The Idaho

Shopper's Guide to Medicare 2021

Idaho Resources for:

- ✓ Medicare Advantage
- ✓ Medigap/Medicare Supplement
- ✓ Medicare Prescription Drug Plans/Part D
- ✓ Long-Term Care Insurance
- ✓ Dental Insurance

Senior Health Insurance Benefits Advisors (SHIBA) A **free service of the Idaho Department of Insurance**

1-800-247-4422 or SHIBA.idaho.gov

SHIBA

IDAHO DEPARTMENT OF INSURANCE
Dedicated to Serving and Protecting Idahoans

Senior Health Insurance Benefits Advisors

DEPARTMENT OF INSURANCE
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To Idaho's Medicare Beneficiaries:

The 2021 Consumer Guide to Medicare, Idaho Shopper's Guide, has been prepared especially for you by the Idaho Department of Insurance office of Senior Health Insurance Benefits Advisors (SHIBA). The Guide provides information you will need to make informed Medicare plan choices.

SHIBA counselors are trained to assist you by explaining options to help you make better informed decisions about your plan for the coming year. We appreciate our dedicated volunteers who generously give of their time providing free help to their neighbors.

Whether you are a disabled or senior citizen Medicare recipient, this guide is for you and your caregivers and family members. Take advantage of our SHIBA support network by calling our toll-free number, 1-800-247-4422, to make an appointment with a SHIBA counselor.

After reviewing this guide, if you want to speak with someone who can make a specific plan recommendation, I would encourage you to contact a local, licensed insurance agent or broker.
Sincerely,

Dean Cameron
Director

The Senior Health Insurance Benefits Advisors (SHIBA) program produced this guide with assistance, in whole or in part, through a grant from the Administration for Community Living (ACL), the federal agency supporting Medicare benefits and fraud education. Information supplied in this guide is in the public domain and may be copied and distributed without permission.

Publication Date: February 2021

SMP Empowering Seniors To Prevent Healthcare Fraud

ship NATIONAL NETWORK state health insurance assistance programs
Local Help for People with Medicare

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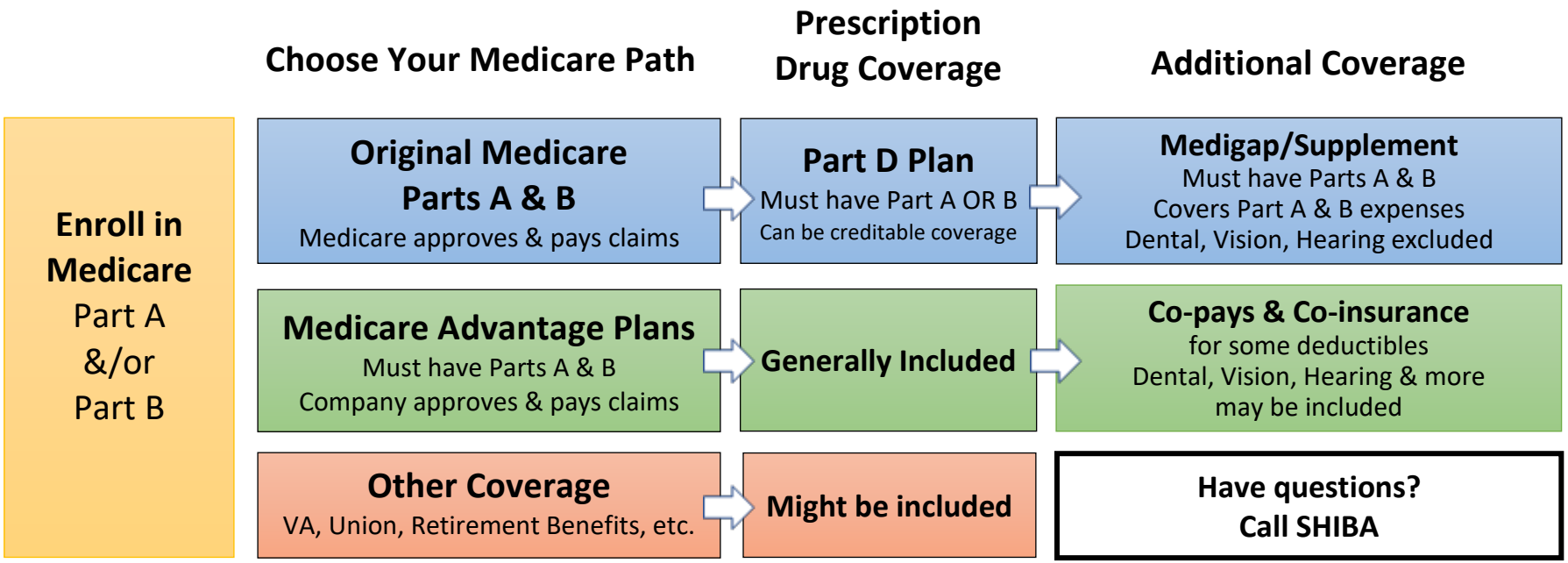
GETTING STARTED: Your Medicare Options

Medicare Part A and Part B cover hospital and medical services but leave part of the cost for you to pay, and provide no limit to what you could owe. There are options that can help pay your share of the costs, including prescription coverage.

Whichever Medicare path is best for you, please follow these important principles:

1. Verify that your preferred doctors, other medical providers and hospitals accept the insurance you're considering. Call their business offices to confirm.
2. Use the Plan Finder tool at www.medicare.gov to ensure the Part D or Medicare Advantage Plan you want covers your prescription drugs.
3. Keep records. Document phone calls (the date, time, name, number, and notes) and save important letters.



The ABC's, and D, of Medicare

Medicare is federal health insurance for:

- People who are 65 years old or older
- People under age 65 who have received Social Security Disability Insurance (SSDI) payments for more than 24 months
- People with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)

This Guide will help you understand how Medicare works, and to decide if you should choose additional insurance to supplement Medicare coverage. There are five elements you should understand, and each is covered in these pages.

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Medigap Plans, also known as Supplements
- Part C: Advantage Plans
- Part D: Prescription Drug Plans

Like most insurance, Medicare requires beneficiaries to share the costs of their care. Many people choose to purchase additional insurance to help manage their cost share.To choose your coverage wisely, it's important to have an idea what things Medicare *does not cover*.

Some services <u>not</u> covered by Medicare Part A or Part B:

- Long-term care
- Alternative care, such as acupuncture and naturopathy
- Routine vision care and eyeglasses
- Annual physicals with lab tests
- Care outside the United States (with limited exceptions)
- Prescription drugs
- Hearing exams and hearing aids
- Dental care

Save Money with Social Security Extra Help & Idaho Medicare Savings Programs

Two programs are available to help people with Medicare stretch their healthcare dollars.

1. **Extra Help - help with prescription drug costs**

   Also called the Limited Income Subsidy (LIS).
   Qualifying beneficiaries save money on Medicare Part D plans and prescription drug costs.

- Reduces the plan's monthly premium, often to $0.00
- Reduces the yearly deductible, often to $0.00
- Reduces and limits pharmacy copay amounts, even on very expensive prescriptions
- Allows you to change plans during the year

Eligibility is based income, assets and marital status.
The Income/asset limits for 2021:

Single:
Income - $1,630 per month or $19,560 per year
Assets - $14,790
Couples:
Income: $2,197.50 per month or $26,370 per year
Assets: $29,520

H**ow to apply for Extra Help:**

- Visit your local Social Security office or
- Fill out an application online at **www.ssa.gov or** call Social Security

  1-800-772-1213

2. **Idaho Medicare Savings Programs (MSP) - help with Part A and Part B premiums, deductibles and co-payments, *and* prescription drug costs**

   Medicare Savings Programs may pay Medicare Part B premiums. An MSP might also pay Part A and Part B deductibles, co-payments and co-insurance, depending on your income.

   MSP's automatically include Part D Extra Help benefits **To see if you qualify or to apply:**

- Call Health and Welfare at **1-877-456-1233**
- Visit a Health and Welfare office
- Download an application at **www.healthandwelfare.idaho.gov**

If you have Medicare and full Medicaid or Supplemental Security Income (SSI), you're already enrolled in these programs.

Neither the Extra Help (LIS) program nor the Medicare Savings Programs will attach your assets to recover costs. Medicaid, however, may. For more information, call the Idaho Medicaid Estate Recovery Office at 1-866-849-3843.

