Medicare Kit

Your coverage on one page, the mail that matters, how supplements and Advantage plans really work, and what to ask in the hospital.

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If you only read one page

Medicare rewards people who read the fine print once a year. These seven points prevent the most expensive mistakes.

1. **Know when your supplement window closes.** For six months after you are 65 and in Part B, you can buy any supplement regardless of your health conditions. After that, most companies can ask health questions or say no.

2. **Straight Medicare has no ceiling.** Original Medicare alone leaves you 20% of most bills with no yearly limit. Pair it with a supplement, or choose an Advantage plan or retiree coverage.

3. **Read the Annual Notice of Change every September.** It is the only place your plan tells you what changes on January 1. Open enrollment runs October 15 to December 7.

4. **Check doctors and drugs before extras.** A grocery card or dental allowance does not help if your hospital is out of network or your drug is dropped.

5. **In the hospital, ask: admitted or observation?** Observation days do not count toward the three inpatient days Original Medicare needs before it pays for rehab.

6. **Ask every hospital for its financial assistance policy.** Nonprofit hospitals must have one, and many cover what Medicare leaves. Apply even after the bill arrives.

7. **Call your SHIP before you sign.** State Health Insurance Assistance Program counselors are free and sell nothing. Find yours at shiphelp.org.

Then start here: **Turning 65: how it all fits together**, page 5.

What is in here

22 worksheets in four sections. Start with the first section, then whichever page someone is about to ask you for. A page filled in roughly is worth more than a blank one.

01

Your coverage

How it all fits together at 65, what you have, what each part pays, and the two paths.

Turning 65: how it all fits together

If you are coming up on 65, start here. This is the whole system on two pages; the rest of the kit goes deeper on each piece.

The full guide: hubstone.com/guides/health-insurance

Medicare comes in parts, and you get it one of two ways. Part A covers the hospital. Part B covers doctors and outpatient care. Part D covers prescriptions. Part C, called Medicare Advantage, is a private plan that bundles A, B and usually D. Most people choose one of the two paths below.

	Path 1: Original Medicare	Path 2: Medicare Advantage
What you sign up for	Parts A and B from the government, a separate Part D drug plan, and usually a supplement (Medigap)	Parts A and B, then one private plan that replaces them and usually includes drugs
Doctors	Any doctor or hospital in the country that accepts Medicare	The plan's network, with approvals often needed first
Your costs	A higher monthly premium for the supplement, then few surprises	Low or no plan premium, then copays up to a yearly limit
The catch	Without a supplement, you owe 20% of most bills with no yearly limit	Networks and drug lists change every year, and leaving later can be hard

The timeline

1. **About six months before 65.** If you or your spouse are still working, ask the employer in writing how many people it employs and who pays first once you turn 65. If you have a health savings account, read the HSA page before you sign up for anything.
2. **Three months before your birthday month.** Your seven-month sign-up window opens. If you already get Social Security, you are enrolled in Parts A and B automatically and the card comes by mail. If not, sign up at ssa.gov/medicare. Sign up early so coverage starts the month you turn 65.
3. **Before coverage starts.** Choose your path. List your doctors, hospital and prescriptions, and check them against each plan at Medicare.gov. A free SHIP counselor will walk through it with you.
4. **Your first six months with Part B.** Your supplement window. Any Medigap company must sell you any plan it offers, at the same price as someone in good health. After this, most can ask health questions, charge more or say no.

5 **Your first 12 months.** Book the free Welcome to Medicare visit. If you chose an Advantage plan at 65 and do not like it, you can switch to Original Medicare and a supplement within these 12 months, with no health questions.

6 **Every September, then October 15 to December 7.** Read the Annual Notice of Change from your plan, then use open enrollment to keep or change plans for January 1.

The three mistakes that cost the most

Mistake	What it costs
Missing Part B without job coverage	10% more on your Part B premium for each full year you went without, for as long as you have Part B
Going 63 days or more without drug coverage	A Part D penalty added to your drug premium every month, for life
Letting the supplement window pass	Later, a supplement company can review your health history, charge more or turn you down

Source: Medicare.gov, Get started with Medicare; enrollment periods; Medigap open enrollment.

Get free help before you sign. State Health Insurance Assistance Program counselors are free, trained and sell nothing. Find yours at shiphelp.org, or call 1-800-MEDICARE. Medicare never calls to sell you a plan.

Your Medicare on one page

Everything someone helping you would need to find, in one place. Write where the cards and numbers are kept, not the numbers themselves.

Name _____ Date of birth _____

Part A started _____ Part B started _____

Medicare card kept at _____ Part B premium paid by _____

How you get coverage ☐ Original Medicare only ☐ Original Medicare, Medigap and a drug plan ☐ Medicare Advantage ☐ Employer or union retiree plan ☐ Medicaid too

Plans and people

Plan or contact	Company or name	Phone	Member card kept at
Medigap (supplement)			
Drug plan (Part D)			
Medicare Advantage plan			
Retiree coverage			
Agent or broker			
State SHIP counselor			

Find the two plan codes on your card. The contract ID is one letter and four numbers: H for a local Advantage plan, R for a regional PPO, S for a stand-alone drug plan, E for an employer's plan. The three numbers after the dash, the plan benefit package, say which of that company's plans you have. Together they make the 8-character plan number, like H1234-001, that names your exact plan. Use them to compare plans and star ratings at Medicare.gov, to ask a doctor's office whether they take your plan, or to report a problem.

