Are You Turning 65?

Understanding Medicare

Information Provided by Senior Network Advisors

SENIOR NETWORK ADVISORS
Senior Housing, Simplified

A plain-language guide and workbook for seniors, families, and caregivers. Educational guide only. Not legal, financial, tax, medical, or insurance advice.

Important Note

This book is for education only. It is not legal, financial, tax, medical, or insurance advice. Medicare rules, plan availability, premiums, deductibles, prescription drug costs, provider networks, and state-specific protections can change. Before enrolling in or changing Medicare coverage, always verify your options directly with Medicare, Social Security, your insurance carrier, your doctors, your pharmacy, your state insurance department, a SHIP counselor, or a licensed Medicare professional.

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Introduction

Turning 65 is a major milestone. For some people, it represents retirement, more freedom, and a new stage of life. For others, it brings a long list of questions, paperwork, mailers, phone calls, television commercials, and decisions that can feel overwhelming.

One of the biggest decisions people face at 65 is Medicare. Most people have heard of Medicare, but many do not realize how many choices come with it. Medicare is not just one card or one simple plan. There is Original Medicare. There are Medicare Advantage plans. There are Medigap plans, also called Medicare Supplement plans. There is Part D prescription drug coverage. There are enrollment windows, penalties, provider networks, drug formularies, deductibles, copays, premiums, and rules that may be different depending on where you live.

This book was created to make Medicare easier to understand. It is written for seniors, families, and caregivers who want a simple explanation of what happens when someone turns 65 and what choices need to be made.

The goal is not to tell you which plan to choose. The goal is to help you understand the difference between the main options so you can ask better questions and avoid common mistakes.

The most important thing to know is this: there is no single Medicare option that is best for everyone. A plan that works beautifully for your neighbor may not be right for you. A plan that has a low monthly premium may not include your doctors. A plan with strong dental benefits may not cover your medications well. A plan that works in one state or county may not be available in another.

Your Medicare decision should be based on your life. That means your doctors, your hospitals, your prescriptions, your health conditions, your budget, your travel habits, your state, and your comfort level with provider networks.

Medicare becomes much easier when you understand that most people are choosing between two main paths. One path is Original Medicare, often paired with a Medigap plan and a separate prescription drug plan. The other path is Medicare Advantage, which is offered through private Medicare-approved insurance companies and often includes additional benefits. Both paths can be good. Both paths can also create problems when people choose without understanding the details.

Chapter 1: The Basics of Medicare

Medicare is federal health insurance for people who are generally age 65 or older. Some younger people may qualify because of certain disabilities, End-Stage Renal Disease, or ALS, but for most people, Medicare begins around age 65.

Although people often say, “I’m going on Medicare,” Medicare is actually made up of different parts. Each part does something different.

Medicare Part A is often called hospital insurance. It helps cover inpatient hospital stays, skilled nursing facility care after a qualifying hospital stay, hospice care, and some home health care. Many people do not pay a monthly premium for Part A because they or their spouse paid Medicare taxes while working.

Medicare Part B is often called medical insurance. It helps cover doctor visits, outpatient care, preventive services, lab work, imaging, durable medical equipment, ambulance services, and many medically necessary services. Most people pay a monthly premium for Part B. In 2026, the standard Part B premium is $202.90 per month, and the Part B deductible is $283.

When Part A and Part B are used together, this is called Original Medicare. Original Medicare is the traditional federal Medicare program.

Medicare Part C is called Medicare Advantage. It is another way to receive Medicare benefits. Medicare Advantage plans are offered by private insurance companies that are approved by Medicare. These plans must cover Medicare-covered services, but they can have their own provider networks, copays, prior authorization rules, and extra benefits.

Medicare Part D is prescription drug coverage. It helps cover outpatient medications. Part D can be purchased as a separate plan if you have Original Medicare, or it may be included in many Medicare Advantage plans.

There is also Medigap, which is also called Medicare Supplement insurance. Medigap is not a part of Medicare in the same way Part A, Part B, Part C, and Part D are. Instead, Medigap is private insurance that works with Original Medicare. It helps pay some of the costs that Original Medicare does not pay, such as certain deductibles, copays, and coinsurance.

A simple way to think about it is this: Original Medicare is Part A and Part B. If you choose Original Medicare, you may also choose to add a Medigap plan and a Part D drug plan. Medicare Advantage is Part C. If you choose Medicare Advantage, you usually receive your hospital, medical, and often prescription drug benefits through one private Medicare-approved plan.