Part A – Original Medicare Hospital Insurance

Service	Benefit	You Pay[1]
Hospitalization Inpatient, not observation; semiprivate room and board; general nursing; and miscellaneous hospital services and supplies	First 60 days	$1,484 deductible per benefit period[2]
	Days 61 – 90	$371 per day
	Days 91 – 150[3]	$742 per day
	Beyond 150 days	All costs
Skilled Nursing Facility (SNF) After three midnights of inpatient hospitalization, within 30 days of discharge, in a facility approved by Medicare	Days 1 – 20	$0.00
	Days 21 – 100	$185.50 per day
	Beyond 100 days	All costs
Home Health Care	Visits limited to part-time or intermittent skilled care	Nothing for services
Hospice Care Available only to the terminally ill	As long as a doctor certifies medical need	Limited cost-sharing for outpatient drugs and inpatient respite care
Blood	Blood	First three pints unless replaced[4]

Amounts are subject to change each year.

[1] There is no Part A premium for most people. People who are not eligible for premium free Part A will pay a monthly premium up to $471.

[2] An inpatient hospital or SNF benefit period begins the day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or associated SNF for 60 days in a row. You could experience several benefit periods and pay several deductibles in a calendar year.

[3] You get 90 lifetime reserve days. Once these days are used, they are not replaced. There is a 190-day lifetime limit for inpatient mental health services.

[4] You may meet this deductible under either Part A or Part B.

Remember: Medicare pays only for Medicare-approved charges, not for the costs of all medical services provided.

Part B – Original Medicare Medical Insurance

Covered Services[1]	You Pay Monthly Part B Premium[2] Plus:
Physician services	20% of Medicare-allowed amount after annual deductible[3]
Emergency room, urgent care	20% of Medicare-allowed amount after annual deductible
Hospital observation stay	Co-payment determined by Medicare payment formula[4] after annual deductible
Diagnostic tests, MRIs, CT scans, and x-rays	20% of Medicare-allowed amount after annual deductible
Diabetes supplies: test meters, strips, and lancets	20% of Medicare-allowed amount after annual deductible
Drugs administered in outpatient facility	20% of Medicare-allowed amount after annual deductible
Physical, occupational, and speech therapy	20% of Medicare-allowed amount after annual deductible; annual limit on amount Medicare covers
Durable Medical Equipment, prosthetics/orthotics, supplies (DMEPOS)	20% of Medicare-allowed amount after annual deductible
Ambulance transportation	20% of Medicare-allowed amount after annual deductible
Home health care (same as Part A)	Nothing for covered services
Outpatient mental health treatment	20% of Medicare-allowed amount after annual deductible
Preventive services, some clinical lab services (blood tests, urinalysis)	Nothing for most tests or procedures; fees for office visits or other costs may apply

[1] These rules apply only to Medicare-approved services.

[2] The Part B premium may vary according to income or penalties. The standard premium is $148.50 in 2021.

[3] The standard part B deductible is $203 per year in 2021 for covered services or items. After that, Medicare pays 80% of the allowed amount and you pay 20% if the provider accepts assignment. **There is no out-of-pocket maximum.**

[4] The Outpatient Prospective Payment System determines your share of payment, which varies by region, hospital, and the services you receive. Call Medicare at **1-800-633-4227** for more information.

Part B Preventive Services

Whether you choose Original Medicare or a Medicare Advantage plan, you are encouraged to make full use of Medicare-covered preventive services. Many of these screening procedures and vaccinations are free if you get them from a provider who accepts Medicare assignment or, in the case of Medicare Advantage plans, from a provider who is in-network. Be aware that you may still have to pay certain fees for the services you receive. Ask your doctor about which services are right for you.

To track when you are eligible for your next test sign up for an account at **www.MyMedicare.gov**.

"Welcome to Medicare" Preventive Visit (one-time)
Annual "Wellness" Visit
Abdominal Aortic Aneurysm Screening
Alcohol Misuse Screening and Counseling
Bone Mass Measurement
Breast Cancer Screening (Mammogram) and **Diagnostic Tests**
Cardiovascular Disease (CVD) Risk Reduction Visit
Cardiovascular Disease Screenings
Cervical and Vaginal Cancer Screenings (Pap Tests and Pelvic Exams) with Clinical Breast Exam
Colorectal Cancer Screenings -Fecal Occult Blood Test -Flexible Sigmoidosocopy -Colonoscopy -Barium Enema*

***These services are subject to cost-sharing**

Depression Screening
Diabetes Screenings and **Self-Management Training***
Flu Shots
Glaucoma Tests*
Hepatitis B Screening and Shots
HIV Screening
Lung Cancer Screening
Medical Nutrition Therapy Services
Obesity Screening and Counseling
Pneumococcal Shot
Prostate Cancer Screening
Sexually Transmitted Infection Screening and Counseling
Tobacco Use Counseling and **Counseling to Prevent Tobacco Use**

Medicare Beneficiaries Under 65

If you are between ages 18 and 65 and qualify for Social Security Disability Insurance (SSDI), your Medicare starts after you've received SSDI checks for 24 months. If you have Amyotrophic Lateral Sclerosis (ALS), the 24-month waiting period is waived. People who have End-Stage Renal Disease (ESRD) may also get Medicare at any age.

Anyone who is under 65, and newly eligible for Medicare, may enroll in a Medigap plan in Idaho, but deadlines may apply. See page 17 for details.

You may enroll in any Medicare Advantage (MA) plan available in your county. As of January 1, 2021, Beneficiaries with existing ESRD are also eligible to join a MA or MAPD plan. If you are already in a plan before you develop ESRD, you may stay in that plan.
You may enroll in a Part D drug plan whether you can join an Advantage plan or not.

If you or someone you help is under 65 and new to Medicare: SHIBA counselors assist ALL people eligible for Medicare and their caregivers. **Call 1-800-247-4422**.

A good source of information about the complicated coverage rules for ESRD is Medicare publication number 10128, Medicare Coverage of Kidney Dialysis and Kidney Transplant Services, available on the Medicare.gov website.

Veterans' Benefits and Medicare

Veterans need to understand how VA and Medicare work together or don't, in their specific case. Veterans who have both Medicare and VA benefits may receive services through either program, but not usually both.

While some vets qualify for free services, others have to share the cost of their care.

To learn how your benefits work, every county is assigned a Veterans Affairs officer to assist vets. To find your local service officer, call the Office of Veterans Advocacy at 1-208-780-1380 or visit www.veterans.idaho.gov/advocacy.

VA drug coverage is considered Medicare "creditable drug coverage," which protects participants against the penalty for delayed enrollment in Medicare Part D. Some veterans may benefit from using both their VA drug benefit and a Medicare plan for drugs the VA doesn't cover. SHIBA counselors can help vets decide if they need Medicare Part D. Call 1-800-247-4422.

TRICARE for Life is for military retirees and their dependents. You must have Medicare Part A and Part B to take advantage of TRICARE for Life.

For eligibility information, you can call TRICARE for Life at 1-866-773-0404, or visit **www.tricare4u.com**.

The Medicare Plan Finder Tool

The Medicare Plan Finder allows you to compare all the Medicare Advantage and Medicare Prescription Drug plans available to you and enroll in one when you are eligible.

How to use to the Plan Finder (Image 2):

1. Go to the **Medicare.gov** home page, select **Find Health & Drug Plans** (Image 1)
2. Choose to **Log in/Create Account** or **Continue without logging In** (Image 2)
3. Answer the questions, enter prescriptions and choose pharmacies to get to the comparison.
4. Choose to sort plans by **Lowest drug + premium cost** to compare true out-of-pocket costs (Image 3)