Contract ID _____ Plan benefit package _____

Checked this year

Doctors confirmed in network on _____ Hospital confirmed in network on _____

Drug list checked on _____ Pharmacy confirmed on _____

Medicare will not call to sell you a plan. Hang up on anyone who calls uninvited asking for your Medicare number. Call 1-800-MEDICARE or your SHIP counselor instead.

Letting family help

Medicare and your plans will not discuss your claims with a spouse or adult child unless you give written permission first. Do it now, while it is easy.

Form	What it does	How to send it
CMS-10106, Authorization to Disclose Personal Health Information	Lets 1-800-MEDICARE talk with the people you name about your claims and coverage. You choose how long it lasts and what they can see.	Mail it to the address on the form
Your plan's own authorization form	Lets your Advantage, drug or supplement plan talk with them. Medicare's form does not cover your plans.	Call member services and ask for it
CMS-1696, Appointment of Representative	Lets someone file and argue an appeal for you.	Send it with the appeal
Health care and financial powers of attorney	Let someone make decisions and handle money if you cannot.	Set up with an attorney; keep copies with this kit

Source: CMS forms CMS-10106 and CMS-1696.

Person	Relationship	Medicare form sent	Plan forms on file

Tell them where this kit is. The people you name should know which plans you have, the plan number, and where the cards and letters are kept.

Parts A, B and D

Medicare comes in parts. Knowing which part pays for what explains most bills and most letters.

The full guide: hubstone.com/guides/health-insurance

Part	What it pays for	What it costs you (2026)
Part A, hospital insurance	Hospital stays as an admitted inpatient, skilled nursing or rehab after a qualifying hospital stay, hospice, and some home health care	Usually no premium if you or your spouse worked about 10 years. $1,736 deductible for each benefit period, then daily costs for long stays
Part B, medical insurance	Doctors, outpatient care and surgery, tests and scans, ambulance, equipment like walkers and oxygen, mental health visits, preventive care, and drugs given in a clinic, such as chemotherapy and infusions	$202.90 a month, more at higher incomes. $283 deductible a year, then usually 20% of the approved amount
Part D, drug coverage	Prescriptions you fill at a pharmacy or by mail, from the plan's drug list	The plan's premium, deductible and copays. Out-of-pocket drug costs stop at $2,100 a year ($2,400 in 2027)
Part C, Medicare Advantage	A private plan that replaces A and B, and usually D, with its own network, copays and yearly limit	You still pay the Part B premium, plus any plan premium

Source: CMS 2026 Medicare Parts A and B fact sheet; Medicare.gov.

The 20% under Original Medicare

After the $283 Part B deductible, you pay 20% of the Medicare-approved amount for most Part B care: every doctor visit, scan, outpatient surgery, dialysis session and chemotherapy dose. Original Medicare has no yearly limit on that 20%. Doctors who do not accept Medicare's approved amount as full payment can add up to 15% more. Most preventive care, like screenings and the yearly wellness visit, costs nothing from doctors who accept it. At a hospital outpatient department, your copay for a single service cannot be more than the Part A deductible.

If the care costs Medicare	Your 20% would be
$500 for a scan	$100
$10,000 in visits, scans and therapy over a year	$2,000
$100,000 for a year of cancer treatment	$20,000, with no cap

The 20% is what a supplement is for. A Medigap Plan G, retiree coverage or Medicaid pays it. An Advantage plan replaces it with copays up to a yearly limit.

Original Medicare or Medicare Advantage

The first choice shapes everything else: which doctors you can see, what you pay and how easy it is to change your mind later.

The full guide: hubstone.com/guides/health-insurance

	Original Medicare	Medicare Advantage
Doctors and hospitals	Any in the country that accept Medicare	The plan's network. Out of network costs more or is not covered, except emergencies
Approvals	Rarely needed before care	Often needed for scans, surgery, rehab and some drugs
Your share	20% of most doctor and outpatient bills, with no yearly limit unless you add a supplement	Copays, with a yearly limit. The federal maximum in 2026 is $9,250 in network, or $13,900 in and out of network for PPOs. Typical plans: about $5,400 in network, $9,800 combined
Drugs	A separate Part D plan	Usually included
Dental, vision, hearing	Not covered	Often included, with dollar limits
Travel	Works anywhere in the US. Medigap plans C, D, F, G, M and N pay 80% of emergencies abroad after $250, up to $50,000 in a lifetime	Emergency and urgent care anywhere in the US. Routine care follows the network
Changing later	You can move to an Advantage plan each fall	You can move back each fall, but a supplement may then ask health questions

What the Advantage limit leaves out. Premiums and drug costs do not count toward it; drugs have their own $2,100 limit. The limit resets every January 1.

2026 costs to know

Cost	2026 amount
Part B premium (standard)	$202.90 a month. Higher if 2024 income was over $109,000 single or $218,000 joint
Part B deductible	$283 a year
Hospital deductible (Part A)	$1,736 for each benefit period, which can happen more than once a year
Hospital days 61 to 90	$434 a day
Skilled nursing days 21 to 100	$217 a day
Drug costs (Part D)	Your out-of-pocket cost for covered drugs is capped at $2,100 a year, rising to $2,400 in 2027
Insulin	No more than $35 for a month's supply

Source: CMS 2026 Medicare Parts A and B fact sheet; CMS Part D program instructions for 2026 and 2027.

Straight Medicare has no ceiling. Original Medicare alone has no yearly out-of-pocket limit. A long hospital stay or cancer treatment can mean 20% of a very large bill. That is why most people pair it with a supplement, or choose an Advantage plan or retiree coverage instead.

Free checkups, and what Medicare skips

Original Medicare pays for a long list of preventive care in full. It also leaves out some things people assume are covered.

