



YOUR ULTIMATE GUIDE TO
MEDICARE &
RETIREMENT
PLANNING

MATT MITCHELL

With Chase Gruening

64+

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Your Ultimate Guide to Medicare & Retirement Planning

Matt Mitchell

Co-Authored By Chase Gruening

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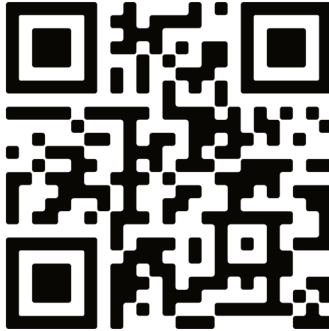
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INTRODUCTION

For most people, Medicare and retirement planning can feel overwhelming.

There are so many parts, so many choices—and so much conflicting information out there. Over the years, I've had countless conversations with people just trying to make the best decisions for themselves or their loved ones. Many of them didn't even know where to start. And that's exactly why this book was written.

It's meant to simplify things. To give you the facts. To help you feel more confident, more informed, and better prepared to take control of this important season of life.

I've spent years working in the Medicare and retirement space—walking people through their options, answering questions, and helping them find the coverage that fits their needs. This book is an extension of that same

mission. Whether you're turning 65 soon, or are already enrolled in Medicare and wondering if your plan is still the right fit, this book is for you.

WHY DID I WRITE THIS BOOK?

We've seen how powerful education can be—not just in one-on-one conversations, but in webinars, seminars, and other resources we offer. Everyone learns a little differently, and some prefer to take their time, flip through pages, and absorb information on their own terms.

This book was created for that exact purpose: to serve as a helpful, go-at-your-own-pace guide to understanding Medicare and retirement planning.

Whether you're holding the paperback version or reading digitally, I hope you find it clear, practical, and useful.

WHY SHOULD YOU LISTEN?

Choosing the right Medicare coverage is a big decision—and it helps to have guidance from someone who's spent time helping others do exactly that.

This book reflects the most common questions, concerns, and situations we've encountered while working with people just like you. It's designed to offer clarity, simplify the process, and help you make informed choices with confidence.

Our goal is to make Medicare easier to understand—and this guide is a great place to start.

WHAT WILL YOU GET FROM THIS BOOK?

This book is designed to give you a clear roadmap. You'll find explanations, examples, and step-by-step guidance to help you feel informed and in control. You'll learn what Medicare is, what your options are, what to look out for—and how to make confident choices for yourself or someone you love.

So, thank you for picking up this guide. Let's get started and take the guesswork out of Medicare and retirement planning—together.

CHAPTER 1

ORIGINAL MEDICARE

Let me begin with a situation I've seen play out time and time again—working with couples or families navigating Medicare for the first time.

One of the earliest lessons I learned in this field is that even people going through the exact same transition often have completely different concerns. I think back to one of my first client meetings with a couple approaching 65 and preparing to retire. They were entering the same season of life, but their priorities couldn't have been more different.

He was ready to be done with it.

She had a list of questions and wanted to understand every detail.

She cared deeply about keeping her current doctors, making sure her essential medications were covered, and

continuing to use the small, independent pharmacy she trusted. He, on the other hand, just wanted to check the box and move on.

That conversation taught me something important: everyone's Medicare journey is different—and a one-size-fits-all approach simply doesn't work.

We sat down together and walked through every single detail—prescriptions, providers, preferred pharmacies, travel needs, and more. We weren't just picking a plan; we were building peace of mind.

And because life changes, we revisit that conversation every single year. We check in on what's changed—doctors, medications, routines—and adjust the plan if needed. That ongoing relationship and annual review process have become one of my favorite parts of this work.

What I want you to take away from that story is simple: what's important to you matters. Your needs, your preferences, and your priorities deserve to be heard and respected.

Sometimes, what's ideal in your mind might not align perfectly with the available plans—but you deserve someone who will walk through the pros and cons with you transparently, and help you make the best possible decision for your situation.

In this chapter—and throughout this book—I’ll show you the same step-by-step approach I use when guiding individuals and families through Medicare. We’ll keep it simple, we’ll break it down clearly, and we’ll walk through the process together—just like I would do if we were sitting across the table.

One thing I always urge people to do is get out a piece of paper and take notes. I think it’s really important to highlight key points in this book and use it as an interactive resource.

That brings me back to one of the first questions I ask people: What is most important to you? Understanding that helps me recognize which points really resonated with you, or which ones didn’t and need further explanation.

But right now, we’re going to break this down from the most foundational part of Medicare: “Original Medicare.” That’s where Medicare was founded, and everyone who enrolls in Medicare must have these two parts. If you’re taking notes or highlighting, the letters you’re going to hear over and over again are Medicare Part A and Part B.

And if we break this down even further, Medicare Part A is your hospital coverage, and Medicare Part B is your doctor coverage.

Let’s take that even further. When we talk about Medicare Part A, which is hospital coverage, that’s the coverage that kicks in when you have inpatient hospital stays. If you stay

overnight in a hospital, Medicare Part A will cover that for you.

Medicare Part A is often automatically provided when you turn 65, or you can sign up for it at 65, even if you're still working. Medicare Part B is your doctor's coverage or outpatient coverage.

Medicare Part A covers inpatient hospital stays, and Medicare Part B covers outpatient doctor visits. If you go to your primary care doctor, see a specialist, or receive any outpatient care, that will fall under Medicare Part B. That, again, is the foundation of Medicare. When you think about that red, white, and blue Medicare card, that's exactly what it says on there. You may even have one right now. And if you do, it will say Medicare Part A – Hospital, and Medicare Part B – Medical (Doctor). If we think about Medicare like building a house, these two parts form the foundation. That is your concrete. That is what holds everything together—Medicare Part A and Medicare Part B.

The next question I often get is: “What does each part cost?” We've already covered what they include, so let's go over the costs.

Medicare Part A is traditionally premium-free.

That can be a little misleading because, if you check your payroll taxes, you'll see a Medicare deduction. If you're self-employed, you've been paying Medicare taxes. You've

actually been contributing to Medicare throughout your working life.

As long as you've worked 40 quarters (10 years) or your spouse has worked 40 quarters (10 years), you will qualify for Medicare Part A at *no additional cost*. Again, you've already paid into it, but once you reach eligibility, there will be no further payments required for Part A. And again, Part A covers hospital care.

Part B, on the other hand, is your doctor and outpatient coverage, and it is not free. Almost everyone on Medicare must pay a Part B premium. The standard Part B premium changes annually. Most people pay a pre-set monthly premium, while higher-income individuals may pay more.

In rare situations, some individuals may qualify for assistance with their Part B premium. If you believe that might apply to you, I strongly encourage you to book a one-on-one appointment to determine eligibility. However, it's not common.

On the other hand, if you are a high-income earner, you may pay more for Part B. We see this quite often. If your adjusted gross income is above a certain threshold, you will be subject to an additional charge known as the Part B IRMAA (Income-Related Monthly Adjustment Amount).

I want to slow down here to ensure that you take note of this if it applies to you. If your adjusted gross income

exceeds the threshold, you will pay more for your Medicare Part B coverage.

I recommend referencing the official Medicare website to determine which Part B premium bracket applies to you. Then, be sure to bring it up during your one-on-one appointment so we can review it together.

The next topic is the enrollment scenario. Many people ask me, “Okay, I understand Medicare Parts A and B. Medicare Part A covers the hospital, and Medicare Part B covers the doctor. But when do I enroll, and when do I get these benefits?”

I don’t want to confuse anyone here, but there are three different Medicare Part B enrollment scenarios that you may fall into. The most important thing is identifying which category applies to you.

The easiest scenario, Scenario 1, is if you are turning 65 and already receiving Social Security. If you’re already drawing Social Security benefits, you’ll automatically be enrolled in Medicare Parts A and B. You’ll receive your red, white, and blue Medicare card about three months before turning 65. While you have the option to delay Medicare Part B, this is uncommon for those already receiving Social Security. That’s the simplest enrollment scenario.

