Medicare

What You Should Know

IntraCare

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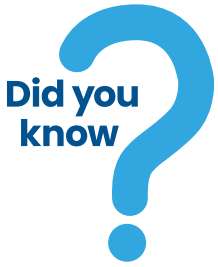
Break Through the Clutter

Find the Plan That is Right for **YOU**

Medicare is confusing. Choosing the right plan is a big deal. As primary care providers, we believe it's very important to clearly understand your options.

This guide will help you understand your options, and answer some of your most pressing questions.



The **No. 1** reason why people file for bankruptcy is due to medical costs. Picking the right Medicare plan is a major decision that could impact your finances for the rest of your life.

Connect with an expert

If you'd like to skip reading, we're more than happy to connect you with a licensed Medicare agent that we trust with our patients.

To book your consultation:

In Arizona call 480-690-8265

In Texas call 214-389-3953

Medicare Plan Comparison	Original Medicare/ Fee-for-Service	Medicare Supplement	Medicare Advantage HMO	Medicare Advantage PPO
$0 monthly premium	No	No	Most	No
Low deductibles	No	No	Most	No
Low co-pays	No	No	Most	No
Limit on how much you pay out-of-pocket annually (max out-of-pocket, MOOP)	No	No	Yes	Yes
Trial period	No	No	Yes	Yes
Emergency coverage while traveling	Yes	Yes	Yes	Yes
General coverage while traveling for extended period	Yes	Yes	No	Yes
Hospital stays	Yes	Yes	Yes	Yes
Doctor visit costs	20% Coinsurance	CoInsurance varies by plan	Copay	Copay
PCP required	No	No	Many	No
Specialist referrals required	No	No	Many	No
Short-term care or skilled nursing facilities	Yes	Yes	Most	Most
Long-term care	No	No	No	No
Online (telehealth) visits	Some	Some	Most	Most
Annual wellness visit	No	No	Yes	Yes
PCPs paid for achieving national quality standards	No	No	Yes	Some
Rates increase as you age	No	Yes	No	No
Prescription drug coverage	No	No	Yes	Yes
Over-the-counter benefits	No	No	Some	Most
Transportation assistance	No	No	Many	Most
Additional value-adds like meals and housing assistance	No	No	Some	No
Dental, vision, hearing aid coverage	No	No	Most	Most
Gym memberships	No	No	Most	Most
Connection to community programs	No	No	Many	Some

Useful definitions to know

Annual Enrollment Period (AEP)
Time from Oct 15-Dec 7 each year when you can join, switch, or drop Medicare Advantage and Part D plans.

Assignment
When a doctor or provider agrees to accept the Medicare-approved amount as full payment.

Benefit Period
The time Medicare uses to measure your hospital or skilled nursing care. It starts when admitted and ends after 60 days without care.

Benefits Review
A yearly check of your Medicare plan to be sure it still meets your health and cost needs.

Chronic Conditions Special Needs Plan (C-SNP)
A Medicare Advantage plan for people with specific chronic health conditions like COPD, Diabetes or Heart Disease..

Co-insurance
The percentage of costs you pay for a covered service after your deductible.

Copayment (copay)
A set dollar amount you pay for a covered service or prescription.

Deductible
The amount you pay out-of-pocket before Medicare or your plan begins to pay.

Dual Eligible Special Needs Plan (D-SNP)
A Medicare Advantage plan for people who qualify for both Medicare and Medicaid.

Fee-for-Service
A type of health plan provided by a private insurer where providers are paid for each service they give you; similar to Original Medicare.

Medigap (Medicare Supplement Insurance)
Private insurance that helps cover costs Original Medicare doesn't pay, like coinsurance and deductibles.

Medicare Advantage Open Enrollment Period (OEP)
From Jan 1-Mar 31 each year, people in Medicare Advantage can switch to another Advantage plan or return to Original Medicare.

Out-of-Pocket Costs
The money you pay yourself for healthcare, including deductibles, copayments, and coinsurance.

Premium
The amount you pay monthly for Medicare or a private plan.

