MEDICARE MADE EASY

4 things you must know before you turn 65

Plus 2 Special Bonus Chapters:
Questions you SHOULD Ask Your Agent, but Probably Won't
and
Plan F - The Big Medicare Supplement Rip-Off

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Introduction

Chapter 1

This is part one of my four-part series on Medicare and the basics of what you need to know when you first enter the Medicare world. In part one, we will cover what is referred to as Original Medicare. In later parts, we will discuss Medicare supplements, Medicare Advantage plans and Medicare Part D (prescription drug plans).

With the current state of uncertainty in individual health plans due to the ever-changing effects of the Affordable Care Act (ACA) and group health plans becoming increasingly expensive, the thought of aging into Medicare is becoming very attractive.

If you worked and paid into the Medicare system for at least 40 quarters, you will be eligible for Medicare when you turn 65. Some people work their whole lives and never pay into the system. The most common are teachers and school district employees, policemen, firefighters, and some other government workers. Others may be just short of 40 quarters, or never worked a paying job, such as stay-at-home moms. If you didn't earn enough credits, you may still be able to get Medicare benefits. If you are only short a few quarters, you may be able to pay an extra premium for Medicare, or you may be able to get Medicare through your spouse's benefits (or even a deceased or exe spouse). In these cases, you will need to consult with the Social Security office in your area to find exactly what your options are.

For everyone else, you will qualify for Medicare parts A and B when you turn 65. There four modes for enrolling in Medicare.

If you are already claiming your Social Security benefits, that is, you are getting your Social Security check, you will be AUTOMATICALLY enrolled in Medicare. You will not need to take any action. You will receive your Medicare ID card in the mail a few weeks before your birthday. If you are not claiming Social Security benefits, you will need to enroll yourself. You

can pay a visit to your local Social Security office. Hint: call ahead and make an appointment.

Or, you can call the Social Security main switchboard (1-800-772-1213).

Or, you can go online to the Social Security website www.ssa.gov and follow the links for Benefits>Enroll in Medicare. Hint: A good independent agent can help you with this process.

Medicare is made up of four parts. Parts A, B, C, and D. Parts A and B are called “Original" Medicare. Part C, or Medicare Advantage, is a combination of A, B, and sometimes D. Healthcare providers sometimes refer to Part C as Medicare Replacement. Part D is the Medicare Prescription Drug program.

Medicare Part A is what you have been paying for all your working life. For most people there is not further cost for part A after you have stopped working. Part A is your hospital insurance. It pays a portion your hospitalization - hospital room and board and hospital services.

Part B is your medical insurance. It pays a portion of your doctor bills as well as a portion of your out-patient services. You have not yet paid for Part B and you will now be billed a premium. $144.60 per month for most people. If you are already claiming Social Security benefits, your Part B premiums will be deducted from your monthly payment. If not, you will be sent a bill in the mail. Once you receive the first bill, you can then call Social Security and have the bill set up on a monthly auto-draft from your bank account.

If you are not insured by a group health plan, you will need to take both part A and B. If you are still insured by your employer or retirement group plan, you will need to have some questions answered.

1. When I turn 65 and go on Medicare, will I be able to keep my insurance? If the answer to this is no, then you will need to keep Parts A and B and then get a good supplemental plan. If the answer is yes, then you will have two more questions:

2. Will my group plan be the primary or secondary payor to Medicare? If your plan is secondary to Medicare then you will need to keep both Medicare parts A and B. Medicare will pay their share of any medical bills first, then your group plan will pay all or some of your share of the bill. If your group plan the primary payor, then you MAY NOT be required to keep - and pay for - Medicare part B. This is not a given. It depends on the group health law in your state and how your company has set up their plan with the insurance company. Usually, group of 50 or more people have the OPTION of requiring Part B. This is important because if you are not required to have part B, then there is no need to pay the premium for it.
3. How much is it going to cost me? Again, depending on how your company has their health plan set up your premium can change. It can go up or down.

Once you get the answers to all these questions you will want to seek the advice of a reputable independent insurance agent who specializes in senior supplemental health insurance. Take all of the documentation from your group plan including an outline of coverage and premium rates, and ask for a side-by-side comparison of several private supplemental plans. Then, you can make an informed decision on whether or not to keep your group plan or get the private insurance. If you decide to keep your group health plan, you may always get a private plan at a later date without penalty as long as your plan is considered creditable coverage under the Medicare guidelines (most major medical plan are creditable coverage).

