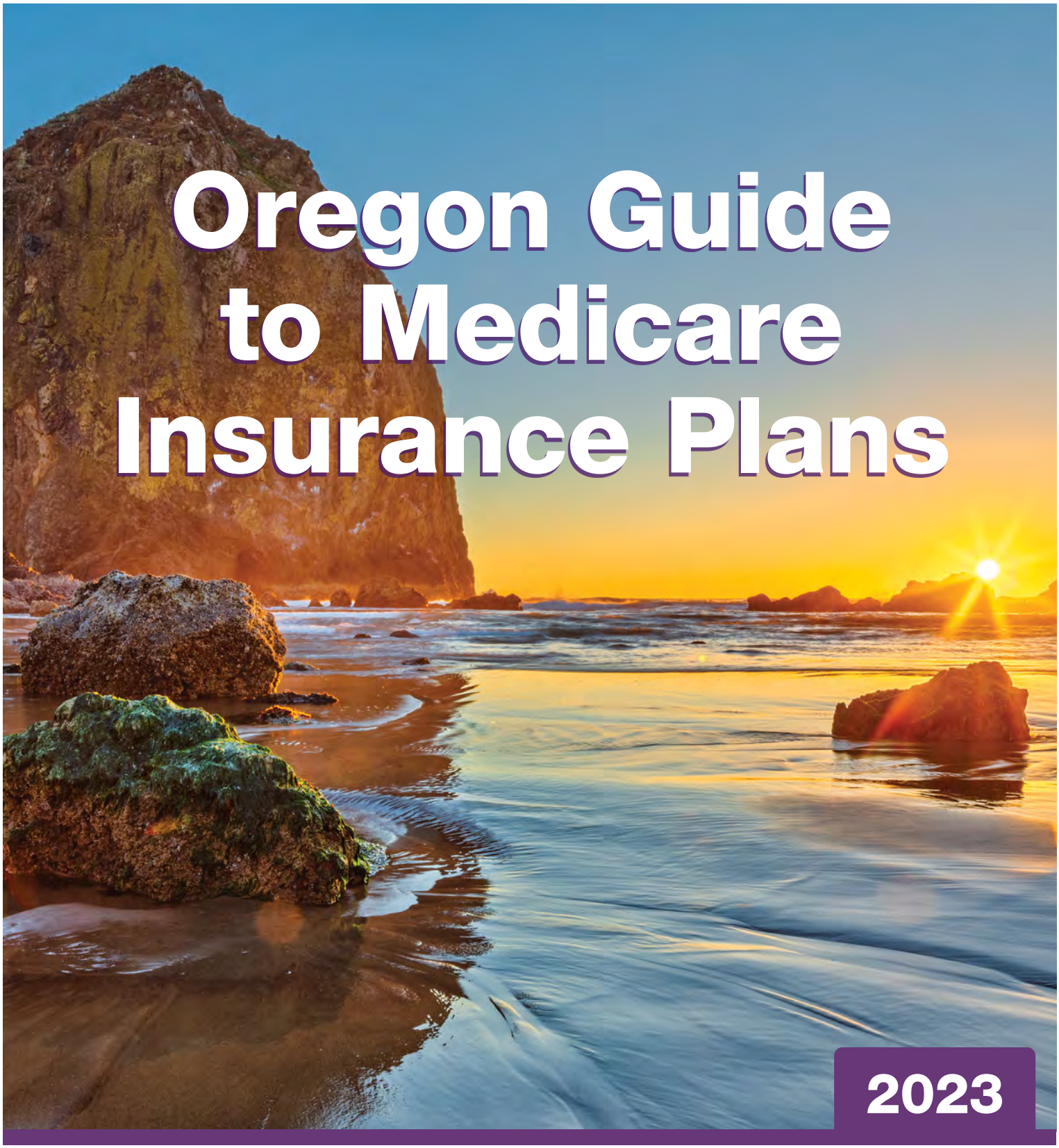

Oregon Guide to Medicare Insurance Plans

2023

Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES
Senior Health Insurance Benefits Assistance

SHIBA
Senior Health Insurance Benefits Assistance

Acknowledgements and notes

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Note: An insurance company may not be listed in this guide because:

- It is not licensed to sell insurance in Oregon
- It is suppressed, or
- Information was unavailable in time for this guide.

Terms are defined in the glossary on page 93.