Image 1: Medicare.gov homepage

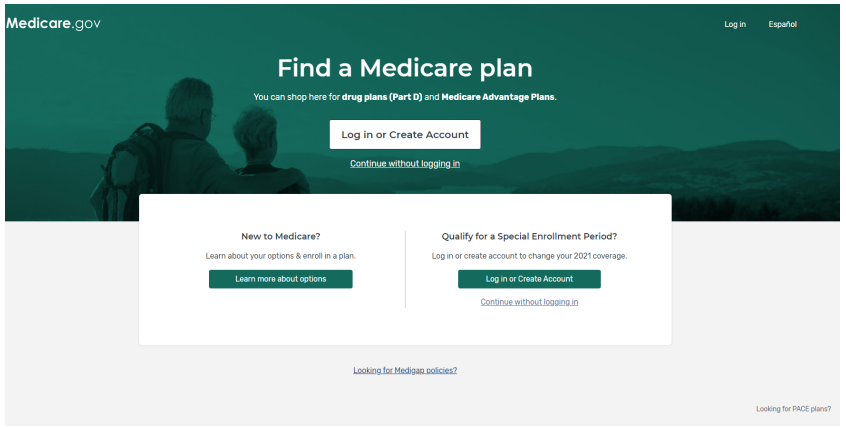


Image 2: Medicare Plan Finder homepage

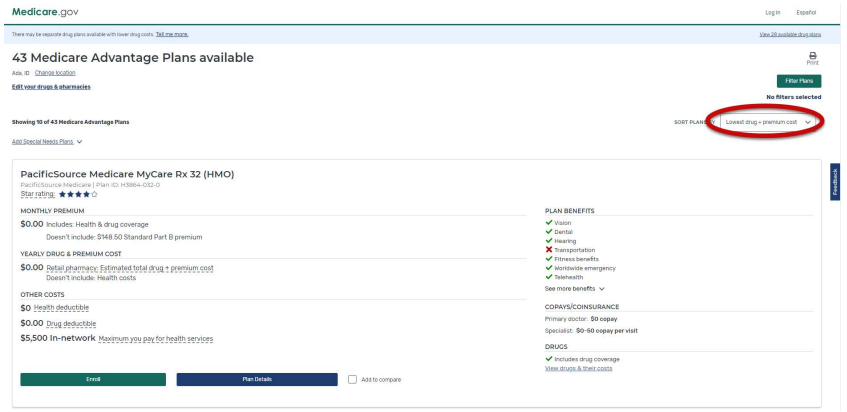


Image 3: Search results in the Medicare Plan Finder

Medicare Part D – Prescription Drug Coverage

Medicare Part D is prescription drug coverage provided by private insurance companies that are contracted with Medicare. You are eligible if you have Medicare Part A, Part B, or both, regardless of your income or your health.

You pay the premium and share part of the cost of your drugs. This applies whether you purchase your insurance through "stand-alone" prescription drug plans (PDPs) or through Medicare Advantage with Prescription Drug coverage.

How much you pay for your Part D premium, co-pays and deductible is determined by which plan you enroll in. It is important that you get good information on the best plans for your unique situation ***every year***. Consider your drug list, your eligibility for assistance programs and other coverage you may have from an employer plan, military service, or Indian Health Service. To learn what you need to know for yourself or those with Medicare that you assist, read the section on Part D in the *Medicare and You* handbook, which covers these and other Part D related topics.

Enrollment Periods

You can join a Part D plan during your Medicare Initial Enrollment Period, the Annual Enrollment Period (**October 15th through December 7th**), or if you have a qualifying event such as a move out of state or receiving a subsidy like Extra Help. (see page 7)

- To switch to a different plan, just enroll in a new PDP or MAPD during a valid enrollment period. *You do not need to take any other action to end your prior plan.*
- ***Caution***: If you have employer or union coverage, call your benefits administrator before you make any changes, or before you sign up for any other coverage. If you drop employer or union coverage, you may not be able to get it back. You also may not be able to drop employer or union **drug** coverage without also dropping the employer or union **health** coverage.
- ***Caution***: If you belong to a Medicare Advantage without Prescription Drug coverage, enrolling in a stand alone PDP will cause you to be dropped from your MA plan.
- If you wish to completely drop your participation in Part D, you must submit a signed statement to your plan. Please speak with a SHIBA counselor to make sure you understand the consequences of this move.
- If you move away from your plan's service area, you must enroll in a new plan in your new state within 63 days, *even if you are enrolled in a national plan.*
- If a **5-Star plan** is available to you, you may switch to a plan with a **5-Star Plan Rating**. Outside the annual enrollment period. Plan ratings can be found at **www.medicare.gov** using the **Plan Finder.**

For help finding the best Part D plan for you: Call SHIBA at 1-800-247-4422

How It Works: Making the Most of Your Prescription Drug Plan

Coverage: While all drug plans must comply with Medicare rules, plans vary greatly. Each plan has its own "formulary," or list of prescription drugs it covers. Plans are allowed to manage access to their drugs through one or more of these *restrictions*:

- **Prior authorization**: The plan will not cover the drug unless your doctor requests the plan's permission to prescribe it and the plan approves the request.
- **Step therapy:** The plan requires that you try less-expensive medications on its formulary before it will cover a more expensive drug. Your doctor may request an exception if you have unsuccessfully tried the less-expensive drugs, or if he or she determines that the desired drug is medically necessary.
- **Quantity limits:** For cost or safety reasons, some plans may limit the number of doses that they will cover over a period of time (for example, 60 doses per month). If you require more than the allowed amount, your doctor must submit proof that it is medically necessary; the plan may then grant an exception to its rule.

Choosing a plan with the fewest restrictions can save money, even if its premium or co-payments are higher. If you choose a plan with restrictions and your request for an exception is denied, you may pay full price for the prescription. Also, having fewer restrictions will reduce delays and paperwork.

Cost: There are a wide range of monthly premiums for Part D plans. More costly premiums do not guarantee better coverage, nor do lower premiums promise lower cost. Many plans have a deductible that you must pay before the plan begins to pay.

A penalty may be added to your premium if you have been eligible for Part D but have gone without coverage. If you had "creditable" (as good as Part D) drug coverage, for example through an employer group plan or from the VA, there is no penalty. If you do not receive a letter of proof of creditable coverage, ask for one.

Your *cost share,* about 25 percent, is collected through either **copayments** (a set amount that stays the same all year) or **coinsurance** (a percentage that changes as drug prices change). If you have a choice, copayments tend to cost less. *S*ee your plans details when you'll pay a percentage.

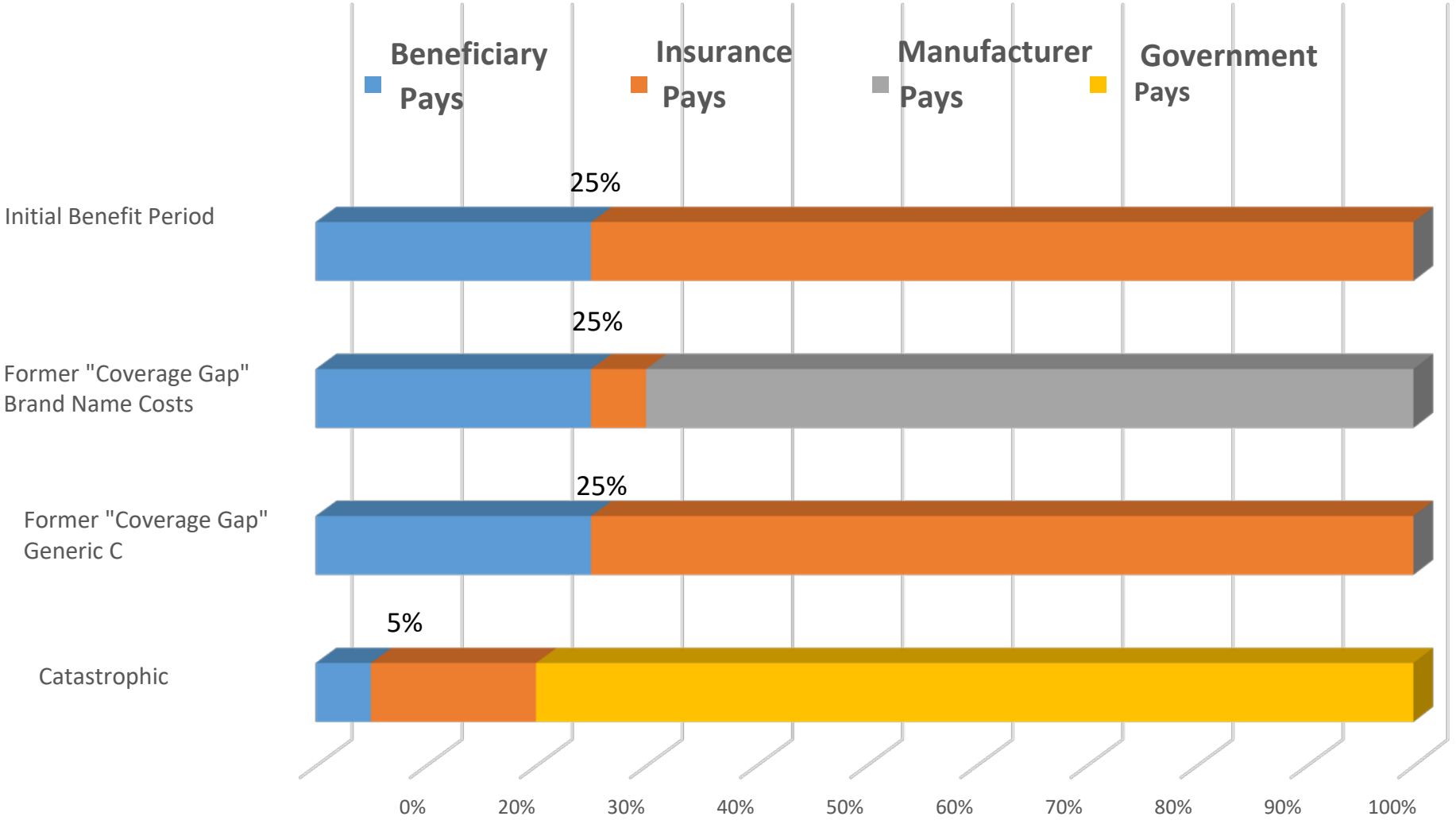
Everything you can do to keep your drug costs down helps you avoid or delay entering the period formerly known as the **Coverage Gap** (or "Donut Hole"). During this time, you can be responsible for 25% of the retail price of a medication. Co-pays during the initial coverage period are often much less than 25%, so your cost for those drugs could go up.