Visit	What it is
Welcome to Medicare visit	Once, within the first 12 months of Part B. A review of your health, medicines and risks, and a plan for screenings.
Yearly wellness visit	Once a year after that. It updates your prevention plan. It is not a head-to-toe physical.
Screenings and shots	Many screenings, such as mammograms and colon cancer screening, and flu, COVID-19, pneumonia and hepatitis B shots cost nothing when the doctor accepts assignment. Drug plans cover recommended adult vaccines like shingles at no cost.

Free visits can still produce a bill. If the doctor also treats a problem or orders extra tests during a wellness visit, those can carry the deductible or the 20%. Ask before anything is added.

What Original Medicare does not cover

Care	Covered?
Routine dental care, cleanings and dentures	No. Buy a stand-alone dental plan, or look at Advantage plans that include it.
Routine eye exams and glasses	No, except eye exams for diabetes and glaucoma checks, and one pair of glasses after cataract surgery with an implant.
Hearing aids and exams for fitting them	No.
Long-term help with daily care	No. Medicaid, long-term care insurance or savings usually fills this gap.
Care outside the US	Almost never. Some supplements pay for emergencies abroad.

02

Dates, mail and the fall review

The windows and penalties, what arrives in the mail, and the yearly check.

Signing up, and who pays first

Some people are enrolled automatically; everyone else has to act. If you have other coverage, which one pays first decides whether you need Part B now.

How you get Medicare

If	What happens
You get Social Security or railroad benefits at least 4 months before 65	You are enrolled in Parts A and B automatically and your card arrives by mail. You can turn down Part B if you have job coverage.
You do not get those benefits yet	Sign up through Social Security: online at ssa.gov/medicare, by phone or at an office.
You delayed Part B because of job coverage and are signing up now	Send form CMS-40B with form CMS-L564, which your employer fills out to prove the coverage. This protects you from the penalty.

Source: Medicare.gov, sign up for Part A and Part B.

Who pays first

Your other coverage	Who pays first
Job coverage (yours or your spouse's), employer with 20 or more employees	The job plan pays first. Delaying Part B is often fine; confirm with the employer.
Job coverage, employer with fewer than 20 employees	Medicare pays first. Without Part B, much of your care may go unpaid.
Retiree coverage or COBRA	Medicare pays first. Neither lets you delay Part B without a penalty.
Under 65 with a disability, employer with 100 or more employees	The job plan pays first.
VA health care	They do not coordinate. The VA pays at VA facilities; Medicare pays elsewhere.
TRICARE For Life	Medicare pays first and TRICARE pays second. You must keep Parts A and B.

Source: Medicare.gov, who pays first; How Medicare Works with Other Insurance.

Ask in writing before you skip Part B. Get the employer's size and a written answer on who pays first from the benefits office.

Enrollment dates and penalties

Medicare runs on windows. Miss one and you may wait months for coverage, or pay a penalty for as long as you have Medicare.

Window	When	What it is for
Initial enrollment	7 months: the 3 months before your 65th birthday month, that month and the 3 after	Signing up for Parts A and B, and choosing a drug or Advantage plan. Sign up before your birthday month and coverage starts that month
Open enrollment	October 15 to December 7, every year	Anyone can switch, join or drop an Advantage or drug plan, or move between Original Medicare and Advantage. Changes start January 1
Advantage open enrollment	January 1 to March 31	People already in an Advantage plan can make one change: another Advantage plan, or back to Original Medicare with a drug plan
General enrollment	January 1 to March 31	If you missed Part A or B entirely. Coverage starts the next month, and penalties can apply
After job coverage ends	8 months after you or your spouse stop working or lose that coverage	Signing up for Part B without a penalty. Drug coverage has a shorter 2-month window
Your plan is leaving	December 8 to the last day of February	Choosing a new plan after a non-renewal notice

Source: Medicare.gov, Understanding Medicare Advantage and drug plan enrollment periods.

The Part B penalty

10% added to your Part B premium for each full 12 months you could have had Part B but did not, unless you had coverage from a current job. It lasts as long as you have Part B.

The Part D penalty

If you go 63 days or more in a row without Part D or other drug coverage at least as good (called creditable coverage) after your first chance to enroll, a penalty is added to your drug premium. It is 1% of the national base premium for each full month you went without, and it lasts as long as you have Medicare drug coverage. The base premium is $38.99 in 2026 and $41.33 in 2027, so the penalty is recalculated each year.

Months without drug coverage	2026 penalty	Each year
12 months	$4.70 a month	$56.40
17 months	$6.60 a month	$79.20
36 months	$14.00 a month	$168.00

Source: Medicare.gov, The Part D Late Enrollment Penalty fact sheet. Amounts rounded to the nearest 10 cents.

Keep the letter that says your drug coverage counts. Employers and unions send a yearly notice saying whether their drug coverage is creditable. It is your proof if Medicare ever charges a penalty. People who get Extra Help do not pay the penalty, and you can ask for a review within 60 days of the notice.

Special enrollment periods (SEPs)

Outside open enrollment, certain life events open a special window to join, switch or drop an Advantage or drug plan. Miss it and you usually wait until fall.

When your plan is not renewing

If your plan was canceled, you have until the end of February to swap to another Advantage plan or enroll in a Part D drug plan. This special enrollment period runs from December 8 to the last day of February, on top of open enrollment. If you do nothing, you return to Original Medicare on January 1 with no drug coverage. The same notice gives you the guaranteed issue right to buy a supplement.

