Medicare Made Simple

Your how-to guide to help you choose
the right Medicare plan.

ClearMatch™
MEDICARE

Your ClearMatch Medicare Agent:

_____

Phone Number:

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Welcome to ClearMatch™ Medicare!

We match each customer with the right plan at the right price to deliver better health and peace of mind. Our goal is to make sure you get all the benefits you deserve.

We have been helping people choose the right Medicare plan since 2006 and have sold over 150,000 policies in that time. With agents licensed in every state and access to over 7,000 plans, we are committed to helping you find the plan that best fits your needs and budget.

With ClearMatch Medicare, you can expect:

Educational Guidance

Our licensed insurance agents know Medicare inside and out. They will get to know what your plan needs are and help you choose the plan that's right for you.

Unbiased, Personal Support

They don't work for the insurance companies, they work for you. Our agents are here to make sure you find the plan that is best for your needs.

Accurate Enrollment

Once you have selected a plan, your agent will assist you with enrollment, ensuring your application is processed correctly.

Continued Support After Enrollment

We will continue to be your advocate for the lifetime of your enrollment. If your medications or doctors change or you move, contact your agent to see if any changes are necessary.

The A, B, C, & D's: Navigating the Medicare Alphabet

You may have heard that Medicare has four parts:
Part A, Part B, Part C and Part D.

Here is a quick overview of each part:

PART A – HOSPITAL INSURANCE

Hospital insurance is free to those who paid Social Security taxes for 10 years (40 calendar quarters); others pay monthly premium. Part A covers most hospital, home health, skilled nursing facility, and hospice care if deemed medically necessary.

PART A IS FREE FOR THOSE WHO WORKED OR PAID SOCIAL SECURITY TAXES FOR 10 YEARS.

PART B – MEDICAL INSURANCE

Medical insurance has a monthly premium and covers mostly medically necessary doctors' services, including:

- Preventive care
- Hospital outpatient services
- Laboratory tests
- X-rays
- Mental healthcare
- Home health
- Ambulance services

PART C – MEDICARE ADVANTAGE

Medicare Part C may require a monthly premium in addition to your Part B premium. Medicare Advantage (MA) most closely resembles traditional health insurance. Part C includes the same coverage as Part A & B, but may include additional coverage, such as vision and dental. Beneficiaries who choose Medicare Advantage choose a Medicare policy offered by a private insurance company, with HMO and PPO plans being the most popular options.

MANY MA PLANS INCLUDE DRUG COVERAGE, BUT NOT ALL. IF YOUR PLAN DOES NOT, YOU MAY ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN.

PART D – OUTPATIENT PRESCRIPTION DRUG INSURANCE

Medicare Part D provides prescription drug coverage for beneficiaries choosing original Medicare. It requires a monthly premium and is provided through private insurers.

PART D IS ONLY AVAILABLE THROUGH PRIVATE INSURANCE COMPANIES

ClearMatch™ MEDICARE

Medicare Parts A & B: What is Covered

If you or your spouse worked and paid Social Security taxes for at least 10 years, you will receive Part A for free. Medicare Part A covers you for a variety of services during your hospitalization, including semi-private rooms, hospital services and supplies, the doctor, emergency room services, and drugs prescribed for your treatment. Hospice, skilled nursing facility and home health services are also covered by Part A. While this coverage is offered to you at no cost, there is a deductible for hospital stays and you may have co-payments for longer stays.

Medicare Part B covers preventative care, doctor visits, outpatient care, home health services, medical equipment, mental health services and other medical services. There is a monthly premium associated with this coverage, as well as a yearly deductible before Medicare pays. When you reach your deductible, you typically pay 20% of the Medicare-approved amount of the service. You won't need to pay for covered preventative services from a doctor or qualified health care provider that accepts Medicare.

For more information on what Medicare Part A and Part B cover, visit www.clearmatchmedicare.com.

Medicare Parts A & B: What isn't Covered

- Most dental care
- Eye examinations related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Long-term care
- Medical care overseas

Medicare Part D:

Medicare Part D is available through private insurance companies, not through the Federal government, and provides coverage for generic and brand-name drugs. You will need to pay a separate monthly premium for this coverage, along with co-pays for your prescriptions. Prescription drug plans vary by types of drugs covered, how much you pay and the pharmacy you can use, so it's important to review the different plans to find the one that is right for your needs.

The Donut Hole

Most Medicare Part D prescription drug plans have a coverage gap which is also referred to as the "donut hole." This means that the prescription drug plan places a temporary limit on what it will cover for prescription drugs. The coverage gap begins after you and your prescription drug plan together have spent a specific amount for covered prescription drugs for that year.