Convenience: Plans have pharmacy networks. Your costs are greatly affected by whether the **pharmacy** you use is *preferred* (the lowest cost*, in-network*, or *out-of-network* (where you pay the full cost, as if you had no insurance). If you live in a remote area, make sure your plan works with your local pharmacy. See if your plan offers a *mail-order option*, which is convenient and can save money. And if you plan to travel, you may want to enroll in a *national plan*.

Remember—plans change their formularies and rules every year. Do a benefits checkup ***every fall.*** Speak with a SHIBA counselor, or use the Plan Finder at www.medicare.gov to get your best combination of coverage, access, and cost.

Prescription Drug Coverage Cost-Sharing

In the past, the beneficiary's share of costs were as high as 100% when they reached the coverage gap.
As of 2020, your maximum share of costs remains the same (25%) until you reach the catastrophic period.



About Medigap (Medicare Supplement) Plans

What is a Medigap?

Beneficiaries enrolled in Original Medicare (Parts A and B) are expected to pay some costs (deductibles, copayments, and coinsurance) of their medical care. To help fill these gaps in coverage, private insurance companies sell Medicare supplement insurance policies also known as Medigap plans. ***You must be enrolled in both Part A and Part B to buy a Medigap plan.***

With Original Medicare, a person who buys a Medigap policy will have Medicare pay primary and then the Medigap policy will pay secondary. Depending on which Medigap policy (A thru N) you select, you may or may not have to pay any cost share.

Medigap plans are named by letter, Plan A through Plan N, not to be confused with Medicare Parts A, B, C, and D. The plans have **standardized benefits**: all plans with the same letter have the same coverage; only the premiums are different. Some companies offer "SELECT" plans, which require using a provider network, or "Innovative" plans, which offer limited extra benefits, such as preventive dental.

All Medigap plans are **guaranteed renewable.** This means that the benefits never change and your policy stays in effect, no matter what health problems you experience, as long as the premiums are paid and the application had no misrepresentation. ***If you enroll in a Medicare Advantage plan, a Medigap policy cannot pay, so you need to contact the company to drop the Medigap.***

Factors that may affect premiums include your age when you took out the policy, health conditions, and tobacco use. Some companies offer discounts to married couples or for paying premiums annually. As with all Medicare coverage, Medigap plans are issued to individuals. Call several companies for a rate quote and to see if you like their customer service.

Current Medigap premiums are available at doi.idaho.gov/SHIBA

Medigaps in Idaho

All Medigap policies must follow federal and state laws. Rules governing Medigaps can differ by state. Medigaps in Idaho are regulated by the Idaho Department of Insurance.

In Idaho:

- Medigap providers are required to sell policies to Medicare beneficiaries under age 65.
- Premium rates for females and males must be the same.
- There are different rates for smokers and non-smokers.
- All policies being sold are "issue-age" or "community" rated.
- Premiums may go up only because of inflation or the pool's healthcare costs but not because the policyholder gets older.

Medigap Innovative Plans

The insurance company can offer some additional benefits at no extra cost to the Medicare beneficiary. With the approval of the state, Innovative benefits cannot be used to change or reduce the standardized benefits, including a change of any cost-sharing provision.

Medigap Innovative Plan benefits can include but are not limited to: annual physical exam, preventive dental care, preventive vision care, or routine hearing exam to name a few.

When Can I Buy a Medigap policy?

There is no annual open enrollment season. During your *Medigap Open Enrollment Period and Guaranteed Issue periods* the companies must sell you a Medigap policy without underwriting. At other times insurance companies can underwrite (consider your medical history) and refuse your application or make you wait for pre-existing conditions to be covered.

About Medigap (Medicare Supplement) Plans

- **Medigap Open Enrollment Period**

  Your open enrollment period for Medigaps begins the day your Part B starts and continues for six months; it cannot be changed once it starts. During this period, all Medigap insurers doing business in Idaho must accept you for any plan they offer in this state, and they cannot base your premiums on your medical history. If you have **not** had continuous creditable coverage for at least six months prior to the open enrollment period, some insurers may impose a pre-existing waiting period for benefits to be paid. If you are under 65, Idaho rules allow Medigap plans to charge up to 150% of the rate for 65 year-old beneficiaries but they cannot decline your application during your open enrollment period.

- **Guaranteed Issue**

  Certain special circumstances trigger Guaranteed Issue rights. See the table on this page. At these times, you are entitled to purchase a Medigap plan with the same rights as during the six-month Medigap open enrollment, except there is no pre-existing waiting period.

Medigap Waiting Periods

Medigap policies can "look back" for pre-existing conditions that were diagnosed or treated for up to six months before a new policy starts, and can refuse to cover those conditions for up to six months after the policy takes effect. The policies must pay for everything else they cover during this waiting period. The waiting period can be eliminated or shortened if you have active health insurance before applying for the Medigap. Most forms of employer health plans count as prior coverage. Most forms of health coverage count as prior creditable coverage. Not all companies use the look-back/waiting period before paying benefits on pre-existing conditions.

The Idaho rule for Medigap plans is IDAPA 18.04.10 The Medicare Supplement Minimum Standards Model Act

Guaranteed Issue Situations	Plan Choices
(**Trial Right**) You joined a Medicare Advantage plan ***when you first enrolled in Medicare, but within the first 12 months of joining the plan*** you want to switch to Original Medicare.	Any plan IDAPA 18.04.10.041.02.h 18.04.10.041.03.b 18.04.10.041.05.d
(**Trial Right**) You terminated a Medigap policy to enroll in a Medicare Advantage plan or Medicare Select policy ***for the first time,*** and now you want to switch back ***after no more than 12 months of enrollment.***	Original plan. If not available, then A,B,G, G-hd, K or L IDAPA 18.04.10.041.02.f 18.04.10.041.03.b
Your Medicare Advantage plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area. **63-day limit*	A,B, G, Ghd, K or L IDAPA 18.04.10.041.02.b 18.04.10.041.03.b 18.04.10.041.05.a
Your employer group health plan (including retiree, union, or COBRA coverage) ends. **63-day limit*	A,B, G, Ghd, K, or L IDAPA 18.04.10.041.02.a 18.04.10.041.03.a 18.04.10.041.05.a
Your Medicare Advantage plan, Medicare Select policy, or employer group health plan ends because you move out of the plan's service area. **63-day limit*	A,B, G, Ghd, K, or L IDAPA 18.04.10.041.02.b 18.04.10.041.03.b 18.04.10.041.05.a
You leave any plan—Medicare Advantage or Medigap—because they have committed fraud. For example, marketing materials were misleading or quality standards were not met. **63-day limit*	A,B,G, Ghd, K or L IDAPA 18.04.10.041.02.d 18.04.10.041.02.e 18.04.10.041.03.f 18.04.10.041.05.a
Your Medigap insurance company goes bankrupt or your Medigap policy coverage otherwise ends through no fault of your own. **63-day limit*	A,B,G, Ghd, K or L IDAPA 18.04.10.041.02.d 18.04.10.041.02.e 18.04.10.041.03.f 18.04.10.041.05.a

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[2]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2021]					**$6,220**	**$3,110**				

1.Plans F and G also have a high deductible option which require first paying a plan deductible of [$2,370] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plans F and G count the payment of the Medicare Part B deductible toward meeting the plan deductible.

