Savvy and 65:

A Woman's Guide to Understanding Medicare

Learn what to know, how to prepare, and when to act



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Society for Women's Health Research



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About HealthyWomen

HealthyWomen is an established and respected nonprofit organization that is dedicated to educating women to make informed health decisions, to advocate for themselves, and to prioritize their health and wellness. Over the past three decades, HealthyWomen has developed an extensive online library of multifaceted content reviewed by and developed with leading health experts, reflecting the latest scientific advancements. Topics range from heart disease and bone health to cancer and wellness, with hundreds of lifestyle and condition-oriented topics in between. HealthyWomen is a proven and trusted resource. For more information, visit healthywomen.org.

Society for Women's Health Research

About SWHR

The Society for Women's Health Research (SWHR) is a national nonprofit and thought leader dedicated to advancing women's health through science, policy, and education while promoting research on sex differences to optimize women's health. Founded in 1990 by a group of physicians, medical researchers, and health advocates, SWHR is making women's health mainstream by addressing unmet needs and research gaps in women's health. Thanks to SWHR's efforts, women are now routinely included in most major medical research studies and more scientists are considering sex as a biological variable in their research. Visit www.swhr.org for more information.

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- Bone Health and Osteoporosis Foundation
- Gerontological Society of America
- National Association of Nurse Practitioners in Women’s Health
- National Caucus and Center on Black Aging
- National Council on Aging
- National Health Council
- National Women’s Health Network
- USAgainstAlzheimer’s
- WomenHeart

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Terms in **teal are glossary terms, and terms in **purple** are links.*

Medicare 101

Turning 65 is an important time in a woman's life for personal, health, and financial reasons. When women reach their mid-60s, they are often undergoing significant life changes and making many decisions, including determinations about Medicare coverage.

Preparing for Medicare, the federal health insurance program for people 65 and over, involves understanding the basics of the program, including the time frames for enrollment, as well as deciding which pathway best supports a woman's unique needs, including her financial goals and life circumstances.

This guide is designed to help equip women with the knowledge they need to make informed decisions about Medicare. It provides a high-level overview of key considerations, along with important information about Medicare benefits that support areas vital to maintaining strength and longevity in older adulthood.

This guidebook is being continuously updated with information on health topics that impact on women.

Preparing for Medicare: One Year Out

While people become eligible for Medicare on their 65th birthday, the year leading up to Medicare eligibility is a critical time for preparation. During this period, people can research available plans and healthcare providers (HCPs), assess their current and potential future health needs, learn when enrollment begins and ends, and seek guidance to determine which coverage options best meet their unique needs. It may be helpful to talk to friends, neighbors, and family members about their Medicare experiences, and possibly even meet with a licensed Medicare broker to explore the different pathways.

This section highlights information women may find particularly useful as they prepare for Medicare in the year before turning 65.



It's important to be proactive and do your own research so you can make informed decisions about Medicare. When it comes to choosing a plan, your personal circumstances will affect which path is best for you. It's also important to know whether you'll be automatically enrolled in Medicare or will need to enroll. Remember, information = empowerment.

Eligibility

Individuals are typically eligible for Medicare once they turn 65. People younger than 65 with certain disabilities; with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease; or with end-stage renal disease (ESRD) qualify for Medicare after being on the Social Security Disability Insurance (SSDI) program for more than two years.

The **Center for Medicare Advocacy** has an overview article with more information.

Resources to Bookmark

Official Medicare Resources

- Website: **Medicare.gov**
- Phone Number: **1-800-633-4227** (for general help, available 24/7 except some federal holidays)

AARP

- **General Medicare Information**
- **Medicare Enrollment Guide**

Medicare Drug Coverage Resources

- **Pharmaceutical Assistance Programs** – offered by some pharmaceutical companies to help people enrolled in Part D pay for prescriptions
- **State Pharmaceutical Assistance Programs** – state-run programs offered to certain populations to help pay for medications

Local Medicare Help

- **State Health Insurance Assistance Program (SHIP)**

Medicare Rights Center

- **Medicare Interactive Tool**

Medicare Plans

Individuals entering Medicare will choose between two pathways to receive their benefits:

1. **Original/Traditional Medicare** is managed by the federal government and includes Part A and Part B
   - **Medicare Part A (hospital insurance) – covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care**
   - **Medicare Part B (medical insurance) – covers outpatient care, medical supplies, preventive services, and certain doctors' services, such as those related to diagnosis, treatment, and prevention of medical conditions**
2. **Medicare Advantage** (also called **Part C**) includes the services covered by Medicare Part A and Medicare Part B but is offered by private companies and often includes extra benefits like vision, dental, and hearing

Extra Coverage

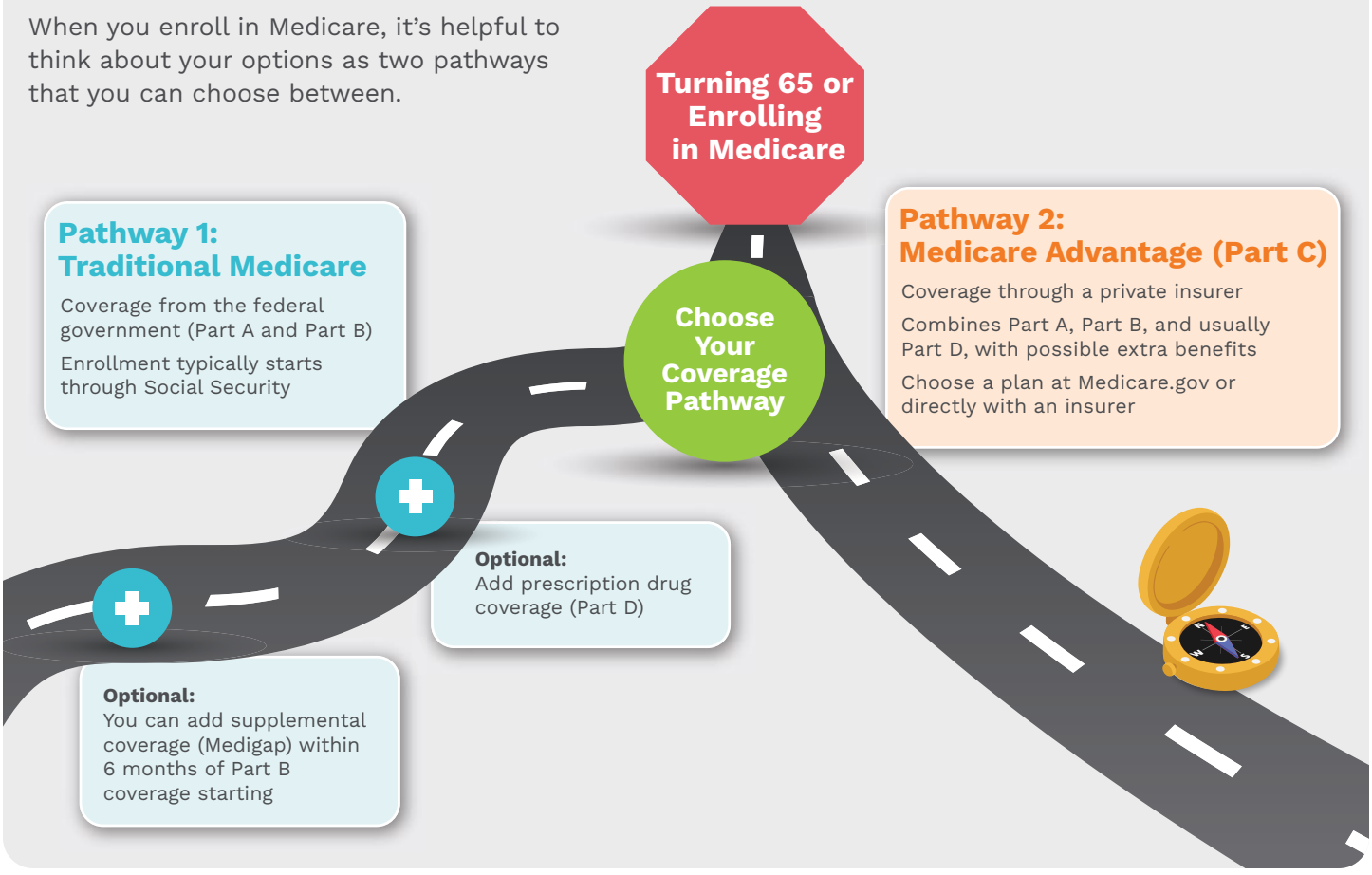
Beyond choosing between Original Medicare or Medicare Advantage, individuals can also choose extra coverage, which could include:

- **Medicare Part D – prescription drug coverage**
- **Medicare Supplement Insurance (Medigap) – extra insurance for people who choose Original Medicare (Medigap can be purchased from a private health insurance company to help with out-of-pocket costs in Original Medicare)**

Note: Medigap is only available with Original Medicare and not Medicare Advantage. This is because Original Medicare has no yearly limit on what you pay out of pocket, while Medicare Advantage does. Medicare Advantage plans generally offer lower **cost-sharing** for routine services, such as primary care visits.

Your Medicare Journey: Two Coverage Paths

When you enroll in Medicare, it's helpful to think about your options as two pathways that you can choose between.



Medicare Options

Original Medicare (Parts A & B)	Medicare Advantage (Part C)
You enroll through Social Security for these plans. Includes:  **Part A** (Hospital Insurance)  **Part B** (Medical Insurance)	You enroll through a private company for a Medicare-approved plan. Requires that you first enroll in Original Medicare Part A and Part B before enrolling in Medicare Advantage (Part C):  **Part A** (Hospital Insurance)  **Part B** (Medical Insurance) Once you've enrolled in Part C, you still have Original Medicare, but you get most of your Part A and Part B coverage from your Medicare Advantage Plan.
Under this pathway, you can visit any HCP or hospital in the United States that accepts Medicare.	These plans often require you to use HCPs within the plan's network. In most cases, people can still see **out-of-network** providers, but at a higher cost. There may be exceptions, such as for medical emergency coverage.
You pay for services as you receive them. Medicare covers a portion of the cost, and you pay a portion. • Most people will pay $0 for Part A (known as **premium-free Part A**) because they paid Medicare taxes long enough to qualify. For those who do not qualify for premium-free, premiums change each year and depend on how long a person or their spouse worked and paid Medicare taxes. **Check premium costs.** • The Part B premium also changes each year and depending on income. **Check premium costs.**	Out-of-pocket costs for various services and the monthly premium will vary based on plans.
Most medically necessary services and supplies are covered. Routine physical exams, eye exams, and most dental care costs are not covered.	Medically necessary services that are covered under Original Medicare are also covered under Medicare Advantage. Plans may use their own coverage criteria to determine what is medically necessary and may offer extra benefits not offered under Original Medicare.
Prior authorization, a process where approval is required from the insurer before certain services or supplies are covered, isn't typically needed for services and supplies under Original Medicare.	In many cases, **prior authorization**, a process where approval is required from the insurer before certain services or supplies are covered, is needed before Medicare Advantage will cover certain services or supplies.

You have the option to add Medicare Part D to help cover the costs of prescription drugs and to add supplemental coverage (Medigap) to help you pay your portion of out-of-pocket costs.	Most plans under Medicare Advantage include Part D coverage and provide an option to add coverage for vision, hearing, and dental services. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan. **Note:** You cannot buy supplemental coverage (Medigap) if you have Medicare Advantage.
Medicare does not cover long-term care stays. Long-term care can be covered by state-run Medicaid programs if you qualify for Medicaid, or you can choose to purchase private long-term care insurance.	Medicare Advantage does not cover long-term care stays. Long-term care can be covered by state-run Medicaid programs if you qualify for Medicaid, or you can choose to purchase private long-term care insurance.

Medicare Part D

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. This prescription drug coverage can come in the form of a stand-alone prescription drug plan (also called a PDP) for those enrolled in Original Medicare or a Medicare Advantage plan that includes prescription drug coverage. Medicare Part D plan options, costs, and coverage vary by state.

People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Medigap

Medigap is **supplemental insurance**, offered by private companies, that helps cover out-of-pocket costs with Original Medicare for those who are not enrolled in Medicaid. It covers costs, such as copayments, coinsurance, and deductibles, and may cover certain services not covered by Original Medicare, depending on the plan. Individuals must have both Medicare Parts A and B to buy a Medigap policy. The best time to enroll is during the "Medigap Open Enrollment Period," which is the first six months after you enroll in Medicare Part B after you are 65 and older. This is the only time you can buy a Medigap plan without health issues being considered as part of your eligibility. After this time, your options may be limited and more expensive. **Learn more at Medicare.gov.**

There are 10 types of Medigap plans named by letters A-N. Each plan has different benefits. No company offers every Medigap plan in every state, but the same basic benefits will be offered for plans with the same letter, no matter where you live or which company you buy from. Price is the only difference between plans with the same letter offered by different companies. In some states, you may be able to buy a type of Medigap policy called Medicare SELECT. Medicare SELECT plans restrict the hospitals and providers they cover but may charge less in premiums. **Compare the benefits and rules offered by each Medigap plan.** Learn more from AARP.

It's important to consider whether switching to Original Medicare from a Medicare Advantage plan to purchase Medigap will affect your healthcare coverage and costs. If you leave Original Medicare for Medicare Advantage and then come back, you may not be able to enroll in a Medigap plan or find an affordable option.

Medicare coverage options can be found on the "Compare Plans" page of Medicare.gov. Cost information can be found on the "What Does Medicare Cost?" page of Medicare.gov.

**Adapted from Medicare.gov*

How Medicare and Social Security Connect

Already getting Social Security or Railroad Retirement Board Benefits at 65?

→ You'll be automatically enrolled in Parts A & B.

→ Medicare card arrives ~3 months before your birthday.

Not receiving Social Security yet?

→ You must apply for Medicare yourself.

→ Do it online, by phone, or at your local office.

Paying for Medicare

→ Most people do not pay a premium for Part A.

→ Part B premiums are taken from your Social Security check.

→ No Social Security yet? You'll get a bill.

Need financial help?

→ There are programs to help. Such as:

- Extra Help/Low Income Subsidy (lowers drug costs)
- Medicaid (covers costs for lower-income individuals)

→ **Note:** Social Security income affects eligibility for Extra Help or Medicaid.

Widowed or divorced?

→ Medicare is an individual healthcare plan, so your former spouse's eligibility does not affect your own.

Tip: You don't have to accept Social Security and Medicare at the same time. Many people delay Social Security but enroll in Medicare at 65 to avoid penalties or gaps in coverage. You should consider which option is best for your personal circumstances or check in with your financial advisor if you have access to one. Medicare is an individual healthcare plan, so your former spouse's eligibility does not affect your own.

Learn more about Social Security and eligibility.

Enrollment

Some people are automatically enrolled in Medicare, while others need to actively sign up for Medicare.

People who are already receiving Social Security or Railroad Retirement Board (RRB) benefits at least four months before turning 65 are automatically enrolled in both Medicare Part A and Part B. They'll receive their Medicare card in the mail about three months before their 65th birthday.

Those who are not yet drawing Social Security benefits must apply for Medicare manually. The application process can be completed online at the Social Security Administration website, by phone, or in person at a local Social Security office. It's ideal to apply during the Medicare **Initial Enrollment Period (IEP)**. The IEP is the seven-month window around an individual's 65th birthday when they can sign up for **Original Medicare** (Parts A and B) and **Medicare Part D**. This window includes the three months prior, the month of, and the three months after the enrolling person's birthday.

Note: This same period is called the **"Initial Coverage Election Period (ICEP)"** for **Medicare Advantage/ Medicare Part C.**



Missing the IEP or ICEP window can result in penalties or gaps in coverage. People who do not have other coverage and miss their IEP or ICEP window will have to pay a late enrollment penalty that is added to the monthly Medicare premium. This is a lifetime penalty — not a one-time late fee — and it goes up the longer people wait to sign up for Medicare.

There are some circumstances under which people can have their late fees reduced or waived. This may include qualifying for a Special Enrollment Period (for Part B penalties) or qualifying for **Extra Help** or **creditable drug coverage** (for Part D penalties). **Learn more about avoiding late penalties.**

Enrollment Periods

Joining, switching, and dropping Medicare plans can only happen during one of Medicare's enrollment periods. There are several different "enrollment periods" related to Original Medicare and Medicare Advantage. Individuals should make sure they have a clear understanding of which enrollment period(s) are relevant for their needs and when they need to join or change a plan.

Enrollment Period:	Relevant For:	Options During Enrollment Period:	Coverage Starts:
Initial Enrollment Period Begins three months before an individual's 65th birthday; includes the birthday month, and ends three months after the birthday month	First-time Medicare enrollees	Join any Medicare plan. • Part A or Part B coverage is required to join a Medicare drug plan. • Part A and Part B are needed to join a Medicare Advantage Plan with or without drug coverage.	Varies based on when the request is received. **Learn more** about joining a plan.
General Enrollment Period January 1–March 31	People who missed the IEP when they first became eligible for Medicare or missed a Special Enrollment Period (if eligible)	Join Medicare Part A, Part B, or both. **Note:** If a person disenrolls from Medicare Advantage to enroll into Original Medicare, there is no guarantee that they will be able to access a supplemental insurance (Medigap) plan or find an affordable plan. It is important to consider which pathway best suits your current and potential future needs before initially choosing between Original Medicare vs. Medicare Advantage.	First month after the request is received.
Open Enrollment Period October 15–December 7	Everyone eligible for Medicare. This also includes individuals who are already enrolled in Medicare and want to change their coverage.	Change Medicare plan or drug coverage: • Move from an Original Medicare to a Medicare Advantage plan or vice versa. • Join, leave, or move to another Medicare drug plan (if in Original Medicare). • Join, leave, or switch to another Medicare Advantage plan with or without drug coverage (or add or drop drug coverage).	January 1 of the next year. *The plan **must** receive the enrollment request by December 7.

Enrollment Period:	Relevant For:	Options During Enrollment Period:	Coverage Starts:
Medicare Advantage Open Enrollment Period January 1–March 31 **Or** Within the first three months after getting Medicare	Those with a Medicare Advantage Plan	• Move to a different Medicare Advantage Plan with or without drug coverage. • Leave a Medicare Advantage Plan and join Original Medicare.	First month after the request to change plans is received.
Medigap Open Enrollment Period* A one-time, six-month window beginning the first month people 65 or older have a Medicare Part B policy	Those with a Medicare Part B policy who need help with out-of-pocket costs in Original Medicare	• Enroll in any Medigap policy.	Typically begins the first month after a person applies.
Special Enrollment Period Situation-dependent	Those undergoing certain life circumstances (e.g., moving to a new address, getting Medicaid)	A person may either join a Medicare Advantage Plan (with or without drug coverage) or a Medicare drug plan, or switch to a different plan, depending on the circumstances.	Typically begins the first month after the request is received by the plan, but timing may vary based on circumstances.

**Adapted from Medicare.gov.*

While people can apply for Medigap beyond the Medigap Open Enrollment Period, applying during the Open Enrollment Period guarantees that health plans can't make a decision based on medical or health information, such as pre-existing health conditions.* **Learn more.

People should make sure they have a clear understanding of which enrollment period(s) are relevant for their needs and when they need to join or change a plan. Get additional details on the **"Joining a Plan" page of Medicare.gov**.

Featured Find!

AARP Medicare Enrollment Guide

A step-by-step tool for first-time Medicare enrollees that creates a personalized introduction to Medicare after you answer three short questions.

When Can I Enroll in Original Medicare?

Different Scenarios:

It is 3 months before, 3 months after or my 65th birthday month.

- This is your Initial Enrollment Period (IEP). You can choose any Medicare pathway for coverage.

I missed my Initial Enrollment Period (IEP).

- From January 1–March 31 (General Enrollment Period), you can enroll in Medicare.

I signed up for Original Medicare and need help with out-of-pocket costs.

- Within the first 6 months of signing up for Original Medicare, you can enroll in Medigap. This is called the Medigap Open Enrollment Period.

I have a Medicare plan and I want to change my coverage.

- From October 15–December 7 (Open Enrollment Period), you can make changes to your plan. You can:
  - Move from Original Medicare to Medicare Advantage
  - Move from Medicare Advantage to Original Medicare
  - Move to a new Medicare Drug Coverage Plan
  - Switch to a different Medicare Advantage Plan

I have a Medicare Advantage Plan and I want to change my coverage.

- You can change your plan if you are in the first 3 months after getting Medicare.
- From January 1–March 31, you can change your plan during the Medicare Advantage Open Enrollment Period.

My circumstances have changed. (For example, I changed where I live OR I lost my current health coverage.)

- You may qualify for a Special Enrollment Period. The types of changes you can make and the timing depend on your life event. Learn more about what events qualify you for a **Special Enrollment Period**.

Medicare Beneficiary Ombudsman: Your Advocate in Medicare

The Medicare Beneficiary Ombudsman (MBO) is an advocate within the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare and Medicaid plans. It was established by Congress in 2003 to provide support for Medicare beneficiaries to understand their rights and protections and assist with complaints or problems related to Medicare coverage.

In addition to helping address people's Medicare concerns and providing educational tools and resources, the MBO is designed to improve Medicare services. It provides an annual report to Congress and provides recommendations for improving the administration of Medicare.

If you have a Medicare-related inquiry or complaint, CMS recommends taking the following steps:

1. **Call your plan or 1-800-MEDICARE.** CMS says that plans are the best place to resolve plan-related issues.
   - If the inquiry or complaint is related to a Medicare Part D or Medicare Advantage (Part C) plan, contact the plan first using the phone number on your member ID card.
   - If your concern is related to Original Medicare, or if your plan was unable to address your concern, contact 1-800-633-4227. TTY users should call 1-877-486-2048.
2. **Contact the SHIP.** State Health Insurance Assistance Programs (SHIPs) provide free local health insurance counseling to people with Medicare regarding their benefits, coverage, appeals, and complaints. Find your local **SHIP**.
3. **Contact the MBO.** If you have been unable to resolve your concern with your plan or 1-800-Medicare, ask a 1-800-MEDICARE representative to submit your complaint or inquiry to the MBO. The MBO will help to ensure that your inquiry is resolved appropriately.

Learn more about the MBO.

Assessing Current Healthcare Needs

Before enrolling in Medicare, it's important to consider your current health needs as well as what your future health needs may be and how your needs, priorities, or circumstances, like income, may change over time. Ask yourself questions like which aspects of coverage are most important to you, or what elements like catastrophic coverage, in-network providers, or preventive care you value most.

Having a list of current HCPs, prescriptions, and preferred hospitals and pharmacies can also be helpful in preparing for the transition to Medicare. This information can be especially useful when comparing Original Medicare with Medicare Advantage to ensure that existing providers will be included, and when reviewing drug plan **formularies** to confirm that needed medications will be covered by the plan — and affordable.

Tip: Prepare for Plan Comparison

- Print out a list of your **current HCPs; medications, including dosage amounts and frequency of use;** and **frequent services** to use when comparing Medicare plans.
- Consider the benefits that are most important to you now and what might be most important to you in the future.



