Medicare: The Guide to Protecting Your Future.

Buffer Insurance

Table of Contents

MEET YOUR LOCAL AGENT

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Taylor Turner is a licensed insurance professional with Buffer Insurance; a local, full-service insurance agency headquartered in North Texas. Taylor specializes in assisting seniors with their transition to Medicare by providing coverages that will best serve their unique needs. Taylor is a University of Texas at Arlington alumnus, a Marine Corps veteran, and considers himself a "cool uncle" to his four nieces and nephews.

Scan here for more agent info

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First Things First

Medicare may not be the first thing on your mind in the morning, but making the transition is a necessity for every person at some point in their life. Perhaps you find yourself approaching your sixty-fifth birthday. You are suddenly seeing a plethora of ads about Medicare and sifting through terms and vocabulary that are confusing. Or perhaps you've decided to delay Medicare and keep working, but retirement is starting to look more and more appealing.

Wherever you find yourself, you are in a unique situation that requires help from a trustworthy source. This book is that source, and Buffer Insurance's team of experts is prepared to help with your unique situation.

This Medicare guide was written with you in mind and explains the fundamentals of Medicare, the pitfalls to look out for and gives you some strategies to make a successful transition to Medicare.

Some readers of this book may be the DIY-ers and others may prefer some consultation before pulling the trigger. Whichever group you identify with, our authentic and responsive agents are available to see that your future impact is ensured.

The Fundamentals

Medicare is a federal insurance program that has been in place for 67 years and has gone through many transformations. There are two parts to Original Medicare: Medicare Part A, which covers inpatient medical expenses, and Medicare Part B that covers outpatient medical expenses. Over the years, Medicare has evolved and private insurance companies have adapted by creating supporting coverage to account for healthcare services that were not part of the original Medicare Parts A and B. Supporting coverage includes Medicare Part C (Medicare Advantage), Medicare Part D (prescription drug coverage) and Medicare Supplement (or Medigap).

The fundamental components of Medicare (Parts A and B) leave you with a substantial amount of out-of-pocket exposure, which is why the vast majority of people enroll in additional coverage.

Medicare vs. Medicaid: If you've ever confused Medicare with Medicaid, you're not alone. Medicaid is a state program that is designed to help with the costs of health care for individuals with limited financial resources. If you qualify for Medicare and Medicaid, there are special plans available that offer amazing benefits and we can help you determine if you are eligible for them.

THE FUNDAMENTALS: MEDICARE PART A

Medicare Part A covers inpatient hospital visits. If you were admitted to a hospital, you would be responsible for the first $1,556 (the Part A deductible). This is a per-instance deductible though, so if you're hospitalized in January, then again in March, and again in October you will pay the Part A deductible each time.

Part A extends to nursing facilities, nursing home care, hospice and home health services (not including Long Term Care).

Most people don't pay a premium for Part A. As long as you have worked for at least 10 years (or 40 quarters) and paid Medicare taxes during that time, you have already paid your "dues" and will not pay a Part A premium. Individuals who are not eligible for premium-free Medicare Part A can still enroll but would be responsible for a monthly payment.

THE FUNDAMENTALS: MEDICARE PART B

Medicare Part B covers outpatient medical services which include common health-related services like doctors visits and preventative care. Your financial responsibility for the year is the first $233 (Part B deductible) and any amount over that is split between you and Medicare; you pay a 20% coinsurance and Medicare would pay the remaining 80%.

Part B services include, but are not limited to:

- The purchase or rental of Durable Medical Equipment (DME)
- Ambulance services
- Outpatient physical, speech and occupational therapy (provided by a Medicare-certified therapist)
- Chiropractic care necessary to correct subluxation of the spine
- Outpatient mental health services
- Home health services (usually for a short period of time, after a hospital stay, and not Long Term Care)
- X-rays and lab tests
- Prescription drugs administered by a doctor (such as immunosuppressant drugs, some anti-cancer drugs, dialysis, etc.)

Medicare covers medically necessary healthcare services and does not include cosmetic or experimental services.

Your Part B premium is determined by your individual or household income. The standard monthly premium in 2022 is $170.10, but the higher your taxable income, the higher your premium will be. If you are considered a high-income earner, you will pay an increased Part B and Part D premium as a result of the Income Related Monthly Adjustment Amount (IRMAA).