Caution: time the switch so there is no gap. Your canceled plan ends December 31. A new plan starts the first of the month after it receives your request, so enroll by December 31 for January 1 coverage; choosing by December 7 is safest. Apply for a supplement early in your guaranteed issue window so it also starts January 1. Waiting until January or February leaves you without drug coverage for those weeks, paying full price at the pharmacy, and a gap of 63 days or more adds the lifelong Part D penalty.

Special enrollment period	When	What you can do
Your plan is not renewing	December 8 to the last day of February	Swap to another Advantage plan, or enroll in a Part D drug plan with Original Medicare
Your plan's contract with Medicare ends early	From 2 months before it ends to 1 full month after	Choose another plan
You move	2 full months after the move (or the month before, if you tell the plan first)	Choose a plan where you live now; return to Original Medicare if you left the service area
You lose job or union coverage	2 full months after it ends	Join an Advantage or drug plan
You lose Medicaid	3 full months from losing it or being told	Join, switch or drop a plan
You have Extra Help or Medicaid	Once a month	Switch drug plans, or leave Advantage for Original Medicare with a drug plan
You move into or out of a nursing home	While there, and 2 full months after leaving	Join, switch or drop a plan
A 5-star plan is available	Once, December 8 to November 30	Switch into a 5-star Advantage or drug plan

Source: Medicare.gov, special enrollment periods.

Call before the window closes. 1-800-MEDICARE or your SHIP can confirm which special window you qualify for and the last day to use it.

What comes in the mail

Medicare mail looks alike and much of it matters. Here is what arrives, roughly when, and what to do with it.

Mail	When	What to do
Annual Notice of Change (ANOC), from your Advantage or drug plan	By September 30	Read it. It lists next year's changes to the premium, drug list, costs and network.
Evidence of Coverage, from your plan	September, often online	Keep it. It is the plan's full rulebook, including how to appeal.
Medicare & You handbook	Early fall	Next year's official summary of costs and rights.
Plan non-renewal letter	Dated by October 2	Your plan is leaving Medicare next year. Choose a new plan by December 7, or by the end of February in a special window. If you do nothing, you return to Original Medicare on January 1, without drug coverage unless you add a plan. It also gives you a guaranteed issue right to buy certain supplements with no health questions, if you apply within 63 days after the old coverage ends.
Grey letter about Extra Help	September	You no longer qualify automatically. Apply at SSA.gov/extrahelp.
Orange letter about Extra Help	October	You still qualify, but your drug copays change. Keep it.
Income notice (IRMAA) from Social Security	November, or any time	Your premium is higher because of income. If income dropped, for example after retiring, appeal with form SSA-44.
Social Security benefit letter	December	Next year's check, after the Part B premium comes out.
Medicare Summary Notice	Every 6 months, if you had care	It is not a bill. Compare it with your bills and report anything you do not recognize.
Drug plan Explanation of Benefits	Monthly, when you fill a prescription	Check the drugs and what you paid.
Medicare premium bill	Around the 10th of the month	Only if premiums are not taken from Social Security. Pay by the due date.

Source: Medicare.gov, mailings about costs, coverage and help with costs.

Keep one folder for Medicare mail. Put each year's ANOC in front. Someone helping you later can see what changed and when.

The fall review

Once a year, check that next year's plan still fits. Most people who overpay simply kept last year's plan without looking.

The full guide: hubstone.com/guides/health-insurance

1. **Read the Annual Notice of Change.** Look first at the premium, the yearly out-of-pocket limit and anything marked as changed.
2. **After October 1, confirm the plan continues.** Next year's plans appear in the Plan Finder at Medicare.gov on October 1. Search your ZIP code, or sign in to your Medicare account, and look for your exact contract ID and plan number, like H1234-001. If it is not listed for next year, the plan may be ending or merging; call the plan or 1-800-MEDICARE.
3. **Check every drug.** Is each one still covered, on which tier, and does it now need approval or have a quantity limit? Enter your list in the Plan Finder at Medicare.gov.
4. **Call your doctors, hospital and pharmacy yourself.** Use the doctor phone audit after this section. Ask each office for the office manager or billing department, not the plan, give them the contract ID and plan number (like H1234-001), and ask whether they will be in this exact plan's network on January 1.
5. **Compare at least three plans on total cost.** Add the premium to what you expect to pay for drugs and visits. The lowest premium is often not the lowest total.
6. **Change by December 7 if you need to.** The new plan starts January 1. If you do nothing and your plan renews, you stay in it.

Do not trust the plan's directory alone. Insurers' own doctor lists are often wrong. Federal reviews have found errors at about half of listed locations, and a 2023 Senate check found a third of listings inaccurate or unreachable. A doctor you have seen for years can leave a plan's network on January 1, and the website may still show them.

The dates

When	What you can do
October 15 to December 7	Anyone can switch Advantage or drug plans, or move between Original Medicare and Advantage.
January 1 to March 31	People in an Advantage plan can switch plans once, or return to Original Medicare and add a drug plan.
Any time something changes	Moving, losing other coverage, getting Extra Help or a plan leaving your area opens a special window.

For 2027, compare drug plans carefully. The extra federal help that held down stand-alone drug plan premiums in 2025 and 2026 ends after this year, so some premiums may rise more than usual.

Plan and contract ID	Yearly premium	Estimated drug cost	Doctors in network?

Free, unbiased help: every state has a State Health Insurance Assistance Program (SHIP). The counselors sell nothing. Find yours at shiphelp.org or call 1-800-MEDICARE.

The doctor phone audit

List every doctor you see, decide which ones you will not give up, then call each office. It is the most reliable network check there is.