Chapter 2: What Happens When You Turn 65

For most people, Medicare eligibility begins around age 65. Your first opportunity to sign up is called your Initial Enrollment Period. For many people, this period lasts seven months. It begins three months before the month you turn 65, includes your birthday month, and ends three months after your birthday month.

This timing matters. If you miss certain enrollment windows, you may have a gap in coverage or face late enrollment penalties.

Some people are automatically enrolled in Medicare because they are already receiving Social Security benefits before turning 65. Other people are not automatically enrolled and need to sign up through Social Security.

One of the most common mistakes people make is assuming everything happens automatically. That is not always true. If you are approaching 65 and you are not already receiving Social Security benefits, it is important to confirm whether you need to actively enroll.

Another common question is whether a person should enroll in Medicare if they are still working. The answer depends on the type of employer coverage you have, whether the coverage is through your own active employment or a spouse’s active employment, the size of the employer, whether your prescription coverage is creditable, and whether you are contributing to a Health Savings Account.

This is why it is wise to start learning about Medicare several months before turning 65. You do not want to wait until the last minute. Your Medicare decision may involve your employer benefits department, Social Security, your spouse’s coverage, your medication list, and your doctors.

Chapter 3: The Two Main Paths

Once you understand the parts of Medicare, the next step is understanding the two main paths.

The first path is Original Medicare. This means you receive your Medicare benefits through the federal Medicare program. Original Medicare includes Part A and Part B. Many people who choose this path also buy a Medigap plan to help with out-of-pocket costs and a Part D plan for prescription medications.

The second path is Medicare Advantage. This means you receive your Medicare benefits through a private Medicare-approved insurance plan. Medicare Advantage plans are also called Part C plans. Many of these plans include prescription drug coverage and extra benefits such as dental, vision, hearing, fitness, transportation, or over-the-counter allowances.

Original Medicare with Medigap often appeals to people who want broad access to doctors and hospitals. It can be especially attractive for people who travel, split time between two states, see specialists, or want fewer network restrictions. The tradeoff is that the monthly premiums are often higher because you may pay for Part B, Medigap, and Part D.

Medicare Advantage often appeals to people who want a lower monthly premium and like the idea of having benefits bundled together. Many Medicare Advantage plans offer extra benefits that Original Medicare does not usually include. The tradeoff is that these plans often have provider networks, prior authorization requirements, copays, and rules that must be followed.

Neither path is automatically better. The right path depends on the person. The key is to choose based on your real life, not based on a commercial, postcard, or someone else’s opinion.

Chapter 4: Original Medicare

Original Medicare is the traditional Medicare program run by the federal government. It includes Part A and Part B.

One of the biggest advantages of Original Medicare is flexibility. In general, you can see any doctor or hospital that accepts Medicare. This can be very valuable if you want access to a wide range of providers, if you travel, or if you see specialists.

Original Medicare covers many medically necessary services. This includes inpatient hospital care, doctor visits, outpatient procedures, emergency care, preventive care, lab work, imaging, durable medical equipment, and certain therapy services.

However, Original Medicare by itself does not cover everything. It has deductibles and coinsurance. It does not usually include routine dental care, routine vision care, hearing aids, long-term custodial care, or most outpatient prescription drugs. Original Medicare also does not have a built-in annual maximum out-of-pocket limit for Part A and Part B services.

That last point is very important. Without additional coverage, a person with Original Medicare could continue to have cost-sharing if they need a lot of care.

This is why many people do not keep Original Medicare alone. Instead, they add a Medigap plan to help cover some of the out-of-pocket costs and a Part D plan to help cover prescriptions.

For many seniors, a common setup looks like this: Medicare Part A, Medicare Part B, a Medigap plan, and a Part D prescription drug plan. This setup can provide strong coverage and broad provider access. However, it usually comes with multiple monthly premiums.

Chapter 5: Medigap, Also Called Medicare Supplement Insurance

Medigap is one of the most important topics to understand before turning 65. Many people call Medigap a gap plan because it helps fill some of the financial gaps left by Original Medicare. The official name is Medicare Supplement Insurance.

Medigap is private insurance. It works with Original Medicare. It does not replace Medicare. It does not work with Medicare Advantage.

When a person has Original Medicare and a Medigap plan, Medicare usually pays its approved share first. Then the Medigap policy may help pay some or all of the remaining cost, depending on the plan.

Medigap may help pay for things like Part A coinsurance, Part B coinsurance, copays, blood, skilled nursing facility coinsurance, and certain deductibles. Some Medigap plans also include limited foreign travel emergency coverage.