High-Income Earners: To see a schedule of the current premium amounts and learn more about How to Appeal these increased premiums, visit our website, **BufferInsurance.com.**

ELIGIBILITY REQUIREMENTS

Most people become eligible for Medicare by turning 65, but age is not the only factor taken into consideration. You can qualify for Medicare if you fall into any of these categories:

- You are 65 years of age or older and a U.S citizen or permanent legal resident for at least 5 consecutive years
- You've been receiving disability benefits for 24 months
- You've been diagnosed with end-stage renal disease (ESRD) and have been on dialysis 4 months
- You've been diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's disease or ALS)

Traveling with Medicare: Whether you're visiting the grandkids in another state, or you're on a scenic, cross-country road trip, Original Medicare provides you with emergency coverage throughout the U.S. and most U.S. territories.

It's important to note that Original Medicare does not cover medical expenses or prescription drugs purchased overseas. However, most Medicare Supplement and Medicare Advantage plans will provide limited coverage for emergency care outside of the U.S.

While most Medicare beneficiaries have some coverage overseas, we recommend purchasing a travel medical plan to supplement your stay abroad. And if you are living overseas, or staying more than 60 days, you should not rely on Medicare to cover you beyond this period.

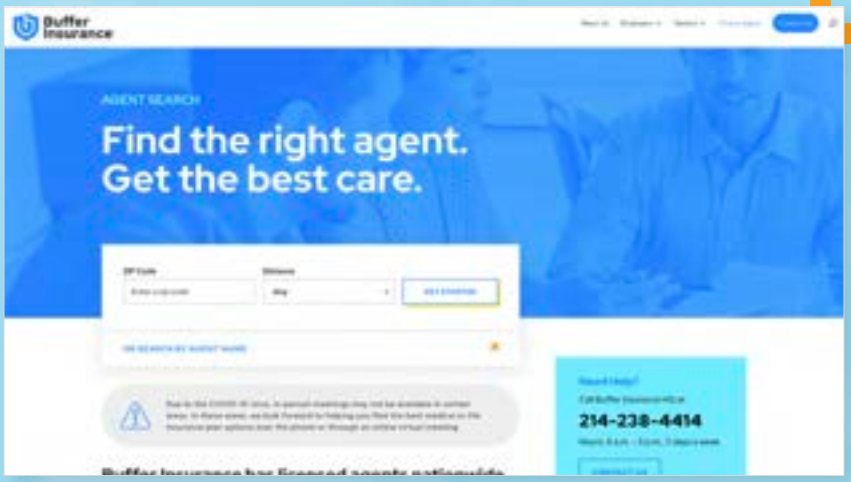
Why Work with An Agent?

Do you need to use an insurance agent for Medicare? The short answer is no, but another question you might consider is 'why should I use a Medicare agent?' Medicare is incredibly complex and having a trustworthy agent by your side to walk you through the process can make all the difference. Buffer Insurance agents live and breathe Medicare but, if you are like most people, you don't deal with this topic every day and most of these concepts are new to you.

There are so many things to look forward to when turning 65 and worrying about your insurance coverage shouldn't be one of them. We'll help you select the perfect plan and navigate Medicare so you can focus on what's important to you—grand kids, travel, or time with friends. By taking this off your plate, you can fill it with the things that really matter.

USING AN AGENT COSTS $0

Agents are compensated by insurance companies and there is no fee for their advice. You can buy your policy from any insurance company on your own, or you can have a trained agent walk you through the entire process and educate you about your coverage – both result in the same premiums and coverage. We make ourselves available to you because we believe your future is important and you deserve to understand how it's being protected. We are proud to offer this education and guidance at no cost to you.



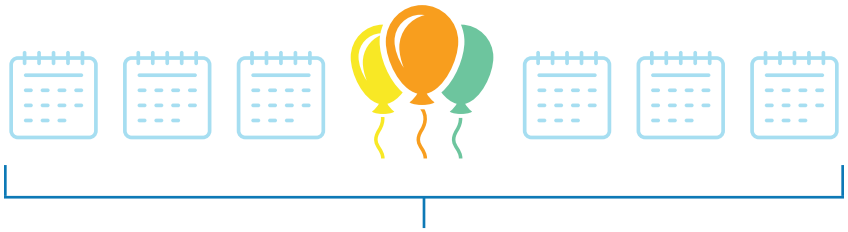
WHY BUFFER INSURANCE AGENCY?

