



INTERMOUNTAIN

I N S U R A N C E



Your Guide to Medicare Coverage

Medicare guidance for residents of Eastern Oregon

Medicare can provide excellent health coverage, but the choices you make when you first become eligible can affect your doctors, prescription costs, monthly premiums, and future ability to buy supplemental coverage.

Intermountain Insurance helps Eastern Oregon residents understand Medicare choices in the context of rural provider access, travel for specialty care, prescription needs, and the way different coverage options work outside your immediate community.

Whether you are approaching age 65, retiring after 65, already enrolled in Medicare, or helping a parent or spouse review coverage, this guide explains the major decisions and the questions worth asking before you enroll or change plans.

Need help now?

Call Intermountain Insurance at (541) 314-9075 or email josh@intermountain.insure.

Medicare in plain English

Medicare is the federal health insurance program for people age 65 and older and for certain younger people who qualify because of disability, End-Stage Renal Disease, or ALS. Medicare is divided into several parts, and understanding what each part does makes the rest of the process much easier. ([Medicare.gov](https://www.medicare.gov))

- **Part A - Hospital Insurance.** Helps cover inpatient hospital care, skilled nursing facility care in qualifying situations, hospice care, and certain home health services.

- **Part B - Medical Insurance.** Helps cover doctors, outpatient care, preventive services, durable medical equipment, and many other medically necessary services.
- **Part C - Medicare Advantage.** A private Medicare-approved alternative to receiving Part A and Part B through Original Medicare. Most Medicare Advantage plans also include Part D prescription drug coverage.
- **Part D - Prescription Drug Coverage.** Helps pay for outpatient prescription medications through a private Medicare-approved drug plan.

A Medicare Supplement policy, commonly called **Medigap**, is not another part of Medicare. It is private supplemental insurance designed to help pay certain out-of-pocket costs left by Original Medicare.

The first big decision: Original Medicare or Medicare Advantage?

Once you have both Part A and Part B, there are two main ways to receive Medicare coverage. Neither approach is automatically best for everyone. The right fit depends on your health care use, providers, medications, budget, travel patterns, and tolerance for network rules and variable cost sharing. (Medicare.gov)

	Original Medicare	Medicare Advantage
How coverage works	Part A + Part B from the federal Medicare program. You may add Part D and Medigap.	Private Medicare-approved plan replaces how you receive Part A and Part B benefits; most plans include Part D.
Doctors & hospitals	Any provider in the U.S. that accepts Medicare.	Usually a local or regional network for non-emergency care; rules vary by plan type.
Out-of-pocket limit	No annual medical out-of-pocket maximum unless you have supplemental coverage.	Plans have an annual limit for covered Medicare medical services.
Drug coverage	Usually purchased separately through a stand-alone Part D plan.	Included in most Medicare Advantage plans.
Supplement	You may buy Medigap if eligible.	You cannot use Medigap to cover Medicare Advantage cost sharing.
Prior authorization	Generally less common for Original Medicare-covered services.	May be required for certain services or supplies.

For Eastern Oregon residents, the provider-access difference deserves special attention. Original Medicare generally allows you to see any doctor or hospital that accepts Medicare anywhere in the United States. Medicare Advantage plans may require you to use a plan network for non-emergency care, although PPO and other plan types may provide some out-of-network coverage at a higher cost. Emergency and urgent care remain available when needed even when a provider is outside a Medicare Advantage network. (Medicare.gov)

Why rural provider networks matter in Eastern Oregon

A Medicare plan should be evaluated based on how you actually receive care - not just the premium printed on the first page of a brochure.

Many Eastern Oregon residents receive routine care locally but may travel for certain specialists, surgery, cancer treatment, advanced imaging, or other complex services. If you are considering Medicare Advantage, confirm that the plan works with the providers and facilities you are likely to use both locally and when referred outside your immediate area.

Before enrolling, check your primary care provider, specialists, local hospital, preferred pharmacies, and any out-of-area facilities you use. If you spend part of the year in another state, ask specifically how routine and follow-up care will work away from the plan service area. Provider directories can change, so it is also wise to verify participation directly with the provider and the plan.

A local issue worth slowing down for

Eastern Oregon checklist: Do not compare Medicare Advantage plans by premium alone. Compare network access, referral rules, prior authorization, maximum out-of-pocket exposure, drug coverage, and how the plan handles care when you travel or are referred outside the region.

Original Medicare and Medigap

Original Medicare covers much of the cost of Medicare-approved services, but it does not cover everything. After the Part B deductible, beneficiaries generally pay 20% of the Medicare-approved amount for Part B services, and Original Medicare has no annual medical out-of-pocket maximum by itself. (Medicare.gov)

A Medigap policy can help pay some of the deductibles, copayments, and coinsurance left by Original Medicare. Medigap policies are standardized by letter, so the medical benefits of a particular lettered plan are the same regardless of which insurance company sells it; premiums and other company features can still differ. (Medicare.gov)

Medigap does **not** replace Original Medicare, and it generally does not provide outpatient prescription drug coverage. Someone using Original Medicare plus Medigap will commonly also enroll in a separate Part D plan.