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Introduction

SHIBA (Senior Health Insurance Benefits Assistance) is a statewide network of certified counselors volunteering in their community to help all Oregonians make educated Medicare decisions.

SHIBA counselors and Oregonians eligible for Medicare can use the "2023 Oregon Guide to Medicare Insurance Plans" to decide what plan works best for them.

Here are some other SHIBA resources:

To get help with Medicare decisions

Call SHIBA at 800-722-4134 (toll-free). You will be asked to use the phone keypad to enter your ZIP code. Depending on where you live, SHIBA may route your call to a local agency, or a SHIBA staff member will return your call.

If you need to talk to state SHIBA staff, do **not** enter your ZIP code. In times of high call volume, you may be redirected to the national Medicare assistance telephone lines.

Learn more about SHIBA at shiba.oregon.gov.

New to Medicare? Check out shiba.oregon.gov/medicare-65.

Be sure to get your Medicare information from an official source such as the Social Security Administration, 800-MEDICARE, a licensed insurance agent, a health insurance plan customer service representative or SHIBA. Document the contact with date, time, number you called from (calls are recorded), name of representative with whom you spoke, and what was said.

- For Social Security, call **800-772-1213** (available 8 a.m.–7 p.m. Monday through Friday). To find a local field office, visit https://www.ssa.gov/locator for Medicare Part A and Part B questions.
- Call 800-MEDICARE (**800-633-4227**) with Part D (drug plan) questions.

To give help

Become a SHIBA-certified counselor. Call SHIBA at **800-722-4134** (toll-free). Counselors must complete an application, successfully complete our training program, pass a background check and work with a SHIBA coordinator in their community.

To apply online, go to https://shiba.oregon.gov/becomeacounselor/Pages/default.aspx.

Medicare agent locator tool

While the SHIBA program offers Medicare counseling services through a statewide volunteer network, help is also available at no cost through licensed health insurance agents. Agents can assist with recommendations and purchase of Medicare insurance plans. If you want to work with a local agent in your community, the Oregon Health Insurance Marketplace has a Medicare agent locator tool available on its website, healthcare.oregon.gov/Pages/find-help.aspx. The agents found on the tool have gone through a state certification process and work in a local office. Be sure to scroll down the page to "Find Local Help" and select "Medicare Agents" when you search.

New to Medicare?

Medicare starts at 65, no matter where you are or what you're doing. Find out how Medicare will affect you. Go to shiba.oregon.gov/medicare-65/.

Immigrants and Medicare

Immigrants may apply for Medicare and other public benefits that support their health, nutrition and housing without adversely affecting their immigration status.

Have legal questions?

- Seek advice from an immigration attorney. Find immigration attorneys at https://oregonimmigrationresource.org/resources/?tab=legal-help
- Seek advice on how applying for benefits can affect immigration status. Call Legal Aid/Oregon Law Center's Public Benefits Hotline at **800-520-5292**.
- Stay informed about changes to public charge by checking oregonimmigrationresource.org and https://protectingimmigrantfamilies.org/.

Medicaid

Medicaid is a program that provides health insurance coverage for individuals with lower incomes. This state and federal partnership provides coverage for medical, dental, and behavioral health. For eligible individuals, it may also pay for long-term care, including help in people's homes.

To learn more about how to apply for Medicaid and other benefits, visit the Oregon One Eligibility website at https://one.oregon.gov/ or call **800-699-9075** (**711** TTY).

Learn how state and community resources can help

For more information on government programs and resources for older adults and people with disabilities, contact the state's Aging and Disability Resource Connection (https://adrcoforegon.org) at **855-673-2372**.

Basics

START HERE

Original Medicare
Part A and Part B

OR

Medicare Advantage Plan
Part C

Part A
Hospital insurance

Part B
Medical insurance

Combines parts A and B
Available with or without prescription coverage (Part D)

Medicare supplement insurance
(Medigap/secondary insurance)

Secondary insurance can also include:

- Retiree benefits (e.g., PERS)
- COBRA (in some cases)
- Tricare for Life/CHAMP VA
- Medicaid
- Indian Health Service (IHS)

Medicare Part D
Prescription drug plan (PDP)

Tips and Hints

Medicare cards will never have the following letters on them as they are too easily confused with numbers: B, I, L, O, S, or Z.