Protecting you and ensuring your future impact is our highest priority. We believe a personalized experience when selecting a Medicare plan is one of the best ways to ensure your future impact. So many people get lost in the impersonal act of choosing a plan, confused by the paperwork and insurance lingo. With the overwhelming amount of information and options, it can be difficult to make a wise decision.

At Buffer, we're advocating for you. We will build our **relationship** with you through authenticity, transparency, and responsiveness. As an independent broker, we'll guide you through the process of selecting an insurance plan that makes sense for your life and financial situation. With Medicare, Buffer Insurance makes insuring you and those you care about simple, comprehensive, and cost effective. By offering personalized service, we're ensuring that you'll be making the most of your golden years.

When to Sign up for Medicare

Unless you are already drawing Social Security or receiving Railroad Retirement Board benefits, enrollment into Medicare is not automatic. There is an Initial Enrollment Period (IEP) surrounding your 65th birthday. This seven-month window consists of the three months before your birth month, your birth month, and the three months following your birth month. Let's say you were born in June: your initial enrollment period would begin March 1st (three months before) and continue through the end of September (three months after). If your birthday happens to fall on the first of the month, your initial enrollment period will begin and end one month earlier.



INITIAL ENROLLMENT PERIOD

Just because you're turning 65 doesn't mean you are required to sign up. The most common reason to delay enrollment is if you or your spouse are working past 65 and you have coverage through an employer plan. There are a few rules to keep in mind if you are considering delaying enrollment into Medicare. The first, and arguably most important, consideration is that employer coverage has to be considered "creditable" in order to avoid late enrollment penalties. Creditable coverage is the baseline set by Medicare, meaning the qualified plans must provide the same level of coverage that Medicare does.

Note: COBRA is not considered creditable coverage for Medicare.

If your employer has twenty or more employees, Medicare is considered secondary to employer insurance and is optional. If your employer has less than twenty employees, Medicare will be considered primary whether you have it or not and does not qualify as creditable coverage.

Although you might be eligible to delay enrollment into Medicare without any penalties, there are times this may not be in your best interest. Comparing the cost and benefits between your employer plan and Medicare will be key in determining which avenue makes sense for you.

LATE ENROLLMENT PENALTIES (LEP)

If you end up delaying entry into Medicare and do not have creditable coverage, there are a few penalties you might incur. Firstly, the Part A late enrollment penalty (LEP) only applies to individuals who pay a premium for Part A - remember, Part A is premium-free if you or your spouse worked and paid taxes for at least 10 years. If you do fall into the category of people who pay a premium, the LEP is 10% and is charged for twice the number of years that you delay enrollment. For example, if you delay for two years, you will pay the additional 10% for four years (two x two years). The penalty applies no matter how long you delay Part A enrollment.

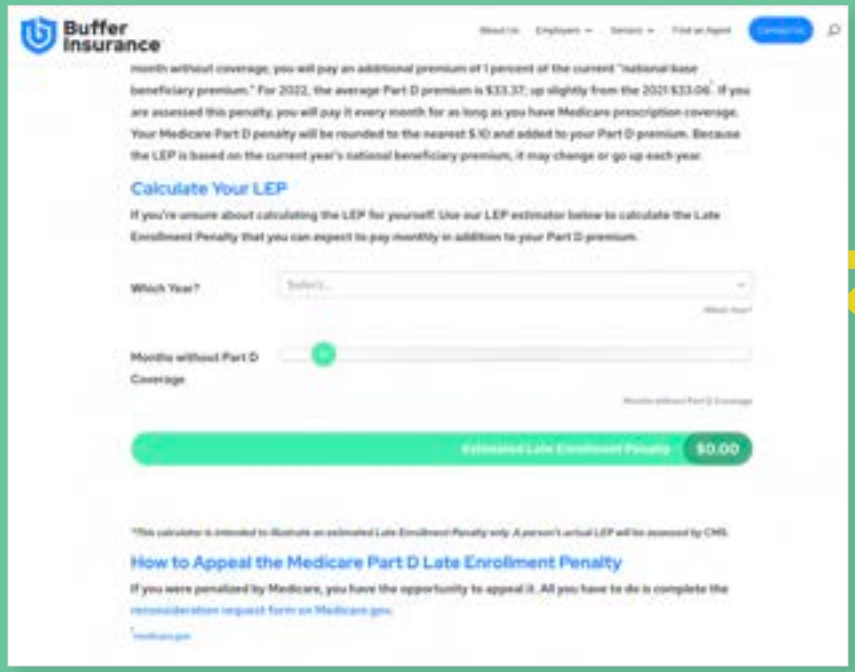
There is a separate LEP for Part B that adds an extra 10% for each 12-month period that you delay enrollment. Let's say your Initial Enrollment Period ended September 30th 2018. Then, you enrolled in Part B during the General Enrollment Period in March 2021. Your LEP would be 20% of the Part B premium, or 2 x 10%. This is because you waited 30 months to sign up, and that time period included 2 full 12-month periods. In most cases, you are required to pay the penalty every month for as long as you have Part B.