Scenario 2 applies if you are no longer working and not drawing Social Security. If you’re not working and not receiving Social Security benefits, you will likely need to

enroll in Medicare Part B yourself. This is where we step in to help guide you through the process. There are several ways to enroll in Medicare—you can do it online, over the phone, in person, or by mail. No matter which method you choose, we will be there to help you, walk you through the options, and determine the easiest way for you to enroll based on your preference. If this scenario applies to you, circle it, or if you're taking notes, make sure you identify which enrollment category fits your situation.

The last scenario, and often the most complicated, is if you are still working, turning 65, not drawing Social Security, and trying to determine what's best for you. This is when meeting with a professional is the best approach. We will compare your group employer coverage with your Medicare options side by side and help you determine the best course of action. This is a case-by-case decision, not a one-size-fits-all solution. For some people, staying on their employer-sponsored insurance makes the most sense. For others, enrolling in Medicare is the better choice. Either way, it's critical that we analyze both options carefully and make an informed decision based on your needs.

As we wrap up these three scenarios, take a moment to identify which one applies to you.

In Scenario 1, you're already drawing Social Security. When you turn 65 in Scenario 1, you're going to be enrolled in Medicare automatically.

In Scenario 2, you are not drawing Social Security, you are turning 65, and you are not working. In that scenario, we will most likely need to manually enroll you into Medicare.

In Scenario 3, you're still working, you still have employer coverage, and we'll need to make a decision on which option is best for you.

These are your three enrollment scenarios for going on to Original Medicare. Medicare Parts A and B are the foundation of the system. But just like building a house, a foundation alone isn't enough—you need more to complete the structure.

What do these leave you with? What exposures? What responsibilities are you left with when it comes to Medicare Parts A and B, and not having any other coverage? Medicare Part A, again, is hospital coverage. On day one, if you have Medicare Part A and are admitted to a hospital without any other coverage, you're responsible for a sizable deductible upfront, followed by a daily co-pay for each day you remain hospitalized.

So that deductible will be paid on the front end, and then a daily co-pay if you have a longer hospital stay. A long-term hospital stay could cost thousands if you only have Medicare Part A. Medicare Part B, on the other hand, is your doctor and outpatient coverage.

A lot of people think of this patient responsibility as 20%—Medicare covers 80%, and you're responsible for 20%.

That's partially true. Medicare Part B covers 80% of doctor visits, and you are responsible for 20% with no cap. At no point is there a max out-of-pocket. At no point is there a stopping point. You owe 20% with no limit. There's also a Medicare Part B deductible and some excess charges.

These are the foundational components of Medicare that we'll need to be aware of as we work through this conversation and understand why it's so important to have coverage that fills these gaps. Medicare Supplement plans and Medicare Advantage plans—you're probably getting a lot of solicitations for these right now—are designed to address these gaps. Medicare Parts A and B are the foundation for all of these options.

I want to wrap up this chapter by sharing a story about a couple who remind me why personalized Medicare planning matters so much.

They were referred by a trusted friend—just like many of the people we work with. When they reached out, both were already on Medicare, but their situations couldn't have been more different. One spouse, let's call her Allison, had serious chronic health issues and was already enrolled in a Medicare Supplement plan. Her biggest concern was that she felt she was paying too much.

And she wasn't wrong—she was paying close to \$300 a month, while her neighbor, living just down the street, was paying around \$100. Naturally, that raised questions. But

after reviewing her medical history and coverage needs, it was clear that staying on her current plan was actually in her best interest. Switching to a cheaper option would have meant risking coverage she relied on daily. While there were lower-cost options available, none offered the same level of protection based on her health conditions.

Her husband, on the other hand—let's call him Roger—was in excellent health. He took very few prescriptions and didn't have any major medical needs. For him, we were able to recommend a zero-premium Medicare Advantage plan, which ended up being a great fit. He's been on it for years and continues to have a positive experience.

I still remember our first phone call. They were living in Florida, which is one of the more expensive Medicare markets, and Allison understandably questioned why her cost was so high compared to her neighbors. But once we sat down, looked at her doctors, medications, and needs, the right answer became clear—even if it wasn't the answer she was hoping for. Sometimes, the best option isn't the cheapest one—it's the one that protects your health and ensures stability over time.

In the years since, we've had regular check-ins, reviewed their coverage annually, and continued making sure they both had the right plan for their evolving needs. Roger still jokes during our reviews about paying nothing and getting a great deal—mostly just to get a reaction from Allison.

But what stands out most is that they came to trust the process. Even when the advice wasn't what they expected, they knew it came from a place of experience, integrity, and a deep understanding of Medicare.

Their story is a good reminder that what works for your neighbor might not work for you. Just because someone else found savings or made a certain choice doesn't mean it's the right one for your situation. The key is to evaluate your personal needs and find a plan that truly fits.

As we continue through this book, that's what we'll keep focusing on: helping you understand your options, ask the right questions, and make decisions based on your priorities—not anyone else's.

CHAPTER 2

MEDICARE SUPPLEMENT VS. MEDICARE ADVANTAGE

As we transition into chapter two and we've covered the foundation of Medicare—Parts A and B—I want to continue building on the house analogy. As we put up the walls of that house, I want to talk about what most people come to us for: Medicare Supplement and Medicare Advantage plans. These are the next essential components of the house we're building together. Almost every single person I meet with comes to me without truly understanding the difference between a Medicare Supplement and a Medicare Advantage plan.

A lot of people think they understand the difference, while others are very upfront and admit they have no clue. I want to share an example from my most recent clients because, as I often say, almost every client fits into this mold. I draw comparisons from Carol and Gary, two clients I met with this past week who were referred by some longtime clients.

They were just like anyone else I would meet with, and I see this same scenario play out quite often.

With Carol and Gary specifically, they came to me with the traditional questions. I asked, “What are the things you want to check off your list today?” and they gave me the usual items.

One thing that stood out to me was when they said, “Well, we want to talk about these zero-premium plans and these food cards and all these extra benefits.”

I said, “Okay, great, you’re referring to a Medicare Advantage plan.”

They responded, “I thought that was a Medicare Supplement plan.”

My point is that you might be feeling just as confused right now as they were, simply by hearing terms like Medicare Supplement, Medicare Advantage, food cards, and so on.

That’s exactly the issue. People come to me overwhelmed by so much information, so many conflicting messages, that oftentimes, we just have to clear away everything they’ve heard and start from the beginning. That’s exactly what I did with Carol and Gary. As we sat down, they really couldn’t explain to me what they were referring to, and I told them, “That’s completely fine.”

This happens all the time—people come to me with something they received in the mail, something they saw in an

email, or something a friend mentioned, but they don't actually know what it means. And that's exactly why I have a job and why we've built a national practice with a strong reputation and countless reviews. We will break everything down, and as you continue writing on your piece of paper or taking notes, remember that there are two main options—two paths you can go down. Everything starts with Original Medicare, Parts A and B. That is the foundation of our house. We can't go anywhere without the foundation, or else the house falls apart.

This is precisely what I explained to Carol and Gary as I sat with them. They were sitting right in front of me, and we walked through exactly what their options were, step by step, to figure out what would best cover the exposures we talked about.

I said, "Okay, Medicare Part A—that's your hospital coverage. Medicare Part B—that's your doctor coverage." I told them, "I want you to write down under Medicare Part A that you have an exposure right away if you're admitted to the hospital, and then you could face a daily co-pay for each day you're there. A hospital stay could cost you thousands of dollars. Part B comes with a monthly premium, but you're still responsible for 20% of your medical expenses, with no cap."

We wrote those two things down on a piece of paper. Then I looked at Carol and Gary and asked, "Now, what's going to cover the rest of that?" And both of them said, "I don't

know.” That’s where Medicare Supplement and Medicare Advantage plans come into play. If you have Medicare, these are the two options you can choose to cover the remaining costs.

Some people also have a third option—employer coverage. If you have that option, we’ll advise you on whether it’s a viable or better choice for you. But for most people, these are the two primary options, and we’re going to focus on them: Medicare Supplement and Medicare Advantage.