Your Medigap enrollment window matters

Federal law gives most people a one-time **six-month Medigap Open Enrollment Period** beginning the first month they are age 65 or older and enrolled in Part B. During that period, an insurer generally cannot deny a Medigap policy because of your health history. After that period, medical underwriting may apply unless you have a guaranteed-issue right. (Medicare.gov)

That makes the decision to begin with Medicare Advantage versus Original Medicare plus Medigap more important than it may first appear. You can change Medicare Advantage plans during permitted enrollment periods, but moving later from Medicare Advantage to Original Medicare does not always guarantee that you can buy the Medigap policy you want.

Oregon Medigap Birthday Rule

Oregon provides an additional protection known as the **Medigap birthday rule**. Beginning 30 days before your birthday and continuing for 30 days after, an Oregon Medigap policyholder may replace an existing Medigap policy with another policy having the same or lesser benefits without health-status underwriting. (Oregon DFR)

The birthday rule helps existing Medigap policyholders shop premiums each year, but it does not create an unrestricted right to move from Medicare Advantage into any Medigap plan.

Medicare Advantage: what to compare

Medicare Advantage plans must cover medically necessary services that Original Medicare covers, but plans can differ significantly in how members access care and what they pay. Many include prescription drug coverage and may also offer benefits Original Medicare does not routinely cover. (Medicare.gov)

When comparing plans, look beyond extra benefits and ask practical questions:

- Are your doctors, specialists, hospital, and preferred facilities in network?
- Is the plan an HMO, PPO, or another plan type, and what happens when you receive non-emergency care outside the network?
- What services require referrals or prior authorization?
- What is the annual medical maximum out-of-pocket amount?
- How are inpatient hospital stays, outpatient surgery, diagnostic imaging, chemotherapy, specialist visits, and ambulance services charged?
- Are your medications on the formulary, at what tier, and which pharmacies provide the lowest cost sharing?

Medicare Advantage plans have an annual limit on what you pay for covered Medicare medical services. Once that plan limit is reached, the plan pays 100% of covered medical services for the remainder of the year. The limit and the costs that accumulate toward it vary by plan. (Medicare.gov)

Prescription drugs: Part D deserves its own review

A Part D plan should be selected around the medications you actually take. Premium alone can be misleading because formularies, drug tiers, preferred pharmacies, deductibles, and cost-sharing rules differ from one plan to another and can change each year.

In **2026**, no Medicare Part D plan may have a deductible above **\$615**, and Part D out-of-pocket spending on covered drugs is capped at **\$2,100** for the year. After reaching the 2026 out-of-pocket threshold, you enter catastrophic coverage and pay \$0 for covered Part D drugs for the rest of the year. These dollar amounts are indexed and may change in future years. (Medicare.gov)

The **Medicare Prescription Payment Plan** is also available through all Part D plans. It can spread eligible out-of-pocket prescription costs across monthly payments during the plan year rather than requiring the entire amount at the pharmacy counter. It changes when you pay those costs, not the total amount you owe. (CMS)

If you go **63 days or more** without Part D or other creditable drug coverage after you are eligible, a Part D late-enrollment penalty may apply and can continue for as long as you have Part D coverage. (Medicare.gov)

When should you enroll in Medicare?

For most people who become eligible at age 65, the **Initial Enrollment Period** lasts seven months: the three months before the month you turn 65, the month you turn 65, and the three months afterward. When coverage begins depends on when you enroll. (Medicare.gov)

Some people who are already receiving Social Security or Railroad Retirement Board benefits are enrolled automatically. Others must actively enroll through Social Security. Do not assume that turning 65 automatically starts Medicare in every situation.

Missing the right enrollment window can create a coverage gap and may trigger lifetime Part B or Part D late-enrollment penalties. If you are uncertain about your date, verify it before your current coverage ends.

Still working at 65? Do not assume you should delay Medicare

People who continue working past age 65 often have more complicated enrollment decisions. Whether Medicare or the employer plan pays first can depend on employer size and the type of coverage you have.

