

The Medicare Transition First Look

Two paths through the same decision. Both work. The work of the conversation is figuring out which one fits you.

A pre-call brief for California families approaching Medicare eligibility.

Dennis Gibbs

Plan Architect, LiveWise Insurance

Independent California-licensed agent
CA License # 4255966 · CA Corp License # 6015092

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Why this brief exists

When you become eligible for Medicare, Original Medicare (Parts A and B) covers about 80% of medically necessary services. The remaining 20% is the open-ended part of the picture. There are two well-established paths to close that gap, and both work well for the families they fit. The work of our conversation is figuring out which path fits yours.

This brief is the same pre-work I send every Medicare Transition Review client. It will not make the decision for you. It will give you enough context to ask the right questions on our call, and to recognize what each path actually does before you commit to one.

Take 15 minutes with this. Then we will walk through your specific situation on the call.

Dennis

SECTION 1

The Medicare timeline that matters

Medicare eligibility begins three months before your 65th birthday and continues for three months after. That seven-month window is your **Initial Enrollment Period**, and it is the single most consequential timing window in your retirement healthcare picture.

Inside that window, you have **guaranteed-issue rights** to enroll in any Medicare Supplement (Medigap) policy without medical underwriting. Outside that window, the rules for switching paths are different in different directions. We will talk through what your specific options look like on the call.

The other key dates worth knowing:

- **The Annual Election Period (October 15 to December 7)** is when you can change Medicare Advantage or Part D plans for the following year, or move from Original Medicare into a Medicare Advantage plan.
- **The Medicare Advantage Open Enrollment Period (January 1 to March 31)** is when current Medicare Advantage enrollees can switch plans or move back to Original Medicare.

If you are still working past 65 and carrying employer or federal coverage (including FEHB), your Initial Enrollment Period can be delayed without penalty until your employer coverage ends. This is technically a Special Enrollment Period, and it has its own rules that we will walk through if it applies to you.

SECTION 2

What Original Medicare covers and what it doesn't

Original Medicare consists of two parts.

Part A covers inpatient hospital, skilled nursing facility care, hospice, and some home health. There is generally no premium if you or your spouse paid Medicare taxes for at least 10 years.

Part B covers doctor visits, outpatient care, preventive services, and durable medical equipment. The standard premium in 2025 is \$185 per month, with higher-income retirees paying more through IRMAA surcharges.

Together, Parts A and B cover approximately 80% of medically necessary services. The remaining 20% is open-ended and is the responsibility of the patient. There is no annual out-of-pocket cap on Original Medicare. The two ways to close that 20% gap are different from each other, and the right one depends on what you value.

SECTION 3

The two paths to close the 20% gap

You can choose one path or the other, but not both at the same time. Both are valid choices, and the right path depends on your providers, your travel patterns, your budget priorities, and your appetite for predictable monthly costs versus richer ancillary benefits.

Medicare Supplement (Medigap)

Medigap policies are standardized federal plans (Plan G, Plan N, and others) sold by private carriers. You pay a monthly premium. In exchange, the policy pays your share of approved Medicare charges. With a Medigap policy, you can see any provider in the country who accepts Medicare. There are no networks, no carrier prior authorization requirements, and predictable monthly costs.

Medigap is often the right fit when:

- You travel between states or live in two homes during the year
- You see specialists outside the major plan networks
- You want predictable monthly costs and minimal year-to-year plan changes
- You anticipate complex healthcare needs over the next 10 to 20 years

Medicare Advantage (Part C)

Medicare Advantage plans replace Original Medicare with a private plan that bundles Parts A, B, and usually D, often including benefits like dental, vision, hearing, gym memberships, and over-the-counter allowances. Most Medicare Advantage plans operate as HMOs or PPOs with provider networks. Premiums are often \$0, and out-of-pocket costs are managed by the plan up to an annual maximum.

Medicare Advantage is often the right fit when:

- You are satisfied with your current providers and they are in the plan's network
- A zero-dollar premium and a hard annual out-of-pocket cap fit your budget priorities
- The dental, vision, hearing, and ancillary benefits are meaningful to you
- You are comfortable reviewing your plan each year during the Annual Election Period

SECTION 4

The timing window worth knowing

Medigap policies come with guaranteed-issue rights during a specific six-month window when you first enroll in Medicare Part B at 65. Outside that window, switching from Medicare Advantage to Medigap may involve medical underwriting in most states. This is not a warning against either choice. It is a fact-of-life that means the initial decision deserves more thought than a Saturday morning quote pull.

The other side of the picture: moving from a Medigap policy to a Medicare Advantage plan during the Annual Election Period is generally allowed without underwriting. So the timing question is most often about whether you want to preserve the option to switch later, or whether you want to commit to a path that fits your situation now and adjust as your health and life circumstances evolve.

For families considering Medicare Advantage, the annual review cycle becomes part of the plan. Plans change benefits and provider networks year over year, and the Annual Election Period gives you a window each fall to compare your current plan against alternatives.

SECTION 5

For federal employees and FEHB carriers

If you are a federal employee, retiree, or surviving spouse with Federal Employees Health Benefits coverage, the Medicare decision interacts with your FEHB plan in ways that most general enrollment conversations do not cover. The questions worth thinking through before our call:

- Should you drop FEHB entirely once Medicare comes online?
- Should you keep FEHB as a secondary payer behind Medicare?
- Should you suspend FEHB so you preserve the right to reactivate later?
- How does the Postal Service Health Benefits program (for USPS retirees) change the picture if it applies to you?

The wrong default decision on FEHB at Medicare eligibility can cost a household roughly \$3,000 to \$5,000 a year in unnecessary premium for the next decade. The right decision preserves flexibility and may meaningfully reduce healthcare costs without sacrificing access to your providers.

SECTION 6

What we will cover on the call

The Medicare Transition Review is 20 minutes on Zoom. The agenda:

1. Your current providers and any prescriptions, mapped against what each path covers.
2. Your retirement income picture, mapped against IRMAA premium brackets for the next few years.
3. The Medigap and Medicare Advantage paths walked side by side, with the trade-offs honest, based on your healthcare history and your provider preferences for the next decade.
4. If applicable, the FEHB or employer-coverage interaction with Medicare.
5. The specific timing window for your decision, including any Special Enrollment Period considerations.

You leave the call with a written one-page summary of which Medicare decisions are time-sensitive for your situation and which can wait. There is no carrier I am steering you toward, no plan I am trying to sell, and no pressure to do anything you are not ready for.

Scope of Appointment

Per CMS rules, at the start of our call we will complete a brief Scope of Appointment form that confirms the topics we will discuss. This is required by federal Medicare regulations and takes 60 seconds.

The next step

If you have not already booked, schedule a Medicare Transition Review at livewiseinsurance.com or by calling (213) 720-2323. The call is 20 minutes on Zoom, with no cost and no pressure.

[Schedule a Medicare Transition Review →](#)

About the author

Dennis Gibbs is the founder of LiveWise Insurance and an independent California-licensed agent. He spent the first 20 years of his career in the wholesale and retail mortgage industries and the corporate foreign currency exchange market. Since 2022, he has applied that experience to architecting retirement, life, and Medicare plans for California families. LiveWise Insurance is independent and carrier-neutral by design, because Dennis works for the families he serves, not for any insurance company.

(213) 720-2323 · dennis@livewiseinsurance.com · livewiseinsurance.com

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This brief is for educational purposes and is not a recommendation of any specific product, plan, or strategy. Plan availability, premiums, benefits, and provider networks vary by location and are subject to change. Medicare plan participation requires meeting eligibility criteria established by the Centers for Medicare and Medicaid Services. Information regarding Medigap guaranteed-issue rights, Medicare Advantage enrollment periods, and Special Enrollment Periods is general in nature; rules vary by state and individual circumstance.

California residents: Dennis Gibbs, CA License # 4255966; LiveWise Insurance CA Corp License # 6015092. Standard 2025 Part B premium and IRMAA bracket information referenced is drawn from publicly available CMS and SSA sources and was accurate as of publication; figures may be updated by CMS and SSA over time.