MEDICARE ENROLLMENT GUIDE

A DETAILED REFERENCE FOR MEDICARE ENROLLMENT DECISIONS

Revised July 2026. Dollar figures are for calendar year 2026 unless otherwise noted; premiums, deductibles, plan availability, and enrollment rules change annually.

Signing up for Medicare may seem a daunting task. All the various "Parts" and sub-options may be confusing. This Guide will hopefully simplify the process.

This Guide is not intended to show a prospective Medicare enrollee what to do, but rather is intended to give the enrollee enough information to intelligently research and balance the various Medicare options, and make an informed decision.

There is a lot of information to absorb, and a number of new terms to learn, so it is suggested that this Guide be re-read to absorb everything. This Guide is presented in .PDF format, so feel free to download it and re-read when it is convenient.

A. MEDICARE TERMS

Part of the Medicare confusion comes from the terms used for all the different Medicare coverages. Enrollees who had previously been covered under classic health insurance are used to a single insurance policy covering most hospital, clinic, doctors, lab tests, prescriptions, and other covered costs - all under a single umbrella.

Not so with Medicare. In Medicare, all the different coverages are broken out into separate "Parts" and some of the "Parts" have other common names, as well as sub-options.

More detail on all the Medicare sections will follow later, but for purposes of learning the material presented in this Guide, the important terms are these:

Medicare Part A - Most hospital & inpatient coverage

Medicare Part B - Doctors, clinics, labs & non-drug non-hospital coverage

Medicare Part D - Prescription drug coverage

Original Medicare - Another name for Medicare Parts A & B together

Medicare Supplement - Private coverage that helps pay the enrollee's share (deductibles, coinsurance, and co-pays) of costs for services covered by Medicare Parts A and B; it generally does not add coverage for services Medicare excludes

Medigap - Another name for Medicare Part A & B supplement

Medicare Advantage - A private plan that serves as an alternative way to receive Medicare Part A & B benefits; most (but not all) Medicare Advantage plans also include Part D prescription drug coverage

Medicare Part C - The common name for a Medicare Advantage plan

HMO - Health Maintenance Organization

PPO - Preferred Provider Organization

In-Network - Refers to hospitals or physician groups that have contracted to accept patients insured by a particular health care insurer

C-SNP - Refers to a Chronic Condition Special Needs Plan

D-SNP - Refers to a Dual Special Needs Plan - a Medicare Advantage plan for people eligible for both Medicare and Medicaid (needs-based) that coordinates Medicare Part A, Part B, and Part D benefits with Medicaid benefits in a single plan

B. ENROLLMENT

As a general rule, absent special circumstances, Medicare becomes an issue as people approach age 65. Age 65 is ordinarily the age at which people first become eligible for Medicare, and enrollment at age 65 is generally necessary to avoid penalties unless the enrollee (or the enrollee's spouse) is still working and the enrollee has health coverage based on that current employment. (Retiree coverage, COBRA, and Marketplace plans do not count as current-employment coverage for this purpose.)

Keep in mind that the full Social Security date is changing over time, and Medicare enrollment may be required years before full Social Security benefits are available. Full Social Security is not available until age 67 for anyone born in 1960 or later. For anyone born between 1955 and 1959, full Social Security is gradually phased in between 66 years and 2 months (for people born in 1955) and 66 years and 10 months (for people born in 1959). Medicare eligibility begins at age 65.

By way of example, a person born in 1962 would ordinarily enroll in Medicare (unless they continued to have an employer provided health plan) at age 65, or in the year 2027 - yet that same person would not be eligible for full Social Security benefits until age 67, or in the year 2029.

The "Initial Enrollment Period" for Medicare starts 3 months before the month in which the enrollee turns age 65. It is 7 months long. The month in which the enrollee turns age 65 is the fourth month, and the Initial Enrollment Period runs for another 3 months thereafter. This gives enrollees a 7-month window in which to enroll without incurring penalties for late enrollment.

People already receiving Social Security benefits at least 4 months before turning age 65 are enrolled in Original Medicare (Medicare Parts A & B) automatically. People who apply for Social Security benefits at or after age 65 are typically enrolled in Part A automatically and choose whether to take Part B as part of the application.