For a person age 65 or older with coverage based on **current employment**, a group health plan from an employer with **20 or more employees** generally pays first and Medicare pays second. If the employer has **fewer than 20 employees**, Medicare generally pays first. In the smaller-employer situation, delaying Part A or Part B can leave bills that the employer plan may not pay. (Medicare.gov)

COBRA, retiree coverage, VA coverage, and individual Marketplace coverage are not treated the same as active-employment group coverage for the Part B Special Enrollment Period. If you are working past 65, confirm your situation with your employer benefits administrator and Social Security before delaying Part B. (Medicare.gov)

HSA warning

If you contribute to a **Health Savings Account (HSA)**, Medicare enrollment requires special planning. You cannot make HSA contributions after Medicare begins, and premium-free Part A can be retroactive for up to six months when you enroll later. Medicare advises people who delay Medicare while working to generally stop HSA contributions six months before they retire or apply for Social Security/Medicare benefits to avoid possible tax problems. (Medicare.gov)

2026 Medicare cost snapshot

Medicare costs change annually. For **2026**, most beneficiaries pay no Part A premium because they or a spouse paid Medicare taxes long enough while working. The Original Medicare Part A inpatient deductible is **\$1,736 per benefit period**. The standard Part B premium is **\$202.90 per month**, and the annual Part B deductible is **\$283**. Higher-income beneficiaries may pay an additional income-related amount for Part B and Part D. (Medicare.gov)

Those figures are useful for understanding the structure of Medicare, but they should not be used to choose a plan by themselves. Medicare Advantage premiums and cost sharing, Medigap premiums, and Part D premiums vary by plan and location.

When can you change Medicare plans?

Medicare has several enrollment periods, and the rules are not interchangeable.

- **Annual Medicare Open Enrollment: October 15 - December 7.** You can switch Medicare Advantage plans, move between Original Medicare and Medicare Advantage, or join/change/drop Part D coverage. Changes generally take effect January 1.
- **Medicare Advantage Open Enrollment: January 1 - March 31.** If you are already enrolled in Medicare Advantage, you may make one change to another Medicare Advantage plan or return to Original Medicare and, if needed, join a Part D plan. This period cannot be used to move from Original Medicare into Medicare Advantage.
- **Special Enrollment Periods.** Certain events - such as moving out of a plan service area, losing other coverage, qualifying for Extra Help or Medicaid, or other specified circumstances - can create additional opportunities to change coverage.

Enrollment rules can be particularly important when a change also involves Medigap, because a Medicare plan enrollment period does not automatically create a guaranteed right to buy a Medigap policy. (Medicare.gov)

Review your coverage every fall

Medicare Advantage and Part D plans can change premiums, copays, formularies, pharmacy networks, provider networks, service areas, and other benefits from year to year. Your medications and medical needs may change too.

If you are enrolled in a Medicare plan, your **Annual Notice of Change (ANOC)** arrives each fall and describes changes taking effect the following January. Medicare advises members to review the ANOC and Evidence of Coverage every year rather than assuming the current plan will remain the best fit. (Medicare.gov)

Planning for 2027

Updated August 2026

Plan-specific 2027 premiums, formularies, provider networks, and benefit designs should be reviewed when the new plan-year information becomes available this fall. Annual Medicare Open Enrollment remains **October 15 through December 7**, with changes generally effective January 1.

If you currently have Medicare Advantage or Part D, use your fall Annual Notice of Change as the starting point - then compare the new-year options using your current doctors, prescriptions, pharmacies, and anticipated care.

Help paying Medicare costs

People with limited income and resources may qualify for programs that reduce Medicare costs. **Medicare Savings Programs** can help eligible beneficiaries with Part A and/or Part B costs, and **Extra Help** can reduce Part D premiums, deductibles, and prescription cost sharing. (Medicare.gov)

Oregon residents can also contact the **Senior Health Insurance Benefits Assistance (SHIBA)** program for free, unbiased Medicare counseling. SHIBA can help explain Medicare, Medicare Advantage, Part D, Medigap, and financial-assistance programs. Oregon SHIBA can be reached at **800-722-4134**. (Oregon SHIBA)

A Medicare checklist for Eastern Oregon residents

Before choosing or changing coverage, gather the information that will actually drive the decision:

- Your Medicare effective dates and whether you have active employer, retiree, VA, TRICARE, Medicaid, or other coverage.
- Your primary doctor, specialists, local hospital, and any hospitals or specialty centers you may travel to for care.
- A complete medication list including dosage, frequency, and preferred pharmacy.
- Your anticipated medical use: specialist visits, imaging, therapy, infusion drugs, surgery, durable medical equipment, or other recurring care.
- How often you travel outside Eastern Oregon or live elsewhere for part of the year.
- Your preference between predictable monthly premiums and paying more of your costs when services are used.
- If considering Original Medicare plus Medigap, whether you are currently within a guaranteed-issue or open-enrollment window.

How Intermountain Insurance Can Help

Medicare is not simply a question of choosing the plan with the lowest monthly premium.

At **Intermountain Insurance**, our goal is to help you understand how your Medicare coverage choices fit the way you actually receive health care. We can help you organize the decision around provider access, prescription coverage, cost sharing, travel needs, and the differences between Original Medicare, Medicare Advantage, Medigap, and Part D.

We understand that health care access in Eastern Oregon can require a different set of questions than it does in a large metropolitan area. Local provider participation, specialty referrals, distance to care, and out-of-area access all deserve attention before you enroll.

Ready to review your options?

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