MEDICARE FAQ

Pacific Medical Centers, 2020-2021

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This Medicare FAQ was prepared in partnership with Connexion Insurance Solutions.

GENERAL

What is Medicare?

Medicare is federal health insurance program created by the US government in 1965 to help those 65 and older pay for their medical expenses. Some people under 65 with certain medical problems also qualify for it.

What age does Medicare start?

The most common way that participants get Medicare coverage is when they turn **65**. The initial enrollment period for Medicare typically begins three months prior to the month when you turn 65, and it continues for three months after that birthday.

Medicare can begin at any age if you are diagnosed with End Stage Renal Disease or if you have been receiving Social Security Disability Income for 24 months.

Does Medicare cover dependents?

There is no family coverage under Medicare. If you have dependents that had been covered by your previous employer's coverage, they may continue coverage under COBRA if you switch to Medicare.

When will I get my Medicare card?

If you're automatically enrolled in Medicare (if you have paid into social security for 10 years), you should receive your Medicare card in the mail 3 months before your 65th birthday or your 25th month of getting disability benefits. Your Medicare card shows that you have Medicare health insurance. It shows whether you have Part A (Hospital Insurance), Part B (Medical Insurance) or both, and it shows the date your coverage starts.

How does Medicare work?

Medicare has four parts, Parts A, B, C and D and one additional type of plan called Medicare Supplement (Medigap):

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ORIGINAL MEDICARE

- **Part A**: Sometimes referred to as hospital insurance, Part A helps pay for overnight hospital stays including your room, tests, and doctor fees. For most people (i.e. if you have paid into social security for 10 years), when they turn 65, they are enrolled into Part A automatically and there is no cost. All the other Medicare Parts have costs.
- **Part B**: Helps pay for outpatient care such as doctor visits, tests, and screenings. Parts A and B together are often referred to as Original Medicare.

OPTIONAL ALTERNATIVES / ADD-ONS TO MEDICARE

- **Part C**: An alternative to Original Medicare that is also known as **Medicare Advantage**. Part C is administered by private insurance companies and can include other benefits not included in Medicare Part B like vision, dental, hearing, prescription drug coverage. Please note that even if you choose a Medicare Advantage Plan, Part B premiums still apply.
- **Part D**: Optional Prescription Drug coverage that can be added to Parts A or B or may be included in a Medicare Advantage Plan.
- **Medicare Supplement (Medigap)**: Optional coverage that covers some of the costs not covered in Parts A or B.

Keep in mind that original Medicare does not pay for 100% of the services that come with your Part A and B benefits. You may have to pay a deductible, co-pay or co-insurance for some covered benefits, as well as for services that are not covered. That is why some people chose an option to replace or add to original Medicare.

Remember also that beneficiaries can chose either Part C or Medigap, but not both.

Can Medicare be refused by doctors?

Doctors can choose to opt-out of Medicare, which prevents doctors for billing Medicare for treatment. Medicare Advantage Plans (Part C) can make changes to their provider network at any time so doctors can leave or join the network.

Please see our newsletters for more information on considerations when choosing healthcare providers under your Medicare coverage.

This Medicare FAQ was prepared in partnership with Connexion Insurance Solutions.

Can Medicare be used in any state?

Original Medicare provides coverage in all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. If you have a Medicare Advantage Plan, the rules for out-of-state coverage will depend on the Medicare Advantage Plan you are enrolled in.

Medicare Advantage plans are either set up to offer access to providers through a Health Maintenance Organization (**HMO**) or through a Preferred Provider Organization (**PPO**) network. In general, HMO Medicare Advantage plans have provider networks that must be used to be covered for routine care, although you will be covered for emergency care, out-of-area urgent care, and kidney dialysis. PPO Medicare Advantage plans are generally more flexible about seeing providers outside your plan's preferred network, although you may have to pay higher co-pays or coinsurance to receive non-emergency care from an out-of-network provider. If you will be travelling out of state, you can contact your Medicare Advantage Plan for more information on coverage while out of your plan's service area.

Can Medicare be used in Canada, Mexico, or other international countries?

Original Medicare provides coverage in all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. However, in most situations Original Medicare will not pay for healthcare outside the United States. Some Medicare Supplement (Medigap) plans include emergency foreign travel coverage if you are outside of the country (up to plan limits). Some Medicare Advantage plans may also cover emergency care abroad. Contact your plan for more information about its coverage rules.

MEDICARE "PARTS"

What is Medicare Part A?

Medicare has four parts: Part A, B, C and D and one additional type of plan called Medicare Supplement (Medigap).

