ECOS MEDICARE SOLUTIONS

Retire With Confidence: The Medicare Guide

Everything You Need to Know About Medicare — Enrollment, Costs, Plans, IRMAA, and the Mistakes That Can Cost You a Fortune

Book 1 of 4 · The Retire With Confidence Series

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Let me tell you about a woman I'll call Linda.

Linda worked 34 years as a school administrator. She was smart, organized, and responsible with her money. She maxed out her 403(b) every year. She paid off her house. She saved diligently. By any measure, she did everything right.

Then she turned 65, and the gauntlet began.

In the span of 18 months, Linda had to make decisions about Medicare Part A, Part B, Part D, Medigap vs. Medicare Advantage, when to file for Social Security, whether to do a Roth conversion, how to handle her Required Minimum Distributions, and what to do about long-term care. Each decision had deadlines. Each decision had penalties for getting it wrong. And almost none of it was explained in plain English.

Linda missed her Initial Enrollment Period for Part B by two months. She didn't think she needed it because she was still on her employer's plan—but her employer had fewer than 20 employees, which meant her coverage wasn't considered "creditable." The result? A 10% penalty on her Part B premium for every year she was late. For the rest of her life.

That single mistake will cost Linda more than $12,000 over the next 20 years.

I wrote this book so that doesn't happen to you.

What You're Up Against

Here's the uncomfortable truth: the retirement system in America is not designed to be easy. Medicare has four parts, dozens of plan types, enrollment windows that open and close on strict timelines, and penalties that never expire. Social Security has more than 2,700 rules governing how benefits are calculated and paid. The tax code treats your retirement savings like a puzzle with pieces that don't fit together unless you know the tricks.

And the people who should be helping you? Many of them are salespeople in disguise, pushing products that pay them commissions rather than plans that protect your future.

That's not what this book is. And that's not who I am.

Why I Wrote This Book

I spent 22 years in the United States Air Force. I started operating heavy equipment on runways, and I ended my career teaching cyber warfare to officers. Along the way, I earned five Master's degrees, became a licensed Gerontologist, a Registered Social Security Analyst, and an independent insurance agent licensed in every major line of coverage that affects retirees.

I've sat across the table from thousands of people approaching retirement. Some were generals. Some were teachers. Some were truck drivers. All of them had the same look in their eyes: equal parts hope and fear.

This book is my attempt to replace that fear with knowledge. Not theory. Not jargon. Real numbers, real scenarios, and real strategies you can use starting today.

What This Book Will Do for You

By the time you finish this book, you will understand exactly how Medicare works—what it covers, what it doesn't, and which plan type is right for you. You'll know when to file for Social Security and how that decision affects your spouse. You'll understand how your 401(k), IRA, Roth IRA, and other accounts work together—and how the wrong withdrawal strategy can cost you tens of thousands in unnecessary taxes. You'll know what IRMAA is and why selling your house at the wrong time could spike your Medicare premiums. And you'll have a clear, year-by-year roadmap from age 59½ to 75 and beyond.

This isn't a book you read once and put on a shelf. It's a reference guide you'll come back to every year. Keep it close.

How to Use This Book

You can read this book cover to cover, or you can jump straight to the chapter that addresses your most pressing concern. Every chapter is designed to stand on its own while also building on the chapters before it.

Throughout the book, you'll find tables with real 2026 numbers, real-world examples with dollar amounts, checklists you can use immediately, and FAQ sections that answer the questions I hear most often. At the end of every chapter, you'll find my contact information. That's not a sales pitch—it's an open invitation. If anything in this book raises a question, pick up the phone or send a text. I'm here to help.

Let's get started.

Disclaimer

This book is for educational purposes only and does not constitute legal, tax, or financial advice. While every effort has been made to ensure accuracy using official 2026 figures from the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA), and the Internal Revenue Service (IRS), rules and figures can change. Always verify current information with official sources and consult with a qualified professional before making financial decisions. Individual results vary based on personal circumstances. The examples in this book use composite characters and hypothetical scenarios for illustration purposes.

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PART I

*Every retirement plan starts with healthcare. Medicare is the

MEDICARE: YOUR FOUNDATION

Every retirement plan starts with healthcare. Medicare is the foundation everything else is built upon.

Chapter 1: Medicare 101 — What It Is, What It Isn't, and Why It Matters More Than You Think

Imagine this: you've just blown out the candles on your 65th birthday cake. Your family is smiling. You're thinking about golf, grandkids, maybe a trip to Europe. But somewhere in that pile of birthday cards is a letter from Medicare that will affect every year of your life from this moment forward.

Ignore that letter, and you could face penalties that last the rest of your life. Misunderstand it, and you could end up with thousands of dollars in unexpected medical bills. Get it right, and you'll have the peace of mind to actually enjoy the retirement you earned.

Medicare is the single most important decision you'll make in retirement. And yet most people spend more time researching their next car than understanding their healthcare coverage.

Let's fix that right now.

What Medicare Actually Is

Medicare is a federal health insurance program run by the Centers for Medicare & Medicaid Services (CMS). It was signed into law in 1965 by President Lyndon B. Johnson as part of the Social Security Act. Its original purpose was straightforward: give Americans aged 65 and older access to affordable healthcare.

Today, Medicare covers more than 67 million Americans. That includes people 65 and older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant) or Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease).

Think of Medicare as the base layer of your retirement healthcare. It's not optional. It's not a luxury. It's the foundation that everything else—Medigap plans, drug coverage, dental, vision, long-term care—is built upon.

What Medicare Is NOT

Here's where people get into trouble. Medicare is not free healthcare. It's not unlimited

healthcare. And it is absolutely not the same thing as Medicaid.

Let me be blunt: Medicare has premiums, deductibles, copays, and coinsurance. It does not cover everything. It does not cover long-term care (nursing homes for extended stays). It does not cover most dental, vision, or hearing care. It does not cover care received outside the United States in most cases. And it comes with enrollment rules so strict that missing a deadline by even one day can result in permanent financial penalties.

I've seen people assume Medicare will "take care of everything." That assumption has bankrupted families. Don't let it bankrupt yours.

Medicare vs. Medicaid: Clear Up the Confusion Now

This is one of the most common mix-ups I see. Medicare and Medicaid are two completely different programs.

Who It's For	People 65+ or with qualifying disabilities	Low-income individuals and families
Funded By	Federal payroll taxes (you've been paying in)	Federal and state governments jointly
Administered By	Federal government (CMS)	Each state individually
Based On	Age or disability	Income and assets
Cost to You	Premiums, deductibles, copays	Little or no cost (varies by state)
Covers Long-Term Care?	Very limited (100 days max)	Yes, for those who qualify

Some people qualify for both Medicare and Medicaid at the same time. They're called "dual eligibles," and they have a unique set of rules we'll cover later in Chapter 36.

Why Medicare Matters More Than Any Other Retirement Decision

Here's a number that should get your attention: the average 65-year-old couple retiring in 2026 will need approximately $351,000 to cover healthcare costs in retirement, according to Fidelity's annual estimate. That's not including long-term care. That's not including dental implants or hearing aids. That's just premiums, copays, deductibles, and prescription drugs over a typical retirement.

Healthcare is likely the single largest expense you'll face in retirement—bigger than housing, bigger than food, and far bigger than most people budget for. The decisions you make about Medicare in your first year of eligibility will determine how much of that $351,000 actually comes out of your pocket versus being covered by your plan.

Get the wrong plan, and you could pay tens of thousands of dollars more than you need to. Get the right plan, and you'll have predictable costs, broad coverage, and the

freedom to focus on living rather than worrying.

The Three Groups of People Who Get Medicare

You're automatically eligible for Medicare if you meet one of these criteria:

Group 1: You're turning 65. This is the most common path. Whether you're still working or fully retired, age 65 is when Medicare eligibility begins for most Americans.

Group 2: You're under 65 with a qualifying disability. If you've been receiving Social Security Disability Insurance (SSDI) for 24 months, you're automatically enrolled in Medicare. This includes conditions like advanced heart failure, severe arthritis, and many others.

Group 3: You have End-Stage Renal Disease or ALS. These conditions grant Medicare eligibility regardless of age, with no 24-month waiting period for ALS.

REAL-WORLD EXAMPLE: The Cost of Waiting

> *Tom, age 66, retired at 65 but assumed his COBRA coverage was "good enough." He didn't sign up for Medicare Part B during his Initial Enrollment Period. When his COBRA ran out 18 months later, he enrolled in Part B during the General Enrollment Period. But because he was 12 months late, he now pays a 20% penalty on his Part B premium—permanently. In 2026, the standard Part B premium is $202.90 per month. Tom pays $223.19 per month. Over 20 years, that's an extra $8,880 he didn't need to spend—all because of a timing mistake.*

The Bottom Line

Medicare is not a set-it-and-forget-it decision. It's a system with moving parts, enrollment windows, penalties, and costs that change every year. But here's the good news: it's learnable. It's manageable. And with the right guidance, you can make decisions that save you thousands of dollars and protect your health for decades.

The chapters that follow will walk you through every piece of Medicare—the four parts, the costs, the enrollment rules, and the plan choices. By the end of Part I, you'll know more about Medicare than 95% of the people enrolled in it.

FREQUENTLY ASKED QUESTIONS

Q: Is Medicare really free?

> *A: Part A (hospital insurance) is premium-free for most people—if you or your spouse paid Medicare payroll taxes for at least 10 years (40 quarters). Part B, Part D, and any supplemental plans all have premiums. And even with Part A, you'll still pay deductibles and copays.*

Q: Do I have to sign up for Medicare at 65?

> *A: Not necessarily. If you're still working and have creditable employer coverage (from an employer with 20+ employees), you can delay Part B without penalty. But the rules are strict—get this wrong and you'll pay a penalty for life.*

Q: What if I'm a veteran? Do I still need Medicare?

> *A: VA benefits are excellent, but they don't count as creditable coverage for Medicare purposes. Most veterans benefit from enrolling in Medicare alongside their VA benefits. We cover this in detail in Chapter 34.*

Q: Can my spouse get Medicare through me?

> *A: Your spouse can qualify for premium-free Part A based on your work record if you have 40+ quarters of Medicare-taxed employment. They still enroll separately and must meet age or disability requirements.*

Q: What happens if I move to another state?

> *A: Medicare is a federal program—it follows you everywhere in the U.S. However, Medicare Advantage and Medigap plan availability and pricing can vary by state and county. If you move, review your plan options in your new area.*

CHAPTER 1 CHECKLIST

> ☐ *I understand that Medicare is not free—it has premiums, deductibles, and copays*
>
> ☐ *I know the difference between Medicare and Medicaid*
>
> ☐ *I understand the three groups who qualify for Medicare*
>
> ☐ *I know that late enrollment can result in permanent penalties*
>
> ☐ *I've noted my 65th birthday and the 7-month window around it*
>
> ☐ *If I'm still working at 65, I've confirmed whether my employer coverage is "creditable"*

READY TO TAKE THE NEXT STEP?

You don't have to figure this out alone. I've helped thousands of people navigate these exact decisions, and I'd be honored to help you, too. Call or text me for a free, no-obligation retirement review. No sales pitch. Just straight answers from someone who's been there.

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Chapter 2: The Four Parts of Medicare — A, B, C, and D Explained Simply

If Medicare were a car, Part A would be the engine, Part B would be the steering wheel, Part C would be the premium upgrade package, and Part D would be the fuel. You need to understand all four to stay on the road.

Too many people sign up for Medicare without understanding what each part does. They end up with coverage they don't need and gaps they don't know about. This chapter will make sure that doesn't happen to you.

Part A: Hospital Insurance

Medicare Part A covers inpatient care. Think of it as your "inside the hospital" coverage. Here's what Part A covers:

Inpatient hospital stays (semi-private room, meals, nursing care, drugs administered in the hospital, and other hospital services). Skilled nursing facility care (up to 100 days per benefit period, after a qualifying 3-day hospital stay). Home health care (part-time skilled nursing, physical therapy, occupational therapy, and other services). Hospice care (comfort care for terminal illness, including medications for pain management).

Here's the key detail most people miss: Part A is premium-free for most Americans. If you or your spouse worked and paid Medicare payroll taxes for at least 10 years (40 quarters), you pay $0 per month for Part A. If you don't have 40 quarters, you can still buy Part A—but the 2026 premium is up to $565 per month.

Part A Costs in 2026

Monthly Premium	$0 (with 40+ quarters)	Free for most people
Monthly Premium (30-39 quarters)	$311 per month	Reduced premium
Monthly Premium (<30 quarters)	$565 per month	Full premium
Inpatient Deductible	$1,736 per benefit period	You pay this before Part A kicks in
Days 1–60	$0 coinsurance	Fully covered after deductible
Days 61–90	$434 per day	You pay this daily coinsurance
Days 91–150 (Lifetime Reserve)	$868 per day	60 lifetime reserve days total
Beyond 150 days	All costs	You pay everything
Skilled Nursing: Days 1-	$0 coinsurance	Fully covered

20	$0 coinsurance	Fully covered
Skilled Nursing: Days 21–100	$217.00 per day	Daily coinsurance
Skilled Nursing: Beyond 100 days	All costs	You pay everything

Notice that Part A coverage has a hard limit. After 60 days in the hospital, you start paying $434 per day. After 90 days, it jumps to $868 per day using your lifetime reserve days—and you only get 60 of those in your entire life. After 150 days total, Medicare stops paying entirely. This is one of the biggest gaps in Medicare, and it's exactly why supplemental insurance matters.

Part B: Medical Insurance

If Part A is your "inside the hospital" coverage, Part B is your "outside the hospital" coverage. It handles doctor visits, outpatient services, preventive care, and medical equipment.

Part B covers: doctor and specialist visits, outpatient surgery and procedures, diagnostic tests (lab work, X-rays, MRIs), mental health services (outpatient), durable medical equipment (wheelchairs, walkers, oxygen), preventive services (annual wellness visits, screenings, flu shots), and ambulance services when medically necessary.

Part B Costs in 2026

Unlike Part A, Part B is not free. Everyone who enrolls in Part B pays a monthly premium. The standard premium for 2026 is $202.90 per month. But here's the catch: if your income is above a certain threshold, you'll pay more. A lot more. This is called IRMAA, and it's so important that we're dedicating an entire chapter to it later (Chapter 11).

Standard Monthly Premium	$202.90
Annual Deductible	$283
Coinsurance (after deductible)	20% of the Medicare-approved amount
Excess Charges	Up to 15% above the Medicare rate (Original Medicare only)

That 20% coinsurance is unlimited. There is no out-of-pocket maximum on Original Medicare Part B. If you have a $205,000 surgery, you owe $40,000. That's not a typo. This is one of the most dangerous gaps in Medicare, and it's the primary reason Medigap insurance exists.

Part C: Medicare Advantage (The All-in-One Option)

Medicare Part C—commonly called Medicare Advantage—is not a separate benefit from the government. It's a way of receiving your Part A and Part B benefits through a private

insurance company instead of through the government directly.

Think of it this way: Original Medicare (Parts A and B) is like buying groceries at the farmers' market—you pick each item individually and pay as you go. Medicare Advantage is like a meal kit subscription—everything is bundled, and the company manages the details.

Medicare Advantage plans often include extra benefits not found in Original Medicare: dental, vision, hearing, gym memberships, transportation to medical appointments, and over-the-counter drug allowances. Most plans include Part D drug coverage built in. And many have $0 monthly premiums (you still pay your Part B premium).

But there are trade-offs. Medicare Advantage plans use networks (HMO, PPO, or PFFS). You may need referrals to see specialists. You're limited to doctors and hospitals within the plan's network (or face higher costs). And if you travel frequently or split time between states, a network-based plan may not cover you well outside your service area.

We'll do a full, side-by-side comparison of Original Medicare vs. Medicare Advantage in Chapter 6.

Part D: Prescription Drug Coverage

Medicare Part D covers outpatient prescription drugs. It's offered through private insurance companies approved by Medicare. Every plan has a formulary—a list of drugs it covers—organized into tiers that determine your cost.

A landmark change is now in effect for 2026: there is a $2,000 annual out-of-pocket cap on prescription drug spending for Part D enrollees. Before this change, some seniors were paying $10,000 or more per year for medications. The $2,000 cap is a game-changer, and Medicare also offers a monthly payment option so you can spread that $2,000 across the year instead of paying it all at once.

We'll cover Part D in full detail in Chapter 8, including how formularies work, how to compare plans, and how the new $2,000 cap changes your financial planning.

How the Four Parts Work Together

Part A	Hospital / Inpatient	$0 (most people)	Premium-free with 40 quarters
Part B	Doctors / Outpatient	$202.90/mo (standard)	No out-of-pocket maximum
Part C	A + B + often D via private plan	$0–$200+/mo	Bundled with extras
Part D	Prescription Drugs	Varies by plan	$2,100 annual OOP cap

REAL-WORLD EXAMPLE: Margaret's Part B Surprise

> *Margaret, age 67, had Original Medicare with Parts A and B and no supplemental coverage. She needed knee replacement surgery. The Medicare-approved cost was $50,000. Part A covered her hospital stay after her $1,736 deductible. But the surgeon's outpatient follow-up care was billed through Part B. After her $283 deductible, she owed 20% of all Part B charges—with no maximum. Her out-of-pocket costs totaled over $11,000. If Margaret had a Medigap Plan G, her total out-of-pocket would have been $283 (the Part B deductible). That's it.*

FREQUENTLY ASKED QUESTIONS

Q: Do I need all four parts?

> *A: At minimum, you need Parts A and B. From there, you choose: either Original Medicare with a Medigap plan and standalone Part D, or a Medicare Advantage plan that bundles everything. We'll help you decide which path is right in Chapter 6.*

Q: Can I have Medicare Advantage AND a Medigap plan?

> *A: No. Medigap only works with Original Medicare (Parts A and B). If you enroll in a Medicare Advantage plan, you cannot use a Medigap plan. It's one path or the other.*

Q: Is Medicare Advantage really free?

> *A: Many plans have $0 premiums, but you still pay your Part B premium ($202.90/month in 2026). And you'll still have copays, deductibles, and coinsurance within the Advantage plan.*

Q: What's the difference between coinsurance and copay?

> *A: A copay is a fixed dollar amount you pay (e.g., $30 for a doctor visit). Coinsurance is a percentage of the total cost (e.g., 20% of a $10,000 procedure = $2,000). Both are your share of the cost after Medicare pays its portion.*

CHAPTER 2 CHECKLIST

> ☐ *I understand what Parts A, B, C, and D each cover*
>
> ☐ *I know Part A is premium-free for most people with 40+ work quarters*
>
> ☐ *I understand that Part B has no out-of-pocket maximum*
>
> ☐ *I know the difference between Original Medicare and Medicare Advantage*

> ☐ *I'm aware of the $2,000 Part D out-of-pocket cap*

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Chapter 3: When and How to Enroll — The 7-Month Window You Cannot Miss

If Chapter 1 explained what Medicare is and Chapter 2 explained how it works, this chapter is about the when—and in Medicare, timing is everything.

Miss your enrollment window by a single day, and you could face penalties that follow you for the rest of your life. I'm not being dramatic. I'm being honest.

Let's walk through every enrollment period, every deadline, and every exception—so you never get caught off guard.

The Initial Enrollment Period (IEP): Your 7-Month Golden Window

Your Initial Enrollment Period is a 7-month window centered around your 65th birthday. It starts 3 months before your birthday month, includes your birthday month, and extends 3 months after your birthday month.

For example, if your birthday is October 15, your IEP runs from July 1 through January 31 of the following year.

During this window, you can sign up for Part A, Part B, or both. This is your cleanest, easiest entry point into Medicare. If you enroll during the three months before your birthday month, your coverage starts on the first day of your birthday month.

3 months before birthday month	1st day of birthday month
During birthday month	1st day of the following month
1 month after birthday month	1st day of 2nd month after enrollment
2 months after birthday month	1st day of 3rd month after enrollment
3 months after birthday month	1st day of 3rd month after enrollment

The message is clear: enroll early. The earlier you enroll within your IEP, the sooner

your coverage starts and the fewer gaps you'll have.

The General Enrollment Period (GEP): The Backup Plan with Penalties

If you miss your IEP and don't qualify for a Special Enrollment Period, your next chance is the General Enrollment Period, which runs from January 1 through March 31 each year. Coverage doesn't start until July 1.