Medicare is automatically enrolled for people awarded Social Security Disability, but it is not immediate. Instead, Medicare will start on the first day of the 25th month after the Social Security Disability entitlement begins. From a practical standpoint, this may mean there is a 29 month waiting period following the disability onset date (5 month waiting period for Social Security disability and 24 months waiting period for Medicare). The Medicare "Initial Enrollment Period" for people awarded Social Security Disability is also 7 months long, running from 3 months before Medicare begins through 3 months after (months 22 through 28 of the disability-benefit entitlement). Enrollment in Parts A and B is ordinarily automatic at month 25; the enrollment window matters chiefly for choosing Part D or Medicare Advantage coverage.

Medicare is also available to people under age 65 with End-Stage Renal Disease (which has its own special eligibility rules) or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease). For ALS, eligibility is tied to entitlement to Social Security disability benefits, but the usual waiting periods are waived, so Medicare begins when disability benefits begin.

Other than Social Security Disability or a qualifying medical condition, Medicare is generally not available to people under age 65, but is always an issue for people when they turn age 65.

C. ENROLLMENT ISSUES

Before discussing the Medicare "Parts" in detail, some important points must be made:

First, eligibility to contribute to a Health Savings Account (HSA) ends with the first month of Medicare enrollment. An enrollee who has worked past age 65 and delayed Medicare should stop HSA contributions at least 6 months before applying for Medicare or Social Security, because premium-free Part A coverage

can be made retroactive for up to 6 months, and HSA contributions made during retroactive coverage months trigger tax penalties.

Second, there can be severe and even permanent penalties for failing to enroll in Medicare in a timely manner.

There is no penalty for late enrollment in Medicare Part A, provided the enrollee is eligible for premium-free Medicare Part A. If the enrollee is required to pay a premium for Medicare Part A, there is a 10% penalty for double the number of years enrollment was delayed. However, the penalties for failing to enroll in Medicare Part B in a timely manner can be severe. If a person turns 65 years of age and does not have active employer-sponsored health coverage, failing to enroll in Medicare Part B at age 65 triggers a lifetime permanent penalty of 10% for each full 12-month period enrollment is delayed. This means that the enrollee will pay a larger monthly premium for Medicare Part B for life.

There is an important safety valve: an enrollee who properly delays Part B because of health coverage based on current employment receives an 8-month Special Enrollment Period to sign up for Part B without penalty, beginning the month the employment or the employer coverage ends, whichever comes first. COBRA and retiree coverage do not extend this deadline.

The penalty for failing to enroll in Medicare Part D is also severe. If a person turns 65 years of age and does not have other "creditable" prescription coverage (i.e. employer health insurance, VA coverage, some union plans) they will pay a penalty of 1% of the national base premium for each full month enrollment is delayed after a continuous gap of 63 days or more without creditable coverage. The national base premium was set at $38.99 for 2026 and may change each year (annual increases are currently capped by law at 6%; the announced 2027 figure is $41.33). For example, a delay of enrollment in Medicare Part D for 12 months will result in the enrollee paying an additional 12% of the then-current national base premium for as long as they have Part D coverage -- a dollar amount that changes as the base premium changes each year.

All other "Parts" or sections of Medicare are optional and do not bear a penalty for non-enrollment.

Be forewarned that there is a quirk in Original Medicare. As a general rule, employer sponsored health plans have to offer coverage to all employees. But, if a person is age 65 and still working and not drawing social security, they should not count on having employer sponsored health insurance unless the employer has 20 or more employees. Under the "Small Employer" Exception, if a person is still working at age 65 and has health coverage from their employer, but the employer has fewer than 20 employees, the person should enroll in premium-free Medicare Part A and should generally also enroll in Part B, because Medicare becomes the primary payer and the employer plan may calculate its benefits as though Medicare had paid -- even if the person never enrolled. Part A alone does not cover physician and outpatient services. Further, the employer's health care plan is permitted to choose to decline to continue to provide the person coverage at all.