1. **List everyone.** Primary care, every specialist, therapists, the hospital you would want, your pharmacy, and any clinic where you get infusions, dialysis or imaging.
2. **Look up each NPI.** Every doctor and facility has a National Provider Identifier (NPI), a 10-digit number that stays with them for life. Find it free at npiregistry.cms.hhs.gov by name and state, or ask the office.
3. **Rank them.** 1 must keep (a specialist managing an ongoing condition, a surgeon mid-treatment, a doctor you have trusted for years), 2 strongly prefer, 3 could replace.
4. **Call the 1s first.** Ask for the office manager or billing; the front desk often does not know next year's contracts. Give them the insurance company, plan name and 8-character plan number. Then check with the plan's member services using the NPI and location: a group can be in network while one doctor is not. Only compare plans that keep every doctor ranked 1.
5. **Write it down, and get it in writing.** Record the date and time, the name and title of the person you spoke with, and exactly what they said. Ask them to confirm by email or letter, and keep it with this page. It is your record for an appeal or complaint.

Insurance company _____ Plan name _____

Plan number (8 characters) _____ Plan member services phone _____

The script. "May I speak with the office manager or a billing representative?" Then: "I am a patient of Dr. ___, NPI ___. Will Dr. ___ at this location be contracted and in network with [insurance company], [plan name], under plan benefit package [H1234-001], starting January 1, and accepting that plan for existing patients? Could you confirm that by email or in writing?" With Original Medicare, ask: "Will Dr. ___ be a participating provider starting January 1, accepting Medicare assignment?"

Rank	Doctor or facility	NPI	Date, time	Name, title	What they said	In network?	In writing?
	Primary care:						

Rank	Doctor or facility	NPI	Date, time	Name, title	What they said	In network?	In writing?
	Hospital:						
	Pharmacy:						

03

Choosing coverage

Supplements, the extras plans compete with, HSAs, and the doors that close.

How supplements (Medigap) work

A supplement pays some or all of what Original Medicare leaves for you. The rules about when you can buy one matter more than which company you pick.

The full guide: hubstone.com/guides/health-insurance

Medigap policies are sold by private insurers and only work with Original Medicare, never with an Advantage plan. They do not cover drugs, so you add a Part D plan. Plans are standardized by letter: a Plan G pays the same benefits from every company, so only the price and service differ. Massachusetts, Minnesota and Wisconsin use their own versions.

Medicare pays 80%. The supplement pays the rest, without the restrictions. For most doctor and outpatient bills, Original Medicare pays 80% of the approved amount and a supplement like Plan G pays the 20%. There is no network: any doctor or hospital in the country that accepts Medicare. No referrals, and no separate approvals from the supplement. When Medicare approves a service, the supplement pays its share automatically.

Plan	What it covers
Plan G	Everything Original Medicare leaves except the $283 Part B deductible. The most common choice for people new to Medicare.
Plan N	Lower premium. You pay the Part B deductible, up to $20 for some office visits, up to $50 for an emergency room visit that does not lead to admission, and any excess charges.
High-deductible G	Lower premium. You pay up to $2,950 in 2026 before the policy pays.
Plans K and L	Pay part of your share, with a yearly limit of $8,000 (K) or $4,000 (L) in 2026.
Plans C and F	Also cover the Part B deductible, but can only be bought by people eligible for Medicare before January 1, 2020.

Source: Medicare.gov, compare Medigap plan benefits.

The window that matters most

Regardless of your health conditions, you can sign up. Your Medigap open enrollment lasts six months and starts the first month you are both 65 or older and enrolled in Part B. During it, you can buy any supplement a company sells in your state, at the same price as someone in perfect health. No health questions, no turning you down. It happens once and cannot be restarted. After it, in most states, companies can ask health questions, charge more or say no. A few states, including New York and Connecticut, let you buy any time.

If	Your six months
You turn 65 in June and Part B starts June 1	June 1 to November 30
You keep working with job coverage and start Part B at 67	The six months after Part B starts at 67, not at 65
You sign up for Part B early but do not buy a supplement	The clock still runs. When it ends, you may face health questions

Supplement or Advantage

	Original Medicare and a supplement	Medicare Advantage
Doctors	Any doctor or hospital in the country that accepts Medicare	The plan's network
Approvals	None from the supplement	Often required first
What you pay	A higher monthly premium, and little or nothing when you get care	Often a low or $0 premium, then copays up to a yearly limit (up to $9,250 in network in 2026)
Drugs and extras	Add a Part D plan. No dental or vision	Drugs usually included, often dental, vision and hearing
Changing your mind	You can move to Advantage any fall	Going back to a supplement after the trial year can mean medical underwriting

The 12-month trial, and when it closes

1. **You try Advantage.** You join an Advantage plan when you first get Medicare at 65, or you drop a supplement to join Advantage for the first time.
2. **For 12 months, you can go back.** Return to Original Medicare and buy a supplement without health questions: any supplement sold in your state if you joined at 65, or your old policy back if the company still sells it.
3. **After 12 months, the window closes.** If you want to go back to a supplement after that, in most states the insurance company can put you through medical underwriting: they give you a health questionnaire and can look at your whole medical history, including your prescription records. Based on it, they can turn you down outright, charge you far more than a healthy person pays, or refuse to cover your pre-existing conditions for up to six months. Mark the date the trial ends.

Advantage plan started on _____ Trial ends on _____

What medical underwriting looks like. The application asks about recent hospital stays, planned surgery, and conditions such as cancer, heart disease, COPD or diabetes with complications. Many people who are turned down are the ones who most need a supplement.

