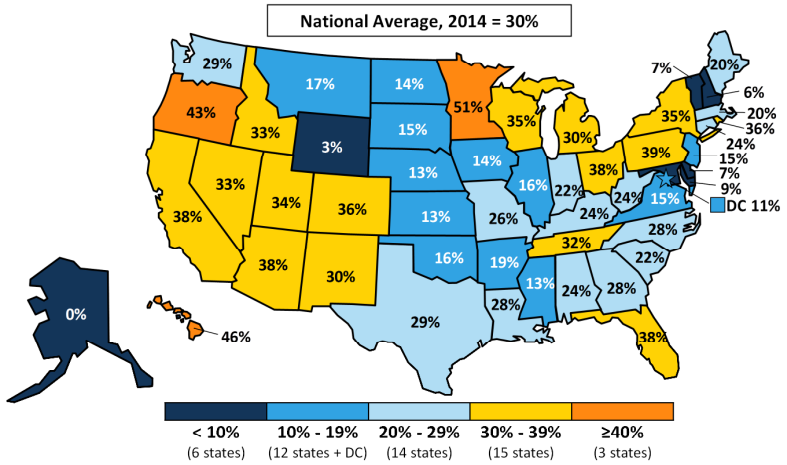
Dual – a SNP for people who have both Medicare and Medicaid. If you are on full AHCCCS (or whatever Medicaid is called in your state) you can enjoy the benefits of a Medicare Advantage plan without most of the normal costs, since Medicaid pays any premium and co-pays. You'll also have drug coverage at a reduced co-pay. These can be set up either as a PPO or (more commonly) an HMO.

There are also PACE, MSA, and Cost plans as well as an occasional demonstration plan. These special plans are available only in a few areas so we won't go into a description here. If one is available in your area your agent will be happy to explain them to you.

As always, there can be exceptions available with any of the above described types depending on your location.

Exhibit 2

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014

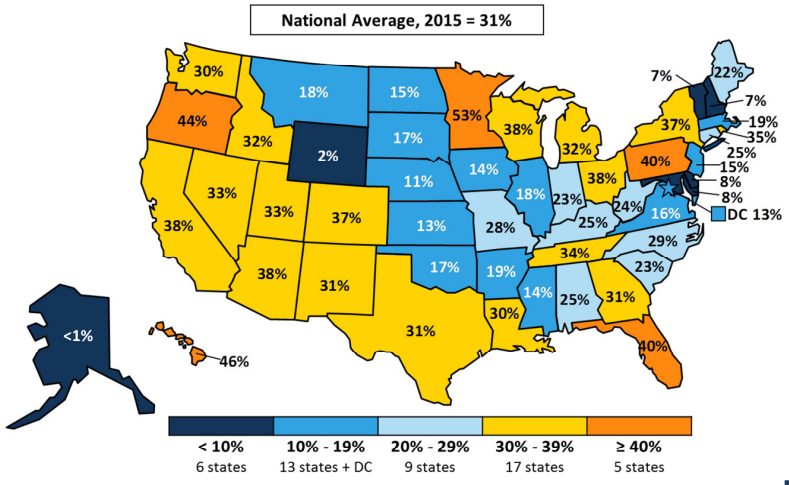


NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2014.

As you can see, Medicare Advantage plans are gaining membership. The charts show the difference between 2014 and 2015.

Figure 5

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2015.

Pitfalls with Option 3:

The pitfalls can depend upon the type of plan you get. If you re-read the above descriptions of the plans you'll get an idea of some of the pitfalls.

If you want the freedom to choose your own doctor an HMO plan is not for you. You also must select a primary care doctor with an HMO. The PPO plans can be more expensive than the HMO. The PFFS plans are being stripped of their effectiveness and at this writing I'm not sure what they'll look like in the future. SNP plans can actually be more expensive for some people in some cases but if you use the extra benefits will usually be a good deal.

You are generally locked into these plans for an entire year, except for the SNP or Dual plans. The annual enrollment period is October 15 through December 7 for a January 1 effective date. Doctors in the networks can change at any time. This means if your doctor decides to leave the network in February you will have to change doctors until you can change plans.