D. MEDICARE "PARTS"

As mentioned, some of the confusion over Medicare is that people are accustomed to their health care insurance covering health costs of many kinds in a single plan. Medicare, instead, breaks out different kinds of coverage into separate "Parts" that provide different coverages. Refer to the list of terms above to understand the references that follow.

Medicare Part A

Medicare Part A is a part of Original Medicare and is a kind of inpatient coverage that includes hospitals, skilled nursing, hospice, and some home health costs, although it does not cover custodial or long-term care. Part A does not cover outpatient doctors, clinics, outpatient labs, or drugs.

Medicare Part A is premium free, provided the enrollee or spouse paid Medicare payroll taxes for at least 10 years. If neither the enrollee nor spouse qualifies, Medicare Part A can still be purchased for a premium.

People need not enroll in Medicare Part A at age 65 if they are still working and have health care coverage through their employer AND their employer has 20 or more employees.

If a person enrolls for Social Security benefits, they are automatically enrolled in "Original Medicare" which includes Medicare Part A.

Medicare Part A claims are administered by the US Government.

Medicare Part B

Medicare Part B is also a part of "Original Medicare." As noted, the employer exception for people not drawing Social Security at age 65, who continue to work and have an employer sponsored health plan for 20 or more employees, is very strict and very limited. When in doubt, people should enroll in Medicare Part B to be safe.

Part B helps cover non-inpatient costs that are not covered by Part A. Medicare Part B covers outpatient services from doctors and many other health care providers, labs, home health care, medical equipment (like wheelchairs, walkers, hospital beds, and other equipment), and many preventive services (like screening, shots or vaccines, and yearly "Wellness" visits). Part B does not cover most self-administered prescription drugs, although it does cover a limited category of drugs administered in a doctor's office or outpatient facility, plus certain vaccines.

Unlike Medicare Part A, Part B is not premium-free. Instead all enrollees pay a set premium. For 2026, the premium is $202.90 per month, and the premium increases each year. Higher earners may pay more due to an income-related adjustment. If an enrollee is drawing Social Security benefits, their Medicare Part B premium is simply deducted from their monthly Social Security benefits. If an enrollee is not drawing Social Security benefits, they must make arrangements to pay the monthly premium to Medicare. Like Medicare Part A, Part B claims are administered by the US Government.

Medicare Part D

Unlike Original Medicare (Part A and Part B), covering inpatient and outpatient services respectively, Medicare Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Unlike Original Medicare (Part A & Part B), Part D prescription coverage is not administered by the US Government. Instead, it is privately purchased from a private insurance carrier which will administer all claims. Premiums vary from carrier to carrier and plan to plan. Part D premiums are in addition to all Part B premiums. CMS reports the average stand-alone Part D plan premium at about $34.50 per month for 2026, though individual plan premiums range widely, with some over $100.00 per month.

Some Part D plans provide greater coverages than others, and each plan has a different annual out-of-pocket deductible. By law, no Part D plan may charge more than $615.00 in annual deductible for 2026, and many plans charge less or waive the deductible for certain drug tiers.

Just as important, out-of-pocket spending on covered Part D prescription drugs is now capped by law -- $2,100.00 for 2026. Once an enrollee reaches that cap, they pay nothing further for covered Part D drugs for the remainder of the calendar year. This cap applies whether drug coverage comes from a stand-alone Part D plan or a Medicare Advantage plan.

Premium alone is not a dependable guide to Part D value -- the plan's formulary, drug tiers, pharmacy network, and deductible usually matter more than the premium. The question for the person trying to choose between plans is to balance total expected costs (premium plus out-of-pocket) against the benefits actually likely to be used.

E. ADDITIONAL CRITICAL POINTS & OPTIONS

Original Medicare Deductibles And Co-pays

Original Medicare (Parts A & B) alone leaves an enrollee exposed to substantial -- and uncapped -- out-of-pocket costs, which is why additional coverage matters so much. Unlike most health insurance, Original Medicare has no annual out-of-pocket maximum -- there is no cap on what an enrollee could owe in a medical emergency.

There are two ways to fill those gaps, and they work very differently -- an enrollee must choose one or the other, not both. The right choice depends on several factors discussed below.