Sometimes referred to as hospital insurance, Part A helps pay for overnight hospital stays including your room, tests, and doctor fees. For most people (i.e. if you have paid into social security for 10 years), when they turn 65, they are enrolled into Part A automatically and there is no cost. All the other Medicare Parts have costs.

What is Medicare Part B?

Medicare has four parts: Part A, B, C and D and one additional type of plan called Medicare Supplement (Medigap).

Medicare Part B helps pay for outpatient care such as outpatient doctor visits, tests, and screenings. Unlike Part A, in which most people are automatically enrolled, most people must enroll for Part B, and it comes with a monthly premium.

What is Medicare Part C?

Medicare has four parts: Part A, B, C and D and one additional type of plan called Medicare Supplement (Medigap).

Part C, also known as Medicare Advantage plans, are provided through private insurance companies, but contracted with and approved by Medicare. They are required to offer at least all the same benefits provided by Medicare Parts A & B and can provide additional coverage for prescription drugs, dental vision, hearing, and gym memberships. For services covered by original Medicare Parts A & B, Medicare Advantage plans typically pay at the same rates and require the same coinsurance (the portion paid by you, the beneficiary) as original Medicare.

It is important to note that **not** all Medicare Advantage plans offer the same benefits and **not** all are available in every state and county. There is competition between the carrier’s plans that are offered and consequently you can seek plans to meet your unique needs.

To learn more about Medicare Advantage you can watch a video on this page.

MEDICARE COSTS & SERVICES

What Medicare is free?

Typically, there is no premium for Medicare Part A if you have worked at least 10 years and paid Medicare taxes. Medicare Part A is hospital insurance that covers inpatient hospital care, limited time in a skilled nursing facility, limited home health care services and hospice care. Please note that Medicare Part A does not cover the entire amount of your hospital bill, so you will likely be responsible for a portion of the costs in the form of a deductible.

Parts B and D are chosen separately, and each must be paid for by most beneficiaries through a monthly or quarterly premium.

Medicare Advantage (Part C) plans generally involve additional cost to beneficiaries, although some plans may be offered at no additional cost.

Medicare Supplemental (Medigap) plans involve additional cost to beneficiaries.

Does Medicare cover dental?

Medicare Advantage Plans (Part C) can include routine dental coverage. Original Medicare (Part A and Part B) does **not** typically include routine dental coverage, such as dental exams, cleanings, fillings, crowns, and bridges. However, there are some exceptions. For example, if you suffer an accident or contract a disease that affects the jaw, Medicare may cover some of the costs. Stand-alone dental plans can also be purchased to cover routine dental costs.

What preventive services are covered by Medicare?

Preventive care is the care you receive to prevent illness, detect medical conditions, and keep you healthy. Medicare Part B covers many preventive services with no cost-sharing (additional cost to you), so long as you meet eligibility requirements.

Medicare Advantage Plans also cover many preventive services, but you should receive services from an in-network provider. If you go out-of-network, you might be responsible for part or all the cost of your preventive service.

Please read our newsletter on what preventive services are covered by Medicare.

Does Medicare pay for hearing aids?

Original Medicare (Part A and Part B) does not cover routine hearing exams, hearing aids, or exams for fitting hearing aids. However, Medicare Part B does cover diagnostic hearing and balance exams if your doctor orders tests for a medical need like a recent hearing loss. If your doctor orders a diagnostic

hearing test, then you would pay 20% of the amount approved by Medicare, plus the Medicare Part B deductible.

Some Medicare Advantage plans (Medicare Part C) do offer coverage for routine hearing exams and hearing aids. Please note that because each Medicare Advantage plan can be different, you need to compare plan benefits carefully to find one that meets your specific needs.

Will Medicare pay for a wheelchair, walker, or scooter?

Medicare Part B typically covers wheelchairs, walkers, or scooters as durable medical equipment (DME) that is appropriate for use in the home. Durable medical equipment (DME) is equipment that helps you complete your daily activities.

In most cases, 80% of DME costs are covered by Medicare Part B if it is prescribed by your doctor. You would be responsible for the additional 20% unless you have a Medigap/supplemental plan to cover that balance. If you are an inpatient in a hospital or skilled nursing facility (SNF), DME is covered by Part A.

If you have a Medicare Advantage Plan, you must follow the plan's rules for getting DME. Your plan may require that you receive approval from the plan before getting your DME, use a supplier in the plan's network, or use a preferred brand. Contact your plan to learn more about its DME rules.

For more information, see our article on durable medical equipment here.

Does Medicare pay for home care?

Home health care includes a wide range of health and social services delivered in the home to treat illness or injury. Medicare does offer a home health benefit that covers some services. If you have a Medicare Advantage Plan, your plan must provide at least the same level of home health care coverage as Original Medicare, but they may impose different rules, restrictions, and costs.