That means you could be without Medicare coverage for months. And here's the penalty: for every 12-month period you could have had Part B but didn't sign up, your Part B premium goes up by 10%. That penalty is permanent.

If you were eligible at 65 but didn't enroll until 67, that's two years late—a 20% penalty. On the 2026 standard premium of $202.90, that's an extra $40.58 per month, or $486.96 per year, for life.

Special Enrollment Periods (SEPs): The Safety Nets

There are several situations that give you a Special Enrollment Period, allowing you to enroll outside of the standard windows without penalty.

The most common SEP is for people who are still working at age 65 and have employer-sponsored health coverage from an employer with 20 or more employees. As long as you have this "creditable coverage," you can delay Part B without penalty. When you leave your job or lose that coverage, you get an 8-month SEP to enroll in Part B.

Other SEPs include: moving out of your plan's service area, losing your current coverage through no fault of your own, qualifying for Medicaid or Extra Help, being released from incarceration, or specific circumstances related to disasters or government errors.

The Creditable Coverage Trap

This is where I've seen the most expensive mistakes. "Creditable coverage" doesn't just mean you have health insurance. It means your current coverage is at least as good as Medicare Part B, AND it comes from an employer with 20 or more employees who is actively employing you.

COBRA does not count as creditable coverage. Retiree insurance may or may not count. Coverage from a spouse's employer with fewer than 20 employees may not count. VA coverage does not count for Medicare purposes. Marketplace (ACA/Obamacare) plans do not count.

If your coverage is not creditable and you delay Part B enrollment, you will owe a permanent penalty. I cannot emphasize this enough: verify your creditable coverage status before making any enrollment decisions.

Medicare Advantage and Part D Enrollment Periods

Medicare Advantage and Part D have their own enrollment seasons:

Annual Enrollment Period (AEP): October 15 through December 7 each year. This is when you can join, switch, or drop a Medicare Advantage plan or Part D plan. Changes take effect January 1.

Medicare Advantage Open Enrollment Period (MA OEP): January 1 through March 31. If you're already in a Medicare Advantage plan, you can switch to a different Advantage plan or return to Original Medicare and pick up a Part D plan. You can make one change during this period.

REAL-WORLD EXAMPLE: The COBRA Mistake

> *Steve retired at 65 and elected COBRA continuation from his former employer. His HR department told him COBRA would "cover him" for 18 months. What they didn't tell him was that COBRA is not creditable coverage for Medicare purposes. Steve assumed he had 18 months to figure out Medicare. He was wrong. When his COBRA ended at age 66½, he enrolled in Part B during the General Enrollment Period—but because he was 18 months late, he faces a permanent 10% Part B penalty. At $202.90/month standard, his penalty adds $20.29/month, or $222/year, for the rest of his life. Total estimated cost over 20 years: $4,440.*

FREQUENTLY ASKED QUESTIONS

Q: I'm turning 65 but still working. Do I have to sign up?

> *A: If your employer has 20+ employees and you have their group health plan, you can delay Part B without penalty. You should still sign up for Part A (it's free and doesn't interfere with employer coverage). When you retire or lose that employer coverage, you'll have an 8-month SEP to enroll in Part B.*

Q: My spouse has employer coverage. Does that protect me?

> *A: It depends. If your spouse's employer has 20+ employees and you're covered under their group plan as a dependent, you can delay Part B. If the employer has fewer than 20 employees, Medicare becomes your primary insurance at 65, and you need to enroll.*

Q: Can I enroll in Medicare online?

> *A: Yes. You can enroll at ssa.gov, by calling Social Security at 1-800-772-1213, or by visiting your local Social Security office. Your initial enrollment in Parts A and B goes through Social Security, not Medicare directly.*

CHAPTER 3 CHECKLIST

> ☐ *I know my 7-month Initial Enrollment Period dates*
>
> ☐ *I've verified whether my current employer coverage is "creditable"*
>
> ☐ *I understand that COBRA is NOT creditable coverage for Medicare*
>
> ☐ *I know the Part B late enrollment penalty is 10% per year, permanently*
>
> ☐ *I know the Annual Enrollment Period runs October 15 – December 7*
>
> ☐ *I've created a calendar reminder 3 months before my 65th birthday*

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Chapter 4: What Medicare Covers (And the Gaps That Will Shock You)

Here's a question I hear all the time: "Darin, I have Medicare. I'm covered, right?"

And my answer is always the same: "You're partially covered. And the uncovered parts can destroy your retirement savings if you're not prepared."

Medicare is excellent at what it does. But what it doesn't do is where families get blindsided. Let's walk through both sides.

What Medicare DOES Cover

Medicare covers a broad range of medically necessary services. Here are the highlights:

Under Part A (Hospital/Inpatient): inpatient hospital care, skilled nursing facility care (up to 100 days), home health services, hospice care, and inpatient psychiatric care (up to 190 lifetime days in a psychiatric hospital).

Under Part B (Medical/Outpatient): doctor visits and specialist consultations, outpatient surgery, preventive services (mammograms, colonoscopies, cardiovascular screening, diabetes screening), annual wellness visits, clinical laboratory services, mental health services (outpatient), durable medical equipment, ambulance services, and some home health services.

Medicare also covers many preventive services at no cost to you—no copay, no deductible—as long as you see a doctor who accepts Medicare assignment. These include your Annual Wellness Visit ("Wellness Visit" is different from a physical exam), flu shots, hepatitis B shots, pneumonia vaccines, COVID-19 vaccines, cardiovascular disease screenings, diabetes screenings, and several cancer screenings.

What Medicare Does NOT Cover

Here's where the conversation gets uncomfortable. Medicare has significant gaps, and these gaps are where financial disaster lives.

Most dental care	Cleanings, fillings, dentures, extractions	$2,000–$10,000+
Routine eye exams	Glasses and contact lenses	$300–$800
Hearing aids	Devices and fitting exams	$2,000–$7,000 per pair
Long-term custodial care	Nursing home stays, assisted living	$60,000–$120,000+/year
Care outside the U.S.	Emergency care abroad (with rare exceptions)	Varies widely
Cosmetic surgery	Elective procedures	$5,000–$20,000+
Acupuncture (most)	Limited to chronic low back pain only	$75–$150 per session
Concierge or boutique medicine	Direct primary care memberships	$1,500–$5,000/year

That long-term care line should stop you in your tracks. A semi-private room in a nursing home averages $8,669 per month nationally in 2026—that's over $104,000 per year. Medicare covers skilled nursing facility care for up to 100 days only, and only after a qualifying 3-day hospital stay. For the millions of Americans who will need long-term care (and roughly 70% of people over 65 will), Medicare provides almost no help.

The 20% Problem: Medicare's Unlimited Coinsurance

I call this the "20% Problem" because it's the single biggest financial risk in Original Medicare, and most people don't discover it until they get a bill.

After you meet your Part B deductible ($283 in 2026), you pay 20% of the Medicare-approved amount for most outpatient services. That sounds manageable for a $200 doctor visit (you'd owe $40). But what about a $300,000 cancer treatment? That's $60,000 out of your pocket. And there is no annual out-of-pocket maximum on Original Medicare.

Let me repeat that: Original Medicare has no cap on what you can owe. Medicare Advantage plans, by contrast, are required to have an out-of-pocket maximum (the limit in 2026 is $8,850 for in-network services). This is one of the most important distinctions between Original Medicare and Medicare Advantage.

REAL-WORLD EXAMPLE: The $47,000 Surprise

> *Patricia, age 72, was diagnosed with non-Hodgkin's lymphoma. Her treatment*

> *included chemotherapy, radiation, multiple specialist visits, and a two-week hospital stay. Total Medicare-approved charges: $287,000. Under Original Medicare with no supplemental coverage, Patricia's share was the Part A deductible ($1,736) plus 20% of Part B outpatient charges, totaling approximately $47,000. If Patricia had a Medigap Plan G, her total cost would have been $283 (the Part B annual deductible). The rest would have been covered.*

FREQUENTLY ASKED QUESTIONS

Q: Does Medicare cover physical therapy?

> *A: Yes, Part B covers outpatient physical therapy, occupational therapy, and speech-language pathology services when medically necessary. There is no longer a hard annual cap, but Medicare may review claims above a certain threshold.*

Q: Does Medicare cover mental health counseling?

> *A: Yes. Part B covers outpatient mental health services, including visits with psychiatrists, psychologists, and clinical social workers. You pay 20% of the Medicare-approved amount after your deductible.*

Q: Does Medicare cover weight-loss drugs like Ozempic or Wegovy?

> *A: Part D now covers certain anti-obesity medications for qualifying conditions as of 2026. Coverage varies by plan and formulary. Check your specific Part D plan's formulary for coverage details and prior authorization requirements.*

CHAPTER 4 CHECKLIST

> ☐ *I understand what Medicare covers and what it doesn't*
>
> ☐ *I know that Original Medicare has NO out-of-pocket maximum*
>
> ☐ *I'm aware that dental, vision, and hearing are not covered by Original Medicare*
>
> ☐ *I understand that Medicare covers only 100 days of skilled nursing—not long-term care*
>
> ☐ *I've started thinking about supplemental coverage to fill Medicare's gaps*

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been there.

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Chapter 5: Medicare Costs in 2026 — Every Premium, Deductible, and Copay

Numbers don't lie. And when it comes to Medicare, knowing the exact numbers is the difference between a budget that works and a retirement that falls apart.

This chapter is your 2026 Medicare cost reference. Dog-ear this page. Bookmark it. Come back to it every time you need to crunch a number. These are the official figures from CMS for the 2026 plan year.

Part A Costs (Hospital Insurance) — 2026

Monthly Premium (40+ quarters)	$0
Monthly Premium (30–39 quarters)	$285
Monthly Premium (<30 quarters)	$518
Inpatient Hospital Deductible	$1,736 per benefit period
Hospital Coinsurance (Days 61–90)	$434 per day
Lifetime Reserve Days (Days 91–150)	$868 per day
Skilled Nursing Facility (Days 1–20)	$0
Skilled Nursing Facility (Days 21–100)	$217.00 per day
Skilled Nursing Facility (Beyond 100 days)	100% — you pay all costs
Blood (first 3 pints)	You pay full cost

Part B Costs (Medical Insurance) — 2026

Standard Monthly Premium	$202.90
Annual Deductible	$283
Coinsurance	20% of Medicare-approved amount
Out-of-Pocket Maximum	NONE (unlimited)
Excess Charges (non-participating providers)	Up to 15% above Medicare rate

Part B IRMAA Surcharges — 2026

If your Modified Adjusted Gross Income (MAGI) from two years ago exceeds certain thresholds, you pay more for Part B. This surcharge is called IRMAA—Income-Related Monthly Adjustment Amount. The 2026 IRMAA brackets are based on your 2024 tax return.

$109,000 or less	$218,000 or less	$202.90
$109,001–$137,000	$218,001–$274,000	$284.10
$137,001–$171,000	$274,001–$342,000	$405.80
$171,001–$205,000	$342,001–$410,000	$527.50
$205,001–$500,000	$410,001–$750,000	$649.20
Above $500,000	Above $750,000	$689.90

Notice the jump: going from $109,000 to $109,001 in individual income costs you an extra $74 per month—$888 per year. And that's per person. A married couple both on Medicare could pay an extra $1,776 per year just for crossing that threshold by a single dollar. This is why income planning around IRMAA is critical, and we'll cover strategies in detail in Chapter 11.

Part D Costs (Prescription Drug Coverage) — 2026

Average Monthly Premium	$46.50 (varies by plan)
Maximum Annual Deductible	$615
Annual Out-of-Pocket Maximum	$2,100
Monthly Payment Option	Available (spread $2,100 over the year)
Late Enrollment Penalty	1% of national base premium per uncovered month
National Base Beneficiary Premium	$38.99

Part D IRMAA Surcharges — 2026

Part D has its own IRMAA surcharge, separate from Part B. The income brackets are the same, but the amounts are different.

$109,000 or less	$218,000 or less	$0.00
$109,001–$137,000	$218,001–$274,000	$14.50
$137,001–$171,000	$274,001–$342,000	$37.50

$171,001–$205,000	$342,001–$410,000	$60.40
$205,001–$500,000	$410,001–$750,000	$83.30
Above $500,000	Above $750,000	$91.00

What Does Medicare Actually Cost Per Year?

Let’s put it all together for a typical retiree with income below the IRMAA thresholds:

Part A Premium	$0	$0
Part B Premium	$202.90	$2,220
Part D Premium (average)	$46.50	$558
Part B Deductible	—	$283
Part D Deductible (max)	—	$615
Medigap Plan G Premium (est.)	$150–$250	$1,800–$3,000
Estimated Total (without major claims)	$381–$481	$4,425–$6,625

That’s the baseline. The moment you have a hospital stay, a surgery, or an expensive medication, those numbers climb—unless you have the right supplemental coverage in place. This is why the plan you choose matters just as much as the premiums you pay.

REAL-WORLD EXAMPLE: The True Cost of Original Medicare Without a Supplement

> *Robert and Susan, both age 68, chose Original Medicare with Part D but decided to skip Medigap to save money. They saved approximately $4,000/year in Medigap premiums ($2,000 each). Then Robert had a heart attack. Three days in the hospital, cardiac catheterization, two stents, and six weeks of cardiac rehab later, the total bill was $189,000. Robert’s share: $1,736 (Part A deductible) plus roughly $28,000 (20% of Part B charges) = nearly $30,000 out of pocket. The $4,000 they saved skipping Medigap was wiped out seven times over in a single health event.*

FREQUENTLY ASKED QUESTIONS

Q: Do Medicare costs go up every year?

> *A: Generally, yes. CMS adjusts premiums, deductibles, and coinsurance annually. Part B premiums have increased in most years. That’s why reviewing your coverage annually during the Annual Enrollment Period (October 15 – December 7) is critical.*

Q: Is the $2,000 Part D cap per person or per couple?

> *A: Per person. Each individual enrolled in Part D has their own $2,000 out-of-pocket maximum.*

Q: What's a benefit period for Part A?

> *A: A benefit period starts the day you're admitted to a hospital or skilled nursing facility and ends when you haven't received inpatient care for 60 consecutive days. If you're readmitted after 60 days, a new benefit period begins—and you pay the deductible again.*

CHAPTER 5 CHECKLIST

> ☐ *I know the 2026 Part A deductible ($1,736) and daily coinsurance amounts*
>
> ☐ *I know the 2026 Part B premium ($202.90/month) and deductible ($283)*
>
> ☐ *I've checked my income against the IRMAA brackets for both Part B and Part D*
>
> ☐ *I understand the $2,100 Part D out-of-pocket cap*
>
> ☐ *I've estimated my total annual Medicare costs*
>
> ☐ *I'm considering whether a Medigap plan is worth the premium to protect against large bills*

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Chapter 6: Original Medicare vs. Medicare Advantage — The Real Trade-Offs

This is the chapter where most people say, "Finally—just tell me which one to pick!"

I wish it were that simple. The truth is, there is no universally "better" option. Original Medicare with a Medigap plan is the best choice for some people. Medicare Advantage is the best choice for others. And the right answer for you depends on your health, your budget, your doctors, your travel habits, and your tolerance for financial risk.

Let’s lay it all out so you can make an informed decision.

Original Medicare: The Government-Run Option

When people say “Original Medicare,” they mean Part A and Part B administered directly by the federal government through CMS. You get a red, white, and blue Medicare card. You can see any doctor or hospital in the country that accepts Medicare—and about 97% of doctors do.

The advantage of Original Medicare is freedom. No networks. No referrals. No prior authorizations for most services. If a doctor accepts Medicare, you can go there. Period.

The disadvantage is cost exposure. Original Medicare has no out-of-pocket maximum. You pay 20% of Part B charges with no cap. You pay the Part A deductible every benefit period. And you get no dental, vision, or hearing coverage.

That’s why most people on Original Medicare pair it with a Medigap (Medicare Supplement) plan and a standalone Part D drug plan. The Medigap plan covers most or all of the gaps, and the Part D plan covers prescriptions.

Medicare Advantage: The Private Plan Bundle

Medicare Advantage plans are offered by private insurance companies (UnitedHealthcare, Humana, Aetna, Blue Cross, and many others) that contract with Medicare. When you join a Medicare Advantage plan, you still have Medicare—but your benefits are delivered through the private insurer.

The advantages of Medicare Advantage include: often $0 or low monthly premiums, extra benefits (dental, vision, hearing, fitness, OTC allowances), a required out-of-pocket maximum ($8,850 or less for in-network services in 2026), and Part D drug coverage is usually included.

The disadvantages include: network restrictions (HMO or PPO), potential need for referrals or prior authorizations, limited coverage outside your plan’s service area, and the plan can change its benefits, network, or formulary every year.

The Side-by-Side Comparison

Monthly Cost	Part B + Medigap + Part D premiums	Part B + plan premium (often $0)
Doctor Choice	Any doctor who accepts Medicare (97%+)	In-network only (or higher costs out-of-network)
Referrals Needed?	No	Often yes (HMO plans)
Prior Authorization?	Rarely	Common for procedures and specialists
	NONE (unlimited) with Original Medicare. Medigap	

Out-of-Pocket Maximum	reduces it to Premium + Part D Deductible + Excess Charges.	$8,850 max for in-network (2026)
Drug Coverage	Separate Part D plan required	Usually included
Dental/Vision/Hearing	Not included	Often included
Travel Coverage	Nationwide (any Medicare provider)	Limited to service area (except emergencies)
Medigap Compatible?	Yes	No
Annual Plan Changes	Medigap benefits are standardized	Plans change benefits/networks yearly
Best For	People who want maximum flexibility and predictability	People who want lower premiums and extra benefits

The Hidden Cost of Medicare Advantage

Medicare Advantage plans look great on paper. Low premiums. Extra benefits. A gym membership. But here's what the TV commercials don't tell you:

Prior authorization denials are a real issue. A 2023 report from the Office of Inspector General found that Medicare Advantage plans denied approximately 13% of prior authorization requests that would have been covered under Original Medicare. That means real people with real medical needs were told "no" by their insurance company—even though Medicare itself would have said "yes."

Network changes happen every year. Your favorite doctor could be in-network this year and out-of-network next year. Your plan could change its formulary, dropping a medication you depend on or moving it to a more expensive tier.

And if you ever want to switch back to Original Medicare and add a Medigap plan, you may face medical underwriting. In most states, after your initial Medigap Open Enrollment Period (the first 6 months after you're 65 and enrolled in Part B), insurance companies can deny you a Medigap plan or charge you more based on your health. If you've been on a Medicare Advantage plan for years and your health has declined, switching back could be difficult or impossible.

Who Should Choose Original Medicare + Medigap?

Original Medicare with a Medigap plan tends to work best for people who want the freedom to see any doctor or specialist without referrals, travel frequently or live in multiple states seasonally, want predictable and low out-of-pocket costs, have chronic conditions requiring frequent specialist visits, or are willing to pay higher monthly premiums for greater financial protection.

Who Should Choose Medicare Advantage?

Medicare Advantage tends to work best for people who are generally healthy and use healthcare infrequently, want the lowest possible monthly premium, value extra benefits

like dental, vision, and hearing, live in one area and don't travel extensively, and are comfortable with networks and prior authorization processes.

REAL-WORLD EXAMPLE: Two Retirees, Two Paths

> *Carol, age 66, chose a Medigap Plan G and a standalone Part D plan. Her total monthly cost: $202.90 (Part B) + $190 (Medigap) + $42 (Part D) = $417/month. When she was diagnosed with breast cancer, her total out-of-pocket cost for the year was $283 (Part B deductible). That's it. Her Medigap plan covered everything else.*
>
> *David, age 66, chose a Medicare Advantage PPO plan with a $0 premium. His monthly cost: $202.90 (Part B only). When he was diagnosed with prostate cancer, his out-of-pocket costs totaled $7,200 over the year (copays, coinsurance, and specialist visit costs up to his plan's out-of-pocket maximum). David saved money in premiums every month—but paid more when he got sick. Neither choice was "wrong." They reflected different priorities and risk tolerances.*

FREQUENTLY ASKED QUESTIONS

Q: Can I switch between Original Medicare and Medicare Advantage?

> *A: Yes, during the Annual Enrollment Period (October 15 – December 7) and the MA Open Enrollment Period (January 1 – March 31). But switching from Advantage back to Original Medicare can create Medigap issues if you're past your initial enrollment period.*

Q: Are Medicare Advantage plans going away?