Knowledge Is Power: Coverage Terms

Insurance plans rarely cover 100% of healthcare costs. Patients are often required to pay for parts of their care. These are called "out-of-pocket costs." The primary out-of-pocket costs include:

- **Deductible** – the preset amount you pay for out-of-pocket costs for healthcare before insurance kicks in and starts helping pay for your care
- **Coinsurance** – an amount (often a percentage) that you pay for services after the deductible has been reached
- **Copayment (copay)** – a preset, flat fee that you pay for services or prescriptions at the time of a visit or upon picking up a prescription
- **Premium** – the monthly amount you pay for Medicare coverage, specifically for Parts B and D

Learn more about **Medicare costs at Medicare.gov.**

Costs

Planning ahead by setting a budget and comparing the cost of available options can ease the transition into Medicare and help people choose coverage that fits both their health needs and financial situation.

When setting your budget, keep in mind that people with higher incomes may face higher premiums.

- **Medicare Part A:** The premium is usually $0. This is referred to as premium-free because either the person or a spouse paid Medicare taxes for at least 10 years while they were working.
- **Medicare Part B:** There is a standard monthly premium, but it can go up, depending on income. This is known as **income-related monthly adjustment amounts (IRMAA)**. The premium can also change every year. **Check premium costs.**
- **Medicare Advantage, Part D, and Medigap:** All have their own **premiums, copays,** and coverage details.

Learn more on the **"Costs" page of Medicare.gov.**

Overview of the Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan (MPPP) is a payment option that allows people with a Medicare Part D plan to spread out payments for prescriptions over the course of the calendar year rather than paying the full amount when the prescription is received. There are several important things to know about the MPPP:

- It is a voluntary program
- There is no cost to participate
- People wishing to opt into the MPPP will need to enroll separately
- Individuals must have a Medicare Part D prescription drug plan before enrolling

When determining whether the MPPP is a good choice, people should consider their estimated total out-of-pocket costs for prescriptions over the year and when in the year they'll be opting into the plan.

The cost-effectiveness of MPPP should be evaluated on a case-by-case basis because MPPP will only benefit certain people. For example, someone who takes an expensive medicine for a chronic condition is more likely to benefit than someone who is taking multiple medications on a short-term basis or generic medication for a long-term condition. People should speak with their pharmacists or their Part D plan administrators to see if they will benefit from this payment plan.

Those who enroll will not pay for prescriptions at the pharmacy and instead will be able to pay in monthly installments throughout the year.

Additional resources on the MPPP:

Medicare Access for Patients Rx (MAPRx) Resources:

- **2026 Medicare Prescription Drug Annual Open Enrollment**
- **Medicare Part D 2026 Changes Infographic**
- **Medicare Part D Prescription Drug Coverage 2026 Guide**
- **What's the Medicare Prescription Payment Plan | Medicare.gov**



Sample Medicare Prep Timeline for the Year Before Turning 65

12 Months Before (Age 64)	Learn the basics of Medicare (Parts A, B, C, D, and Medigap) Determine your eligibility date Check your current employer/retirement coverage rules Review your health needs (HCPs, prescriptions, preferred hospitals)
6–9 Months Before	Estimate your income to determine whether you'll pay a higher Part B premium Research Medicare Advantage and Medigap plans in your area Review prescription drug coverage options (Part D) Compare Original Medicare vs. Medicare Advantage Set a budget for premiums, copays, and out-of-pocket costs
3–6 Months Before	Confirm your employer/retirement insurance status Gather important documentation (e.g., Social Security number, birth certificate, work history, military service history) Speak with a Medicare counselor or licensed broker. Resources include: • **Centers for Medicare and Medicaid Services (CMS)** • **HealthCare.gov's Find Local Help Tool** • **Medicare** • **Medicare Agents Hub** • **Medicare Rights Center** • **State Health Insurance Assistance Program (SHIP)** Narrow down your plan choices (Options may vary. View coverage options at **Medicare.gov**.)
3 Months Before (Start of Initial Enrollment Period)	Enroll in desired coverage pathway and choose your specific plan(s) Cancel or adjust current insurance, if needed Set up premium payment option, such as automatic recurring payments
1 Month Before	Make sure your Medicare card and plan materials have arrived (if you're still waiting for your card, make sure your mailing address is correct with the **Social Security Administration** and sign into your **Medicare.gov** account to check the status of your card or request a temporary card) Review coverage start dates Contact HCPs to confirm whether they accept your new plan Fill any necessary prescriptions before switching coverage
Medicare Start Month	Use your new Medicare and any additional plan cards at appointments Set up online accounts (Medicare.gov, plan provider portals) Track any out-of-pocket costs and services

How Insurances Interact

It is possible for people on Medicare to have more than one insurance plan. Individuals enrolled in Medicare can also receive health insurance through:

- Their employer
- Their spouse's/domestic partner's private health insurance
- TRICARE (insurance for active and retired members of the military and their families)
- COBRA (temporary health insurance offered by an employer's insurance company under certain circumstances, such as job loss, reduced hours, or other life events)
- Medicaid (when individuals are dual-eligible for Medicare and Medicaid, Medicare serves as the primary for healthcare services, while Medicaid may cover costs or partial costs not fully covered by Medicare, such as certain prescription drugs, premiums and cost-sharing)

The health plans interact differently based on the types of insurance an individual has and their personal circumstances.



What Happens to My Current Insurance When I Go on Medicare?

One of the insurers will become the "primary **payer**" and pay for healthcare services first, and the other will become the "secondary payer." The primary payer will pay the maximum amount it can pay based on your coverage. Any remaining balance will be paid by the secondary payer (or the insured person if the secondary payer doesn't cover or fully cover the service).

Visit **Medicare.gov** to determine which insurer will become the primary payer and which will be the secondary payer.

Here are some examples:

Example 1. Meet Sally. Sally is 65 years old and works for a small nonprofit organization with fewer than 20 employees. Sally has both private insurance through her employer and Medicare. Because her employer has fewer than 20 employees, Medicare is the primary payer, and her group plan is the secondary payer. Sally will need to enroll in Part B to avoid future premium penalties.

Sally's best friend, Jen, is also 65 and also has both private insurance and Medicare. However, Jen works for a mid-size company with 30 employees. Because her group plan has 20 or more employees, her group plan pays first, and Medicare pays second. Jen will not need to enroll in Part B or D at this time.

Example 2. Meet Alice. Alice is an active-duty member of the military. She has TRICARE insurance and Medicare. Given her active-duty status, TRICARE will pay first, including paying for any services covered by Medicare, services covered by TRICARE but not Medicare, and deductibles and coinsurance costs. However, for her colleague Joe, who has Medicare and TRICARE, but is not on active duty, Medicare is the primary payer.

Medicare and Medicaid: What's the Difference?

Medicare and Medicaid are both government health programs, but they serve different people and have different rules:

- **Medicare** is mainly for people 65 and older or those with certain disabilities, regardless of income
- **Medicaid** is for people of any age who have limited income and resources

Medicare is run by the federal government, while Medicaid is a state and federal partnership, so benefits vary by state.

Dual Eligibility

For those who qualify for both Medicare and Medicaid (based on various factors, including income level, age, number of people in family, and whether an individual is pregnant or has a disability), the two plans will work together to cover health services and medical costs. Dual eligibility is when a person qualifies for both Medicare and Medicaid.

Here are some important facts about dual eligibility:

- Medicare pays first, and Medicaid pays last, after Medicare and any other insurance that a person has. Medicare covers most primary healthcare costs, and Medicaid may help with remaining expenses.
- Medicaid may cover services and medications that Medicare does not. This may include additional prescription drugs.
- Medicaid often pays for long-term care benefits.
- Extra benefits, such as coverage of deductibles and copayments, may vary by state. Individuals should check with their state's Medicaid office to learn more about what additional coverage is available.
- Dual eligibility also applies to private group plans, but the specifics will depend on the state and the plan. People who are dual eligible in private group plans can enroll in **Dual-Eligible Special Needs Plans (D-SNPs)**.

Note regarding dual eligibility: As some states transition to Medicaid Managed Care, rules about eligibility and enrollment may change. To find state-specific information, visit **CMS** and your local **SHIP**.

To determine how Medicare works with an additional insurance plan and how it might be affected by a person's unique circumstances, people can contact Medicare at 1-800-MEDICARE (1-800-633-4227), the Social Security Administration at 1-800-772-1213, or their local **SHIP**. **Visit the SHIP website**.

What are SNPs?

Special Needs Plans (SNPs) are plans offered by private companies to administer benefits. SNPs cover the same services as Original Medicare, but like Medicare Advantage plans, they have different costs, coverage, and rules. There are three types of SNPs:

- **Chronic Condition SNPs (C-SNPs)** are plans designed for people with certain chronic conditions, such as cancer and dementia.
- **Institutional SNPs (I-SNPs)** are plans designed for people who live in an institution, such as an assisted living facility.
- **Dual Eligible Special Needs Plans (D-SNPs)** are plans designed for people who have Medicare and Medicaid and may need additional help due to disabilities, age, or certain health conditions. They are a type of Medicare Advantage plan, offered by private insurance companies and designed to coordinate benefits across Medicare and Medicaid.

SNPs may offer benefits beyond those provided by Original Medicare. However, they have specific eligibility requirements and often have a specific network of HCPs. Whether someone should get an SNP will depend on personal circumstances, including whether the individual has a specific qualifying condition or lives in a long-term care facility and whether they are comfortable having a designated list of HCPs.

**This guide is intended to serve as an educational and informative resource, but it is not intended or implied to serve as a substitute for medical or professional advice. The Society for Women's Health Research and HealthyWomen do not make medical, diagnosis, or treatment recommendations, nor are they an authority on Medicare policy. Individuals should confirm the information included in this guide independently and consult with their healthcare provider and other relevant trusted professionals to determine individual needs. The Society for Women's Health Research and HealthyWomen will not be liable for any direct, indirect, or other damages arising therefrom.*

Doctor Discussion Checklist: Preparing for Medicare

This form has sample questions you can use at your next appointment to determine whether your care team and coverage will still work for you once you're on Medicare.

Confirm Network Participation

Ask your HCP or the front desk staff:

- Are you and your clinic in-network for Medicare?
- Do you accept Original Medicare (Parts A & B)?
- Do you accept Medicare Advantage plans? If so, which ones?
- Will I need to switch providers if I join a Medicare Advantage plan?

Understand Cost & Coverage Changes

Ask your HCP's billing office:

- Will any of my current services (e.g., labs, physical therapy) have different costs under Medicare?
- Will I need referrals for specialists under certain Medicare plans?
- Are there any services I use now that may no longer be covered or might require prior authorization?

Review Medications & Prescriptions

Ask your SHIP counselor or Medicare broker:

- Can we review my current prescriptions to see if they're typically covered under Medicare Part D?
- Do you have a preferred pharmacy or recommendation for a Part D plan that covers my medications?



Considerations for Caregivers

Recovering from a major medical event, such as a heart attack, bone fracture, or surgery, is a physically and emotionally demanding process. During this period and beyond, caregivers play a vital role in a patient's recovery journey, providing support that allows patients to heal more comfortably and safely. Caregivers may help with responsibilities that include everything from daily activities to navigating health insurance.



Did you know that an estimated 66% of caregivers are women — and the value of informal care that women provide ranges from $148–188 billion annually?

Who is a caregiver? CMS defines a caregiver as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition."

Becoming a Decision-Maker for a Medicare Beneficiary

Given the prominent role caregivers play in the lives of people who need assistance, it's important to have conversations early — before urgent issues arise — to ensure that the beneficiary's preferences are known and that the caregiver understands exactly what role they are to play.

If caregiving responsibilities extend beyond assistance with daily activities, such as running errands or helping a person with bathing and dressing, the caregiver will need to receive legal permission from the Medicare beneficiary to gain access to their personal medical information and health plan information.

This is where advance care planning is essential. It provides both individual people and caregivers the opportunity to discuss and share their wishes, values, preferences, and beliefs for future healthcare decisions and end of life.



Tip: Preparing for the Unexpected

Medical emergencies are always stressful. Not being prepared can result in added stress. Having essential medical and legal documents like advanced directives and insurance information readily available can help provide peace of mind and ensure caregivers have the guidance they need. Caregivers may consider putting together a folder with the following information:

- Emergency contacts (names, phone numbers, relationship)
- Current medications (names, doses, frequency)
- Allergies
- Medical conditions and diagnoses
- List of medical devices or implants (e.g., pacemaker, insulin pump)
- Surgeries or hospitalizations, with dates, if available
- Health insurance cards
- Living will (may also be called advance directive, advance healthcare directive, medical directive)
- Medical power of attorney (may also be called healthcare power of attorney or power of attorney for health care)
- Do-not-resuscitate (DNR) or Do-not-intubate (DNI) orders, if applicable

The first step is to have the beneficiary fill out Medicare's **Authorization to Disclose Personal Health Information** form. It allows caregiver access to personal health information that may be needed for healthcare appointments, medication management, or supportive decision-making. This is different from other documents, such as a healthcare power of attorney, that are needed to make medical decisions on the Medicare recipient's behalf.

Advanced directives can be created. These are legal documents that go into effect if a person can no longer make decisions for themselves or communicate their wishes.

Advanced directives include the two following documents:

Advanced Directive Documents	Description
Medical Power of Attorney (MPOA) May also be called: • Healthcare power of attorney • Power of attorney for health care *These documents may be temporary or durable (permanent). If the POA is durable, the document remains in effect, even when the person who grants the POA (called the principal) becomes incapacitated.*	A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so. Depending on what state you live in, the person appointed is called one of the following: • healthcare proxy • healthcare agent • healthcare representative • healthcare surrogate
Living Will May also be called: • Advance directive • Advance healthcare directive • Medical directive	A legal document that outlines what treatments or types of care are and are not wanted, and in what situation each decision applies. This is often specific to types of care, such as: • CPR • Breathing machines • Tube feeding (artificial hydration and nutrition) • Dialysis • Pacemakers and implantable cardioverter defibrillators • Pain medication Wishes for organ, tissue, and body donation can also be designated in a living will.



In addition to the advanced directives, other documents that may be useful for advance care planning include:

- **Power of attorney (POA):** This is broader than a medical power of attorney, giving someone the authority to act on a person's behalf for financial and legal matters.
  - **Financial (or fiduciary) power of attorney: A specific power of attorney for financial tasks, such as managing bank accounts, paying bills, handling investments, filing taxes and conducting real estate transactions.**
- **Do-not-resuscitate (DNR) order:** This may also be known as a cardiopulmonary resuscitation (CPR) direction. This document directs a medical team not to administer CPR if the heart or breathing stops.

Each state has its own forms and requirements for creating these forms, such as the need for a notary or a signature from a witness. The forms can be prepared by a lawyer, but they do not have to be.

Forms may be found at **AARP's Advance Directives Forms by State**.

Support for Caregivers

Medicare Part B covers caregiver training services if the patient's treatment requires caregiver support and if the training will help meet the health and treatment goals identified by the patient and their HCP. The training may involve an individual or group training session with the provider and may involve instruction on things like how to administer medications, move the patient safely, and care for wounds. Learn more about **support for caregivers**.

Additional Caregiving Resources:

- **Caregiver Action Network**
- **Eldercare Locator**
- **National Alliance for Caregiving**
- **National Council on Aging**
- **Society for Women's Health Research**

Being Aware of Medicare Scams

Those who are enrolling in Medicare should be aware that there are several Medicare scams that will try to trick beneficiaries into providing their Medicare or Social Security number. The scams have become very sophisticated and often sound legitimate.

The National Council on Aging has put together a **guide** to help people spot scammers (such as people promising free items or services or applying pressure to switch Medicare plans) and offers tips to avoid being scammed:

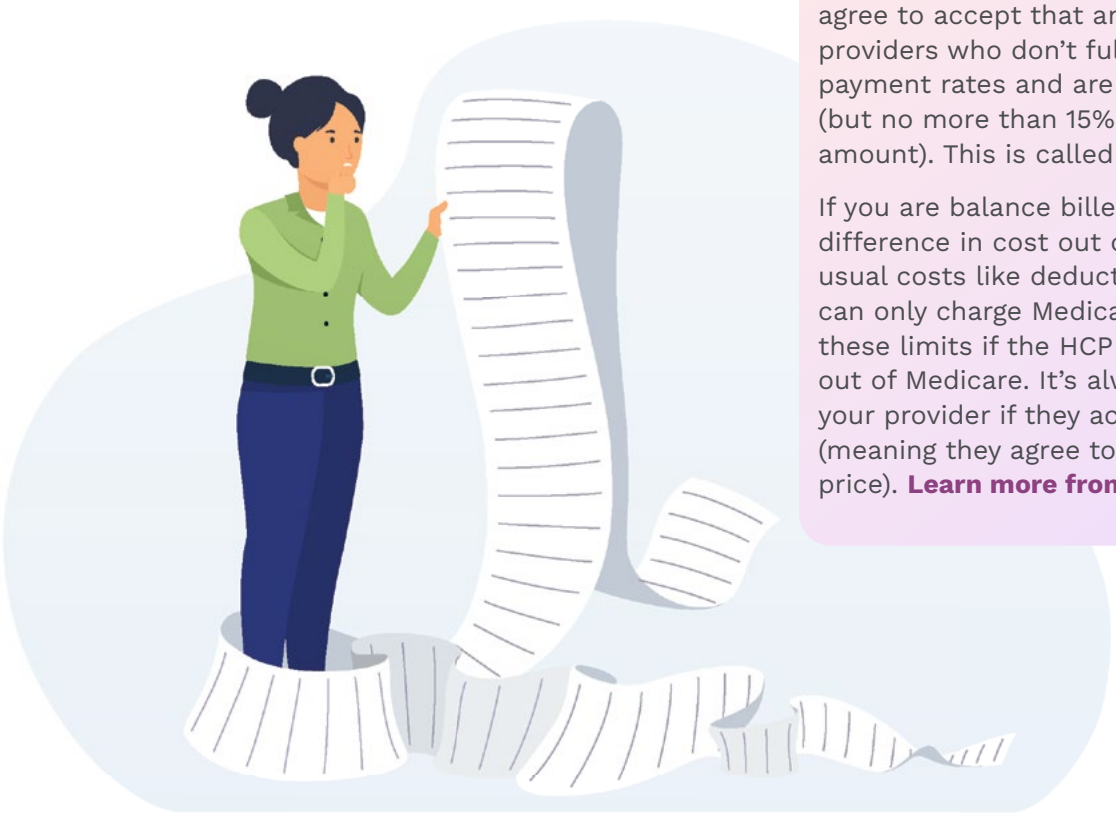
1. Do not share your Medicare number with people who contact you out of the blue
2. Don't click on suspicious links
3. Don't be afraid of threats about canceling your benefits
4. Don't speak to anyone who tries to convince you to sign up for a certain Medicare plan
5. Destroy your old Medicare card immediately if you receive a new one from Medicare
6. Keep your personal medical information close and do not share it with anyone beyond healthcare providers or trusted caregivers
7. Don't accept unauthorized genetic testing kits

Report Medicare scams immediately by calling 1-800-MEDICARE (800-633-4227) or **submit a report online** to the Federal Trade Commission (FTC).

Your Right To an Appeal

Sometimes Medicare won't pay for a service it typically covers. For example, Medicare may deny payment for physical, occupational, or speech therapy if it decides the person is not likely to improve from the therapy.

If Medicare denies payment for a certain treatment, you can file an appeal for reconsideration of the coverage decision by an independent entity known as a **qualified independent contractor (QIC)**. Your HCP can provide information to make your appeal stronger. **Learn more about appeals in Original Medicare**, or contact your local **State Health Insurance Assistance Program (SHIP)** or **local Area Agency on Aging**.



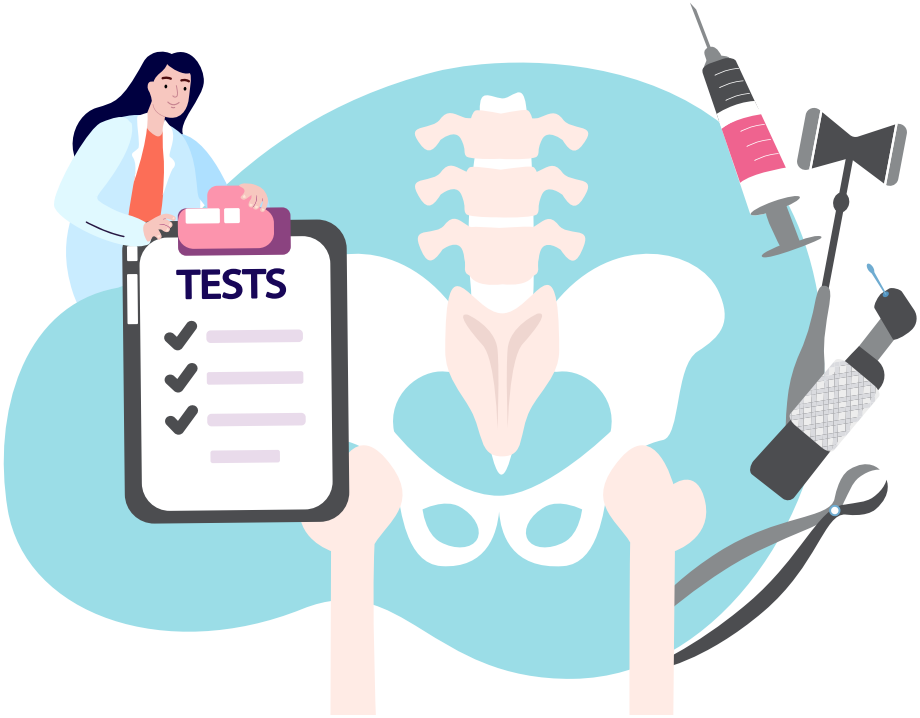
What Is Balance Billing?

Balance billing under Medicare is when an HCP charges you more than what Medicare has approved for a service. Medicare sets a standard amount it will pay, and in most cases, HCPs agree to accept that amount. But there are some providers who don't fully accept Medicare's payment rates and are allowed to charge extra (but no more than 15% of the Medicare-approved amount). This is called balance billing.

If you are balance billed, you may have to pay the difference in cost out of pocket, on top of your usual costs like deductibles or coinsurance. HCPs can only charge Medicare beneficiaries more than these limits if the HCP has completely opted out of Medicare. It's always a good idea to ask your provider if they accept Medicare assignment (meaning they agree to the Medicare-approved price). **Learn more from AARP.**

Women's Bone Health

In this chapter, readers will learn about bone health at Medicare age, including osteoporosis risk factors to be aware of and how to lead a bone-healthy lifestyle, as well as what Medicare benefits and services are available for women to support their bone health in older age.



Why Should Women Focus on Bone Health?

Bone health is important throughout life, and it becomes even more important as people get older — especially for women. Women who are 60 and older are at significantly higher risk for osteoporosis, the most common form of bone disease, and for fractures that result from bone loss after menopause.

In fact, approximately **80% of the 10 million Americans with osteoporosis are women**, and **1 in 2 women** will experience an osteoporosis-related fracture in their lifetime. These fractures can lead to complications, including the loss of mobility and independence, which can affect quality of life.

Too often, people don't think about their bone health until they experience a fracture. But bone health should be top of mind. Consider these statistics shared by the **Bone Health and Osteoporosis Foundation (BHOF)** in 2024:

- 1.8 million people on Medicare — 7 out of 10 of them women — experience approximately 2.1 million osteoporotic fractures each year
- Nearly 1 in 5 people on Medicare died from complications within 12 months after an osteoporotic fracture — and more than 6 out of 10 of them were women
- 3 out of 10 of Americans who have a hip fracture die within a year

While these statistics are troubling, it's important to remember that osteoporosis is not always a natural consequence of aging, and there are many steps that women can take to protect, preserve, and safeguard their bone health into older age.