Contact these insurance options if available to you

- **Employer or union group plan:** Plan customer service
- **Military benefits:** Your county Veteran Services Office, **800-692-9666**
- **Medicaid:** Your Medicaid case manager, https://one.oregon.gov/ or **800-699-9075** (**711** TTY)

Your Medicare options

Enrolling in Medicare

If you are turning 65 and are already receiving Social Security or Railroad Retirement Board benefits, you should get a Medicare card and packet in the mail about three months before your birthday. Make sure to update your address with Social Security to ensure prompt delivery.

If you are not already receiving retirement benefits, you **must** contact Social Security to enroll in Medicare or to see if you can delay enrolling without penalty. You have seven months surrounding your 65th birth month to enroll, but benefits are delayed the longer you wait. See the table on **page 13** for details.

If you miss the seven-month enrollment period at age 65, you can enroll from Jan. 1 through March 31 each year. Medical benefits will begin July 1. However, you may have a late enrollment penalty.

The Social Security Administration determines eligibility, premiums and penalties. If you have questions about enrollment in Medicare, call Social Security at 800-772-1213 (toll-free) (8 a.m. to 7 p.m. Monday to Friday). Always keep an accurate record of the date, time and name of all service representatives you talk to.

You may delay enrolling in Medicare without penalty if you or your legal spouse are actively working and you are covered by an employer group health plan. However, Medicare may be primary in some cases.

Contact your benefits administrator to see if this applies.

What is Medicare Part A and Part B?

Medicare Part A and Part B, also known as "Original Medicare," cover basic hospital and medical services. However, you will share part of the cost. This guide also explains additional insurance options for health and prescription drug coverage.

Whichever Medicare path is best for you, please:

1. Call **Social Security** for information on enrolling in Part A and Part B. Call Medicare at **800-MEDICARE** or (**800-633-4227**, toll-free) for information on benefits, claims or Part D drug coverage. **Always** document the date and name of the customer service representative.
2. Make sure your providers, including hospitals, accept your insurance. Call the plans to be sure your providers, including hospitals, are in the plan's network.
3. Use the Medicare Health and Drug Plan Finder at medicare.gov, or call your plan to find out.
4. Keep records. Document phone calls with the date, time, number you called from, name of the person with whom you spoke and the information you received.

Part A – Original Medicare hospital insurance

2023 Part A premium.	Fewer than 30 work credits, $506; 30-39 credits, $278. Most people have no premium if they have 40 or more work credits. Check with Social Security for work credits.

Service	Benefit	You pay
Hospitalization Inpatient, **not observation**; semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	$1,600 deductible per benefit period. You could pay multiple deductibles in a calendar year. A deductible is required if another hospitalization occurs after the beneficiary has been discharged from the hospital or skilled nursing facility for 60 consecutive days.
	Days 61–90	$400 a day
	Days 91–150 (lifetime reserve days)	$800 a day (limited to 60 days per lifetime)
	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
	Days 21–100	Up to $200 a day
	More than 100 days	All costs
Home health care With a Medicare-certified agency	Visits limited to part-time or intermittent skilled nursing care	Nothing for services
Hospice care Available only to the terminally ill	As long as a doctor certifies medical need	Limited cost-sharing option for outpatient drugs and inpatient respite care
Blood	Blood	If the hospital has to buy blood for you, you must pay for the first 3 units or have the blood donated.

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

Part B – Original Medicare medical insurance

2023 Part B premium.	The standard Part B premium amount in 2023 is $164.90 (or higher depending on your income).
2023 Part B cost share.	After paying the annual deductible of $226, Medicare generally pays 80 percent of the Medicare-allowed amount for covered services and you pay the other 20 percent. There is no out-of-pocket maximum.

Covered services	You pay monthly Part B premium plus:
• Physician services • Emergency room, urgent care • Diagnostic tests, lab tests, MRIs, CT scans and X-rays • Part B covered drugs administered in outpatient facility	20 percent of the Medicare-allowed amount after annual deductible.
• Ambulance transportation	Nothing if it is a threat to your life to travel in any other way.
• Diabetes supplies • Durable medical equipment, prosthetics/orthotics	See page 16 for details.
Hospital observation stay	Copayment determined by Medicare payment formula, after annual deductible.
Occupational, physical and speech therapy	20 percent of Medicare-allowed amount after annual deductible.
Acupuncture	20 percent of Medicare-allowed amount after annual deductible for treatment of chronic low back pain.
Home health care (same as in Part A)	Nothing for covered services.
Preventive services, some clinical lab services (blood tests, urinalysis)	Nothing for most tests or procedures; fees for office visits or other costs may apply.
Mental health	20 percent of Medicare-allowed amount after annual deductible.

