



Medicare Basics

Who

Anyone 65 or older, or who has a qualifying disability for 2 or more years is eligible for Medicare.

What

Medicare is Federal Health Insurance Plans for those who qualify vs Medicaid which is Federal Health Insurance given to those with qualifying low incomes.

When

Medicare Open Enrollment is October 15th-December 7th. Private insurance representatives receive a commission for signing you up for plans.

Where

You can receive help with Medicare using public resources like Nebraska Area Agency on Aging, who's contact information is on the attached sheet.

Parts of Medicare

Understand the A,B,Cs of
Medicare Coverage



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Part A 

Call Social Security 800-329-5527

Hospital Stays (inpatient), **Skilled Nursing, Hospice**

Part B 

Doctor Visits (outpatient), **Screenings and Vaccines,**
Home Health Care, Durable Medical Equipment

Part C 

**Medicare Advantage: Part A & B, some extra
benefits, and exceptions.**

Part D 

Call Medicare 800-633-4227

Prescription Drug Coverage

Know the Difference

Traditional Medicare vs Medicare Advantage

Medicare Advantage is not the same as traditional Medicare. There are key differences that can have a real impact on how, when and where you get the medical care you might need.



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Traditional Medicare



Most doctors participate in traditional Medicare. You can see any doctor, anywhere in the U.S.



No referrals required to see a specialist.



Services are covered no matter where you are in the U.S.



No limit. A doctor decides how long you need to stay based on condition and needs.



Your doctor decides with you if you need a diagnostic procedure.



Your doctor decides with you if you need home health or medical equipment.



Services are covered.

ACCESS TO DOCTORS

SPECIALISTS

ACCESS TO CARE WHEN TRAVELING

HOSPITAL STAY LIMITS

LAB, X-RAY, & DIAGNOSTIC SERVICES

HOME HEALTH & MEDICAL EQUIPMENT

Physical/ Occupational/ Speech Therapy

Medicare Advantage



Most plans limit the doctors you can see. A needed specialist might not participate in your plan.



Referrals or prior plan approval are almost always required before you can see a specialist.



Coverage is usually limited to doctors and services in the plan's network and geographic area.



A plan can limit a hospital stay and make decisions that are different from a doctor's recommendations.



Most plans require approval for services that can take up to 3 days and be denied, even if a doctor orders the procedure.



Most plans require pre-approval for home health or medical equipment. Approval can take up to 3 days and be denied.



Requires authorization, potential delay in care waiting for decision. Limited number of visits and out-of-pocket copays required per visit.

“Even though they are supposed to follow the same rules and regulations as Traditional Medicare, we are finding additional barriers to care.” - Robert Dyer, CEO CCHS





Medicare Resources

Nebraska Area Agency on Aging



(308)535-8195

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