Lastly, the Medicare Part D penalty applies for folks who have a gap between creditable coverage and Medicare prescription coverage for more than 63 days outside of your initial enrollment period. The penalty is based on the number of months you went without drug coverage. For each month without coverage, you will pay 1-percent of the current "national base beneficiary premium" on top of any drug plan premiums. In 2022, the national base beneficiary premium for Part D is $33.37 and, because the LEP is based on the current year's national beneficiary premium, it will change year to year. Suppose your Initial Enrollment Period ended and you waited 24 months to sign up for Part D. Your Part D penalty would be 24-percent of the national beneficiary premium (1-percent for each month delayed).

Your Medicare Part D penalty will be rounded to the nearest $.10 and added to your Part D premium. If you are assessed this penalty, you will pay it every month for as long as you have Medicare prescription coverage.

Exception: If you're under 65 and disabled, any Part D penalty will end once you turn 65 because you'll have another Initial Enrollment Period based on your age.

You can use the custom calculator on the Buffer Insurance website to determine your penalty amount based on the number of months you have gone without creditable Part D coverage – Late Enrollment Penalty Calculator



Additional Coverage: Medicare Supplement & Medicare Advantage

Although Medicare limits some of your financial burden, your potential exposure is technically unlimited due to the design of Parts A and B that we discussed earlier. Medical expenses are notorious for adding up extremely quickly; in fact, they are the number one cause of bankruptcy. Medicare is no exception, even though it is a tax-payer funded government program.

Since there is no ceiling for costs on Original Medicare, it is best practice to choose a Medicare Supplement or Advantage plan to complement Part A and Part B and limit your out-of-pocket exposure. In fact, according to the Kaiser Foundation1, 9 in 10 people with Medicare in 2018 had a supplement, employer-sponsored insurance, Medicaid, or a Medicare Advantage plan.

The vast number of plan names and structures may seem overwhelming at first, but the choice mostly boils down to two types of coverage. Both are excellent plan options, especially when you compare them against many of the employer or individual insurance plans in the market.

The key to understanding these products is to keep an open mind, which will allow you to truly appreciate how they function.

Medicare Supplement

Medicare supplement plans, also known as Medigap plans, were designed to complement Original Medicare by placing a ceiling on how much you pay out-of-pocket. These plans are standardized by the federal government, so every company offers identical benefit designs. For example, Plan G with Insurance Company X will be the same as Plan G with Insurance Company Y.

You're probably wondering "what is Plan G"? Medigap plans are named as letters (A, K, L, N, G, F, etc.) that are used to define the different plan options, which has earned them the nickname "alphabet soup" of Medicare. Most individuals today choose Plan G or Plan N because they are two of the more robust coverage options. For instance, Plan G makes it so that you are only responsible for the yearly Part B deductible of a couple hundred dollars; then no more out-of-pocket costs after this.

Medigap plans have a monthly premium on top of the Part B premium. You can expect these premiums to increase gradually over time. Rate increases are typically delivered on the anniversary date of the policy. We jokingly say that this is the insurance company's way of wishing you a happy birthday.

Medigap plans are not network based, allowing you to visit any doctor that accepts Medicare assignment, and this insurance does not require you to obtain a referral to see a specialist.

Supplement plans do not offer prescription drug coverage, so we recommend that you also enroll in a standalone "Part D" prescription drug plan to help with the costs of drugs and to avoid the Part D late enrollment penalty.