The amount varies each year, and once you and your plan reach this limit, you will pay no more than 25% of the price for brand names prescription drugs and up to 25% for generic prescription drugs. A person's yearly deductible, coinsurance/co-payments, and what a person pays while in the coverage gap all count toward this yearly limit. The limit doesn't include premiums paid monthly, pharmacy dispensing fees or what a person pays for prescription drugs that aren't covered by the prescription drug plan.

What You Pay During Initial Coverage	
Deductible, Co-Payments and Co-Insurance (all of which vary by plan)	Until total spending (i.e., both your out-of-pocket cost and spending by insurance company) reaches $4,430

What You Pay When You Reach Coverage Gap	
25% of cost of brand-name drugs 25% of cost of generic drugs	Until you reach $7,050 in out-of-pocket spending (includes manufacturer's contribution to cost of brand-name drugs)

What You Pay When You Reach Catastrophic Coverage	
The greater of $9.85 or 5% for brand name drugs and the greater of $3.95 or 5% for generic drugs.	$7,050 or more in out-of-pocket spending

Medicare A + B + D = More Coverage May Be Needed

So, now that we've gone through Parts A, B & D, you may come to realize Original Medicare does provide you with the coverage you need, but it may not cover everything. Medicare Advantage Plans (Part C) and Medicare Supplement Plans (Medigap) pick up where Original Medicare leaves off. Which plan should you choose? Well, that depends on your needs and your budget. Here's a brief description of each plan:

Medicare Part C: Medicare Advantage

Medicare Advantage, or Part C, combines Parts A & B with other benefits, such as prescription plans. It's more like an HMO or PPO, which you may be more familiar with. These plans are provided by private insurance companies but are Medicare approved. Most Medicare Advantage Plans offer extra coverage, like vision, hearing, dental, and other health and wellness services

With this coverage, however, you can only use the providers in the plan's network. And along with your Part B premium, you may have to pay monthly premium for your Medicare Advantage Plan and the co-pays needed for your doctor visits and prescription drugs.

Medicare Supplement Plans: Closing the Gap

Medicare Supplement, or Medigap, plans help to cover the costs — or fill in the "gap" — in coverage that Medicare Parts A & B don't cover, like co-payments, co-insurance and deductibles. These plans are also provided by private insurance companies and must follow Federal and state laws. There are many different plans available in most states and they are labeled by letters. Coverage levels and premiums vary by plan and carrier, but the benefits within each plan are the same.

You do need to be enrolled in Parts A & B to be eligible for Medicare supplement coverage, and you will need to have a separate Part D (Prescription Drug Plan) coverage. But the way it works, if you have a hospital bill, Original Medicare will pay first and then your Medicare supplement plan will fill in the gaps. And you can go to any provider that accepts Medicare.

Eligibility: When To Sign Up

You can sign up for Medicare three months before and after your 65th birthday. This is called the initial enrollment period.

You must also fall into the following criteria:

Original Medicare

- You are 65 years or older and eligible to receive Social Security
- You must be a U.S. resident or have been a legal resident for five consecutive years
- You are under 65, are permantly disabled and have received Social Security disability payments for a least 2 years
- You require ongoing dialysis for end-stage renal disease (ESRD) or need a kidney transplant

Medicare Supplement Plans

- You must be eligible for Medicare Part A and enrolled in Part B
- You must live in the Plan's service area
- You continue to pay your Part B premium (and Part A, if applicable)

Medicare Advantage Plans

- You must be eligible for Medicare Part A and enrolled in Part B
- You must live in the Plan's service area
- You continue to pay your Part B premium (and Part A, if applicable)

Medicare Prescription Plans

- You must be eligible for Medicare Part A and enrolled in Part B
- You must live in the Plan's service area
- You continue to pay your Part B premium (and Part A, if applicable)

We Know Medicare

At ClearMatch™ Medicare, we're experts at one thing: Medicare. Our licensed insurance agents know it back to front, which means they also know that it can be complicated, confusing, and overwhelming. They are committed to "de-complexifying" Medicare for customers across the country.

Our experienced agents pride themselves on treating our customers with genuine empathy, truly taking the time to understand the person beyond the plan. They take the time to really listen and get to know our customers, so we can tailor solutions for each them, one at a time, every time.

Glossary of Medicare Terms

AEP (Annual Election Period) – This is the period of time each year when you are able to make changes to your Medicare Advantage Plan and Medicare Prescription Drug Plan. This includes switching from a Medicare Advantage Plan back to Medicare Parts A and B. The AEP spans from Oct. 15 to Dec. 7.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency within the U.S. Department of Health and Human Services. CMS covers millions of people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. CMS works to provide better coverage at lower costs and to improve the overall health of its members.