I want you to take a piece of paper and draw a line down the middle—just one straight line down the center, “hot dog style,” as we used to call it in elementary school. Now, on one side, write “Medicare Supplement,” and on the other side, write “Medicare Advantage.”

This is where the conversation begins. We’re going to take a deep dive into each of these options and help you decide which one is best for you.

We’ll start on the left-hand side. If you’re taking notes, Medicare Supplement should be on the left, and Medicare Advantage should be on the right. There’s no particular reason for this—it’s just easier for me to start with Medicare Supplement since it was originally part of Medicare, while Medicare Advantage came later.

So, we know that no matter what, you have to pay the Medicare Part B premium. Whether you choose Medicare Supplement or Medicare Advantage, you can write “Part B

premium” on both sides of your paper—that’s a monthly cost you’re responsible for either way.

If you are drawing Social Security, your Medicare Part B premium will be automatically deducted from your Social Security payments. If you are not drawing Social Security, you will receive a bill from Social Security.

Each side of our paper should have “Part B premium.” We know we’re going to pay that amount either way, okay? Now, on the Medicare Supplement side, let’s work our way down that list. Medicare Supplement plans are known for providing the most comprehensive, robust coverage.

Let’s take a look at a Medicare Supplement plan. It provides top-notch coverage and gives you the freedom to see any doctor or hospital in the United States that accepts Medicare, which is virtually all of them. For someone with ongoing health concerns or who values flexibility, it’s often a clear choice. Medicare Supplement plans offer peace of mind by allowing access to care nationwide, as long as the provider accepts Medicare.

Now, if you’re writing things down, you should have “Part B premium,” and then next to it, write “comprehensive coverage, any doctor, any hospital that takes Medicare.” Below that, add “Medicare Supplement.”

Traditionally, Medicare Supplement plans come with a once-a-year deductible. That’s your Part B deductible, and

once you meet it, your Medicare-approved doctor and hospital services are typically covered at 100%.

A Medicare Supplement plan also has an additional premium, which depends on your zip code. You're going to hear me talk about zip codes quite a bit in this book. Premiums, quotes, and plan designs are all based on your zip code. So, with a Medicare Supplement plan, you pay the Part B premium, and then you have an additional premium for the supplement, which varies by location.

This plan offers the most robust coverage, allows you to see any doctor or hospital, and has no network restrictions, as long as the provider accepts Medicare. It provides comprehensive coverage with a simple, once-a-year deductible. Those are all things you should write down.

This picture is going to become very clear, I promise. You will also need to add prescription coverage if you want to avoid a penalty. The last thing to write down in this section is "Prescription Drug Coverage (Part D)."

I'll summarize this one last time. I know it's repetitive, but that's what it takes to fully understand this. Repetition is key. You need to write this down and approach it like you're learning something new for the first time. Think of it like learning to ride a bike—at first it takes focus and practice, but once it clicks, it becomes second nature.

That's exactly how I want to ensure you understand this. We have "Part B Premium" written down for Medicare

Part B. You have an additional premium for your Medicare Supplement—your no-network plan that lets you see any doctor or hospital as long as they take Medicare. And you also need a prescription plan.

Let's now transition to the right-hand side of the page—the Medicare Advantage plan. Medicare Advantage is newer to the scene and is a form of managed care, which we'll discuss further later on in the book. It actually replaces Medicare Parts A and B, but you must still be enrolled in Medicare Part A and continue paying your Part B premium. When you choose a Medicare Advantage plan, you're enrolling in a managed care plan that provides your Medicare benefits.

These plans are often zero-premium or have a very small premium. What attracts many people to these plans are the additional benefits they offer.

So, as we write on this page, start by writing "Part B premium," because we know that's something you have to pay either way. After that, let's compare the networks side by side. Medicare Advantage plans typically have a more restrictive network.

They're PPO or HMO plans, and you'll need to see a doctor within the plan's network to get the best coverage or the best pricing. These plans have more restrictions and specific networks, but that's not necessarily a bad thing.

Full transparency—we have thousands of people on both types of plans.

There is no one-size-fits-all solution, and both options can be great choices. The biggest difference is the cost, especially depending on where you are in the country. Some of these plans, as I mentioned, have a \$0 premium, meaning you don't pay anything for them. That can mean significant savings on monthly premiums, and if you're on a budget, this may be one of your only options, so it's definitely a relevant conversation. I often compare these plans to group insurance coverage.

Medicare Advantage plans include co-pays, maximum out-of-pocket limits, deductibles, and co-insurance. This means they are more of a gamble when it comes to your healthcare costs. I can't tell you exactly what you'll pay out of pocket with these plans—it all depends on your health and the services you require.

So, as we write things down, start with “Part B premium.” Then, note that you have a network-based plan, with premiums typically ranging from \$0 to \$50. After that, write down co-pays, max out-of-pocket costs, deductibles, and co-insurance. These are important factors to consider.

The last thing to write down here is “extra benefits.” These plans offer additional benefits, including dental, vision, hearing, gym memberships (such as SilverSneakers), and over-the-counter benefits. Medicare Supplement

plans, on the other hand, do not offer these extra benefits.

A Medicare Supplement plan does not include dental, vision, or hearing coverage. Some plans may offer a gym membership, but most do not. There are clear differences between the two options.

Also, on the right-hand side of your page, under Medicare Advantage plans, note that prescription drug coverage is included, so you don't need to purchase an additional prescription plan.

If I were in an elevator with you and had only 45 seconds to explain the difference between a Medicare Supplement plan and a Medicare Advantage plan, I would put it like this:

A Medicare Supplement plan costs more, but you get more. You take on less financial risk, your costs are predictable throughout the year, and you don't have to worry about unexpected medical expenses. You pay a little more up front, but it provides peace of mind.

I always say that money changes hands when problems are solved. Medicare Supplement plans solve the problem of unpredictable healthcare costs, and you pay for that security.

Medicare Advantage plans, on the other hand, typically have little to no monthly cost, but if you need care, you'll

be paying out of pocket, and in some cases, you could end up spending much more than if you had just chosen a Medicare Supplement plan in the first place.

Medicare Supplement plans don't include extra benefits, which may be a deciding factor for some people. It may also simply come down to budget. But, in short, with one option, you pay more and get more; with the other, you pay less but take on more financial exposure.

Sticking with our construction metaphor, we've started putting up the walls of the house, and we're beginning to build a solid educational understanding of Medicare Supplement and Medicare Advantage plans.

As we transition and wrap up this chapter, I want to touch on a couple of really important things that you'll hear us discuss throughout the book. The first is the importance of critical illness coverage—specifically, cancer, heart attack, and stroke coverage. Long story short, no matter which option you choose, we highly recommend adding a cancer, heart attack, and stroke rider.

There are a number of reasons for this, but the bottom line is that if you experience a cancer diagnosis, heart attack, or stroke, this is an area where Medicare will leave you with out-of-pocket expenses that your plan may or may not cover. We have clients who are diagnosed with these conditions every single day, and each one of them faces unexpected medical costs.

The next thing we're going to talk about is skilled nursing coverage.

One of the most important—and often overlooked—parts of Medicare and retirement planning is skilled care, nursing coverage, and home care. This is one of the biggest threats to your financial security. The only way to protect yourself from the costs of a nursing home or skilled care claim is to have a plan in place—unless you plan to self-pay, which could deplete your assets or put you in a Medicaid spend-down situation that could even take your home away. You need a plan in place.

What you need to know is that Medicare only covers up to 100 days of skilled care. That is the maximum coverage you can receive through Medicare. After those 100 days, there is absolutely nothing that covers you except a private plan.

If you take away anything from this book, make sure you understand the importance of protecting yourself from a \$7,000, \$8,000, or even \$10,000 per month nursing home bill, depending on the facility and level of care. The last thing I'm going to show you in this chapter is our umbrella coverage options. We have three different umbrella options.