The Medicare Supplement Open Enrollment Period is the 6-month window after your Part B effective date. After this enrollment period, you may not be able to buy a Medigap policy.

Guaranteed Issue: This term refers to situations where insurance companies are required to accept your enrollment into the plan; they cannot deny you based on pre-existing conditions, or charge more because of past health issues. Outside of your initial enrollment period, there are special circumstances that dictate whether the insurance company guarantees your acceptance. One of the more common scenarios where guarantee issue rights are utilized is when a person loses employer health coverage. In this instance, you cannot be denied by the Supplement insurance carrier. If you are unable to pass underwriting, the alternative for additional coverage is Medicare Advantage.

Medical Underwriting: If you do not fall into a scenario that grants you guaranteed issuance, you will be subject to medical underwriting. This simply means that the insurance company will conduct a health questionnaire and review your medical history to determine if they will accept you. If you are currently enrolled in a Supplement, you could receive a lower monthly premium by going through underwriting.

Trial Right: During your first 12 months on an Advantage plan, you have the option to revert to a Supplement with guaranteed issue rights. This allows you to test a Medicare Advantage Plan before making a long-term commitment.

Medicare Advantage

Medicare Advantage plans, sometimes referred to as "Part C", are required by law to cover the same services as Original Medicare, usually include prescription drug coverage, and may offer additional benefits that are not covered by Original Medicare.

Similar to Medigap plans, these plans will also protect your finances by setting a specific out-of-pocket maximum. This 'ceiling' will be unique to each plan so it is important to examine each Advantage plan's benefit highlights, or summary of benefits, for exact details.

These plan designs vary based on where you live, so we recommend that you speak with one of our agents who can offer more insight on what plans are available in your area.

CONSUMER RATINGS

When you first consider making a purchase, you probably take a quick glance (if not a deep dive) at the product's reviews before making your decision. Shopping for an Advantage plan is no different than finding a mechanic to work on your car. You want somebody knowledgeable and reputable working on your vehicle. Why would you treat your healthcare any different? Medicare Advantage products are graded each year on a scale of 1 to 5 with 5 being the highest rated plan. It is a good idea to look at Star Ratings when choosing your coverage because they indicate the type of experience others have had using their insurance.

Star Ratings: The Center for Medicare and Medicaid Services (CMS) has a rating system that grades the performance of Advantage plans and standalone drug plans. These plans are rated from 1 to 5 with 5 being the highest overall in terms of quality and performance. These ratings are released annually and reflect the experiences of the people enrolled in the plans throughout the year.

Just like you rely on customer reviews to make purchases online, this star rating system can be used similarly with higher rated plans exhibiting better performance than lower rated plans.

Plans that have a 5-star rating have special permissions, generally allowing Medicare beneficiaries to enroll mid-year into that plan, outside of the Annual Enrollment Period.

EXTRA BENEFITS

Though you'll still be responsible for your Part B premium, Medicare Advantage plans generally offer low, or even $0 premiums. These plans often include additional benefits that are not found with Original Medicare or a Medicare supplement. For instance, many Advantage products include dental coverage which usually covers cleanings and can even provide benefits for other services up to a certain dollar amount. Vision benefits are also prevalent within Medicare Advantage plans and allow for routine eye exams, as well as an allowance for frames or contacts.

Gym memberships are another way that Advantage plans set themselves apart. Most will include access to a multitude of gyms, classes, and other exercise programs. Some Advantage plans even include over-the-counter credits that you can spend on vitamins, supplements, or other non-prescription resources.

PROVIDER NETWORKS

Unlike Medigap plans, Medicare Advantage plans are network-based, meaning they have either an HMO or PPO network. You've likely heard of these networks before, but it never hurts to get a refresher on how they work.

An "HMO" is a Health Maintenance Organization plan and they generally require referrals to see specialists and limit you to certain participating physicians (except for emergencies). In practice, this means you can't decide to go see a dermatologist to check a mole while you're on vacation in another state, you'll want to wait until you get home and ensure the referral is in place if required.

On the other hand, there is the "PPO" plan which stands for Preferred Provider Organization plan. These types of plans do not require a referral for specialists and do allow out-of-network physician visits; it will cost quite a bit more when using out-of-network doctors. The PPO is a much more flexible managed care option, but it is usually paired with higher co-payments and scaled-back added benefits to Original Medicare.