Co-insurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Co-insurance is usually a percentage (for example, 20%).

Co-payment (co-pay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A co-payment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost sharing – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include co-payments, co-insurance, and/or deductibles.

Coverage Gap – A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

Deductible – The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Formulary – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Medicare Advantage – A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medigap Policy – Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare – Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out-of-pocket costs – Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Part D (prescription drug plan) – Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

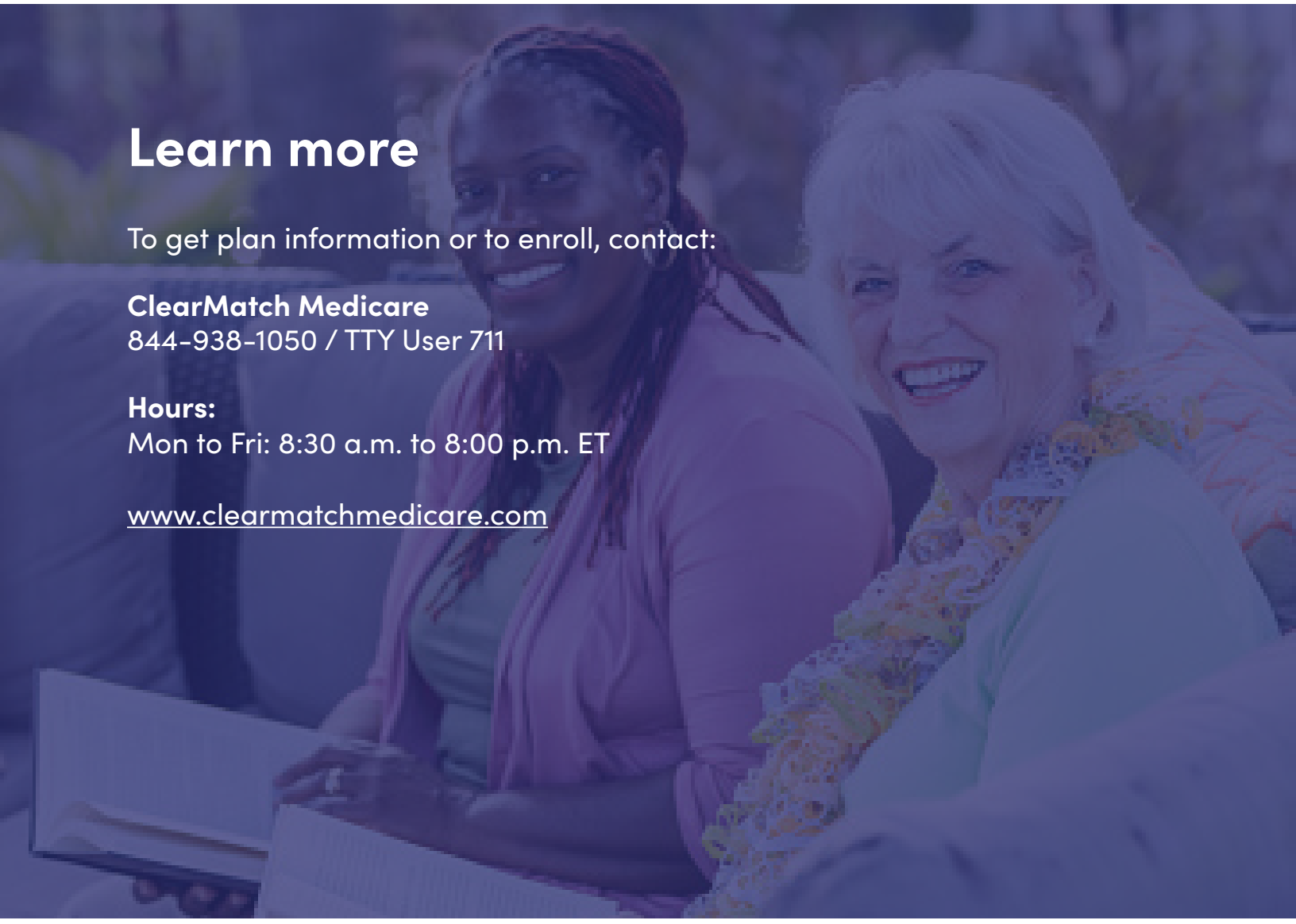
Preventive care – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Service area – A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may dis-enroll you if you move out of the plan's service area.

Source: Medicare & You 2020

Notes

Notes



Learn more

To get plan information or to enroll, contact:

ClearMatch Medicare
844-938-1050 / TTY User 711

Hours:
Mon to Fri: 8:30 a.m. to 8:00 p.m. ET

www.clearmatchmedicare.com

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