The ABCs – and D – of Medicare

What is Medicare?

Medicare is health insurance for:

- People age 65 years and older
- People younger than 65 receiving Social Security Disability Insurance (SSDI) income for more than 24 months
- People with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

This guide contains information on the following areas of Medicare coverage:

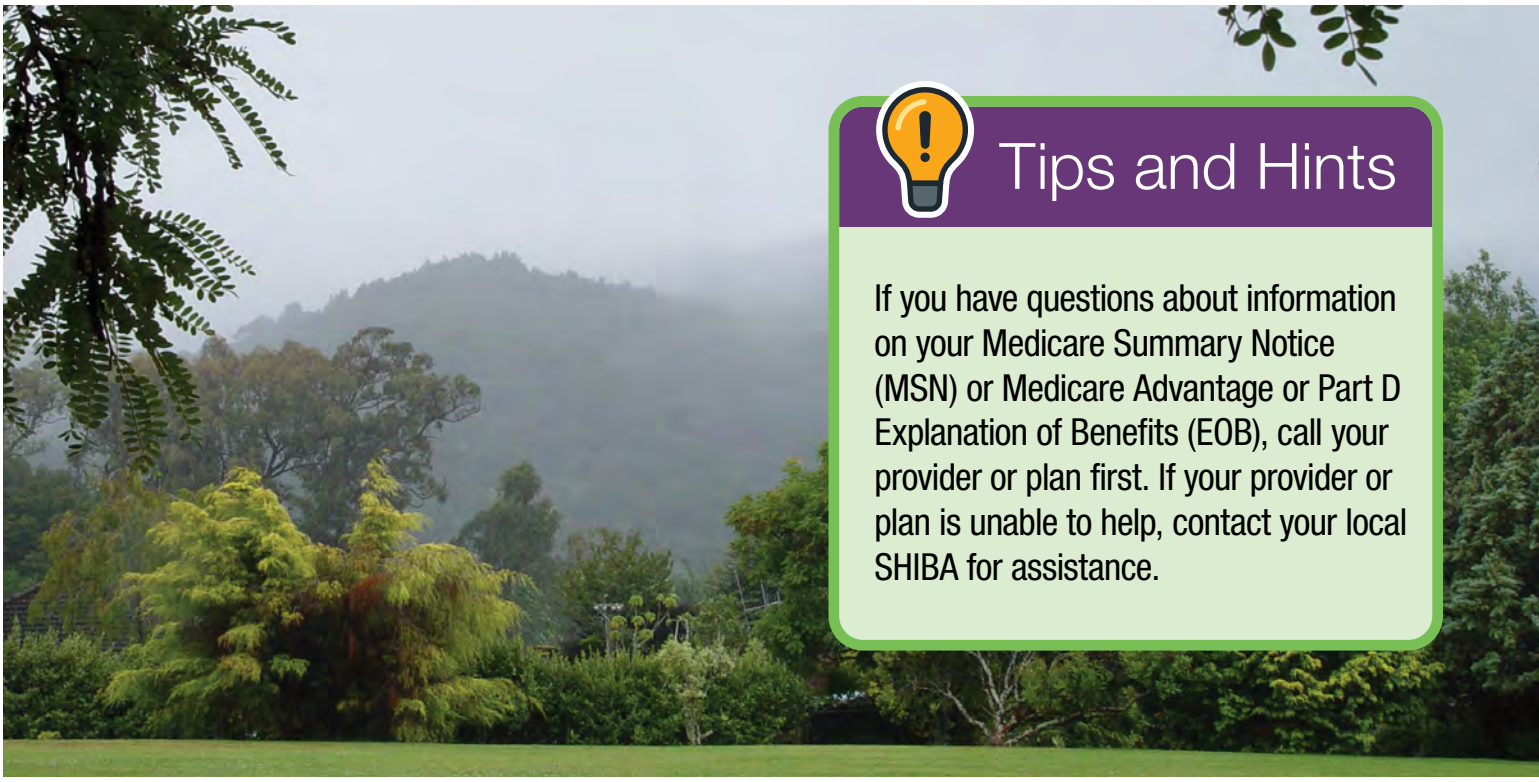
- Part A: Hospital insurance*
- Part B: Medical insurance*
- Medicare supplements, also called Medigap plans
- Part C: Medicare Advantage plans and private Medicare health insurance plans
- Part D: Prescription drug coverage.