2.Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Original Medicare + Medigap vs. Medicare Advantage Comparison

Original Medicare with a Medigap	*Comparison point:*	Medicare Advantage: HMO, PPO, or PFFS
Must have Parts A and B. Companies must accept all eligible applicants during Medigap open enrollment and Guaranteed Issue periods.	***Eligibility:***	Must have Parts A and B, and live in service area.
Standardized plans have the same benefits but premium varies by company, may vary by age at time plan is purchased, and/or whether the beneficiary smokes. Cost sharing varies by plan; no cost sharing with Plan F. Original Medicare has no out-of-pocket maximum.	***Costs:*** *Premiums, cost sharing, and out-of-pocket maximum*	All plan members pay same premium, regardless of age, gender, or health. Cost sharing (co-pays and/or co-insurance) must be paid for most medical services. Plans have an out-of- pocket annual maximum.
Can generally see any provider who accepts Medicare. "SELECT" Medigap plans may require using specific network of providers or specific hospitals. May be used for treatments at specialty medical facilities, such as Mayo Clinics, etc.	***Provider choice and availability:*** *Always ask your providers what insurance they accept*	**HMOs and PPOs:** Maintain provider networks; they must have available providers in order to accept new members. **HMOs:** Generally, they cover in-network only. Referrals may be required for specialist visits. **PPOs:** Cover out-of-network, but costs may be higher for out-of-network. No referrals required.
Not included. If you want Rx coverage, you may enroll in a stand-alone Medicare prescription drug plan.	***Prescription drug coverage:*** *Be sure to use* *www.medicare.gov* ***Find Health and Drug Plans***	Most plans cover drugs. With HMO and PPO plans, you must use drug coverage included with plan. HMO and PPO plans that do not offer drug coverage are designed for people who have drug coverage through the VA, IHS, etc.
Yes, guaranteed renewable as long as you pay the premium and there was no misrepresentation on the application. Benefits never change. No election season for Medigaps.	*Is it **renewable?***	No, benefits may change yearly. However, you usually remain in a plan unless you dis-enroll at election times, or your plan terminates in your area.
No routine dental, vision, etc., except "innovative" plans; no alternative medicine.	***Extras:***	Some plans include routine dental, hearing, or vision. Some may offer additional alternative medicine package.
Good for travelers or "snow birds." May save money for people needing high-cost or frequent care. Customize elements of your Medicare picture—choose doctors and drug plan.	*It may be **best** for:*	May save money if you do not need frequent appointments or treatments. Having a coordinated plan may simplify choices. Network plans may be good for people who otherwise can't find a Medicare provider.
Because Medigaps are standardized, price and customer service are the only difference. Current rates are posted on the SHIBA website at: **http://doi.idaho.gov/shiba/shmedigap**	*How to **comparison** shop:*	Plans are not standardized—use comparison pages in this Guide or at **www.medicare.gov**, or call SHIBA, **1-800-247-4422**.
Regulated by the Idaho Department of Insurance.	*Who **regulates** it?*	Regulated by Medicare/CMS; sales agents are licensed by the Idaho Department of Insurance.

About Medicare Advantage Plans

What is Medicare Advantage?

Medicare offers two ways to get your benefits: from **Original Medicare** (Part A and Part B), plus Part D, or from a **Medicare Advantage (MA)** plan, which combines Part A, Part B and usually Part D, and is sometimes called Part C. Advantage plans with Part D coverage are sometimes called **MAPD** plans. Private insurance companies contract with Medicare to offer MA and MAPD coverage. Medicare pays these plans to provide your Medicare-approved services. The plans must cover everything Medicare covers, but not necessarily at the same rate.

When you enroll in a Medicare Advantage (MA) plan, you agree to that plan's terms and conditions.

Frequent questions:

- **Do I still have Medicare?** Yes, you are still on Medicare and receive Medicare benefits, but you agree to have your health care administered by a private insurance company.
- **What does it cost?** You pay the Part B premium, usually a premium to the plan for coverage, and cost sharing for most services.
- **Are there extras?** Some Medicare Advantage plans offer additional coverage, such as limited vision and dental.

Medicare Advantage plans contract with the Centers for Medicare and Medicaid Services (CMS) for one year at a time. This means the policies are not guaranteed renewable. However, if your plan renews its contract with CMS your coverage will continue unless you decide on a change during the annual enrollment period. If your plan does not renew its contract, you have rights that enable you to join another plan or to purchase a Medigap policy.

Who Can Join a Medicare Advantage Plan?

Most people who have Medicare Part A and Part B and live in a plan's service area can join that plan. SHIBA can tell you which plans are available in your area or use the Plan Finder tool at www.medicare.gov to compare all available plans.

There are no restrictions for age, gender or health conditions.

Medicare Advantage Plan Types

There are different types of MA plans. It is important that you speak with the billing office of your providers to make sure that they accept an insurance plan and, if so, whether they are *in-network*.

- **HMOs (Health Maintenance Organizations)** offer health care through a network. In order for the plan to pay for your care, you must use only the providers (doctors, hospitals, and suppliers) that are in the plan's network, except for urgent or emergency care. You may need a referral from a primary care provider in order to see a specialist.

- **HMO-POS (Point-of-Service)** plans **may** allow you to use providers outside the network for a higher cost. Check with the plan for what services can be covered out-of-network.

- **PPOs (Preferred Provider Organizations)** also operate through a network. You may use providers outside the network, but your cost share (co-payment) is lower when you stay in network. Check with out-of-network providers to make sure they will accept your plan. Referrals are not needed in a PPO plan. However, pre-authorization for some services may be required by the plan. Read your plan summary.

- **SNPs (Special Needs Plans)** are specially designed Medicare Advantage plans with membership limited to certain groups of people. Part D coverage is included in all SNPs. Idaho has two SNPs, and they are for beneficiaries who have both Medicare and full Medicaid. Only available in select counties.
  - **Idaho's SNPs:**
    Blue Cross of Idaho
    True Blue Special Needs Plan (HMO SNP)
    Phone: 888-492-2583
  - Molina Healthcare of Idaho
    Molina Medicare Options Plus (HMO SNP)
    Phone: 1-866-403-8293

Important note about drug coverage: If you want to have drug coverage together with either HMO or PPO health coverage, you must enroll in an MA plan with drug coverage. If you enroll in a health-only Medicare Advantage HMO or PPO plan and then enroll in a Part D plan (PDP) you will be dis-enrolled from your MA plan and end up with Original Medicare and the PDP. If you are eligible for VA or IHS drug coverage, you can take a health-only MA plan and use the VA or IHS benefit, as long as it covers your drugs. Some retiree plans offer only drug coverage and you could also enroll in a Medicare Advantage plan without drug coverage and have your drugs covered by the retiree plan.

Enrollment Periods

You can Join a Medicare Advantage plan:

- during your Medicare Initial Enrollment Period
- during the Annual Enrollment Period **(October 15th through December 7th)** when you can add, drop, or switch plans
- If you're already enrolled in a Medicare Advantage Plan, you can use the Medicare Advantage Open Enrollment Period between January 1st and March 31st to switch MAPD plans or switch to Original Medicare with a Part D drug plan.
- You may also enroll during Special Enrollment Periods, such as after a move or after you qualify for limited-income assistance.
- To switch to a different plan, simply enroll in a new MA or MAPD. *You do not need to take any other action to end your prior plan.*
- If you want to drop Medicare Advantage coverage and switch to Original Medicare, enroll in a stand-alone Part D plan. If you do not want to have any Part D drug coverage, dis-enroll by writing to your plan.
- If such a plan is available, you may switch to a plan with a **5-Star Overall Plan Rating** once between December 8th and November 30th. Plan ratings can be found at www.medicare.gov using the Plan Finder Tool.

Note: Opting to leave a MA or MAPD **does not** qualify you for Guaranteed Issue to a Medigap policy, but you may submit an application to any company that sells Medigaps in Idaho.

Choosing a Medicare Advantage Plan

Local availability, coverage, and cost are all important considerations when deciding on a plan. Call SHIBA at **1-800-247-4422**, use the information in this book, or visit **www.medicare.gov** to use the **Plan Finder Tool.**

- **What plans are offered in my area?**
  If you have Medicare Parts A and B you may enroll in any plan available in the county where you legally reside. The charts on pages 26-38 of this book show the plans offered in your county. Another way to get this information is to go online and use the Plan Finder at www.medicare.gov. It searches by ZIP code and provides a list of plans available in your area.

