Savvy and 65:

A Woman's Guide to Understanding Medicare

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

healthywomen

Society for Women's Health Research

Disclaimer

This guide is intended to be a helpful and informative resource, but it is not a substitute for professional medical, legal, or financial advice. Because Medicare policies can change over time, HealthyWomen and SWHR encourage readers to independently verify information and consult qualified professionals to address their specific needs. HealthyWomen and SWHR disclaim any liability for direct, indirect, or other damages that may result from the use of this guide.

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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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Organizations in the Working Group included the following:

- Alliance for Aging Research
- Alliance for Women’s Health and Prevention
- American Heart Association
- 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
- 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 two areas vital to maintaining strength and longevity in older adulthood — bone health and heart health.

Bone and heart health were chosen as initial focus areas for this guide given their impact on women, and additional areas will be added in the future.

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 Webinars**

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** (Parts A and B) 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

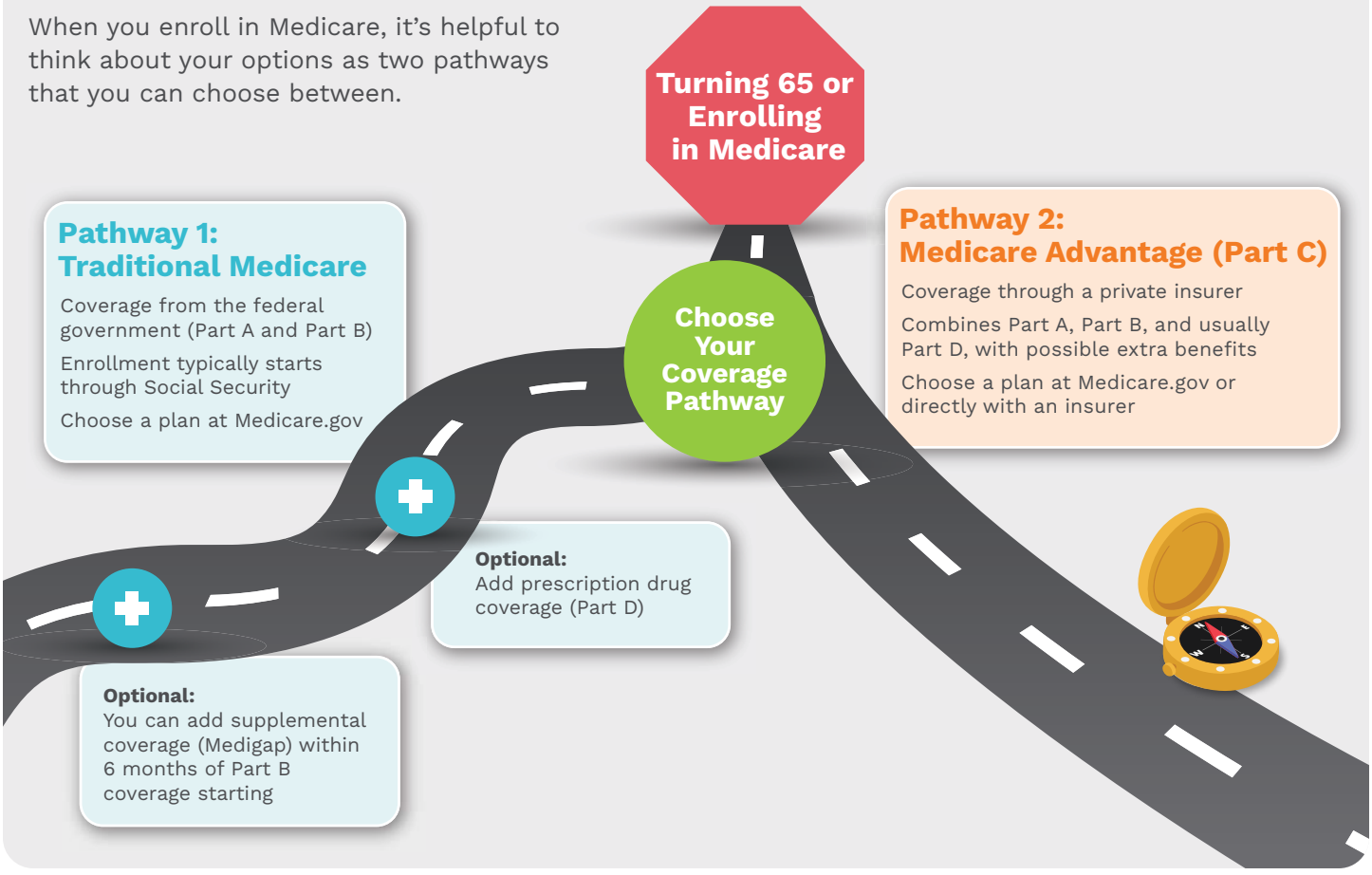
Beyond choosing between Original Medicare or Medicare Advantage, individuals can also choose extra coverage, which could include:

- **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 doctor 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 Part A, the 2025 fee is either $285 or $518 each month, depending on how long a person or their spouse worked and paid Medicaid taxes. • The Part B premium is $185 each month or higher, depending on income.	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** that helps cover out-of-pocket costs with Original Medicare for those who do not qualify for 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, and the best time to enroll is generally when you first enroll in Medicare.

There are 10 different types of Medigap plans named by letters: A-D, F, G, and K-N. Each plan has different benefits. Not every state or company offers every Medigap plan, but the same basic benefits will be offered for plans with the same letter, no matter where you live or which insurance company you buy the policy from. Price is the only difference between plans with the same letter that are sold by different insurance companies. In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. **Compare the benefits offered by each plan.**

However, some states may have their own enrollment rules, and some plans may not be available to everyone. **Learn more from AARP.**

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.
- From October 15–December 7 (Open 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)**. For 2025, the standard monthly premium is $185. The premium can also change every year. **Learn more**.
- **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:

- **2025 Medicare Prescription Drug Annual Open Enrollment**
- **Medicare Part D 2025 Changes Infographic**
- **Medicare Part D Prescription Drug Coverage 2025 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 **MyMedicare.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 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, Sally 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.
- 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**

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.

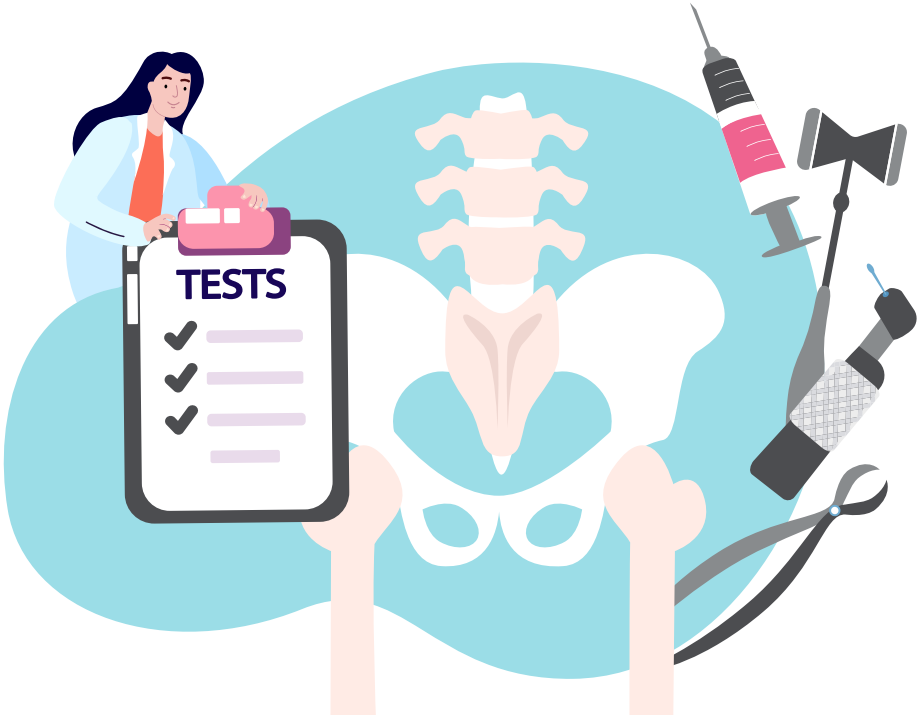
The National Council on Aging has put together a **guide** to help people spot scammers (such as people promising free items or services or applying pressure to switch Medicare plans) and offers tips to avoid being scammed:

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).