> *A: No. Medicare Advantage is growing. In 2026, more than 54% of all Medicare beneficiaries are enrolled in Advantage plans. However, CMS has been tightening regulations on these plans regarding prior authorizations and network adequacy.*

Q: What if I hate my Medicare Advantage plan?

> *A: During the MA Open Enrollment Period (January 1 – March 31), you can switch to a different Advantage plan or return to Original Medicare and add a Part D plan. You can make one change during this window.*

CHAPTER 6 CHECKLIST

> *☐ I understand the key differences between Original Medicare and Medicare Advantage*

> ☐ *I know Original Medicare has no out-of-pocket maximum*
>
> ☐ *I know Medicare Advantage requires using network providers*
>
> ☐ *I've considered my health, travel habits, and doctor preferences*
>
> ☐ *I understand the risks of prior authorization denials in Advantage plans*
>
> ☐ *I know that switching from Advantage to Original Medicare may involve Medigap underwriting*

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Chapter 7: Medigap / Medicare Supplement — The Plans That Make Medicare Bulletproof

If Original Medicare is a roof over your head, Medigap is the insurance policy that repairs the roof when a storm blows through. It doesn't replace Medicare. It completes it.

Medigap plans—also called Medicare Supplement plans—are sold by private insurance companies, but their benefits are standardized by the federal government. That means Plan G from Company A covers exactly the same benefits as Plan G from Company B. The only differences are price and customer service.

That standardization is a gift. It means you can compare plans on one simple variable: cost.

How Medigap Works

A Medigap policy works alongside Original Medicare (Parts A and B). When you receive a medical service, Medicare pays its share first, and then your Medigap plan pays some or all of the remaining costs—deductibles, coinsurance, copays, and even excess charges, depending on which plan you choose.

You pay your monthly Medigap premium on top of your Part B premium. In exchange, you get predictable costs and protection from catastrophic medical bills. With the right Medigap plan, you can see any doctor in the country who accepts Medicare, get treated without referrals or prior authorizations, and know that your out-of-pocket exposure is minimal.

The 2026 Medigap Plans at a Glance

There are currently 10 standardized Medigap plans available, identified by letters. Not all plans are available in every state, and Plans C and F are only available to people who were eligible for Medicare before January 1, 2020.

Part A Hospital Coinsurance	100%	100%	100%	100%	100%	100%
Part A Deductible ($1,736)	No	100%	100%	50%	75%	100%
Part B Deductible ($283)	No	No	No	No	No	No
Part B Coinsurance (20%)	100%	100%	100%	50%	75%	100%*
Part B Excess Charges	No	No	100%	No	No	No
Blood (first 3 pints)	100%	100%	100%	50%	75%	100%
SNF Coinsurance	No	No	100%	50%	75%	100%
Foreign Travel Emergency	No	No	80%	No	No	80%
Out-of-Pocket Limit	None	None	None	$7,060	$3,530	None

*Plan N note: Plan N covers Part B coinsurance except for a copay of up to $20 for some office visits and up to $50 for emergency room visits that don’t result in an inpatient admission.

The Two Most Popular Plans: G and N

Since Plans C and F are no longer available to new Medicare enrollees (those eligible after January 1, 2020), Plan G has become the gold standard of Medigap coverage. It covers everything except the Part B deductible ($283 in 2026). For most people, Plan G offers the most comprehensive protection at a reasonable price.

Plan N is a popular alternative for people who want lower premiums. It covers most of what Plan G covers but requires small copays for certain office visits and ER visits, and it does not cover Part B excess charges. If your doctors all accept Medicare assignment (meaning they agree to charge only the Medicare-approved amount), Plan N can save you money.

The Medigap Open Enrollment Period: Use It or Lose It

This is critical. Your Medigap Open Enrollment Period lasts 6 months. It starts the

month you're 65 AND enrolled in Part B (both conditions must be met). During this window, insurance companies must sell you any Medigap plan they offer, at the best available price, regardless of your health. They cannot deny you or charge you more because of pre-existing conditions.

After this 6-month window closes, insurance companies in most states can use medical underwriting to decide whether to sell you a plan and how much to charge. If you've developed health conditions since turning 65, you could be denied coverage or face significantly higher premiums.

Do not let this window close without making a decision. Even if you choose Medicare Advantage today, understand that switching to Original Medicare with a Medigap plan later may not be easy.

How Medigap Pricing Works

Medigap premiums are set by private insurance companies and vary based on three pricing methods:

Community-rated (no-age-rated): Everyone pays the same premium regardless of age. Premiums won't increase just because you get older.

Issue-age-rated: Your premium is based on your age when you first buy the policy. It won't increase because of aging, but it may increase due to inflation or other factors.

Attained-age-rated: Your premium starts low but increases as you get older. This is the most common pricing method. Plans may be cheaper initially but can become expensive over time.

When comparing plans, ask the insurance company which pricing method they use. A plan that's $30/month cheaper today could be $100/month more expensive in 10 years if it's attained-age-rated.

REAL-WORLD EXAMPLE: Why the Medigap Window Matters

> *Janet enrolled in a Medicare Advantage plan at age 65 because the $0 premium was attractive. At age 72, after being diagnosed with rheumatoid arthritis and diabetes, she wanted to switch to Original Medicare with a Medigap plan so she could see specialists without network restrictions. Problem: her Medigap Open Enrollment Period had closed seven years ago. When she applied for Medigap Plan G, she was either denied by most companies or quoted premiums 40–60% higher than the standard rate due to her health conditions. Janet is now stuck paying more for less coverage—or staying in a plan that doesn't meet her needs.*

FREQUENTLY ASKED QUESTIONS

Q: Can I have a Medigap plan and a Medicare Advantage plan at the same time?

> *A: No. Medigap only works with Original Medicare. If you join a Medicare Advantage plan, your Medigap plan won't pay for anything, and it's illegal for a*

> *company to knowingly sell you a Medigap plan while you're in an Advantage plan.*

Q: Do Medigap premiums go up every year?

> *A: Premiums can increase due to inflation, increased medical costs, or age (if you have an attained-age-rated plan). However, the benefits themselves are standardized and don't change.*

Q: Which is better: Plan G or Plan N?

> *A: Plan G offers more complete coverage (it covers Part B excess charges and has no copays). Plan N offers lower premiums in exchange for small copays and no excess charge coverage. If cost is your priority and your doctors accept Medicare assignment, Plan N is worth considering. If comprehensive protection is your priority, Plan G is usually the better choice.*

Q: Do I need a separate Part D plan with Medigap?

> *A: Yes. Medigap plans do not cover prescription drugs. You'll need a standalone Part D plan for drug coverage.*

CHAPTER 7 CHECKLIST

> ☐ *I understand that Medigap plans are standardized by the government*
>
> ☐ *I know my 6-month Medigap Open Enrollment Period dates*
>
> ☐ *I've compared Plan G and Plan N based on my health and budget*
>
> ☐ *I've asked about pricing methods (community, issue-age, or attained-age)*
>
> ☐ *I know that Medigap does NOT include drug coverage (I need separate Part D)*
>
> ☐ *I understand that missing my Medigap window could mean higher costs or denial later*

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Chapter 8: Part D — Prescription Drugs, Formularies, and the $2,000 Cap

Prescription drugs are one of the top three expenses in retirement, right behind housing and food. For some retirees, medications cost more than their mortgage. And until recently, there was no limit on how much you could be asked to pay out of pocket.

That changed in a big way. Medicare Part D now includes a $2,000 annual out-of-pocket spending cap. This is one of the most significant improvements to Medicare in decades, and it's worth understanding exactly how it works.

How Part D Works

Medicare Part D is offered through private insurance companies approved by Medicare. You can get Part D coverage in two ways: a standalone Prescription Drug Plan (PDP) that pairs with Original Medicare and Medigap, or through a Medicare Advantage plan that includes drug coverage (called an MA-PD).

Every Part D plan has a formulary—a list of covered drugs organized into tiers. The tier determines how much you pay for each medication.

Typical Part D Drug Tiers

Tier 1	Preferred Generic	$0–$15 copay
Tier 2	Generic	$15–$45 copay
Tier 3	Preferred Brand	$30–$100 copay
Tier 4	Non-Preferred Brand	25–50% coinsurance
Tier 5	Specialty	25–33% coinsurance (up to $2,000 cap)

Your out-of-pocket cost depends on which tier your drug falls into, whether you've met your deductible, and the specific plan you chose. Not all plans cover every drug, and the same drug can be on different tiers in different plans. This is why comparing Part D plans annually is so important.

The $2,000 Out-of-Pocket Cap: A Game-Changer

Previously, Part D had a coverage structure called the "donut hole"—a gap in coverage where you paid a higher share of drug costs. For people on expensive medications, annual out-of-pocket costs could exceed $10,000 or more.

The Inflation Reduction Act eliminated the donut hole and replaced it with a hard $2,000 annual cap on out-of-pocket spending for Part D drugs. Once you've paid $2,000 in a calendar year, you pay $0 for the rest of the year for all Part D covered drugs.

Even better: Medicare offers a monthly payment option called the Medicare Prescription Payment Plan. Instead of paying your drug costs as they occur (which could mean a $1,500 bill in January for a specialty drug), you can spread your total out-of-pocket costs evenly across the remaining months of the year. This makes budgeting much easier.

The Part D Late Enrollment Penalty

If you go 63 or more consecutive days without creditable prescription drug coverage after you're first eligible for Part D, you'll pay a late enrollment penalty when you do enroll. The penalty is calculated as 1% of the "national base beneficiary premium" ($36.78 in 2026) multiplied by the number of months you went without coverage. This penalty is added to your monthly premium permanently.

Example: if you went 24 months without Part D coverage, your penalty would be 24 x 1% x $36.78 = $8.83 per month, or $105.96 per year, for life.

How to Choose the Right Part D Plan

Choosing the right Part D plan comes down to three factors: whether your specific drugs are on the plan's formulary, whether your preferred pharmacy is in the plan's network, and the total cost of the plan (premiums + deductibles + copays for your specific drugs).

The best tool for comparing plans is Medicare's official Plan Finder at Medicare.gov. Enter your drugs, your pharmacy, and your zip code, and it will show you the total estimated annual cost for each available plan. This is far more useful than just comparing monthly premiums.

REAL-WORLD EXAMPLE: Why Formularies Matter

> *Frank takes three medications: a generic blood pressure drug ($12/month), a brand-name cholesterol drug ($180/month), and a specialty biologic for psoriasis ($3,200/month). Under Plan A, his biologic is on Tier 5 with 33% coinsurance. Under Plan B, the same biologic is on Tier 4 with a flat $250 copay. Both plans cap his total at $2,000/year, but Frank hits that cap in January with Plan A (paying the full $2,000 in one month) versus spreading smaller payments across five months with Plan B. Frank chooses Plan B and uses the Medicare Prescription Payment Plan to spread his $2,000 across 12 months—about $167/month—making his budget predictable and manageable.*

FREQUENTLY ASKED QUESTIONS

Q: Do I have to have Part D even if I don't take any medications?

> *A: You're not required to enroll, but if you don't have creditable drug coverage and go without for more than 63 days, you'll face a permanent penalty when you do enroll. Many basic Part D plans cost $10–$20/month—cheap insurance against a future penalty.*

Q: Can I change my Part D plan every year?

> *A: Yes. During the Annual Enrollment Period (October 15 – December 7), you can switch Part D plans. Because formularies change yearly, reviewing your plan annually is essential.*

Q: Does the $2,000 cap include my premium?

> *A: No. The $2,000 cap applies only to out-of-pocket costs (deductibles, copays, and coinsurance). Your monthly premium is separate.*

Q: What if my drug isn't on any plan's formulary?

> *A: You can request a formulary exception from your plan, appeal a denial, or work with your doctor to find a covered alternative. You can also contact a licensed agent to help you find a plan that covers your specific medications.*

CHAPTER 8 CHECKLIST

> ☐ *I've made a list of all my current medications (name, dosage, frequency)*
>
> ☐ *I've used Medicare.gov Plan Finder to compare Part D plans*
>
> ☐ *I know which tier each of my drugs falls on in my plan*
>
> ☐ *I understand the $2,000 annual out-of-pocket cap*
>
> ☐ *I've considered the Medicare Prescription Payment Plan for monthly budgeting*
>
> ☐ *I know the Part D late enrollment penalty and how to avoid it*

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Chapter 9: Dental, Vision, Hearing, and the Benefits Medicare Ignores

Here's a fact that shocks almost everyone I talk to: Original Medicare—the program

designed to cover healthcare for seniors—does not cover the three things that deteriorate most predictably as we age: our teeth, our eyes, and our hearing.

Think about that for a moment. You pay into Medicare your entire working life. You turn 65. And the program doesn't cover the dental crown you need, the glasses you can't see without, or the hearing aids that let you participate in a conversation with your grandchildren.

This isn't an oversight. It's a gap that was built into Medicare in 1965 and has never been fixed. Understanding this gap—and filling it—is one of the most important things you can do to protect your health and your wallet in retirement.

The Dental Gap

Medicare Part A covers some dental care—but only in very specific circumstances, such as dental services related to jaw reconstruction after an accident, or extractions done in a hospital setting before cardiac surgery. Routine dental care—cleanings, fillings, root canals, crowns, dentures, and implants—is excluded.

The average retiree spends between $2,000 and $5,000 per year on dental care. A single dental implant can cost $3,000 to $5,000. Full dentures run $1,500 to $3,000. And periodontal disease—which affects nearly half of adults over 65—can require treatments costing $5,000 or more.

The Vision Gap

Medicare Part B covers certain eye conditions—glaucoma screening, diabetic eye exams, and macular degeneration treatment. But routine eye exams for glasses, contact lens fittings, and the glasses or contacts themselves are not covered.

A comprehensive eye exam runs $100 to $300. A pair of progressive lenses with frames costs $300 to $800. Cataract surgery, which about half of all Americans will need by age 80, is covered by Medicare—but the "premium" lens options that eliminate the need for glasses after surgery are an out-of-pocket upgrade.

The Hearing Gap

Medicare does not cover hearing aids or the exams required to fit them. Given that approximately one-third of people between ages 65 and 74 have hearing loss, and that number rises to nearly 50% for those over 75, this is a massive gap.

A single hearing aid costs $1,000 to $4,000, and most people need two. That's $2,000 to $8,000 every 3 to 5 years. Over a 20-year retirement, hearing aid costs alone can total $10,000 to $30,000.

Medicare does cover diagnostic hearing exams ordered by a doctor to determine if you have a medical condition causing hearing loss. But the hearing aids themselves? That's on you.

How to Fill These Gaps

You have several options for covering dental, vision, and hearing:

Medicare Advantage plans: Many MA plans include dental, vision, and hearing benefits as part of their package. The level of coverage varies widely—some plans offer basic preventive dental and vision only, while others include significant allowances for crowns, implants, glasses, and hearing aids. Always read the specifics.

Standalone dental, vision, and hearing insurance: These policies are available from many private insurers. Dental plans typically cost $25 to $75 per month and may have annual benefit caps of $1,000 to $2,000. Vision plans range from $10 to $25 per month. Hearing-specific plans are less common but available through some carriers.

Discount programs and membership plans: Some dental offices offer in-house savings plans (not insurance) that provide discounted rates for an annual membership fee. Organizations like AARP also negotiate group rates on dental and vision services.

Over-the-counter hearing aids: Since 2022, the FDA has allowed over-the-counter hearing aids for adults with mild to moderate hearing loss. These devices cost $200 to $1,000 per pair—a fraction of the cost of prescription hearing aids. They're available at pharmacies and electronics retailers.

Medicare Advantage (built-in)	$0 additional	Varies ($500–$3,000)	People already on MA plans
Standalone Dental Insurance	$25–$75	$1,000–$2,000	Regular dental care needs
Standalone Vision Insurance	$10–$25	$200–$500 allowance	Annual exams + glasses
Dental Savings Plans	$80–$200/year	No limit (discounted rates)	People needing major work
OTC Hearing Aids	N/A (one-time purchase)	N/A	Mild to moderate hearing loss

REAL-WORLD EXAMPLE: The $23,000 Dental Surprise

> *George, age 71, had been on Original Medicare with a Medigap plan for six years. He was well-protected against hospital and medical costs. But he'd neglected his teeth. When he finally went to the dentist, he needed three root canals, two crowns, a bridge, and treatment for advanced periodontal disease. Total estimated cost: $23,000. Medicare covered $0. George's Medigap plan covered $0 (Medigap doesn't cover dental). George had to dip into his retirement savings to pay the bill. A $50/month dental plan purchased years earlier could have covered $1,500–$2,000/year of that cost, and more importantly, preventive coverage would have caught the problems earlier when they were cheaper to treat.*

FREQUENTLY ASKED QUESTIONS

Q: Will Medicare ever cover dental and vision?

> *A: Congress has debated adding dental, vision, and hearing benefits to Medicare for years. As of 2026, these benefits remain excluded from Original Medicare. Medicare Advantage plans are currently the primary way to get these benefits within the Medicare system.*

Q: Are standalone dental plans worth it?

> *A: For most retirees, yes. Even a basic plan that covers two cleanings per year and 50–80% of major procedures can save you thousands of dollars over time. The key is choosing a plan with a benefit cap high enough to be meaningful.*

Q: Do I need vision insurance if I'm healthy?

> *A: If you wear glasses or contacts, a basic vision plan pays for itself in one visit. If you don't currently need corrective lenses, a plan may not be necessary—but remember, vision needs typically increase after age 60.*

CHAPTER 9 CHECKLIST

> ☐ *I understand that Original Medicare does NOT cover dental, vision, or hearing*
>
> ☐ *I've evaluated dental, vision, and hearing coverage options*
>
> ☐ *I've checked whether my Medicare Advantage plan includes these benefits (if applicable)*
>
> ☐ *I've considered standalone dental and vision insurance*
>
> ☐ *I've looked into OTC hearing aids if I have mild to moderate hearing loss*
>
> ☐ *I've budgeted for dental, vision, and hearing costs in my retirement plan*

READY TO TAKE THE NEXT STEP?

You don't have to figure this out alone. I've helped thousands of people navigate these exact decisions, and I'd be honored to help you, too. Call or text me for a free, no-obligation retirement review. No sales pitch. Just straight answers from someone who's been there.

Darin Weidauer | 702-706-6564 | darinweidauer@ecos.care

Chapter 10: Filling the Gaps — Indemnity, Cancer, Hospital, and Accident Plans

Let me ask you a question: if you were diagnosed with cancer tomorrow, could your household survive on your Medicare coverage alone?

Medicare would cover the medical treatment—the surgery, the chemo, the radiation. But who would cover the mortgage while you're recovering? The car payment? The groceries? The gas to drive 90 minutes each way to the oncology center three times a week?

These are the expenses that Medicare was never designed to cover. And they're the expenses that push families into financial crisis during a health event. That's where supplemental indemnity plans come in.

What Are Indemnity Plans?

Indemnity insurance—also called supplemental insurance or "cash benefit" insurance—pays a fixed dollar amount directly to you when a qualifying health event occurs. It doesn't pay doctors or hospitals. It pays you.

The money is yours to use however you need: rent, food, utilities, travel expenses, childcare for grandchildren, home modifications, or simply replacing lost income during recovery. There are no restrictions on how you spend it.

Indemnity plans work alongside Medicare, Medigap, and Medicare Advantage. They don't replace those plans—they supplement them by covering the non-medical costs that come with a health crisis.

Types of Indemnity Plans

Cancer Insurance

Cancer insurance pays a lump sum or scheduled benefits when you're diagnosed with cancer. Some plans pay a one-time lump sum (commonly $10,000 to $50,000) at diagnosis. Others pay specific amounts for each phase of treatment: surgery, chemotherapy, radiation, hospital stays, transportation, and experimental treatments.

Cancer is the second leading cause of death in the U.S. and one of the most expensive conditions to treat. Even with excellent Medicare coverage, the non-medical costs of cancer (time off work for a spouse-caregiver, travel, dietary changes, home care) can exceed $20,000 in the first year alone.

Hospital Indemnity Insurance

Hospital indemnity plans pay a daily, weekly, or per-admission cash benefit when you're admitted to the hospital. A typical plan might pay $100 to $500 per day of hospitalization, or a lump sum of $1,000 to $3,000 per hospital admission.

Remember: even with Medigap, a hospital stay means time away from normal life. Bills don't stop because you're in a hospital bed. A hospital indemnity plan gives you cash in hand to cover those bills.

Accident Insurance

Accident insurance pays benefits when you're injured in an accident. This can include falls (the leading cause of injury for adults over 65), car accidents, burns, and other covered injuries. Benefits typically include lump sums for fractures, dislocations, ER visits, ambulance rides, and follow-up care.

According to the CDC, one in four Americans aged 65 and older falls each year. Falls are the leading cause of injury-related death for seniors. An accident plan can provide $1,000 to $10,000 or more depending on the severity of the injury.

Critical Illness Insurance

Critical illness insurance pays a lump sum when you're diagnosed with a qualifying condition. Covered conditions typically include heart attack, stroke, cancer, kidney failure, major organ transplant, and sometimes conditions like Alzheimer's, Parkinson's, or blindness.

Lump-sum payments range from $5,000 to $100,000. This money can be used for anything—medical expenses, household bills, a vacation with your grandchildren before starting treatment, or simply building a financial cushion.

How Much Do These Plans Cost?

Cancer Insurance	$25–$80	$10,000–$50,000 lump sum
Hospital Indemnity	$20–$60	$100–$500/day or $1,000–$3,000/admission
Accident Insurance	$15–$40	$1,000–$10,000 per event
Critical Illness	$30–$100	$5,000–$100,000 lump sum

These premiums are modest compared to the financial protection they provide. For $50 to $150 per month, you can build a safety net that covers the gaps Medicare can't touch.

Who Needs Indemnity Plans?

Not everyone needs every type of indemnity plan. But most retirees should consider at least one or two. Here's a quick guide:

You should strongly consider cancer insurance if you have a family history of cancer or if your household depends on two incomes (even in retirement).

You should strongly consider hospital indemnity if you have chronic conditions that could require hospitalization (heart disease, diabetes, COPD) or if you want cash to

cover household costs during a hospital stay.

You should strongly consider accident insurance if you're active, live alone, or have balance or mobility concerns. Falls happen, and they're expensive.

REAL-WORLD EXAMPLE: How a $40/Month Plan Saved a Family

> *Betty, age 69, had a Medicare Advantage plan and a $40/month hospital indemnity plan that paid $250/day for hospital stays. When she had a stroke and spent 12 days in the hospital followed by 30 days in a skilled nursing facility, her Medicare Advantage plan covered the medical costs. But her hospital indemnity plan paid her $3,000 (12 days x $250) directly. That money covered her utility bills, her husband's travel to and from the hospital, and a home aide for the first two weeks after she came home. Without that plan, her husband would have had to dip into their retirement savings—savings they'd need for the years ahead.*

FREQUENTLY ASKED QUESTIONS

Q: Can I buy indemnity plans if I have pre-existing conditions?

> *A: It depends on the plan and the insurer. Some plans have simplified underwriting with limited health questions. Others are guaranteed issue (no health questions) but may have waiting periods for pre-existing conditions. A licensed agent can help you find the right plan for your situation.*

Q: Are indemnity plan payouts taxable?

> *A: In most cases, benefits paid from personally-owned indemnity plans are received tax-free. Consult a tax advisor for your specific situation.*

Q: Do indemnity plans replace Medigap or Medicare Advantage?

> *A: No. Indemnity plans supplement your existing Medicare coverage. They don't pay medical bills—they pay you directly for the non-medical costs that accompany a health event.*

Q: Can I buy these plans at any time?

> *A: In many cases, yes. Unlike Medigap, indemnity plans don't have the same strict enrollment windows. However, premiums may be higher if you're older or have health conditions, and some plans have waiting periods.*

CHAPTER 10 CHECKLIST

> ☐ *I understand what indemnity insurance is and how it differs from medical insurance*
>
> ☐ *I've considered whether cancer, hospital, accident, or critical illness plans are appropriate for me*
>
> ☐ *I've reviewed my family health history and assessed my risk factors*
>
> ☐ *I've evaluated how my household would handle non-medical costs during a health crisis*
>
> ☐ *I've spoken with a licensed agent about my supplemental insurance options*

READY TO TAKE THE NEXT STEP?

You don't have to figure this out alone. I've helped thousands of people navigate these exact decisions, and I'd be honored to help you, too. Call or text me for a free, no-obligation retirement review. No sales pitch. Just straight answers from someone who's been there.

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PART II

IRMAA, PENALTIES, AND COSTLY MISTAKES

The mistakes in this section are permanent, expensive, and shockingly common.

Every one of them is preventable.

Chapter 11: IRMAA — The Hidden Medicare Tax Nobody Warned You About

Of all the surprises lurking in retirement, IRMAA might be the most infuriating. Not because it's complicated—once you understand it, the math is straightforward. It's infuriating because almost nobody tells you about it until it's too late.

IRMAA stands for Income-Related Monthly Adjustment Amount. In plain English, it's a surcharge—an extra amount added to your Medicare Part B and Part D premiums—based on your income. The higher your income, the more you pay. And the income Medicare looks at isn't this year's income. It's your income from two years ago.

That two-year lookback is where the trap lives.

How IRMAA Works

Every year, the Social Security Administration reviews your tax return from two years prior. In 2026, they're looking at your 2024 Modified Adjusted Gross Income (MAGI). Your MAGI is your Adjusted Gross Income (AGI) plus any tax-exempt interest income

(like municipal bond interest).

If your MAGI exceeds certain thresholds, you pay more for Part B and Part D. The surcharges are applied per person—so if you're married and both on Medicare, both of you could be hit with higher premiums.

Here's what makes IRMAA especially painful: the thresholds are cliff-based, not gradual. If your income is $109,000, you pay the standard Part B premium of $202.90 per month. If your income is $109,001—one dollar more—you jump to $284.10 per month. That's an extra $888 per year because of a single dollar.

2026 IRMAA Brackets: Part B

$109,000 or less	$218,000 or less	$202.90 (standard)
$109,001 – $137,000	$218,001 – $274,000	$284.10
$137,001 – $171,000	$274,001 – $342,000	$405.80
$171,001 – $205,000	$342,001 – $410,000	$527.50
$205,001 – $500,000	$410,001 – $750,000	$649.20
Above $500,000	Above $750,000	$689.90

2026 IRMAA Brackets: Part D

Part D has its own separate surcharge, layered on top of whatever your Part D plan charges.

$109,000 or less	$218,000 or less	$0.00
$109,001 – $137,000	$218,001 – $274,000	$14.50
$137,001 – $171,000	$274,001 – $342,000	$37.50
$171,001 – $205,000	$342,001 – $410,000	$60.40
$205,001 – $500,000	$410,001 – $750,000	$83.30
Above $500,000	Above $750,000	$91.00

The Total IRMAA Damage: A Married Couple

Let's see what IRMAA actually costs when you add Part B and Part D together for two people.

$218,000 or less	$0	$0	$0
$218,001 – $274,000	$95.70	$191.40	$2,296.80
$274,001 – $342,000	$240.20	$480.40	$5,764.80
$342,001 – $410,000	$384.70	$769.40	$9,232.80
$410,001 – $750,000	$529.20	$1,058.40	$12,700.80
Above $750,000	$577.60	$1,155.20	$13,862.40

At the highest tier, a married couple pays an extra $13,862.40 per year in IRMAA surcharges alone—on top of their standard premiums. Over a 20-year retirement, that's more than $254,000 in additional Medicare costs.

And remember: IRMAA surcharges are not deductible. They're not refundable. They're simply extra money out of your pocket.

The Two-Year Lookback: Why Timing Is Everything

IRMAA uses a two-year lookback. In 2026, Social Security looks at your 2024 tax return. In 2027, they look at 2025. This creates a dangerous delay between the income event and the premium impact.

Here's why that matters: a one-time income spike—selling a property, taking a large IRA distribution, doing a Roth conversion, exercising stock options, or receiving a lump-sum pension payout—can push you into a higher IRMAA bracket two years later, even if your regular income is modest.

And the surcharge applies for the entire year. It doesn't matter that the income spike was a one-time event. You pay the higher premium for 12 months.

Common IRMAA Triggers

These are the most common income events that trigger unexpected IRMAA surcharges:

Selling a home with significant capital gains (even with the $250K/$500K exclusion, the gain may push you over a threshold). Taking a large Required Minimum Distribution (RMD) from a traditional IRA or 401(k). Doing a Roth conversion. Exercising stock options or receiving a large bonus in the year before retirement. Receiving a lump-sum pension payout. Selling a business or investment property. Realizing capital gains from stock sales. Receiving a large inheritance that generates taxable income. Municipal bond interest (tax-free for income tax but counts for IRMAA).

⚠ CRITICAL WARNING: MUNICIPAL BOND INTEREST COUNTS

> *Many retirees invest in municipal bonds because the interest is "tax-free." And it is—for federal income tax purposes. But municipal bond interest IS included in your MAGI for IRMAA calculations. I've seen retirees with modest taxable income get hit with IRMAA surcharges because their $80,000 in muni bond interest pushed them over the threshold. "Tax-free" does not mean "IRMAA-free."*

How to Reduce or Avoid IRMAA

IRMAA is not inevitable. With proper planning, you can manage your income to stay below the thresholds—or minimize the time you spend in higher brackets. Here are the key strategies:

Strategy 1: Roth Conversions Before Medicare

Roth IRA distributions are not included in MAGI. If you convert traditional IRA funds to a Roth before age 63 (so the income hits your tax return before the IRMAA lookback period matters), you can reduce future RMDs and future MAGI—potentially keeping yourself below IRMAA thresholds for life. The conversion itself will increase your income in the year you do it, so timing and amounts matter. This strategy works best between ages 59½ and 63.

Strategy 2: Manage the Timing of Income Events

If you're planning to sell a home, take a large distribution, or realize capital gains, consider the IRMAA impact two years later. Can you split the income across two tax years? Can you time the event so it falls in a year where your other income is lower? Can you offset the gain with deductions, losses, or charitable contributions?

Strategy 3: Qualified Charitable Distributions (QCDs)

If you're 70½ or older, you can donate up to $105,000 per year (2024 limit, indexed for inflation) directly from your traditional IRA to a qualified charity. This satisfies your RMD without adding the distribution to your taxable income—and without adding it to your MAGI for IRMAA purposes. It's one of the most powerful IRMAA-reduction tools available.

Strategy 4: Appeal a Life-Changing Event

If your income was unusually high two years ago due to a "life-changing event," you can file Form SSA-44 to request that Social Security use a more recent year's income instead. Qualifying life-changing events include: marriage, divorce, death of a spouse, work stoppage (retirement), work reduction, loss of income-producing property (due to disaster or other event beyond your control), and loss of pension income.

This is an underused tool. If your 2024 income was inflated by a one-time event but your 2025 or projected 2026 income is lower, filing SSA-44 could save you thousands in IRMAA surcharges.

Strategy 5: Income Layering

Work with a financial advisor to create a "retirement income layer cake" that draws from different sources in the right proportions each year: some from Roth (not counted in MAGI), some from taxable accounts (where you control the timing of gains), and some from Social Security and pensions (which are partially or fully included in MAGI). The goal is to keep your total MAGI just below the nearest IRMAA threshold every year.

REAL-WORLD EXAMPLE: The $11,000 IRMAA Surprise

> *Richard and Maria, both 68, have a comfortable retirement. Their combined Social Security is $62,000. Richard's pension is $48,000. They take $40,000 from their traditional IRAs each year. Maria also earns $15,000 in municipal bond interest from a portfolio she inherited. Their total MAGI: $62,000 + $48,000 + $40,000 + $15,000 = $165,000. That's well under the $218,000 married threshold.*
>
> *But then Richard's financial advisor suggested a $120,000 Roth conversion to "save on taxes later." Great idea in theory. But that conversion pushed their 2024 MAGI to $285,000—squarely into the second IRMAA bracket. Two years later, in 2026, both Richard and Maria are paying $405.80/month for Part B (instead of $202.90) and $37.50/month in Part D surcharges. Total extra cost for the year: ($185 + $37.50) x 2 people x 12 months = $5,764.80. The Roth conversion may still have been a good long-term move—but nobody warned Richard and Maria about the $5,287 IRMAA bill. Proper planning would have spread the conversion over multiple years to stay below the threshold.*

FREQUENTLY ASKED QUESTIONS

Q: Is IRMAA a permanent surcharge?

> *A: No. IRMAA is recalculated every year based on your tax return from two years prior. If your income drops, your IRMAA surcharge drops—or disappears entirely—the following year. But it does apply for the full year once it's determined.*

Q: Does IRMAA apply to Medicare Advantage plans too?

> *A: Yes. IRMAA affects your Part B premium regardless of whether you're on Original Medicare or Medicare Advantage. And Part D IRMAA applies to any Part D plan, whether standalone or bundled into an Advantage plan.*

Q: Can I deduct IRMAA surcharges on my taxes?

> *A: IRMAA surcharges are considered Medicare premiums, and Medicare premiums may be deductible as medical expenses on Schedule A—but only if your total medical expenses exceed 7.5% of your AGI. For most people, this threshold is difficult to meet.*

Q: My income was high two years ago because I sold a rental property. Can I appeal?

> *A: Loss of income-producing property can qualify as a life-changing event for SSA-*

> *44 purposes, but a voluntary sale may not qualify. Consult with a licensed agent or financial advisor to determine if your specific situation qualifies.*

Q: Does my spouse's income affect my IRMAA if we file jointly?

> *A: Yes. IRMAA uses your joint MAGI if you file a joint return. Even if only one spouse has high income, both spouses pay the surcharge if both are on Medicare.*

CHAPTER 11 CHECKLIST

> ☐ *I understand what IRMAA is and how the two-year lookback works*
>
> ☐ *I've reviewed my 2024 tax return to estimate my 2026 IRMAA exposure*
>
> ☐ *I know the current IRMAA thresholds for both Part B and Part D*
>
> ☐ *I've identified any upcoming income events that could trigger IRMAA (home sale, Roth conversion, RMDs)*
>
> ☐ *I've considered Roth conversions before age 63 to reduce future IRMAA*
>
> ☐ *I know about Form SSA-44 and life-changing event appeals*
>
> ☐ *I've evaluated whether Qualified Charitable Distributions can lower my MAGI*
>
> ☐ *I've considered working with a professional to build an IRMAA-aware income strategy*

READY TO TAKE THE NEXT STEP?

IRMAA alone can cost you tens of thousands of dollars over the course of your retirement. But it doesn't have to. I help clients build income strategies that keep them below IRMAA thresholds—legally, ethically, and effectively. Let's talk about your numbers. No pressure. Just clarity.

Darin Weidauer | 702-706-6564 | darinweidauer@ecos.care

Chapter 12: Medicare Penalties — Late Enrollment Mistakes That Last a Lifetime

I want you to imagine a financial mistake so severe that it follows you every single month for the rest of your life. Not a one-time fee. Not a fine you pay and forget. A permanent increase to a bill you'll pay every month until the day you die.

That's what Medicare late enrollment penalties are. And they're more common than you'd think.

Every year, I meet smart, responsible people who made one incorrect assumption about Medicare enrollment—and now they're paying for it. Permanently. This chapter exists to make sure you never join that group.

The Part A Late Enrollment Penalty

Most people get Part A for free because they or their spouse paid Medicare payroll taxes for 40+ quarters. But if you don't qualify for premium-free Part A and you don't sign up during your Initial Enrollment Period, you face a penalty.

The Part A penalty is 10% of the premium, and it lasts for twice the number of years you could have had Part A but didn't. For example, if you went two years without Part A, you'd pay a 10% penalty for four years.

Since the 2026 Part A premium for people with fewer than 30 quarters is $565/month, a 10% penalty adds $51.80/month. While this penalty eventually expires, the years of overpayment add up.

The good news: most Americans are eligible for premium-free Part A, so this penalty is relatively uncommon. The real killers are the Part B and Part D penalties.

The Part B Late Enrollment Penalty: The Big One

This is the penalty that devastates retirement budgets. Here's how it works:

For every 12-month period you were eligible for Part B but didn't sign up (and didn't have creditable coverage), your Part B premium increases by 10%. This penalty is permanent. It never goes away. It compounds with every premium increase for the rest of your life.

⚠ THE MATH THAT SHOULD SCARE YOU

> *2026 standard Part B premium: $202.90/month. If you were 2 years late: 20% penalty = $37.00 extra/month = $486.96/year = $8,880 over 20 years. If you were 3 years late: 30% penalty = $55.50 extra/month = $666/year = $13,320 over 20 years. If you were 5 years late: 50% penalty = $92.50 extra/month = $1,110/year = $22,200 over 20 years. And these numbers grow every year as the base premium increases.*

1 year	10%	$18.50	$222	$4,440+
2 years	20%	$37.00	$444	$8,880+
3 years	30%	$55.50	$666	$13,320+
5 years	50%	$92.50	$1,110	$22,200+
7 years	70%	$129.50	$1,554	$31,080+
10 years	100%	$202.90	$2,220	$44,400+

10 years	100%	$202.90	$2,220	$44,400+

Let me put that last line in perspective: if you delayed Part B by 10 years with no creditable coverage, you'd pay double the standard premium for life. At 2026 rates, that's $405.80/month just for Part B. And the base premium will continue to rise in future years, making the dollar amount of the penalty even larger.

The Most Common Part B Penalty Mistakes

In my 22 years of helping people with Medicare, these are the mistakes I see most often:

Mistake #1: Assuming COBRA Is Creditable Coverage

COBRA is a continuation of your employer's group plan after you leave your job. It's valuable for bridging gaps in coverage. But COBRA is NOT creditable coverage for Medicare purposes. If you turn 65 on COBRA and don't enroll in Part B, you will face a penalty when your COBRA ends.

This is the single most common Part B penalty mistake I encounter. HR departments frequently fail to explain this distinction. If you're on COBRA at 65, enroll in Part B immediately.

Mistake #2: Thinking Retiree Insurance Protects You

Some former employers offer retiree health insurance. In many cases, this coverage becomes secondary to Medicare once you turn 65—meaning Medicare is expected to pay first. If you don't have Part B, your retiree plan may pay nothing, or it may pay at a reduced rate, leaving you with enormous bills.

Always check with your former employer's benefits department: "Is my retiree coverage creditable for Medicare purposes?" Get the answer in writing.

Mistake #3: Working for a Small Employer

If you're 65 and working for an employer with fewer than 20 employees, Medicare becomes your primary insurance. Your employer's group plan becomes secondary. If you don't enroll in Part B, you could face gaps in coverage AND a penalty.

The 20-employee threshold is critical. At 20+ employees, your employer plan is primary and Part B can be delayed without penalty. Below 20, Medicare is primary and Part B enrollment is essential.

Mistake #4: Assuming VA Coverage Counts

Veterans Affairs healthcare is excellent. But VA coverage is NOT creditable coverage for Medicare Part B purposes. If you rely solely on VA care and don't enroll in Part B at 65, you will face a penalty when you eventually sign up. Most veterans benefit from having both VA coverage and Medicare.

Mistake #5: Not Knowing About the Special Enrollment Period

If you're working past 65 with creditable employer coverage (20+ employees), you have an 8-month Special Enrollment Period to sign up for Part B after you or your spouse

stops working, or the coverage ends—whichever comes first. Miss this 8-month window, and you'll have to wait for the General Enrollment Period (January 1–March 31) with coverage not starting until July 1—plus a potential penalty.

The Part D Late Enrollment Penalty

Part D has its own penalty, separate from Part B. If you go 63 or more consecutive days without creditable prescription drug coverage after you're first eligible, you'll pay a penalty.

The calculation: 1% of the "national base beneficiary premium" ($36.78 in 2026) multiplied by the number of full uncovered months. This penalty is added to your Part D premium permanently.

12 months	$4.41	$52.92	$1,058
24 months	$8.83	$105.96	$2,119
36 months	$13.24	$158.88	$3,178
60 months (5 years)	$22.07	$264.84	$5,297

The Part D penalty is smaller in dollar terms than the Part B penalty, but it still adds up over a long retirement. And like Part B, it's permanent.

