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

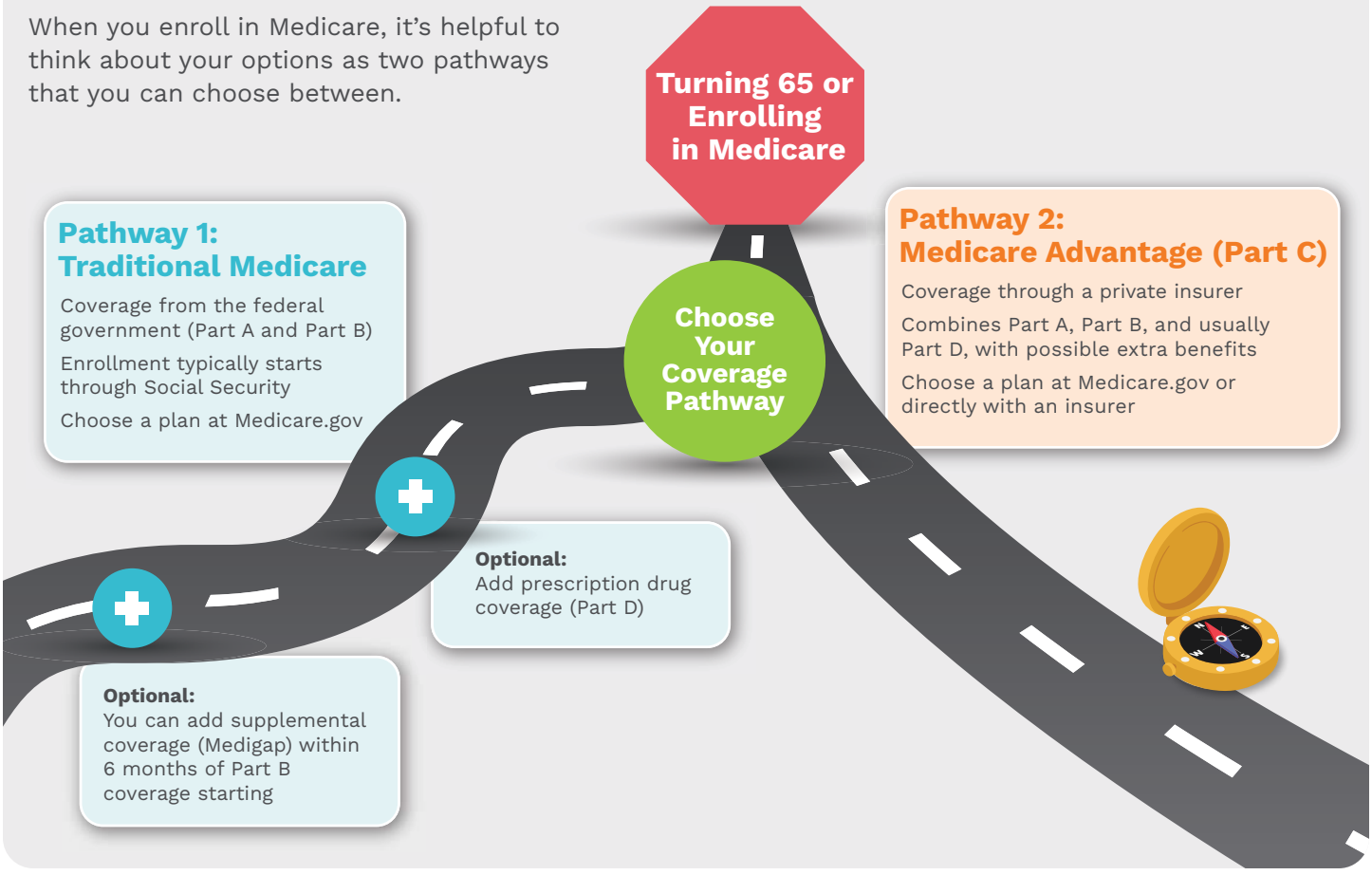
Beyond choosing between Original Medicare or Medicare Advantage, individuals can also choose extra coverage, which could include:

- **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).