Medigap usually does not include prescription drug coverage. That means a person with Original Medicare and Medigap usually needs a separate Part D plan for medications. Medigap also usually does not cover routine dental, routine vision, hearing aids, long-term custodial care, or private-duty nursing.

In most states, Medigap plans are standardized by letter. For example, Plan G from one insurance company has the same basic medical benefits as Plan G from another company in the same state. The price may be different, but the standardized benefits are the same. Massachusetts, Minnesota, and Wisconsin use different Medigap structures.

The most important Medigap issue is timing. Your Medigap Open Enrollment Period generally starts when you are both 65 or older and enrolled in Medicare Part B. This window lasts six months. During this time, you generally have the strongest right to buy a Medigap policy sold in your state without being denied because of health conditions.

After that window ends, things can become more complicated. In many states, if you try to buy Medigap later, the insurance company may ask health questions. Depending on your situation, the company may be allowed to deny you, charge more, or delay coverage unless you have a guaranteed issue right or a state-specific protection.

This surprises many people. They may think they can choose Medicare Advantage at 65 and then switch to Original Medicare with Medigap later if they get sick. In some situations, that may not be easy.

Chapter 6: Medicare Advantage

Medicare Advantage is also called Part C. It is another way to receive Medicare benefits. With Medicare Advantage, you still have Medicare, but your benefits are managed through a private insurance company approved by Medicare.

These plans must cover Medicare-covered services, but they can have their own rules, networks, copays, and prior authorization requirements. Many Medicare Advantage plans include prescription drug coverage. Many also include extra benefits that Original Medicare does not usually cover, such as dental, vision, hearing, fitness memberships, transportation, over-the-counter allowances, and other supplemental benefits.

This is why Medicare Advantage can look very attractive. A person may see a plan with a low or even $0 monthly premium, prescription coverage included, and extra benefits. For some people, this can be a good fit.

But it is important to look deeper. A low premium does not mean healthcare is free. You may still pay your Part B premium. You may also have copays, deductibles, coinsurance, and out-of-pocket costs when you use care.

Provider networks are one of the most important parts of Medicare Advantage. Some plans are HMOs, which generally require you to use in-network providers except in emergencies. Some plans are PPOs, which may allow more flexibility, including some out-of-network coverage, but usually at a higher cost.

Prior authorization is another important issue. Some services, tests, procedures, therapies, or medications may require approval from the plan before they are covered. This does not mean the service will be denied, but it does mean there may be an extra step.

Medicare Advantage plans can also change every year. Premiums, copays, provider networks, drug formularies, pharmacy networks, dental benefits, vision benefits, and prior authorization rules may change. That is why anyone enrolled in Medicare Advantage should review their plan every year during the Medicare Annual Enrollment Period.

Chapter 7: Prescription Drug Coverage

Prescription drug coverage is called Medicare Part D. Part D is offered by private insurance companies approved by Medicare. You can get Part D in two main ways. If you have Original Medicare, you can buy a standalone Part D plan. If you have Medicare Advantage, your plan may already include prescription drug coverage.

Drug coverage is one of the most important areas to review carefully because plans can vary a lot. A plan that works well for one person may be terrible for another person simply because their medications are different.

Every Part D plan has a formulary, which is the list of medications the plan covers. A medication may be covered by one plan but not another. A medication may be placed on a lower-cost tier in one plan and a higher-cost tier in another.

Plans may also have rules such as prior authorization, step therapy, or quantity limits. Prior authorization means the plan must approve the medication before it pays. Step therapy means the plan may want you to try a different medication first. Quantity limits restrict how much medication the plan will cover during a certain period.

Pharmacy choice also matters. Many Part D plans have preferred pharmacies. A medication may cost less at a preferred pharmacy than at a standard pharmacy.

Before choosing drug coverage, make a complete medication list. Include the drug name, dosage, how often you take it, whether you use brand or generic, and which pharmacy you prefer. Then compare plans based on your actual medications.

For 2026, CMS states that the annual out-of-pocket threshold for covered Part D drugs is $2,100. This is an important change in the Part D program. However, it does not mean that every drug is covered or that every medication will be free. It is still important to make sure your medications are covered by the plan.

Chapter 8: Comparing Original Medicare and Medicare Advantage

When people compare Medicare options, they often want a simple answer. They ask, Which one is better? The more honest answer is, Better for whom?

Original Medicare with Medigap and Part D may be better for someone who wants flexibility and predictability. Medicare Advantage may be better for someone who wants lower monthly premiums and extra benefits bundled into one plan.