Before comparing those two options, it helps to know exactly what Original Medicare does NOT cover.

Medicare Part A Deductibles & Co-pays

For inpatient services under Part A, enrollees pay a flat $1,736.00 deductible in 2026 for each benefit period (not per calendar year), covering the first 60 days of a hospital stay; after that, Medicare covers 100% of the bill for that period. Days 61-90 carry a $434.00 per-day coinsurance, with Medicare paying the rest. From day 91 on, enrollees pay $868.00 per day for up to 60 more days (a 150-day total), after which they are responsible for the full bill.

Those days 91-150 are called "lifetime reserve" days, and they can be used only once. If an enrollee needs another hospital stay after using them up, the same Day 1-90 billing applies, but from Day 91 on the enrollee owes 100% of the bill.

For skilled nursing under Part A, Medicare covers 100% of days 1-20. Days 21-100 carry a $217 per-day coinsurance. From day 101 on, Medicare pays nothing and the patient owes the full bill. Medicare Part A has no annual out-of-pocket maximum.

Medicare Part B Deductibles and Co-pays

For Part B services, enrollees first pay a $283.00 annual deductible; after that, Medicare covers 80% of the bill and the enrollee owes the remaining 20% as coinsurance -- again with no annual out-of-pocket maximum.

Options To Add Coverage To Original Medicare (Parts A & B)

With that gap in mind, here are the two ways to fill it.

Option #1: Medicare Supplemental Insurance or Medigap Insurance

Medicare Supplement coverage -- commonly called Medigap -- is extra insurance purchased from a private company that pays some or all of the enrollee's share (deductibles and coinsurance) of costs for Medicare-covered services. It generally does not add coverage for services Medicare excludes, such as most dental, vision, or long-term care.

Most Medigap policies are standardized and, in most states, named by letters -- Plan G, Plan N, Plan F, and so on. (Plans C and F are available only to people who first became eligible for Medicare before January 1, 2020.) The benefits in each lettered plan are identical no matter which company sells it in a given state, though premiums vary widely between carriers. Ten Medigap plans are commonly available; a few examples (the premium figures below are dated illustrations only -- actual Medigap premiums vary widely by state, ZIP code, age, sex, tobacco status, rating method, and carrier):

- Plan G, one of the most popular options, costs roughly $120-$180 per month and covers most out-of-pocket costs except the Part B deductible.
- Plan N averages $90-$150 per month but, unlike Plan G, requires a co-pay for doctor and ER visits.
- Plan K has lower premiums but requires 50% coinsurance until an annual out-of-pocket maximum is met -- $8,000.00 for 2026 -- after which it pays 100%.

All ten Medigap Plans are also sometimes colloquially called "Parts" (for example, "Part G" instead of "Plan G"). Don't be confused by the word "Parts."

Like Medicare Part D plans, Medigap plans are administered by private insurance carriers.

Remember: Medigap supplements Original Medicare, it does not replace it.

Option #2: Medicare Advantage or Medicare Part C

Medicare Advantage -- also called Part C -- is an all-in-one, "bundled" health plan sold by private insurers approved by Medicare. It covers everything Original Medicare covers (Part A and Part B), and often adds extras like prescription drugs, dental, vision, and hearing.

Think of it this way: Medigap adds to Part A and Part B. With Part C, the enrollee remains enrolled in Parts A and B (and still pays the Part B premium to Medicare), but receives most Part A and Part B benefits through the private plan rather than through Original Medicare; most Part C plans also include Part D coverage, and many add other coverages on top.

That difference matters: an Original Medicare/Medigap/Part D combination is partly government-administered and partly private, while Part C benefits are administered by private insurers under contract with, and regulated by, Medicare -- part of why Part C premiums can be so competitive.

F. MAKING A CHOICE: ORIGINAL MEDICARE WITH MEDIGAP PLAN AND PART D PLAN VS. MEDICARE ADVANTAGE (PART C)

Which is better -- Original Medicare plus Medigap and Part D, or an all-in-one Part C plan?

Answer: neither is universally better. It comes down to health, budget, and often where the enrollee lives -- and remember, only one path can be chosen.