Why many people feel stuck in Advantage, and the way out. People with health conditions often cannot pass underwriting, so they stay in an Advantage plan for good. The exception is when the plan ends. If your plan leaves Medicare, stops serving your area, or you move out of its area, you get a guaranteed issue right to buy Plan A, B, D or G (C or F if you were eligible before 2020) with no health questions. Apply as early as 60 days before the plan ends and no later than 63 days after. A non-renewal letter can be the door back. The next page lists every guaranteed issue right.

Ask how the price will change. Premiums are set by one of three methods: the same for everyone (community rated), your age when you buy (issue age), or your age each year (attained age), which rises as you get older.

What a Plan G pays in 2026

Cost under Original Medicare	Plan G
Hospital deductible, $1,736 per benefit period	Pays it
Hospital days 61 to 90, $434 a day, and beyond	Pays it, plus 365 extra hospital days in your lifetime
Skilled nursing days 21 to 100, $217 a day	Pays it
The 20% on doctor and outpatient bills	Pays it
Excess charges from doctors who do not accept assignment	Pays it (Plan N does not)
Part B deductible, $283	You pay it
Emergency care abroad	80% after $250, up to $50,000 in a lifetime

Source: Medicare.gov, compare Medigap plan benefits; CMS 2026 Medicare costs.

Guaranteed issue rights

A guaranteed issue right is a legal right to buy a supplement with no health questions: the company must sell you the policy, must cover your pre-existing conditions and cannot charge more for your health. Outside your six-month open enrollment, these are the only times you have it.

The full guide: hubstone.com/guides/health-insurance

When this happens	You can buy	Apply
Your Advantage plan leaves Medicare, stops serving your area, or you move out of its area	Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	From 60 days before the plan ends to 63 days after
You joined an Advantage plan when you first got Medicare at 65, and want out within the first year	Any supplement sold in your state	From 60 days before to 63 days after leaving the plan
You dropped a supplement to try Advantage for the first time, and want out within the first year	Your old policy if the company still sells it, otherwise Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	From 60 days before to 63 days after leaving the plan
Your employer or union coverage that pays after Medicare is ending	Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	Within 63 days after the coverage ends or you get the notice, whichever is later
You have a Medicare SELECT policy and move out of its area	Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	From 60 days before to 63 days after the policy ends
Your supplement company goes bankrupt, or your policy ends through no fault of your own	Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	Within 63 days after the policy ends
Your Advantage plan or supplement company misled you or broke the rules	Plan A, B, D or G (C or F if you were eligible for Medicare before 2020)	Within 63 days after the coverage ends

Source: Medicare.gov, Choosing a Medigap Policy, guaranteed issue rights. Some states add more rights; ask your SHIP.

When your Advantage plan ends: Plan G and a drug plan

1 **Apply for Plan G.** Your guaranteed issue window opens 60 days before the Advantage plan ends and closes 63 days after. Apply early in the window, so Plan G starts the day the Advantage plan ends with no gap. Send a copy of your non-renewal notice with the application; it may be required as proof of your right.

2 **Choose a stand-alone drug plan.** A supplement does not cover prescriptions. Pick a Part D plan between October 15 and December 7 so it starts January 1; the special window runs to the end of February. A gap of 63 days or more brings the lifelong drug penalty.

3 **January 1.** You have good coverage without networks or prior authorization: Original Medicare, Plan G and a drug plan. Any doctor or hospital in the country that accepts Medicare, no referrals, and the supplement pays whatever Medicare approves. (Original Medicare itself requires approval for only a short list of services, such as some equipment, and in six states a pilot adds a few procedures.)

Keep your non-renewal notice. It may be required. The supplement company may require a copy as proof of your guaranteed issue right. For other situations, the proof is the employer's notice that coverage is ending or a letter showing your move. Keep the original, and send copies.

Event that gave me the right _____ Date coverage ends _____

Window opens (60 days before) _____ Window closes (63 days after) _____

Proof letter kept at _____

Supplements and the law

The law protects you once you have a supplement and limits how one can be sold. Some of what is legal surprises people too.

The full guide: hubstone.com/guides/health-insurance

Your protections

	What the law says
It cannot be canceled for health	Standardized supplements bought after 1992 renew every year, whatever your health, as long as you pay the premium and told the truth on the application.
Pre-existing conditions	A company can delay coverage up to six months for a condition treated in the six months before the policy starts. If you had six months of continuous prior coverage, it cannot make you wait.
No genetic questions	A company cannot ask about family history or require a genetic test.
A free look when you switch	You get 30 days to review a new supplement. Keep the old one until the new one is approved; you pay both premiums for that month.

What is illegal

A seller or company cannot
Sell you a supplement while you are in an Advantage plan, unless you are switching back to Original Medicare
Sell you a second supplement when they know you already have one
Sign you up for an Advantage plan when you said you want Original Medicare and a supplement
Sell you a supplement if you have Medicaid, with limited exceptions
Pressure you, or lie to get you to switch companies or policies
Claim to be from Medicare, or say a policy is part of Medicare or approved by the government

Legal, but a surprise

	What to know
Health questions later	Outside your six-month open enrollment and the special guaranteed rights, most states let companies use medical underwriting: ask health questions, charge more or turn you down.
One person per policy	A supplement covers one person. Spouses each buy their own, and premiums can rise every year.

Report a problem. Call your state insurance department, and tell your SHIP counselor. For suspected Medicare fraud, call 1-800-MEDICARE.

Why plans compete so hard for you

Medicare pays Advantage plans a set monthly amount for each member, so plans compete for members with extras. The extras are real, and they are the last thing to compare.