With Original Medicare, you generally have broad access to providers who accept Medicare. This can be very helpful if you see specialists, travel, or want access to large health systems in different areas. If you add a Medigap plan, your out-of-pocket medical costs may become more predictable. However, you will usually pay more in monthly premiums.

With Medicare Advantage, you may have a lower monthly premium. Many plans include prescription drug coverage and extra benefits such as dental, vision, hearing, and fitness. However, you may need to use a provider network, follow plan rules, get prior authorizations, and review your plan carefully each year.

The most important thing is to look beyond the premium. Medicare is not just about what you pay each month. It is also about what happens when you actually need care.

Chapter 9: What Medicare Usually Does Not Cover

Many people are surprised to learn that Medicare does not cover everything.

One of the biggest misunderstandings involves long-term care. Medicare generally does not pay for long-term custodial care. Custodial care means help with everyday activities such as bathing, dressing, eating, toileting, transferring, and supervision when skilled medical care is not required.

Medicare may cover skilled nursing facility care under certain conditions and for a limited time after a qualifying hospital stay, but that is very different from paying for long-term nursing home care or assisted living.

Original Medicare also usually does not cover routine dental care. It generally does not cover routine cleanings, fillings, dentures, or extractions unless connected to certain medical situations. Many Medicare Advantage plans advertise dental benefits, but those benefits may have annual limits, networks, exclusions, or prior authorization requirements.

Original Medicare usually does not cover routine vision exams for glasses or contact lenses. It may cover certain medical eye care. Original Medicare generally does not cover hearing aids or routine hearing exams for fitting hearing aids. Some Medicare Advantage plans include vision or hearing benefits, but the details vary.

The lesson is simple: do not assume Medicare covers everything. Always ask what is covered, what is not covered, what requires approval, and what your cost may be.

Chapter 10: Working Past 65

More people are working past age 65, and this can make Medicare decisions more complicated.

If you are still working when you turn 65, or if you are covered by a spouse's employer plan, you may not need to enroll in every part of Medicare right away. But you should never assume. The rules depend on your specific coverage.

Employer size matters. If you work for a larger employer and have active employer group health coverage, you may be able to delay Part B without a penalty. If you work for a smaller employer, Medicare may become primary when you turn 65, and delaying Part B could create problems.

Active employer coverage is also different from retiree coverage. COBRA can also be confusing. COBRA is not the same as active employer coverage for Medicare enrollment purposes. Some people mistakenly think COBRA allows them to delay Medicare safely, but this can lead to penalties or gaps in coverage.

Prescription coverage is another issue. If you delay Part D because you have other drug coverage, make sure the coverage is creditable. Health Savings Accounts also require planning. Once you enroll in Medicare, you generally cannot continue contributing to an HSA.

If you are working past 65, ask your employer benefits department whether your coverage is active employer group health coverage, whether Medicare will be primary or secondary, whether your drug coverage is creditable, and how your spouse's coverage may be affected.

Chapter 11: Why Your State and ZIP Code Matter

Medicare is a federal program, but where you live still matters.

Original Medicare is national. If you have Original Medicare, you can generally see providers across the country who accept Medicare. Medicare Advantage and Part D plans are different. These plans are local. They are often based on your county and ZIP code.

This means a person in one part of Michigan may have different Medicare Advantage options than someone in another part of Michigan. A person in Florida may have a completely different set of plans than someone in Ohio, Texas, California, or New York.

Provider networks are also local. A Medicare Advantage plan may include one hospital system but not another. It may include one cardiology group but not another. It may include a large network in one county and a smaller network in another.

Medigap also varies by state. In most states, Medigap plans are standardized by letters, such as Plan G or Plan N. But premiums can vary significantly by state and ZIP code. Massachusetts, Minnesota, and Wisconsin are special because they use different Medigap standardization systems.

Some states also offer extra Medigap protections. Certain states may have rules that allow people to switch Medigap plans during specific windows without full medical underwriting. These rules vary by state and can change.

People who split time between two states, often called snowbirds, should be especially careful. If you spend half the year in one state and half the year in another, you need to know where your plan works, where your doctors are, and what happens if you need non-emergency care while away.

Chapter 12: How to Choose Based on Your Real Life

Choosing Medicare should begin with your life, not with a plan brochure.

Start with your doctors. Write down every doctor you see, including your primary care doctor and any specialists. If you are considering Medicare Advantage, confirm that each doctor is in the plan network and accepting patients with that plan. If you are considering Original Medicare, confirm that the doctor accepts Medicare.