Many people have the perspective that HMOs are inferior to PPOs but we find that this type of thinking is more applicable to employer insurance plans than it is to Medicare. More and more doctors are contracted with both of these plan types. If you prioritize the flexibility of going to the doctor of your choice whenever you want to, and don't mind paying a bit more, the PPO is an excellent option. However, if you like the idea of keeping your co-payments as low as possible, and maximizing your added benefits, then the HMO is right for you.

An important part of our process is to review your preferred physicians and ensure that the insurance we recommend does not interfere with those relationships.

Prescription Drug Coverage

As Medicare has evolved throughout the years, so has the need for prescription drug coverage, which is not included in Medicare Parts A or B. These prescription drug plans (also known as PDPs) can be purchased through private insurance companies and provide coverage for your medications. Each plan has a unique list of drugs that are covered, referred to as a formulary, which varies from plan to plan.

There are two ways to obtain Part D coverage—either a through a standalone PDP or a Medicare Advantage plan that has prescription coverage built-in. Most Medicare Advantage plans come with Part D coverage, but this will be a separate purchase if you proceed with a Medigap plan. We touched on late enrollment penalties in the Late Enrollment Penalties section and it is important to remember that you will be penalized if you do not maintain creditable prescription drug coverage.

PHASES OF PART D COVERAGE

The standardized cost-sharing model for Part D plans is as follows: deductible phase, initial coverage phase, the coverage gap, and the catastrophic coverage phase.

Deductible Phase: Depending on the plan you select, you may have to reach a yearly deductible before the plan begins to share the cost of prescriptions with you. The standard deductible for 2022 is $480 but plans can set lower deductibles if they choose to.

Initial Coverage Phase: After you reach the deductible (if your plan has one), you will enter the initial coverage phase, where you will pay the co-pay amount set by the plan for covered medications. As an example, the plan may set a $0 co-pay for Tier 1 drugs but a 33% coinsurance for Tier 5 drugs. If the Tier 5 drug costs $300 for a month's supply, your out-of-pocket cost would be about $100 per month.

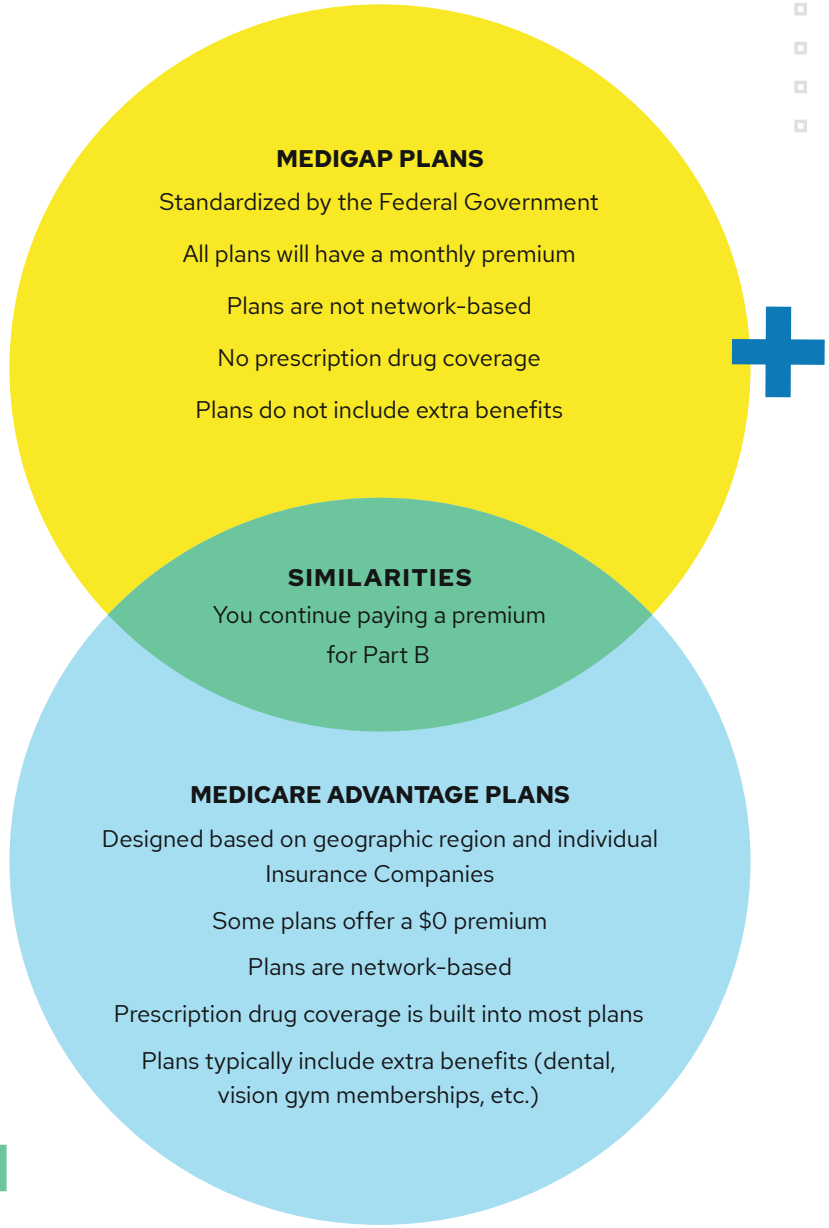
Coverage Gap (also known as the Donut Hole): You will enter the coverage gap after you, and the insurance company, spend $4,430 in 2022. During your time in the coverage gap, you'll be responsible for 25% of the plan's cost for brand-name and generic drugs. To illustrate this, let's assume that a Tier 3 drug you're taking costs the plan $500 per month to fill. In that case, you'd be responsible to pay $125 each month as long as you are in the coverage gap. You will stay in this phase until your yearly out-of-pocket drug costs reach $7,050 in 2022 - Most people do not reach this stage, but for those that do, the vast majority do not exit the donut hole.