Special Enrollment Period (SEP)
A time outside standard enrollment periods when you can sign up for Medicare due to certain life events (like losing coverage, moving, or if your plan is no longer available, etc.).

Medicare Part A
(hospital insurance)

When you turn 65, you may be automatically enrolled in Medicare Part A (hospital insurance) if you're already receiving Social Security or Railroad Retirement Board benefits. If not, you will need to sign up.

Medicare Part A is healthcare coverage managed by the federal government. It provides essential protection against the high cost of hospital care. It helps cover inpatient care in hospitals and care at skilled nursing facilities, hospice and home health.

Coverage for hospital stays includes room, meals, general nursing care, and medications that are part of your inpatient treatment.

If you need short-term rehabilitation after a hospital stay, Part A may cover services in a skilled nursing facility, and limited home health services if you meet specific requirements, but it does not cover long-term custodial care.

All Medicare Advantage plans also include standard Part A coverage.

Some things to think about with Medicare Part A

- Most people don't pay a monthly premium for Part A. This is because you or a spouse paid Medicare taxes while working. If you don't qualify for premium-free Part A, you may be able to buy it.
- However, even $0-premium Part A requires you to pay a deductible. This is a set dollar amount that is fixed for each year.
  You pay the deductible for services used before Medicare begins covering hospital expenses.

For example, if you fall, get injured, and need to stay in the hospital, you'll first pay the Part A deductible of $0,000 to cover care costs. After you meet that deductible, Medicare Part A will cover the approved hospital stay for up to 60 days in that benefit period.

You will have to pay daily coinsurance after a certain number of days. Generally, days 1-60 have no coinsurance as long as you have paid the deductible. From day 61 to day 90, you will pay the necessary per-day coinsurance. After 90 days, you can use "lifetime reserve days", which cost more.

Lifetime reserve days are a special safety net built into Part A hospital coverage for very long hospitalizations. These are 60 days you can use after you have spent 90 days in hospital. Lifetime reserve days can be used only once in your lifetime.

Example: You are hospitalized for 95 days straight

- The first 90 days are covered under regular Part A rules.
- For days 91–95, you would use 5 of your 60 lifetime reserve days.
- That leaves you with 55 lifetime reserve days to use for future hospital stays.

Medicare Part B
(medical insurance)

Part B, is part of Original Medicare (the government's Fee-for-Service program). It helps cover services from doctors and other healthcare providers, such as outpatient care, lab tests, and some home health care.

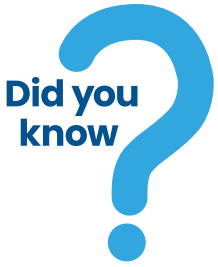
Part B also covers durable medical equipment like wheelchairs, walkers, and hospital beds, and many preventive services like screenings and shots.

All Medicare Advantage plans also include standard Part B coverage.

Some things to think about with Medicare Part B

- Part B is optional. You are not required to enroll in it, but most people do choose to get it because it covers care costs that Part A (hospital insurance) does not cover.
- You will pay a monthly premium. For 2026.
- There is no maximum out-of-pocket limit, so there is no limit to how much you will pay annually for care. This means if you have a lot of doctor visits, tests, or long hospital stays, your costs (deductibles, coinsurance, copayments) can keep adding up. There is no maximum limit where Medicare says, "You've paid enough, now we'll cover 100%."
- You will pay 20% coinsurance for your care.
- Part B offers an initial preventive exam when you join Medicare. However, it does not cover an Annual Wellness Visit which is covered in Medicare Advantage plans.
- Part B does not cover prescription drugs. If you want prescription drug coverage you will have to buy a Medicare Part D drug plan or select a Medicare Advantage plan.
- You can see any health care provider who accepts Original Medicare. (**Note:** Not all doctors accept Original Medicare. Before your visit, always ask if the doctor takes Medicare. If they don't, you may have to pay the full cost yourself.)
- Part B does not cover costs a healthcare provider may charge if they want to charge more than what the government (Medicare) agrees to pay for care.