UMBRELLA COVERAGE OPTIONS

Eliminates **Major Exposures*

UMBRELLA #3	UMBRELLA #2	UMBRELLA #1
Medicare Plan with Prescription Coverage	Medicare Plan with Prescription Coverage	Medicare Plan with Prescription Coverage
Cancer Heart or Stroke (CHS)	Cancer Heart or Stroke (CHS)	Cancer Heart or Stroke (CHS)
Dental Vision Hearing (DVH) or HIP Plan	Dental Vision Hearing (DVH) or HIP Plan	
Recovery Care		

These are going to eliminate these additional exposures—cancer, heart attack, stroke, nursing home, dental, hospital expenses, and more. This is how you cover the major costs that Medicare alone will not cover. We'll go into more detail throughout the book, but it's helpful to briefly introduce them here in Chapter 2.

Lastly, this chapter wouldn't be complete without sharing the story of a couple—Mark and his wife, Lisa. Back in 2018, I met them during a routine annual enrollment season. They lived in an affluent neighborhood and had done well for themselves financially. Lisa was focused on getting the best healthcare coverage in place. She chose a Medicare Supplement plan, and it quickly became clear that she was the one who took the lead when it came to their healthcare decisions. With many couples, there's usually one spouse who takes the reins, and for them, it was Lisa.

Mark was a different story. A strong, independent thinker who had been very successful in life, Mark preferred to go his own way. He had been advised to enroll in a Medicare Supplement or Advantage plan, but he declined. He didn't want to pay extra for something he didn't think he'd need. After all, he had the money to cover anything that came up.

Then in 2023, Mark was diagnosed with leukemia. His treatment required very specific medications and therapies—most of which fell under Medicare Part B. That meant Medicare only covered 80%, leaving him responsible for the remaining 20% with no cap.

In the end, Mark paid tens of thousands of dollars out of pocket. He could afford it, but that didn't mean it didn't sting. He called me and admitted, "I should have gone with something." Unfortunately, because of his diagnosis, he no longer qualified for a Medicare Supplement. The only available option at that point was a Medicare Advantage plan.

Today, Mark and Lisa still review their coverage every year. They're in the best position possible now—but it could have been much better if the right steps had been taken from the start.

The takeaway is simple: doing nothing is the worst decision you can make. There are many options available, even free ones in some cases. But the key is to take action early. Being proactive makes all the difference.

CHAPTER 3

MEDICARE SUPPLEMENTS DEEP DIVE

I want to start this chapter by sharing a few insights from years of helping people navigate Medicare. Over time, I've had the privilege of walking with clients through some of life's biggest transitions—whether they were just turning 65 or already well into retirement.

In that time, I've seen a lot of change. Medicare itself continues to evolve, but even more impactful are the changes I witness in people's lives—their health, their priorities, and their families. I've seen how different plans hold up when it matters most: during sudden diagnoses, major procedures, and sometimes even during end-of-life care. I've worked with families in those seasons, helping them make sense of the coverage and the costs when emotions were already running high.

And if there's one thing that experience has shown me again and again, it's this: Medicare Supplement plans offer the most consistent, reliable coverage available. We touched on it in the last chapter, but it's worth repeating—these plans bring peace of mind. They reduce worry. They minimize financial surprises. They do what they're supposed to do when life becomes unpredictable.

One story that has always stuck with me is from one of my very first clients. We met year after year to review their coverage. Over time, I got to know not just their healthcare needs, but also their personalities, their family, and even their favorite lunch spot.

Eventually, I got word that they had passed away. That one hit a little harder. Not just because they were a long-time client, but because I had walked alongside them through so many seasons of life. What gave me peace—and more importantly, what gave their family peace—was knowing that their Medicare Supplement plan had done exactly what it was supposed to do. There were hospital stays. There were challenges. But there were no surprise bills. No financial strain. No panic over what was or wasn't covered.

Stories like this serve as powerful reminders of why Medicare Supplement coverage is so highly recommended. I know that at the end of the day, when someone has a Medicare Supplement, they are going to receive the best care possible when they need it most.

Now that we've touched on one of the more emotional sides of this decision, let's look at another real-life story—still important, but a bit lighter—as we continue exploring what this coverage can mean for you.

After working with thousands of Medicare beneficiaries over the last decade, one of the most common issues I see—and one of the most common types of clients I meet—is someone over 65 who is paying too much for a Medicare Supplement plan. I see this all the time. Long story short, if you have been on Medicare and have a Medicare Supplement, chances are you're overpaying for it.

One of the most overlooked aspects of Medicare is the assumption that just because you purchased a plan when you turned 65—or have been on it for a couple of years—that there isn't a better plan or a lower price available for you.

And probably the hardest part of my job is helping people understand that just because they have a Medicare Supplement—whether it's Plan G or Plan N (we'll talk a lot about Plan G and Plan N in this chapter)—doesn't mean there isn't an identical plan available for them at a much lower cost. What we see time and time again is people overpaying for the coverage they already have.

So I urge you, if you are already on a Medicare Supplement, to consider reviewing your options. This is one of the easiest changes to make. We're not changing your

coverage—we're simply seeing if the same coverage is available at a lower price. That's something we do every day, and I want to make sure you, as the reader, know that you have that opportunity. It doesn't have to be during Medicare's open enrollment period—you can review and switch at any time throughout the year.

As we transition, we're going to take a deep dive into Medicare Supplement plans.

In the last chapter, we compared Medicare Supplements and Medicare Advantage plans side by side. Now, after hearing these stories and going through the pre-education from the last chapter, some of you may have already decided that a Medicare Supplement is the right choice for you. Or maybe you've done some research and are leaning toward a Medicare Supplement. Whatever the case may be, if you're considering a Medicare Supplement plan, we're going to focus in and help you understand it as thoroughly as possible.

I want to start by reviewing Medicare's biggest cost exposures. So again, remember Medicare Part A is your hospital coverage. If you have a hospital stay and only have Medicare Parts A and B (with no additional coverage), you'll be responsible for a significant deductible upfront, followed by a daily co-pay if your hospitalization extends over multiple days.

Now, Medicare Part B provides about 80% coverage, but you are responsible for the remaining 20% with no limit. Additionally, you have a deductible and some excess charges.

Now—drum roll—if you have a Medicare Supplement, that is what’s called your “secondary insurance,” and it essentially plugs those gaps up. It covers those major exposures. Original Medicare is primary; that’s your red, white, and blue card. Your Medicare Supplement comes in behind that and covers up those gaps, and you are covered comprehensively. You have Original Medicare, you have your Medicare Supplement, and then most people would have a prescription plan that we’ll talk about in the next chapter. Those three things combined are what Original Medicare was built on. That was the only option available until Medicare Advantage plans hit the scene.

This is really the foundation of Medicare, and it was the only available version at one time. Now, when it comes to Medicare Supplement plans, numerous questions arise: What are they? How many are available? How do I choose one? What are all the different things I need to know? We’re going to tackle that here.

When people sit down with me to talk about Medicare, I often see the moment it hits—they realize just how many different Medicare Supplement plans are out there. It can feel overwhelming at first, and that’s completely normal. The truth is, there are several plan options available, each

offering a different level of coverage. It's no wonder people often look at all the choices and say, "There are so many different options."

Well, if you're writing, you can go ahead and cross out some plans, or what I would actually do is just circle these plans: Plan F, G, and N. Those are the only plans I ever see anyone on. Over the last decade, I can count on one hand how many people have had a Medicare Supplement that wasn't a Plan F, G, or N. These are the most popular plans. Additionally, if you are going on Medicare after January 1, 2020, you cannot choose a Plan F, so that one is not even an option for you.

That leaves you with a Plan G and a Plan N. If you went on Medicare prior to January 1, 2020, you can still choose Plan F. As we really zoom in on these, for the purpose of this book, we're going to focus on Plan G and Plan N because they are relevant to everyone reading. Plan G covers almost 100% of the co-insurance of all Medicare expenses, except for the Medicare Part B deductible. To make it simple, your supplement is going to cover essentially 100% of Medicare-approved charges after you satisfy your annual deductible.

Everybody has to pay the Medicare Part B premium, no matter what you do. Plan N is going to be very similar to Plan G. You have the same deductible, but now you have what's called excess charges. And again, let's really simplify this.