- **Will my doctor and hospital accept the plan?**
  It is important to ask the billing offices of your doctors and hospital if they are in the network for a plan you are considering. Even though a plan may be offered in your area, providers ***do not*** have to participate. *Call for this information for yourself.* Provider lists on plan web pages and printed materials from a plan may not be up to date.

- **If I want drug coverage, does the plan's formulary include my medications?**
  Be sure that you or a helper uses the Drug Plan Finder at **www.medicare.gov** to see how different plans' formularies and rules cover your drugs. This tool researches the drug coverage in MAPD plans as well as in stand-alone PDP drug plans. Please see "How It Works", page 13, for more on this specific topic.

- **Can I afford the plan?**
  Make sure you understand the coverage, including premiums and cost sharing. The plan detail pages in this book list your share of the costs.

Here are some of the terms you will need to understand:

- **Premiums:** The amount you pay monthly for a plan, whether or not you use services. If you qualify for Extra Help, your premium may be reduced; see the plan description pages. In a few cases, plans have a $0 premium. **Do not make your plan selection based only on the premium; research what your out-of-pocket costs may be when you use services.**
- **Deductible:** An annual set amount that you must pay for covered services before the plan begins paying. Not all plans have deductibles. Some plans have separate deductibles for drug coverage and health care coverage.
- **Maximum out-of-pocket costs:** After allowable cost-sharing amounts during the plan year reach this amount, the plan pays 100% for any additional allowable expenses. ***Caution:*** Not all covered services may count toward the out-of-pocket maximum. If you have a frequent need for a certain service, ask the plan if the co-pay would count toward the out-of-pocket maximum.
- **Co-payments:** A fixed amount you pay for each service.
- **Co-insurance:** A percentage of costs you pay for a service.

About Additional Benefits

Original Medicare ***does not*** cover routine dental, vision care, or hearing aids. Some Medicare Advantage plans are like Original Medicare and do not cover these benefits. Other MA plans choose to cover some care, such as exams or cleanings, up to a capped limit—sometimes for an additional cost.

Enrollment Periods and Deadlines

Plan	IEP	OEP/GEP/5-Star	SEP/GI	MA OEP	Late Penalty
Medicare Part A	The **7 months** that begin 3 months before age 65; or auto-enrolled after 24 months of receiving Social Security Disability Income. (SSDI)	Anytime, if for free premium; otherwise, GEP is **January, February, and March** each year; coverage effective July 1.	None	If you're already in a Medicare Advantage plan, you may switch to Original Medicare, **Jan. 1- March 31**	None if Part **A** premium is free. Penalty is 10% of premium per year of delay; lasts twice as long as enrollment was delayed.
Medicare Part B	The **7 months** that begin 3 months before age 65; or auto-enrolled after 24 months if already receiving SSDI.	GEP: **January, February, and March** each year; coverage effective July 1.	Up to **8 months** after active work (self or spouse) or EGHP ends, whichever happens first.	If you're already in a Medicare Advantage plan, you may switch to Original Medicare, **Jan. 1- March 31**	Premium penalty is 10% of current Part **B** premium per year of delayed enrollment; continues for lifetime.
Medigap	May purchase as soon as you have Part A, Part B. Open enrollment for first 6 months of Part B enrollment.	Anytime, but at plan's discretion; company may underwrite or deny for pre-existing health conditions.	**63-day GI period** from date previous plan ends through no fault of your own.	If you have an Advantage plan,You may switch to Original Medicare/Medigap **Jan. 1- March 31. Underwriting may apply.**	May cost more. If beyond OEP and GI periods, plan may refuse to insure due to health conditions.
Medicare Advantage	The **7-month period,** that begins 3 months before turning age 65, or before the date of qualifying for Medicare due to Social Security Disability Income.	OEP: **Oct. 15-Dec. 7** GEP: **April 1-June 30;** effective July 1 5-Star: December 8th through November 30th of next year.	**60 days** after moving out of a plan's service area or after EGHP ends; 31 days after plan is discontinued. **Continuous** for those receiving Extra Help or Medicaid.	If you're already in a Medicare Advantage plan, you may switch to Original Medicare, **Jan. 1- March 31**	None for health coverage. Delayed drug enrollment may incur Part D penalty added to premium.
Medicare Part D	The **7-month** period that begins 3 months before age 65, or before the date of qualifying for Medicare due to Social Security Disability Income.	OEP: **Oct. 15-Dec. 7** GEP: **April 1-June 30;** effective July 1 5-Star: December 8th through November 30th of next year.	**60 days** after moving out of a plan's service area or plan is discontinued, or after EGHP ends. **Continuous** for those receiving Extra Help or Medicaid.	If you're already in a Medicare Advantage plan, you may switch to Original Medicare, **Jan. 1- March 31**	Penalty for each month enrollment was delayed is 1% of National Base Beneficiary premium; 24 months of delay becomes 24% penalty; continues for lifetime unless you qualify for Extra Help.

EGHP: Employer Group Health Plan **GI**: Guaranteed Issue **IEP:** Initial Enrollment Period **GEP:** General Enrollment Period **MA**: Medicare Advantage **MAOEP:** Medicare Advantage Open Enrollment Period **MAPD:** Medicare Advantage with Prescription Drug **OEP:** Open Enrollment Period **SEP:** Special Enrollment Period **5-Star:** 5-Star overall plan rating

Idaho Long-Term Care Partnership

Long-term care is a wide range of support services that can be provided in one's home or other residential settings, such as assisted living facilities, and nursing homes. These services help people who have physical or mental limitations with tasks like dressing, walking, eating, grooming, and bathing. Do not count on Medicare to pay the majority of long-term care needs.

Purchasing long-term care insurance is one option that may be appropriate for some wanting to finance long-term care services. The National Association of Insurance Commissioners (NAIC) has information at **www.naic.org t**hat can help with this decision, as well as information on how to obtain a Shopper's Guide to Long-Term Care, published by the NAIC.

The Idaho Long-Term Care Partnership Program is a collaboration of state government and private insurers. Under the Partnership Program, the state will "disregard" some of a policyholder's assets, equal to the amount the insurance policy pays out in benefits, when it determines eligibility for Medicaid coverage of long-term care. This way a person might qualify for Medicaid assistance without first spending all of their personal assets on care. Only certain types of long-term care policies qualify for the Partnership Program. The list on this page is of companies that are licensed and currently marketing LTC policies in Idaho. Ask each company if they sell Partnership Qualified Policies that meet the terms and conditions of Idaho's program.

Company Name	Telephone Number
Bankers Life and Casualty Company	208-375-7540
Country Life Insurance Company	309-821-3000
Genworth Life Insurance Company	888-436-9678
LifeSecure Insurance Company	866-582-7702
Massachusetts Mutual Life Insurance Company	800-272-2216
Mutual of Omaha Insurance Company	800-896-5988
New York Life Insurance Company	800-710-7945
Northwestern Long Term-Care Insurance Company	800-890-6704
National Guardian Life Insurance Company	888-505-2332
State Farm Mutual Automobile Insurance Company	844-803-1573
Transamerica Life Insurance Company	866-478-5209
Thrivent Financial for Lutherans	800-847-4836

Dental Insurance

Individual dental policies are available to Idaho's Medicare beneficiaries through the following companies. This list is not a guarantee that the companies will offer coverage in Idaho throughout 2021.