When you enroll in Medicare you will have two options for how you obtain your coverage, Original Medicare or Part C - Medicare Advantage. Part D is available on both sides depending on what type of plan you get. These are two separate routes. You must pick one or the other, you can't have both.

First, it will be helpful to know what original Medicare covers, and more importantly, what it doesn't cover. If you have Medicare Parts A and B and no other supplemental insurance plan, Medicare will cover the majority of your medical bills. However, medical expense being as high as

they are, your share of the bills after Medicare pays will still be significant - unaffordable for many families. Remember, Part covers hospital room and board and normal hospital services. So if you are admitted to the hospital for 1 to 60 days, you will be responsible for the first $1,408. This is the Part A deductible. Be very careful here, this is not an annual deductible. This is per eligibility period. Once you have left the hospital and stay out for 60 consecutive days, the part A deductible will reset and if you go back to the hospital you will owe that $1,408 again.

If you are in the hospital for more than 60 days you then fall into the Part A co-pay days and will owe $352 per day co-pay for days 61 to 90. At day 90 your Medicare benefits technically end, but you will now have what is called your 60 lifetime reserve days. They are called lifetime reserve days because you only get them once in your lifetime and once you use them you don't get them back. When you are in your lifetime reserve days, for day 91-150 you will owe $704 per day co-pay for each day that you are in the hospital. And when you hit day 151, you are out of Medicare days and you will owe the entire bill. Medicare doesn't pay another penny. That is until, you LEAVE the hospital and stay out of the hospital for 60 consecutive days, and a NEW eligibility period begins. Only now, you will have use up your 60 lifetime reserve days do when you get to day 91 you will owe the entire bill. There are some other items that are covered by part A that we won't get into in detail here like skilled nursing and hospice.

That's just the hospital bill! But what do we all know about these events? We get home and receive the hospital bill in the mail and what follows shortly after? The doctor bills! You are going to get a bill from your surgeon, your anesthesiologist, your radiologist, the lab, pretty much anybody that walked by your door while you were in the hospital is going to send you a bill. These bills are covered under Medicare Part B.

Part B is a little bit more cut and dry. Remember, you did not pay for part B with your payroll taxes, so when you enroll you will pay a monthly premium. The premium is based on your income, but most people will pay $144.60 per month. After you have paid the premium, there is a $198 annual deductible. Once you have met the annual deductible, it is an 80%/20% split. Medicare pays 80% and you owe the remaining 20% with

no maximum. Part B also covers out-patient office visits, urgent care centers, emergency rooms, out-patient labs surgeries, infusion type treatments in a clinical facility such as cancer treatments, and various other services. All on the 80/20 split. Then, we have what is called the Part B Excess Charge. This is a 15% additional charge that providers who do not accept Medicare assignment are allowed to bill you in addition to the 20% you already paid. What that means is that you may be on the hook for between 20 and 35 percent of your total doctor and out-patient bills. Now, most people would agree that with original Medicare alone and no supplemental insurance, you will have a dangerous out of pocket risk. The part A charges alone for a 150 day hospital stay will be close to $50,000.

Chapter 2

In chapter one, we learned about Original Medicare - what it pays, and more importantly, what it doesn't pay. In part two we will discuss Medigap plans - AKA Medicare Supplements. As of this writing, there are 11 Medicare supplements available. Plans A, B, C, D, F, High Deductible Plan F, G, K, L, M, and N. They are labeled in the order in which they were introduced. So, plan A is the oldest and N is the newest. The most important thing you need to remember is that these plans are standardized. That means that we are comparing apples to apples from company to company. A plan F from company 1 is identical in benefits to a plan F from company 2 and a plan G from company 3 is identical in benefits to a plan G from company 4. The difference will be in the price you pay for it in the form of premiums and the strength, service, and track record of the company.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2020**			
							$5,880	$2,940		

The older plans (A-D) are rarely bought these days and offer less benefits than the newer plans. And, because they are older, they will have more claims experience than the newer plans. In other words, they have older,

sicker people in them that cost the companies more money. To remain profitable, the companies have to charge higher premiums for these older plans than for newer plans that may have better benefits but less claims experience.