Consideration #1:

- Choose Original Medicare with a Medicare Supplement (Medigap) and a Part D prescription plan for broad freedom to select any doctor who accepts Medicare, and very predictable bills.

vs.

- Choose Medicare Advantage (Part C) for lower up-front premiums and bundled coverages (like prescription drugs, dental, vision or hearing).

Consideration #2:

- Original Medicare with Medigap and Medicare Part D have higher monthly premiums but fewer out-of-pocket costs.

vs.

- Medicare Advantage costs less monthly (sometimes $0.00 premium above the $202.90 Part B premium) but charges co-pays and has deductibles.

One more difference worth weighing: Medicare Advantage plans commonly require prior authorization (advance plan approval) for certain services, while Original Medicare generally does not. For some enrollees this matters as much as premiums and networks.

In short: people who value provider flexibility and predictable costs may prefer Original Medicare with a Medigap Plan and Part D; people focused on lower monthly premiums, who have good in-network providers nearby, may prefer Part C.

Also, people with fairly regular medical needs may save money overall with a Medigap plan/Part D combination, while people with relatively minor or infrequent treatment needs may find a more affordable overall cost with a Part C plan if they have network providers available.

Part C plans also come with an HMO-vs-PPO choice, explained below.

The cost differences can be significant.

For example, a person enrolling in Original Medicare (Parts A and B) who adds a Part D plan and a Plan G Medigap plan can currently expect to pay a monthly premium average of:

- $0.00 (Part A)
- $202.90 (Part B), plus
- $34.50 (Part D drugs) (2026 average premium), plus
- $180.00 (Plan G Medigap) (average premium)

for a consistent $417.40 per month, or $5,291.80 annually including the $283.00 Part B deductible, plus any drug co-pays. Plan G covers most health care costs other than prescription drugs -- it does not pay the Part B deductible, but it does cover the 20% Part B coinsurance, which is the more important protection.

Medicare Advantage/Part C can cost substantially less for enrollees who need little care, though total costs depend heavily on how much care is actually used. All Part C enrollees still pay the $202.90 monthly Part B premium ($2,434.80 a year), but many plans add no premium on top of that -- so with minimal co-pays and deductibles, annual costs can run as low as $2,434.80.

For example, UnitedHealthcare (UHC) -- reportedly the largest health insurer by enrollment -- offers several $0.00-premium Part C plans, both through AARP and independently. In Phelps County, Missouri, at least three major carriers with broad provider networks offer $0.00-premium Part C plans.

Looking at one of those UHC $0.00-premium plans as an example (an illustration only, based on one carrier's 2026 offering in one county - plan benefits, networks, and availability change every year and must be verified before relying on any figure): its maximum in-network out-of-pocket is $2,900 per year, and its benefits include:

- $0.00 co-pay for visits to a primary care physician
- $35.00 co-pay for a specialist
- $65.00 co-pay for urgent care visits
- $150.00 co-pay for hospital visits
- $0.00 co-pay for home health care and supplies
- $0.00 deductible for Tiers 1 & 2 drugs
- $335.00 annual deductible for Tier 3-5 drugs
- Minimal dental coverage with $0.00 cost dental exams, routine cleaning, x-rays, etc.
- Basic vision care with $0.00 co-pay for routine eye exams and a $300.00 credit for glasses or contacts every two years
- Basic hearing coverage with a $0.00 co-pay routine hearing exam and includes coverage for hearing aids, with a significant (starting at $199.00) co-pay per device.
- $40.00 credit per quarter for purchasing OTC items
- $0.00 cost membership at certain listed gyms
- Up to six routine foot care visits per year at $20.00 each
- $0.00 co-pay for 28 meals after being discharged from a hospital or skilled nursing facility.

Enrollees in this plan pay the $202.90 monthly Part B premium ($2,434.80/year); combined with the $2,900.00 in-network maximum out-of-pocket (which most covered medical co-pays count toward), the worst case for covered in-network medical care is $5,334.80 a year. Prescription drug costs are separate (capped at $2,100.00 for covered Part D drugs in 2026), as are costs for non-covered services and some out-of-network care.