This is the part where, if you're writing things down, it's going to be really helpful just to take some notes and reference them. With a Plan N Medicare Supplement, you could pay a small co-pay if you see a doctor or go to an emergency room. And then the excess charge is a small additional cost if the doctor charges more than the Medicare-approved amount. We'll break that down even further in a moment.

Another area where it's important to understand how coverage works is skilled nursing. Medicare Supplements can help cover many of the costs Medicare leaves behind, but there are still limits to what Medicare itself will pay for. Skilled nursing, nursing homes, and assisted living represent some of the biggest financial exposures in Medicare, yet they're also some of the most overlooked. Long story short: after 100 days in a skilled nursing facility, nursing home, or rehabilitation center, Medicare stops covering the cost—and at that point, you're completely on your own.

You heard that correctly. If you have an extended stay beyond 100 days and do not have a private plan, you will have to pay out of pocket. And even getting those 100 days of coverage is extremely complicated.

To qualify for any coverage at all, you must have a three-day hospital admission. Then, to continue receiving coverage, you must show improvement in your condition.

Regardless of these factors, after 100 days, Medicare stops paying, and you either have to self-pay or find an alternative plan. Many people don't fully understand their options. The reality is that you either need to have a plan in place or be prepared to self-pay. When I say self-pay, that means using your 401(k), retirement savings, or cash in the bank.

If you don't have assets to cover the costs, you may have to go through a Medicaid spend-down, which can include losing your home or other valuable assets.

Situations like these can significantly impact the legacy you leave behind. That's why it's so important to consider umbrella coverage, which includes skilled care, home care, and nursing home coverage. This should be a priority. We never recommend any of these plans without also discussing umbrella coverage to protect against these major financial risks.

The next question I commonly get when people begin their Medicare journey is: How much does all of this cost? How much does a supplement cost? How much does umbrella coverage cost? What is the overall cost? Great question.

The first thing I'll ask for is your zip code. I can give you an average, but prices vary widely depending on where you live. On the low end, a Medicare Supplement plan might cost around \$100 per month, while on the high end, it could be closer to \$200. Pricing can differ significantly

from one area to another—even from one zip code to the next—so it wouldn't be fair to give you a hard number without knowing your location.

Now, as we analyze the two Medicare Supplement plans, remember, we are focusing on Plan G and Plan N because they are relevant to everyone. Plan G, again, typically ranges from \$100 to \$200 per month.

And essentially, as we talked about, that will cover your Medicare-approved expenses after Medicare A and B. So it supplements your Medicare Part A and Part B coverage, paying for the remainder of your Medicare-approved expenses after you pay your annual deductible.

Now, for Plan N, we talked about how it differs slightly. Traditionally, I think a good estimate is that Plan N saves you around \$20 to \$40 per month compared to Plan G.

By choosing Plan N, you take on slightly more financial exposure. However, many people prefer Plan N because the lower premium leaves room in their budget for umbrella coverage—such as skilled nursing, home care, cancer, heart attack, and stroke riders, as well as a dental plan. These additional coverages help fill the gaps Medicare leaves behind.

So many people like Plan N. Now, Plan N is going to have the same Medicare Part B deductible. It also has a small co-pay for a doctor visit and a small co-pay for an emergency

room visit if you're admitted—\$20 for a doctor visit and \$50 for an emergency room visit.

I tell people all the time that many of my clients on Plan N report back to me that their doctor doesn't charge a co-pay. I always tell them, "Don't go asking for it." A lot of times, you may not even be charged a co-pay—it's up to the doctor.

Then, the excess charge, in bold there at the bottom—it says 15%, but remember, that's 15% of the 20%. If we do some quick math, let's say your bill was \$1,000. Medicare covers 80%, leaving you responsible for 20%, which is \$200. If the doctor applies an excess charge, it's 15% of that \$200, which is \$30. At the end of the day, even as those numbers add up, the excess charge is still relatively small.

If you're going on Medicare for the first time, I strongly recommend doing this six months before you turn 65. That way, you lock in the lowest rates possible. One thing I always tell clients is that Medicare Supplement plans don't decrease in price. Insurance, in general, rarely sees rate reductions. Prices typically go up. The best time to enroll is six months prior, when you can secure the lowest rates available. This can actually lock in your rate for up to 18 months, and it helps you avoid costly mistakes.

If you start six months ahead, you also have time to fix any errors. Number one, if a mistake happens, we have plenty of time to correct it. Number two, pre-planning helps

prevent mistakes in the first place. I've had clients enroll six months before turning 65, and I've had others wait until six days before. I promise you—the ones who do it six months ahead are far less stressed than those scrambling at the last minute. I urge you to begin the process as close to that six-month mark as possible.

And lastly, just check it off your list. We all have lingering to-do lists, but this process is actually much simpler when you have a trusted agency and an experienced agent guiding you.

Again, I want to remind you about the standardization of these plans. One example I always use is this: if you go to your local grocery store and buy a 12-pack of Coca-Cola, and then go across the street to Walmart and buy another 12-pack of Coca-Cola, what do you have? The exact same 12-pack. They were probably even delivered by the same truck. But the price you pay will likely be different. That's exactly what happens with Medicare Supplement plans. You can choose Company A, B, C, or D. For example, you could choose a Blue Cross supplement, or you could choose Cigna or Mutual of Omaha. All of these companies offer the exact same plan—the only difference is the price.

And that's one of the hardest things for people to understand. As discussed earlier in the chapter, even clients with substantial financial knowledge struggle to grasp that the insurance carrier does not provide any additional benefits or better coverage. These plans are standardized. The

federal government mandates which plans insurance companies can offer and what coverage they must provide. The only thing that carriers control is the price.

So we have a list of companies here, and there are many different options to choose from. I just want to make it very clear: *we work for you, not the insurance company*. Our job is to represent all these companies independently and find the best plan for you and your needs.

As we start to wrap up this chapter, I think it's important to address some common myths about working with a Medicare broker or agency—especially from someone who has been educating people on Medicare for over ten years.

The first myth is that you have to pay the agent. I've had many people in the past come to me and ask, "How much do I owe you?" or "How much does this cost?" I tell them, "Absolutely nothing," and they often look at me, completely surprised.

First, charging a fee would be illegal. Second, the insurance companies pay us—not you.

That leads to myth number two: "Nobody works for free, so the insurance company must charge a higher price if I go through someone like you."

Absolutely false. I cannot say this enough: you will pay the exact same price whether you work with a broker or do everything on your own.

The only difference is that without a broker, you wouldn't have an expert by your side to help guide you through changes year after year. And that is often the most overlooked benefit of using a broker.

Do big changes happen in Medicare? Absolutely. I talk to thousands of clients, and most have no idea what's changed since our last conversation. Having someone who stays on top of these changes—and who can help you adjust accordingly—is invaluable. And again, you don't have to pay a single penny for it.

Myth number three: “If you get paid by the insurance companies, you must be biased toward one company over another.”

Completely false. This is exactly why we represent so many different plans. We work for you, not the insurance company.

At the end of the day, if you came to me and said, “I want Company [X],” I would say, “That's fine.” But if Company [Z] offers the exact same coverage at a lower price, I would point that out to you. If you still choose Company X, I'm not going to argue with you. Again, I work for you—not the insurance company.

My job is to educate you. My job is to ensure you have the best plan at the best price for your needs. But ultimately, the decision is yours. And I'll be here, year after year, to help you make those decisions. So to summarize:

- Truth number one: There are no fees charged.
- Truth number two: The price you pay the insurance company is the same with or without a broker.
- Truth number three: With over 25 companies to choose from, there is no bias in plan selection.

To close this chapter, I look back on the last several years and think about Dan and Karen's story, along with the thousands of people we've helped with Medicare Supplement plans. At the end of the day, I know that when someone chooses a Medicare Supplement, they are going to have peace of mind.

They will have the best coverage when they need it and the ability to see the doctor or provider of their choice.