Next, think about your hospitals. Many people check their doctor but forget to check the hospital. This can be a costly mistake. If you prefer a specific hospital system, cancer center, heart hospital, orthopedic center, or academic medical center, make sure it is covered under the plan you choose.

Then review your prescriptions. A plan that looks good overall may be a poor fit if it does not cover your medications well. Make a medication list that includes the drug name, dosage, frequency, and preferred pharmacy.

Your budget also matters. Do not look only at the monthly premium. A low premium plan may still have copays, deductibles, coinsurance, and higher costs when you use care. A higher premium plan may feel expensive each month but may provide more predictable costs.

Think about what you could afford in a bad health year. Travel is another factor. If you travel frequently, spend winters in another state, or want national provider flexibility, make sure you understand how your coverage works away from home.

Finally, be honest about your personality and preferences. Some people do not mind using networks, getting referrals, calling the insurance company, and checking benefits each year. Other people find that stressful and prefer more flexibility.

Chapter 13: Common Mistakes to Avoid

One of the most common Medicare mistakes is choosing a plan based only on a $0 premium. A $0 premium does not mean free healthcare. You may still pay your Part B premium, copays, deductibles, coinsurance, drug costs, dental costs beyond plan limits, and other out-of-pocket expenses.

Another common mistake is not checking doctors. A plan may sound excellent, but if your primary doctor or specialist is not in network, it may not work well for you. Hospital access is just as important.

Many people also forget to review prescriptions. Drug coverage changes. Your medications may change. A plan that worked last year may not be the best plan this year.

A very important mistake is missing the Medigap Open Enrollment Period. In many states, this six-month window after you are 65 or older and enrolled in Part B is your best opportunity to buy Medigap without health underwriting.

People also sometimes assume they can switch from Medicare Advantage to Original Medicare with Medigap anytime. While there are enrollment periods that may allow someone to leave Medicare Advantage, getting a Medigap policy later may not be guaranteed in many states.

Another mistake is assuming Medicare pays for long-term care. Medicare generally does not pay for long-term custodial care, assisted living, or ongoing help with daily activities. Finally, many people choose a plan and never review it again.

Chapter 14: Questions to Ask Before Enrolling

Before choosing Medicare coverage, it helps to slow down and ask the right questions.

Start with your doctors. Are they covered? Are they accepting patients with the plan? Do you need referrals to see specialists? If you choose Original Medicare, do they accept Medicare? If you choose Medicare Advantage, are they in network?

Then ask about hospitals. Is your preferred hospital covered? What hospital would you use if you needed surgery? Are major specialty centers in network? If you have a serious diagnosis, would you be able to access the providers you would want?

Next, ask about prescriptions. Are all your medications covered? What tier are they on? Is prior authorization required? Is step therapy required? Is your pharmacy preferred? Would mail order save money?

Ask about total costs. What is the monthly premium? What is the deductible? What are the copays? What is the coinsurance? What is the maximum out-of-pocket amount? What costs do not count toward that maximum?

Ask about dental, vision, and hearing benefits. Ask about travel. Ask about future flexibility. If you choose Medicare Advantage now, can you get Medigap later? Would you have to answer health questions? Does your state offer extra Medigap protections? These questions may take time, but they can prevent expensive mistakes.

Chapter 15: The Medicare Timeline

Medicare has important enrollment windows. For many people, the first window is the Initial Enrollment Period. It begins three months before the month you turn 65, includes your birthday month, and ends three months after your birthday month.

Several months before turning 65, start gathering information. Make a list of your doctors, hospitals, medications, pharmacies, current insurance, employer coverage, and travel plans.

Three months before your birthday month, confirm whether you need to enroll in Medicare or whether you will be automatically enrolled. If you are still working, confirm how your employer coverage works with Medicare.

When your Part B begins, pay close attention to the Medigap timeline. If you are 65 or older, your Medigap Open Enrollment Period generally starts when you are enrolled in Part B and lasts six months. This is an important window if you want Medicare Supplement coverage.

Every year, there is also a Medicare Annual Enrollment Period from October 15 to December 7. During this time, people can generally change Medicare Advantage plans, switch from Original Medicare to Medicare Advantage, switch from Medicare Advantage back to Original Medicare, join or change Part D plans, or drop Part D coverage.

There is also a Medicare Advantage Open Enrollment Period from January 1 to March 31. This is for people who are already enrolled in a Medicare Advantage plan. Special Enrollment Periods may also apply when certain life events happen.