How to Avoid All Medicare Penalties

The rules are straightforward once you know them:

Enroll in Part A at 65 (it's free for most people and there's no reason to delay). Enroll in Part B at 65 unless you have creditable employer coverage from a company with 20+ employees—and you're actively working there (not retired). When you stop working or lose employer coverage, enroll in Part B within 8 months. Enroll in Part D when you first become eligible, unless you have other creditable prescription drug coverage. Never assume COBRA, VA, marketplace, or retiree coverage counts as creditable without verifying. Mark every deadline on your calendar. When in doubt, call a licensed agent.

REAL-WORLD EXAMPLE: The $31,000 Assumption

> *Diane, age 72, spent seven years assuming her husband's small-employer health plan (15 employees) was keeping her safe. She thought she didn't need Part B as long as she had "insurance." When her husband retired at 73, Diane tried to enroll in Medicare Part B. That's when she learned the penalty: 70% of the standard premium—permanently. At $202.90 standard in 2026, Diane pays $314.50 per month for Part B. Over the next 20 years, she'll pay approximately $31,080 more than someone who enrolled on time. One phone call to a licensed agent at age 65 would have prevented this entirely.*

FREQUENTLY ASKED QUESTIONS

Q: Can Medicare penalties ever be forgiven?

> *A: In very rare cases, if the penalty was caused by an error by a government agency or employer, you may be able to appeal. But in the vast majority of cases, penalties are permanent. Prevention is the only reliable strategy.*

Q: I have TRICARE. Do I still need Part B?

> *A: TRICARE for Life requires you to have both Part A and Part B. If you drop or don't enroll in Part B, TRICARE for Life will not cover you. Always maintain both parts.*

Q: Does Medicare Advantage eliminate penalties?

> *A: No. You must have Part A and Part B to join a Medicare Advantage plan. If you have Part B penalties, those carry over to your Medicare Advantage premium structure.*

Q: I turned 65 three months ago and didn't sign up. Am I in trouble?

> *A: Not necessarily. Your Initial Enrollment Period extends 3 months after your birthday month. Check your dates carefully—you may still be within your IEP. If not, explore whether you have any creditable coverage that would qualify you for a Special Enrollment Period.*

CHAPTER 12 CHECKLIST

> ☐ *I understand the Part B late enrollment penalty (10% per year, permanent)*
>
> ☐ *I understand the Part D late enrollment penalty (1% per month, permanent)*
>
> ☐ *I know that COBRA is NOT creditable coverage for Medicare*
>
> ☐ *I know that VA coverage is NOT creditable coverage for Part B*
>
> ☐ *I've verified my current coverage's creditable status in writing*
>
> ☐ *I know I have an 8-month SEP when employer coverage ends*
>
> ☐ *I've set calendar reminders for all enrollment deadlines*

READY TO TAKE THE NEXT STEP?

Penalties are permanent, but they're also preventable. If you're not sure whether you're enrolled correctly—or whether your current coverage qualifies as "creditable"—don't guess. One phone call can save you a lifetime of extra costs.

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Chapter 13: The Home Sale Trap — How Selling Your House After Age 63 Can Spike Your Medicare Costs

This is the chapter I wish every real estate agent, financial advisor, and tax preparer would read. Because the advice most retirees get about selling their home ignores one of the most expensive consequences: IRMAA.

Selling your home in retirement can be a smart financial move. You downsize. You free up equity. You simplify your life. But if you don't plan the timing carefully, the capital gain from that sale can spike your Medicare premiums for one or two years—costing you thousands of dollars in IRMAA surcharges that nobody warned you about.

Let's break down exactly how this works and, more importantly, how to avoid it.

The Capital Gains Exclusion: The Part Everyone Knows

When you sell your primary residence, the IRS allows you to exclude a portion of the capital gain from your taxable income. For a single filer, the exclusion is $250,000. For a married couple filing jointly, it's $500,000. To qualify, you must have owned the home and lived in it as your primary residence for at least two of the last five years.

Most people think that's the end of the story. You sell your house, take the exclusion, and move on. But here's what nobody mentions: any gain above the exclusion is taxable—and it's included in your MAGI for IRMAA purposes.

The Part Nobody Tells You: IRMAA Impact

Remember, IRMAA uses a two-year lookback. If you sell your home in 2024, the capital gain shows up on your 2024 tax return, which Medicare uses to determine your 2026 IRMAA surcharges.

Even if the gain is partially or fully excluded for income tax purposes, any portion that IS taxable gets added to your MAGI. And for many long-time homeowners—especially in high-appreciation markets like California, Nevada, Florida, Arizona, and the Northeast—the gain often exceeds the exclusion.

The Math: A Real Home Sale Scenario

Let's walk through a realistic example.

REAL-WORLD EXAMPLE: The Henderson Home Sale

> *Jim and Karen, both 67, bought their home in Henderson, Nevada, in 1998 for $185,000. Over 26 years, they made $65,000 in capital improvements (new roof, kitchen remodel, bathroom upgrades). Their adjusted cost basis is $250,000.*
>
> *In 2024, they sell the home for $620,000. Their capital gain is $620,000 – $250,000 = $370,000. They apply the $500,000 married exclusion, so the entire gain is excluded for income tax purposes. Their taxable gain from the home sale: $0.*
>
> *But now let's change one detail. Suppose they sell for $820,000 instead. Their capital gain is $820,000 – $250,000 = $570,000. After the $500,000 exclusion, they have a taxable gain of $70,000.*
>
> *Jim and Karen's regular income (Social Security + pension + IRA withdrawals) is $150,000. Add the $70,000 taxable gain: their 2024 MAGI is $220,000. That pushes them over the $218,000 married IRMAA threshold. In 2026, both Jim and Karen pay $284.10/month for Part B (instead of $202.90) and $14.50/month in Part D surcharges. Extra cost: ($74 + $14.50) x 2 people x 12 months = $2,296.80 in IRMAA surcharges for that year.*

The Timing Strategy: When to Sell

The IRMAA impact of a home sale depends entirely on when you sell relative to your Medicare enrollment. Here's the timing framework:

Sell before age 63	Gain hits tax return before IRMAA lookback period affects Medicare premiums at 65	Ideal if possible — sell early
Sell at age 63	Gain shows on tax return, affects IRMAA at age 65 (first year of Medicare)	Risky — first year on Medicare starts with a surcharge
Sell at age 64–65	Gain affects IRMAA at age 66–67	Plan carefully — you'll be on Medicare when the surcharge hits
Sell at age 66+	Gain affects IRMAA at age 68+	IRMAA hit is unavoidable without other strategies
Sell and file SSA-44	May reduce or eliminate IRMAA if qualifying life-changing event applies	Worth exploring — see below

Strategy 1: Sell Before Age 63

If your home sale gain will exceed the exclusion, the cleanest strategy is to sell before age 63. That way, the gain appears on your tax return two or more years before you turn 65—before you're on Medicare and before IRMAA applies.

Of course, this isn't always practical. Real estate decisions depend on housing markets, family needs, and life circumstances. But if you have flexibility, timing the sale before 63 eliminates the IRMAA problem entirely.

Strategy 2: Increase Your Cost Basis

Your cost basis reduces the taxable gain. Capital improvements to your home—not repairs, but improvements—increase your basis. Keep meticulous records of every improvement: new roof, HVAC system, kitchen remodel, bathroom renovation, room addition, landscaping that adds value, new driveway, new windows, and more.

Every dollar you add to your cost basis is a dollar less in capital gain. If your home has appreciated significantly, the difference between a $205,000 basis and a $300,000 basis could determine whether you trigger IRMAA or not.

Strategy 3: Installment Sale

Instead of receiving the full sale price at closing, you can structure an installment sale where the buyer pays you over multiple years. This spreads the capital gain across tax years, potentially keeping your MAGI below the IRMAA threshold in any single year.

This strategy requires careful legal and tax planning, and it's not appropriate for every situation. But for the right seller and buyer, it can save thousands in both taxes and IRMAA surcharges.

Strategy 4: Offset With Losses or Charitable Giving

Capital losses from other investments can offset capital gains from a home sale. If you have losing investments in a taxable brokerage account, harvesting those losses in the same year as the home sale can reduce your net gain.

Similarly, making large charitable contributions—especially donating appreciated stock directly to charity—can reduce your AGI, which in turn reduces your MAGI.

Strategy 5: File Form SSA-44

If the home sale qualifies as a "loss of income-producing property" (for example, if you sold a home that was also generating rental income), you may be able to file Form SSA-44 and request that Social Security use your current year's income instead of the lookback year. This is a nuanced argument, and not every home sale qualifies—but it's worth exploring with a licensed professional.

The Home Sale IRMAA Trap: A Complete Illustration

2024	Jim & Karen sell home; $70,000 taxable gain	MAGI rises from $150,000 to $220,000	No immediate effect (2024 tax year)
			2025 IRMAA based on

2025	Normal income year	MAGI: $150,000	2023 taxes (below threshold)
2026	IRMAA lookback hits 2024 return	SSA sees $220,000 MAGI	Both pay extra $95.70/mo each = $2,296.80/year
2027	IRMAA lookback hits 2025 return	SSA sees $150,000 MAGI	Back to standard premiums

One home sale. One year of elevated income. One year of IRMAA surcharges. $2,296.80 in extra Medicare costs. And that's for a relatively modest $70,000 in taxable gain. For larger gains—especially in high-cost real estate markets—the IRMAA hit can be $5,000, $8,000, or even $12,000.

FREQUENTLY ASKED QUESTIONS

Q: Does the $250K/$500K exclusion fully protect me from IRMAA?

> *A: Only if your total gain is below the exclusion amount. Any gain above the exclusion is taxable and counts toward IRMAA. Even within the exclusion, other income sources can still push you over an IRMAA threshold.*

Q: I'm selling a rental property, not my primary home. Does the exclusion apply?

> *A: No. The $250K/$500K capital gains exclusion only applies to your primary residence. Gains from rental or investment properties are fully taxable and fully counted in your MAGI. Consider a 1031 exchange to defer the gain if you plan to reinvest in another rental property.*

Q: My real estate agent never mentioned IRMAA. Is this common?

> *A: Extremely common. Most real estate agents don't know about IRMAA. Most tax preparers don't proactively plan for it. This is a gap in the advice most retirees receive, which is why working with a retirement specialist who understands the full picture is so important.*

Q: Can I avoid the home sale trap by putting the proceeds in a Roth IRA?

> *A: Not directly. The capital gain is triggered by the sale itself, not by what you do with the proceeds. However, if you use some of the proceeds to fund Roth conversions in future years (at a pace that avoids IRMAA), you can build tax-free income for the future.*

CHAPTER 13 CHECKLIST

>

> ☐ *I understand how a home sale can trigger IRMAA surcharges via the two-year lookback*
>
> ☐ *I know the capital gains exclusion amounts ($250K single / $500K married)*
>
> ☐ *I've calculated my home's approximate cost basis, including improvements*
>
> ☐ *I've estimated my potential taxable gain if I sell*
>
> ☐ *I've considered the optimal timing for a home sale relative to my Medicare enrollment*
>
> ☐ *I've explored strategies like installment sales, loss harvesting, and charitable giving*
>
> ☐ *I've spoken with a retirement specialist before listing my home*

READY TO TAKE THE NEXT STEP?

Selling your home is one of the biggest financial events of your retirement. The IRMAA implications alone can cost you thousands. Before you list that house, let's make sure the timing is right. I've helped dozens of clients time their home sales to minimize Medicare surcharges.

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Chapter 14: Roth Conversions, IRA Withdrawals, and IRMAA — Planning Your Income to Avoid the Surcharge

If Chapter 11 showed you what IRMAA is and Chapter 13 showed you how a home sale can trigger it, this chapter is about the income sources you control every day—and how managing them strategically can keep thousands of dollars in your pocket instead of handing them to Medicare.

Your traditional IRA, 401(k), 403(b), and TSP are retirement income powerhouses. But every dollar you withdraw from these accounts shows up on your tax return—and every dollar on your tax return feeds into your MAGI, which feeds into IRMAA.

The question isn't whether to use these accounts. The question is how much to take, when to take it, and whether converting some of it to a Roth can change the game entirely.

Understanding the MAGI Equation

Your Modified Adjusted Gross Income (MAGI) for IRMAA includes:

Adjusted Gross Income (your total income minus specific deductions like educator expenses, student loan interest, and IRA contributions) PLUS tax-exempt interest

income (including municipal bond interest).

Here's what counts in your AGI:

Social Security benefits	Yes (up to 85%)	Taxable portion counts toward AGI
Traditional IRA/401(k)/403(b) withdrawals	Yes (100%)	Fully taxable as ordinary income
Roth IRA distributions	NO	Not included in AGI or MAGI
Roth 401(k) distributions	NO	Not included in AGI or MAGI
Pension income	Yes (100%)	Fully taxable
Wages / self-employment income	Yes (100%)	Fully taxable
Capital gains (stocks, property)	Yes (100%)	Short-term and long-term gains both count
Rental income (net)	Yes	After deductions
Municipal bond interest	Yes (for IRMAA only)	Tax-free for income tax but counts for MAGI
Dividends	Yes	Both qualified and ordinary
Annuity income (non-qualified)	Partially	Only the earnings portion is taxable
Life insurance cash value withdrawals	It depends	Loans are tax-free; withdrawals above basis are taxable
Roth conversions	Yes (in conversion year)	The converted amount is taxable income
Required Minimum Distributions	Yes (100%)	Fully taxable from traditional accounts
Health Savings Account withdrawals	No (if qualified)	Tax-free for medical expenses

The golden takeaway from this table: Roth IRA distributions do not count in your MAGI. That single fact makes Roth conversions one of the most powerful IRMAA avoidance strategies available.

The Roth Conversion Strategy for IRMAA Reduction

A Roth conversion is when you move money from a traditional IRA, 401(k), or other pre-tax retirement account into a Roth IRA. You pay income tax on the converted amount in the year you convert. But after that, the money grows tax-free, and qualified distributions from the Roth are not included in your MAGI.

Here’s the strategic framework:

Phase 1: The Conversion Window (Ages 59½ to 63)

The ideal time for Roth conversions is between ages 59½ (when you can access retirement funds without the 10% early withdrawal penalty) and age 63. Why age 63? Because IRMAA uses a two-year lookback. A conversion done at age 63 affects your IRMAA at age 65—your first year on Medicare. If you complete your conversions by age 62, the income from those conversions may not affect your IRMAA at all (depending on when in the year you turn 65 and when the lookback lands).

The goal: convert enough traditional IRA money to a Roth to significantly reduce your future RMDs, lower your future MAGI, and keep you below IRMAA thresholds for life—all while paying tax at today’s rates, which may be lower than future rates.

Phase 2: The Careful Zone (Ages 63 to 70)

After age 63, conversions still work—but you need to be more precise. Every conversion increases your MAGI in the conversion year, which will increase your IRMAA two years later. The strategy shifts to “precision conversions”: convert just enough to fill the space between your current MAGI and the next IRMAA threshold, but not so much that you jump into a higher bracket.

Phase 3: The RMD Years (Age 73+)

Once Required Minimum Distributions begin (age 73 for most people in 2026), your traditional IRA forces money into your MAGI whether you want it there or not. If you’ve done significant Roth conversions in earlier years, your remaining traditional IRA balance is smaller, your RMDs are smaller, and your MAGI stays lower. That’s the payoff of early planning.

Roth Conversion IRMAA Impact Calculator

Let’s see how different conversion amounts affect IRMAA for a married couple with $150,000 in base income.

$0 (no conversion)	$150,000	Standard ($202.90/mo)	$0
$50,000	$205,000	Standard ($202.90/mo)	$0
$62,000	$218,000	Standard ($202.90/mo)	$0 (right at threshold)
$62,001	$218,001	Tier 2 ($284.10/mo)	$2,296.80
$100,000	$250,000	Tier 2 ($284.10/mo)	$2,296.80
$116,000	$274,000	Tier 2 ($284.10/mo)	$2,296.80 (right at threshold)

$116,001	$274,001	Tier 3 ($405.80/mo)	$5,764.80
$205,000	$350,000	Tier 4 ($527.50/mo)	$9,232.80

Look at the difference between converting $62,000 and $62,001 for this couple. One extra dollar triggers $2,296.80 in annual IRMAA surcharges. That's not a gradual increase—it's a cliff. This is why precision matters.

The optimal strategy for this couple: convert up to $62,000 per year (bringing their MAGI to exactly $218,000), filling the space just below the IRMAA threshold. Over five years, they could convert $310,000 to a Roth without triggering any IRMAA—and dramatically reduce their future RMDs.

Traditional IRA Withdrawals: The Annual Calibration

Even if you're not doing Roth conversions, the amount you withdraw from traditional accounts each year should be carefully calibrated against IRMAA thresholds. Here's a simple annual planning process:

Step 1: Estimate your "fixed" MAGI components for the year (Social Security, pension, wages, rental income, etc.). Step 2: Identify the nearest IRMAA threshold above your fixed income. Step 3: The gap between your fixed income and the threshold is your "safe withdrawal zone" from traditional accounts. Step 4: If you need more income than the safe zone allows, draw the excess from Roth accounts, cash savings, or other non-MAGI sources.

The Power of Multiple Income Buckets

The most IRMAA-efficient retirees don't rely on a single income source. They maintain multiple "buckets" of money, each with different tax treatment:

Pre-Tax	Traditional IRA, 401(k), 403(b), TSP	Yes (100%)	Yes	High
Tax-Free	Roth IRA, Roth 401(k)	No	No	None
After-Tax	Brokerage accounts, savings	Gains/dividends only	Yes (gains)	Moderate
Tax-Advantaged	HSA, cash value life insurance	No (if rules followed)	Usually no	Low/None
Social Security	SS benefits	Up to 85%	Yes (taxable portion)	Moderate

By drawing from different buckets in the right proportions each year, you can control

your MAGI with remarkable precision. This is the essence of retirement income planning—and it's why working with a professional who understands both taxes and Medicare is worth its weight in gold.

RMDs and IRMAA: The Forced Income Problem

Starting at age 73, the IRS requires you to take minimum distributions from your traditional retirement accounts (IRA, 401(k), 403(b), TSP). These Required Minimum Distributions are based on your account balance and life expectancy. The larger your traditional account balance, the larger your RMD—and the higher your MAGI.

Here's the problem: by the time RMDs begin, you have no choice about the income. It's forced. If your traditional IRA has grown to $1,000,000 by age 73, your first RMD is approximately $37,736 (using the Uniform Lifetime Table). At $2,000,000, it's about $75,472. At $3,000,000, it's roughly $113,208.

If those RMDs push you over an IRMAA threshold, you're paying surcharges on money you were forced to take. This is the "RMD-IRMAA trap," and the only way to avoid it is to reduce your traditional account balances before RMDs begin—through Roth conversions, strategic withdrawals, or qualified charitable distributions.

$300,000	$11,321	$91,321	Standard
$500,000	$18,868	$98,868	Standard
$700,000	$26,415	$106,415	Tier 2 ($284.10/mo)
$1,000,000	$37,736	$117,736	Tier 2 ($284.10/mo)
$1,500,000	$56,604	$136,604	Tier 3 ($405.80/mo)
$2,000,000	$75,472	$155,472	Tier 3 ($405.80/mo)
$3,000,000	$113,208	$193,208	Tier 4 ($527.50/mo)

A single person with $80,000 in other income and a $700,000 traditional IRA would pay $284.10/month for Part B instead of $202.90/month—an extra $888 per year—solely because of their RMD. Over 20 years, that's nearly $18,000 in extra Medicare costs from one account they couldn't avoid tapping.

The Optimal Strategy: Putting It All Together

Here's the integrated approach I recommend to my clients:

Before age 63: Do aggressive (but tax-smart) Roth conversions, filling up the space below IRMAA thresholds each year. The goal is to move as much as possible from traditional accounts to Roth while paying tax at today's rates.

Ages 63–72: Continue precision Roth conversions calibrated to stay just below IRMAA thresholds. Supplement income from Roth and taxable accounts as needed. Begin drawing down traditional accounts strategically.

Age 73+: RMDs kick in. If you've done your conversions, the remaining traditional balance is manageable and RMDs stay below IRMAA thresholds. Use Qualified Charitable Distributions (QCDs) for any charitable giving to further reduce MAGI.

Throughout retirement: Review your income plan annually. IRMAA thresholds, tax brackets, and personal circumstances change. What worked last year may not work next year.

REAL-WORLD EXAMPLE: The Five-Year Conversion Plan

> *Tom and Sarah, both 60, have $1,200,000 in traditional IRAs, $80,000 in combined Social Security (projected at 67), and $30,000 in pension income. Their projected MAGI at 67 without conversions: $80,000 + $30,000 + ~$45,000 RMD (at 73) = $155,000. But their IRA will grow. By age 73, it could be $1,800,000, producing an RMD of approximately $67,924—pushing their MAGI to $177,924 and dangerously close to the $218,000 married threshold.*
>
> *Tom and Sarah's plan: between ages 60 and 64, they convert $60,000 per year ($300,000 total) to a Roth. They pay approximately $15,000–$18,000 per year in federal taxes on the conversions (at the 22–24% marginal rate). Total conversion tax cost: approximately $75,000–$90,000 over five years.*
>
> *Result: By age 73, their traditional IRA balance is roughly $1,100,000 instead of $1,800,000. Their first RMD is approximately $41,509 instead of $67,924. Their MAGI stays below the $218,000 married threshold. IRMAA avoided: $2,296.80/year (minimum). Over 20 years, that's $42,096 in IRMAA savings—plus the compounding tax-free growth in their Roth IRA, which could be worth hundreds of thousands more.*
>
> *Total estimated benefit of the conversion plan: $42,096 in IRMAA savings + $30,000–$50,000 in reduced income taxes on RMDs + tax-free Roth growth. Total cost: $75,000–$90,000 in conversion taxes. Net benefit: potentially $100,000+ over their retirement.*

FREQUENTLY ASKED QUESTIONS

Q: Should I do all my Roth conversions at once?

> *A: Almost never. A large, one-time conversion creates a massive income spike that pushes you into higher tax brackets and higher IRMAA tiers. The strategy is to spread conversions over multiple years, staying within your tax bracket and below IRMAA thresholds each year.*

Q: I'm already 70. Is it too late for Roth conversions?

> *A: It's never too late, but the strategy changes. At 70+, you have fewer years before RMDs begin (at 73), so the "runway" for conversions is shorter. You can still do precision conversions each year to reduce your traditional balance. Every dollar*

> *converted is a dollar less in future RMDs.*

Q: Do Roth conversions affect my Social Security taxes too?

> *A: Yes. The converted amount increases your income, which can increase the taxable portion of your Social Security benefits (up to 85% of benefits can be taxable). This is another reason to do conversions before you start collecting Social Security if possible.*

Q: My financial advisor never mentioned IRMAA. Should I be concerned?

> *A: Many financial advisors focus on investment performance and tax brackets but overlook Medicare implications. IRMAA is a relatively new consideration for many planners. If your advisor isn't factoring Medicare costs into your withdrawal strategy, you should bring it up—or work with someone who understands both sides.*

Q: Can I 'undo' a Roth conversion if it pushes me into IRMAA?

> *A: No. Since 2018, Roth conversions are irrevocable. Once you convert, you cannot reverse it (this is called "recharacterization," and it was eliminated by the Tax Cuts and Jobs Act). This makes planning before converting even more critical.*

CHAPTER 14 CHECKLIST

> ☐ *I understand how traditional IRA withdrawals and Roth conversions affect my MAGI*
>
> ☐ *I know which income sources count toward MAGI and which don't (Roth = safe)*
>
> ☐ *I've calculated the gap between my current MAGI and the nearest IRMAA threshold*
>
> ☐ *I've evaluated whether Roth conversions before age 63 make sense for my situation*
>
> ☐ *I understand how RMDs at age 73 could push me into IRMAA territory*
>
> ☐ *I've considered building multiple income "buckets" (pre-tax, tax-free, after-tax)*
>
> ☐ *I've reviewed the QCD strategy for charitable giving after age 70½*
>
> ☐ *I've discussed IRMAA with my financial advisor or retirement specialist*

READY TO TAKE THE NEXT STEP?

Roth conversions can be the most powerful tax tool in your retirement toolkit—or the

most expensive mistake. The difference comes down to planning. Let me run the numbers with you, for free, so you can see exactly what a conversion would mean for your taxes, your Medicare premiums, and your long-term wealth.

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PART III

SPECIAL MEDICARE TOPICS

Veterans, federal employees, workers past 65, and everyone who's

been targeted by a Medicare scam. These chapters are for you.

Chapter 15: Veterans, TRICARE, and VA Benefits — How They Work With Medicare

This chapter is personal. I spent 22 years in the United States Air Force, starting as a Heavy Construction Equipment Operator and finishing as a Cyber Warfare Officer and University Professor. I know the military healthcare system from the inside. I've used it. I've navigated it. And now I help fellow veterans make the most of it alongside Medicare.

If you're a veteran, you're in a unique position. You may have access to VA healthcare, TRICARE, military retirement benefits, a Thrift Savings Plan, and Social Security—all at the same time. The question is how to coordinate these benefits with Medicare so you get the best coverage, the lowest costs, and the maximum financial protection.

Let's break it down.

VA Healthcare and Medicare: Two Separate Systems

The VA healthcare system and Medicare are completely independent programs. They don't talk to each other. They don't coordinate benefits automatically. And critically, VA healthcare does NOT count as creditable coverage for Medicare Part B purposes.

Let me repeat that because it's the most common mistake veterans make: VA coverage is not creditable coverage for Medicare. If you rely solely on VA healthcare and don't enroll in Medicare Part B at age 65, you will face a permanent Part B late enrollment penalty when you eventually do enroll.

⚠ CRITICAL FOR ALL VETERANS

> *Enroll in Medicare Part A at age 65. It's free (assuming 40+ quarters of work), and there's no reason not to. Enroll in Medicare Part B at age 65 unless you have creditable employer coverage from a current employer with 20+ employees. VA coverage alone does NOT protect you from the Part B penalty. If you delay Part B without creditable employer coverage, you will pay a 10% penalty for every year you were late—for the rest of your life.*

TRICARE and Medicare: The Three Paths

TRICARE is the healthcare program for active-duty service members, retirees, and their dependents. There are three main TRICARE programs that interact with Medicare:

TRICARE for Life (TFL)

TRICARE for Life is the gold standard for military retirees with 20+ years of service (or medical retirement). TFL acts as a wraparound supplement to Medicare—essentially functioning like a Medigap plan, but at no additional premium cost.

How it works: Medicare pays first, and TRICARE for Life picks up most or all of the remaining costs. For Medicare-covered services, your out-of-pocket cost is typically zero. TFL also covers many services Medicare doesn't, including prescription drugs through the TRICARE pharmacy benefit, overseas coverage, and certain dental and vision benefits.

⚠ TRICARE FOR LIFE REQUIRES PART B

> *To remain eligible for TRICARE for Life, you MUST have both Medicare Part A and Part B. If you drop Part B or fail to enroll, TRICARE for Life coverage is suspended. This is non-negotiable. The cost of Part B ($202.90/month in 2026) is the "premium" for keeping TFL active—and it's one of the best deals in healthcare.*

TRICARE Prime

TRICARE Prime is an HMO-style managed care option available to military retirees under 65. At age 65 (when Medicare eligibility begins), most retirees transition from TRICARE Prime to TRICARE for Life. If you're approaching 65 on TRICARE Prime, the transition to TFL should be seamless as long as you're enrolled in both Medicare Part A and Part B.

TRICARE Select

TRICARE Select is a PPO-style option with annual enrollment fees, deductibles, and cost-shares. Like TRICARE Prime, at age 65 you transition to TRICARE for Life once enrolled in Medicare Parts A and B. TRICARE Select can act as secondary coverage for Medicare-covered services.

TRICARE for Life vs. Medigap vs. Medicare Advantage

Monthly Premium (beyond Part B)	$0	$150–$300	$0–$200+
Part A Deductible Covered	Yes	Yes	Varies
Part B Coinsurance Covered	Yes	Yes (after $283 deductible)	Copays/coinsurance apply

Part B Excess Charges	Yes	Yes	N/A (network-based)
Prescription Drugs	TRICARE pharmacy (low cost)	No (need separate Part D)	Usually included
Dental Coverage	Limited through TRICARE Dental	No	Often included (basic)
Provider Network	Any Medicare provider + military facilities	Any Medicare provider	In-network only
Overseas Coverage	Yes (worldwide)	Limited (80% for emergencies)	Limited to service area
Prior Authorization	Rarely	No	Common
Out-of-Pocket Maximum	Catastrophic cap applies	None needed (comprehensive)	$8,850 in-network (2026)
Best For	Military retirees (20+ years)	Non-military Medicare enrollees	Cost-conscious enrollees wanting extras

If you're a military retiree eligible for TRICARE for Life, you have what is arguably the best healthcare coverage available to any American. Your only cost is the Part B premium. There is almost never a reason for a TFL-eligible retiree to purchase a Medigap plan or enroll in a Medicare Advantage plan—TFL is superior to both in almost every way.

VA Healthcare for Non-Retirees

Not all veterans are TRICARE-eligible. TRICARE is for military retirees (20+ years or medical retirement) and their dependents. Veterans who served but didn't retire from the military may be eligible for VA healthcare based on service-connected disability, income, or other factors.

VA healthcare is excellent, but it has limitations: you must use VA facilities (unless authorized for community care), wait times can be long for non-urgent care, and not all services are available at every VA facility. Many veterans benefit from having both VA healthcare AND Medicare—using the VA for specialty services, mental health, and service-connected conditions, and Medicare for everything else.

VA Disability Compensation and Income Planning

VA disability compensation is tax-free. It is not included in your Adjusted Gross Income, your MAGI, or your provisional income for Social Security taxation. This makes VA disability one of the most tax-efficient income sources in retirement.

However, VA disability compensation can affect other benefits. For military retirees, there are two programs that allow you to receive both military retirement pay and VA

disability simultaneously: Concurrent Retirement and Disability Pay (CRDP) for those with 50%+ VA disability, and Combat-Related Special Compensation (CRSC) for combat-related disabilities. Without these programs, VA disability would offset your military retirement dollar-for-dollar.

VA Disability Compensation	No	No	None	None
VA Pension (non-disability)	Depends	Depends	Possible	Possible
Military Retirement Pay	Yes	Yes	Yes	Yes
CRDP (concurrent pay)	Retirement portion: Yes; VA portion: No	Partial	Partial	Partial
CRSC (combat-related)	No	No	None	None

VA Long-Term Care Benefits

The VA offers several long-term care programs for eligible veterans, including: Community Living Centers (VA nursing homes) for veterans with 70%+ service-connected disability or who meet clinical need. Aid and Attendance benefit (a pension supplement for veterans who need help with ADLs)—up to $2,431/month for a single veteran in 2026 or $2,874/month for a veteran with a dependent spouse. Housebound benefit for veterans confined to their home. Home-Based Primary Care and Homemaker/Home Health Aide services.

These VA benefits can complement private long-term care insurance and Medicare coverage. However, VA LTC programs have eligibility requirements, wait lists, and geographic limitations. They should be part of your long-term care plan, not your entire plan.

REAL-WORLD EXAMPLE: The Retired Colonel Who Almost Lost TFL

> *Colonel (Ret.) James, age 65, had relied on TRICARE Prime his entire post-military career. When he turned 65, he assumed TRICARE would "just keep going." He didn't enroll in Medicare Part B. Six months later, he discovered that TRICARE for Life had suspended his coverage because he lacked Part B. He enrolled during the General Enrollment Period, but coverage didn't start until July 1—leaving him with a 6-month gap and a permanent 5% Part B penalty. His annual extra cost: $111/year for life. A single phone call at age 64 would have prevented this.*

FREQUENTLY ASKED QUESTIONS

Q: I have a 100% VA disability rating. Do I still need Medicare?

A: Even with 100% VA disability, Medicare Part A is free and provides coverage outside the VA system. Part B is strongly recommended to maintain TRICARE for Life eligibility (if applicable) and to give you the flexibility to see any Medicare provider. Many veterans with high disability ratings still benefit from having Medicare as a backup system.

Q: Does my military service count toward Social Security?

A: Yes. Active-duty military service is covered by Social Security. You paid FICA taxes during service, and those years count toward your 35-year earnings calculation. Special credits may apply for earlier service periods. Check your Social Security Statement to verify all military years are correctly credited.

Q: Can I use the VA and Medicare at the same time?

A: You can be enrolled in both, but for any single service, only one program pays. You can't bill both Medicare and the VA for the same treatment. However, you can use the VA for some services (like service-connected care or prescriptions) and Medicare for others (like seeing a civilian specialist). Many veterans use both systems strategically.

Q: My spouse was never in the military. Are they covered by TRICARE?

A: If you're a military retiree, your spouse is eligible for TRICARE (and TRICARE for Life after 65 with Medicare Parts A and B). If you're a veteran but not a military retiree, your spouse is generally not eligible for TRICARE but may qualify for CHAMPVA if you have a permanent and total service-connected disability.

Q: What is CHAMPVA?

A: CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) provides healthcare coverage for the spouse and dependents of a veteran with a permanent and total service-connected disability, or for the surviving spouse and dependents of a veteran who died from a service-connected condition. At 65, CHAMPVA becomes secondary to Medicare.

CHAPTER 34 CHECKLIST

☐ *I understand that VA coverage is NOT creditable coverage for Medicare Part B*

☐ *I've enrolled in (or plan to enroll in) Medicare Part A at age 65*

> ☐ *If TRICARE-eligible, I've confirmed enrollment in Part B to maintain TRICARE for Life*
>
> ☐ *I know my VA disability rating and which VA benefits I'm eligible for*
>
> ☐ *I've verified my military years are correctly reflected on my Social Security Statement*
>
> ☐ *I've explored VA long-term care benefits (Aid and Attendance, Community Living Centers)*
>
> ☐ *I've evaluated how VA disability compensation fits into my IRMAA-free income strategy*
>
> ☐ *I've updated all beneficiary designations on my TSP, SGLI/VGLI, and other policies*

READY TO TAKE THE NEXT STEP?

Fellow veteran: I served 22 years so I could help people like you navigate the transition from military to civilian retirement. TRICARE, VA benefits, TSP, Social Security, Medicare—I've lived all of it. Let me put my experience to work for you. Call a brother-in-arms. I've got your six.

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Chapter 16: Federal Employees and FEHB — Your Medicare Strategy Is Different

If you're a federal civilian employee or retiree, your healthcare picture is different from everyone else's. You have the Federal Employees Health Benefits (FEHB) program—one of the largest and best employer-sponsored health plans in the country. And the way FEHB interacts with Medicare creates both opportunities and potential traps that most people don't understand.

FEHB Basics for Retirees

If you're a federal employee who retires with at least 5 years of FEHB enrollment (and you were enrolled at the time of retirement), you can continue FEHB coverage into retirement. The government continues to pay its share of the premium—typically 72–75% of the total—making FEHB one of the most affordable retiree health plans available.

Here's what makes FEHB unique: FEHB is creditable coverage for Medicare purposes. You can delay Medicare Part B without penalty as long as you have FEHB. However, there are significant advantages to enrolling in Part B even if you have FEHB.

Should You Enroll in Part B If You Have FEHB?

This is the most important question for federal retirees, and the answer for most people is yes. Here's why:

FEHB + Medicare = Virtually Zero Out-of-Pocket Costs

When you have both FEHB and Medicare, they coordinate benefits. Medicare becomes your primary insurance and FEHB becomes secondary. Together, they cover virtually all of your healthcare costs—most federal retirees with both FEHB and Medicare pay little to nothing out of pocket for covered services.

Additionally, many FEHB plans offer premium reductions or waive deductibles and copays when you're enrolled in Medicare Parts A and B. Some plans even offer special "Medicare wraparound" options that are significantly cheaper than the standard FEHB premium.

The Math: FEHB Alone vs. FEHB + Medicare

FEHB Only (Self Only)	$200–$500 (your share)	Deductibles + copays can reach $5,000–$8,000/year	Limited to FEHB network and benefits
FEHB + Medicare Part A Only	$200–$500 (FEHB) + $0 (Part A)	Reduced hospital costs; Part A covers inpatient first	Part B services still subject to FEHB cost-sharing
FEHB + Medicare Parts A and B	$200–$500 (FEHB) + $202.90 (Part B)	Near-zero for most services	Virtually none for Medicare-covered services
Reduced FEHB + Medicare A and B	$50–$200 (reduced FEHB) + $202.90 (Part B)	Near-zero	Virtually none; best value

For most federal retirees, the sweet spot is enrolling in both Medicare Parts A and B, then switching to a lower-cost FEHB plan that's designed to work with Medicare. The combined cost may be similar to or less than a full FEHB plan alone, with dramatically better coverage.

The Suspension Strategy

Federal retirees have a unique advantage: you can suspend your FEHB enrollment, enroll in Medicare (with or without a Medigap plan), and later re-enroll in FEHB during Open Season if your needs change. This gives you flexibility that private-sector retirees don't have.

However, if you suspend FEHB for more than one Open Season period, you may need to wait for a qualifying life event or the next Open Season to re-enroll. Don't suspend FEHB without understanding the re-enrollment rules.

FEHB and Part D: Do You Need It?

Most FEHB plans provide prescription drug coverage that's at least as good as Medicare Part D. As a result, FEHB is considered creditable drug coverage for Part D purposes. You do NOT need a separate Part D plan if you have FEHB, and you will NOT face a Part D late enrollment penalty as long as you maintain FEHB.

In fact, enrolling in a standalone Part D plan while keeping FEHB can create coordination-of-benefits confusion. In most cases, stick with your FEHB drug coverage unless a specific Part D plan offers significantly better coverage for your particular medications.

FERS Pension, TSP, and Income Planning

Federal employees under the Federal Employees Retirement System (FERS) have a three-legged retirement stool: FERS pension (a defined benefit based on years of service and high-3 average salary), TSP (the federal 401(k)—see Chapter 23), and Social Security.

For IRMAA planning, your FERS pension is fully taxable and counts in your MAGI. TSP withdrawals from the traditional side are fully taxable and count in your MAGI. TSP withdrawals from the Roth side are tax-free and do NOT count in your MAGI. Social Security is partially taxable.

The Roth TSP and Roth IRA are your most powerful IRMAA-avoidance tools as a federal retiree. Every dollar in a Roth is income that Medicare can't see.

REAL-WORLD EXAMPLE: The GS-14 Who Saved $2,400/Year

> *Patricia, a retired GS-14 with 30 years of service, had been paying $420/month for FEHB Blue Cross Blue Shield Standard (Self Only) in retirement. At 65, she enrolled in Medicare Parts A and B. She then switched to the FEHB Blue Cross Basic plan—which offers a Medicare wraparound option for only $95/month. Her new total cost: $95 (reduced FEHB) + $202.90 (Part B) = $280/month, down from $420. That's $1,680/year in savings. Her coverage? Better than before—because Medicare and the wraparound FEHB plan together cover virtually everything, with near-zero copays and deductibles.*

FREQUENTLY ASKED QUESTIONS

Q: Do I need Medigap if I have FEHB?

> *A: Generally no. FEHB with Medicare provides coverage comparable to or better than most Medigap plans. Adding Medigap on top of FEHB would be redundant and wasteful. However, if you plan to drop FEHB entirely, you'd want Medigap during your Medigap Open Enrollment Period.*

Q: Can I keep FEHB in retirement if I only worked 5 years?

> *A: You must have been enrolled in FEHB for at least 5 consecutive years immediately before retirement (with some exceptions). If you meet this requirement and retire under FERS or CSRS, you can continue FEHB for life.*

Q: I'm a CSRS retiree. Do I qualify for Medicare?

> *A: CSRS employees hired before 1984 did not pay into Medicare through payroll taxes. If you don't have 40 quarters of Medicare-covered employment (from a second job, spouse's record, or other covered work), you may not qualify for premium-free Part A. You can still purchase Part A ($565/month in 2026) or qualify through a spouse's work record.*

Q: Does my FERS pension count toward IRMAA?

> *A: Yes. Your FERS annuity is fully taxable ordinary income and is included in your MAGI for IRMAA purposes. If your FERS pension plus other income approaches IRMAA thresholds, consider Roth TSP withdrawals and other strategies to manage your MAGI.*

CHAPTER 35 CHECKLIST

> ☐ *I understand how FEHB coordinates with Medicare as secondary coverage*
>
> ☐ *I've evaluated whether enrolling in Part B reduces my total costs through FEHB premium reduction*
>
> ☐ *I know that FEHB is creditable coverage for both Part B and Part D*
>
> ☐ *I've compared my current FEHB plan to Medicare wraparound options*
>
> ☐ *I've confirmed my FEHB continuation eligibility (5+ years enrolled before retirement)*
>
> ☐ *I've considered the IRMAA impact of my FERS pension + TSP withdrawals*
>
> ☐ *I've explored Roth TSP contributions or conversions to manage MAGI*

READY TO TAKE THE NEXT STEP?

Federal retirement is a three-legged stool—FERS, TSP, and Social Security—with FEHB and Medicare layered on top. Getting the coordination right can save you thousands per year. I've worked with hundreds of federal employees and retirees to optimize this exact puzzle. Let me help you find the right combination.

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Chapter 17: Working Past 65 — HSAs, Creditable Coverage, and Timing Your Medicare

More Americans are working past 65 than at any time in the last 50 years. Some work because they want to. Some work because they need to. Either way, working past 65 creates a unique set of Medicare coordination challenges—and opportunities—that can save or cost you thousands of dollars depending on the decisions you make.

The Big Question: When Does Medicare Become Mandatory?

Medicare is never technically "mandatory." But if you don't enroll when you're supposed to, penalties follow you for life. The key variable is whether your employer has 20 or more employees.

Working, employer 20+ employees, employer coverage	Yes (it's free)	Can delay without penalty	Can delay if drug coverage is creditable	8-month SEP when you leave job or lose coverage
Working, employer <20 employees	Yes	Yes — MUST enroll	Yes — MUST enroll	Medicare is primary; employer plan is secondary
Self-employed (no group plan)	Yes	Yes — MUST enroll	Yes — MUST enroll	ACA/marketplace plans are NOT creditable
Spouse's employer (20+ employees)	Yes	Can delay if covered as dependent	Can delay if drug coverage is creditable	8-month SEP when spouse leaves job or coverage ends
COBRA	Yes	Yes — MUST enroll	Yes — MUST enroll	COBRA is NOT creditable coverage
Retired, no employer coverage	Yes	Yes — MUST enroll	Yes — MUST enroll	Enroll during IEP (7-month window around 65th birthday)

The HSA Advantage—And the HSA Trap

Health Savings Accounts (HSAs) are one of the most powerful tax tools in America. If you're still working and have a High-Deductible Health Plan (HDHP) from your employer, you can contribute to an HSA with triple tax benefits: contributions are tax-deductible, growth is tax-free, and withdrawals for qualified medical expenses are tax-free.

The 2026 HSA contribution limits are $4,300 for individual coverage and $8,550 for family coverage, with an additional $1,000 catch-up contribution for those age 55+.

⚠ THE HSA-MEDICARE TRAP

> *Once you enroll in any part of Medicare—including Part A—you can no longer contribute to an HSA. This creates a trap for workers over 65:*
>
> *If you file for Social Security at or after 65, you are automatically enrolled in Part A (it's retroactive up to 6 months). Once Part A starts, HSA contributions must stop. If you continue contributing after Part A enrollment, you'll face a 6% excise tax on the excess contributions.*
>
> *Strategy: If you want to keep contributing to your HSA past 65, do NOT file for Social Security and do NOT enroll in Medicare Part A. You can delay Part A and Part B as long as you have creditable employer coverage from an employer with 20+ employees. Once you're ready to stop HSA contributions, enroll in Medicare.*
>
> *Important timing detail: stop HSA contributions at least 6 months before you enroll in Part A, because Part A enrollment can be retroactive up to 6 months. If you fail to stop contributions in time, you may owe the excise tax.*

2026 HSA Contribution Limits

Individual HDHP	$4,300	$4,300 + $1,000	$5,300
Family HDHP	$8,550	$8,550 + $1,000	$9,550

HSA as a Retirement Super-Account

Even if you stop contributing at 65, your existing HSA balance continues to grow tax-free. After age 65, you can withdraw HSA funds for any purpose (not just medical expenses) without penalty—you'll just pay ordinary income tax, like a traditional IRA withdrawal. For medical expenses, withdrawals remain completely tax-free.

This makes the HSA a dual-purpose retirement account: tax-free for medical expenses and tax-deferred for non-medical expenses. If you've been maximizing your HSA for years, you may have a substantial balance that can help fund Medicare premiums, Medigap premiums, long-term care premiums, dental and vision costs, and prescription drug copays—all tax-free.

Coordinating Employer Coverage With Medicare

If your employer has 20+ employees and you're covered by their group plan, your employer plan is primary (pays first) and Medicare is secondary. You can delay Part B without penalty. When you retire or lose that employer coverage, you have an 8-month

Special Enrollment Period to enroll in Part B.

During that 8-month window, you should also enroll in Part D (if you don't have creditable drug coverage elsewhere), select a Medigap plan or Medicare Advantage plan, and coordinate your transition timing so there's no gap in coverage.

The Employer Coverage Verification Checklist

Before making any Medicare decisions while working past 65, verify these facts with your employer's HR department:

QUESTIONS TO ASK YOUR EMPLOYER

> *1. How many employees does the company have? (The 20-employee threshold determines everything.)*
>
> *2. Is the company's group health plan "creditable coverage" for Medicare Part B purposes?*
>
> *3. Is the company's prescription drug coverage "creditable" for Medicare Part D purposes? (Your employer is required to send you an annual notice about this.)*
>
> *4. What happens to my coverage when I retire—does the company offer retiree insurance?*
>
> *5. If retiree insurance is offered, does it become secondary to Medicare at 65?*
>
> *6. Can I get these answers in writing?*

REAL-WORLD EXAMPLE: The HSA Maximizer

> *Kevin, age 64, earned $130,000 as a senior engineer at a company with 500 employees. He had a family HDHP and had been contributing the maximum to his HSA for 12 years. His HSA balance: $142,000. Kevin's plan: delay Social Security and Medicare until 67, contributing an additional $9,550/year to his HSA for three more years ($28,650 total). At 67, he enrolls in Medicare, stops HSA contributions, and begins using his $170,000+ HSA balance to pay for Medicare premiums ($202.90/month Part B), Medigap premiums ($200/month Plan G), and dental/vision costs—all tax-free. At $6,000/year in medical expenses, his HSA will last 28+ years, providing tax-free healthcare funding through his entire retirement.*

FREQUENTLY ASKED QUESTIONS

Q: I'm 67 and still working. Do I need Part B?

> *A: If your employer has 20+ employees and you have their group plan, you can continue to delay Part B. When you leave or lose the coverage, you'll have an 8-month SEP. If your employer has fewer than 20 employees, you should have enrolled*

> *at 65.*

Q: Can I keep my ACA marketplace plan instead of Medicare?

> *A: You can, but marketplace plans are NOT creditable coverage for Medicare. If you delay Part B while on a marketplace plan, you'll face a permanent penalty. Also, once you're eligible for Medicare, you lose eligibility for marketplace premium subsidies. Switch to Medicare at 65.*

Q: My husband is 67 and works. I'm 65 and on his plan. Do I need Medicare?

> *A: If his employer has 20+ employees and you're covered as a dependent on his group plan, you can delay Part B. When his employment or coverage ends, you get an 8-month SEP. If his employer has fewer than 20 employees, you should enroll in Part B at 65.*

Q: I have an HSA. Can I use it to pay Medicare premiums?

> *A: Yes. You can use HSA funds to pay Medicare Part B, Part D, and Medicare Advantage premiums tax-free. You cannot use HSA funds for Medigap premiums tax-free (this is an IRS rule). All other qualified medical expenses can be paid from your HSA tax-free.*

CHAPTER 37 CHECKLIST

> ☐ *I know whether my employer has 20+ employees (determines Medicare timing)*
>
> ☐ *I've verified my employer coverage is creditable for Part B and Part D*
>
> ☐ *If I have an HSA, I know to stop contributions before enrolling in Part A*
>
> ☐ *I understand the 8-month SEP for Part B when employer coverage ends*
>
> ☐ *I've asked my employer the six verification questions and gotten answers in writing*
>
> ☐ *If on COBRA or a marketplace plan, I know these are NOT creditable coverage*
>
> ☐ *I've planned my HSA as a long-term retirement healthcare fund*

READY TO TAKE THE NEXT STEP?

Working past 65 creates Medicare coordination questions that trip up even the smartest people. The rules around creditable coverage, HSAs, and enrollment timing are strict and unforgiving. Let me review your specific situation and make sure you're making the

right decisions at the right time. A quick call now can prevent a permanent penalty later.

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Chapter 18: Annual Medicare Review — Why Your Perfect Plan Today May Be Wrong Tomorrow

Let me tell you about a woman I'll call Angela. Angela spent three hours with me in 2024 finding the perfect Medicare Advantage plan. It covered her doctors. It covered her medications. It had a gym benefit and dental coverage she loved. She was thrilled.

One year later, that same plan dropped two of her three medications from its formulary, removed her cardiologist from the network, and increased her specialist copay from $30 to $50. The "perfect" plan had changed. Angela hadn't reviewed it. And by the time she noticed, the Annual Enrollment Period had closed.

Angela spent the next 12 months paying out of pocket for medications that used to be covered and driving 45 minutes to an out-of-network cardiologist because the closest in-network one wasn't accepting new patients.

Don't be Angela.

Why Plans Change Every Year

Medicare Advantage plans and Part D plans are allowed to change their benefits, networks, formularies, premiums, and cost-sharing structures every year. They submit these changes to CMS (the Centers for Medicare & Medicaid Services) for approval, and new plan details are published each fall before the Annual Enrollment Period.

Common changes include: drugs being removed from the formulary or moved to a higher (more expensive) tier, doctors and hospitals leaving the plan's network, copay and coinsurance amounts increasing, prior authorization requirements being added for services that were previously covered without them, premium increases, maximum out-of-pocket limits changing, and supplemental benefits (dental, vision, hearing, OTC allowances) being reduced or eliminated.

The Annual Enrollment Period: Your Window to Act

The Annual Enrollment Period runs from October 15 through December 7 every year. During this window, you can switch from one Medicare Advantage plan to another, switch from Medicare Advantage back to Original Medicare (and add a Medigap plan, subject to underwriting), change your Part D prescription drug plan, and join a Medicare Advantage plan from Original Medicare.

Changes made during AEP take effect on January 1 of the following year.

The Annual Review Process: Your Step-by-Step Guide

Every September, before the AEP begins, follow this process:

Step 1: Review Your Annual Notice of Change (ANOC)

Your plan is required to send you an Annual Notice of Change by September 30 each year. This document details every change to your plan for the coming year. Read it carefully. Look for changes to your premium, deductible, copays, drug formulary, provider network, and any new restrictions or prior authorization requirements.

Step 2: Check Your Medications

Go to Medicare.gov's Plan Finder and enter all your current medications, dosages, and your preferred pharmacy. Compare your current plan to other available plans. Even if your plan hasn't changed its formulary, a competing plan might now cover your drugs at a lower cost.

Step 3: Verify Your Doctors

Confirm that your primary care physician, specialists, and preferred hospital are still in your plan's network. Network changes are common and can leave you scrambling for new providers if you don't check.

Step 4: Reassess Your Health Needs

Your health may have changed since you last enrolled. If you've been diagnosed with a new condition, started new medications, or had a change in your mobility or care needs, your current plan may no longer be the best fit.

Step 5: Compare Plans

Use Medicare.gov's Plan Finder to compare all available plans in your area. Look at total estimated annual cost (not just the monthly premium), formulary coverage for your specific drugs, network access for your providers, and the maximum out-of-pocket limit.

Step 6: Consider Whether Original Medicare + Medigap Is Better

If your Medicare Advantage plan has been causing frustrations—network restrictions, prior authorization denials, formulary changes—consider whether Original Medicare with a Medigap plan and standalone Part D might be a better fit. Remember: Medigap underwriting may apply if you're past your initial open enrollment period, so evaluate this option carefully.

Step 7: Call a Licensed Agent

A good independent agent does this work every day. They know which plans are gaining or losing providers, which formularies have changed, and which plans offer the best value in your specific zip code. A 30-minute conversation with an agent who knows the local market can save you hours of research and thousands of dollars.

September	Receive and review your ANOC	Know what's changing before AEP opens
October 1–14	Research alternatives on Medicare.gov Plan Finder	Be ready to act when AEP opens October 15
October 15	AEP opens — you can now make changes	Don't rush; you have until December 7
October–November	Meet with a licensed agent to compare options	Get personalized advice for your specific situation
By December 7	Make your final plan selection	AEP closes at midnight; changes take effect January 1
January 1–March 31	MA Open Enrollment — one more chance to switch	If your new plan isn't working, you can make one change

REAL-WORLD EXAMPLE: The $3,400 Formulary Surprise

> *Walter, age 74, had been on the same Medicare Advantage plan for four years. In year five, his plan moved his blood thinner (brand-name, $380/month retail) from Tier 3 (preferred brand, $45 copay) to Tier 4 (non-preferred brand, 40% coinsurance). His new monthly cost for that single drug: $152. Annual increase: $1,284 just for one medication. A competing plan in his zip code covered the same drug on Tier 3 with a $40 copay. By switching during AEP, Walter saved $1,344 in the first year alone. Over three years, the savings exceeded $3,400—all because he reviewed his plan instead of auto-renewing.*

FREQUENTLY ASKED QUESTIONS

Q: What happens if I don't make any changes during AEP?

> *A: Your current plan auto-renews with whatever new terms it's published for the coming year. You'll keep the plan, but you'll also keep any unfavorable changes (higher costs, narrower network, reduced formulary). Auto-renewal is not the same as active confirmation that the plan still fits your needs.*

Q: Can I change plans outside of AEP?

> *A: In most cases, no. Outside of AEP, changes require a qualifying Special Enrollment Period (moving, losing coverage, qualifying for Medicaid, etc.) or the Medicare Advantage Open Enrollment Period (January 1–March 31, one change allowed).*

Q: How often should I review my Medigap plan?

> *A: Medigap benefits are standardized and don't change. But premiums can increase.*

> *It's worth comparing premiums from other carriers periodically—especially if your current carrier has had large rate increases. Switching Medigap plans may involve underwriting in most states.*

Q: Is there a fee to work with a Medicare agent?

> *A: No. Licensed Medicare agents are paid by the insurance companies, not by you. There is no fee to use an agent, and the plans cost the same whether you enroll through an agent or on your own. You get professional guidance at no additional cost.*

CHAPTER 39 CHECKLIST

> ☐ *I've marked my calendar for September (ANOC review) and October 15 (AEP opens)*
>
> ☐ *I know how to access Medicare.gov's Plan Finder to compare plans*
>
> ☐ *I've created a list of all my current medications (name, dosage, frequency)*
>
> ☐ *I've confirmed my doctors are still in my plan's network for next year*
>
> ☐ *I've reviewed my ANOC for any changes to premiums, copays, or formulary*
>
> ☐ *I've scheduled a meeting with a licensed agent before December 7*

READY TO TAKE THE NEXT STEP?

I review plans for my clients every single year. Not because I have to—because it's the right thing to do. Plans change. Needs change. And what was perfect last year may cost you thousands this year. Let me review your coverage before the next AEP. It's free, and it takes less time than you think.

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Chapter 19: Protecting Yourself from Medicare Scams, Fraud, and TV Commercial Lies

I'm going to be blunt: billions of dollars are stolen from seniors every year through Medicare fraud, scams, and misleading marketing. And the perpetrators range from sophisticated criminal organizations to the familiar faces on your television screen promising you "free" Medicare benefits.

As someone who has worked in this industry for years and taught at more than 54

colleges across Southern California, I've seen every scam and every misleading tactic. This chapter will arm you with the knowledge to protect yourself.

The TV Commercial Problem

Every fall during Medicare's Annual Enrollment Period, your TV becomes a battleground of Medicare Advantage commercials. Celebrity spokespeople promise "$0 premiums," "free dental and vision," "money back in your Social Security check," and "benefits you're not getting."

Let me be clear: these commercials are not lying, exactly. But they are designed to mislead. Here's what they don't tell you:

"$0 premium" plans still cost you your Part B premium ($202.90/month) and have copays, deductibles, and coinsurance when you use care. The $0 premium means $0 additional premium—not $0 total cost.

"Money back in your Social Security check" refers to Part B giveback programs where certain Advantage plans reduce your Part B premium by a small amount ($30–$100/month). This sounds great until you realize you may be giving up much more in network restrictions, prior authorization delays, and limited provider choices.

"Free dental, vision, and hearing" benefits in Advantage plans are often very basic. A $1,000 annual dental allowance sounds good until you need a $4,000 crown. A "free" eye exam doesn't cover the $800 progressive lenses you actually need.

The celebrities in these commercials are paid spokespeople. They are not insurance agents. They are not Medicare experts. They are actors reading a script designed to generate phone calls to a sales center.

The Most Common Medicare Scams

Scam #1: The "New Medicare Card" Call

You get a phone call (or text) saying Medicare is issuing new cards and needs to verify your Medicare number and personal information. This is a scam. Medicare will never call you to ask for your Medicare number. They already have it. Anyone asking for your Medicare number by phone is trying to steal your identity.

Scam #2: The "Free" Genetic Testing Kit

Someone offers you a "free" genetic testing or cancer screening kit—at a health fair, at your door, or by mail. They ask for your Medicare number to "bill Medicare" for the kit. What actually happens: your Medicare number is used to submit fraudulent claims, often totaling thousands of dollars. The test results (if any) are useless or never delivered. And you may receive bills for services you never authorized.

Scam #3: The Door-to-Door or Cold-Call Enrollment

Someone comes to your door or calls you unsolicited, offering to enroll you in a "better" Medicare plan. Federal law prohibits door-to-door Medicare sales without a prior

appointment, and it prohibits cold-calling for Medicare plan enrollment. If someone shows up at your door or calls you without your permission to discuss Medicare plans, they are breaking the law.

Scam #4: The "Provider" Billing Scam

You receive a bill for a medical service, equipment, or test you never received. Or you receive medical equipment you never ordered (common with back braces, knee braces, and diabetic supplies). These are billed to Medicare in your name, and the scammer pockets the Medicare payment. Always review your Medicare Summary Notices (MSNs) for services you didn't receive.

Scam #5: The "Free Health Screening" at a Hotel or Community Center

You're invited to a "free lunch" or "free health screening" event at a hotel or community center. The event is actually a high-pressure sales pitch for a specific Medicare Advantage plan, annuity, or other financial product. The "screening" is designed to collect your personal information and Medicare number.

How to Protect Yourself

Never give your Medicare number to anyone who contacts you first	Medicare will never call, text, or email asking for your number
Review your Medicare Summary Notice (MSN) every quarter	Catch fraudulent charges early; report anything unfamiliar
Don't open the door to unsolicited Medicare salespeople	Door-to-door sales without a prior appointment are illegal
Never sign up for a plan at a "free lunch" event on the spot	Take materials home, compare options, and consult a trusted agent
If it sounds too good to be true, it is	No plan gives you everything for free with no trade-offs
Use only Medicare.gov or a licensed, trusted agent for plan comparisons	Official sources and independent agents work for you, not a sales quota
Report suspected fraud to 1-800-MEDICARE (1-800-633-4227)	Or online at Medicare.gov or the OIG hotline at 1-800-HHS-TIPS
Guard your Medicare card like a credit card	Your Medicare number is linked to your identity and your benefits
Be skeptical of celebrity endorsements	Paid actors are not insurance experts; their recommendations are scripted sales pitches
Work with an independent agent, not a captive agent	Independent agents compare plans from many companies; captive agents sell only their company's products

How to Spot a Legitimate Medicare Agent vs. a Scammer

Licensed and appointed in your state	Cannot produce a license number when asked
Sets appointments before visiting	Shows up unannounced at your door
Compares multiple plans from multiple carriers	Pushes only one plan or one company
Explains trade-offs honestly	Says a plan is “perfect” or “the best” with no downsides
Never asks for your Medicare number by phone first	Calls you and immediately asks for your Medicare number
Follows Medicare’s marketing rules	Uses high-pressure tactics, urgency, or fear
Gives you time to decide	Pressures you to sign up “right now”
Discloses that they earn a commission	Denies earning any compensation
Provides a Scope of Appointment form before the meeting	Skips the Scope of Appointment
Has verifiable credentials (AHIP certification, state license)	Cannot verify credentials

The Annual Enrollment Period: A Feeding Frenzy

The Annual Enrollment Period (October 15 – December 7) is the busiest—and most dangerous—time for Medicare scams and aggressive marketing. During this window, plan changes take effect for the following year, and the volume of calls, mail, and advertising explodes.