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

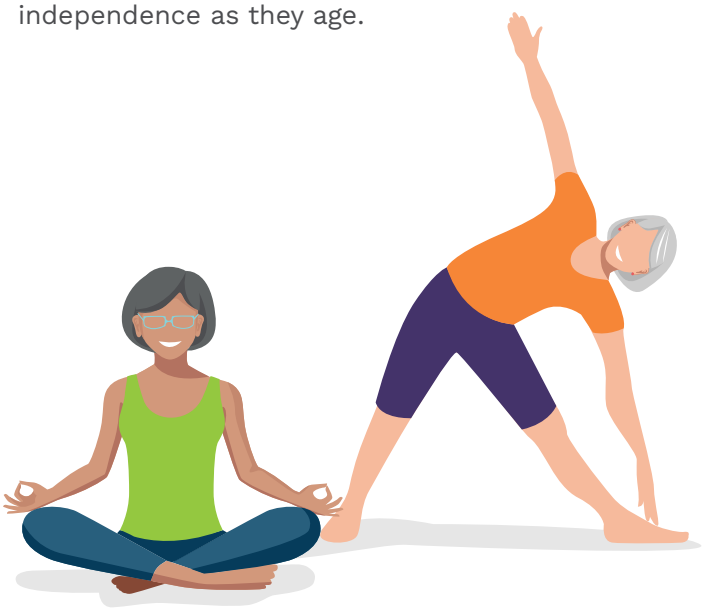
Bone Health at Medicare Age: What to Know

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: Doctor and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any doctor or hospital in the United States that accepts Medicare.	In many cases, you can only visit doctors 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 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.**
    - 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:

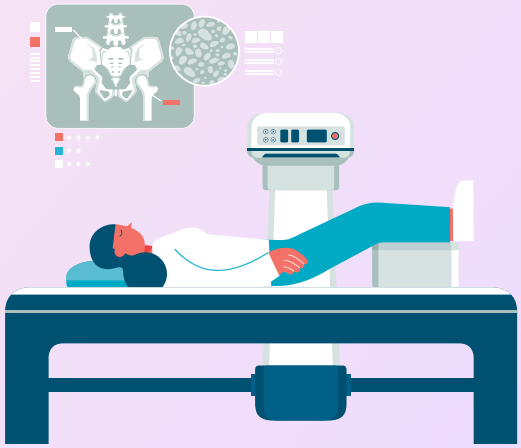
- You're a woman who has been diagnosed as estrogen-deficient by a doctor and is at risk for osteoporosis.
- Your X-rays show possible osteoporosis, osteopenia, or vertebral fractures.
- You're taking prednisone or steroid-type drugs or are planning to begin this treatment.
- You've been diagnosed with 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 suffering a hip fracture. 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 is 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. As of 2025, people pay $0 for days 1–60 (after the Part A deductible has been met) and $419 each day for days 61–90. Information about longer stays 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. As of 2025, people pay $0 for days 1–60 (after the Part A deductible has been met) and $419 each day for days 61–90. Information about coverage for longer stays 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. If the HCP is part of an **Accountable Care Organization (ACO)**, the three-day requirement may be waived, and you may be able to get skilled nursing care without staying in a hospital first. 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 to a Skilled Nursing Facility (SNF):** The patient must enter the SNF in a specific time frame (generally 30 days) of leaving the hospital.
- **Medically Necessary Skilled Care:** An 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 disease – a form of cardiovascular disease specifically related to the heart's structure and function

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

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

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

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

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.

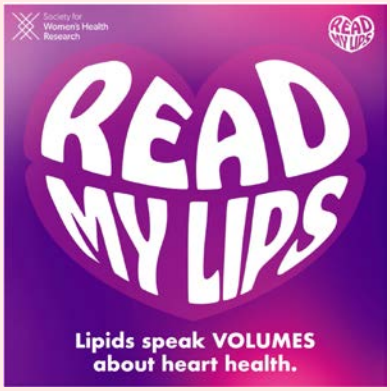
Healthcare Providers

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 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 for those deemed at risk for developing diabetes. **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 is 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. As of 2025, people pay $0 for days 1–60 (after the Part A deductible has been met) and $419 each day for days 61–90. Information about longer stays 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. As of 2025, people pay $0 for days 1–60 (after the Part A deductible has been met) and $419 each day for days 61–90. Information about coverage for longer stays 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

? **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 by-pass 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 to a Skilled Nursing Facility (SNF):** The patient must enter the SNF within a specific time (generally 30 days) of leaving the hospital.
- **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.

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?** Often. 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**

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

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

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.

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.

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

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.

Do-not-resuscitate (DNR) 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.

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.

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.

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 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.

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 healthcare system and may be able to offer a wide variety of services, including setting up healthcare provider's appointments, communicating with insurance, and providing social support while individuals navigate 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.

Power of attorney (POA) – 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.

Secondary insurance – An additional insurance plan that helps pay for healthcare costs that are not covered by a person's regular health insurance plan.

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

healthywomen

Society for Women's Health Research