By comparison, using this same UHC example:

- Original Medicare with Plan G and Part D offers more provider flexibility, with a predictable annual cost of about $5,291.80, plus any Part D deductibles or co-pays.

vs.

- This Part C example includes vision, dental, and hearing, with a worst case of $5,334.80 for covered in-network medical care (plus drug costs) -- and could cost substantially less for enrollees who need little care, or more in a year of heavy use.

As always, the right choice depends on health needs, budget, and location.

Medicare Advantage/Part C Sub-Options: HMO vs. PPO

Part C plans also require a choice between two network types: HMO or PPO.

Original Medicare/Medigap/Part D enrollees can see any provider nationwide who accepts Medicare. Part C enrollees, by contrast, generally must use the plan's network for full benefits. HMO plans typically pay nothing for out-of-network care except in emergencies; PPO plans cover out-of-network care, but at higher cost. Depending on the plan, out-of-network spending may fall under a separate, higher combined out-of-pocket limit or may not be capped at all -- the plan's Evidence of Coverage controls.

"In-network" means the provider has a contract with the insurer to accept a negotiated reimbursement rate; the enrollee owes only co-pays and deductibles, not the unpaid difference. These contracts are renegotiated annually.

PPO stands for "Preferred Provider Organization." In-network providers are "Preferred Care Providers." Going out-of-network with a PPO still gets paid, just at a reduced benefit level. PPOs generally offer more provider flexibility, and enrollees usually do not need a referral to see a specialist.

HMO means "Health Maintenance Organization." Care is limited to a specific, contracted network, which is part of why HMO plans can cost less. Enrollees generally need a Primary Care Physician and a referral to see specialists, and -- except for emergencies - HMO plans typically pay nothing for out-of-network care.

Enrollees in a large urban area whose local hospital or physician group covers every specialty in-house may find an HMO advantageous, since all their care can stay with that one provider -- in exchange for accepting the managed-care restrictions described above.

Enrollees in rural areas, where specialists are scattered across different hospitals and health groups, may prefer a PPO: its broader, out-of-network-friendly coverage improves access to specialists, usually at the cost of somewhat lower benefits than an HMO.

Medigap, Part D, and Part C plans all typically come in multiple "levels." Only Part C plans (and the drug coverage bundled inside them) commonly start at $0.00 above the mandatory Part B premium; stand-alone Part D and Medigap plans ordinarily charge their own separate premiums. Generally, the higher the premium, the better the benefits and the lower the co-pays -- but compare total expected costs, not premium alone. In Missouri, UHC, Humana, and Aetna (among others) have broad PPO networks, while Aetna, Blue Cross/Blue Shield, Humana, and Cigna all offer HMO options as well.

Basic Summary With Comparison Matrix

- Enrollees in an Original Medicare (Parts A&B)/Medicare Supplement (Medigap)/Part D program will face a consistent annual average cost (premium dependent) of $5,291.80 (including Part B deductible) plus Part D (drugs) and co-pays.
- Enrollees in a Medicare Advantage/Part C program will face a highly variable annual cost, as low as an average of $2,434.80 and as high an average of $5,334.80 plus co-pays, or even higher if treatments are substantial.
- People with substantial medical needs, who need to be able to go to any Medicare-accepting doctor and need to have a fixed medical cost budget, may be best served by Original Medicare supplemented by a Medigap Supplement and a Part D prescription drug plan.
- Enrollees who don't have significant medical needs who can be served by PPO doctors in-network (perhaps spread over a large area) or doctors within an HMO, who want to try to save up-front costs and don't mind less predictable co-pay costs, may be able to benefit from substantial annual savings under a Medicare Advantage/Part C plan.