Chapter 16: A Note for Families and Caregivers

Many seniors make Medicare decisions with help from a spouse, adult child, caregiver, or trusted advisor. If you are helping someone choose Medicare coverage, your role is important. Medicare decisions can affect access to doctors, hospitals, prescriptions, and out-of-pocket costs.

Start by gathering the person's current information. You will need their doctor list, medication list, preferred pharmacy, current insurance, employer or retiree coverage details, hospital preferences, and monthly budget.

It also helps to understand their personality. Some people are comfortable with managed care, provider networks, and calling the insurance company. Others are not. Some people want the lowest monthly premium. Others want broader access and fewer surprises.

Do not choose based only on what looks good in a brochure. Sit down with the person and talk through how they actually use healthcare. Ask how often they see doctors, whether they have specialists they trust, whether they travel, whether they have upcoming surgeries, and whether they would be upset if a doctor was out of network.

Helping someone with Medicare is not just about choosing insurance. It is about protecting access to care.

Chapter 17: Simple Definitions

Medicare has its own language. Understanding the words can make the process less intimidating.

A premium is the amount you pay each month for coverage. A deductible is the amount you may need to pay before coverage begins paying certain costs. A copay is a fixed amount you pay for a service, such as a doctor visit. Coinsurance is a percentage of the cost that you pay.

A formulary is a drug plan's list of covered medications. Prior authorization means the plan must approve a service or medication before it is covered. Step therapy means the plan may require you to try a different medication before it covers another one.

A provider network is the group of doctors, hospitals, pharmacies, and other providers that contract with a plan. A maximum out-of-pocket limit is the most you pay for certain covered services during the year under a Medicare Advantage plan, not including every possible cost.

A Special Enrollment Period is a time outside normal enrollment periods when you may be allowed to enroll or change coverage because of a qualifying event. A guaranteed issue right is a protection that may allow you to buy certain Medigap policies without being denied or charged more because of health conditions. SHIP stands for State Health Insurance Assistance Program, which provides free Medicare counseling.

This section is designed to help you organize your information before comparing Medicare options. You can print these pages, fill them out by hand, or use them as a guide when speaking with Medicare, Social Security, a licensed insurance agent, a SHIP counselor, your doctors, or your pharmacy.

The goal is not to choose a plan quickly. The goal is to make sure the plan you choose fits your real life.

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Back Cover Copy

Turning 65 brings one of the most important healthcare decisions of your life.

Conclusion

Turning 65 is a major milestone, and choosing Medicare coverage is one of the most important healthcare decisions that comes with it. At first, the process can feel confusing because there are so many terms, deadlines, plan types, and advertisements competing for attention. But once the choices are broken down, Medicare becomes much easier to understand.

The most important decision is usually between two main paths. One path is Original Medicare, often paired with a Medigap plan and a separate Part D prescription drug plan. This option may offer broader provider access, more flexibility, and more predictable medical costs when paired with the right supplemental coverage.

The other path is Medicare Advantage, also called Part C. This option may offer lower monthly premiums, built-in prescription drug coverage, and extra benefits such as dental, vision, hearing, fitness, transportation, and over-the-counter allowances. However, Medicare Advantage plans often come with provider networks, prior authorization rules, copays, and benefits that may change each year.

Neither choice is automatically better. The right choice depends on the person. Your doctors, hospitals, medications, health conditions, budget, travel habits, ZIP code, and comfort with networks all matter. A plan that works well for a friend, neighbor, or family member may not be the best fit for you.

Before enrolling, take time to review the full picture. Check whether your doctors and hospitals are included. Review your prescriptions. Understand the monthly premium, deductible, copays, coinsurance, and maximum out-of-pocket costs. Ask what happens if you travel or move. Most importantly, understand whether you will have the ability to change coverage later, especially if you may want a Medigap plan in the future.

Medicare is not just about choosing an insurance card. It is about protecting your access to care, managing your healthcare costs, and making sure your coverage fits the way you live. You do not need to know every Medicare rule by memory. You simply need to know the right questions to ask, where to verify the answers, and when to ask for help. With the right information and careful planning, you can make a Medicare decision with confidence.

This book explains Medicare in plain language so seniors, families, and caregivers can understand the difference between Original Medicare, Medicare Advantage, Medigap, and Part D prescription drug coverage.

Inside, you will learn why your doctors, medications, budget, state, and ZIP code all matter when choosing Medicare coverage.

Before choosing a plan, understand your options.

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