A Medicare supplement's only job is to pay your share or a portion of your share of the Medicare bill. Medicare always pays first and Medicare sets the prices for services. This means that there are no doctor networks. You can go to any doctor or hospital that accepts original Medicare. There is no requirement for the provider to be contracted with the supplement company. In fact, in most cases, the provider does not even bill the supplement company, they bill Medicare and Medicare bills the supplement. This is called the crossover. This is why providers much prefer original Medicare over Part C. They don't have to deal with the insurance companies. You also will not need referrals to see specialists. And because there are no networks, there are no geographical boundaries. Your plan will work exactly the same anywhere in the US. Some supplements even provide some foreign travel coverage.

Another thing you will **not** have with Medicare supplements is what is known as Managed Care. What that means to you is that, for the most part, what the doctor orders is what you get, with few exceptions. Medicare approves just about anything that is deemed medically necessary. There is no need to get a pre-approval or preauthorization from the insurance company. If Medicare pays, the supplement is obligated by law to pay your share.

One big caution here is for what are called preventative screening procedures. Preventative screening procedures and tests are things the doctor orders when there nothing wrong with you, or they don't know what is wrong with you and are just guessing. Most diagnostic procedures fall under the preventative testing category. A good example is a colonoscopy. The current medical guidelines say that if you are over a certain age and have no risk factors, you only need a colonoscopy about every ten years. Well, that is about how often Medicare likes to pay for colonoscopies. Some people have risk factors and so their doctor may order a colonoscopy every three or five years. Without the proper supporting justification, Medicare may decline to pay for these earlier

screenings. You will want to make sure your doctor's office is doing a good job on the front end to prevent any delays in having a claim paid. In the rare event Medicare declines to pay for a service, it is usually resolved by having the doctor's office resubmit the claim with more documentation supporting medical necessity.

So, which plan should you buy? That depends on how much risk you want to take. Remember, all insurance is, is a way to transfer risk from yourself to somebody else. In this case, the risk you have is with all of the Medicare deductibles and copays and coinsurance. The more risk you transfer, the more premium you pay.

Plan F is the most comprehensive. It pays 100% of your share of the Medicare bill. So, with a plan F you have essentially no risk. Therefore, the plan F is the most expensive of the newer plans (for this discussion, we will not consider plans A-D). But being the most comprehensive does not necessarily make it the best value. You see, premiums are called premiums for a reason. The insurance company is taking all of the risk and they are going to charge you a pretty penny for that.

Plan F is the most popular, but only because it is the easiest for lazy insurance agents to sell. "Buy this plan F from me and you'll never pay a penny in out of pocket expense". That may be true, but what they don't tell you is that if you are willing to share in the risk, even just a little bit, you can usually save more on premiums than the actual dollar amount of the risk you are taking.

Plan F (and Plan C) as of January 1, 2020 are only available to people who were already on Medicare prior to January 1, 2020. Anybody new to Medicare after 1-1-2020 can not get a plan F (or Plan C).

Look at it this way - If you bought a plan F and the premiums are $1700 per year. That is your total health care cost for the year (excluding Rx). But if you bought a plan G for $1100 a year your only other cost would be the $198 Part B deductible. After you have paid the deductible, the plan G works just like a plan F. So, $1100 + $198 is $1298. A savings of $402 per year over the plan F. This is why I think plan F is such a ripoff. Plan N and plan K are the only others I would consider based on a person’s high

risk tolerance. But for now, plan G seems to be the best value for your money.

There is no open enrollment season for Medicare Supplements. You can change plans any time you wish – the one catch to that being that if you are over 65 ½ and not coming off of a retirement or employer health plan you will be subject to medical underwriting. You will have to answer a series of health questions, and, based on your answers to those questions, you may be declined.

You need to make a very well-informed decision now, when you have the chance, to select the best plan and company, because this may be the plan you have for the rest of your life. Though the benefits are the same, some companies' rates and track records are better than others. That's where I come in. I keep track of all the companies' rates and rate increases, as well as their time in the business and reputations. I can help you select the best plan from the best company that will be the best for you for the longest time.