See our full article on what home health services does Medicare cover here.

Does Medicare pay for vaccinations such as the Flu Shot?

If your healthcare provider accepts Medicare, both Original Medicare and Medicare Advantage plans cover 100% of the costs of seasonal flu shots once a year during the fall or winter.

Does Medicare pay for eyeglasses?

In general, Original Medicare (Part A and Part B) does not provide coverage for routine vision costs such as exams, eyeglasses or contact lenses. The exception is if you have had cataract surgery to insert an intraocular lens (IOL), Medicare Part B covers one pair of corrective lenses (either one pair of prescription eyeglasses or contact lenses).

Some Medicare Advantage Plans (Part C) offer additional benefits not included in Original Medicare, including routine vision or dental, hearing services or wellness programs. Depending on the plans available in your area, you may be able to find a plan that offers coverage for the costs associated with prescription eyeglasses, contact lenses, annual exams, or fittings.

MEDICARE WITH OTHER INSURANCE

How does Medicare work with employer insurance?

If you have insurance through your employer or spouse’s employer when you become eligible for Medicare, you can delay Medicare enrollment without penalty.

You also have the option of enrolling in Medicare while still receiving company-provided insurance. You may also carry Medicare and employer-provided insurance at the same time. In most cases, this will cover 100% of eligible costs as one insurance pays first (primary) according to their coverage rules, and the other insurance pays secondary, covering any remaining costs that are eligible under the secondary plan’s rules.

Medicare works with employer-provided insurance differently based on the size of the employer. If the employer-provided insurance comes from a company with fewer than 20 employees, then Medicare pays primary, and you may be required to activate Part B at the same time your Part A goes into effect. To find out if you need to activate your Part B benefits, contact your employer’s benefits manager. If your employer-provided insurance comes from a company with more than 20 employees, Medicare pays secondary.

If you carry both Medicare and employer-provided insurance together, it is important to keep your health care providers updated about your insurance situation so they can bill correctly. You also need to keep Medicare updated regarding your employment status, such as if you change jobs, if your employer size changes, or if you go on COBRA. Medicare makes the decisions about which insurance pays primary and which pays secondary based on the information they have. If Medicare does not have accurate information, it can result in improper payments on your claims and potential financial liability to you, or lengthy paperwork to correct.

Once you stop working or lose your employer coverage, you have an eight-month window to enroll in Part B without penalty.

Does Medicare work with a Health Savings Account (HSA)?

Once you enroll in Medicare Parts A and or Part B, you can no longer contribute pre-tax dollars to your HSA, however, you can still access the funds you have saved to pay for qualified medical expenses. To continue contributions to your HSA, you can delay both parts of Medicare until you stop working or lose employer coverage.

You will not pay a penalty for delaying Medicare if you enroll within eight months of losing your coverage or stop working. When you activate your Medicare benefits after being on an HSA, your coverage will become retroactive effective going back 6 months. You should stop making contributions to your HSA 6 months before putting your Medicare coverage into effect or you may incur a tax penalty. Please talk with your employer benefits manager about whether it makes sense to delay Medicare Parts A & B.

How does Medicare work with Veterans?

Please see our newsletter on how Medicare works with Federal and Military Benefits.

MEDICARE OPTIONS, ALTERNATIVES, and PLANS

What Medicare Plan is best?

Consumers should seek Medicare plans that are a fit for their individual unique circumstances. That can include, but is not limited to, an individual's location, budget, health, prescriptions, and doctors. A consultation with a licensed

Medicare insurance specialist is recommended so that they can help tailor a recommendation for you based on your specific needs.

What is Medicare Advantage?

Medicare has four parts: Part A, B, C and D and one additional type of plan called Medicare Supplement (Medigap). Part C, also known as Medicare Advantage plans, are provided through private insurance companies, but contracted with and approved by Medicare. They are required to offer at least all of the same benefits provided by original Medicare Parts A & B. Medicare Advantage plans pay at the same or higher rate as Medicare for services covered under original Medicare, and can provide additional coverage for prescription drugs, dental vision, hearing and gym memberships. It is important to note that **not** all Medicare Advantage plans offer the same benefits and **not** all are available in every state and county. There is competition between the carrier's plans that are offered and consequently you can seek plans to meet your unique needs.

To learn more about Medicare Advantage, visit the Medicare Advantate page of the Washington Insurance Commissioner or learn more from Connexion.

Are Medicare Advantage plans HMOs?

There are different types of Medicare Advantage Plans.