Catastrophic Coverage Phase: If you spend $7,050 on medications throughout the year, you will exit the coverage gap and enter the catastrophic coverage phase. In this phase, you'll pay a small coinsurance for covered prescriptions for the remainder of the year.

Our role, with Part D, is to review your list of prescriptions, dosages, and your preferred pharmacy to determine the prescription drug plan that will work best for you. Our complimentary analysis will serve to determine which plan will keep your drug costs as low as possible throughout the course of the year. To go a step further, we can review your drugs each year to determine if you need to make a plan change for the following year.

COMPARING MEDIGAP AND MEDICARE ADVANTAGE PLANS

At first glance, Medigap and Medicare Advantage plans are quite similar, but if you're looking for specific coverage then the two can offer very different results for you.



Similarities

- You continue paying a premium for Part B

Medigap Plans

- Standardized by the Federal Government
- All plans will have a monthly premium
- Plans are not network-based
- No prescription drug coverage
- Plans do not include extra benefits

Medicare Advantage Plans

- Designed based on geographic region and individual Insurance Companies
- Some plans offer a $0 premium
- Plans are network-based
- Prescription drug coverage is built into most plans
- Plans typically include extra benefits (dental, vision gym memberships, etc.)

Now that we've gone over these plan designs individually, let's look at a side-by-side summary of the two types of plans.

Medigap plans are standardized by the federal government, offering identical medical and hospital benefits no matter which state you live in, while Advantage plan designs are based on your geographic region and the insurance company you choose.

Both plans require you to continue paying for your part B premium and the premium associated with the plan. Although some Advantage plans have a $0 monthly premium, you are still responsible for the Part B premium.

Medicare Supplement plans do not rely on a network of doctors, while Medicare Advantage plans have HMO and PPO networks.

Prescription Drug Coverage is not included with Medigap plans so you'll need to purchase a standalone prescription drug plan, while most Medicare Advantage plans have this coverage built in as part of the plan. Medicare Advantage plans typically include extra benefits, such as dental, vision, gym memberships, over-the-counter credits, and more. Generally, Medigap plans do not provide any of these perks.

Enrolling into Original Medicare

Now that you have read this entire book you are a Medicare expert, right? If you're like most people, you are probably figuring out that you now have a better idea about how the Medicare program works, but still do not know what plan you should pick. This is a big decision, and it is important that you take your time to understand how this all transfers from the pages of a book into the real world.

As insurance agents, we ask questions to get to know your needs and then educate you with the resources necessary to make a decision you're happy with. We'll work with you to determine what your needs are, which plan suits them best, or if it is in your best interest to move onto Medicare right now.