Women most at risk for fractures and bone disease are likely to be Medicare-eligible or enrolled in Medicare. Therefore, access to healthcare providers (HCPs), screening opportunities, and affordable treatments are critical during this time.

Key Bone Health Terms

- **Bone Density** – the amount of minerals (mostly calcium and phosphorus) in a specific area of bone that contribute to bone strength
- **Fracture** – a crack or break in a bone
- **Osteoporosis** – a medical condition in which bones, especially of the hip, spine and wrists, lose density and thickness, becoming weak and more likely to fracture
- **Osteopenia** – a moderate decrease in bone density that is not as severe as osteoporosis but still increases the risk of fractures

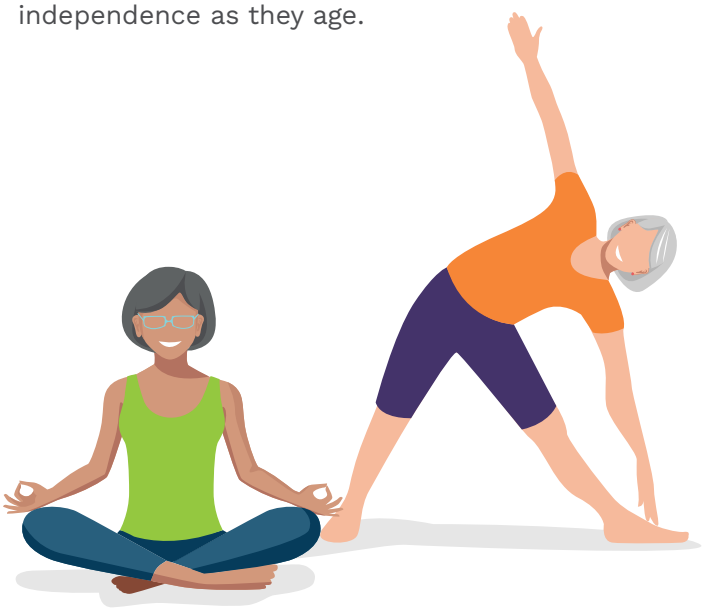
Bone Health at Medicare Age: What to Know

Risk Factors

Age and biological sex are the greatest risk factors for osteoporosis and fractures. Risk for women is higher due to factors such as having lower peak bone mass and longer lifespans than men, and declining levels of estrogen (an important hormone for bone density) during and after menopause. Other risk factors include:

- Low body mass index (BMI)
- A previous fracture
- Poor nutrition (e.g., not enough dietary calcium or fruits and vegetables or too much protein, sodium, and caffeine)
- Vitamin D deficiency
- Lack of physical activity
- Smoking
- Alcohol use (more than 2 to 3 drinks per day)
- Having an eating disorder
- Certain medications (e.g., corticosteroids) and certain treatments (e.g., chemotherapy)
- Certain diseases (e.g., multiple myeloma, diabetes, and autoimmune diseases like rheumatoid arthritis and Crohn's disease)
- A family history of osteoporosis

By knowing the risk factors for fractures and osteoporosis, women can take early steps to prevent fractures and secondary fractures, maintain mobility, and protect long-term independence as they age.



Tips to Support Strong Bones

Prevention is the greatest tool for safeguarding, improving and maintaining bone health.

To maintain strong bones, focus on getting enough calcium and vitamin D in your diet, doing weight-bearing and muscle-strengthening exercises, having regular bone density screenings, and taking steps to reduce the risk of falling. A bone-healthy lifestyle can help reduce fracture risk.

- **Nutrition:** Aim to get 1,200 mg of calcium and 800–1,000 IU of vitamin D per day*
- **Exercise:** Do weight-bearing exercises on your feet like walking, dancing, and stair climbing or muscle-strengthening exercises like squats and yoga that build and protect bone strength
- **Fall Prevention:** Think about changes you can make in your daily habits and around your home that might reduce your risk of injury:
  - Reduce clutter around the house
  - Tape or fasten loose rugs and electrical cords
  - Make sure rooms are well lit
  - Install handrails on the stairs or non-slip mats in the bathtub
  - Wear low-heel and non-slip shoes or non-slip socks
  - Use assistive devices, such as canes or walkers, if needed
  - Check whether your medications may cause dizziness
  - Get your hearing and vision checked regularly
  - Work with your HCP to manage any conditions that can affect walking or balance

**These recommendations are not intended to serve as a substitute for medical or professional advice. Individuals should confirm information and consult with their HCP to determine individual needs.*

Taking Charge: My Bone Health Habit Tracker

Regardless of your stage of life, you can take steps now to support and maintain your bone health. This daily bone health habit tracker can help ensure you're taking steps from week to week to care for your bones and live a bone healthy lifestyle.



- ☑ I ate calcium-rich foods (e.g., dairy, leafy greens, beans and lentils, seeds, almonds)
- ☑ I got some vitamin D (e.g., sunlight exposure, fatty fish, fortified foods, or supplements, if needed)
- ☑ I limited excess salt
- ☑ I limited soda and alcohol
- ☑ I did not smoke
- ☑ I did weight-bearing or strength training exercises (e.g., brisk walking, dancing, stair climbing)
- ☑ I got quality sleep
- ☑ I made sure my space was clear of clutter to prevent trips and falls

Healthcare Providers

Several types of HCPs can diagnose and treat conditions affecting bones or help manage bone health. They include primary care providers, rheumatologists, endocrinologists, and orthopedic surgeons.

Coverage for visits with specialists, such as a rheumatologist, may be dependent on whether the specialist participates in Medicare. Because of the impact of osteoporosis on women's health, establishing coverage and confirming care networks before enrollment is critical.

A Reminder: Healthcare Provider and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any HCP or hospital in the United States that accepts Medicare.	In many cases, you can only visit HCPs within the plan's network.
In most cases, referrals are not needed to see a specialist.	A referral may be needed to see a specialist.

**Adapted from Medicare.gov.*

Medicare Coverage for Bone Health

Medicare provides the following types of coverage that can help support bone health as you age:

- **Preventive and Screening Services:** Medicare Part B covers many preventive services, including health risk assessments and health screenings. These include:
  - **"Welcome to Medicare" Visit:** An initial, one-time visit that takes place within the first 12 months of enrolling in Medicare Part B
  - **Annual Wellness Visit:** Available every 12 months after the first year on Medicare Part B

    Note: Medicare does not cover routine physical exams. **Learn more about yearly wellness visits.**
  - **Preventive Screenings:** Medicare covers free bone health-related preventive screenings. These include:
    - **Bone Density Test:** Medicare Part B covers a dual-energy X-ray absorptiometry scan (known as a DEXA scan) to measure bone density and identify people at risk for bone fractures. Coverage permits DEXA scans for women once every 24 months (or more if needed) for the following situations:
      - Estrogen-deficient and at risk for osteoporosis
      - Possible osteoporosis, osteopenia, or vertebral fractures shown on an X-ray
      - Taking certain medications that increase risk, such as steroids
      - A diagnosis of primary hyperparathyroidism
      - Monitoring to see if osteoporosis drug therapy is working

Note: Preventive screenings are covered based on certain conditions, such as various risk factors. As is the case with most health screenings, bone mass measurements are fully covered if the HCP **accepts the assignment** (meaning the HCP accepts Medicare and agrees to the Medicare-approved payment for the service). Find a **full list of preventive and screening services covered by Medicare Part B.**

- **Medication Coverage:** Medicare Part D will help pay for for non-injectable retail prescription drugs. Medicare Parts A and B will help pay for hospital and HCP-administered injectable and infused osteoporosis drugs and home health nurse visits for giving injectable and infused treatments if certain **eligibility requirements** are met. Once the Part B plan's deductible has been met, most people will pay up to 20% of the Medicare-approved amount for medications covered under Medicare Part B. The coinsurance amount can change based on the drug's price. **Learn more about medication coverage.**
- **Lifestyle Support:** Medicare Part B offers several resources related to lifestyle and nutrition that could be beneficial in an individual's bone health journey:
  - **Physical therapy** for strengthening bones and improving mobility for people who qualify. Individuals **pay 20%** of the Medicare-approved amount after the Part B plan's deductible has been met. Certain Medigap plans will cover the 20% payment, so people with those plans should check their **explanation of benefits** to see if the service will be covered.
  - **Nutrition counseling/medical nutrition therapy services** for people with osteoporosis who also have diabetes or kidney disease. People with these conditions do not pay anything for these services. **Learn more about medical nutrition therapy services.**
  - **Durable medical equipment,** when prescribed by an HCP and considered medically necessary. Coverage for certain medical equipment, such as walkers and canes, may be based on functional need, such as difficulty moving around the home. An in-person mobility assessment may be required to determine whether a device like a scooter is medically necessary. *Approved equipment is likely to cost 20% of the Medicare-approved cost after the Part B plan's deductible has been met.* **Learn more about durable medical equipment coverage at Medicare.gov** and in the official government booklet, **"Medicare Coverage of Durable Medical Equipment & Other Devices."**
    - Certain Medicare Advantage plans may cover specific **home safety equipment** or structural modifications for people with chronic conditions.

DEXA Decoded

Dual-energy X-ray absorptiometry scans, known as DXA or DEXA scans, measure bone density and identify individuals at risk for bone fractures. These scans are considered the gold standard in assessing bone mineral density (BMD). And they're important tools for helping catch osteoporosis, osteopenia, and fracture risk early.

Medicare Coverage for DEXA

In most cases, Medicare Part B covers bone density tests, like DEXA, once every two years if one or more of the following conditions are met:

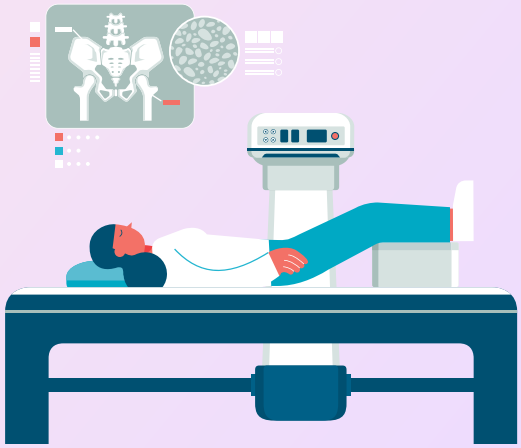
- You're a woman who has been diagnosed as estrogen-deficient by an HCP and is at risk for osteoporosis.
- Your X-rays show possible osteoporosis, osteopenia, or vertebral fractures.
- You're taking prednisone or steroid-type drugs or are planning to begin this treatment.
- You've been diagnosed with primary hyperparathyroidism.
- You're being monitored to see if your osteoporosis drug therapy is working.

You may be eligible for more frequent DEXA scans if they are considered medically necessary.

Source:* **Bone Mass Measurements, CMS.gov

Taking Charge of Your Bone Health

Talk to your HCP about your osteoporosis risk factors (e.g., family history, low body weight, history of fractures, use of medications like corticosteroids) to determine when you should get your first DEXA scan and how often you should be getting them. Your yearly wellness visit is an ideal time to develop a plan.



Bone Health Questions to Ask During Medicare Wellness Visits

These questions can be tailored to personal circumstances, medical history, and awareness of personal fracture risk. You can also download this question checklist from the Bone Health and Osteoporosis Foundation.

- Am I at risk for osteoporosis or other bone conditions?
- Do I have any signs of bone loss?
- When will I need a bone density test (DEXA scan)?
- Do I need a DEXA scan more frequently than every two years?
- How else can I reduce my risk for osteoporosis and fractures?
- Do I need a referral or to meet specific criteria to qualify for coverage?
- Should I be taking calcium or vitamin D supplements?
- Are any medications I'm on increasing my risk of fractures?
- Should I be on a prescription medication to help prevent or treat bone loss?
- What changes to diet or exercise would best support my bone health?
- Are there weight-bearing exercises or balance activities you recommend?
- Can we assess my fall risk?
- Does my Medicare plan cover the medications or services you're recommending?
- Do I have any health issues (such as chronic conditions, history of diseases) that might increase my risk of bone loss or fractures?

Additional Resource

Questions to Ask Your HCP About Osteoporosis, HealthyWomen

Drug Plan Rules

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Like private insurance companies, Medicare drug plans have rules about whether they cover certain drugs and how they cover them. Drugs may be evaluated for medical necessity, appropriateness, and efficiency of use. These rules include:

- **Prior Authorization:** A process requiring the review and approval of a specific drug before it is covered by insurance based on specific criteria
- **Step Therapy:** A policy that requires a patient to try and "fail" a lower-cost treatment before the treatment originally prescribed or recommended by an HCP can be covered
- **Quantity Limits:** Restrictions about the amount of drugs that can be covered over a certain period for cost and safety reasons

People should check with their specific plan to learn their coverage rules and to determine whether their pharmacy is considered in-network or out-of-network. **Learn more about Medicare drug coverage.**

Note: When Medicare drug coverage begins, a **beneficiary** may receive a one-time, 30-day supply of the medication they've been taking — even if the drug isn't covered by their new plan or requires prior authorization or step therapy — to aid in the transition to their new plan.

Featured Find!

Medicare.gov's Prescription Drug Plan Finder

Institutional and Long-Term Care Medicare.gov Resources

- **Home Health Services**
- **Inpatient Hospital Care**
- **Inpatient Rehabilitation Facility**
- **Long-Term Care**
- **Medicare & Home Health Care**
- **Nursing Homes**
- **Outpatient Hospital Services**
- **Resources & Information for Patients and Caregivers**



Bone Health and Medicare: What If ...?

COVERAGE AND MEDICATION

Q: What if I can't afford my osteoporosis medication?

A: If you can't afford your medication through a Part D plan, you may qualify for the Extra Help program, which helps cover the cost of deductibles and copays. **Learn more about the Extra Help program**. Switching to a generic version of medication or applying for a **pharmaceutical assistance program**, when available, may also help reduce out-of-pocket costs. **Learn more about pharmaceutical assistance programs**.

Q: What if my osteoporosis medicine is not covered or stops being covered by my Medicare drug plan?

A: Part D drug plans' **formularies** can change annually. You can ask your HCP whether there is an alternative drug that's covered under your plan, request a formulary exception, or switch plans during open enrollment (October 15–December 7).

Q: What if my pharmacy no longer carries my prescribed medication?

A: Look for a pharmacy that carries your medication by contacting pharmacies in your area directly or contacting your insurer to help find one. There may also be mail-order options or other equivalent medications. Discuss these options with your HCP. Individuals with low income who are on the Extra Help program can change their drug coverage plans throughout the year.

Q: Are the same services that I would get under Original Medicare covered under Medicare Advantage as well?

A: Medicare Advantage plans must cover all medically necessary services that are covered under Original Medicare. However, plans will use their own coverage criteria to determine medical necessity for certain services and may offer other benefits that are not covered under Original Medicare.

PROVIDERS

Q: What if my specialist isn't in my Medicare Advantage plan's network?

A: You may need to get a referral, or you could face higher costs for seeing an out-of-network provider. During open enrollment (October 15–December 7), you can explore switching to a plan that includes your current HCPs.

PREVENTIVE CARE

Q: Does Medicare cover bone-strengthening nutrition or exercise programs?

A: Original Medicare does not cover gym memberships or fitness programs, but Medicare Part B does cover medical nutrition therapy services if you meet certain conditions and are referred for the service by an HCP. Fitness classes and gym memberships may be a part of coverage options under Medicare Advantage or Medigap plans. Check with your plan about wellness-related benefits.



Institutional and Long-Term Care for Bone Health: Covered or Not?

Fractures can present challenges, including pain, reduced mobility and independence, and increased risk for future fractures. According to the Bone Health and Osteoporosis Foundation, **42,000 patients move into nursing homes within three years after fracturing a hip**. For this reason, it's important to be familiar with Medicare coverage provisions related to care facilities or for long-term care.

Type: Home Health Care?

Description: Services that can be provided within the home for an illness or injury

? **Covered?** Maybe. **Medicare Part A and/or Part B** cover eligible home health services if certain conditions are met, such as when a person is homebound and requires skilled services. Non-skilled services such as assisting with everyday care and needs are not covered. **Medicare Advantage plans** cover home health care, but the coverage may be different than under Original Medicare.

Type: Inpatient Hospital Care

Description: Medical care provided in a hospital or facility that involves the patient staying overnight or longer.

✓ **Covered?** Yes. **Medicare Part A** typically covers inpatient hospital care if: 1) the person is admitted after an HCP's order and 2) the hospital accepts Medicare. Information about costs for coverage can be found on **Medicare.gov**. **Medicare Part B** typically pays for the HCPs' services at the hospital. It usually pays 80% of the Medicare-approved amount for those services.

Type: Inpatient Rehabilitation Facility

Description: Rehabilitation programs in rehab hospitals or rehab units in acute care hospitals

✓ **Covered?** Yes. **Medicare Part A** covers medically necessary care received in an inpatient rehab facility if an HCP certifies the care. Information about costs for coverage can be found on **Medicare.gov**. **Medical Part B** covers HCPs' services while in the facility. **Medicare Advantage** plans may have different rehabilitation benefits and approvals, so people should review this information when selecting a Medicare plan.

Type: Long-Term Care

Description: A range of support services to help people live independently and safely

✗ **Covered?** No. Original Medicare, Medicare Advantage, and Medigap plans generally do not cover long-term care. Medicare Advantage may cover some supplemental healthcare benefits, such as meal delivery. If you qualify for dual eligiblity, you may be able to get long-term care coverage through Medicaid. **Learn more about options for long-term care resources.**

Type: Nursing Homes

Description: Live-in facilities that provide medical care on a full-time, long-term basis

? **Covered?** Maybe. Original Medicare may cover skilled care at a nursing home or via home health care if the beneficiary meets certain conditions and requires short-term skilled care for an illness or injury. These conditions include:

- **Qualifying Hospital Stay:** The person must have been an inpatient in a hospital for at least three consecutive days. Certain skilled nursing facilities may also be able to bypass the three-day requirement through the **skilled nursing facility three-day rule waiver**. Patients should ask their social worker or **patient navigator** whether the stay will be covered by their plan.
- **Admission Within a Certain Window After Leaving the Hospital:** The acceptable time frame is generally 30 days.
- **Medically Necessary Skilled Care:** Your HCP must certify that the patient needs daily skilled care.
- **Medicare-Certified Facility:** The SNF must be Medicare-certified.

If the above conditions are met, Medicare Part A will cover benefits that include a semi-private room, skilled nursing care, medications, medical supplies and equipment, and more. **Learn more about skilled nursing facility care.**

Type: Outpatient Hospital Services

Description: Procedures and treatments that may be performed at a hospital but don't require an overnight stay (e.g., laboratory tests billed by the hospital, preventive and screening services, X-rays and other radiology services billed by the hospital)

? **Covered?** Maybe. Medicare Part B covers several diagnostic and treatment services that are performed in hospitals that accept Medicare. Beneficiaries usually pay 20% of the Medicare-approved amount for the services and a copayment for each service received in a hospital outpatient setting, unless it's a preventive service that doesn't have a copayment.

Peace of Mind: Preparing Financially for Long-Term Care

The Administration for Community Living says someone turning 65 today has almost a **70% chance** of needing long-term care services and supports in their remaining years. Generally, Medicare does not offer coverage for this care.

While you can't predict your future healthcare needs, you can plan ahead so you'll understand potential costs and will have done some financial planning if you do wind up needing these services.

Here are some resources that may be helpful in your financial planning journey:

- **How to Prepare for the Costs of Long-Term Care** – Merrill
- **Retirement Planning: Preparing for Long-Term Care** – Vanguard
- **How to Plan for the Cost of Long-Term Care** – Ameriprise Financial

Bone Health Resources and Support

Bone Health and Osteoporosis Foundation (BHOF): Provides education on osteoporosis prevention and treatment and bone health

HealthyWomen: Offers education on bone health and osteoporosis for women across their lifespan

Local Senior Centers & Health Departments: May offer exercise programs, fall prevention workshops, and bone health screenings

Medicaid.gov: Provides essential services to support bone health, particularly for low-income individuals

Medicare.gov: Offers details on coverage options for osteoporosis screening and treatment

Society for Women's Health Research: Offers resources on diseases, conditions, and life stages that uniquely, differently, or disproportionately affect women — including bone health — for patients, families, clinicians, and policymakers

State Health Insurance Assistance Programs: Provide free counseling to help navigate Medicare benefits

Women's Heart Health

In this chapter, readers will learn about heart health at Medicare age, including how to lead a heart-healthy lifestyle, what cardiovascular disease risk factors women should look out for, as well as what Medicare benefits and services are available for women to support their heart health in older age.

Why Women Should Care About Heart Health

Cardiovascular disease (CVD) is the leading cause of death for women in the United States, claiming more lives each year than all forms of cancer combined. By the time women reach their 60s and beyond, the risk increases significantly. According to the **American Heart Association**, 76.3% of women ages 60 to 79 have some form of CVD — and that number increases to 85.1% for those 80 and older.

Women also face **a 20% greater chance** of developing heart failure or dying within five years after their first severe heart attack compared with men.

Despite its prevalence and severe effects, CVD is still thought of as a man's disease and is often overlooked in women's health discussions. Conversations with healthcare providers (HCPs), education about CVD, and access to screening and treatment are especially important for women. This becomes even more important after menopause because hormonal changes play a major role in increasing risk for CVD.



Key Heart Health Terms

Cardiovascular disease (CVD) – a range of conditions affecting the heart or blood vessels; includes heart disease, stroke, heart failure, and high blood pressure

Coronary artery disease – a form of heart disease that affects the blood vessels and leads to decreased blood flow to the heart

Heart attack – a blockage of blood flow to the heart muscle causing damage to the heart

Heart disease – a form of cardiovascular disease specifically related to the heart's structure and function

Heart failure – a condition that occurs when the heart isn't pumping as well as it should

Hypercholesterolemia (high cholesterol) – a condition in which people have high levels of low-density lipoproteins (or "bad" cholesterol) in the blood, which can increase the risk of a heart attack or stroke

Hypertension – a chronic condition that occurs when blood pressure is consistently too high, potentially leading to a heart attack or stroke

Stroke – a loss of blood flow to the brain that occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts

Heart Health at Medicare Age: What to Know

Risk Factors

Postmenopausal (defined as 12 months after a woman's final period) women face an elevated risk for heart disease due to the natural decline in estrogen, a hormone that has a protective effect on the heart. For some women, hormone therapy may reduce the risk of heart disease as women age. Several risk factors for heart disease can be reduced, prevented, or controlled through lifestyle changes. These include:

- High cholesterol
- High blood pressure (hypertension)
- Smoking
- Drinking alcohol
- Obesity (high body mass index)
- Inadequate sleep
- Lack of physical activity
- Diet high in saturated fats and sodium (salt)
- Other chronic health conditions (e.g., diabetes, kidney disease)

Some risk factors for CVD cannot be changed, such as age, family history, sex, race, and ethnicity.

When women know the risk factors for heart disease, they can make informed decisions, understand their personal risk, implement heart-healthy habits into their daily routines, and protect their heart health as they age.

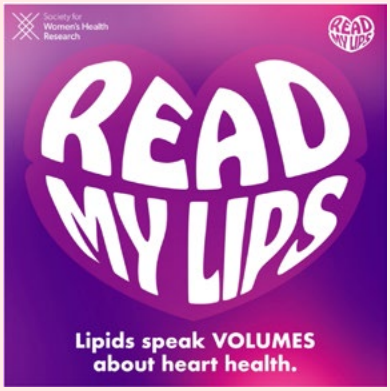
Healthcare Providers

Several types of HCPs see patients for heart health concerns or conditions. Most often, people will see a primary care provider, who can assist with prevention, lifestyle management, and condition management for conditions such as high cholesterol and blood pressure. Other people may see a cardiologist, who can diagnose and treat problems related to the heart and blood vessels. Specialized cardiologists include cardiac imaging specialists, congenital heart specialists, cardiac rehabilitation specialists, heart surgeons, and more.

Coverage for visits with specialists, such as a cardiologist, may be dependent on whether the specialist participates in Medicare. Because of the impact of CVD on women's health, establishing coverage and confirming care networks before enrollment is critical.

Learn more about Medicare coverage for heart disease from the **National Council on Aging**.

Featured Finds!



Read My Lips

Society for Women's Health Research

Campaign that shares information on risk factors for heart disease and the role of cholesterol screening — and specifically lipid panel testing — for women's heart health.



WomenTalk: The Link Between Diabetes and Your Heart

HealthyWomen

Webinar explaining the link between heart disease, stroke, and diabetes, including what factors increase the risk of disease and how to lower that risk.

A Reminder: Healthcare Provider and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any HCP or hospital in the United States that accepts Medicare.	In many cases, you can only visit HCPs and hospitals within the plan's network.
In most cases, referrals are not needed to see a specialist.	A referral may be needed to see a specialist.

**Adapted from Medicare.gov.*

Medicare Coverage for Heart Health

Medicare provides the following types of coverage that can help support heart health during older age:

- **Preventive and Screening Services:** Medicare Part B covers many preventive services, including health risk assessments and health screenings. These include:
  - **"Welcome to Medicare" Visit:** An initial, one-time visit that takes place within the first 12 months of enrolling in Medicare Part B
  - **Annual Wellness Visit:** Available every 12 months after the first year on Medicare Part B

    Note: Medicare does not cover routine physical exams. **Learn more about yearly wellness visits.**
  - **Preventive Screenings:** Medicare covers free heart health-related preventive screenings. These include:
    - **Cardiovascular Behavioral Therapy.** This involves a yearly visit with a primary care provider to check blood pressure and discuss risk reduction strategies for cardiovascular disease.
    - **Cardiovascular Disease Screenings.** These tests are given every five years and check for "good" (high-density lipoproteins) and "bad" cholesterol (low-density lipoproteins) levels and triglycerides (a type of fat in the blood).
    - **Diabetes Screenings:** Up to two blood glucose (blood sugar) screenings for individuals at risk of developing diabetes are covered under Medicare Part B. **Learn more about diabetes screenings.**

      Note: Preventive screenings are covered based on certain conditions, such as various risk factors. Find a **full list of preventive and screening services covered by Medicare Part B.**
- **Chronic care management** is available for individuals with two or more serious chronic conditions, such as cardiovascular disease and diabetes. **Learn more about chronic care management.**
- **Principal illness navigation services** (navigation services that help guide patients through their medical condition or diagnosis or the healthcare system) may be covered for people with serious health conditions that are expected to last three months or longer and raise the risk of being hospitalized, needing nursing home care, getting worse, experiencing physical or mental decline, or dying. **Learn more about principal illness navigation services.**
- **Lifestyle Support:** Medicare Part B offers several resources related to lifestyle and nutrition that could be beneficial in an individual's heart health journey, including:
  - Both regular and intensive **cardiac rehabilitation programs** in an HCP's office or out-patient hospital setting. These medically supervised programs are designed to help individuals recover from heart problems and improve their overall cardiovascular health



Featured Find!

Know the Difference: Cardiovascular Disease, Heart Disease, Coronary Heart Disease – National Heart, Lung, and Blood Institute

through exercise training, education, and counseling. These programs are covered if a person meets at least one of the following conditions (as listed on **Medicare.gov**):

- Heart attack in the last 12 months
- Coronary artery bypass surgery
- Stable angina pectoris (chest pain)
- Heart valve repair or replacement
- Coronary angioplasty or a coronary stenting
- Heart or lung transplant
- Stable chronic heart failure

- A **cardiovascular risk assessment for those who have not been diagnosed with CVD and management services** if a person is deemed to be at risk by an HCP. Risk management services may include blood pressure management, cholesterol management, and assistance with quitting smoking. **Learn more about cardiovascular risk assessment and management services.**
- Up to 10 hours of **diabetes self-management training** to help individuals manage their diabetes, with up to two hours of follow-up training each year after the initial training.
- **Medical nutrition therapy for certain conditions, including diabetes.**
- **Obesity screening and behavioral counseling** for those with a body mass index (BMI) of 30 or more and if the HCP will provide the counseling in a primary care setting. **Learn more about obesity behavioral therapy.**
- Up to **eight smoking cessation counseling** sessions over a 12-month period to help people stop smoking or using tobacco. The sessions are fully covered if the HCP **accepts the assignment** (meaning the HCP accepts Medicare and agrees to the Medicare-approved payment for the service). **Learn more about smoking cessation counseling services.**

Heart Health Questions to Ask During Medicare Wellness Visits

These questions can be tailored to personal circumstances, medical history, and awareness of personal cardiovascular disease risk.

- Am I at risk for heart disease based on my age, health history, or lifestyle?
- What changes should I incorporate into my lifestyle to make sure I'm caring for my heart health and preventing cardiovascular diseases as best I can?
- Should I be screened for high blood pressure or high cholesterol?
- If so, can we do that today? When should we check my blood pressure and cholesterol again?
- How often should I be screened for cardiovascular disease?
- Should I be taking any medications for my heart health?
- Are any of my current medications affecting my heart health?
- What should I be paying attention to when it comes to monitoring my heart health?
- Will this imaging test be covered by Medicare, and do I need any prior approval or referrals for it?

- **Medication, Device, and Monitoring Coverage:** Medicare Part B will cover certain items if they are determined to be medically necessary and appropriate for treatment:
  - **Implantable cardioverter defibrillator**
  - **Pacemaker**
  - **Remote patient monitoring** for the collection of data for chronic and acute conditions, such as high blood pressure. **Learn more about remote patient monitoring.**

Taking Charge: My Heart Health Habit Tracker

Regardless of your stage of life, you can take steps now to support your heart health. This daily heart health habit tracker can help ensure you're taking steps from week to week to lead a heart healthy lifestyle.

- ☑ I ate a good variety of fruits and vegetables
- ☑ I chose whole grains (e.g., oats, brown rice) over processed foods
- ☑ My meals included healthy fats (e.g., olive oil, avocado, fatty fish, seeds)
- ☑ I limited salt and sugars
- ☑ I got at least 30 minutes of moderate physical activity
- ☑ I did not smoke
- ☑ I limited alcohol
- ☑ I got quality sleep
- ☑ I practiced stress management
- ☑ I followed my doctor's recommendations (e.g., taking medications, checking blood pressure)



Drug Plan Rules

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Like private insurance companies, Medicare drug plans have rules about whether they cover certain drugs and how they cover them. Drugs may be evaluated for medical necessity, appropriateness, and efficiency of use. These rules include:

- **Prior Authorization:** A process requiring the review and approval of a specific drug before it is covered by insurance based on specific criteria
- **Step Therapy:** A policy that requires a patient to try and "fail" a lower-cost treatment before the treatment originally prescribed or recommended by an HCP can be covered
- **Quantity Limits:** Restrictions about the amount of drugs that can be covered over a certain period for cost and safety reasons



Featured Find!

Medicare Prescription Drug Plan Finder

People should check with their specific plan to learn their coverage rules and to determine whether their pharmacy is considered in-network or out-of-network. **Learn more about Medicare drug coverage.**

Note: When Medicare drug coverage begins, **beneficiaries** may receive a one-time, 30-day supply of the medication they've been taking — even if the drug isn't covered by their new plan or requires prior authorization or step therapy — to aid in the transition to their new plan.

Heart Health and Medicare: What If ...?

PREVENTIVE CARE

Q: What if my HCP recommends a heart screening that Medicare doesn't typically cover?

A: While Medicare covers some heart-related screenings, it doesn't cover all of them. If your HCP recommends a service not covered by Medicare, ask them if there is an alternative test that would be covered or if the test is considered medically necessary.

Q: I haven't had a heart health checkup appointment in years. What should I do?

A: The Annual Wellness Visit is a great opportunity to assess your heart health, discuss risk factors, and ask whether heart health screenings, like a blood pressure check, are due. Many of these tests are covered under Medicare.

MEDICATION COVERAGE

Q: What if my heart medication is not covered or stops being covered by my Medicare drug plan?

A: Part D drug plans' **formularies** can change annually. You can ask your HCP whether there is an alternative drug that's covered under your plan, request a formulary exception, or switch plans during open enrollment (October 15–December 7). Individuals with low income who are on the Extra Help program can change their drug coverage plan throughout the year.

Q: What if my pharmacy no longer carries my prescribed medication?

A: Look for a pharmacy that does carry your medication by contacting pharmacies in your area directly or contacting your insurer to help find one. There may also be mail-order options or other equivalent medications. Discuss these options with your HCP.

Q: What if I can't afford my heart medication?

A: If you can't afford your medication through a Part D plan, you may qualify for the Extra Help program, which helps cover the cost of deductibles and copays. **Learn more about the Extra Help program.** Switching to a generic version of medication or applying for a **pharmaceutical assistance program**, when available, may also help reduce out-of-pocket costs. **Learn more about pharmaceutical assistance programs.**

PROCEDURES

Q: What if I need a heart procedure, such as getting a pacemaker or stent?

A: These services are typically covered under Medicare, but the services must be determined to be medically necessary by an HCP and may vary based on whether the procedure is inpatient or outpatient. Always confirm whether your provider and hospital are Medicare-participating to ensure the services will be covered under Medicare.

FOLLOW-UP AND ONGOING CARE

Q: What if my specialist isn't in my Medicare Advantage plan's network?

A: You may need to get a referral, or you could face higher costs for seeing an out-of-network provider. During open enrollment, you can explore switching to a plan that includes your current specialists.

Q: Are the same services that I would get under Original Medicare covered under Medicare Advantage as well?

A: Medicare Advantage plans must cover all medically necessary services that are covered under Original Medicare. However, plans will use their own coverage criteria to determine medical necessity for certain services and may offer other benefits that are not covered under Original Medicare.

Q: What if I need cardiac rehabilitation after a heart event?

A: Medicare Part B covers cardiac rehabilitation programs if you've had certain heart conditions, like a heart attack. Ask your HCP for a referral and ensure the facility accepts Medicare.

Q: What if I have other conditions that complicate my heart health, like diabetes or kidney disease?

A: Coordinated care is key. Ask your HCP if you qualify for a personalized care plan or team-based services under Medicare that address multiple conditions together.

Q: Will Medicare help me manage my heart disease long-term?

A: Yes. Medicare may cover disease management visits and care coordination. Chronic care management (CCM) services may also be available if you have multiple chronic conditions.



Institutional and Long-Term Care for Heart Health: Covered or Not?

People who have a heart attack or other heart health problems will likely require a hospital stay and, while most people take two weeks to three months to recover from a heart attack, some may find themselves in need of long-term care or other services. Here are some coverage provisions related to care facilities and long-term care in Medicare.

Type: Home Health Care

Description: Services that can be provided within the home for an illness or injury

? **Covered?** Maybe. **Medicare Part A and/or Part B** cover eligible home health services if certain conditions are met, such as when a person is homebound and requires skilled services. Non-skilled services such as assisting with everyday care and needs are not covered. **Medicare Advantage plans** cover home health care, but the coverage may be different than under Original Medicare.

Type: Inpatient Hospital Care

Description: Medical care provided in a hospital or facility that involves the patient staying overnight or longer.

✓ **Covered?** Yes. **Medicare Part A** typically covers inpatient hospital care if: 1) the person is admitted after an HCP's order and 2) the hospital accepts Medicare. Information about costs for coverage can be found on **Medicare.gov**. **Medicare Part B** typically pays for the HCPs' services at the hospital. It usually pays 80% of the Medicare-approved amount for those services.

Type: Inpatient Rehabilitation Facility

Description: Rehabilitation programs in rehab hospitals or rehab units in acute care hospitals.

✓ **Covered?** Yes. **Medicare Part A** covers medically necessary care received in an inpatient rehab facility if an HCP certifies the care. Information about costs for coverage can be found on **Medicare.gov**. **Medical Part B** covers HCPs' services while in the facility. **Medicare Advantage plans** may have different rehabilitation benefits and approvals, so people should review this information when selecting a Medicare plan.

Type: Long-Term Care

Description: A range of support services to help people live independently and safely

✗ **Covered?** No. Original Medicare, Medicare Advantage, and Medigap plans generally do not cover long-term care. Medicare Advantage may cover some supplemental healthcare benefits, such as meal delivery. If you qualify for dual eligibility, you may be able to get long-term care coverage through Medicaid. **Learn more about options for long-term care resources.**

Type: Nursing Homes

Description: Live-in facilities that provide medical care on a full-time, long-term basis

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- **Qualifying Hospital Stay: The person must have been an inpatient in a hospital for at least three consecutive days. Certain skilled nursing facilities may also be able to bypass the three-day requirement through the "skilled nursing facility three-day rule waiver." Patients should ask their social worker or patient navigator whether the stay will be covered by their plan.**
- **Admission Within a Certain Window After Leaving the Hospital: The acceptable time frame is generally 30 days.**
- **Medically Necessary Skilled Care: Your HCP must certify that the patient needs daily skilled care.**
- **Medicare-Certified Facility: The SNF must be Medicare-certified.**

If all the above conditions are met, Medicare Part A will cover benefits that include a semi-private room, skilled nursing care, medications, medical supplies, and equipment, and more. **Learn more about skilled nursing facility care.**

Type: Outpatient Hospital Services

Description: Procedures and treatments that may be performed at a hospital but don't require an overnight stay (e.g., laboratory tests billed by the hospital, preventive and screening services, X-rays, and other radiology services billed by the hospital)

? **Covered?** Maybe. Medicare Part B covers several diagnostic and treatment services that are performed in hospitals that accept Medicare. Beneficiaries usually pay 20% of the Medicare-approved amount for the services and a copayment for each service received in a hospital outpatient setting, unless it's a preventive service that doesn't have a copayment.

Institutional and Long-Term Care Medicare.gov Resources

- **Home Health Services**
- **Inpatient Hospital Care**
- **Inpatient Rehabilitation Facility**
- **Long-Term Care**
- **Medicare & Home Health Care**
- **Nursing Homes**
- **Outpatient Hospital Services**
- **Resources & Information for Patients and Caregivers**

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The Administration for Community Living says someone turning 65 today has almost a **70% chance** of needing long-term care services and supports in their remaining years. Generally, Medicare does not offer coverage for this care.

While you can't predict your future healthcare needs, you can plan ahead so you'll understand potential costs and will have done some financial planning if you do wind up needing these services.

Here are some resources that may be helpful in your financial planning journey:

- **How to Prepare for the Costs of Long-Term Care** – Merrill
- **Retirement Planning: Preparing for Long-Term Care** – Vanguard
- **How to Plan for the Cost of Long-Term Care** – Ameriprise Financial



Heart Health Resources and Support

American Heart Association: Provides information and resources to fight heart disease and stroke

American Stroke Association: A division of the American Heart Association that educates people about stroke prevention and treatment

HealthyWomen: Offers education on heart health for women across their lifespan

Local Senior Centers & Health Departments: May offer exercise programs, educational sessions, and access to resources that can support heart health

Medicaid.gov: Provides essential services to support heart health, particularly for low-income individuals

Medicare.gov: Offers details on coverage options for heart health screening and treatment

National Council on Aging (NCOA): Provides tools and resources, including on heart health, so people can age with health and economic well-being

Society for Women's Health Research: Offers resources on diseases, conditions, and life stages that uniquely, differently, or disproportionately affect women — including heart health — for patients, families, clinicians, and policymakers

State Health Insurance Assistance Programs: Provide free counseling to help navigate Medicare benefits

WomenHeart: Provides, among other resources, education, support and training to enable women to take charge of their heart health



Women's Brain Health

Brain health is a broad and multifaceted field. In this chapter, readers will learn about brain health and diseases that can impact the brain, with a specific focus on mild cognitive impairment (MCI), Alzheimer's disease, and other types of dementia. Readers will also learn what Medicare benefits and services are available for women to support their brain health and manage diseases that can impact the brain as they age.

Why Should Women Focus on Brain Health?

The brain is a critical, complex organ. As the nervous system's command center, it controls motor function, memory, thought, emotion, and sensation. It also regulates daily functions like walking, talking, and eating.

It's important for people to care for their brains across their lifespan. Caring for your brain includes taking proactive, **evidence-based steps** to keep the brain as healthy as possible, such as eating a healthy diet, getting enough physical exercise, and doing brain exercises as well as having regular screenings. Regular cognitive screenings can help detect neurological changes early, allowing people to take action as early as possible to address their symptoms, improve treatment outcomes, and potentially even slow the progression of serious brain conditions.

Brain Health vs. Cognitive Health

According to the **National Institute on Aging (NIA)**, brain health is an overarching term referring to how well a person's brain functions across several areas. Those areas include:

- **Cognitive health** – how well a person thinks, learns, and remembers
- **Emotional function** – how well a person interprets and responds to emotions
- **Motor function** – how well a person controls their movements and balance
- **Sensory function** – how well a person can see, hear, taste, and smell
- **Tactile function** – how well a person feels and responds to touch and temperature

As people age, some mild cognitive changes, such as decreases in attention and thinking speed, are considered normal. Other changes, such as having trouble expressing oneself in conversation or quickly forgetting things, aren't. Experiencing these types of changes could point to cognitive impairment related to Alzheimer's disease; frontotemporal dementia (brain disorders caused by damage to the frontal and temporal lobes of the brain); vascular dementia (dementia that occurs when there is not enough blood flow to the brain); or dementia with Lewy bodies (a disease of the brain caused by abnormal clumps of alpha-synuclein protein in the brain), among others.

Alzheimer's disease is the most common cause of dementia, affecting more than **7 million people** ages 65 and older in the United States. In fact, 1 in 9 people 65 and older has Alzheimer's disease. And women account for about two-thirds of Americans living with Alzheimer's disease.

It also is estimated that women represent more than **60% of unpaid caregivers for people living with dementia** in the United States. This is important because, though caregiving can be rewarding, it can take a toll on the caregiver's financial well-being and physical health.

For many years, it was believed that this greater impact of Alzheimer's on women was simply a result of the fact that women live longer than men and older age is the greatest risk factor. However, research is showing that dementia also affects women differently than men. **Research** suggests women may start

Stages of Alzheimer's Disease

Adapted from the* **Alzheimer's Association.

Every person's experience with Alzheimer's disease is unique. People may experience varying symptoms of Alzheimer's disease and may move through the stages of Alzheimer's disease differently.*

Preclinical Alzheimer's Disease – The period when brain changes associated with Alzheimer's disease begin. These changes can begin to occur years before any signs or symptoms of the disease appear.

Mild Cognitive Impairment Due to Alzheimer's Disease – In this stage, mild changes in memory and thinking are noticeable and can be measured on mental status tests, but they are not severe enough to disrupt a person's day-to-day life.

Early-Stage Alzheimer's Disease (Mild) – With early-stage Alzheimer's disease, a person may function independently but may feel more forgetful. They may have trouble performing work tasks or producing the right word, forget material they just read, or misplace objects.

Middle-Stage Alzheimer's Disease (Moderate) – Dementia symptoms in the middle stage are more prominent, requiring a greater level of care. People in this stage may not be able to perform routine tasks or express their thoughts and may begin to struggle recalling personal information, such as their address, telephone number, or high school. They may get lost more easily, be confused about where they are, or need help with things like choosing seasonally appropriate clothing. Middle-stage Alzheimer's is typically the longest stage and can last for years.

Late-Stage Alzheimer's Disease (Severe) – Late-stage Alzheimer's disease occurs when dementia symptoms become intense, affecting how people are able to interact and move. People in this stage may experience physical changes, such as difficulty walking or swallowing; require around-the-clock assistance with daily care; and lose awareness of their surroundings.

**Almost everyone diagnosed with Alzheimer's disease develops neuropsychiatric symptoms at some point during their disease. Neuropsychiatric symptoms are behavioral and psychological changes that may include aggression, agitation, anxiety, apathy, and depression. These symptoms can affect daily function and quality of life.*

For information about how the stages of Alzheimer's disease are defined and used in regulatory and clinical contexts, see the **U.S. Food and Drug Administration's guidance**.

out with higher cognition levels and better executive function and memory, but if they get dementia, they have faster cognitive decline than men. Studies have looked at the effect of hormones, both estrogen and testosterone; differences in the makeup of the brain and stronger inflammatory responses in women than men; as well as work, education, and family patterns throughout a woman's lifetime. There are a number of reasons why women are impacted differently, and researchers are still determining what drives sex-based differences in Alzheimer's disease.

Key Brain Health Terms

- **Alzheimer's disease** – a progressive neurological disorder that affects memory, thinking, and behavior and is the most common form of dementia
- **Alzheimer's disease and related dementias (AD/ADRD)** – an umbrella term describing a group of conditions (including Alzheimer's disease, vascular dementia, and Lewy body dementia) that impair memory, thought processes, and functioning
- **Brain health** – how well a person's brain functions with respect to cognitive health, emotional function, motor function, sensory function, and tactile function
- **Cognitive health** – how well a person thinks, learns, and remembers
- **Dementia** – a general term for declines in memory, language, problem-solving, and other cognitive abilities that become serious enough to disrupt daily life
- **Mild cognitive impairment (MCI)** – a condition where memory and other cognitive abilities have declined more than what occurs in normal aging but have not yet reached the stage of dementia
- **Neurodegenerative diseases** – diseases or injuries that can harm the brain, affecting how people perceive and engage with the world and often resulting in substantial or sometimes disabling behavioral or psychological symptoms
- **Neuropsychiatric symptoms (NPS)** – psychiatric symptoms that stem from underlying brain disorders; NPS of Alzheimer's disease are often typical of more severe cognitive decline and advancing disease and include depression, anxiety, agitation, aggression, apathy, sleep disturbances, psychosis, and wandering

Brain Health at Medicare Age: What to Know?

Risk Factors

While much is still being discovered about the brain, we know that the greatest non-modifiable risk factors for all types of dementia are age, genetics, family history, race, and ethnicity. African Americans, Latinos, American Indians, and Alaska Natives **have the highest rates** of dementia. Other risk factors for dementia include:

- Excessive alcohol use or substance use
- Poor cardiovascular and metabolic health (e.g., high blood pressure, heart disease, obesity, diabetes)
- Chronic kidney disease
- Traumatic brain injury or repeated head impacts or concussions
- Seizure disorders
- Long-term use of certain medications
- Poor mental health
- Physical inactivity
- Poor nutrition (e.g., not enough whole foods; too many processed foods; foods high in fat, salt, additives, and sugar)
- Poor sleep
- Using tobacco
- High stress
- Social isolation

For Alzheimer's disease, biological sex is a risk factor; women have a higher risk of developing the disease.

While some risk factors for Alzheimer's disease and other dementias may be outside of their control, women can take specific steps in their daily habits to potentially reduce their risk.

Featured Find!

Brain Health Habit Builder

Alzheimer's Association

This online tool shares how daily habits affect brain health, offers insights about where improvements can be made, and helps build an action plan for better brain health.

Tips to Support Brain Health

Studies have shown that certain lifestyle choices, including following a healthy diet, getting regular physical activity, engaging in social interactions, and pursuing creative and intellectual activities, can have a positive influence on overall brain health as well as cognitive health. **Research** has shown that even at older ages, lifestyle changes can improve thinking and memory and even slow typical cognitive decline associated with aging.

Even small changes in your daily activities can support your brain health. This includes activities such as:

- **Creative and intellectual engagement:** Keep your brain engaged through mentally stimulating and creative activities. This could include reading, solving puzzles or math problems, taking courses, learning new skills, painting, or doing crafts. Mentoring or volunteering also provides intellectual stimulation and purpose.
- **Heart health: Control high blood pressure (hypertension), high cholesterol, and blood sugar**.
- **Nutrition:** Focus on eating whole foods (fruits, vegetables, whole grains) and a balanced diet that includes lean meats, seafood, and unsaturated fats (e.g., olive oil). Try to limit processed and **ultraprocessed foods** and other fats and sugars. **The MIND diet** is a brain-healthy eating plan that has been linked to a lower risk of cognitive impairment and slower rates of cognitive decline.
- **Physical activity:** Get in as much moderate-intensity physical activity each week as you can. "Moderate-intensity" means that you're working hard enough to raise your heart rate and break a sweat, but you can still carry on a conversation. Some studies have suggested 150 minutes per week is ideal, but other studies show that even as little as **35 minutes of moderate to vigorous physical activity per week** can lower the risk of developing dementia.
- **Sleep:** Try to get seven to eight hours of sleep each night. Identifying and treating any sleep disorders, such as obstructive sleep apnea, may also help improve cognition.
- **Socialization:** Connect with people, including friends and family, for emotional support and mental stimulation.

Healthcare Providers

Several types of healthcare providers (HCPs) see patients for brain health concerns or conditions.

- A **primary care provider (PCP)** is an HCP who helps manage a person's general health over time. They offer preventive care, screenings, and immunizations and also diagnose and treat a wide range of conditions.
- A **geriatrician** is a clinician who specializes in conditions of older adults, including cognitive decline and chronic diseases, and their care.
- A **neurologist** is a doctor who specializes in the nervous system, including the brain and spinal cord. People may be referred to a neurologist by a primary care provider or geriatrician if Alzheimer's disease or dementia is suspected.
- A **physician assistant/physician associate (PA)** is a licensed clinician who practices medicine across different specialties and healthcare settings. PAs are important members of a care team, conducting cognitive assessments, developing care plans, and providing ongoing support and education to patients and families.
- A **nurse practitioner (NP)**, a type of advanced practice registered nurse (APRN), is a registered nurse with advanced training in administering patient care. NPs diagnose, treat and manage acute and chronic diseases, while emphasizing health.

Providers who also may assist in the treatment of those with MCI, Alzheimer's disease, or other dementias include neuropsychologists, neurodegenerative disorder specialists, physical therapists, occupational therapists, mental health professionals, and speech-language pathologists, among others.

While Medicare generally covers visits for primary care providers and geriatricians, coverage and deductibles may vary depending on factors such as the type of Medicare plan and provider participation. Those with Medicare Advantage will likely have to stay within the plan's network and may require a referral. Coverage for visits with other specialists may be dependent on whether the specialist participates in Medicare. Checking with your plan to confirm what is covered in advance is important and could prevent unexpected bills.

Cognitive Assessments and Diagnostic Tests for Alzheimer's Disease

To test for cognitive impairment, including for Alzheimer's disease, your HCP may do some of these tests at your healthcare visit or refer you to a specialist:

- Medical history and physical exam.
- Neurological exam to test reflexes, coordination, muscle strength, eye movement, and sensation.
- Cognitive assessment tests to evaluate memory, thinking, and problem-solving skills. These tests can be brief or more comprehensive and may be oral questions and answers or written items or may use computer programs.
- Blood biomarker tests to look for beta amyloid plaques, which indicate the possible presence of Alzheimer's disease.
- Genetic testing to look for the APOE-e4 gene for Alzheimer's disease or other genes related to other dementias.
- Brain imaging, such as magnetic resonance imaging (MRI), computed tomography (CT) and/or positron emission tomography (PET) scans.
- Cerebrospinal fluid tests.
- Sleep tests (at home or in a facility).
- Formal neuropsychiatric evaluation.

In May 2025, the U.S. Food and Drug Administration (FDA) **cleared the first blood test**, the Lumipulse G pTau 217/β-Amyloid 1-42 Plasma Ratio test, to help with detecting amyloid plaques associated with Alzheimer's disease. Medicare coverage for this test may vary, so ask your HCP whether they offer the test and contact your Medicare or Medicare Advantage plan to ask about coverage.

In October 2025, the FDA **approved the Elecsys pTau181 test** as the first blood-based biomarker test for use in primary care settings to help aid in the initial assessment of Alzheimer's disease and other causes of cognitive decline in adults ages 55 and older. Ask your HCP whether this test is appropriate for you.

Important: Currently no single test provides a definitive Alzheimer's diagnosis. Your HCP should interpret results alongside other clinical information.



A Reminder: Healthcare Provider and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any HPC or hospital in the United States that accepts Medicare.	These plans often require you to use HPCs and hospitals within the plan's network.
In most cases, referrals are not needed to see a specialist.	A referral from your primary care provider may be needed to see a specialist.

**Adapted from Medicare.gov.*

Brain Health Questions to Ask During Medicare Wellness Visits

These questions can be tailored to personal circumstances, medical history, and awareness of personal risk for Alzheimer's disease and dementia.

- How do you check for memory or thinking problems during this visit?
- Which, if any, tools do you use for cognitive or brain health assessment?
- My parent/grandparent/sibling had dementia. Does that increase my risk?
- What changes should I incorporate into my lifestyle to make sure I'm caring for my brain health as best I can?
- Are there activities or programs you recommend that could help keep my mind sharp?
- I've noticed some changes in my memory. [Describe memory changes here.] Are these changes a normal part of aging?
- How can I tell the difference between signs of dementia and normal aging?
- When you evaluate my memory, what kind of tool will you use?
- Are there signs I should watch for that might suggest cognitive decline or that I should come in for a cognitive health screening?
- Should I have a more complete cognitive evaluation? If not now, when?
- How often should I be screened for memory or thinking changes?
- Are any of my medications or my current health conditions possibly affecting my cognitive health?

Alzheimer's Association: What to expect when being evaluated for memory and thinking problems.

Taking Charge: My Brain Health Habit Tracker

Regardless of your stage of life, you can take steps now to support your brain health. This daily brain health habit tracker can help ensure you're taking steps each week to lead a brain-healthy lifestyle.

- ☑ I got at least 150 minutes (30 minutes a day, five days a week) of moderate-intensity physical activity.
- ☑ I put my brain to work by trying a new skill, taking a course, or solving puzzles.
- ☑ I did not smoke or vape.
- ☑ I ate whole, less processed foods, including vegetables, fish, and healthy fats.
- ☑ I prioritized my sleep (7-8 hours a night).
- ☑ I engaged with friends and family.
- ☑ I managed my blood pressure and controlled any other health conditions, such as diabetes.
- ☑ I protected my head by wearing my seatbelt in the car and wearing a helmet during activities like biking, skiing, and skating.



Care Considerations with Original Medicare and Medicare Advantage

As you think about which coverage pathway between Original Medicare and Medicare Advantage is right for you, you'll have to consider your unique circumstances and which path provides services that are most important to you.

For example, a 2022 **analysis of Medicare beneficiaries** found that Medicare Advantage enrollees were in a plan that included about half (48%) of the physicians available to Original Medicare beneficiaries. The narrower network of providers available with Medicare Advantage could significantly limit timely and consistent access to specialists, such as neurologists, unless the enrollees were to go out-of-network and pay more. Additionally, under Medicare Advantage, beneficiaries are not able to buy supplemental coverage to help pay out-of-pocket costs (Medigap).

Yet, Medicare Advantage plans may offer additional benefits that could be valuable for someone with dementia, including protections for out-of-pocket costs. Most Medicare Advantage plans also include Medicare Part D, or prescription drug coverage, as part of their overall health benefits.

It's important to understand your coverage and needs and what will save you the most on costs.



Validated Cognitive Assessment Tools

There are several tools that exist to help assess cognitive impairment. While there's no single tool that's considered the "best," there are tools that are standardized and evidence-based. These are called validated cognitive assessment tools.

Some of the most well-known cognitive assessment tools include:

- **AD8 Dementia Screening Interview** – a short test consisting of eight yes-or-no questions about changes in a person's thinking, memory, and behavior.
- **Mini-Cog** – a three-minute test that includes a three-item recall test for memory and a clock drawing test.
- **Montreal Cognitive Assessment (MoCA)** – a 10-12 minute assessment that tests memory, executive functions (e.g., planning, focus), language, and visuospatial abilities (i.e., ability to understand and work with what you see around you).
- **Rowland Universal Dementia Assessment Scale (RUDAS)** – a six-item screening measure that is designed to assess cognitive performance.

Learn more from the **National Institute on Aging**.

Medicare Coverage for Brain Health

Eligibility

While most people start Medicare at age 65, people with a qualifying disability who have been receiving Social Security Disability Insurance (SSDI) benefits for more than 24 months **may be able to receive Medicare coverage earlier**. For example, **early-onset or young-onset Alzheimer's disease**, which is Alzheimer's diagnosed before age 65, counts as a qualifying disability.

Coverage

Since testing, treatment, and care options for Alzheimer's disease and dementia are rapidly evolving, it is important to continue discussing your Medicare coverage for brain health with your HCP. For example, the Medicare program is also testing how to support new care models for those

diagnosed with dementia, such as the **GUIDE (Guiding an Improved Dementia Experience) Model**, that provide greater support for families and their care needs. You can check with your HCP to see if they are participating in one of these programs.

A Note on Medicare Coverage

Original Medicare and Medicare Advantage plans may have different **cost-sharing** amounts (the out-of-pocket expenses like deductibles, coinsurance, and copayments that beneficiaries pay for Medicare services), so it's important to check your plan's coverage details. Additionally, many people with Original Medicare purchase Medigap — a supplemental insurance — that helps pay for these cost-shares. For those who qualify for retiree benefits through their former employer, their retiree plan may cover these costs. And for those who are dually eligible for Medicaid, states pay for Part B cost-sharing.

Consider reaching out to Medicare at **1-800-MEDICARE (1-800-633-4227)** or your State Health Insurance Assistance Program to answer questions and provide additional clarification.

Today, Medicare provides **the following types of coverage** that can help support brain health specifically related to MCI, Alzheimer's disease, and dementia:

- **Preventive and Screening Services**
  Medicare Part B covers many preventive services that can help women support their brain health as they age, including health risk assessments and health screenings. These include:
  - **"Welcome to Medicare" visit** – An initial, one-time visit that takes place within the first 12 months of enrolling in Medicare Part B.
  - **Annual wellness visit** – Available every 12 months after the first year on Medicare Part B and focused on prevention, including a health risk assessment, review of current providers and medications, creation of a screening checklist, and cognitive impairment screening. While screenings may be provided during these visits, some HCPs do not proactively offer them unless the patient raises concerns about their cognitive health. If you have concerns, it's important to speak to your HCP.

    Note: Medicare does not cover routine physical exams. **Learn more about yearly wellness visits**.
  - **Cognitive assessment** – If your HCP suspects cognitive impairment during your annual wellness visit or at any other appointment, a separate visit will be scheduled. During this visit, your HCP may evaluate cognitive function using diagnostic tools, such as cognitive and functional assessments, neurological exams, and brain imaging. Brain imaging may include MRI, CT, or PET scans. **Learn more at AARP.**

    Cognitive assessments are subject to Medicare's Part B deductible and 20% **coinsurance. If you have Medigap or other sources of supplemental coverage, it can help cover your coinsurance.*
- **Diagnostic and Evaluation Services**
  - **Brain imaging** – Brain imaging is usually covered by Medicare Part B, as long as it's deemed medically necessary by your HCP.
    - **Magnetic resonance imaging (MRI) scan** – Medicare will cover an MRI to help inform a diagnosis after cognitive impairment is identified.

      **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible. If you have Medigap or other sources of supplemental coverage, it can help cover your coinsurance. Those with Medicare Advantage plans may have different cost-sharing amounts, so it's important to check your plan's details.*
    - **Computed tomography (CT) scan** – Medicare Part B covers CT scans when they're deemed medically necessary for a diagnosis of dementia.

      **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible. If you have Medigap or other sources of supplemental coverage, it can help cover your coinsurance.*
    - **Positron emission tomography (PET) scan** – PET scans are generally covered by Medicare Part B to help inform the diagnosis of Alzheimer's disease if they are deemed medically necessary and conducted at a Medicare-approved facility. However, there may be some nuances related to coverage depending on the type of PET scan you receive. Additionally, depending on your plan, you may need a referral to a specialist or prior authorization.

Medicare beneficiaries who get a PET scan may incur some out-of-pocket costs, such as deductibles, **copayments, or coinsurance.*

- **Genetic testing** – Medicare Part B **may cover genetic tests** if an HCP has ordered the test, the test is deemed necessary to diagnose or treat a medical condition, and if the FDA has approved or cleared the test. Generally, a person must be showing signs and symptoms of a condition to receive Medicare coverage; the test won't be covered to determine risk of developing a disease in the future.

  Only tests that are recommended by the **U.S. Preventive Services Task Force, a panel of experts who make recommendations regarding preventive health services, are fully covered with no cost-sharing or out-of-pocket costs. See the list of **recommended medical services**.*

- **Neuropsychological testing** – These tests, which measure abilities like memory, attention, and problem-solving, are covered by Medicare to help inform the diagnosis of cognitive impairment.

  **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

- **Treatment: Medications, Devices, and Monitoring**
  There are several drugs available for people navigating cognitive impairment, whether it is MCI, Alzheimer's disease, or other forms of dementia. Some drugs are used to treat the symptoms of cognitive impairment, while others are designed to change the course of cognitive impairment. These drugs are covered differently under Medicare Part B and Medicare Part D, depending on how they are administered (i.e., by mouth or through infusion or injection administered in a hospital or physician's office).

  - **Medicare Part B Drugs**

    Monoclonal antibodies – Medicare Part B covers monoclonal antibody treatments (donanemab and lecanemab) — which target beta-amyloid plaques — that have been approved by the FDA for the treatment of MCI due to Alzheimer's disease and early Alzheimer's disease. To get coverage for treatment:

    - Your HCP will need to enroll you in a CMS-approved study or registry for Medicare requirements.
    - You must meet certain eligibility requirements for coverage (e.g., have a diagnosis of MCI due to Alzheimer's disease or early Alzheimer's dementia, have testing that shows amyloid plaque accumulation).
    - You must be diagnosed with either MCI due to Alzheimer's disease or mild dementia due to Alzheimer's disease.

    The treatment landscape in Alzheimer's disease and evidence on Alzheimer's treatment are rapidly changing. So, it's important to continue to check with your HCP to determine whether a treatment is covered, whether you are eligible for it, and whether you may be eligible for payment. **Learn more about monoclonal antibodies coverage**.

    **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible. If you have Medigap, it can help cover your coinsurance.*

  - **Medicare Part D Drugs**
    Medicare Part D drug plans must cover at least two medications in each drug category, including some drugs used to treat Alzheimer's disease. These drugs are decided by the plan's **formulary**. However, Part D plans don't have to cover every medication used to treat Alzheimer's disease symptoms. Because each plan covers different medications, it's important to check whether your specific prescriptions are included when choosing or changing a Part D plan.

    Note: Your total costs for Medicare drug coverage will depend on your plan. If your plan has a deductible, you pay all out-of-pocket costs for your medications until you reach the full deductible. Then, you'll pay a percentage of the cost as coinsurance for your drugs until your out-of-pocket reaches a maximum amount. This maximum amount changes each year. **Learn more at Medicare.gov.**

    - **Behavioral and psychological (neuropsychiatric) medications** – Medicare drug plans (Part D) are required to cover almost all medications in certain important categories, including antidepressants, antipsychotics, and anti-seizure medicines. These medications are often used to help manage symptoms that can occur with Alzheimer's disease and other **dementias**.

This rule is meant to help make sure people with Medicare can continue getting the medications their HCPs say they need. However, your plan may still place medications on different cost tiers or require steps like prior authorization before covering them.

- **Cholinesterase inhibitors** – All Medicare Part D plans must cover at least two cholinesterase inhibitors, which are used to treat mild to moderate dementia symptoms (e.g., memory, thinking, judgment) in their formularies.
- **Glutamate regulators** – Medicare Part D plans must cover at least two glutamate regulators, which may be prescribed to improve dementia symptoms, such as attention, memory, and reason, in their formularies.
- **Sleep medications** – Sleep medications are generally covered by Medicare Part D plans if they are prescribed by an HCP, but plans may cover different drugs under their formulary. Similarly, pricing for sleep medications will vary from plan to plan.

- **Remote monitoring** – Your HCP may offer remote monitoring, which lets you collect and share health data (e.g., blood pressure, glucose levels) with your HCP. This service, if offered by your HCP, is broadly covered for chronic and acute conditions. Coverage will be dependent on whether the device is deemed necessary by an HCP for monitoring. **Learn more at CMS.gov.**

  Original Medicare **doesn't cover medical alert systems**, but certain Medicare Advantage plans may. Review various plans' coverage details for additional information.



Importance of Reviewing Coverage Annually

Choosing the Right Medicare Coverage as Your Needs Change

Your access to certain services and benefits can vary depending on whether you have Original Medicare or a Medicare Advantage plan. Similarly, coverage rules, provider networks, prior authorization requirements, and out-of-pocket costs can be different between plans. This includes differences in coverage for testing and for treatment of cognitive health. Even if your current plan covers the benefits you need today, it's important to review your coverage regularly as your health needs change.

It's also important to consider whether switching from Original Medicare to a Medicare Advantage plan (or vice versa) will cause any disruptions to your health and financial needs. For example, you may not be able to enroll in a Medigap plan if you switch to a Medicare Advantage plan and then try to come back to Original Medicare.

Alzheimer's disease or other progressive conditions can require different types and levels of care over time, so reassessing and consulting with your plan each year on your specific testing and treatment needs can help make sure you continue to have access to the services and supports that are right for you.

- **Care Management and Planning**
  - **Care planning** – Your HCP may offer care planning for people diagnosed with cognitive impairment and their caregivers. Care planning provides information about medical and non-medical treatment options, **clinical trials**, and local support services. People diagnosed with cognitive impairment can get Medicare coverage for care planning with a medical professional. **Learn more from the Alzheimer's Association.**
  - **Chronic care management** – Your HCP may offer **chronic care management (CCM) services**, which are services for people with two or more significant chronic conditions, including Alzheimer's disease. These services, which take place by phone or on a telehealth

platform, include helping patients manage their condition (e.g., support going between health settings, review of medications) and providing access to a 24/7 healthcare team. **CCM** services are covered for eligible individuals by Medicare Part B. **Learn more about CCM.**

**You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

- **Advance care planning** – Medicare Part B covers advance care planning, which are discussions with your HCP about preparing for future medical care if you'll need help making decisions for yourself. The service can be a part of your annual wellness visit, or your provider can offer it separately as a medically necessary service if the meeting takes place at another time. **Learn more about advance care planning coverage** and **access advance care planning worksheets.**

  **You won't pay anything if the meeting happens as part of your annual wellness visit. If you get the service at another time, the Part B deductible and coinsurance will apply.*

- **Caregiver training services** – Medicare Part B covers caregiver training services for certain caregivers of people on Medicare. If it is deemed appropriate by an HCP, the caregiver can get an individual or group training session that will teach caregivers how to give medications, help with daily tasks, care for wounds, and more. **Learn more about caregiver training services.**

  **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

- **Rehabilitation and Functional Support Services** Medicare Part B offers several services that can support people diagnosed with dementia. These services are aimed at preserving independence and improving quality of life.
  - **Occupational therapy** is intended to help people develop, maintain, or recover the physical skills needed to perform everyday tasks, such as exercises to help improve basic and fine motor skills or slow the rate of decline. Medicare Part B will provide coverage for occupational services if an HCP certifies that it is necessary and if the services are delivered in an outpatient setting. **Learn more about occupational therapy.**

    **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

  - **Physical therapy** helps restore or improve physical movement in the body after an injury, illness, or surgery. Medicare Part B provides coverage if an HCP certifies it is necessary and if the services are delivered in an outpatient setting. **Learn more about physical therapy.**

    **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

  - **Speech-language pathology services** evaluate speech and language skills, including cognitive and swallowing skills, and provide rehabilitation. Medicare Part B will provide coverage if an HCP certifies them necessary and if the services are delivered in an outpatient setting. **Learn more about speech therapy.**

    **You are responsible for 20% of the Medicare-approved amount after meeting the Part B deductible.*

  - **Mobility assistive equipment** includes certain items, such as canes, walkers, and wheelchairs, that Medicare will cover if deemed reasonable and necessary for your condition by your HCP.

    You are responsible for* **20% of the cost.

- **Mental Health and Behavioral Health Services**
  - **Annual Depression Screening:** Medicare covers an annual depression screening provided by your HCP.

    **This visit is covered as long as the HCP accepts Medicare.*

Featured Find!

What Does Medicare Cover for Alzheimer's Disease?

National Council on Aging

988 Suicide & Crisis Lifeline

If you or someone you know is struggling or in crisis or having thoughts of suicide, help is available 24 hours a day, seven days a week.

Call or text 988, the free and confidential Suicide & Crisis Lifeline. You can also connect with a trained crisis counselor through web chat at **988lifeline.org**. The lifeline is also available to people who are deaf/heard of hearing and Spanish speakers.

- **Outpatient Mental Health Services** – Medicare Part B covers several outpatient mental health services, including psychiatric evaluation, family counseling, and safety planning interventions. **Learn more about outpatient mental health services.**
- **Medical Social Services** – If you are getting skilled care (e.g., physical or occupational therapy), your HCP may order medical social services to help address social and emotional concerns that may interfere with recovery. **Learn more about Medicare and home health care.**

Featured Find! Alzheimer's Disease Topic Sheets on Medicare

Alzheimer's Association

- **Choosing a Medicare Drug Plan for Individuals with Alzheimer's Disease**
- **Medicare Hospice Benefit**
- **What a Beneficiary Can Do If Medicare Refuses to Pay for a Medical Service**
- **Assistance with the Costs of Medicare Premiums and Deductibles**
- **Medicare Home Health Training for Dementia Caregivers**

Find all of the topic sheets on the **Alzheimer's Association website**.

Medicare Special Needs Plans (SNPs) are a special kind of Medicare Advantage plan that are uniquely designed for — and are uniquely available to — individuals with Alzheimer's and other forms of dementia.

Cognitive Health and Medicare: What If ...?

CARE COVERAGE AND ONGOING CARE

Q: What should I do if I'm worried about my memory?

A: Tell your HCP right away, even if the changes seem small. Medicare covers cognitive assessments, including follow-up testing, if your HCP has concerns. Early evaluation can help identify conditions, allow for more treatment options, and connect you to support services, such as care planning or dementia care programs.

Q: What if I need to travel to another state for my dementia care? Will my coverage be affected?

A: Your coverage might be affected when traveling to another state, depending on what plan you have. If you have Original Medicare (Parts A and B), you can visit any HCP or hospital in the United States that accepts Medicare, though prescription drug coverage under Part D can vary from state to state.

If you have a Medicare Advantage plan, your coverage outside of your home state will depend on your specific plan. It's important to understand the specifics of your plan before obtaining care in another state.

Contact your Original Medicare or Medicare Advantage plan for specific information about coverage in other states.

Q: What if my specialist isn't in my Medicare Advantage plan's network?

A: You may need to get a referral, or you could face higher costs for seeing an out-of-network provider. Some Medicare Advantage plans do not offer any coverage if you go out of network. During open enrollment, you can explore switching to a different Medicare Advantage plan that includes your current specialists or enrolling in Original Medicare.

Q: Will Medicare cover telehealth for my brain health or dementia-related care?

A: In many cases, yes. Medicare covers a wide range of telehealth services, such as video telehealth visits, when provided by eligible clinicians for routine brain-health and dementia-care conversations. For other services, such

as functional maintenance services (e.g., occupational therapy, physical therapy), coverage can differ, especially if the visits are happening across state lines. Before your visit, it's a good idea to check with your provider or plan to confirm coverage.

MEDICATION COVERAGE

Q: Will Medicare cover my prescribed medication(s) for Alzheimer's?

A: Coverage will depend on the medication and your specific Medicare plan. Most oral medications for Alzheimer's disease are generally covered under Medicare Part D. Other treatments, such as monoclonal antibodies that are given as an infusion, are covered under Medicare Part B and may require additional steps, such as meeting clinical criteria or enrolling in a study or registry. Your HCP and your plan can explain what's covered and what your out-of-pocket cost may be.

Q: What if I can't afford my Alzheimer's medication?

A: If you can't afford your medication through a Part D plan:

- You may qualify for the Extra Help program, which helps cover the cost of deductibles and copays. Additionally, whether you receive your medications through a Part D plan or Medicare Advantage plan, you are able to participate in the Medicare Prescription Payment Plan and spread the costs of your Alzheimer's medication throughout the year rather than paying all costs at once. **Learn more about the Extra Help program** and the **Medicare Prescription Payment Plan**.
- Some states also administer State Pharmaceutical Assistance Programs (SPAPs) that provide financial assistance with Medicare drug plan premiums and/or cost-sharing. **Learn more about SPAPs in your area.**
- Some pharmaceutical companies help pay for prescriptions for people who have Medicare Part D through pharmaceutical assistance programs. Applying for a **pharmaceutical assistance program**, when available, or switching to a generic version of your medication, may also help reduce out-of-pocket costs. **Learn about pharmaceutical assistance programs.**

If you can't afford your medication through Medicare Part B:

- You may be able to get help from your state through a **Medicare Savings Program (MSP)**. Even if you don't think you qualify, you should still apply. MSPs that may support coverage for medications include:
  - **Qualified Medicare Beneficiary Program** – Helps pay for Part A premiums (if you don't have premium-free Part A) and Part B premiums, deductibles, coinsurance, and copayments.
  - **Specified Low-Income Medicare Beneficiary Program** – Helps pay for Part B premiums. (You must have both Medicare Part A and Medicare Part B to qualify.)
  - **Qualifying Individual Program** – Helps pay for Medicare Part B premiums. (You must have both Medicare Part A and Medicare Part B to qualify.)
- You may be able to purchase a Medigap plan (supplemental insurance) that can help cover coinsurance costs, depending on your health status. However, it's important to note that if you are enrolled in a Medicare Advantage plan and want to move to Original Medicare, it may be difficult to find an affordable Medigap plan. Medigap plans can reject your application, require additional premium amounts, or impose a waiting period for coverage if you have certain health conditions. This applies in all states other than Connecticut, Massachusetts, Maine, and New York.
- Explore whether you might be eligible for Medicaid. Medicaid eligibility varies by state and is based on income, household size, and factors like age or disability. If you're eligible for Medicaid, it may help cover out-of-pocket costs.



CAREGIVERS

Q: What if I'm a caregiver for someone with Alzheimer's or dementia and need help?

A: Talk to the HCP of the person for whom you're caring. Medicare-covered care planning visits allow caregivers to participate. If your local providers participate in the **GUIDE Model**, caregivers may also have access to education, navigation support, and respite services.

The Alzheimer's Association also has a **24/7 Alzheimer's & Dementia Helpline** (1-800-272-3900) that is staffed by licensed social workers. It's a free service that offers support for people living with dementia as well as their caregivers, their families, and the public.

A Primer on the Medicare Guide Model

The Guiding an Improved Dementia Experience (GUIDE) Model is a voluntary, nationwide program designed to make life easier for people living with dementia and the caregivers who support them. The program began July 1, 2024, and will run for eight years to test how providing comprehensive services can improve quality of life and reduce stress for families.

If you are eligible for GUIDE, you can find an HCP or care team participating in GUIDE and offering GUIDE services, including:

- A **dedicated care navigator** who can help coordinate care, answer questions, and connect you with community resources
- **Medical and nonmedical support**, including planning, symptom management, and social services
- **Help for caregivers**, including respite services so caregivers can recharge and feel more confident in their caregiving duties
- An **interdisciplinary care team** of HCPs and specialists who work together to streamline your care experience

Learn more about how GUIDE works, whether you're eligible, and how to find a provider.

Institutional and Long-Term Care for Brain Health: Covered or Not?

People living with dementia, including Alzheimer's disease, often require institutional and long-term care as their condition progresses because the disease can affect behavior and the ability to perform daily activities. It can be helpful for people who are experiencing cognitive decline to get support outside the home, including continuous supervision, structured routines, and specialized medical support. Long-term care settings can provide safe spaces where people living with dementia have access to important medical care while receiving ongoing support for their brain health and overall well-being.

Featured Find!

Institutional and Long-Term Care Medicare.gov Resources

- **Outpatient Hospital Services**
- **Inpatient Hospital Care Services**
- **Inpatient Rehabilitation Facilities**
- **Home Health Services**
- **Medicare and Home Health Care**
- **Long-Term Care**
- **Nursing Homes**
- **Resources and Information for Patients and Caregivers**

Type: Outpatient Hospital Services

Description: Procedures and treatments that may be performed at a hospital but don't require an overnight stay (e.g., laboratory tests billed by the hospital, preventive and screening services, X-rays, and other radiology services billed by the hospital).

? **Covered?** Maybe. Medicare Part B covers several diagnostic and treatment services that are performed in hospitals that accept Medicare. Beneficiaries usually pay 20% of the Medicare-approved amount for the services and a copayment for each service received in a hospital outpatient setting, unless it's a preventive service that doesn't have a copayment. **Learn more about outpatient hospital services.**

Type: Inpatient (Acute-Care) Hospital Services

Description: Medical care provided in a hospital or facility that involves the patient staying overnight or longer.

✓ **Covered?** Yes. Medicare Part A typically covers inpatient hospital care if: 1) the person is admitted after an HCP's order and 2) the hospital accepts Medicare. (Most hospitals accept Original Medicare; some hospitals do not accept Medicare Advantage plans.) People pay $0 for days 1–60 (after the Part A deductible has been met). The cost for days 61-90 changes each year. For hospital stays longer than 90 days, the patient may opt to use **lifetime reserve days**. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medicare Part B typically pays 80% of the Medicare-approved amount for the HCPs' services at the hospital. **Learn more about inpatient hospital care.**

Type: Inpatient Rehabilitation Facilities

Description: Rehabilitation programs in rehab hospitals or rehab units in acute care hospitals.

✓ **Covered?** Yes. Medicare Part A covers medically necessary care received in an inpatient rehab facility if an HCP certifies the care. People pay $0 for days 1–60 (after the Part A deductible has been met). The cost for days 61-90 changes each year. For hospital stays longer than 90 days, the patient may opt to use lifetime reserve days. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medical Part B covers the HCP's services while in the facility. Medicare Advantage plans may have different rehabilitation benefits and approvals, so you should review this information when selecting a Medicare plan. **Learn more about inpatient rehabilitation care.**

Type: Long-Term Care Hospital Services

Description: Provide care to patients who need hospital care for more than 25 days on average and often have more than one serious medical condition. Many of these patients are transferred from an intensive or critical care unit.

✓ **Covered?** Yes, Medicare Part A covers long-term care hospital stays under certain circumstances, such as when patients need services such as respiratory therapy, head trauma treatment, therapy for a spinal cord injury, or pain management. **Learn more about long-term care hospital services.**

Lifetime Reserve Days

In Original Medicare, lifetime reserve days are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days you can use during your lifetime. These days cover any type of inpatient stay, including:

- Inpatient acute-care hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities

These days cannot be used for skilled nursing facilities.

Note that, while there are no limits on the number of hospital admissions that Medicare will cover, lifetime reserve days are not renewable year to year. You have 60 days to use over your lifetime. For example, if you use 35 days for one hospital stay, you will have 25 days left to use at any other time in life. If you have a Medigap policy, it will provide coverage of hospital coinsurance costs and extra days of inpatient coverage after your Medicare lifetime reserve days are used up.

While Medicare Advantage plans must cover the same inpatient hospital benefits as Original Medicare, including the 60 reserve days, Medicare Advantage plans may differ in terms of costs, such as copayments. Check your specific Medicare Advantage plan to determine coverage specifics.

Type: Hospice Care

Description: End-of-life care.

✓ **Covered?** Yes, Medicare Part A covers hospice care for eligible individuals that meet the following conditions:

- Your hospice provider and regular HCP certify you're terminally ill (with a life expectancy of six months or less).
- You accept comfort care instead of care to treat or cure your illness.
- You sign a statement choosing hospice care instead of other Medicare-covered treatment for your terminal illness.

Note that some hospice providers offer palliative care services, which do not require a patient to stop receiving other Medicare-covered benefits. Your HCP may discuss whether palliative care may be appropriate for you. **Learn more about hospice care.**

Type: Home Health Care

Description: Services that can be provided within the home for an illness or injury.

? **Covered?** Maybe. Medicare Part A and/or Part B cover eligible home health services if certain conditions are met, such as when a person is homebound and requires skilled services. People with dementia typically have home health care covered if it's deemed medically necessary and ordered by an HCP. Non-skilled services, such as assisting with everyday care and needs, are not covered. Medicare Advantage plans cover home health care, but the coverage may be different than under Original Medicare. **Learn more about home health services.**

Type: Long-Term Care Services

Description: Non-medical support services that help people live independently and safely, whether provided in a facility such as a nursing home or in a community setting. This may include assistance with transportation; help with daily activities, such as dressing and bathing; and meal delivery.

✓ **Covered?** No. Original Medicare, Medicare Advantage, and Medigap plans generally do not cover long-term care. Medicare Advantage may cover some supplemental healthcare benefits, such as meal delivery. **Learn more about options for long-term care resources.** If you qualify for dual eligibility, you may be able to get long-term care coverage through Medicaid. **Learn more about Medicaid coverage for long-term care.** Other federal programs such as the Older Americans Act and the Department of Veterans Affairs pay for long-term care services, but only for specific populations and in certain circumstances.

Paying for Non-Medical Long-Term Care

If a person with Alzheimer's disease or dementia needs more care than can be provided at home or if they would prefer to be in a living environment with other people, there are a number of residential long-term care options to consider. However, Medicare does not pay for these options. Medicaid or private long-term care insurance may cover some of this care, or you can pay for this yourself out of pocket.

Note that Medicaid may seek repayment from the estate of a person who received Medicaid-funded long-term care after they pass away, including stays in nursing facilities and home and community-based services, through a process known as Medicaid estate recovery. Medicaid estate recovery can include claims against assets, including the Medicaid recipient's home. It's important to note that, while Medicare may not cover important care needs, using Medicaid may have implications for asset protection and estate planning. Understanding these rules can help families make informed decisions. **Learn more from the American Council on Aging.**

Type: Residential Memory Care (also called Alzheimer's Special Care Units)

Description: A type of residential long-term care that provides specialized, 24/7 care for people with memory issues. Memory care is different from assisted living facilities because it's specifically designed to meet the unique needs of people living with dementia.

? **Covered?** Partly. Original Medicare and Medicare Advantage will pay for any **medical care** administered within the facility, but they generally don't cover room and board or personal care.

Type: Skilled Nursing Facilities (SNFs)

Description: Live-in facilities that provide medical care on a full-time, short-term basis.

? **Covered?** Maybe. Original Medicare may cover skilled care at a nursing home or via home health care if the beneficiary meets certain conditions and requires short-term skilled care for an illness or injury. These conditions include:

- **Qualifying Hospital Stay:** The person must have been an inpatient in a hospital for at least three consecutive days. Certain SNFs may also be able to bypass the three-day requirement through the **skilled nursing facility three-day rule waiver**. Patients should ask their social worker or patient navigator whether the stay will be covered by their plan.
- **Admission Within a Certain Window After Leaving the Hospital:** The acceptable time frame is generally 30 days.
- **Medically Necessary Skilled Care:** Your HCP must certify that you need daily skilled care.
- **Medicare-Certified Facility:** The SNF must be Medicare-certified.

If all the conditions are met, Medicare Part A will cover benefits that include a semi-private room, skilled nursing care, medications, medical supplies, equipment, and more. **Learn more about skilled nursing facility care.**

Resources for Non-Medical Long-Term Care

Eldercare Locator: A search engine for eldercare support in your area, including state-specific Medicare, aging, and health insurance agencies. You can also connect with this resource by calling 800-677-1116.

LongTermCare.gov: Offers planning resources and a search engine for long-term care options.

Long-Term Care Ombudsman: Connects you with ombudsmen who are advocates for residents of nursing homes, board and care homes, and assisted living facilities and provides information about finding a facility that provides quality care.

National Council on Aging:

- **Assisted Living and Medicare**
- **Nursing Homes and Medicare**

Drug Plan Rules

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Beneficiaries do not need to enroll in a separate Part D plan if their Medicare Advantage plan includes Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Like private insurance companies, Medicare drug plans have rules about whether they cover certain drugs and how they cover them. Drugs may be evaluated for medical necessity, appropriateness, and efficiency of use.

These rules include:

- **Prior Authorization:** A process requiring the review and approval of a specific drug before it is prescribed based on specific criteria
- **Step Therapy:** A policy that requires a patient to try and "fail" a lower-cost treatment before the treatment originally prescribed or recommended by an HCP can be prescribed
- **Quantity Limits:** Restrictions about the amount of drugs that can be covered over a certain period for cost and safety reasons

You should check with your specific plan to learn coverage rules and to determine whether your pharmacy is considered in-network or out-of-network. **Learn more about Medicare drug coverage.**

Note: When Medicare drug coverage begins, or when switching to a new Part D plan, **beneficiaries** may receive a one-time, 30-day supply of the medication they've been taking — even if the drug isn't covered by their new plan or requires prior authorization or step therapy — to aid in the transition to their new plan.

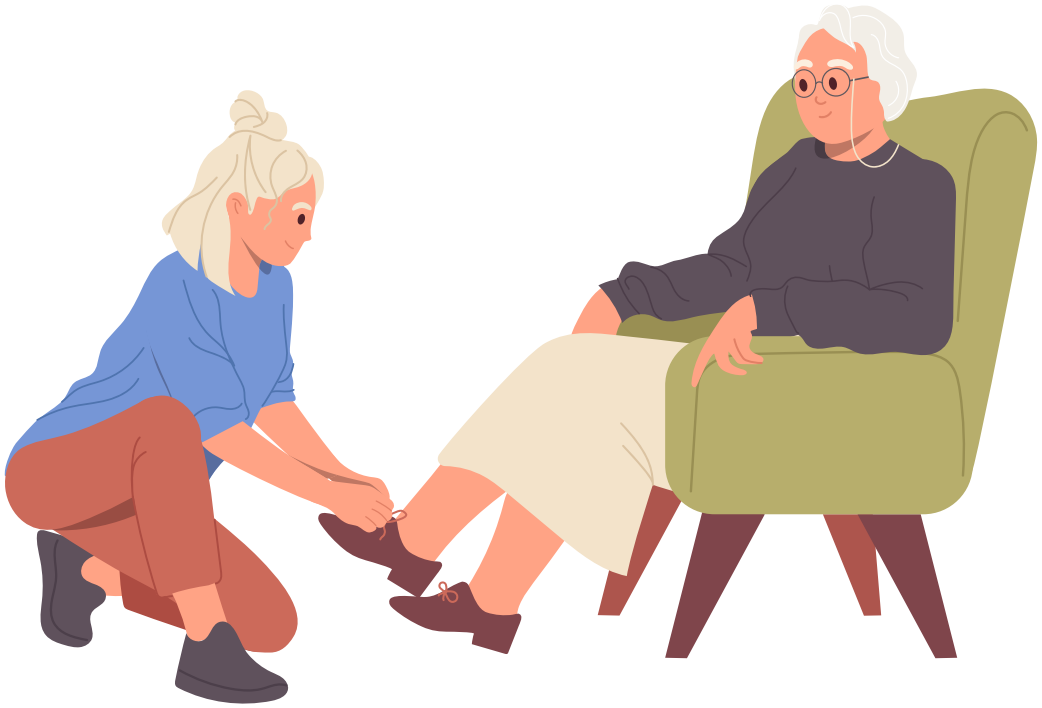


Support for Caregivers

Caregiving for someone living with dementia or Alzheimer's disease can be rewarding and fulfilling and can bring moments of connection and meaning. At the same time, the ongoing demands of care can place emotional, physical, and financial strain on caregivers. Ensuring that caregivers have access to a support system as well as resources and information that can assist them in their caregiving duties is essential for sustaining caregiver well-being.

There are several resources that exist for people caring for someone with Alzheimer's disease or dementia:

Alzheimer's and Dementia 24/7 Helpline *Alzheimer's Association* The 24/7 Helpline (1-800-272-3900) is a free service offering support for people living with dementia, caregivers, families, and the public.	**Community Support Groups** *Alzheimer's Association* The Alzheimer's Association facilitates connections with local support groups and online communities for those affected by Alzheimer's disease.	**Family Caregiver Toolbox** *Caregiver Action Network* A collection of resources for caregivers on topics, such as caregiving basics, financial and legal tools, and medical decisions and support.
Guidebooks *National Alliance for Caregiving* A series of guidebooks, including a Memory Loss Conversation Guide, aimed at improving the caregiving experience.	**National Caregiver Help Desk** *Caregiver Action Network* The National Caregiver Help Desk (1-855-227-3640) connects callers with a caregiving expert who provides advice or offers access to resources.	**Take Care Community Resources** *National Alliance for Caregiving and the Adira Foundation* A collection of resources for caregivers, from blog posts on financial health and e-books on future planning to guides and tips for funeral planning.



Track Your Cognitive Health

There are several tools and self-assessments available to help you track your brain health over time. These tools may be helpful to reference in conversations with your HCP, who can help you determine whether additional tests or screenings are needed.

- **AANP Cognitive Health in Aging** – geared toward nurse practitioners but accessible by all; information and resources on screening tools, lifestyle changes, and treatment options.
- **AARP Staying Sharp** – online cognitive assessments that measure speed and memory.
- **NIH Toolbox** – a set of modules and tracking tools to assess cognitive, emotional, motor, and sensory function.
- **SAGE (Self-Administered Gerocognitive Exam) Test** – a downloadable, self-administered test to check for early signs of cognitive, memory, or thinking impairment

Brain Health Resources and Support

Alliance for Aging Research: Advocates for issues that impact health, access, and medical innovation and provides resources on issues related to healthy aging, including Alzheimer's disease and related dementias.

Alzheimers.gov: Offers resources specific to Alzheimer's care and planning, including clinical trial search tools, caregiver resources, and HCP materials.

Alzheimer's Association: Conducts work on Alzheimer's care, support, research, and advocacy.

Alzheimer's Disease Research Centers (ADRCs): Focus on researching prevention, improved diagnosis, and care for people with Alzheimer's disease and other types of dementia.

American Association of Nurse Practitioners: Provides education and resources on common conditions that have cognitive impacts, lifestyle interventions for supporting brain health, diagnosis, and treatment options. Although designed for nurse practitioners, the tool can be used by anyone.

American Medical Women's Association: Offers educational fact sheets and infographics that cover topics such as the cognitive effects of aging and menopause, the role of lifestyle and environmental factors in dementia risk, caregiving challenges, and emerging innovations like AI in diagnosis and care.

HealthyWomen: Offers education on brain health for women across their lifespan.

Medicaid.gov: Provides essential services to support brain health, particularly for low-income individuals.

Medicare.gov: Offers details on coverage options for brain health screening and treatment.

National Council on Aging (NCOA): Provides tools and resources — including on Alzheimer's disease, dementia, brain health, and caregiver support — so people can age with health and economic well-being.

Society for Women's Health Research: Offers resources on diseases, conditions, and life stages that uniquely, differently, or disproportionately affect women — including Alzheimer's disease — for patients, families, clinicians, and policymakers.

State Health Insurance Assistance Programs: Provide free counseling to help navigate Medicare benefits.

UsAgainstAlzheimer's: Seeks to improve dementia prevention, early detection, and access to treatments through advocacy, policy, convening, and high-leveraged programs.

Women and Obesity

In this chapter, readers will learn about comprehensive obesity care, including the classifications for overweight and obesity, causes and risk factors, treatment and management, and what Medicare benefits and services are available for obesity care in older age.



Why Should Women Focus on Obesity?

Obesity is a complex chronic disease that results from the interaction of many different environmental and genetic factors. It can affect your health and quality of life and lead to high medical costs over time. It is associated with more than 200 health complications, such as cardiovascular disease, high blood pressure, Type 2 diabetes, certain cancers, polyendocrine metabolic ovarian syndrome (PMOS), worse menopause symptoms, and mental illness, among others.

In 2022, almost **4 out of 10 women 60 and over** in the U.S. were living with obesity. Obesity affects women of color more than other groups, with almost 6 out of 10 Black women and 5 out of 10 Hispanic women living with obesity. These differences show that everyone needs access to evidence-based prevention, treatment, and long-term care for obesity. This high level of obesity among women is partially because of changes in women's bodies that come with aging and menopause. Physical changes that happen during menopause — from **burning fewer calories to producing less estrogen** — can lead to excess body fat, especially in the belly. This can raise a woman's long-term **cardiovascular and metabolic risks**. Obesity has also been **linked** to higher rates of disability and poor overall health.

Managing obesity is important for general health and well-being, mobility, and improving quality of life. The best way to treat and manage obesity is with a personalized, evidence-based approach that may include a combination of nutrition strategies, physical activity, bariatric surgery, behavioral therapy, and obesity medications. A plan that is tailored to each person's unique circumstances, lifestyle, and needs can help women maintain their strength, reduce the onset and seriousness of chronic conditions, and support healthy aging.