Compare:

TYPE	MEDICARE ADVANTAGE	MEDICARE SUPPLEMENT
Coverages	Includes Original Medicare Parts A and B plus common extra benefits, such as dental, vision, routine hearing	Helps fill the "gaps" in Original Medicare, covering out-of-pocket costs Medicare Parts A & B don't
Enrollment	There are specific enrollment periods during the year when the enrollee can enroll in or switch to a Medicare Advantage Plan	Enrollees can apply for a Medigap plan at any time throughout the year, but outside the one-time 6-month Medigap Open Enrollment Period or a guaranteed-issue right, the insurer may underwrite, charge more, or decline the application
Providers	Required to use in-network/PPO/HMO health care providers	Enrollees can see any health care provider that accepts Medicare patients
Referrals	May need referrals for specialists	No referrals necessary
Costs	Premiums vary by company, location and plan choice, but some plans feature $0 monthly premiums above Part B premium	Premiums vary by company, location and plan choice
Prescription	Often included in a Medicare Advantage/Medicare Part C plan	Medicare Supplement insurance plans do not provide prescription drug coverage
Underwriting	No medical underwriting -- eligibility generally requires only enrollment in Parts A & B and residence in the plan's service area (special eligibility rules apply to SNPs); End-Stage Renal Disease no longer bars enrollment	Not required if applying during the 6-month Medigap Open Enrollment Period or if the enrollee qualifies for a guaranteed issue

G. OTHER SPECIAL NEEDS PLANS

Two other specialty plans should be mentioned, and are called the Chronic Condition Special Needs Plan (or C-SNP) and the Dual Special Needs Plan (or D-SNP). These are specialty plans for a limited group of people - the former with chronic conditions and the latter for people on both Medicare and Medicaid.

This Guide is not intended to delve into the complexities of specialty plans, and only is intended to address basic Medicare enrollment. C-SNP and D-SNP Medicare Advantage are simply mentioned as types of Medicare Advantage plans that would be addressed in detail in other materials.

H. PROCESS TO ARRIVE AT A FINAL CHOICE

Action #1: Compare Original Medicare/Medigap/Part D with Medicare Advantage/Part C using the Basic Summary and Matrix above.

- The Considerations from the "Making A Choice" section above still apply here.

Action #2: Decide between Original Medicare/Medigap/Part D and Medicare Advantage/Part C, using the guidance above.

- A Medigap/Part D combination costs more up front but offers predictable out-of-pocket costs and complete freedom to select a doctor, while a Medicare Advantage/Part C plan has lower up-front costs and bundled coverages but less predictable out-of-pocket expenses and restrictions on doctor selection.

Action #3: If choosing Original Medicare/Medigap/Part D, research the available Medigap plans and pick the one that best balances premium against benefits -- generally, the higher the premium, the better the benefits. Do the same for Part D, weighing the premium against the prescription drug benefits likely to be used.

Action #4: Consider prescription drug use and projected cost. Different drugs are listed by the insurance carriers on different "Tiers" (commonly 1 - 5).

Each "Tier" describes a class of drugs. Tier structures vary from plan to plan; the descriptions and co-pay ranges below are common illustrations only, and each plan's formulary and Evidence of Coverage control:

- Tier 1 usually represents most low-cost generic drugs.
- Tier 2 represents higher cost generic drugs.
- Tier 3 are "preferred" name brand drugs approved by the carrier and which have no generic equivalent.
- Tier 4 are non-preferred name brand drugs that may have a more cost-effective generic or preferred brand equivalent.
- Tier 5 are specialty drugs.

Each Tier carries a different co-pay. While this varies by carrier, a common example:

- Tier 1: $0.00 co-pay
- Tier 2: $0.00 to $10.00 co-pay
- Tier 3: 15% to 20% coinsurance
- Tier 4: 25% to 40% coinsurance
- Tier 5: 25% to 33% coinsurance

Before selecting a Part D plan, list all current prescriptions and check which Tier each falls under to estimate the monthly drug co-pays for each plan option.

Action #5: Enrollees selecting a Medicare Advantage plan must decide if they want an HMO or PPO plan.

Before choosing an HMO, confirm a Primary Care Physician is available locally and that needed specialists are within a reasonable traveling distance; if not -- or if broad provider access matters more than lower co-pays -- a PPO may be the better fit.

Before deciding, compare costs and benefits both across different insurance companies and between their HMO and PPO options.

Finally, remember that only a subset of Part C plans will actually be available in the enrollee's home county -- limit comparisons to those.