There is certainly more to learn about Medicare Supplements. I good, local independent insurance broker will be able to explain, in easy-to-understand terms, which plan is best for your situation. In our next chapter, we will discuss Medicare Part C also known as Medicare Advantage. This is where it starts to get complicated.

Chapter 3

In the first two chpters on Medicare, we learned how original Medicare along with a Medigap plan (AKA Medicare Supplement) can help to reduce or even eliminate your out-of-pocket risk. In part three, we will discuss the Medicare Prescription Drug Program known as Part D.

Medicare Part D – the Medicare prescription drug plan was introduced on January 1, 2006. It is a government plan administered by private insurance companies that have a contract with Medicare to provide the service. Part D is optional, you don't have to sign up. But, if you don't sign up AND you don't have prescription coverage from another source such as a retirement or employer plan, you will pay a penalty if and when you do sign up for Part D. The later you are, the bigger the penalty is, and you pay the penalty for the rest of your life. You can enroll when you are turning 65, then you can change plans every year during the annual enrollment period that runs from October 15th to December 7th. Once the December 7th deadline expires, you are stuck with your plan for the next calendar year. There are other special enrollment periods that come up from time to time, but most folks are going to be limited to their initial and annual enrollment periods.

There are two ways to get the coverage; either a stand-alone prescription drug plan (PDP) for people with original Medicare or combined with their Medicare Advantage plan (MA-PD). For most people, you must have Parts A and B or Part C – also known as Medicare Advantage. If your Part C plan does not include drug coverage then you MAY be allowed to get a PDP (but you may not).

All Medicare prescription plans are cost-sharing plans. That means that YOU share the costs with Medicare and the insurance companies. If you have a PDP you will pay a monthly premium, an annual deductible ($0-$435 in 2020), and once the deductible is met, you will have either a copay which is a set flat fee, or a coinsurance which is a percentage of the total cost for each drug at the pharmacy.

Medicare Prescription Drug Plan

Member: Jane Doe
ID# 3452786

BIN#: rn6538
RX#: 358

Effective Date: 01/01/2013

Deductible	**0-325**
Tier 1 – Generic	$6
Tier 2 – Preferred Brand	$42
Tier 3 – Non Preferred Brand	$91
Tier 4 – Specialty	33%

This is an example only!

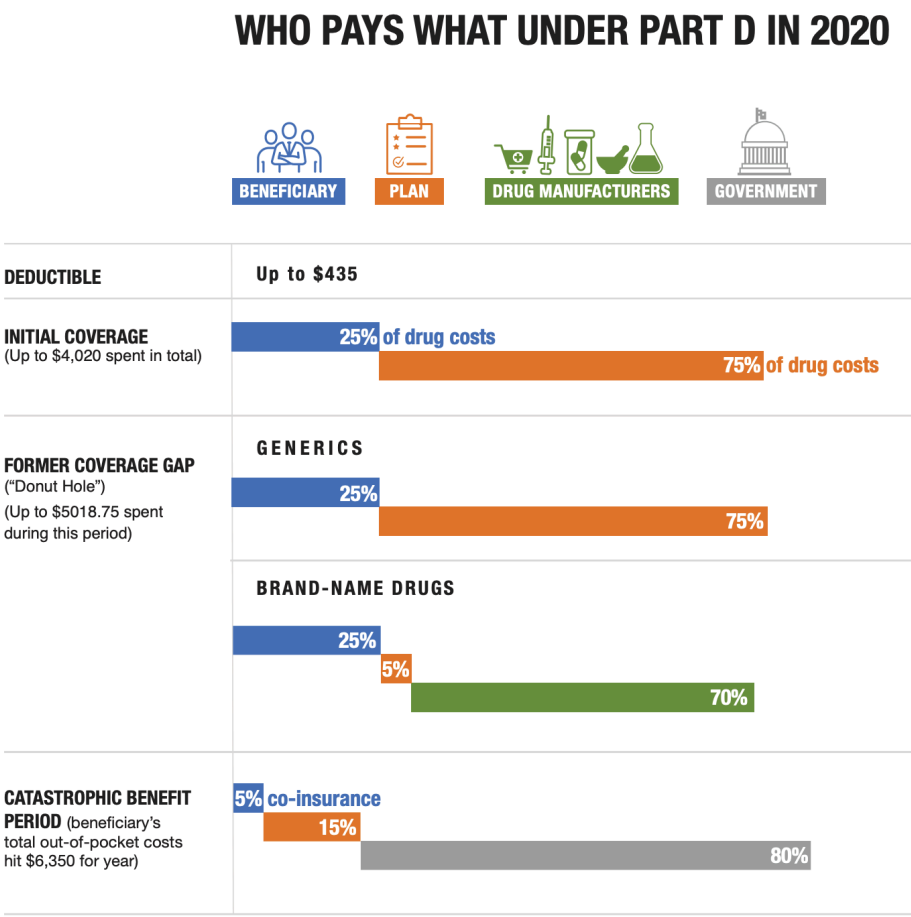
Co-Pays Vary
Premiums Vary
Deductibles Vary
Formularies Vary