What you see	What to ask
$0 premium	You still pay the Part B premium. What are the copays and the yearly limit?
Part B giveback	The plan pays part of your Part B premium. What do the network and copays look like?
Dental, vision and hearing	What is the yearly dollar limit, and which dentists and hearing centers take it?
Flex or grocery card	Is it only for members with certain chronic conditions? Which stores and items? Does unused money expire?
Gym, rides, meals at home	Useful extras. Are your doctors and hospital in the network first?
Star rating	Medicare's 1 to 5 quality score. You can switch into a 5-star plan once at almost any time of year.

Who is selling

Agents and brokers are paid by the insurance companies, and a new enrollment usually pays more than a renewal. Many represent only some companies. Marketing companies must tell you they do not offer every plan in your area. Ads for a Medicare hotline or benefits helpline are usually private companies. The government's number is 1-800-MEDICARE.

- [ ] Ask which companies the agent represents
- [ ] Call your doctors' offices yourself to confirm they take each plan next year. Directories are often wrong
- [ ] Ask what the plan pays if you need rehab or a nursing facility
- [ ] Get the plan's name and contract number in writing
- [ ] Take a day before you sign anything

Choose the doctors first, the extras last. A grocery card does not help if the hospital you trust is out of network.

Health savings accounts (HSAs)

An HSA is a savings account for medical costs that you own for life. It may be the best tax deal available, and it has hard rules once Medicare starts.

	How it works
Who can put money in	Anyone covered by a qualifying high-deductible health plan with no other health coverage, who is not enrolled in any part of Medicare and is not claimed as someone's dependent. Since 2026, Marketplace bronze and catastrophic plans qualify.
2026 limits	$4,400 with self-only coverage, $8,750 with family coverage, plus $1,000 at age 55 or older. You have until the tax filing deadline, usually April 15 of the next year.
The plan it pairs with	In 2026, a deductible of at least $1,700 for one person or $3,400 for a family, and an out-of-pocket limit no higher than $8,500 or $17,000.
Three tax breaks	Money goes in tax-deductible (through payroll it also skips Social Security and Medicare tax), grows tax-free, and comes out tax-free for medical costs.
It is yours	It stays with you when you change jobs or retire. Nothing is lost at year end, and the balance can be invested.

Source: IRS Rev. Proc. 2025-19; IRS guidance on the One, Big, Beautiful Bill HSA changes; IRS Publication 969.

Spending it

	The rule
Medical costs	Doctor and hospital bills, prescriptions, dental, vision and hearing care are tax-free.
Anything else, before 65	Income tax plus a 20% penalty.
Anything else, at 65 or older	Income tax only, no penalty. It works like a traditional IRA.
Insurance premiums	Generally not, except COBRA, coverage while you receive unemployment, some long-term care premiums, and at 65 or older Medicare Part A, B, D and Advantage premiums. Never supplement (Medigap) premiums.
Old receipts	You can pay yourself back years later for medical costs from after the account was opened, as long as you keep the receipts.

HSAs and Medicare

1. **Medicare ends new contributions.** Once you are enrolled in any part of Medicare, you can no longer add money. You can keep spending what is there.
2. **Signing up after 65 backdates Part A.** Part A starts up to six months before you apply, so stop contributing six months before you sign up.
3. **Social Security brings Part A with it.** Starting Social Security at 65 or later enrolls you in Part A automatically, which ends contributions.
4. **The last year is prorated.** In the year Medicare starts, the limit is cut to the months you were eligible.
5. **Putting in too much costs 6% a year.** Take out any excess before the tax filing deadline to avoid the tax.

Name a beneficiary. A spouse inherits the HSA as their own. Anyone else owes income tax on the whole balance that year.

HSA held at

Beneficiary named

Receipts kept at

Last month of contributions

When better coverage closes a door

Some coverage choices cannot be undone. Before you change anything, ask what you would lose.

If you	What can close
Leave a supplement for an Advantage plan	After the 12-month trial, a supplement company can put you through medical underwriting, and you can be charged more or turned down.
Join an Advantage plan while on employer or union retiree coverage	You may lose the retiree coverage, sometimes for your spouse too, and not be able to get it back. Ask the benefits office first.
Enroll in Medicare while funding an HSA	New HSA contributions must stop once Medicare starts. Part A signed up for after 65 backdates up to six months, so stop contributing six months before you apply. The balance can still pay medical costs and most Medicare premiums, but not supplement premiums.
Have Medicare and want a Marketplace plan	Once you have Medicare, Marketplace premium tax credits are no longer available.
Earn more	Income over $109,000 single or $218,000 joint in 2026 raises Part B and Part D premiums. Extra Help and Medicare Savings Programs have much lower income limits.
Keep more in savings	Extra Help, Medicaid and, in many states, Medicare Savings Programs have limits on savings as well as income.
Skip Part B because other coverage seems good enough	Retiree plans, COBRA and VA care do not count as current job coverage. The late penalty is 10% for each full year missed, for life.
Pick a narrow network	The best-known hospital near you may not be in it. In 2026 more than 30 health systems ended contracts with some Advantage plans.

Write down what you cannot undo. Before any change, note the date your Medigap open enrollment ended and whether you still have a trial right.

Special situations

A few situations change the usual advice. If one of these fits you, a SHIP counselor is worth an hour.