During AEP, protect yourself by working only with a licensed agent you trust or using Medicare.gov’s official Plan Finder. Don’t respond to unsolicited calls, texts, or emails. If you receive a robocall about Medicare, hang up. Take your time reviewing options—you have the full window from October 15 to December 7 to make a decision.

And remember: the right plan for you depends on your doctors, your medications, your budget, and your health needs. No TV commercial can assess those factors. Only a person who sits down with you and reviews your specific situation can give you a trustworthy recommendation.

REAL-WORLD EXAMPLE: The $6,500 Genetic Testing Scam

> *Howard, age 72, attended a health fair at a community center. A friendly representative offered him a “free cancer screening genetic test” and asked for his Medicare number to “cover the cost.” Howard provided his number and swabbed his cheek. Three months later, he received a Medicare Summary Notice showing a $6,500 charge for a genetic test he didn’t understand or need. The test results were never delivered. Howard reported the fraud to 1-800-MEDICARE, and after*

investigation, the charge was reversed. But the scam company had already been paid by Medicare—and taxpayers footed the bill. Howard was lucky; many people never check their MSNs and never know they've been victimized.

FREQUENTLY ASKED QUESTIONS

Q: Can I trust the insurance agents at my doctor's office?

A: Be cautious. Some agents have relationships with medical offices to gain access to patients. Evaluate any agent the same way you would one who came to your door: are they licensed, independent, comparing multiple plans, and giving you time to decide?

Q: I gave my Medicare number to a caller. What should I do?

A: Contact Medicare immediately at 1-800-MEDICARE. Monitor your Medicare Summary Notices for fraudulent claims. Consider placing a fraud alert on your credit with the major credit bureaus. Report the incident to the Federal Trade Commission (FTC) at reportfraud.ftc.gov.

Q: Are those "Medicare enrollment centers" legitimate?

A: Some are; some aren't. Many "enrollment centers" advertised online or on TV are call centers that sell specific plans for commissions. They may not compare all available options. An independent licensed agent in your community is typically a more trustworthy resource.

Q: How do I report Medicare fraud?

A: Call 1-800-MEDICARE (1-800-633-4227), visit Medicare.gov, or contact the HHS Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477). You can also contact your State Senior Medicare Patrol (SMP) program.

CHAPTER 38 CHECKLIST

☐ *I know the most common Medicare scams (fake cards, genetic testing, door-to-door, billing fraud)*

☐ *I will never give my Medicare number to anyone who contacts me unsolicited*

☐ *I review my Medicare Summary Notice every quarter for unfamiliar charges*

☐ *I understand that TV commercial promises require careful evaluation*

> ☐ *I know the difference between a legitimate agent and a scammer*
>
> ☐ *I have the fraud reporting numbers saved: 1-800-MEDICARE and 1-800-HHS-TIPS*
>
> ☐ *During AEP, I will work only with a trusted, licensed, independent agent*

READY TO TAKE THE NEXT STEP?

In a world full of misleading commercials and outright scams, working with a trusted, independent, licensed agent is your best defense. I don't work for any insurance company—I work for you. I compare plans across dozens of carriers, I explain the trade-offs honestly, and I never pressure you to make a decision. That's the difference between a salesperson and an advisor. Let me be your advisor.

Darin Weidauer | 702-706-6564 | darinweidauer@ecos.care

2026 Quick Reference Card

All key numbers on one page. Print this card and keep it with your important documents.

Medicare Costs — 2026

Part A Premium (40+ quarters)	$0
Part A Inpatient Deductible	$1,736
Part A Days 61–90 Coinsurance	$434/day
Part A Lifetime Reserve (Days 91–150)	$868/day
Part A SNF Days 21–100	$217.00/day
Part B Standard Premium	$202.90/month
Part B Annual Deductible	$283
Part B Coinsurance	20% (no OOP max)
Part D Max Deductible	$590
Part D OOP Cap	$2,000/year
Part D National Base Premium	$36.78/month

IRMAA Thresholds — 2026 (Based on 2024 Tax Return)

≤$109,000	≤$218,000	$202.90	$0
$109,001–$137,000	$218,001–$274,000	$284.10	+$14.50

$137,001–$171,000	$274,001–$342,000	$405.80	+$37.50
$171,001–$205,000	$342,001–$410,000	$527.50	+$60.40
$205,001–$500,000	$410,001–$750,000	$649.20	+$83.30
>$500,000	>$750,000	$689.90	+$91.00

Social Security — 2026

COLA	2.5%
Maximum Taxable Earnings	$176,100
Average Monthly Benefit	~$1,976
Maximum at FRA (67)	$4,018/month
Maximum at 70	$5,108/month
Earnings Test (under FRA)	$23,920 ($1 withheld per $2 over)
Earnings Test (FRA year)	$63,480 ($1 withheld per $3 over)
FRA (born 1960+)	Age 67

Retirement Account Limits — 2026

401(k) / 403(b) / TSP	$23,500	$31,000	$34,750
Traditional / Roth IRA	$7,000	$8,000	$8,000
HSA (Individual / Family)	$4,300 / $8,550	+$1,000	—

Key Tax Numbers — 2026

Standard Deduction (Single)	$15,700
Standard Deduction (MFJ)	$31,400
Standard Deduction (65+ additional)	$1,600 (single) / $1,300 (married, each)
RMD Starting Age (born 1951–1959)	73
RMD Starting Age (born 1960+)	75
QCD Annual Limit	$105,000
Estate Tax Exemption	$13.99 million (individual)

Contact

Darin Weidauer | 702-706-6564 | darinweidauer@ecos.care

Free Retirement Blueprint Session — Call or Text Anytime

Glossary of Retirement and Medicare Terms

This glossary defines 60+ key terms referenced throughout this book. Use it as a quick reference whenever you encounter unfamiliar terminology.

Activities of Daily Living (ADLs)

> *Six basic self-care activities (bathing, dressing, eating, toileting, transferring, continence) used to determine eligibility for long-term care benefits.*

Adjusted Gross Income (AGI)

> *Your total gross income minus specific deductions (IRA contributions, student loan interest, etc.). The starting point for calculating MAGI.*

Annual Enrollment Period (AEP)

> *October 15 – December 7 each year. The window to change Medicare Advantage plans, Part D plans, or switch between Original Medicare and Advantage.*

Annuity

> *An insurance contract that provides guaranteed periodic payments, often for life, in exchange for a premium payment.*

Asset-Based Long-Term Care

> *A hybrid insurance product combining life insurance or an annuity with long-term care benefits. If unused for care, provides a death benefit or return of premium.*

Average Indexed Monthly Earnings (AIME)

> *The average of your 35 highest years of indexed earnings, divided by 420 months. Used to calculate your Social Security PIA.*

Bend Points

> *Dollar thresholds in the Social Security benefit formula where the replacement rate changes (90%, 32%, 15%). Adjusted annually for wage growth.*

Benefit Period

> *In Medicare Part A, begins when you're admitted to a hospital and ends when you haven't received inpatient care for 60 consecutive days.*

CHAMPVA

> *Civilian Health and Medical Program of the Department of Veterans Affairs. Provides coverage for dependents of veterans with permanent total service-connected disability.*

COBRA

> *Continuation of employer health coverage after leaving a job. Lasts up to 18 months but is NOT creditable coverage for Medicare purposes.*

Coinsurance

> *Your share of costs for a covered service, calculated as a percentage (e.g., 20% of the Medicare-approved amount for Part B services).*

Community Spouse Resource Allowance (CSRA)

> *The maximum amount of assets the non-institutionalized spouse can retain when the other spouse qualifies for Medicaid long-term care.*

Copay (Copayment)

> *A fixed dollar amount you pay for a covered service (e.g., $30 for a doctor visit).*

Cost-of-Living Adjustment (COLA)

> *Annual increase to Social Security benefits based on inflation, as measured by the Consumer Price Index. The 2026 COLA is 2.5%.*

Creditable Coverage

> *Health insurance that is at least as comprehensive as Medicare Part B (or Part D for drug coverage). Determines whether late enrollment penalties apply.*

CRDP

> *Concurrent Retirement and Disability Pay. Allows military retirees with 50%+ VA disability to receive both military retirement and VA disability without offset.*

Custodial Care

> *Non-medical assistance with Activities of Daily Living (bathing, dressing, eating). NOT covered by Medicare.*

Deductible

> *The amount you pay before insurance begins covering costs (e.g., the Part A inpatient deductible of $1,736 in 2026).*

Delayed Retirement Credits

> *The 8% per year increase in Social Security benefits for each year you delay filing beyond your Full Retirement Age, up to age 70.*

Dual Eligible

> *A person who qualifies for both Medicare and Medicaid simultaneously.*

D-SNP

> *Dual Eligible Special Needs Plan. A type of Medicare Advantage plan designed specifically for people with both Medicare and Medicaid.*

Earnings Test

> *Social Security's rule that reduces benefits for people who file before FRA and continue to earn above a certain threshold ($23,920 in 2026).*

Elimination Period

> *A waiting period (typically 0–180 days) before long-term care insurance benefits begin paying.*

Extra Help (Low-Income Subsidy)

> *A federal program that helps people with limited income and assets pay Part D premiums, deductibles, and copays.*

FEHB

> *Federal Employees Health Benefits. The health insurance program for federal civilian employees and retirees.*

FERS

> *Federal Employees Retirement System. The three-part retirement program (pension, TSP, Social Security) for federal employees hired after 1983.*

Formulary

> *A list of prescription drugs covered by a Part D or Medicare Advantage plan, organized into cost tiers.*

Full Retirement Age (FRA)

> *The age at which you're entitled to 100% of your Social Security PIA. Age 67 for those born in 1960 or later.*

General Enrollment Period (GEP)

> *January 1 – March 31 each year. A backup enrollment period for Part B with coverage starting July 1 and potential penalties.*

Government Pension Offset (GPO)

> *Reduces Social Security spousal or survivor benefits by two-thirds of a government pension from non-Social-Security-covered work.*

Guaranteed Issue

> *An insurance policy that accepts all applicants regardless of health. Common in final expense and some short-term care policies.*

HECM

> *Home Equity Conversion Mortgage. The FHA-insured reverse mortgage program for homeowners aged 62+.*

HSA

> *Health Savings Account. A tax-advantaged account for people with High-Deductible Health Plans. Triple tax benefit: deductible contributions, tax-free growth, tax-free withdrawals for medical expenses.*

Indemnity Insurance

> *Supplemental insurance that pays a fixed cash benefit directly to you when a qualifying health event occurs (e.g., cancer diagnosis, hospitalization, accident).*

Initial Enrollment Period (IEP)

> *The 7-month window around your 65th birthday during which you can enroll in Medicare Parts A and B without penalty.*

IRMAA

> *Income-Related Monthly Adjustment Amount. A surcharge on Medicare Part B and Part D premiums for people with higher incomes. Uses a two-year lookback.*

Lifetime Reserve Days

> *60 days of additional Medicare Part A hospital coverage available once you've*

> *exceeded 90 days in a benefit period. Non-renewable.*

MAGI

> *Modified Adjusted Gross Income. Your AGI plus tax-exempt interest income. Used to determine IRMAA and ACA premium subsidies.*

Medicaid

> *A joint federal-state program providing healthcare coverage to low-income individuals, including long-term care for those who qualify.*

Medicare Advantage (Part C)

> *A private plan that delivers Part A and Part B benefits (and usually Part D) through an insurance company instead of Original Medicare.*

Medicare Savings Program (MSP)

> *State programs that help low-income Medicare beneficiaries pay for premiums, deductibles, and copays (QMB, SLMB, QI, QDWI).*

Medigap (Medicare Supplement)

> *Standardized private insurance plans that cover cost-sharing gaps in Original Medicare (deductibles, coinsurance, copays).*

Modified Adjusted Gross Income

> *See MAGI.*

MYGA

> *Multi-Year Guaranteed Annuity. A fixed annuity with a guaranteed interest rate for a specified period, similar to a CD.*

Original Medicare

> *Traditional Medicare consisting of Part A (hospital) and Part B (medical) administered directly by the federal government.*

Part A

> *Medicare hospital insurance covering inpatient care, skilled nursing, home health, and hospice.*

Part B

> *Medicare medical insurance covering outpatient care, doctor visits, preventive services, and durable medical equipment.*

Part C

> *See Medicare Advantage.*

Part D

> *Medicare prescription drug coverage, delivered through private insurance plans.*

PIA (Primary Insurance Amount)

> *Your monthly Social Security benefit amount at Full Retirement Age, calculated from your AIME using the bend point formula.*

Prior Authorization

> *A requirement that your insurance plan approve a medical service before it's provided. Common in Medicare Advantage plans.*

Provisional Income

> *AGI (without Social Security) + tax-exempt interest + 50% of Social Security benefits. Used to determine how much of your Social Security is taxable.*

QCD (Qualified Charitable Distribution)

>

> *A direct transfer of up to $105,000/year (2026) from a traditional IRA to a qualified charity. Counts toward RMD but is excluded from taxable income.*

QMB (Qualified Medicare Beneficiary)

> *A Medicare Savings Program that pays Part A and Part B premiums, deductibles, copays, and coinsurance for low-income beneficiaries.*

Required Minimum Distribution (RMD)

> *Mandatory annual withdrawals from traditional retirement accounts starting at age 73 (or 75 for those born 1960+).*

Roth Conversion

> *Moving money from a traditional retirement account to a Roth IRA, paying income tax on the converted amount but gaining tax-free growth and withdrawals.*

RSSA

> *Registered Social Security Analyst. A professional certified in Social Security optimization strategies.*

Section 1035 Exchange

> *A tax-free exchange of one life insurance policy or annuity for another, commonly used to reposition assets into an asset-based LTC policy.*

SECURE 2.0 Act

> *Legislation signed in 2022 that changed RMD ages, introduced Super Catch-Up contributions, and made other retirement savings reforms.*

Skilled Nursing Facility (SNF)

> *A facility providing skilled nursing care and rehabilitation after a qualifying hospital stay. Medicare covers up to 100 days per benefit period.*

Special Enrollment Period (SEP)

> *A period outside standard enrollment windows when you can sign up for Medicare due to special circumstances (e.g., losing employer coverage).*

SPIA

> *Single Premium Immediate Annuity. A lump-sum purchase that begins monthly income payments immediately, often for life.*

SSA-44

> *The form used to request IRMAA reconsideration due to a life-changing event that reduced your income.*

Thrift Savings Plan (TSP)

> *The federal government's retirement savings plan for federal employees and uniformed services members. Similar to a 401(k).*

TRICARE for Life

> *Healthcare coverage for military retirees (20+ years) that wraps around Medicare. Requires enrollment in Medicare Parts A and B.*

Windfall Elimination Provision (WEP)

> *A formula that reduces Social Security benefits for people who receive pensions from work not covered by Social Security.*

Resources and Official Links

These are the official government and industry sources referenced throughout this book. Bookmark them for ongoing reference.

Medicare

Medicare.gov — https://www.medicare.gov (Plan Finder, enrollment, benefits)

1-800-MEDICARE — 1-800-633-4227 (24/7 assistance)

CMS.gov — https://www.cms.gov (Centers for Medicare & Medicaid Services)

State Health Insurance Assistance Program (SHIP) — https://www.shiphelp.org (free local Medicare counseling)

Medicare Rights Center — https://www.medicarerights.org

Medicare Fraud Reporting — 1-800-HHS-TIPS (1-800-447-8477)

Social Security

SSA.gov — https://www.ssa.gov (benefits, statements, enrollment)

My Social Security Account — https://www.ssa.gov/myaccount

Social Security Office Locator — https://secure.ssa.gov/ICON/main.jsp

1-800-772-1213 — Social Security Administration phone line

Form SSA-44 (IRMAA Appeal) — https://www.ssa.gov/forms/ssa-44.pdf

National Association of Registered Social Security Analysts — https://www.narssa.org

Internal Revenue Service (IRS)

IRS.gov — https://www.irs.gov

IRS Publication 590-B (IRA Distributions) — https://www.irs.gov/pub/irs-pdf/p590b.pdf

IRS Publication 575 (Pension and Annuity Income) — https://www.irs.gov/pub/irs-pdf/p575.pdf

RMD Worksheets — https://www.irs.gov/retirement-plans/required-minimum-distributions

Form W-4V (Voluntary Withholding from SS) — https://www.irs.gov/forms-pubs/about-form-w-4v

Veterans and Military

VA.gov — https://www.va.gov (benefits, healthcare, disability)

TRICARE — https://www.tricare.mil

TRICARE for Life — https://www.tricare.mil/tfl

VA Aid & Attendance — https://www.va.gov/pension/aid-attendance-housebound

Thrift Savings Plan — https://www.tsp.gov

CHAMPVA — https://www.va.gov/communitycare/programs/dependents/champva

Federal Employees

OPM.gov (FEHB, FERS, CSRS) — https://www.opm.gov

FEHB Plan Comparison Tool — https://www.opm.gov/healthcare-insurance/healthcare

Long-Term Care and Aging

LongTermCare.acl.gov — https://longtermcare.acl.gov (federal LTC planning resources)

Eldercare Locator — https://eldercare.acl.gov / 1-800-677-1116

Genworth Cost of Care Survey — https://www.genworth.com/aging-and-you/finances/cost-of-care.html

National Academy of Elder Law Attorneys — https://www.naela.org

Alzheimer's Association — https://www.alz.org / 1-800-272-3900

Consumer Protection

Federal Trade Commission (Report Fraud) — https://reportfraud.ftc.gov

Senior Medicare Patrol — https://www.smpresource.org

National Do Not Call Registry — https://www.donotcall.gov

Consumer Financial Protection Bureau — https://www.consumerfinance.gov

RETIRE WITH CONFIDENCE

"*This book is the conversation I wish every American could have before they turn 65.*"

— Darin Weidauer

Author portrait

Why You Need This Book

Medicare has four parts, dozens of plan types, and enrollment penalties that last a lifetime. Social Security has over 2,700 rules. The tax code punishes retirees who don't plan their withdrawals strategically. And long-term care can erase a lifetime of savings in a matter of years.

This book gives you everything you need to navigate the retirement gauntlet: every Medicare premium, deductible, and IRMAA bracket for 2026; the Social Security filing strategy that could put $100,000+ more in your pocket; Roth conversion tactics that slash your taxes and protect your Medicare premiums; and long-term care strategies

that safeguard your family's financial future.

Written in plain English, packed with real numbers and real examples, and designed to be referenced year after year.

"*I've attended hundreds of retirement seminars. This book taught me more in one weekend than all of them combined.*"

"*Darin doesn't sell—he educates. And that education saved us over $40,000.*"

"*I wish I had read this book five years ago. Every page has something I didn't know.*"

WHAT'S NEXT IN THE SERIES

This book is Book 1 of 4 in the Retire With Confidence series. Each book stands alone, but together they form a complete retirement planning library.

BOOK 2: The Social Security Maximizer

How to Claim Smarter, Earn More, and Protect Your Spouse. Covers filing strategies at 62 vs. 67 vs. 70, spousal and survivor benefits, divorced spouse benefits, the Earnings Test, Social Security taxation, and why working with a Registered Social Security Analyst could be the best investment you ever make.

BOOK 3: The Retirement Income Playbook

401(k)s, IRAs, Roth Conversions, RMDs, Annuities, and the Tax Strategies That Could Save You Six Figures. Learn how to build a retirement income stack, manage your tax brackets, execute a Roth conversion ladder, and create a year-by-year roadmap from age 59½ to 75+.

BOOK 4: Protecting What You've Built

Long-Term Care, Final Expenses, Medicaid, and the Insurance Strategies That Keep Your Family Safe. Covers the 70% long-term care risk, asset-based hybrid policies, short-term care insurance, Medicaid planning, and your complete retirement blueprint.

To get any book in the series, or to schedule your free Retirement Blueprint Session:

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Ready for Your Free Medicare Consultation?

Call or text Darin directly:

(720) 295-2611

Email: darinweidauer@ecos.care
Web: coloradomedicareenrollment.com

No pressure. No sales pitch. Just answers.