Company Name	Telephone	Website
Aetna Life Insurance Company	855-837-6453	http://dentaldirect.aetna.com
Ameritas Life Insurance Company	888-336-7601	http://myplan.ameritas.com
Best Life & Health Insurance Company	800-433-0088	www.bestlife.com
Blue Cross of Idaho (Healthy Smiles)	888-492-2583	www.bcidaho.com
Central United Life Insurance	800-669-9030	www.manhattanlife.com
Cigna Health & Life Insurance Company	855-556-4453	http://cigna.com/dental
Colonial Life & Accident Insurance	800-325-4368	www.coloniallife.com/individuals/products/dental-vision-insurance
Delta Dental of Idaho	855-703-3582	www.deltadentalid.com
Guardian Life Insurance Co of America	844-561-5600	www.dentalexchange.guardiandirect.com
Humana Insurance Company	800-708-1147	www.humana.com
Independence American	800-920-7125	http://www.independenceamerican.com/dental-insurance/
Madison National Life Ins Co	800-356-9601	www.madisonlife.com
Manhattan Insurance Group	888-441-0770	www.manhattanlife.com/Seniors
Metropolitan Life Insurance Co	866-322-2824	www.mybenefits.metlife.com
Mutual of Omaha Insurance Co	402-351-6910	www.mutualofomaha.com/dental-insurance
United Commercial Travelers of America	800-848-0123	www.uct.org
Pacific Source Health Plans	866-373-7053	pacificsource.com
Philadelphia American Life Ins. Company	800-441-0380	http://www1.careington.com/
Regence BlueShield of Idaho	800-253-0838	http://www.regence.com/provider/products/dental
Renaissance Life & Health Ins Co	888-791-5995	http://renaissancefamily.com/
Reserve National Insurance Company	800-654-9106	http://www.reservenational.com/
Starmount Life Insurance Company	888-400-9304	http://www.starmountlife.com/
United Health Care Insurance Company	800-721-0627	www.uhc.com
United National Life Insurance Co of America	800-207-8050	www.unlinsurance.com

Glossary

Advance Beneficiary Notice (ABN) — A notice given to Medicare beneficiaries indicating the cost of an item or service that Medicare may not cover.

Administration for Community Living (ACL) — The portion of the federal Department of Health and Human Services that administers the nationwide SHIP program and the Idaho SHIBA program.

Ambulatory Service Center (ASC) — A health-care facility that specializes in providing surgery, including certain pain management and diagnostic (e.g., colonoscopy) services in an outpatient setting.

Annual Enrollment Period (AEP) - The period from Oct. 15 to Dec. 7 in which Medicare beneficaries may join or dis-enroll from Part D prescription drug coverage or a Medicare Advantage plan. Changes usually become effective Jan. 1. Also know as Open Enrollment.

Assignment — A method of payment under Medicare Part B. The provider agrees to accept the amount of the Medicare-approved amount as full payment.

Attained age — A way of establishing rates for Medigap insurance policies where premiums increase based on the age of the insured. Attained age rated policies are not allowed in Idaho.

Beneficiary — The person covered under an insurance plan.

Benefit period — The period for which benefits are payable. Under Medicare Part A, for example, the benefit period begins the day one is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received services for 60 days in a row.

Benefits — The items that are covered under an insurance plan; also referred to as coverage.

Catastrophic coverage — In Part D coverage, a level of coverage where the beneficiary pays approximately 5 percent of the drug cost. Catastrophic coverage is reached when the beneficiary's True Out-of- Pocket (TROoP) costs reach a specified level ($6,550 in 2021).

Claim — A request for payment of medical services under the terms of an insurance policy. Usually made by either a provider or an insured person.

Centers for Medicare and Medicaid Services (CMS) — The division of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

Co-insurance — A fixed percentage paid per service received or prescription filled.

Community rating — A rating method for Medigap insurance that assigns a single rate to all ages and classes of individuals in the group, regardless of risk factors such as age or health.

Consolidated Omnibus Budget Reconciliation Act (COBRA) — Rules that permit former employees to buy insurance at group rates from their former employers' insurance companies for a set period of time after they leave their jobs or retire.

Coordination of Benefits (COB) — The process of determining which coverage pays first, or if at all, when a beneficiary may have other coverage or coverage under multiple plans.

Copayment or Copay — A fixed dollar amount paid per service received or prescription filled.

Glossary

Coverage Gap — Ended in 2020, a stage in Medicare prescription drug coverage when the beneficiary paid a higher percentage of drug costs than paid during initial coverage phase. *Also known as the donut hole*.

Creditable coverage — Insurance coverage that is determined to be as good as or better than Medicare coverage.

Critical access hospital — a small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Crossover claim participant — A Medigap company that has claims submitted to them electronically, directly from Medicare. This eliminates the need for the beneficiary to submit claims to a secondary payer.

Custodial care — Care provided to assist a person with the Activities of Daily Living (ADLs), such as getting into or out of bed, toileting, bathing, eating, etc. Medicare does not cover custodial care.

Deductible — A dollar amount determined by an individual's insurance policy (including Medicare) that must be paid by the insured individual for covered services before Medicare or the insurance policy begins paying.

Diagnostic tests — Tests ordered by a physician to provide information that assists in making a diagnosis when symptoms are present.

Disenrollment — Cancellation of an individual's enrollment in a health plan. Beneficiaries may elect to dis-enroll from a plan or a plan can elect to drop someone from coverage, but only for cause, such as failure to pay plan premiums.

Donut hole — *See Coverage Gap.*

Durable Medical Equipment (DME) — Equipment that is medically necessary and prescribed by a doctor for use in the home, such as oxygen equipment, wheelchairs, and other medically necessary equipment.

Effective date — The date on which insurance policy coverage begins.

Electronic Funds Transfer (EFT) — The transfer of funds from one account to another by computer. A method that can be used to pay premiums.

Election period — The timeframe during which an eligible person may join or leave Original Medicare or a Medicare Advantage plan.

Employer Group Health Plan (EGHP) — A health insurance or benefit plan that is offered through an employer of 20 or more employees.

End-Stage Renal Disease (ESRD) — A medical condition in which a person's kidneys no longer function, requiring dialysis or a kidney transplant to maintain life.

Enrollee — A person eligible and receiving benefits from an insurance plan or managed care organization. Also called a member when referring to Medicare Advantage plans. See Beneficiary.

Excess charges — Doctors who do not accept Medicare assignment may charge moe than the Medicare approved amount. They cannot charge more than 15% over the Medicare approved amount for non-participaitng doctors. Also called the "limiting charge".

Glossary

Extra Help — A program administered by the Social Security Administration to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance. *Also known as LIS.*

Foreign travel benefits — Medicare coverage for emergency care in a foreign country; covers 80 percent of billed charges not covered by Medicare for Medicare-eligible expenses. Subject to time limits, deductibles, and a lifetime maximum.

Formulary — A list of drugs that a health plan will cover. Formulary drugs usually have lower co-payments than non-formulary drugs. *A formulary is also known as a preferred drug list.*

Federal Poverty Level (FPL) — The income level set by the federal government to determine eligibility for many needs-based programs.

Fraud — Occurs when someone intentionally deceives or misrepresents himself or herself in a way that could result in unauthorized payments being made.

General Enrollment Period (GEP) — An enrollment period for people who did not sign up for Medicare Part A or Part B during their Initial Enrollment Period. It lasts from January through March and coverage becomes effective July 1.

Generic drug — A drug sold or dispensed under a name that is not protected by a trademark.

Guaranteed Issue rights — A consumer's right to purchase insurance policies during certain periods and under certain circumstances in which insurance companies are required by law to offer them.

Guaranteed renewable — A policy that cannot be canceled by the insurer for any reason as long as the premium is paid and the policyholder did not give false information to obtain coverage.

Health Maintenance Organization (HMO) — A type of insurance plan that requires beneficiaries to get services from providers who are part of the plan's network. Generally, a primary care provider acts as gatekeeper for services and makes referrals for tests or to specialists. Medicare Advantage plans may be HMOs.

Health Maintenance Organization – Point of Service (HMO-POS) — HMO plans that *may* allow you to get some services out-of-network for a higher copayment or coinsurance.

High-deductible Medigap policy — A Medicare supplement policy in which the beneficiary is responsible for payment of expenses up to a set amount or deductible; once the deductible is met the policy pays 100 percent of covered out-of-pocket expenses.

Hospice — A public or private agency that provides support services to the terminally ill and their families.

Initial Enrollment Period (IEP) — A seven-month period during which a person can enroll in Medicare, Medicare Advantage plans, or Medicare Prescription Drug Plans. It includes three months before the person's 65th birthday, the month of and three months after the person's birthday.

Inpatient care — Care given an admitted patient in a hospital, nursing home, or other medical or post-acute institution.

Institutional care — Care provided in Intermediate Care Facilities, Long Term Hospitals, Nursing Facilities, Psychiatric Hospitals/Units, Rehabilitation Hospitals/Units, Skilled Nursing Facilities or Swing Bed Hospitals.

Glossary

Issue age — Policies whose premiums are based on your age when purchased. Premiums will not increase due to an increase in age; however, premiums may increase for other reasons.

Late enrollment penalty — An amount added to your monthly premium for Medicare Part B or Part D if beneficiaries do not join when they are first eligible. The penalty remains in place as long as the beneficiary has Medicare, with a few exceptions.