Situation	What to know
You have Medicare and Medicaid	Dual special needs plans (D-SNPs) are Advantage plans built for you, with drugs included and some Medicaid benefits coordinated. They are heavily marketed. Check that your doctors take both the plan and Medicaid.
You have a serious chronic condition	Chronic condition special needs plans (C-SNPs) serve people with conditions such as diabetes, heart failure or COPD. You can stay only while you have the condition.
You live in a nursing home	Institutional special needs plans (I-SNPs) coordinate care inside the facility.
You split the year between two homes, or travel for long stretches	Advantage networks are local, so routine care away from home may be out of network. Original Medicare works anywhere in the US. Ask any plan how it covers care in your second state.
You are a veteran	VA care and Medicare do not coordinate. Many veterans keep Part B for care outside the VA. TRICARE For Life requires Parts A and B.
You are under 65, with Medicare because of a disability or kidney failure	Federal law does not require companies to sell you a supplement. About 30 states require at least one option, often at a higher price. When you turn 65, you get a new six-month supplement open enrollment.

Source: Medicare.gov, special needs plans and who pays first; KFF, Medigap enrollment and consumer protections by state.

04

Hospitals, bills and appeals

The questions to ask in the hospital, help with the bill, and what to do when a plan says no.

Medicare in the hospital

What happens in the hospital decides what Medicare pays afterward. Ask these questions out loud, and write down the answers.

Question	What to know
Am I admitted, or here for observation?	Only a doctor's inpatient order makes you an inpatient. Observation is outpatient care, even overnight. If you are in observation for more than 24 hours, the hospital must give you a written notice (the MOON).
Will rehab be covered after?	Original Medicare covers a skilled nursing facility only after three days as an admitted inpatient. Observation days do not count. Many Advantage plans drop this rule but require approval.
They changed me from inpatient to observation	In Original Medicare, since 2025 you can appeal to your region's quality organization while you are still in the hospital, and get a decision within about a day.
They say I must leave and I am not ready	You get the Important Message from Medicare at admission and before discharge. Call the number on it no later than your planned discharge day for a fast review. You can usually stay while it is decided.
Does my plan need to approve this?	Advantage plans often require approval first. Since January 2026 they must decide within 72 hours for urgent requests and 7 days for others, and give a specific reason for any denial.
Is this hospital in my network?	Emergency care is covered at any hospital in the US. For planned care, check the network. Hospitals and plans can end contracts, so check each fall.

Date	Who I spoke with	What they said

Get the status in writing. Ask the case manager to write down whether you are an inpatient or in observation, and the date it started.

Help with hospital bills

Nonprofit hospitals must offer financial help, and many people with Medicare qualify for help with what Medicare leaves. You have to ask.

Tax-exempt hospitals must have a written financial assistance policy for emergency and medically necessary care, post it where patients can find it, and not charge eligible patients more than they generally bill insured patients. Federal law does not set the income limit. Each hospital sets its own, and some states require every hospital to offer help. For reference, 400% of the 2026 poverty guideline is $86,560 for a household of two.

1. **Ask for the financial assistance application.** The billing office has it and it is usually on the hospital's website. Ask even if you have Medicare and a supplement.
2. **Ask what it covers.** Many policies cover the deductibles and coinsurance left after Medicare. Some cover only people without insurance.
3. **Apply even after the bill arrives.** Nonprofit hospitals must accept applications for at least 240 days after the first bill.
4. **Ask them to hold collections.** Before reporting you to credit bureaus or suing, a nonprofit hospital must make reasonable efforts to see if you qualify.
5. **Ask for an itemized bill.** Check every line against your Medicare Summary Notice or plan statement.

Help paying Medicare itself

Program	What it pays	Where to apply
Medicare Savings Programs	Your Part B premium, and at lower incomes your deductibles and coinsurance	Your state Medicaid office
Extra Help	Most of your drug plan's premium and costs	SSA.gov/extrahelp
Medicaid	Costs Medicare does not, including long-term care	Your state Medicaid office

Hospital	Applied on	Decision and amount

A SHIP counselor can check whether you qualify for any of these, for free. Find yours at shiphelp.org.

When a plan says no

Denials can be appealed, and many are overturned. Act inside the deadline, and ask your doctor for a supporting letter.

Advantage plan denials

1. **Read the denial notice.** It must give the specific reason and your appeal rights. Note the date on it.
2. **Ask the plan to reconsider within 65 days.** The plan decides within 30 days for care you have not had yet, 60 days for a bill, and 72 hours if waiting could seriously harm your health. Ask for a fast appeal when it is urgent.
3. **If the plan says no again, it goes to independent review automatically.** An outside reviewer, not the plan, decides.
4. **Further levels.** A hearing with a judge, the Medicare Appeals Council, then federal court. The hearing needs at least $1,960 in dispute in 2026, and each step has a 60-day deadline.

Drug plan denials and exceptions

If a drug is not on the plan's list, needs approval or costs too much, ask the plan for an exception. Your doctor sends a statement explaining why you need that drug. The plan decides within 72 hours, or 24 hours if your health is at risk. If it says no, you have 65 days to appeal to the plan, then 60 days to go to independent review.

Spreading out drug costs

Every drug plan offers the Medicare Prescription Payment Plan. Instead of paying at the pharmacy, you get a monthly bill from your plan spread across the rest of the year. It does not lower what you pay in total, but it helps if one expensive prescription early in the year would cost hundreds at once. Ask your plan to sign you up; there is no cost to join.

Date	What was denied	Appeal sent	Result

This does not have to stay paper

You have just written down the things your family would otherwise have to work out under pressure. Keep this binder somewhere two people know about, and tell them it exists.

Paper goes stale. A phone number changes, a policy renews, a parent moves, and the page you filled in last spring is quietly wrong.

Hubstone holds the same record and keeps it current. Enter something once, and share each page only with the people who should see it. When a detail changes, the record changes with it, and the reminder comes before the deadline. The Medicare Kit is free, on paper and in the app.

Fill it in once

Scan to start at hubstone.com/start. No card needed.