Breaking down BMI

Obesity is typically screened for using body mass index (BMI), a calculation to measure body composition based on a person's height and weight. The **U.S. Centers for Disease Control and Prevention** categorizes BMI for adults 20 years and older as:

- Underweight: BMI < 18.5 (kg/m2)
- Healthy Weight: BMI = 18.5 to less than 25
- Overweight: BMI = 25 to less than 30
- Obesity: BMI = 30 or greater
  - Class 1 Obesity: BMI = 30 to less than 35
  - Class 2 Obesity: BMI = 35 to less than 40
  - Class 3 Obesity (Severe Obesity): BMI = 40 or greater

Note: BMI is considered by many to be an **imperfect tool for diagnosing obesity**. It does not account for the location of or types of body fat and does not necessarily reflect someone's health or how factors like race or ethnicity may influence the link between their body composition and potential health risks.

Key Obesity Terms

- **Adiposity** – the state of having a high amount of adipose (fat) tissue in the body
- **Body mass index (BMI)** – a measure of body fat based on height and weight
- **Chronic disease** – a condition that lasts one year or more and requires ongoing medical attention, limits activities of daily living, or both
- **Comorbidity** – a disease or medical condition that occurs at the same time as one or more other conditions in a patient
- **Obesity** – a chronic disease that occurs when there is an increase in the size and amount of fat cells in the body that cause metabolic dysfunction (typically measured as having a BMI of 30 or higher)
- **Overweight** – a condition of excessive fat deposits (typically measured as having a BMI between 25 and 29.9)

Metabolic Health at Medicare Age: What to Know

Causes and Risk Factors

Obesity is regularly described as a complex disease because it can be caused by many factors from genetics to eating behaviors to the broader environment where people live. While some risk factors for obesity can be changed, many contributing factors are outside of a person's control or may be difficult to change. Causes of obesity may include:

- Family history
- Genetic factors
- Health conditions (e.g., metabolic syndrome, polycystic ovary syndrome (PCOS)/polyendocrine metabolic ovarian syndrome (PMOS))
- Lack of physical activity
- Psychological factors (e.g., stress)
- Poor sleep patterns
- Poor nutrition (e.g., lack of nutrient-dense foods and well-balanced diet)
- Certain medications (e.g., antidepressants, certain diabetes medications)
- Environmental factors (e.g., lack of access to healthy foods and safe recreational spaces)

Tips to Support Metabolic Health

While each person's journey with obesity looks different, there are evidence-based lifestyle choices, including following a healthy diet, engaging in regular physical activity, and getting enough sleep, that can have a positive influence on a person's weight and overall health.

Even a modest weight loss of 5%–10% can help lower blood pressure, cholesterol, and blood sugar levels, decreasing the risk for chronic diseases such as heart disease and Type 2 diabetes.

- **Nutrition:** A **healthy diet** prioritizes nutrient-dense protein foods, such as seafood and lean meats; a variety of fruits and vegetables; healthy fats found in dairy, avocados, and olives; and whole grains. A healthy diet also avoids processed foods, added sugars, sodium, and saturated fats and stays within a person's daily calorie needs.
- **Exercise:** The general **recommendation** for adults is to get at least 150 minutes of moderate-intensity aerobic activity each week. "Moderate-intensity aerobic activity" means that you're working hard enough to raise your heart rate and break a sweat, but you can still carry on a conversation. However, more physical activity may be needed to maintain a healthy weight. The exact amount will vary from person to person. If you have a chronic condition or a disability, you can **modify your physical activity routine** to match your abilities.
- **Sleep:** It is recommended that adults sleep seven to eight hours each night. A lack of sleep can lead to an **imbalance in the hormones** that regulate appetite and stress and can affect blood sugar levels.
- **Stress:** **Studies** show that a person's lived environment, including hardships and other social challenges, can affect the body in ways that make it harder to manage weight. While people can't always change their individual circumstances, they may be able to practice stress management through activities like meditation, journaling, and spending time outdoors. Stress can also negatively impact food choices and portion sizes.
- **Support:** There are many ways people can get positive support for managing overweight or obesity. One way is to reach out to trusted friends, family, or coworkers, especially those who may have similar goals. You can exercise together, encourage success, or share helpful tips or resources like healthy recipes. You can also seek help from a healthcare provider (HCP) that specializes in obesity and weight management

or an accredited weight-loss specialist or join a structured program with a support group.

It's important to remember that everyone's journey can look different, and there is no solution that works for everyone. Work with your HCP to discuss which options are right for you to help you manage overweight or obesity and safely maintain your weight. **Learn more from the National Institute of Diabetes and Digestive and Kidney Diseases.**

Featured Find!

Life's Essential 8 – How to Keep a Healthy Weight Fact Sheet

American Heart Association

A fact sheet sharing ideas for managing weight, such as increasing the amount of fiber you eat, and tips for success, including portion control.

Healthcare Providers

Several types of HCPs see people for obesity concerns and treatment management.

- A **primary care provider (PCP)** is an HCP who helps manage a person's general health over time and can refer patients for specialty care. They offer preventive care, screenings, and immunizations and also diagnose and treat a wide range of conditions.
- An **obesity medicine specialist/bariatrician/ bariatric healthcare provider** is a doctor who specializes in the comprehensive management of obesity and its associated health conditions.
- A **bariatric surgeon** is a doctor who performs surgeries that are used in treating obesity by making changes to your digestive system, such as gastric bypass and gastric sleeves.
- An **endocrinologist** is a doctor who specializes in the diagnosis and treatment of disorders of the endocrine system (the organs and glands that make hormones).
- A **gastroenterologist** is a doctor who specializes in the diagnosis and treatment of disorders of the digestive system.
- A **registered dietitian**, also known as a registered dietitian nutritionist, is a credentialed HCP who specializes in diet and nutrition. They often work in coordination with primary care and specialty care teams to help people with diet-related matters, such as improving diabetes management.
- A **physician assistant/physician associate (PA)** is a licensed clinician who practices medicine across different specialties and healthcare settings. PAs are important members of a care team, developing care plans, and providing ongoing support and education to patients and families.
- A **nurse practitioner (NP)**, a type of advanced practice registered nurse (APRN), is a registered nurse with advanced training in administering patient care. NPs diagnose, treat, and manage acute and chronic diseases while emphasizing health promotion and disease prevention.

In addition to these HCPs, there are other types of providers who may see people for conditions related to obesity. These include, but are not limited to, cardiologists (who can diagnose and treat problems related to the heart and blood vessels), dermatologists, nephrologists (doctors who specialize in kidney care), psychologists, pulmonologists (doctors who specialize in the respiratory system and treat conditions like sleep apnea), ophthalmologists and optometrists (who may see patients for obesity-related eye diseases, such as diabetic retinopathy), and podiatrists (foot health specialists).

While Medicare generally covers visits for PCPs, coverage and deductibles may vary depending on factors such as the type of Medicare plan and provider participation. Those with Medicare Advantage will likely have to stay within the plan's network and may require a referral to see specialists. Coverage for visits with other specialists may be dependent on whether the specialist participates in Medicare. Checking with your plan to confirm what is covered in advance is important and could prevent unexpected bills.

A Reminder: Healthcare Provider and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any HCP or hospital in the United States that accepts Medicare.	These plans often require you to use HCPs and hospitals within the plan's network.
In most cases, referrals are not needed to see a specialist.	A referral from your PCP may be needed to see a specialist.

**Adapted from Medicare.gov.*

Taking Charge: My Health Management Habit Tracker

Regardless of your stage of life, you can take steps now to support your overall health. This daily health management habit tracker can help ensure you're taking steps from week to week to lead a healthy lifestyle.

- ☑ I was mindful of portion size at each meal
- ☑ I ate a good variety of fruits and vegetables
- ☑ I chose whole grains (e.g., oats, brown rice)
- ☑ I limited salt and added sugars
- ☑ I drank at least 8 cups of water
- ☑ I got at least 30 minutes of moderate-intensity physical activity
- ☑ I got quality sleep
- ☑ I practiced stress management
- ☑ I tracked my habits (e.g., daily steps, duration of activity, active vs. sedentary time)



Care Considerations With Original Medicare and Medicare Advantage

As you think about which coverage pathway between Original Medicare and Medicare Advantage is right for you, you'll have to consider your unique circumstances and which path provides services that are most important to you.

For example, a 2022 **analysis of Medicare beneficiaries** found that Medicare Advantage enrollees were in a plan that included about half (48%) of the physicians available to Original Medicare beneficiaries. The narrower network of providers available with Medicare Advantage could significantly limit timely and consistent access to specialists, such as obesity medicine doctors, unless the enrollees were to go out-of-network and pay more. Additionally, under Medicare Advantage, beneficiaries are not always able to buy or afford supplemental coverage to help pay out-of-pocket costs (Medigap) if they decide to disenroll from their Medicare Advantage plan and move to Original Medicare.

Yet, Medicare Advantage plans may offer additional benefits that could be valuable for someone with obesity, including limits for out-of-pocket costs. Most Medicare Advantage plans also include Medicare Part D, or prescription drug coverage, as part of their overall health benefits. As described below, some Medicare Advantage plans may offer additional services to assist with exercise and weight management.

It's important to understand your coverage needs and what will save you the most on costs.

Medicare Coverage for Obesity

Eligibility

While most people start Medicare at age 65, people with a qualifying disability who have been receiving Social Security Disability Insurance (SSDI) benefits for more than 24 months **may be able to receive Medicare coverage earlier**.

While obesity alone does not qualify a person for disability benefits, the **Social Security Administration (SSA)** does recognize obesity as a **medically determinable impairment (MDI)** and considers its combined effects with other conditions when evaluating disability claims. In evaluating claims, the SSA will review medical records from your HCP, such as laboratory findings, and your medical history to review whether there is a consistent pattern of obesity. The SSA will also consider whether someone living with obesity is experiencing functional limitations in their ability to work (e.g., sitting, standing, walking).

Coverage

Both Original Medicare and Medicare Advantage provide the following types of coverage that can help support women in managing their weight and for women affected by obesity:

- **Preventive and Screening Services:** Medicare Part B covers many preventive services, including health exams and screenings, programs for health monitoring, and counseling and education to help women take care of their health as they age. These include:
  - **"Welcome to Medicare" Visit:** An initial, one-time visit that takes place within the first 12 months of enrolling in Medicare Part B.
  - **Annual Wellness Visit:** Available every 12 months after the first year on Medicare Part B and focused on prevention, including a health risk assessment, review of current providers and medications, and creation of a screening checklist.

    Note: Medicare does not cover routine physical exams. **Learn more about yearly wellness visits.**
  - **Obesity behavioral therapy:** Includes an initial screening for BMI and behavioral therapy sessions that include a dietary assessment and counseling. Medicare Part B covers this type of counseling for people with a BMI of 30 or more whose PCP provides the counseling in a primary care setting. Medicare will cover counseling visits for up to 12 months. Receiving these services from another specialist, such as a registered dietitian, could mean having to pay for services out of pocket. Individuals who qualify and have their appointments within a primary care setting pay nothing for this service if the provider **accepts the assignment** (meaning the HCP accepts Medicare and agrees to the Medicare-approved payment for the service). **Learn more about obesity behavioral therapy.**
  - **Thyroid testing:** Includes up to two thyroid tests, including the TSH, T3, and T4 blood tests, per year for clinically stable patients if an HCP deems them medically necessary for diagnosing or treating thyroid dysfunction. Medicare Part B covers these tests once the Part B plan's deductible has been met. Costs may vary for those with Medicare Advantage plans, and Medicare Advantage plans may offer additional testing. Tests done during an inpatient hospital stay are covered under Medicare Part A. **Learn more about thyroid testing.**
- **Lifestyle Support:** Medicare Part B offers several resources related to lifestyle and nutrition that could be beneficial in a person's obesity management journey:
  - **Diabetes self-management training**, which provides tips for eating healthy and being active, monitoring blood sugar, and taking prescription drugs, for those who have been diagnosed with diabetes. An HCP must provide a written order for this training, and exceptions may apply based on the individual's needs or whether services (i.e., group sessions) aren't available where you live. **Learn more about diabetes self-management training.**
  - **Durable medical equipment**, when prescribed by an HCP and considered medically necessary. Coverage for certain medical equipment, such as walkers and canes, may be based on functional need, such as difficulty moving around the home. Approved equipment is likely to cost 20% of the Medicare-approved amount after the Part B plan's deductible has been met. Medicare Advantage plans must cover the same medically necessary categories of durable medical equipment items as Original Medicare, but the suppliers of the equipment and costs will depend on an individual's specific Medicare Advantage plan. **Learn more about durable medical equipment coverage at Medicare.gov** and in the official government booklet, **"Medicare Coverage of Durable Medical Equipment & Other Devices."**
  - **Lymphedema compression treatment items** (gradient compression garments and gradient compression wraps with adjustable straps and compression bandaging supplies) for those diagnosed with lymphedema and who have been prescribed the treatment items by an HCP. Additional items to treat lymphedema are covered by Medicare, such as pneumatic compression pumps (covered under durable medical equipment) and manual lymphedema drainage (covered under occupational or physical therapy). Individuals will pay 20% of the Medicare-approved cost after the Part B plan's deductible has been met. **Learn more about lymphedema compression treatment items.**
  - **Medical nutrition therapy** for those with diabetes or kidney disease or those who have had a kidney transplant in the last 36 months. Only a treating physician or a primary care physician can refer an individual for this service,

which is provided by a registered dietitian. Individuals pay nothing for these services if they qualify and if they received the service from dietitians who accept Medicare rates. **Learn more about medical nutrition therapy services.**

- **Occupational therapy** to help improve or maintain current capabilities for daily living (e.g., getting dressed) for people who need it. An HCP must certify that this care is needed. Individuals pay 20% of the Medicare-approved amount after the Part B plan's deductible has been met. Medigap plans will generally cover the 20% payment, so people with those plans should check their **explanation of benefits** to see if the service will be covered. **Learn more about occupational therapy services.**
- **Physical therapy** to improve or maintain current function for people who qualify. Individuals pay 20% of the Medicare-approved amount after the Part B plan's deductible has been met. Medigap plans will generally cover the 20% payment, so people with those plans should check their **explanation of benefits** to see if the service will be covered. **Learn more about physical therapy services.**

Coverage Extras Under Medicare Advantage

Some Medicare Advantage plans may provide coverage for additional health and wellness services that can support obesity management or weight-loss efforts. This could include coverage for gym memberships or fitness programs, such as SilverSneakers, a fitness and lifestyle program for adults ages 65 and older. SilverSneakers may also be available through a Medicare Supplement Plan. Other programs that may be offered as an alternative include Renew Active, Silver&Fit, and Golden Sneakers.

Some Medicare Advantage plans may also offer food delivery services. For those with a chronic medical condition, such as diabetes, plans may pay for meals tailored to the condition. These services will vary from plan to plan and will have different costs and eligibility criteria. Check with your specific Medicare Advantage plans to determine benefits.

Learn more from the National Council on Aging.

- **Medication Coverage:** Medicare coverage for obesity medications can vary depending on individual circumstances. Drugs may be covered under Medicare Part B or Medicare Part D when other chronic conditions are present in addition to obesity. Medications include:
  - **Glucagon-like-peptide-1 (GLP-1) medications:** Certain semaglutide treatments (such as Ozempic and Wegovy) and tirzepatide treatments (such as Mounjaro and Zepbound) are covered by Medicare when they are prescribed for U.S. Food and Drug Administration (FDA)-approved conditions such as Type 2 diabetes, moderate-to-severe sleep apnea, and metabolic dysfunction-associated steatohepatitis (MASH, formerly called non-alcoholic steatohepatitis or NASH), as well as cardiovascular risk reduction in some cases.
  - By law, Medicare cannot cover these medications for obesity or weight loss alone. However, a 2026 demonstration program administered by the Centers for Medicare and Medicaid Services (CMS), called the "Medicare GLP-1 Bridge," covers GLP-1 medications. This demonstration program provides eligible Medicare beneficiaries who are enrolled in Medicare Part D with access to certain GLP-1 medications through the end of 2027. Medicare beneficiaries should check with their treating or primary care physician to find out whether they may be **eligible for this demonstration** due to their clinical condition(s).
  - Patients who are not eligible for coverage through Medicare Part D or who are deemed ineligible for the CMS Bridge program should work with their HCP to identify other options for financial assistance, such as discount programs offered by pharmaceutical companies.



A 101 on the Medicare GLP-1 Bridge

In April 2026, CMS announced a new initiative to cover most of the costs of GLP-1 medications for people who are enrolled in Medicare Part D and meet the eligibility requirements for GLP-1s. This program, known as the **Medicare GLP-1 Bridge**, began in July 2026 and will run until the end of 2027. **Medicare beneficiaries who wish to participate will need an HCP to write a prescription** and submit a **prior authorization** request to determine eligibility. Those determined to be eligible will be able to access GLP-1 medications with a monthly $50 copay. It is important to note that this copay will not count toward a participant's Medicare Part D deductible or out-of-pocket costs, as the program operates outside of Medicare Part D. CMS has not yet announced whether or how the program will provide coverage after 2027.

Learn more about the Medicare GLP-1 Bridge.

- **Surgery:** Medicare Part B covers some surgical procedures if a person is deemed eligible.
  - Medicare covers some **bariatric surgical procedures** if a person has a qualifying BMI of 35 or more and meets certain conditions. Individuals must have at least one related **comorbidity** (e.g., diabetes, heart disease) and show that they have previously tried and failed to lose weight through medically supervised, non-invasive methods. A psychological evaluation may also be required to ensure that the individual is prepared for a life-altering procedure. Bariatric surgeries covered by Medicare as of June 2026 include:
    - **Adjustable gastric banding**
    - **Biliopancreatic diversion with duodenal switch**
    - **Gastric bypass surgery (Roux-en-Y)**
    - **Laparoscopic sleeve gastrectomy**
    - **Vertical banded gastroplasty**

    Your physician may also recommend endobariatric procedures, which are covered by Medicare on a case-by-case basis. Medical evidence and coverage for these procedures may evolve over time, so it's important to check with your plan to determine if your physician-recommended option is covered before scheduling the surgery.

    It is difficult to predict the out-of-pocket costs of surgeries and procedures in advance. Factors that may affect how much you'll pay include where the procedure takes place, whether the procedure will be **outpatient** or **inpatient**, and whether you have supplemental insurance through Medigap, Medicaid, your employer, or your spouse's employer. **Learn more about bariatric surgery.**
  - Medicare Part B may cover **panniculectomies** (removal of excess skin and tissue from the lower abdomen) if they are deemed medically necessary by an HCP. Medicare will not cover the surgery as a cosmetic procedure. If the procedure requires prior authorization and Medicare approves it, the individual should only be responsible for the deductible and coinsurance from the procedure. **Learn more about cosmetic surgery.**

A Note on Medicare Coverage

Original Medicare and Medicare Advantage plans may have different **cost-sharing** amounts (the out-of-pocket expenses like deductibles, coinsurance, and copayments that beneficiaries pay for Medicare services), so it's important to check your plan's coverage details. Additionally, many people with Original Medicare purchase Medigap — a supplemental insurance — that helps pay for these cost-shares. For those who qualify for retiree benefits through their former employer, their retiree plan may cover these costs. And for those who are dually eligible for Medicaid, states pay for Part B cost-sharing.

Consider reaching out to Medicare at **1-800-MEDICARE (1-800-633-4227)** or your State Health Insurance Assistance Program to answer questions and provide additional clarification.

Obesity Management Questions to Ask During Medicare Wellness Visits

These questions can be tailored to personal circumstances and medical history.

- What is my current BMI?
- How is having overweight or obesity affecting my overall health risk right now?
- Could my stress or sleep be affecting my weight?
- What can I do if pain or mobility issues make exercise hard?
- What kinds of physical activity would be best for me to meet my weight goals?
- Is there a specific obesity management program you would recommend for me?
- Am I currently taking any medications that might contribute to overweight/obesity?
- What are the pros and cons of medications like semaglutide, tirzepatide, or orforglipron for me?
  - If I were to go on one of these medications, would it be covered under Medicare?
  - How long would I need to take these medications for?
- What strategies could help me work through the challenges I'm facing with my weight?

Importance of Reviewing Coverage Annually

Choosing the Right Medicare Coverage as Your Needs Change

Your access to certain services and benefits can vary depending on whether you have Original Medicare or a Medicare Advantage plan. Similarly, coverage rules, provider networks, prior authorization requirements, and out-of-pocket costs can be different between plans. This includes differences in coverage for treatment of obesity. Even if your current plan covers the benefits you need today, it's important to review your coverage regularly as your health needs change.

It's also important to consider whether switching from Original Medicare to a Medicare Advantage plan (or vice versa) will cause any disruptions to your health and financial needs. For example, you may not be able to enroll in a Medigap plan if you switch to a Medicare Advantage plan and then try to come back to Original Medicare.

Obesity and related chronic conditions can require different types and levels of care over time, so reassessing and consulting with your plan each year on your specific testing and treatment needs can help ensure that you continue to have access to the services and supports that are right for you.



Featured Find!

Navigating Obesity Care Coverage Denials

EveryBODY Covered

If you have been denied coverage for obesity treatment, it can be challenging to understand the reasons why and what to do next. This resource includes helpful tips for navigating common coverage challenges, whether you get your insurance from your employer, the government, or the marketplace. Before getting started, know that gaining coverage may require persistence, and your HCP may have helpful advice about and offer assistance with navigating insurance denials.

Drug Plan Rules

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Beneficiaries do not need to enroll in a separate Part D plan if their Medicare Advantage plan includes Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Like private insurance companies, Medicare drug plans have rules about whether they cover certain drugs and how they cover them. Drugs may be evaluated for medical necessity, appropriateness, and efficiency of use.

These rules include:

- **Prior Authorization:** A process requiring the review and approval of a specific drug before it is prescribed based on specific criteria
- **Step Therapy:** A policy that requires a patient to try and "fail" a lower-cost treatment before the treatment originally prescribed or recommended by an HCP can be prescribed
- **Quantity Limits:** Restrictions about the amount of drugs that can be covered over a certain period for cost and safety reasons

You should check with your specific plan to learn your coverage rules and to determine whether your pharmacy is considered in-network or out-of-network. **Learn more about Medicare drug coverage.**

Note: When Medicare drug coverage begins, or when switching to a new Part D plan, **beneficiaries** may receive a one-time, 30-day supply of the medication they've been taking — even if the drug isn't covered by their new plan or requires prior authorization or step therapy — to aid in the transition to their new plan.

Obesity and Medicare: What If ...?

MEDICATION COVERAGE

Q: What if Medicare won't cover my obesity medication?

A: Prior to July 2026, Medicare only covered GLP-1 medications prescribed for people with certain conditions like diabetes, sleep apnea, or heart disease. Now, Medicare covers certain GLP-1s under the **Medicare GLP-1 Bridge** program. You should ask your provider if you **qualify for the Bridge program**. If you have questions about the Bridge program, visit the **OCAN website**. Continue to check with **Medicare** for the most up-to-date coverage information.

If you don't qualify, ask your HCP about non-drug options that Medicare does cover, such as obesity behavioral therapy or nutrition counseling.

Q: What if my medication requires prior authorization or gets denied?