As you finish this chapter, I urge you to consider whether a Medicare Supplement is the right plan for you. Are you leaning toward Plan G or Plan N? Which umbrella coverage best fits your needs? I cannot say this enough—having the right plan in place makes all the difference.

The umbrella coverage, again, helps cover Medicare's major exposures, including skilled nursing, home care, critical illness coverage for cancer, heart attack, and stroke, as well as additional dental coverage if needed. We look forward to going over your notes with you when you book a one-on-one meeting, and customizing your coverage to meet your needs.

CHAPTER 4

PRESCRIPTION DRUG COVERAGE

I want to start this chapter on prescription drug coverage by going back to a familiar story—Mark and his wife, Lisa.

As mentioned earlier, Mark and Lisa are one of those couples who've always taken a thoughtful approach to their health coverage. When they first sat down to review their Medicare options, Lisa quickly enrolled in a Medicare Supplement plan and a Prescription Drug Plan. She understood the importance of having the right protection in place from day one.

Mark, on the other hand, took a different route. At the time, he was healthy, wasn't taking any medications, and didn't see the value in paying for a drug plan he didn't think he needed. That's not uncommon. Many people who

are just turning 65 feel the same way. If you've gone your whole life with good health and no prescriptions, it's easy to assume that won't change anytime soon.

But as we all know, health can change—sometimes faster than expected.

In Mark's case, several years passed without issue. Then came a leukemia diagnosis. It was sudden, serious, and required expensive, ongoing prescription treatments. One of the first calls Mark made was to talk about what could be done.

And that's when he said something that sticks with a lot of agents who've heard this story: "I was dumb for not taking prescription drug coverage."

It's not that the decision was unreasonable at the time. Mark simply didn't know what was ahead. Most people don't. But because he had opted out of a drug plan when he was first eligible, he couldn't just enroll mid-year. He had to wait until the next Annual Enrollment Period (October 15 – December 7), with his new coverage not starting until January. That meant going without drug coverage during one of the most critical health moments of his life.

Eventually, he was enrolled in a Prescription Drug Plan—but by that time, he had already spent thousands of dollars out of pocket. And since he had missed his initial enrollment window, he was also hit with a late enrollment

penalty—a fee added to his monthly premium that never goes away.

The point here isn't to scare anyone. It's simply to help you make an informed decision. Declining prescription drug coverage is an option—but it's important to understand the risk. You may not need it now, but the cost of not having it later can be significant.

With Medicare (and any insurance), you're not just paying for what you need today—you're protecting yourself from what might come tomorrow. And that's where a good conversation with your agent makes all the difference.

So as we walk through prescription drug plans in this chapter, keep Mark's story in mind. It's a powerful reminder that the right plan—chosen at the right time—can save you stress, money, and hard decisions down the road.

When enrolling in Medicare, it's important to understand how prescription drug coverage fits into your healthcare plan. Original Medicare (Part A and Part B) covers hospital and medical services, but it does not include coverage for most prescription medications.

To ensure you have access to the medications you need, you can enroll in a stand-alone Prescription Drug Plan (PDP)—also known as Medicare Part D—which is offered by private insurance companies. However, “Medigap” plans

do not include drug coverage. That's why enrolling in a separate Part D plan is critical for ensuring you have prescription coverage and avoid penalties.

By combining these three components—Original Medicare, a Medicare Supplement, and a Prescription Drug Plan—you create a comprehensive healthcare plan that covers hospital care, doctor visits, and necessary medications. Note that if you choose to go the Medicare Advantage route (which we will discuss in more detail in the next chapter), it often includes prescription drug coverage.

Here, I really want to focus on its key components. And I want to caution you—the reader—that it's easy to get lost in the details of Part D prescription drug coverage. My goal in this chapter is to make it as simple and easy to understand as possible.

Most people take prescription drugs. But everyone takes different ones. Your neighbor is taking different prescriptions than you. Your best friend is taking different prescribed medications than you. Even your own spouse may be taking different prescriptions than you. While this won't be an individualized conversation, I want to break down the components of a Prescription Drug plan and highlight some key changes.

The first thing to understand is the components of a Prescription Drug plan.

The first and most obvious component is the premium you pay for your Prescription Drug plan. Almost every Prescription Drug plan comes with a monthly premium, which you'll pay in addition to your Part B or any other premiums. The cost of your Prescription Drug plan depends on the plan you choose and your zip code. The first step we take is to enter your zip code to see what prescription plans are available in your area. The second step is entering your prescriptions. When we input your prescriptions, they will be matched to the plan's formulary, which is the list of drugs that the plan covers and how it covers them. The two key factors thus far are premium and formulary. The formulary is essential because it determines how your specific medications are covered under a given plan.

Next, there is a co-insurance or co-pay, which is the amount you pay when you fill a prescription. This is pretty self-explanatory.

Finally, many plans have a deductible—the amount you must pay before your plan begins to cover some or all of your medication costs.

These are the four major components of a Prescription Drug plan: premium, formulary, co-insurance or co-pay, and deductible. We will tie all of these together as we continue.

I want to quickly walk you through our extremely straightforward process. We make this super simple. The first thing we're going to do is use Medicare.gov's online calculator. If you're reading this, you can pause, go to Medicare.gov, enter your zip code, and type in your prescriptions. That's exactly what I do—I input your prescription drugs into the system. It doesn't matter if you have two prescriptions or twenty; we will enter them all into the Medicare Part D calculator.

Next, we'll choose your pharmacy. We'll look at the pharmacy or pharmacies you prefer. This decision is based entirely on your preference. Some pharmacies may cover your medications better than others, but ultimately, it's your choice.

Then, we'll compare all the available Prescription Drug plans in your area. In some areas, there are about 15 or 16 different plans—sometimes more—so there are plenty of options. But here's what I always say: the computer will identify the best plan for us.

This makes the process very straightforward. After we enter your personal information, the system will tell us which plan is best for you. Then, we'll enroll you in that plan.

Pretty simple, right? We'll enter the appropriate information, enroll you in the plan, and then each year, we'll re-evaluate it.

If you remember my discussion about the annual enrollment period (October 15 through December 7), that is our opportunity every year to review and adjust your plan as needed.

And more often than not, that's exactly what happens. Your health changes every year. Your medications change every year. That's why the annual review and re-evaluation process is so important. We have to make sure your plan keeps up with your personal changes. Just because a Prescription Drug plan works for you one year doesn't mean it will be the best plan for you the next year.

This is often the hardest concept for clients to grasp: Medicare is not a set-it-and-forget-it decision. Top-level service and expertise mean re-evaluating your plan each year to ensure you're on the right Part D prescription plan—not just for this year, but for the years and decades ahead. So whether you're working with us or someone else, make sure they are reviewing your prescription plan annually.

I also want to highlight the Inflation Reduction Act. If you've been on Medicare before 2025, you know that Prescription Drug plans used to work differently. There was the "donut hole," along with various coverage stages. But in 2025, all of that went away. The system is now much simpler to understand.

Now, there is a \$2,000 annual cap on prescription drug costs in formulary. This is a huge improvement for people who take multiple medications. If you require several prescriptions, this change benefits you significantly. Before this change, there was no cap—you would continue paying co-insurance indefinitely, regardless of how much you had already spent on medications. This new \$2,000 cap means you will never spend more than that amount out of pocket on your prescriptions in a single year, as long as they are in the plan's formulary.

This is a very good thing for someone taking a lot of prescriptions, including cancer medications, heart and stroke medications, rheumatoid arthritis medications, and insulin. It's a very beneficial change.

However, for this savings or cap to exist, the money has to be accounted for elsewhere. What has happened as a result is an increase in deductibles and an increase in plan premiums. For people who do not take medications, this may have affected them negatively. Overall, the impact of the Inflation Reduction Act means there will be fewer plans to choose from. Each of those plans must now include a \$2,000 maximum out-of-pocket cap, as long as your prescriptions are in formulary. The key phrase here is "in formulary."

Bringing umbrella coverage back into focus, we always recommend umbrella coverage, especially for prescription

coverage. A major gap that umbrella coverage helps fill is the cost of prescriptions.