This is one area where the Medicare website can be very useful. That website can tell you exactly which PDP will be the best for you each year based on your current prescriptions. If you enter your current prescriptions, it will tell you what your total out of pocket costs will be for the entire year for each plan that is available in your area. That includes the premiums you pay, the deductibles, and the copay/coinsurance at the pharmacies. It will even tell you which pharmacies are the best priced for your prescriptions and plan.

It is very important that you check with the Medicare website (or your favorite independent insurance agent) every year during the annual enrollment period to see if your plan is going to be the best plan for you in the upcoming year. Both PDPs and MA-PDs are one year

contracts. That means that they are subject to change every year. Any or all aspects can change. The plan that you have may work just fine this year, but one small change in the plan formulary or copay structure can costs you major dollars out of pocket if you fail to re-evaluate.

Part D has built into it a gap in the coverage, not-so-affectionately known as the Doughnut Hole. There are four distinct phases of coverage during each year. Listed in order they are: Deductible, Initial, Gap, and Catastrophic. During the deductible phase, you are the only one paying full price for your drugs until you have satisfied your deductible ($0-$435 in 2020) if you have a $0 deductible plan then you skip this phase and move straight to the initial phase. In the initial phase, you share the cost of your drugs with the insurance company. You pay the copay/coinsurance and the company pays the rest. Then when your total drug costs including what both what you and in the company have paid reach $3310 in 2016 you will enter the gap phase. In other words you have just fallen into the Doughnut Hole. Once again, you are the only one paying. There are some discounts that help, but no money. Now, when your total costs from the first of the year reach $7062.50 you come out of the doughnut hole and enter the catastrophic phase. Now, Medicare will pay 95% of the bill and you pay the remaining 5%. Until January 1st when it starts all over again.



Based on your prescriptions you may never reach the gap, or you may get in and out of the gap very early in the year. The unlucky ones are the people who reach the gap mid-year and never get out before January 1st.

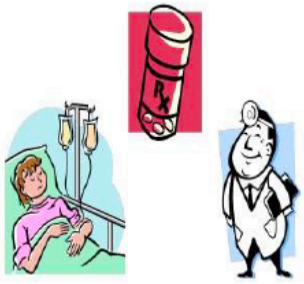
Again, finding an experienced independent agent to help you with this process each year will make a world of difference as well take the stress out of the process. Next time we will wrap up our series with a discussion of Medicare Advantage Plans.

Chapter 4

In the first three chapters, we learned about Original Medicare, Medicare Supplements, and the Medicare Prescription Drug Program. In the fourth and final chapter, we will attempt to demystify Medicare Part C, also known as Medicare Advantage.

Medicare Advantage, or Medicare Part C plans replace your original Medicare A and B with an “all-in-one” plan administered by a private insurance company that you choose. You will continue to pay your Medicare Part B premium, but Medicare will now send that money to the Part C Plan that you have elected. The insurer will then combine your hospital and medical coverage and sometimes your drug coverage into one plan. I want to make one point very clear here, you do not lose Medicare. You are still in the system, but you have now been contracted out to this private insurance company. Medicare says, “Here’s the money, you take care of them”. These plans take many forms, but most are PPOs and HMOs.

Part C plans are not standardized like Medigap plans. Every plan from every company can be different. The “Advantage” is that in addition to the Part B premium that you will continue to pay, you may pay no additional monthly premium for your plan. Most of the HMOs are still zero premium, but the PPOs usually do come with a separate monthly cost. Some of the PPOs cost as much or even more than a Medicare Supplement.