Because Medicare is health **insurance**, you share the costs of your care.

*Some of the items not covered by Part A or Part B

- Long-term care
- Dental care and dentures
- Outpatient prescription drugs
- Hearing aids/exams for fitting hearing aids
- Routine vision and eyeglasses
- Routine annual physical exams with lab tests
- Travel outside the United States, with limited exceptions
- Alternative care (naturopathic, therapeutic massage)
- Medical transport services including non-life-threatening ambulance rides

Notes



Tips and Hints

If you have questions about information on your Medicare Summary Notice (MSN) or Medicare Advantage or Part D Explanation of Benefits (EOB), call your provider or plan first. If your provider or plan is unable to help, contact your local SHIBA for assistance.

Enrollment periods

Initial enrollment period (IEP)

The initial enrollment period is a seven-month period surrounding your 65th birth month (the three months before your 65th birth month; the month of your 65th birthday; and the three months following your 65th birth month).

People who are not auto-enrolled, or those who must pay a premium for Part A coverage, can sign up for Medicare during the initial or general enrollment periods (IEPs or GEPs).

Everyone is eligible for Medicare at age 65, as long as they have resided legally in the United States for five years or longer. For people older than age 65 who have not yet met this legal residency time period, the 60th month of legal residency would be treated the same as their 65th birth month. The initial enrollment period would then start on the 57th month and end on the 63rd month of their legal residency.

I missed my initial enrollment period (IEP)

If you missed your IEP and are not covered by your or your spouse's active employer group health plan (EGHP), you will need to enroll in Medicare during the general enrollment period. The general enrollment period is Jan. 1 to March 31 each year. Go to Social Security or call them at **800-772-1213** to initiate your enrollment. Premium-free Part A is effective six months before contacting Social Security. Part B is effective the month following the enrollment request.

After you use the general enrollment period between Jan. 1 and March 31, you must enroll in a Medicare Advantage plan before Medicare takes effect to start with your Medicare Part A and Part B. Late enrollment penalties for Part B and prescription drug plans may apply.

Initial enrollment period and effective dates	
If you enroll in this month of your IEP	**Your Medicare coverage starts the first day of this month:**
First month (3 months before birth month)	Month of 65th birthday
Second month (2 months before birth month)	Month of 65th birthday
Third month (1 month before birth month)	Month of 65th birthday
Fourth month (birth month)	Month after birth month
Fifth month (1 month after birth month)	Month following enrollment request
Sixth month (2 months after birth month)	Month following enrollment request
Seventh month (3 months after birth month)	Month following enrollment request
Exception: If your birthday is on the first day of the month, then your IEP starts one month earlier.	

Enrollment periods and deadlines

(See acronym definitions starting on page 91.)

Plan	IEP/OEP	AEP/GEP	SEP/GI	MA OEP	Late penalty
Medicare Part A	The **seven months** that begin three months before age 65, or auto-enrolled after 24 months of receiving SSDI. Auto-enrolled if receiving Social Security Retirement Benefits.	GEP: **Occurs every January through March**; if Part A free, effective date is 6 months retroactive from application; if Part A premium paid, takes effect the month following the enrollment request.	Any time if premium free. If not premium free, any time while covered by an **EGHP** through active work (self or spouse), or up to **eight months** starting with the month active work ends.	N/A	None, unless premium is not free – penalty is 10 percent of premium; lasts twice as long as enrollment was delayed.
Medicare Part B	The **seven months** that begin three months before age 65, or auto-enrolled after 24 months if already receiving SSDI. Auto enrolled if receiving Social Security Retirement Benefits prior to 65th birth month.	GEP: **January, February and March** each year; Part B coverage effective the month following the enrollment request.	Any time while covered by an EGHP through active work (self or spouse), or up to **eight months** starting with the month active work ends.	N/A	Premium penalty is 10 percent of current Part B premium per year of delayed enrollment; continues for lifetime, unless you qualify for MSP.
Medigap	May purchase as soon as you have both Part A and Part B. **OEP w/GI for first six months of Part B, regardless of age (under or over 65).**	Any time, but at plan's discretion; company may underwrite or deny for pre-existing health conditions, unless GI applies.	**63-day GI period** from date previous health coverage ends **30-day GI period** (starting on current policyholder's birthday) to switch to a different company. See page 36 for trial right guaranteed issue period information.	N/A	May cost more. If beyond OEP and GI periods, plan may refuse to insure due to health conditions

(See acronym definitions starting on page 91.)