The cancer, heart attack, and stroke coverage included in umbrella coverage protects you from non-formulary prescription costs. It also helps bridge the gap in max out-of-pocket expenses.

To wrap up this section, no matter which Prescription Drug plan you choose, it is crucial to have umbrella coverage. This will help cover any gaps in prescription drug costs that you may be responsible for. At the end of the day, this is part of our service and process. We will input your prescriptions, find the best plan for you, and make everything as simple as possible.

This is a highly individualized conversation. Some people may have a very quick and simple process, while others may require more time and planning. That's why I don't want to take up too much of this book going into every possible scenario.

We touched on this briefly with Mark's story. Mark, as you may recall, chose not to have prescription coverage during his first few years on Medicare. As a result, Mark incurred what's called a late enrollment penalty. A late enrollment penalty applies only if you choose not to have prescription coverage when you're first eligible and later decide to enroll in a plan. If you go your entire life without prescription drug coverage, you will not have a penalty. It only

applies if you go without coverage and then decide to enroll at a later date.

People often ask me, “What is the late enrollment penalty?” The penalty is calculated based on the number of uncovered months you went without a Prescription Drug plan before enrolling. It varies for each person. The national average late enrollment penalty is about 33 cents per uncovered month. For example, if someone went without a Prescription Drug plan for five years, we could calculate an estimated penalty. However, it is unique to each person’s situation.

Long story short, there are some very inexpensive Prescription Drug plans available. If you are concerned about the penalty, I urge you to enroll in a plan, even if you are not currently taking any medications. If you choose not to, just be aware that you could face a penalty if you decide to enroll in a plan later.

As we wrap up this chapter, I want to reiterate that prescription drug coverage is a highly personalized decision. No two people have the same health needs, and that means their prescription plans shouldn’t be identical either. One person might take multiple daily medications for chronic conditions, while another may only take one or two. And that’s okay—that’s exactly how it should be when you’re working with someone who understands how to tailor a plan to your individual needs.

We evaluate spouses individually. We evaluate every person individually. When you take an individualized approach, you ensure that each person gets the right plan for their specific needs. That's what everyone reading this book needs to understand—Prescription Drug plans are highly personalized. They are tailored to your specific medications.

Our goal is to make sure you have the right price, the right plan, and the right coverage for your unique situation.

CHAPTER 5

MEDICARE ADVANTAGE DEEP DIVE

As we start Chapter 5, we're going to take a deep dive into Medicare Advantage.

If you remember from earlier in the book, we briefly reviewed the differences between Medicare Supplement and Medicare Advantage. Medicare Supplement plans cost more, but they provide more comprehensive coverage and leave you with less financial exposure. With a Medicare Supplement, you can see any provider you want.

Medicare Advantage plans, on the other hand, typically cost less but leave you with a bit more financial responsibility. They require you to use certain doctors and hospitals to get the best possible price and coverage. However, they also offer additional benefits.

I want to share a couple of real stories from clients over the years. These examples highlight something every Medicare

agent knows to be true: Medicare is not a one-size-fits-all decision.

There are thousands of people on both Medicare Supplement and Medicare Advantage plans, and for many, a Medicare Advantage plan turns out to be the right choice. The key is knowing which option fits each person's health needs, lifestyle, and financial situation.

Let's start with Bill.

Bill is one of those people you don't forget—he's always cheerful, always joking, and always brings a smile into the room. When we first met, he had a Medicare Supplement plan, but after a couple of years, he transitioned to a Medicare Advantage plan. And for Bill, it was a smart move.

At the time, he only had one prescription, was in good health, and needed to be mindful of his monthly expenses. A Medicare Advantage plan made more sense financially—it offered him significant savings on premiums while also including extra benefits his previous plan didn't provide.

One of the standout features for Bill was the dental coverage. His plan came with \$3,000 a year in dental benefits, which allowed him to finally get dentures at no additional cost. It made a real difference. He was already a happy guy, but now he had the smile to match.

His plan also included vision and hearing benefits—all wrapped into a budget-friendly option that worked for his needs. When you add it up over a few years, Bill has saved thousands of dollars in premiums, while still having a safety net in place. Should anything serious happen—like a hospital stay, cancer diagnosis, or stroke—his plan offers protection with a cap on his out-of-pocket expenses. That kind of peace of mind matters, especially for someone on a fixed income.

Now, let's revisit another story from earlier in the book—Mark.

Mark is someone who has done well financially. When he first became eligible for Medicare, he opted out of additional coverage altogether. He didn't see the need and didn't want to pay for something he didn't think he'd use. But several years later, when he was diagnosed with leukemia, the lack of coverage quickly became a problem.

Because he had gone without coverage, he had to wait until the next open enrollment period to get on a plan. In the meantime, he was responsible for 20% of his medical costs under Medicare Part B—with no cap. That added up quickly. Treatments, procedures, and medications became extremely expensive out-of-pocket.

Eventually, Mark was able to enroll in a Medicare Advantage plan. The good news? That plan now gives him a defined maximum out-of-pocket limit, which means once

he reaches that threshold in a calendar year, he doesn't have to pay for covered expenses out of pocket. He doesn't pay anything extra for the plan itself, but it offers him financial protection that Original Medicare alone couldn't provide.

Mark is a great example of how Medicare Advantage plans aren't just for those on tight budgets—they can also be the right fit for someone with significant assets who simply wants to put a stop-loss in place to protect against catastrophic costs. Over the years, I've helped thousands of people with Medicare Advantage plans, and I've seen first-hand how these plans perform—both during the good times and the tough ones. From routine doctor visits to serious health challenges, these plans offer consistent coverage when it matters most, no matter the situation.

Whether you're like Bill or like Mark—or somewhere in between—the important thing is to understand what each plan type offers, and what kind of risks or benefits come with the decision. Medicare Advantage plans aren't for everyone, but for many, they're an affordable, flexible way to get comprehensive coverage.

With those two stories to establish the context, let's now get into the details—the educational side of Medicare Advantage plans. To provide a short summary, Medicare Advantage plans are managed care plans. You are still responsible for paying your Medicare Part B premium. However, the key difference is that when you enroll in a

Medicare Advantage plan, you are leaving the federal Medicare system and moving to a private insurance company that manages your care. For example, many major companies offer Medicare Advantage plans. What happens here is that instead of Medicare handling your benefits directly, the federal government pays these private insurance companies a monthly stipend to manage your care.

Insurance companies offering Medicare Advantage plans have a strong incentive to keep their members healthy. They focus on managing care efficiently to help reduce costly claims, which supports the overall success of their plans. Because of this, there are clear benefits to managed care—these companies are motivated to provide plans that work well both for members and for their business.

To encourage this, they offer many extra benefits. They entice you with incentives and encourage you to visit the doctor regularly, ensuring that you are proactive with your health rather than reactive.

So there are definite advantages to Medicare Advantage plans. But remember, when you enroll in one, you are moving into private healthcare and managed care. However, the one key rule is that these plans must provide you with the same basic benefits as Original Medicare (Parts A and B). That means they must still cover the same 20% Part B co-insurance and hospital exposure that Original Medicare covers.

The difference is that, with a Medicare Advantage plan, the 20% and the hospital co-insurance gaps are your responsibility. There are ways to reduce this exposure—such as using umbrella coverage to make it function more like a Medicare Supplement—but it’s important to understand that these plans can vary significantly.

In this chapter, we won’t compare specific plans side by side, because Medicare Advantage plans vary by zip code and county. They differ substantially from state to state. For example, plans available in California may look completely different from those in Maine. That’s why it’s essential to evaluate plans based on your zip code and county to understand exactly what is available to you.

These plans can be as low as a zero premium. You’ve probably seen the advertisements—zero-premium plans, food cards, and all sorts of extra benefits being promoted when you turn 65. However, one thing to keep in mind with these plans is that they include co-pays, deductibles, co-insurance, and out-of-pocket maximums.

With a Medicare Supplement, most of this exposure is covered. With a Medicare Advantage plan, you pay less up front but take on more financial responsibility. For this reason, we never recommend a Medicare Advantage plan without umbrella coverage. Very rarely do we see someone enroll in a Medicare Advantage plan without some form of umbrella coverage.

