

The 20 Minute AEP Checklist

What to gather, what to ask, and what most people miss.
From Giardini Medicare. Your transition to Medicare team.

START HERE

Is this even your window?

The Annual Enrollment Period runs **October 15 to December 7**. Changes you make take effect **January 1**.

AEP is for people **already on Medicare**. If that is not you yet, skip to the last page. There is a section for you and this one will only confuse things.

And here is the part the industry does not make clear.

Leaving a Medicare Advantage plan is not something you can do whenever you want. There are two windows:

October 15 to December 7. The Annual Enrollment Period.

January 1 to March 31. A second window, if you are in an Advantage plan on January 1.

That is it. You cannot decide in June that you want out and make the change in June. There are a few limited exceptions, like moving out of your plan's service area, so ask if you think one applies to you.

But an open window is not the same as an open door. Just because it is October and the enrollment window is open does not mean you can leave your Advantage plan and automatically get a Medicare Supplement.

AEP lets you leave the Advantage plan. It does not get you approved for a Supplement. Those are two separate steps with two separate sets of rules, and outside of a guaranteed issue window a Supplement usually requires medical underwriting, which means you can be turned down for health reasons.

So if someone tells you that you can "just switch back during AEP," that is not how it works. Ask more questions.

IF YOU HAVE A SUPPLEMENT

Your Medigap renews by itself

Every year we get the same question: *"What do I have to do to make my Medicare Supplement renew?"*

Nothing. Pay your bill.

Medicare Supplements sold today are guaranteed renewable. As long as you pay the premium, the plan renews on its own. Your carrier cannot drop you because you got sick or because you used it. There is no form, no re-application, and no annual re-enrollment. AEP does not touch it.

Your premium can still change, and over time it usually does. That is a rate question and it is worth reviewing. But nothing you do or do not do during AEP makes your Supplement lapse.

Here is what you do need to review: your Part D drug plan.

That one changes every single year. The formulary changes, the tiers change, the pharmacy network changes, and the cost changes. Your Supplement does not protect you from any of it, because your Supplement is not your drug coverage.

So if you have a Medicare Supplement, your AEP job is short:

- ☐ **Do nothing about the Supplement.** It renews on its own.
- ☐ **Review your Part D drug plan.** Every year. No exceptions.
- ☐ **If your birthday falls during this stretch,** ask whether your state has a birthday rule, because that could be a window to change Supplement plans.

THE WINDOW

What AEP actually lets you do

Check the one that describes you.

- ☐ Switch from one Medicare Advantage plan to another
- ☐ **Switch from Medicare Advantage back to Original Medicare, add a drug plan, and look at a Medicare Supplement.** Get the drug plan even if you take no prescriptions today, because going without creditable drug coverage can mean a late enrollment penalty that stays with you for as long as you have Medicare. And Original Medicare on its own has no cap on what you can pay in a year, which is what a Supplement is for. Apply for the Supplement and get approved **before** you drop the Advantage plan, because approval is not automatic.
- ☐ **Switch from Original Medicare to a Medicare Advantage plan.** Some people have only Original Medicare, but most have a Medicare Supplement in place. If that is you, cancel the Supplement yourself when you make the change. It does not cancel automatically, and it will not pay anything toward an Advantage plan, so you would be paying for coverage you cannot use.
- ☐ **Join, switch, or drop a Part D drug plan.** Dropping one carries that same penalty risk.
- ☐ Do nothing and stay put

That last one is a real choice, and sometimes it is the right one. But make it on purpose, not by accident. Your plan can change even when you do not.

STEP 1

Find your ANOC letter

Your plan has to mail you an **Annual Notice of Change** by **September 30**. It tells you exactly what is changing about your plan for next year.

It looks like junk mail. It is the single most important piece of paper you will get all year.

- ☐ Found the ANOC
- ☐ Read the section on what is changing
- ☐ Checked whether my costs are changing
- ☐ Checked whether my drug coverage is changing
- ☐ Confirmed my pharmacy is still a preferred pharmacy. A plan can keep your pharmacy in the network but move it from preferred to standard, and your copays go up without anything else about the plan changing.

THE MISSING LETTER

What if the letter never comes?

This is the question we get more than any other, and it is usually from someone who is sure it never showed up. Sometimes it did and it looked like junk mail. Sometimes it genuinely did not arrive. Either way, it does not change what you do next, because the letter is not the only copy. The information exists whether or not the paper made it to your table.

- ☐ Check your plan's online portal first. Most plans post the ANOC under plan documents or plan materials, and it is often there before the mail would have reached you.
- ☐ Check your email. If you switched to paperless at some point, and a lot of people did that years ago and forgot, it went there instead.
- ☐ Call your plan and ask them to send it again. The number is on the back of your member ID card. Ask for the Annual Notice of Change by name, and while you have them on the phone, ask them to tell you what is changing.
- ☐ Look at Medicare.gov starting October 1. Next year's plan information is posted there, so you can see what your plan is doing for next year even without the letter in hand.

Your plan is required to get the ANOC to you by September 30. If it is past that and you have nothing, that is worth a phone call, not a shrug.

What you should not do is treat a missing letter as a reason to skip this step. A plan that changed while you were not looking is still a plan that changed.

STEP 2

Gather these seven things

Put them all in one pile before you compare anything. This is the part that turns a three hour headache into twenty minutes.

- ☐ **Your current plan name** and your member ID card
- ☐ **Your ANOC letter**
- ☐ **Every prescription you take.** Exact name, exact dose, how often. Not "my blood pressure pill."
- ☐ **The pharmacy you actually use,** and whether you would switch pharmacies to save money
- ☐ **Your doctors.** Primary care, every specialist, and the hospital system you would want to use
- ☐ **Anything you know is coming next year.** A knee, a shoulder, a procedure you have been putting off
- ☐ **Your travel.** Do you spend months in another state? Do you see doctors in more than one place?

STEP 3

Run these five questions on any plan

Every plan. Same five questions. No exceptions.

- ☐ **Are all of my drugs covered, and on what tier?** A plan can cover your drug and still make it expensive.
- ☐ **Are my doctors in network?** Confirm this by calling the doctor's office, not by trusting the plan's online directory. Directories are wrong often enough that it is worth the phone call.
- ☐ **What is the most I could pay in a bad year?** Find the out of pocket maximum and write it down.
- ☐ **What do I pay for the things I actually use?** Not the brochure highlights. Your specialist visit, your imaging, your hospital stay.
- ☐ **What happens if I travel, or if I move?** This is where plans differ the most and where people get surprised.

THE TRAPS

What most people miss

- ☐ **A plan with no monthly premium is not a plan with no cost.** The cost shows up when you use it. Look at the out of pocket maximum, not the premium.
- ☐ **Your drug coverage can change even when your plan name does not.** Same plan, same card, different formulary. Check every single year.
- ☐ **The provider directory may be out of date.** Call the office and ask them directly, using the exact plan name.

- ☐ **Doing nothing is a decision.** If your plan changed and you stayed, you chose the new version of it.
- ☐ **A Supplement can be out of reach later, whether or not you have ever had one.** There is one window where a Medicare Supplement is guaranteed to you with no health questions. It starts when you are 65 and enrolled in Part B, it lasts 6 months, and it does not come back. After that you usually have to answer health questions and you can be declined. That is true whether you are leaving an Advantage plan or buying a Supplement for the first time. Some states offer more protection than this, so ask what yours allows.

MARK YOUR CALENDAR

The dates

Date	What happens
By September 30	Your ANOC letter should be in your hands
October 1	The first day anyone is allowed to tell you about next year's plans
October 15 to December 7	The Annual Enrollment Period. This is the window.
January 1	Whatever you chose takes effect
January 1 to March 31	If you are in a Medicare Advantage plan, you get one more chance to change it or go back to Original Medicare

BEFORE YOU DECIDE

Covering the gap

If you are looking at Medicare Advantage, or at a High Deductible Plan G, we suggest the same thing either way: look at what a bad year actually costs you, and consider pairing it with coverage that handles that gap.

Both of those options keep your monthly cost low. Both of them leave you exposed if something happens. That is not a reason to avoid them. It is a reason to plan for it.

Here is what covering the gap actually means. These are separate policies. They are not Medicare, they are not a Medicare Supplement, and they do not replace either one. What they do is pay cash when something specific happens:

Cancer

Heart attack

Stroke

Hospital stays, covered by a hospital indemnity plan.

The money goes to **you**, not to the hospital. So it can go toward your deductible, your copays, the drive back and forth to treatment, the mortgage while you are not working, or the help you need around the house. That is the point of it. A bad health year is rarely just a medical bill.

What these cost depends on your age and your health. For most people they are a small monthly amount next to the gap they are covering, and we will show you real numbers for your situation rather than a range.

We are not going to tell you that you need all of these. Most people do not. But a plan with a low premium and a real deductible is a plan with a gap in it, and it is worth deciding on purpose whether to leave that gap open.

NOT 65 YET

If you are not on Medicare yet

Maybe you are 62 and still working. Maybe you are 64 and starting to get the mail. AEP is not your window, so here is what actually matters for you.

- ☐ **Your window is your Initial Enrollment Period.** It starts 3 months before the month you turn 65 and runs 3 months after. Missing it can cost you a penalty that lasts as long as you have Medicare.
- ☐ **If you are working past 65 with employer coverage, you may be able to delay without a penalty.** It depends on the size of your employer and on the kind of coverage you have, so get it confirmed for your situation before you assume it. Our guide at **WorkPast65.com** walks through it.
- ☐ **Your best pricing and your easiest approval on a Medicare Supplement is usually at 65,** during your one time open enrollment when health questions do not apply. Later on, they usually do.
- ☐ **Start looking at 64, not at 64 and eleven months.** Every person we talk to who felt rushed made the decision in a short window with a stack of mail on the table.

IF YOU WANT TO GO FURTHER

Keep going on your own

Everything above is yours to use whether or not you ever talk to us. That is on purpose. If you want to keep going without picking up the phone, start here:

Medigapmath.com, run the Medicare Supplement numbers yourself.

HDGcombo.com, the High Deductible Plan G approach, explained.

WorkPast65.com, if you are still working past 65.

Who we do our best work with

We are Giardini Medicare. We are independent, so we are not here to make one company's plan fit you. We are also a small team, and we would rather go deep with a smaller number of people than go shallow with everyone. So here is who we are the right fit for.

You are new to Medicare, or getting close. You would rather start this right than fix it in three years.

You are thinking five and ten years out, not just about what looks cheapest in January.

You want to understand the decision, not just be told what to do.

If that sounds like you, call us. We will run your actual numbers, show you the math behind them, and tell you what we see, including when the right answer is to stay exactly where you are. That happens more than you would think.

If you already have an agent and you want a second opinion on a plan they sold you, call them first. They know your file and that is what they are there for. If they do not call you back, then call us.

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We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.