Plan	IEP/OEP	AEP/GEP	SEP/GI	MA OEP	Late penalty
Medicare Advantage	The **seven-month period** that begins three months before turning age 65, or before the date of qualifying for Medicare due to SSDI.	AEP: **Oct. 15–Dec. 7**; effective Jan. 1. GEP: If enrolling in Part A and B during GEP, then MA enrollment must take place prior to the effective date of Medicare Part B.	**60 days** following loss of other coverage, or within the first 12 months of first plan. **Also includes five-star and low-performing plan SEPs.** **See page 51.** **First three quarters of the year for those receiving** Extra Help or Medicaid.	Jan. 1–March 31 or first three months of MA if new to Medicare. Only one action allowed. See page 51.	None for health coverage. Delayed drug enrollment may incur Part D penalty added to premium.
Medicare Part D	The **seven-month** period that begins three months before age 65, or before the date of qualifying for Medicare due to SSDI.	AEP: **Oct. 15–Dec. 7**; effective Jan. 1. GEP: If paying Part A premium, then PDP enrollment April 1–June 30; effective July 1.	**60 days** following loss of other coverage. Also includes five-star and low-performing plan SEPs. See page 51. **First three quarters of the year for those receiving** Extra Help or Medicaid.	Jan. 1–March 31 each year if in an MA plan on Jan 1. Only one action allowed. See page 51.	Penalty for each month enrollment was delayed is 1 percent of a benchmark premium; e.g., 24 months of delay becomes 24 percent penalty; continues for lifetime unless you qualify for Extra Help. See page 25.

Part B Medicare preventive services

Medicare offers some preventive services at reduced cost if you get them from a provider that accepts the Medicare assigned fee. Certain facilities' fees or office visit charges may apply to some benefits. Ask your doctor which services are right for you.

Before receiving any preventive service, ask your doctor's billing office if the service is a Medicare-covered expense for you. Restrictions apply to all benefits. Be sure to keep an accurate record of all preventive services received.

Tip: If you use Original Medicare, you can keep track of your preventive services by creating your own medicare.gov account.

Medicare-covered preventive services

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings and counseling
- Bone mass measurements (bone density)
- Cardiovascular disease screenings

- Cardiovascular disease (behavioral therapy)
- Cervical and vaginal cancer screening
- Colorectal cancer screenings
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Hepatitis B infection screening
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Nutrition therapy services
- Obesity screenings and counseling
- One-time Welcome to Medicare preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening and counseling
- Shots:
  - » Flu shots
  - » Hepatitis B shots
  - » Pneumococcal shots
- Tobacco use cessation counseling
- Yearly wellness visit

Medicare Advantage plans must provide these preventive screenings. Check with your plan for any facility or other fees.

Preventive visits

(Applies only to Original Medicare, not Medicare Advantage)

The Welcome to Medicare preventive visit

You can get this free visit within the first 12 months you have Part B. This visit includes a review of your medical and social history related to your health and education; it also includes counseling about preventive services, including certain screenings, shots and referrals for other care, if needed. It also provides:

- Height, weight and blood pressure
- Calculation of your body mass index
- Simple vision test
- Review of your potential risk for depression and your level of safety
- An offer to talk with you about creating an advance directive
- A written plan to let you know about what screenings, shots and other preventive services you need.

This is a one-time visit; you are not required to go to it for your yearly wellness visit to be covered. The Welcome to Medicare visit may not be covered if any other services are provided that day. Make sure when you make the appointment to inform them you want the Welcome to Medicare visit. This is not an annual physical.