So how do you choose a Medicare Advantage plan?

First and foremost, your zip code matters. But beyond that, the most critical factors are your doctors, hospitals, and medications. Every plan has a formulary. And we have to look and see if your medications are in that plan.

The first thing I look for is whether your medications are covered by the plan. Next, I check if your doctors are in-network. If your doctors are included, hospitals usually are as well, but we verify hospital coverage, too. The key deciding factors for these plans are doctors, hospitals, and medications—along with the extra benefits they offer.

For example, one client wanted dental coverage. This plan provided free dental. Almost all of these plans also include a free gym membership.

These companies want you to stay healthy. They want to manage your care proactively so you live longer, which is why they offer free gym memberships.

Many plans also include vision and hearing benefits, as well as over-the-counter allowances. If you qualify, some even provide food cards or spending card benefits. These plans come with a variety of additional perks designed to enhance your overall healthcare experience.

One thing we always do is pull up the outline of coverage for these plans. The outline of coverage allows you to see exactly what your benefits look like—how much you

would pay for a procedure, how much you would pay for a hospital stay, and how much you would pay for a doctor visit. It provides a clear breakdown of your coverage.

Then, we take that umbrella coverage and layer it on top to help fill in the gaps.

The next question I often get is, “How and when do I sign up for these plans?”

These plans work slightly differently. You have to wait until at least three months before you turn 65 to sign up for a Medicare Advantage plan.

In comparison, Medicare Supplement enrollment can begin six months before you turn 65, whereas Medicare Advantage enrollment starts three months prior.

Each year, there is also the annual enrollment period from October 15 through December 7. This is when you can make changes to your Medicare Advantage plan. Additionally, there is a Medicare Advantage open enrollment period from January through March, during which you can make a one-time change.

These plans have more restrictions on when you can change them, which is why using a broker is so valuable, especially when dealing with Medicare Advantage plans. Having a trusted representative or educator is crucial, because Medicare Advantage plans can be complex. I see many people make poor decisions when choosing these

plans, and I cannot emphasize enough that if you are considering Medicare Advantage, do not navigate this alone.

There are many different plan types, including PPOs, HMOs, and POS plans. If you don't know what those mean, that's another reason to work with a broker or educator.

These acronyms refer to network types:

- **PPO (Preferred Provider Organization)** allows more flexibility in choosing doctors and hospitals.
- **HMO (Health Maintenance Organization)** has a more restrictive network with required referrals.
- **POS (Point of Service)** combines elements of PPO AND HMO, sometimes allowing out-of-network care at a higher cost.

It is important to understand these differences before enrolling in a plan.

As we wrap up our discussion of these two options, we are moving through the core of this book. We've covered Medicare Supplement plans, prescription drug coverage, and Medicare Advantage plans. I don't want to overcomplicate this book, so if you had to take away one key comparison, this is it:

- **Medicare Supplements:** You pay more, but you have more comprehensive coverage and less financial exposure.
- **Medicare Advantage:** You pay less upfront, but you take on more financial exposure.

These plans often come with additional benefits, which may be important to you.

And once again, I cannot emphasize enough—whether you choose a Medicare Supplement or a Medicare Advantage plan, do not enroll without umbrella coverage. Umbrella coverage eliminates major, catastrophic financial risks and helps protect the assets you’ve worked so hard to accumulate. It ensures your legacy remains intact and prevents your savings from being drained by costly medical events like cancer treatment or nursing home care.

As we wrap up this chapter, I want to reiterate that these plans offer significant value and are the right fit for many people. That’s why, during the first one-on-one call, our job is to understand you as an individual, assess your needs, and determine the plan, price, and coverage that best suit your unique situation.

CHAPTER 6

RETIREMENT PLANNING

A lot of people first come to us for one thing: Medicare planning. That's typically what opens the door. But what many don't realize is that Medicare is just one part of a much bigger picture. It's often the beginning of a broader conversation—one about retirement.

We've found that as people approach age 65 and begin planning for Medicare, they're also entering a new financial phase of life. This transition—from working and earning to drawing from retirement savings—is one of the most important (and often overlooked) stages in someone's financial journey.

That's why it's so important to also think through retirement planning—because your financial strategy should shift as your lifestyle changes. For decades, you may have contributed to 401(k)s, IRAs, or other investment accounts.

You may have been focused on growth, riding the ups and downs of the market. But now you're approaching a time when protecting what you've built becomes just as important—if not more important—than chasing big returns.

We encourage everyone nearing retirement to step back and ask:

- Has my financial strategy changed to reflect this new season of life?
- Am I still taking on the same risks I did when I was working?
- Do I have a plan in place to generate income, protect my assets, and preserve my legacy?

These are the types of conversations we have every day. Whether you're looking to protect your nest egg, reduce unnecessary fees, generate reliable income, or ensure your assets pass smoothly to your beneficiaries—we can help guide you through it.

Many people have a mix of accounts—such as 401(k)s, IRAs, Roth IRAs, or other savings vehicles—some actively managed, some self-managed, and others that have been left untouched for years. Regardless of where you're starting, the goal is to structure your retirement assets in a way that offers stability, flexibility, and peace of mind.

Our approach focuses on four key pillars:

Income – Creating lifetime income strategies to help ensure you never run out of money and always have enough to live comfortably in retirement

Protection – Safeguarding your retirement savings from unnecessary risk or market exposure

Growth – Utilizing strategies that allow your savings to continue growing responsibly over time

Legacy – Ensuring your assets are passed on efficiently and in line with your wishes

Retirement planning is about creating confidence. It's about knowing your money is protected and positioned to support your goals, your lifestyle, and your loved ones—not just today, but for years to come.

If you're thinking about retirement—or already retired, but haven't taken a fresh look at your financial picture—now is the time. These are the conversations we have every day, and we're here to help guide you through them with clarity and confidence.

CONCLUSION: PUTTING IT ALL TOGETHER

First and foremost, thank you for taking the time to read this guide. Medicare and retirement planning can feel overwhelming, and by getting to this point, you've already taken a huge step toward understanding your options and making confident decisions.

Our approach is simple—educate, advise, and support. You've completed the first step by learning the fundamentals through this book. The next step is to apply what you've learned to your personal situation. Every person's needs are different, and the right plan depends on your specific doctors, prescriptions, lifestyle, and goals.

That's where we come in. We're here to help you review your options, answer your questions, and make sure you're getting the coverage that truly fits your needs. Together, we'll look at your available plans, review your doctors and

CONCLUSION: PUTTING IT ALL TOGETHER

medications, and walk through your best choices step by step.

Once your plan is in place, we'll continue to support you with ongoing reviews and guidance—because Medicare isn't a one-time decision. As your needs change, we'll be here to make sure your coverage changes with you.

If you're ready to take the next step, reach out to schedule a no-cost consultation. Whether that conversation happens by phone, video, or another convenient format, we'll make the process simple, transparent, and tailored to you.

Thank you again for trusting this guide as part of your Medicare journey. We look forward to helping you put everything you've learned into action.

64+

Medicare shouldn't be complicated. Yet, too many people feel overwhelmed by confusing options, unexpected costs, and last-minute decisions. *64+* is your clear, step-by-step guide to navigating Medicare and retirement planning with confidence. Written by industry expert Chase Gruening, this book simplifies enrollment, breaks down coverage choices, and helps you avoid costly mistakes. Whether you're approaching 65, still working, or helping a loved one, *64+* ensures you understand your options and secure the best plan for your needs. With real-world insights and expert advice, this guide gives you the tools to protect your health, finances, and future—so you can navigate the next chapter with confidence.



MATT MITCHELL

Matt Mitchell began his career in the insurance industry in 2008. His passion for Medicare was ignited when he saw his grandmother struggling to understand its complexities. Motivated by her confusion, Matt has dedicated himself to simplifying Medicare for others. His mission is to help individuals navigate this often confusing topic, ensuring they can compare the pros and cons of each option and make informed decisions based on clear, factual information.