There are some instances when you may want to decide to wait to enroll in Medicare (refer to When to Sign up for Medicare). In that case, we'll let you know what to do when it is time to sign up for your benefits. When the time is right to go onto Medicare, the first step in the process is applying for Original Medicare (Part A and Part B). This process is different depending on whether you are applying at age 65 or if you have delayed enrollment.

ENROLLING IN MEDICARE AT 65:

The application for Medicare is done through your Social Security profile but you do not have to draw Social Security retirement benefits at age 65. We've outlined the process of applying for Medicare below:

Step 1:

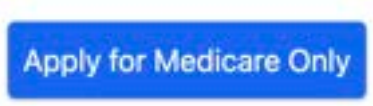
Create a login/account with Social Security at https://www.ssa.gov/myaccount/.

Step 2:

The next step will be to apply for Medicare.

If you're not planning to draw Social Security benefits, there is a blue button on the link below that will say "Apply for Medicare Only": https://www.ssa.gov/benefits/Medicare/.

If you are planning to draw Social Security retirement checks, you'll want to follow the prompts to get that process going and then apply for Medicare.



Step 3:

Set an appointment with me to discuss Medicare plan options and we can narrow down the best plan to suit your needs during that appointment.

DELAYED ENROLLMENT IN MEDICARE:

If you delay enrollment in Medicare, there is a slightly different application process than the one you follow when getting onto Medicare at age 65. You will be required to mail or fax an application to your local Social Security office and, in order to avoid late enrollment penalties, you will have to submit the "employer verification form" (CMS-L457). This is a document, filled out by your employer, that confirms you maintained creditable coverage through an employer following your 65th birthday.

Both the Medicare application and the employer verification forms are available for download or print on our website: https://bufferinsurance.com/seniors/Medicare-forms/.

You can find your local Social Security office by visiting their website: https://secure.ssa.gov/ICON/main.jsp#officeResults.

Choosing a Plan

After applying for Medicare, it generally takes 2-3 weeks to be approved and for you to receive your "red, white, and blue" Medicare card in the mail. You can also login to your Social Security account and check your application status. When you have an 11-digit Medicare number (see image below), we can help you with enrolling in either a Medigap plan paired with a prescription drug plan or a Medicare Advantage plan of your choosing.

Some people find themselves paralyzed because they think they only get one shot at deciding on coverage beyond Original Medicare. While there are rules on when and how you can change your coverage, you can make changes to your Medicare over the years based on changes in your needs. If you choose to stick with Original Medicare and purchase a Medigap plan to supplement it, you can switch to a Medicare Advantage plan in the future, as long as there is an available enrollment period such as the Annual Enrollment Period which runs from October 15th to December 7th. On the other hand, if you decide on an Advantage plan you may have to go through medical underwriting to get onto a Medigap plan in the future.

This book is an excellent start, but we truly believe that working with an expert insurance agent is the best way to ensure you're equipped with the knowledge necessary to make an informed decision on the topic of Medicare. Our agency exists to break down this complex subject in a way that makes sense to everyday people so you can feel confident with the decisions you make about your insurance.

Please reach out to us if you have any questions or would like to meet with us to talk about your Medicare journey. *Contact info is on the back.*

Our Values

EXCELLENCE

We consistently put forth our best effort, and strive to exceed expectations.

We impact the lives of others by educating and ensuring their future.

We provide effective solutions that fit our client's specific needs, never sacrificing quality or taking shortcuts.

TEAMWORK

We put others first and treat them with respect.

We value the collective expertise in our team and seek ways to learn from others.

We effectively collaborate with others to deliver superior service and outcomes to our customers.

HEALTH

We pursue physical, spiritual, and mental health.

We advocate for a balanced, healthy lifestyle and lead by example.

We discipline ourselves today to ensure our future impact on the lives of others.

TRUST

We build intentional relationships with others through authenticity, transparency, and responsiveness.

We take responsibility for our work and follow through on our commitments.

We listen to others and act with integrity and compassion.

GROWTH

We embrace challenges and see them as an opportunity to better ourselves and the company.

We constantly pursue improvement both personally and professionally in order to better impact our clients and community.

We are passionate about our purpose and inspire others to protect their future.

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