A: Your HCP can submit paperwork showing the medication is medically necessary. If it's denied, you can file an appeal. It is also important to note that there are a number of non-FDA approved medications or compounded versions of medications on the market. These medications may not be approved based on safety and efficacy standards, which means that they may come with unknown risk and may not have the evidence to show that they are the right fit for you. Any medication should only be used after consultation with your HCP.

Questions to Ask if You're Considering Obesity Medications

- Have you checked the latest guidance from CMS?
- Have you talked to your HCP to see if you meet the clinical requirements for obesity medications?
- Have you talked to your HCP to determine how obesity medication may impact any other co-existing conditions?
- If your treatment requires prior authorization from Medicare, will your HCP submit it?
- What will the total cost for medication be (including copays, deductibles, and any monthly costs)?
- Will the costs change over time? If so, can you afford to continue medication or will you need to stop?
- Are there any Medicare-covered alternatives?

Q: What if I'm not sure whether my condition qualifies for coverage?

A: Ask your HCP or call your Part D plan. Coverage for obesity medications often depends on specific diagnoses and FDA-approved uses.

Q: What if I start a treatment but can't continue it because the long-term cost is too much?

A: If your medication is covered by your Medicare Part D plan:

- You may qualify for the Extra Help program, which helps cover the cost of deductibles and copays. Additionally, whether you receive your medications through a Part D plan or Medicare Advantage plan, you are able to participate in the Medicare Prescription Payment Plan and spread the costs of your medication throughout the year rather than paying all costs at once. **Learn more about the Extra Help program** and the **Medicare Prescription Payment Plan**.
- Some states also administer State Pharmaceutical Assistance Programs (SPAPs) that provide financial assistance with Medicare drug plan premiums and/or cost-sharing. **Learn more about SPAPs in your area.**
- Some pharmaceutical companies help pay for prescriptions for people who have Medicare Part D through **pharmaceutical assistance programs**. Applying for a pharmaceutical assistance program, when available, or switching to a generic version of your medication, may also help reduce out-of-pocket costs. **Learn about pharmaceutical assistance programs.**

It's important to plan ahead. Ask your HCP about long-term affordability, lower-cost options, or strategies for transitioning to a different treatment option early.

SURGICAL PROCEDURES COVERAGE

Q: What if Medicare won't cover my surgical procedures?

A: Medicare generally covers bariatric surgical procedures if they are deemed medically necessary by an HCP, if a person has a qualifying BMI of 35 or more, and if they have an obesity-related condition, such as diabetes or heart disease. The surgery also must take place at a Medicare-approved facility. If you learn that your coverage has been denied, first check that these criteria have been met and that all of the correct paperwork has been submitted. Also, you can discuss with your HCP whether any additional information is needed in order to appeal.

ONGOING CARE AND PLAN SPECIFICS

Q: What if my plan changes what it covers?

A: Review your plan's benefits during Medicare Open Enrollment (October 15–December 7) each year to make sure that your current plan still meets your needs. If it doesn't, you might consider switching to a different plan.

Q: What if my specialist isn't in my Medicare Advantage plan's network?

A: You may need to get a referral, or you could face higher costs for seeing an out-of-network provider. During Medicare Open Enrollment (October 15–December 7), you can explore switching to a plan that includes your current specialists.

Q: Are the same services that I would get under Original Medicare covered under Medicare Advantage as well?

A: Medicare Advantage plans must cover all medically necessary services that are covered under Original Medicare. However, plans will use their own coverage criteria to determine medical necessity for certain services and may offer other benefits that are not covered under Original Medicare.

Featured Find!

Understanding Obesity in Caregiving

Caregiver Action Network

This interactive learning experience from Caregiver Action Network and Paradigm Medical Communications is designed to help caregivers and care partners better support loved ones living with obesity. The tool combines expert guidance, real-world stories, and quizzes to give caregivers and care partners ways to offer meaningful support without bias or shame.

Obesity Medications: What to Consider When Buying Direct

If you purchase a GLP-1 outside of your Medicare Part D plan, such as paying cash through a discount website or telehealth service, those costs generally do not count toward your Part D coverage. This means the amount you pay won't apply to your plan's deductible or its out-of-pocket spending cap. If you decide to use these options, know that, while they may offer lower upfront prices, they do operate separately from Medicare. This means they won't count toward your out-of-pocket maximum. In Medicare D, once you hit your out-of-pocket spending limit, you won't pay for prescriptions for the rest of the year. If you buy direct, the cost of these prescriptions will not count toward your out-of-pocket limit, so you may end up paying more overall for your medications through the year.

Featured Find!

How to Support a Loved One Living with Obesity

HealthyWomen

This article discusses how people can best support people in their lives who are living with obesity. Tips include recognizing obesity as a chronic disease, learning about the disease, asking questions, and testing your own bias.

Institutional and Long-Term Care for Obesity: Covered or Not?

Medicare beneficiaries who are living with obesity are more likely to have Type 2 diabetes, cardiovascular disease, sleep apnea, or mobility limitations, which may mean they require institutional care as part of their treatment plan. While determining coverage for certain facilities can be challenging, Medicare beneficiaries who are living with obesity may also have trouble accessing appropriately equipped facilities and safe transitions between settings.

Type: Outpatient Hospital Services

Description: Procedures and treatments that may be performed at a hospital but don't require an overnight stay (e.g., laboratory tests billed by the hospital, preventive and screening services, X-rays, and other radiology services billed by the hospital).

? **Covered?** Maybe. Medicare Part B covers several diagnostic and treatment services that are performed in hospitals that accept Medicare. Beneficiaries usually pay 20% of the Medicare-approved amount for the services and a copayment for each service received in a hospital outpatient setting, unless it's a preventive service that doesn't have a copayment. **Learn more about outpatient hospital services.**

Type: Inpatient (Acute-Care) Hospital Services

Description: Medical care provided in a hospital or facility that involves the patient staying overnight or longer.

✓ **Covered?** Yes. Medicare Part A typically covers inpatient hospital care if: 1) the person is admitted after an HCP's order and 2) the hospital accepts Medicare. (Most hospitals accept Original Medicare; some hospitals do not accept Medicare Advantage plans.) People pay $0 for days 1–60 (after the Part A deductible has been met). The cost for days 61–90 changes each year. For hospital stays longer than 90 days, the patient may opt to use **lifetime reserve days**. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medicare Part B typically pays 80% of the Medicare-approved amount for the HCP's services at the hospital. **Learn more about inpatient hospital care.**

Type: Inpatient Rehabilitation Facilities

Description: Rehabilitation programs in rehab hospitals or rehab units in acute care hospitals.

✓ **Covered?** Yes. Medicare Part A covers medically necessary care received in an inpatient rehab facility if an HCP certifies the care. People pay $0 for days 1–60 (after the Part A deductible has been met). The cost for days 61–90 changes each year. For hospital stays longer than 90 days, the patient may opt to use lifetime reserve days. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medicare Part B covers the HCP's services while in the facility. Medicare Advantage plans may have different rehabilitation benefits and approvals, so you should review this information when selecting a Medicare plan. **Learn more about inpatient rehabilitation care.**

Lifetime Reserve Days

In Original Medicare, lifetime reserve days are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days you can use during your lifetime. These days cover any type of inpatient stay, including:

- Inpatient acute-care hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities

These days cannot be used for skilled nursing facilities.

Note that, while there are no limits on the number of hospital admissions that Medicare will cover, lifetime reserve days are not renewable year to year. You have 60 days to use over your lifetime. For example, if you use 35 days for one hospital stay, you will have 25 days left to use at any other time in life. If you have a Medigap policy, it will provide coverage of hospital coinsurance costs and extra days of inpatient coverage after your Medicare lifetime reserve days are used up.

While Medicare Advantage plans must cover the same inpatient hospital benefits as Original Medicare, including the 60 reserve days, Medicare Advantage plans may differ in terms of costs, such as copayments. Check your specific Medicare Advantage plan to determine coverage specifics.

Type: Long-Term Care Hospital Services

Description: Provide care to patients who need hospital care for more than 25 days on average and often have more than one serious medical condition. Many of these patients are transferred from an intensive or critical care unit.

✓ **Covered?** Yes, Medicare Part A covers long-term care hospital stays under certain circumstances, such as when patients need services such as respiratory therapy, head trauma treatment, therapy for a spinal cord injury, or pain management. **Learn more about long-term care hospital services.**

Featured Find!

Institutional and Long-Term Care Medicare.gov Resources

- **Outpatient Hospital Services**
- **Inpatient Hospital Care Services**
- **Inpatient Rehabilitation Facilities**
- **Home Health Services**
- **Medicare & Home Health Care**
- **Long-Term Care**
- **Nursing Homes**
- **Resources & Information for Patients and Caregivers**

Type: Long-Term Care Services

Description: Non-medical support services that help people live independently and safely, whether provided in a facility such as a nursing home or in a community setting. This may include assistance with transportation; help with daily activities, such as dressing and bathing; and meal delivery.

X **Covered?** No. Original Medicare, Medicare Advantage, and Medigap plans generally do not cover long-term care. Medicare Advantage may cover some supplemental healthcare benefits, such as meal delivery. **Learn more about options for long-term care resources**. If you qualify for dual eligibility, you may be able to get long-term care coverage through Medicaid. **Learn more about Medicaid coverage for long-term care**. Other federal programs such as the Older Americans Act and the Department of Veterans Affairs pay for long-term care services, but only for specific populations and in certain circumstances.

Type: Skilled Nursing Facilities (SNFs)

Description: Live-in facilities that provide medical care on a full-time, short-term basis.

? **Covered?** Maybe. Original Medicare may cover skilled care at a nursing home or via home health care if the beneficiary meets certain conditions and requires short-term skilled care for an illness or injury. These conditions include:

- **Qualifying Hospital Stay:** The person must have been an inpatient in a hospital for at least three consecutive days. Certain skilled nursing facilities may also be able to bypass the three-day requirement through the **skilled nursing facility three-day rule** waiver. Patients should ask their social worker or **patient navigator** whether the stay will be covered by their plan.
- **Admission Within a Certain Window After Leaving the Hospital:** The acceptable time frame is generally 30 days.
- **Medically Necessary Skilled Care:** Your HCP must certify that you need daily skilled care.
- **Medicare-Certified Facility:** The SNF must be Medicare-certified.

If all the above conditions are met, Medicare Part A will cover benefits that include a semi-private room, skilled nursing care, medications, medical supplies and equipment, and more. Learn more about skilled nursing facility care.

Note on Institutional Care: If you're living with obesity, it's important to know that Medicare may cover your stay but that not every facility is equipped to meet your needs. For example, not all facilities will have bariatric equipment, such as patient lifts, which could lead to delays in placement or being sent to a facility that's farther from your home. Planning ahead and asking the right questions can help you get safer, more appropriate care. Questions that can be helpful to ask the healthcare facility include the following (and can be tailored based on your personal circumstances and needs):

- Does this facility have bariatric equipment (beds, lifts, chairs)?
- Are staff trained to safely assist patients with my needs?
- Have you cared for patients with similar needs before?

Type: Home Health Care

Description: Services that can be provided within the home for an illness or injury.

? **Covered?** Maybe. **Medicare Part A and/or Part B** cover eligible home health services if certain conditions are met, such as when a person is homebound and requires skilled services. People living with obesity may have home health care covered if it's deemed medically necessary and ordered by an HCP. Non-skilled services such as assisting with everyday care and needs are not covered. **Medicare Advantage plans** cover home health care, but the coverage may be different than under Original Medicare. **Learn more about home health services.**

Obesity Resources and Support

Alliance for Women's Health & Prevention: Through its **EveryBODY Covered** campaign, AWHP advocates for expanded access to comprehensive, evidence-based obesity care.

American Heart Association: Provides information for understanding weight and the intersection between metabolic, heart, and kidney health.

American Medical Women's Association: Provides education about obesity, its comorbidities, and management to public health HCPs.

American Society for Metabolic and Bariatric Surgery: Works to enhance the well-being of individuals affected by obesity and related conditions through advances in metabolic and bariatric surgical techniques and other medical interventions.

HealthyWomen: Offers education on obesity for women across their lifespan.

Medicaid.gov: Provides essential services to support obesity management, particularly for low-income individuals.

Medicare.gov: Offers details on coverage options for obesity screening and treatment.

National Council on Aging: Provides tools and resources, including on obesity care and treatment, so people can age with health and economic well-being.

Obesity Action Coalition: Works to help individuals along their journey toward better health through education, advocacy, awareness, and support.

Obesity Association: A division of the American Diabetes Association that works to reduce the prevalence of obesity and improve health in at-risk and affected communities, including by setting standards for obesity care in clinical practice.

Obesity Care Advocacy Network (OCAN): Aims to increase access to evidence-based obesity treatments by uniting key stakeholders and the broader obesity community around significant education, policy, and legislative efforts.

Prevent Blindness: Offers bilingual obesity-related diabetic eye disease education, support, and resources.

Society for Women's Health Research: Offers resources for patients, families, clinicians, and policymakers on diseases, conditions, and life stages, including obesity, that uniquely, differently, or disproportionately affect women.

State Health Insurance Assistance Programs: Provide free counseling to help navigate Medicare benefits.

Strategies to Overcome and Prevent (STOP) Obesity Alliance: Conducts research, makes policy recommendations, and develops hands-on tools for providers, advocates, consumers, and policymakers.

Medicare 101 Guide: Glossary

Accepts the assignment – When a healthcare provider accepts Medicare and has agreed to the Medicare-approved payment for a service.

Accountable care organization (ACO) – A group of doctors, hospitals, and other healthcare providers who work together with a goal of providing high-quality care for Medicare patients. They have agreements with Medicare to be accountable for the cost and experience of care that Medicare patients receive. If they work well to coordinate and improve care while keeping costs down, they may earn a financial bonus from Medicare. If they underperform, they may pay a penalty.

Balance billing – Occurs when HCPs who don't fully accept Medicare's payment rates charge you the difference between what Medicare has approved for a service and what they charge for the service.

Beneficiary – A person who is enrolled in Medicare and receives Medicare benefits.

Cardiopulmonary resuscitation (CPR) direction (also called do-not-resuscitate order) – A document that directs a medical team not to administer CPR if the heart or breathing stops.

Coinsurance – An amount (often a percentage) that a person must pay for services after a deductible has been reached.

Comorbidity – Medical conditions that occur simultaneously with a primary diagnosis; may include medical and psychiatric disorders.

Copayment (or copay) – A preset, flat fee that a person must pay for each healthcare service, appointment prescription, test, etc.

Cost-sharing – The portion of medical expenses that you pay out of pocket, including deductibles, coinsurance, and copayments, with your insurance provider covering the rest of the cost.

Creditable drug coverage – Prescription drug coverage that is expected to pay, on average, at least as much as Medicare Part D for prescriptions. Individuals with creditable coverage from an employer, union, or another source can delay enrolling in Medicare Part D without facing a late enrollment penalty.

Deductible – A preset amount that a person must pay before their insurance kicks in.

Dual-Eligible Special Needs Plans (D-SNPs) – Plans that enroll people who are entitled to both Medicare and Medicaid.

Do-not-resuscitate order (also called cardiopulmonary resuscitation (CPR) direction) – A document that directs a medical team not to administer CPR if the heart or breathing stops.

Explanation of benefits (EOB) – A summary of your claims and costs sent by your plan. The EOB describes the costs involved for your visits to your healthcare provider or prescriptions you received and how your plan processed the claim for these services. You will receive an EOB every month that you fill a prescription or visit a healthcare provider.

Extra Help (also called Low Income Subsidy) – A program to help people with limited income and resources pay for Medicare Part D costs. Some people may get Extra Help automatically, including those who receive full Medicaid coverage. Others may qualify after applying.

Formulary – A list of generic and brand-name prescription medications covered by a specific health insurance plan.

General Enrollment Period (GEP) — A time period each year (January 1–March 31) when people who didn't sign up for Medicare Part A and/or Medicare Part B when they were first eligible for Medicare can enroll. Coverage begins the month after you sign up. People who don't sign up when they are first eligible may have to pay a late enrollment penalty.

Healthcare power of attorney (also called medical power of attorney/power of attorney for health care) – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

In-network coverage – Healthcare services received from providers who have a contract with your insurance company. These providers have agreed to the plan's set prices, so you typically will only need to pay your deductible and any applicable copay or coinsurance.

Income-Related Monthly Adjustment Amounts (IRMAA) – An additional charge on Medicare Part B and Medicare Part D premiums for people above a certain income. The IRMAA is calculated on a sliding scale and is based on your past two years of tax returns.

Initial Coverage Election Period (ICEP) – The time frame during which individuals who are newly eligible for Medicare can first enroll in a Medicare Advantage (also called Medicare Part C) plan. The ICEP coincides with the Initial Enrollment Period (IEP) for Medicare Parts A and B, which includes the three months prior, the month of, and the three months after a person's birthday.

Initial Enrollment Period (IEP) — The seven-month window around your 65th birthday to sign up for Medicare Part A, Medicare Part B, and Medicare Part D — specifically the three months prior, the month of, and the three months after the person's birthday. This same period is called the initial coverage election period (ICEP) for Medicare Part C.

Inpatient – When a patient is admitted to the hospital and stays one or more nights.

Late Enrollment Penalty – An extra cost someone may have to pay if they sign up for Medicare any time after they were first eligible. Late enrollment penalties are not just one-time fees. They are usually added to your monthly premium and can last as long as you have Medicare.

Lifetime reserve days – An additional 60 days of coverage after you have used your 90 days of inpatient hospital care that are provided each benefit period with Original Medicare. The 60 days can only be used one time, and you pay a coinsurance for each day. Lifetime reserve days do not have to be used for the same time hospital visit. They can be used for different hospital visits throughout your lifetime.

Living will – A legal document that outlines what treatments or types of care are and are not wanted, and in what situation each decision applies.

Low Income Subsidy (also called Extra Help) – A program to help people with limited income and resources pay for Medicare Part D costs. Some people may get Extra Help automatically, including those who receive full Medicaid coverage. Others may qualify after applying.

Medical power of attorney (also called healthcare power of attorney/power of attorney for health care) – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

Medically determinable impairment (MDI) – A physical or mental condition that can be established by medical evidence beyond a person's reported symptoms (e.g., clinical signs, laboratory findings, diagnostic tests) from an acceptable medical source.

Medicare Advantage (also called Medicare Part C) – Health plans offered by private companies that cover the same type of services covered by Medicare Part A and Medicare Part B and are an alternative to Original (traditional) Medicare. Medicare Advantage often includes extra benefits like vision, dental, and hearing.

Medicare Advantage Open Enrollment Period – Period from January 1–March 31 (or within the first 3 months of getting Medicare) for individuals who are already enrolled in a Medicare Advantage Plan to switch to another Medicare Advantage Plan (with or without drug coverage) or drop a Medicare Advantage Plan and return to Original Medicare.

Medicare Part A (Hospital Insurance) – A health plan managed by the federal government that covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B (Medical Insurance) – A health plan managed by the federal government that covers outpatient care, medical supplies, preventive services, and certain doctors' services, such as those related to diagnosis, treatment, and prevention of medical conditions.

Medicare Part C (also called Medicare Advantage) – Health plans offered by private companies that cover the same type of services covered by Medicare Part A and Medicare Part B and are an alternative to Original (traditional) Medicare. Medicare Advantage often includes extra benefits like vision, dental, and hearing.

Medicare Part D – The part of Medicare that helps cover the cost of prescription drugs. Medicare Part D is offered by private insurance companies approved by Medicare and can be added to Original Medicare or included in some Medicare Advantage plans.

Medicare Savings Program – A state-administered Medicaid program that can help people with limited resources cover Medicare Part A and B premiums and potentially with deductibles, coinsurance, and copayments.

Medicare supplement insurance (also called Medigap) – Extra insurance that people can purchase from a private health insurance company to help pay for their share of out-of-pocket costs in Original Medicare.

Medigap (also called medical supplement insurance) – Extra insurance that people can purchase from a private health insurance company to help pay for their share of out-of-pocket costs in Original Medicare.

Out-of-network – Healthcare services received from providers or at facilities that do not have a contract with your health plan. These providers and facilities haven't agreed to the plan's set prices, so you may pay more, or the service might not be covered at all.

Out-of-pocket costs – The portion of healthcare costs a person is responsible for paying, including copayments, coinsurance, and costs for noncovered healthcare services.

Outpatient – When a patient visits a hospital, clinic, or facility for a service, such as a treatment or a procedure, but is not hospitalized overnight.

Open Enrollment Period – The time period each year (October 15–December 7) when people can make changes to Medicare health plans for coverage or prescription drug plans. Changes can include moving from an Original Medicare to a Medicare Advantage plan or vice versa; joining, leaving, or moving to another Medicare drug plan (if in Original Medicare); or joining, leaving, or switching to another Medicare Advantage plan with or without drug coverage (or adding or dropping drug coverage). Coverage begins January 1 of the next calendar year.

Original Medicare (also called Traditional Medicare) – A federally managed healthcare plan that includes Medicare Part A and Medicare Part B.

Patient navigator (also called a patient advocate) – People who help guide patients through the health-care system and may be able to offer a wide variety of services, including setting up healthcare provid-er's appointments, communicating with insurance, and providing social support while individuals navi-gate complex medical conditions and care.

Payer (or payor) – An entity — often a health insurance company — that pays for healthcare services on behalf of an individual.

Pharmaceutical assistance program – Programs run by pharmaceutical companies, specialty pharmacies, state programs and nonprofit organizations that lower the cost of medicine if you don't have insurance or are underinsured and can't pay for your medications.

Power of attorney – A legal document that gives someone the authority to act on another person's behalf for various matters. The scope of a power of attorney document may involve financial, legal, and medical matters.

Power of attorney for health care (also called medical power of attorney/healthcare power of attorney) – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

Premium – The monthly fee that people will pay for their Medicare coverage.

Premium-free Part A – Hospital insurance under Medicare that doesn't require a monthly premium. Most people qualify for premium-free Part A if they or their spouse paid Medicare taxes while working for at least 10 years.

Prior authorization – A process used by some health insurance companies that requires the review and approval of a specific procedure, service, or drug before it is paid for, even if it has been recommended or prescribed by a healthcare provider.

Secondary insurance (also called supplemental insurance) – An additional insurance plan that helps pay for health care costs that are not covered by a person's regular health insurance plan.

Skilled nursing facility three-day rule waiver – An exception allowing someone to get Medicare-covered care in a skilled nursing facility even if they haven't stayed in the hospital for the three days typically required by Medicare.

Special Enrollment Period (SEP) — A time outside of regular enrollment periods when people can sign up for Medicare, typically triggered by life events like losing employer-sponsored insurance coverage or moving to a new address.

State Health Insurance Assistance Program (SHIP) – A national program that provides free, unbiased counseling and assistance to Medicare beneficiaries, their families, and caregivers on topics such as enrollment and plan comparisons. SHIP has offices across the country and, depending on the region of the country, may be referred to by another name.

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Traditional Medicare (also called Original Medicare) – A federally managed healthcare plan that includes Medicare Part A and Medicare Part B.Prior authorization – A process used by some health insurance companies that requires the review and approval of a specific procedure, service, or drug before it is paid for, even if it has been recommended or prescribed by a healthcare provider.

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