Medicare Advantage Plans
Medicare Part C

	Medicare Advantage Plan 1	Medicare Advantage Plan 2	Medicare Advantage Plan 3	Medicare Advantage Plan 4	Medicare Advantage Plan 5
Monthly Premium (in addition to Part B)	0.00	0.00	54.00	19.00	39.00
Primary Care Physician (Office Visit)	0	5	15	15	20
Specialist (Office Visit)	20	30	30	30	40
Hospital Inpatient – Cost Per Day	100	150	200	175	190
# of Days	1-5	1-5	1-14	1-10	1-20
Outpatient Surgery	100	150	20%	175	100
MRI, Cat Scans	20%	20%	20%	20%	50
Tests, X-Rays	20%	15	10	15	20%
Emergency Room	65	65	65	65	65
May I see any doctor I chcose?	NO	NO	YES	NO	NO
Do I need a referral to see a specialist?	NO	YES	YES	NO	YES
Includes Part D Prescription Drug Plan	YES	YES	NO	YES	YES
Plan includes routine visit coverage	YES	YES	NO	NO	NO
Plan includes Fitness Club Membership	YES	YES	NO	NO	NO

Please notice the plans, co-pays and premiums vary from company to company!

*This chart is for illustration purposes only and does not reflect the benefits of any one plan or company.

Where you WILL pay is when you use the insurance. Now, you have cost sharing in the form of co-pays, co-insurance, and deductibles. The cost sharing is limited. Most plans will limit your maximum out of pocket (MOOP) to somewhere between $3000 to about $7000 per year depending on the plan. You will have to pay a co-pay for office visits. A co-pay is a set fee for routine items. You may pay a co-pay or co-insurance for in and out patient care. Co-insurance is a percentage of the total bill. Most co-insurance is about 20%. The means that if your total outpatient bill is $1000, you will be responsible for paying $200 out of pocket.

Remember, Medicare is out of the picture, so now the insurance companies get to set the rates that they pay the doctors. Now, we have to deal with doctor networks. Now, you must go to their doctors. If you have an HMO that is very strict. You can only go to their doctors. If you have a PPO, they are more open. PPOs will allow you to go to out-of-network providers, you just pay the out-of-network cost, which is usually much more. The fact is that a lot of providers are just not willing to accept Medicare Advantage. So, your choices are limited. And, because there is a network, you will also likely have a service area where you must live and obtain your health care services. If you move or travel outside of that service area, your insurance may not work.

Part C plans also come with what is called managed care. In fact, they are often referred to as "managed care plans" by providers. Managed care means to you is that it is the insurance company that manages your care, not you and your doctors. You must get a referral to see a specialist, and for anything that is not a life and death emergency or a regular office visit, you must get permission from the insurance company first. They can, and do say no. It is this feature that turns most people off of Part C. Most people want to be in charge of their own health care. They don't want to be told by a team of accountants at an insurance company what treatments they can and cannot have.

Further, Medicare Advantage plans are one year contracts. They have a one-year contract with Medicare, the doctors, and you. If any one of those three things changes, you will find yourself shopping for a new insurance plan or a new doctor. Most people will find themselves in this position every year or two.

By now you probably think it's a jungle out there, and it can be if you try to go it alone. Let us be your pathfinders. We've seen the land mines and know where the pitfalls are. Remember, we don't sell products – we educate you and guide you to making a well-informed, wise decision. We work for you, not the insurance companies.

You may very aware of the Medicare Annual Enrollment Period (AEP). This is the time of year from October 15th to December 7th when you can

make changes to Medicare Advantage plans and Medicare Prescription Drug plans.

You may recall from my past chapters that there are two sides to Medicare, Original Medicare and Medicare Advantage (Part C). On the Part C side, you tell Medicare that you want one of their contracted plans to combine and administer your health care and Prescription coverage. So, for that year you are locked into that Part C plan. Except under certain special circumstances, you will not be able to make changes to your coverage until the next AEP. During the AEP, you are only allowed to move from a Part C plan to another Part C plan, or from Original Medicare to Part C.