In a Health Maintenance Organization (HMO) Medicare Advantage plan, you can typically only go to health care providers in the plan's network unless it is an urgent or emergency situation. For some HMO plans you may need to get a referral from your primary care physician to see other specialists.

In a Preferred Provider Organization (PPO) Medicare Advantage Plans, you typically have more flexibility to choose providers that do not belong to the plan's network, but it may cost more. Please note that Medicare Advantage Plans are offered by private insurance companies and that benefits vary by plan.

How does Medigap/Medicare Supplemental insurance work?

Medicare has four parts: Part A, B, C and D and one additional type of plan called Medicare Supplement (Medigap). Medicare Supplement Plans, also called Medigap Plans, are designed to help pay the remaining coinsurance for hospital and medical costs not covered by original Medicare (Parts A and B) and are sold

by private insurance companies. Generally, you have to be enrolled in Medicare Parts A and B to buy a Medigap plan and continue to pay your Part B Premium. Medigap plans are designed and regulated according to definitions set by Medicare for various "plans."

There are 10 Medigap plans in every state (except for Massachusetts, Minnesota, and Wisconsin), denoted with a letter A, B, C, D, F, G, K, L, M and N. The benefits of each Medigap plan type are standardized across the country although prices may vary across different insurers.

To learn more, visit the Medigap page of the Washington Insurance Commissioner.

What are Medigap plans A/B/D/G etc.—and how much do they cost?

There are 10 Medigap plans in every state (except for Massachusetts, Minnesota, and Wisconsin), denoted with a letter A, B, C, D, F, G, K, L, M and N. Each plan offers a different set of supplemental coverages, and carries a different cost.

While the supplemental coverage of each Medigap plan is standardized across the country, the premium prices and insurers offering each plan in your area may change year to year. To see the most current Medigap offerings in Washintgon State, visit this page from the Washington State Insurance Commissioner.

Generally, you must be enrolled in Medicare Parts A and B to buy a Medigap plan and continue to pay your Part B premium.

ENROLLING OR CHANGING YOUR PLAN

What and when is Medicare Open Enrollment?

The Annual Enrollment Period (AEP) for Medicare, also known as Open Enrollment, is between October 15 and December 7th. During AEP you can make changes to your coverage such as:

- Switch from one Medicare Advantage plan to another
- Switch from Original Medicare to Medicare Advantage or vice versa

What are the different Medicare Enrollment Periods?

Whether you are already enrolled in a plan or first starting to look at your options, it is important to know the different Medicare enrollment periods and what actions you can take during each period. Enrollment periods include:

1. Initial Enrollment Period (IEP) – the seven-month window beginning three months before through three months after your 65th birthday. If you intend to use Medicare, it is best to sign up during your IEP. If you enroll later, you may have a lifetime penalty added to your monthly Part B premium, and it goes up the longer you wait to sign up.

2. Annual Enrollment Period (AEP) – runs from October 15 to December 7. Also known as Open Enrollment, this is your annual window to switch or make changes to your existing plan for the upcoming year.

3. General Enrollment Period (GEP) – runs from January 1 to March 31. This period is primarily for those who missed their initial enrollment period. If you enroll during GEP, your coverage will start July 1. People signing up during GEP may pay a penalty for Part B premiums for not signing up during their Initial Enrollment Period.

4. Special Enrollment Period (SEP) – occurs when certain qualifying events happen in your life. For instance, one may be when you move to a new service area. Or within the first 12 months of your first enrollment in a Medicare Advantage plan, you have a one-time opportunity to change back to a Medigap policy.

OTHER

What is Connexion?

Connexion is one of the largest general agencies in Washington State, and has served the Pacific Northwest for over 30 years. We are passionate about helping seniors, businesses and self-employed individuals and families find the right insurance plans to safeguard their financial health and future. We currently provide Medicare support to seniors in **Washington**, **Oregon, Idaho**, **Montana, and Alaska**.

Where can I get more information or personalized insurance help?

Connexion offers no cost, no obligation Medicare Insurance consultations as well as a free Medicare Information Helpline on year-round at **877.315.3279 (TTY 771, Mon-Fri 8am – 5pm)**. You can also visit them online at www.MedicareConnexion.com

PacMed also partners with Connexion to offer no-cost, no-obligation Educational Workshops throughout the year. Find scheduled dates on the Connexion website above or by visiting www.pacmed.org/Medicare.

The official Medicare website can be found at www.Medicare.gov.

Washington State also has a team of volunteers to help with insurance questions, known as SHIBA (Statewide Health insurance Benefits Advisors). They also offer a free Insurance Consumer Hotline at **800.562.6900**. Learn more at www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba