Resting Sycamore Advisors

The chronic condition field guide

Medicare when you are living with diabetes or a heart condition

There is a kind of Medicare plan built specifically around these conditions. Most people who qualify have never heard of it, and unlike most of Medicare, you usually do not have to wait until fall.

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WHERE TO START

Find your situation

Read it front to back if you like. Or start with the line that matches you.

Nothing in here needs deciding today. These plans are not a limited-time offer, and a good decision in March is better than a rushed one in November.

WHERE TO START

Dates worth knowing

And the one exception that applies to these plans.

Window	What it is
Seven months around 65	Your Initial Enrollment Period. Starts three months before the month you turn 65 and ends three months after it.
October 15 to December 7	Annual Enrollment. Most people's one chance to change Medicare coverage for the following year.
January 1 to March 31	Medicare Advantage Open Enrollment, and the General Enrollment Period for anyone who missed their first window.
Certain events	Moving, losing employer coverage, and some other changes open a Special Enrollment Period.

The exception worth knowing

Plans built around chronic conditions have their own enrollment rule. If you qualify because of a condition you live with, you can generally enroll outside the fall window — in February, in June, whenever the situation is right. Whether it applies to you depends on your condition and what you are enrolled in now, so it is worth asking rather than assuming.

What to have handy

Most Medicare questions come back to four things. Your ZIP code, the doctors you want to keep, the prescriptions you take, and what

THE SHORT VERSION

Four things worth knowing first

There is a plan type built around your condition

Medicare allows a kind of Medicare Advantage plan designed for people living with specific long-term conditions. Nearly all of them are built around the same three: diabetes, heart failure, and heart or blood vessel conditions.

Your doctor has to confirm the diagnosis

This is the part that surprises people. Enrollment is not complete on your say-so. A short confirmation has to come back from the doctor who treats the condition, and there is a deadline on it. Page 7.

You are not usually locked to the fall

Most Medicare changes happen between October 15 and December 7. Qualifying for one of these plans generally opens a window at other times of year.

Qualifying does not mean it is the better choice

Being eligible and being better off are two different questions. These plans use networks, and the answer depends on your doctors, your prescriptions, and your county. Sometimes the honest answer is to stay where you are.

General education. Your county, your doctors, and your diagnoses all change the answer.

SECTION ONE

What these plans actually are

A narrower kind of Medicare Advantage plan.

Medicare Advantage is the private alternative to Original Medicare. Within it, Medicare permits a narrower category for people living with certain long-term conditions. Everyone enrolled in one of these plans has a qualifying condition. That is the whole idea.

Because the membership is narrower, the plan can be shaped around it — the provider network, the drug list, and the care support are organized around managing that condition rather than around the general 65-and-older population.

What it is not

- It is not a supplement that sits on top of what you have. It replaces how you get your Medicare benefits.
- It is not a diagnosis or a medical program. It is a way of paying for care.
- It is not automatic. Qualifying does not enroll you in anything.
- It is not permanent. If it does not suit you, there are windows to change.

> *Everyone in the plan has the condition. That is the point of it, and it is also the reason the enrollment rules are different.*

The conditions these plans are built around

Medicare permits a longer list of qualifying conditions. In practice the overwhelming majority of these plans are built around three, and they are usually grouped together in the same plan.

Commonly covered together	
Diabetes	Type 1 or type 2
Chronic heart failure	Sometimes called CHF
Cardiovascular disorders	Heart and blood vessel conditions

If you have been treated for more than one of these, you are in a very common situation. A single plan generally covers the whole group, so having two or three does not mean two or three plans.

If your condition is not on the list

Other conditions can qualify — kidney disease and some lung conditions among them — but far fewer plans are built around them, and availability varies a great deal by county. It is worth asking specifically rather than assuming one exists near you.

Which conditions a given plan covers is set by that plan, and plans differ by county. The reliable way to know is to check the plans available where you live.

SECTION TWO

Your doctor's part in this

The step most people are not told about.

For most Medicare plans, enrollment is between you and the plan. These are different. Because eligibility depends on a medical condition, the plan has to confirm the diagnosis with a clinician who treats you.

You are not asking your doctor to recommend a plan, and most will not. You are asking the office to confirm something already in your chart.

How it usually goes

1. You apply, or you tell the plan which condition you have.
2. The plan sends a short form to the doctor who treats that condition, or asks you a set of screening questions and then follows up with the office.
3. Someone at the practice confirms the diagnosis from your records and sends it back.
4. Your enrollment is confirmed.

Sometimes this happens before your coverage starts. Sometimes coverage begins and the confirmation follows. Either is normal.

There is a deadline on it

This is the single most useful thing in this guide, and almost nobody is told it at the time they enroll.

If the confirmation does not come back from your doctor's office within the first month of coverage, Medicare's rules require the plan to end the enrollment. You would get a notice, and the coverage would stop at the end of the following month.

It is almost always paperwork, not eligibility

When this goes wrong it is rarely because someone did not qualify. It is because a form sat in a pile at a busy practice. You genuinely had the condition the whole time.

What you can do about it

- Ask which doctor's office the form is going to, and write it down.
- Call that office about a week later and ask whether it arrived and who handles it.
- If you get a notice saying your coverage is ending, do not ignore it. Call the plan the same week.
- If you work with an agent, this is exactly the kind of thing to hand to them.

> *A plan that ends because a fax sat on a desk is a solvable problem, but only if somebody notices in time.*

SECTION THREE

What these plans generally include

In general terms. The specifics vary by plan and county.

Like other Medicare Advantage plans, these bundle your hospital and medical coverage, and nearly always your prescription drug coverage, into one plan.

What tends to differ is the emphasis:

- **Care coordination.** Many assign a nurse or care coordinator to help manage the condition between visits. For someone juggling several specialists, this is often the part that matters most.
- **Condition-related supplies and medications.** The drug list and cost sharing are usually organized around the conditions the plan is built for.
- **Specialist access.** Networks are typically built to include the specialists these members actually see.
- **Routine extras.** Many include dental, vision, or hearing coverage, as other Medicare Advantage plans often do.

Cost sharing, drug lists, networks, and extra benefits are set by each plan and change every year. Two plans in the same county can be quite different. Nothing here describes any particular plan.

The grocery and utility question

Widely advertised, widely misunderstood.

You have probably seen advertising for cards that help with groceries or utility bills. These are real, and some plans do offer them. They are also one of the most misunderstood things in Medicare marketing right now, so it is worth being precise.

They are special supplemental benefits for members who are chronically ill. They are not part of the base plan, and **being enrolled in a plan that offers one does not mean you will receive it.**

A rule change worth knowing about

As of 2026, plans must have a documented, provider-confirmed chronic condition on file before these benefits can be used, and there is a time limit for getting that documentation in. If your doctor's office recently asked you about a form like this, that is likely why.

What to ask

- What exactly is required for me to qualify for it?
- What documentation is needed, and by when?
- What happens if I do not qualify — what does the plan look like then?

Judge a plan on its coverage, its network, and its drug list first. Treat an extra benefit as a bonus you may or may not receive.

[illegible], and similar allowances are special supplemental benefits for the chronically ill. Not 9 all members will qualify. To be eligible, you must have a qualifying chronic condition, which may include diabetes, chronic heart failure, cardiovascular disorders, chronic lung disorders, or chronic kidney disease. Other conditions may also qualify. Even if you have one of these conditions, you

SECTION FOUR

What to check before you change anything

Four checks, in order of how often they cause regret.

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1. **Your doctors.** Check every specialist you see, by name, not just your primary care doctor. Someone managing diabetes and a heart condition may be seeing four or five clinicians. One of them being out of network can undo the whole thing.
2. **Your prescriptions.** Check each one against the plan's drug list, at your dose. Insulin and cardiac medications are usually where the differences show up.
3. **Your pharmacy.** Plans have preferred pharmacies, and the same drug can cost differently depending on where you fill it. If you have used the same pharmacy for years, check it.
4. **Your travel.** If you spend part of the year in another state, ask how the network handles it before you enroll, not after.

> *If you are managing two or three conditions, you are seeing more specialists than most Medicare members. That makes the network check more important for you, not less.*

SECTION FIVE

If you already have a Medicare Advantage plan

Many people who would qualify for one of these plans are already enrolled in a regular Medicare Advantage plan and have simply never been told this category exists.

Worth asking about if any of the following is true:

- Your diagnosis came after you chose your current plan.
- You are seeing noticeably more specialists than you were when you enrolled.
- Your prescription costs have changed in a way you cannot account for.
- You are managing the condition largely on your own between appointments.

And an honest caution

Switching is not automatically an improvement. If your current plan covers your doctors and your drugs well, moving may gain you very little and could cost you a relationship with a specialist you like.

The right way to settle it is a side-by-side comparison using your actual doctors and your actual prescription list. That takes about twenty minutes and it is worth doing properly.

SECTION SIX

If you have both Medicare and Medicaid

A significant share of people managing diabetes and heart conditions also qualify for Medicaid, either fully or for help with Medicare costs. If that is you, there is a second category of plan built for that situation specifically.

Which one fits better depends on your circumstances, and sometimes the answer is that one plan covers both situations at once. This is genuinely one of the more complicated corners of Medicare, and it is not worth guessing at.

Worth checking whether you qualify for help you are not getting. Programs exist that help pay Medicare premiums, deductibles, and prescription costs for people under certain income and resource limits. Many people who qualify never apply, often because nobody told them the programs existed. Your State Health Insurance Assistance Program offers unbiased counseling on this, does not sell anything, and does not charge you for it.

Income and resource limits change each year and vary by state. Being close to a limit is not the same as being over it. If you are unsure, ask.

SECTION SEVEN

Questions worth asking

Of anyone who wants to enroll you in something.

1. **Which of my conditions does this plan cover, and which of my doctors has to confirm it?**
2. **Are all of my specialists in the network?** Ask them to check each one by name while you are on the phone.
3. **What do my prescriptions cost on this plan, at my doses, at my pharmacy?**
4. **What happens to my coverage if the confirmation form does not come back in time?**
5. **What am I giving up by leaving what I have now?** A person who cannot answer this is not comparing, they are selling.
6. **How many plans do you represent, and are there others in my county you cannot offer me?**

You never have to decide on the call

There is no version of this where a good decision requires deciding immediately. Anyone pressing you to enroll today is telling you something useful about themselves.

SECTION EIGHT

Two situations, drawn from many

Composites. Not accounts of particular people.

A retired school bus driver, 71

Type 2 diabetes for nine years, and a stent placed two years ago. She was in a regular Medicare Advantage plan chosen before either diagnosis, seeing an endocrinologist, a cardiologist, and a podiatrist, and coordinating between them herself.

A comparison in her county found a plan built for her combination of conditions that included all three of her doctors and assigned a care coordinator. Her insulin landed on a better tier. She moved in April, which surprised her — she had assumed she had to wait until October.

A retired warehouse supervisor, 68

Heart failure, diagnosed the previous year. He enrolled in one of these plans in the fall and then received a notice two months later saying his coverage was ending.

His cardiologist's office had never sent the confirmation back. The form had been sent to his primary care doctor, who did not treat the heart condition. It was sorted out, but it took three weeks and some worry that was avoidable. Knowing which office holds the form is worth more than it sounds.

Your circumstances, your county, and the plans available to you will differ.

SECTION NINE

If someone contacts you out of the blue

People managing chronic conditions get targeted more than most.

Lists of people with certain diagnoses circulate, and the advertising around extra benefits has drawn in some bad actors. A few things are worth knowing so you can tell the difference quickly.

What is not allowed

- **Cold calls.** A licensed agent may not call you about Medicare plans unless you asked them to.
- **Showing up at your door** uninvited, or leaving materials there.
- **Approaching you** in a parking lot, a lobby, or a waiting room.
- **Texts or direct messages** on social media that you did not ask for.
- **Asking for your Medicare number** in exchange for a card, a benefit, or supplies.

A useful rule

Your Medicare number is like your Social Security number. Anyone who already has a legitimate reason to contact you will not need you to read it out over the phone to a call you did not place.

If it happens

You do not owe anyone an explanation. Hang up, or say you will call back through a number you look up yourself. If you want to report it, the Senior Medicare Patrol in your state handles exactly this, and

IF YOU WANT A SECOND READ

Who wrote this

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I wrote this because the same three things come up over and over with people managing these conditions: they did not know this category of plan existed, they did not know the enrollment window was different, and nobody explained the confirmation form until something went wrong with it.

I speak Cebuano. If that is easier for you or for your spouse, we can do this in Bisaya.

Quoted on Medicare policy in

Newsweek · NTD · InsuranceNewsNet

A first conversation is mostly questions. Your conditions, your doctors, your prescriptions, your county. Often the answer is that your current setup is already right, and I say so.

My services are $0.00, forever. The carriers we represent compensate us, but my service to you will always be $0.00.

If you want to talk it through

There is no charge for a conversation, and nothing to decide during it.

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YOUR NOTES

Questions to ask

Easier written down than remembered.

YOUR NOTES

My conditions and my care team

Bring this to any conversation about a plan. It answers most of the questions before they are asked.

Condition	Doctor who treats it

My prescriptions

My pharmacy

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If you are living with diabetes, heart failure, or a heart condition, a conversation costs nothing and there is nothing to decide during it.

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We do not offer every plan available in your area. We represent multiple organizations which offer many products in your area, and any information we provide is limited to those plans we do offer. To review every option available to you, please contact Medicare.gov or call 1-800-MEDICARE.

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