If you wish to leave Part C and return to the Original Medicare side, unless you qualify for one of a few Special Enrollment Periods (SEP), you must wait for the annual Medicare Advantage Open Enrollment Period (OEP). That period begins January 1st and ends March 31st. The Part C Open Enrollment Period allows you to get out of Medicare Advantage and go back to Original Medicare, or make a one-time change from one MAPD to another MAPD. The catch here is that you may not qualify (based on your health) for a Medicare Supplement (Medigap) Plan.

Under Original Medicare, once you turn 65 and six months, if you want to purchase a Medigap plan, you must answer several health questions (unless you have a qualifying GI basis). Based on your answers to those questions, you can be declined by the Medigap company. In that case, you would be left with Medicare alone and no supplemental coverage. This is a recipe for disaster and you would be better off staying with Part C.

There several special circumstances that may qualify you for Guaranteed Issue of a Medigap plan with no health questions asked. One of those situations is that during your first year of being in a Part C plan you can change your mind and go back to Original Medicare. Another common guaranteed issue situation is when your Medicare Advantage plan cancels your coverage or moves out of your area.

Whatever your circumstance, you should consult a reputable, local, independent broker who is experienced in not only health care, but holistic retirement planning. He or she will be able to guide you to making a well-informed, wise decision. Making the wrong choice may be irreversible and can cost you thousands of dollars in out of pocket costs.

With approximately 10,000 people turning 65 every day in the United States, there is a lot of interest in Medicare. One of the first questions people ask themselves is “Do I need an insurance agent for Medicare?” Medicare does take time to learn, especially for those that do not work with insurance every day. It is easy to miss important information and to make the wrong choices that can cost you thousands of dollars down the road. The right insurance professional can help save you time, reduce confusion and can save you thousands in medical expenses.

Chapter 5

FAQ's

How does your agent get paid?

It's important to understand how much commissions are involved in Medicare and who pays those commissions. **You don't pay the agents' commissions.** The agent is paid by the insurance company. A good agent will be willing to disclose the commission rates so that you, the consumer, can see if there is any bias based on potential income. In most states, the first year you purchase a Medicare Advantage Plan, the agent is paid $510. If you renew, the agent is paid $255. For Medigap plans the insurance company will set the rate within the State guidelines. In general, the insurance company will pay between 18% and 22% of the first year annual premium. For Medicare Supplement Plans, the agent is making between $180 and $330 during the first year of your plan.

What is the difference between an Agent and a Broker?

There are two different types of insurance professionals; the captive agent and the independent broker. The captive agent works for the insurance company and they can only show you, quote you and offer you the products allowed by the insurance company. An independent broker does not work for any insurance company. They may work for an insurance agency or for themselves, but their goal is to represent you and your best interest.

How do I find the right insurance professional?

Not all insurance brokers are the same and it is in your best interest to find one that has the knowledge, wisdom and experience to be you advocate. It's important to sift out the below average and average insurance professional and find the ones that can add the most value and meet your needs. Also, when prices change as you age, the company that is best priced for you at age 65 is not always the best price for you when

you are 70. A good independent broker will review your plan and the competition to make certain you never overpay for your coverage. Lastly, follow your gut. If you have an uneasy feeling about a person, don't work with them.

Questions to ask:

Is your agent…

- **Licensed in your state?** Always ask them to email you their license number and check on your state Department of Insurance website.

- **A full-time agent?** The majority of people working as insurance agents and brokers do so part-time. You want to find an insurance professional who is available every business day morning until evening. A good insurance professional will be able to pull quotes for you and will be easy to get in contact with.

- **Appointed with multiple insurance carriers?** A number over 10 is a good standard. Some with years of experience are appointed with much more. This information can usually be found on the state department of insurance website.

- **Online?** Having no website is a major red flag. It is also a good idea to check for a Facebook page. There should be articles published by the agent and that are full of helpful information. The person that can write about a subject has a deeper understanding of the subject than those who don't

- **Adding their point of view?** Expect them to add value by sharing why one plan may be better than the other. That's how they add value. As long as you know the broker will be paid, you will be able to make the right decision for yourself.

- **Being transparent?** Your broker should be completely open about the commissions paid by each company, they should show you all the prices and plans available if asked. Keep in mind, if a

broker does not show you all the plans and prices up front that is not necessarily a bad thing. An experienced broker will know what plans offer the best value in each state. They may show those plans first and will then explain why the other plans are not good values later.