Plans have an annual contract with Medicare. This means they can and do change each year. They can also stop the plan completely. They can bring on new plans and discontinue old plans. There can be new companies in your area, while current companies can pull out completely. This means you need to check each and every year to make sure your plan is continuing (you will be notified if your plan is exiting the market in your area) and that you have the best plan available.

You'll generally have to pay a co-pay or co-insurance when you use medical services. In some cases these costs will erase any premium advantage you'll have with these plans over a Medicare Supplement.

Medicare Advantage plans generally have drug coverage included. If you get a PFFS or an MSA plan without drug coverage you have the option to purchase a separate stand-alone drug plan. However, and this can be a big pitfall so I'll highlight it:

****If you get an HMO or a PPO plan without drug coverage you are not allowed to purchase a stand-alone drug plan**.**

If you try to get a drug plan when you have an HMO or PPO without drug coverage you will be enrolled in the drug plan but you will be ***automatically*** dis-enrolled from the Advantage plan. Conversely, if you have a stand-alone drug plan and try to enroll in an HMO or PPO Advantage plan without drugs you will be ***automatically*** dis-enrolled from the drug plan. Please contact me if you don't understand this.

Premium, co-pay, and drug costs may be different on each plan from the same company. So if you have a company you like, but want to switch to a plan with a lower premium of that same company, you'll want to check the drug coverage. Many times a lower premium plan will have a higher co-pay for your drugs.

Some big name doctors and medical clinics, such as the Mayo Clinic, do not accept ANY Medicare Advantage Plans. So if we go back to the example of several pages ago concerning the Mayo Clinic neither Medicare nor the Medicare Advantage plan will pay anything. You will be responsible for the full charges.

Step Four???: 👣

Other options to purchase.

I know I said there were only three steps, and for choosing a Medicare plan that is correct. However, for a greater peace of mind you may want to consider Step Four, which includes other insurance types. These types include:

Dental and Vision – although some Medicare Advantage plans have dental and/or vision included or as an option, in general Medicare does not cover routine dental or vision. Plans that do cover dental and/or vision might not be the best option available to you.

Long Term Care and Short Term Recovery – Medicare does not cover care for longer than 100 days, and will not cover custodial care at all. If your budget doesn't have room for Long Term Care premiums there are short term plans covering 360 days or less which are much less expensive than Long Term Care plans.

Cancer and/or Critical Illness – pays on first diagnosis. Even if Medicare covers the medical costs there are usually other costs involved, which may include travelling to a facility that gives you better care than your local hospital or someone to take care of your pet or home while you are going through treatments. For the average cancer patient Medicare and/or their health insurance will only pay 65% of all expenses associated with a cancer diagnosis.

Hospital Indemnity Plans – especially if you have a Medicare Advantage plan - these plans can pay all or a portion of (or even more than) the inpatient hospital co-pay.

International Travel Policies – essential if you are traveling outside of the U.S., even though some Medicare plans do cover foreign travel emergencies. In general, if you are out of the country and have an emergency the provider in that country will require you pay them directly before they'll let you leave. They may not be willing to wait for the Medicare plans to pay. However, they will usually wait if you have an International Travel Policy. Contact me for more information or visit my website: http://yourhealthplanadvisor.com/international/

Final Expense Plans – helps your kids figure out how to pay for your funeral and other associated costs.

Contact us for more information on any of these additional policies at whitepaper@guidingarizonaseniors.com

SUMMARY

I hope this white paper helps you in your selection of the best Medicare plan.

To review, here are the three steps:

Step one – analyze your prescription coverage – find the most cost effective plans
Step two – check to see what plans your doctor will accept
Step three – decide which type of plan to get.

If you have any questions or if you need assistance anytime during your research please don't hesitate to give me a call. You can also shoot me an email at

whitepaper@guidingarizonaseniors.com

I would also like the opportunity to earn your business. Even if you've made a final decision as to which plan and company to purchase without my assistance (other than this white paper!) if you sign up through me you'll have someone who can make sure you actually get enrolled. You'll have someone who will check on the application daily to make sure it is being processed and to smooth over any bumps may occur. There will be no extra fees signing up through me. One additional plus – I have one phone line. When you call me you are calling direct. You will not have to listen to any menu options only to find the option you need is not available.