- Doctors are paid for the volume of services they provide. They are not incented to help keep you healthy by providing care based on proven national quality standards, although some may participate in a Medicare Shared Savings Program (MSSP) that will reward them for keeping their patients healthier.
- Doctors generally do not work together to coordinate and discuss care plans.



Many people do not know that Original Medicare (Part A and Part B) doesn't cover everything. You can purchase a Medicare Supplement (Medigap) plan to help cover what Original Medicare doesn't cover. But even Medicare Supplement plans with 100% coverage do not cover everything.

Medicare Part C
(Medicare Advantage)

Part C, also called Medicare Advantage, is a Medicare-approved plan offered by private insurance companies. It's an alternative to Original Medicare and offers everything that Original Medicare does and more, usually at no extra cost.

Medicare Advantage plans include Part A and Part B of Original Medicare. Most also have Part D prescription benefits built in, and most offer extras such as vision, dental, hearing aids, transportation, and more.

Medicare Advantage plans usually have lower out-of-pocket costs than Original Medicare and some (mostly PPOs) have an additional premium.

Monthly premiums for Part C are not identical across the board. Depending on the insurance company, type of plan, and where you live, your premium could be as low as $0.
(**Note:** You will still have to pay the standard Part B premium, since Part B comes packaged in Part C plans.)

Some things to think about with Part C Medicare Advantage

- Some Medicare Advantage plans now offer additional extra benefits to help with meals, transportation, over-the-counter medications, housing, and more.
- Offers a covered Annual Wellness Visit (every year) to help ensure that you're maintaining your health.
- Some Medicare Advantage plans incent doctors who provide quality care that helps keep you healthy. This type of care is called value-based care. The purpose is to stay on top of your health and better manage conditions and symptoms, while keeping overall healthcare costs down.
- Medicare Advantage beneficiaries report spending less annually in total healthcare spending compared to individuals on Original Medicare or Fee-for-Service plans.
- Medicare Advantage beneficiaries spend an average of $3,486 less per year on out-of-pocket costs and premiums compared to those enrolled in Fee-for-Service Medicare, according to an independent analysis released today by ATI Advisory and commissioned by Better Medicare Alliance.

Did you know

95% of Medicare Advantage members are satisfied with their plan.

Medicare Part D
(prescription drug coverage)

Part D helps cover the cost of prescription drugs, including many recommended shots and vaccines.

If you have Original Medicare (Part A and Part B), you can buy a standalone Part D plan from a private insurance company to cover the cost of your prescription drugs.

Most Medicare Advantage, or Part C, plans have Part D built in.

Some things to think about with Medicare Part D

- Part D plans charge a monthly premium, which can vary by plan. You'll also have costs like deductibles and copayments.
- Each plan has its own drug list (called a formulary), so make sure the plan you choose covers the prescriptions you take.
- Check if your local pharmacy is in the plan's network. Using preferred pharmacies may save you money.
- Part D plans can change their costs and drug lists every year. It's a good idea to review your coverage during Medicare's Open Enrollment (October 15-December 7).

Part D carries a late enrollment penalty. If you don't sign up when you become eligible for Medicare in your 65th year, and you don't already have other creditable drug coverage (like from an employer or union plan), Medicare will add a late enrollment penalty to your Part D premium. This penalty is permanent; you will have to pay it every month for as long as you have Part D.

Medicare Supplement
(Medigap)

Medicare Supplement insurance, sometimes called Medigap, is extra insurance you can buy from a private health insurance company to supplement the coverage not provided by Original Medicare.

Medigap helps pay your share of out-of-pocket costs that come with Original Medicare plans.

It does not offer many of the added benefits that usually come with most Medicare Advantage plans, like prescription drugs, dental, and vision.

Generally, you must have Original Medicare (Part A and Part B) to buy a Medicare Supplement plan.

You are not eligible to purchase a Medigap plan if you have Part C Medicare Advantage.