Lifetime reserve days — A beneficiary is entitled to 60 additional reserve days after Medicare provides 90 days of benefits for hospitalization. These days are not renewable.

Limiting charge — *See Excess charges.*

Limited Income Subsidy (LIS) — The LIS program is operated by the Social Security Administration and provides Extra Help with prescription drug costs for individuals who meet the income and asset requirements. Also called Extra Help—*see Extra Help.*

Long-term care (LTC) — A general term that includes a wide range of services that address the health, medical, personal, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders (such as Alzheimer's). The delivery of LTC services can include skilled nursing care in a nursing home, in-home health and personal care, assisted living, adult day care facilities, and other options. Medicare does not cover LTC.

Long-term care hospital — An acute care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Lookback — *See Waiting period.*

Low or Limited Income Subsidy (LIS) — A program that is operated by the Social Security Administration that provides Extra Help with prescription drug costs for individuals who meet the income and asset requirements. *See Extra Help.*

Medicaid — A federal-state partnership designed to ensure that America's aged, sick, and impoverished are cared for. This program provides aid in the form of medical services to poor people who fall below the state-established poverty line. There are strict income and asset guidelines used to qualify people for Medicaid. Administered in Idaho by the Department of Health and Welfare. *Also known as M.A. (Medical Assistance), or Title 19 (XIX).*

Medicare Advantage (MA) — Any health care organization, including health care providers, insurers, health care services contractors, health maintenance organizations, or any combination thereof that provides directly or by contract basic health care services on a prepaid capitated basis to patients enrolled in the plan and the managed health care system. The plan receives a premium from Medicare, plus additional out-of-pocket co-payments, co-insurance or deductibles, and/or monthly premiums from Medicare beneficiaries. *Also known as Managed Care, Part C.*

Medicare Advantage with Prescription Drug Coverage (MAPD) — Medicare Advantage plan that includes a Part D plan.

Medically necessary — Services or supplies that are needed for the diagnosis or treatment of a medical condition and that meet accepted standards of medical practice. *Also known as Reasonable and Necessary.*

Glossary

Medicare — A federal health insurance program that pays health care costs for people 65 and older, those receiving SSD on the 25th month, and those with ESRD and ALS.

Medicare Part A — Provides coverage for hospital care, skilled nursing facility care, home health care services, and hospice services.

Medicare Part B — Provides coverage for a portion of most medically necessary doctors' services, preventive care, durable medical equipment and an array of outpatient services.

Medicare Part C — *See Medicare Advantage.*

Medicare Part D — Prescription drug benefit as authorized by the Medicare Modernization Act of 2003. It is an optional coverage. *Also known as PDP or stand-alone drug coverage.*

Medicare Savings Program (MSP) — A state-administered program that provides assistance with some or all of Medicare premiums, deductibles, and co-insurance for lower-income/ asset beneficiaries who are not eligible for full Medicaid benefits. *See Partial Dual Eligible.*

Medicare Select — A type of Medigap policy that requires you to use specific hospitals and, in some cases, specific doctors or other health care providers to get full coverage for non-emergency and non-urgent care.

Medicare Summary Notice (MSN)--A form sent to a beneficary that explains which claims were paid at what level.

Medigap plans — Private supplemental health insurance plans sold to Medicare beneficiaries that provide coverage for medical expenses not or only partially covered by Medicare. *Also known as a Medicare Supplement.*

National plan — A Medicare prescription drug insurance plan that allows you to fill your prescriptions at pharmacies nationwide.

Open Enrollment Period (OEP) — The period October 15 through December 7 of every year in which Medicare beneficaries may join or disenroll from Medicare Part D or a Medicare Advantage Plan. change becomes effective January 1.

Original Medicare — Parts A and B of Medicare coverage.

Out-of-Pocket (OOP) cost — The patient's share of any medical care costs not covered by insurance, Medicare, or Medicaid. These are the deductibles, co-insurance, and copayments that beneficiaries are required to pay.

Out-of-Pocket Maximum — A limit, in Medicare Advantage plans, on out-of-pocket expenses. Beneficiaries whose out-of-pocket expenses reach the maximum don't have further financial responsibility for covered expenses for the rest of the plan year.

Outpatient care — Services provided by physicians, clinics, mobile X-ray, or free-standing dialysis unit, including physical therapy, X-ray, and lab tests. The patient does not require admission to the hospital as an inpatient.

Partial dual eligible — Applies to not being eligible for full Medicaid benefits, but eligible to receive assistance with some or all of one's Medicare premiums and cost sharing. *See Medicare Savings Program*.

Point of Service (POS) — An option that is available with some HMO plans that allow the beneficiary to use doctors and hospitals outside the plan for an additional cost.

Preauthorization — A practice that insurance plans use in order to require that providers receive authorization for certain services or prescriptions from the plan before a claim will be paid.

Pre-existing conditions — A medical condition diagnosed, treated, or needing treatment prior to the purchase of an insurance policy.

Glossary

Preferred drug list — *See Formulary.*

Preferred Provider Organization (PPO) — A type of Medicare Advantage Plan in which the beneficiaries pay less if they use doctors, hospitals, and providers that belong to the plan's network. If they use doctors, hospitals, and providers outside of the network there will be an additional cost.

Premium — The total of all sums charged, received, or deposited as consideration for a contract.

Prescription drug — A drug that must have a health care provider's written order (prescription) in order to be dispensed.

Prescription Drug Plan (PDP) — A Medicare Part D plan that covers only drugs. *Also known as a stand-alone drug plan.*

Preventive care — Health care that is intended to keep people from becoming ill (e.g., checkups, mammograms, immunizations, and screening tests).

Primary Care Provider (PCP) — The provider who sees a patient regularly for routine and preventive care.

Provider — The doctor, hospital, home health agency, hospice, nursing facility, or therapist that delivers health services.

Quality Improvement Organization (QIO) — A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to people with Medicare.

Screening tests — Tests used to try to detect a disease when there is little or no evidence of a suspected disease.

Senior Health Insurance Benefits Advisors (SHIBA) — The Idaho program that uses a statewide network of trained counselors who educate, assist, and advocate for Medicare beneficiaries about their rights and options regarding health insurance so they can make informed choices.

Service area — The specified area that an insurance plan has agreed to cover.

Skilled care — Acute care for an illness or injury that requires the training and skills of a licensed professional nurse, is prescribed by a physician, and is medically necessary for the condition or illness of the patient.

Skilled Nursing Facility (SNF) — A facility at which medically necessary prescribed care is provided by licensed health care professionals.

Social Security Administration (SSA) — The government agency responsible for the Social Security system.

Social Security Disability Insurance (SSDI) — Determined by Social Security, a monthly benefit for eligible people who are unable to work for a year or more due to a disability.

Special Enrollment Period (SEP) — A period during which a beneficiary may leave or enroll in a plan, having to do with meeting special enrollment conditions, such as moving outside a plan service area.

Specialist — A physician who provides expertise and care in a particular area (e.g., surgeon, oncologist, dermatologist, and allergist).

Glossary

Special Needs Plan (SNP) — Private insurance plans that provide Medicare benefits, including drug coverage. People eligible for Medicare and Medicaid, those living in certain LTC facilities, and those with severe chronic or disabling conditions may qualify to join.

Stand-alone drug plan — *See Prescription Drug Plan (PDP).*

State Health Insurance Assistance Program (SHIP) — A nationwide state-based program that offers local one-on-one counseling and assistance to people with Medicare and their families. Through ACL-funded grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. SHIBA is Idaho's SHIP.

Supplement insurance — Private health insurance designed to fill some of the gaps in Medicare. *Also known as Medigap.*

Tier — Used with prescription drug plans as a way to establish copayments and co-insurance for drugs. The lower the tier within a plan, the lower the cost of the drug. Generally, generic drugs are in the lowest tier(s), with brand name drugs in higher tiers. The same drug may be in different tiers in different plans.

TRICARE — A health insurance program offered by the Department of Defense to military personnel.

Total drug costs — The total amount paid for prescription medications. It includes what the beneficiary pays and also what the drug plan pays.

True Out-of-Pocket (TrOOP) costs — Total amount a beneficiary pays out of pocket in a Part D plan.

Underwriting — A process by which an insurer determines whether or not, and on what basis, it will accept an application for insurance.

Waiting period — The amount of time that must pass before benefits will be paid or before pre-existing conditions or specific illnesses are covered by a health insurance policy.

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