Important Note: This process is not just done at the beginning of Medicare enrollment; it should be revisited annually for Part D and Medicare Advantage coverage. (Medigap premiums are also worth reviewing, but switching Medigap policies outside protected periods may involve medical underwriting -- never cancel an existing Medigap policy until the replacement is in force.) Medicare premiums are subject to change annually as costs change, insurance carriers change rates, and U.S. Government Medicare subsidies change.

For example, CMS launched Part D Premium Stabilization Demonstration subsidies in 2025, including a $15.00 base premium cut and other cost-increase limits. CMS announced on July 28, 2026 that the demonstration will be discontinued after 2026. The 2027 national base beneficiary premium will rise from $38.99 to $41.33, and many stand-alone Part D enrollees are expected to see premium increases for 2027.

The broader point: Medicare costs and programs shift every year for many reasons, so it pays to shop coverage annually.

I. SUMMARY

Selecting the appropriate Medicare plan is an important choice. Enrolling in Medicare Part A and Part B is the start, but Original Medicare alone leaves substantial, uncapped out-of-pocket exposure and no coverage for most prescription drugs. Most enrollees therefore add either a Medicare Supplement/Medigap plan combined with a Part D plan, or a Medicare Advantage/Part C plan -- although some are instead covered through employer, retiree, union, TRICARE, VA, or Medicaid benefits that fill the same role.

Enrollees should remember that if they are dissatisfied with their selection they can choose a new option, but there are restrictions. Medigap applications can be submitted at any time, but outside the one-time 6-month Medigap Open Enrollment Period or a guaranteed-issue right, the insurer may apply medical underwriting and can charge more or decline coverage; an existing Medigap policy should never be cancelled until the replacement policy is in force. Part D prescription plans can only be changed during the Annual Enrollment Period (October 15 to December 7). Medicare Advantage plans can be changed during the Annual Enrollment Period or during the Medicare Advantage Open Enrollment Period (January 1 - March 31). Special Enrollment Periods triggered by certain events -- such as moving to a different locale, losing other coverage, or qualifying for specific assistance -- may also permit changes, but each Special Enrollment Period is event-specific: the changes allowed and the deadlines depend on the triggering event.

Selecting a Medicare Supplement (Medigap)/Part D plan or Medicare Advantage plan should not be undertaken without careful research and consideration - both of which should take place at least 3 months before Medicare Part A and Part B enrollment is to occur. Great care must be taken to enroll in Original Medicare Part A and Part B in a timely manner. When in doubt, enrollees should confirm their situation with Medicare (1-800-MEDICARE), the Social Security Administration, their employer's benefits administrator, or a SHIP counselor (below) before the applicable deadline -- enrolling "just in case" can carry its own consequences, such as ending HSA contribution eligibility or interfering with other coverage.

This Guide is not intended to recommend any one course of action, nor intended to recommend any particular carrier. It is not intended to make a decision for enrollees. This Guide is simply intended to provide prospective enrollees with sufficient background information about Medicare so that enrollees can intelligently research their choices with advance knowledge of the terms and issues.

It should be noted that even with this background information, selection of Medicare options may still pose a confusing set of choices for prospective enrollees. There are independent advisors, who do not work for any insurance broker and can sell nothing, who can be hired to answer questions, make recommendations, and assist prospective enrollees in making their final decisions.

In addition, Missouri residents can use Missouri SHIP (the State Health Insurance Assistance Program, formerly CLAIM), a federally funded, state-certified nonprofit program that is independent of insurance companies, sells nothing, and provides free, unbiased guidance from certified counselors who can help prospective enrollees through their decision. The SHIP program can be found on-line at www.missouriship.org or by calling 800-390-3330.

Did You Know? This Guide is presented by Williams | Robinson | Wiggins as a public service to assist prospective Medicare enrollees in understanding the decisions they face. This Guide is not intended to provide legal advice and it should not be taken as such. Every case depends upon specific facts which an attorney hired by you must consider in forming legal opinions and advice. Downloading or reading this Guide is not intended to create an attorney/client relationship.

Need more information? Feel free to contact us at (573) 341-2266 to obtain more detailed assistance.