Some things to think about with Medicare Supplement

- You will pay a monthly premium for Medicare Supplement insurance. This is in addition to the premium you pay for Medicare Part B.
- Medigap plans generally don't cover long-term care (like care in a nursing home), private nursing duty, vision, dental care, or hearing aids.
- You can see any provider who accepts Medicare, but most Medicare Supplement plans do not cover costs if the provider wants to charge more than what Medicare will reimburse. You will be responsible for paying 100% of these 'excess charges' out of your own pocket.
- Some plan premiums may increase as you age.
- Doctors are generally not paid to help keep you healthy by providing care based on proven national quality standards.
- Doctors generally do not work together to coordinate and discuss care plans.

Did you know

Most Medigap plans don't cover prescription drugs. To get medication coverage, you'll usually need a separate Part D plan.

Medicare Advantage HMOs

There are two main kinds of Medicare Advantage plans: Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs).

HMOs are a type of managed-care plan offered by private insurance companies. HMOs typically have lower out-of-pocket costs if you get your care from healthcare providers within the plan's preferred network of doctors.

An HMO covers all the benefits of Original Medicare (Part A and Part B), and extras, all in one plan, for generally less than you would pay out-of-pocket for Original Medicare, Medicare Supplement or Medicare Advantage PPO plans. And, it puts a maximum on how much you will pay out-of-pocket every year.

Some things to keep in mind with a Medicare Advantage HMO

- Most have $0 monthly premiums, depending on your area. All you will pay is the standard Part B premium, since Part B is packaged in the plan.
- Monthly premiums do not increase based on age.
- To keep costs down, you'll need to get care from healthcare providers within the plan's network, except in emergencies.
- Some require you to see a PCP who will coordinate, communicate, and direct all of your care with specialists.
- Some do not require referrals to see specialists who are in the preferred network.
- Healthcare providers may refer individuals to specialists who are not in-network at in-network rates in certain circumstances.
- Some, not all, HMOs have smaller networks of providers who are selected to participate in the network.
- Most encourage preventive healthcare to help keep you healthy by covering entire costs or offering low copays.
- Some offer access to doctors who are held responsible and paid to help keep you healthy by using proven national standards that encourage medical teams (primary care doctors and specialists) to work and communicate with each other to coordinate your care. Also, you will not pay extra for more PCP visits; it's all part of staying on top of your health to keep you healthy.

The rate of potentially avoidable hospitalizations in Medicare Advantage beneficiaries is 43% lower than Original Medicare beneficiaries.

Medicare Advantage PPO

The second kind of Medicare Advantage plan is the Preferred Provider Organizations (PPOs).

PPOs are offered by private insurance companies. This type of plan covers all the benefits of Original Medicare (Part A and Part B) with a network of preferred as well as out-of-network doctors.

PPOs have higher premiums and out-of-pocket costs than HMOs. They include extras not offered with Original Medicare or Medicare Supplement, as well as extras like dental, vision, hearing aids, gym memberships, and more.

Like HMOs, PPOs also limit how much you pay every year, but your out-of-pocket maximum will generally be higher with a PPO plan.

Some things to keep in mind with a Medicare Advantage PPO

- Monthly premiums and out-of-pockets are higher than Medicare Advantage HMOs. (Most HMO plans have a $0 monthly premium. However, you will be required to pay the standard Part B premium since Part B comes packaged in the plan.)
- PPOs have higher deductibles than HMOs. You must pay these before the plan's coverage starts.
- Monthly premiums do not increase based on age.
- You can choose to get care at in-network or out-of-network doctors. (**Note:** Out-of-network providers will cost more.)
- In some areas, the difference between a PPO preferred network and HMO network is not a lot.
- Most PPOs don't require a designated primary care physician, so you don't have anyone to oversee all of your healthcare needs. You will be responsible for managing and coordinating your care, and for identifying your specialists.
- Healthcare providers are not held responsible for delivering care based on national standards and evidence-based medicine.

A December 2021 survey from Morning Consult reported that Medicare Advantage has a 94% consumer satisfaction rating. In fact, 98% of people elect to stay in a Medicare Advantage plan upon renewal.

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