- **Established?** Find out how long the agent has been in business. Insurance is a tough business, and most new agents will not last more than a year or two. This means they will likely not be there for you when it comes time to review your plan or when you need them. An established agent will have an office, employees and will be there for you for the long haul.

Bonus Chapter: Plan F is a Rip-Off

A lot of people new to Medicare will come to see me already having done some homework. They have a pretty good idea of how Medicare works and understand the difference in Original Medicare and Medicare Advantage. They might have even decided on which Medicare supplement they want. That supplement is almost always the Plan F. They have made this choice based on one fact – the plan F pays it all. For Medicare approved visits and procedures, Plan F will pay 100% of your share of the bill. And that is where the homework stopped. They didn't investigate the other plans such as the Plan G.

The Plan G pays everything except for the Medicare Part B deductible, which as of the date of this writing, is $198 annually. The ONLY difference between a Plan F and a Plan G is a $198 annual deductible.

Let's look at an example:

John goes for a checkup and blood work with his cardiologist on January 1st. The doctor bills $200 for the visit and EKG, and the lab bills $175 for the bloodwork. The total bill is $375. John has a Plan F supplement, so he pays nothing out of pocket for the visit but his monthly premium for the plan is $145 or $1740.00 per year. The plan F pays the first $198 – the deductible, leaving $177. Then Medicare pays their 80% share – $141.60. Finally, John's Plan F pays John's 20% share - $35.40. Has no other office or hospital visits for the rest of the year, and he is a happy camper.

Total Bill	$375
Part B Deductible	$198 Paid by Supplement
Part B 80%	$141.60 Paid by Medicare
Part B 20%	$35.40 Paid by Supplement

Total Paid	$375
Total out of pocket	$0.00 Paid by John
Plan F premium	$1740.00

Total annual expenses for John $1740.00 He is only out his premium.

Now let's look at another example: Laura goes for her well-woman checkup in January. Her total bill is $375. Laura has a Medicare supplement plan G and she pays $98 per month premium. Since the plan G does not pay the Part B deductible, that will come out of Laura's pocket - $198. Next, Medicare pays their 80% share – $141.60. Then, Laura's Plan G pays her 20% share of $35.40. She has one more office visit in June and is billed $75 for that visit. Medicare pays 80% - $60 and Plan G pays 20% - $15.

Total Bill	$450
Part B Deductible	$198 Paid by Laura
Part B 80%	$201.60 Paid by Medicare
Part B 20%	$50.40 Paid by Supplement
Total Paid	$450
Total out of pocket	$198.00 Paid by Laura
Plan G premium	$1176.00 Paid by Laura

Total Laura paid during the year including premium and deductible - $1374.00. That means that just because Laura chose to pay the deductible herself rather than paying an insurance company to do it, she saved $366 over what John paid.

Plan F almost always costs you more than the deductible. And, because it costs more, agents get paid more to sell it. Any agent that

recommends a plan F over a Plan G either is not allowed to sell the Plan G because they are a captive agent, or they simply do not have your best interest at heart.

Laura sought the advice of a good, independent broker, John did not.

About the Author

Ronald Ray is a Texas state licensed insurance agent and financial advisor who specializes in solving the problems of today's Baby Boomer generation. Through the avenues of Health, Life, and Long Term Care insurance, as well as retirement income planning and investments, Ronald has been able to help his clients enjoy their retirement years free from the worries that many seniors face.

A life-long servant to others, Ronald has been a police officer for 19 years and holds a Master Peace Officer certificate from the State of Texas. He left law enforcement as a fulltime career in 2009 only to continue helping others in the field of insurance.

Ron lives in New Braunfels with his wife Summer, and their son Gunnar (6) and daughter Gemma (3). They attend Oakwood Baptist Church and are actively involved in their community through various civic and service organizations.

Ronald provides his clients with a personalized ***comprehensive asset protection service***. He brings to the table not only his own experience, but the many decades of experience of his associates. Ronald has assembled a ***team of experts*** in the fields of insurance, tax planning and preparation, estate planning and elder law issues, and retirement and financial planning.

He has dedicated his service to the families he helps by acting as ***an advocate.*** He regularly locates doctors, addresses medical billing issues, can help with funeral arrangements, etc.