The yearly wellness visit

If you have had Part B longer than 12 months, you can get this free visit to develop or update a personalized plan to prevent disease and disability based on your current health and risk factors. Your provider will ask you to fill out a health risk assessment as part of the visit, which will help you and your provider develop a personalized prevention plan to help you stay healthy. The visit also includes:

- Review of your medical and family history
- Developing and updating a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- List of your risk factors and treatment options
- A screening schedule for appropriate preventive services
- Advance care planning

This visit is covered once every 12 months (11 months must have passed since the last visit).

Original Medicare – ABN and DMEPOS

Advance Beneficiary Notices (ABNs) Mandatory and Voluntary

Sometimes, medical providers or suppliers **must** notify you in writing (with an ABN) if they believe Medicare will not cover a particular service. The ABN should identify the specific service that is not covered and your costs.

If you do not get the notice to sign and it was required, you may not have to pay the bills. The ABN is not required for items and services that are never covered by Medicare. Also, the notices apply to people in Original Medicare and not those with Medicare Advantage plans. ***Never sign a blank ABN.***

Routine ABNs (a practice of obtaining beneficiary signatures on blank forms and then completing them later) are a violation of Medicare rules. Telling the patient "we need you to sign because we never know if Medicare will pay" is also not allowed. The provider should know based on medical codes used if Medicare will cover a service.

Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

All DMEPOS purchases must be physician prescribed, usually accompanied with a statement of medical necessity and made through a Medicare-contracted supplier. Your share is 20 percent of the Medicare-assigned rate if the supplier accepts assignment. To find a supplier, go to medicare.gov/medical-equipment-suppliers/

Note: Medicare will not reimburse you if you pay a supplier the full amount up front. Make sure you are receiving supplies from a Medicare-contracted supplier that directly bills Medicare.

Mail-order diabetic supplies

Medicare will reimburse only contracted suppliers for diabetic testing supplies delivered to beneficiaries' residences. Mail order means items shipped or delivered to the beneficiaries' residences, including home deliveries offered through some pharmacies.

If you have a Medicare Advantage plan, contact the plan to find out the suppliers your plan contracts with; use these suppliers to obtain all your DMEPOS.

Veterans' benefits and Medicare

Veterans need to understand how the Department of Veterans Affairs (VA) and Medicare work together in their case. Veterans who have Medicare and VA may receive services through either program. However, **they must choose which benefit they will use each time they see a doctor or receive health care** (e.g., in a hospital). Medicare will not pay for the same service that VA authorized; similarly, veterans' benefits will not make primary payment for the same service covered by Medicare. Some veterans receive their health care for free, including prescriptions. Others may be responsible for making copayments, which Medicare will not reimburse.

To receive services under VA benefits, a person must receive their health care at a VA facility **or** have the VA authorize services in a non-VA facility.

Veterans could be subject to a penalty for enrolling late for Medicare Part B, even if they are enrolled in VA health care.

VA drug coverage is considered Medicare creditable, which protects against the penalty for delayed enrollment in Medicare Part D. To avoid penalty when enrolling in a Medicare drug plan, you must provide proof of VA drug coverage. To request a letter of creditable coverage or information regarding current benefit status, contact the VA health benefits hotline at **877-222-VETS (8387)** (toll-free).

Some veterans benefit from using both their VA drug benefit and enrolling in a Medicare plan for those drugs the VA may not cover. When a Medicare drug plan is used, VA does not reimburse out-of-pocket expenses and VA is not a secondary payer.

Every county is assigned a veterans service officer (VSO) to help you with your VA benefits. To find your local VSO, go to oregon.gov/odva/services/pages/county-services.aspx or call **800-828-8801** (toll-free).

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

For eligibility information, call the Department of Defense at **866-773-0404** (toll-free) or visit tricare4u.com.

Program	Medicare Required?	Coordination
Federal Employee Health Benefits (FEHB)	No, but late enrollment penalty (LEP) still applies.	Yes, if enrolled in Medicare Parts A&B.
Tricare For Life (TFL)	Yes, both Parts A&B	TFL pays secondary after Medicare
CHAMPVA	Yes, both Parts A&B	CHAMPVA pays secondary after Medicare
Veterans Affairs (VA)	No, but late enrollment penalty (LEP) still applies.	Rarely will coordinate with Medicare. Either VA pays or Medicare pays.
Indian Health Service (IHS)	No, but late enrollment penalty (LEP) still applies.	Saves tribal dollars if Medicare enrolled. IHS pays secondary after Medicare.

Retiree plans and Medicare

In most cases, you must be enrolled in Medicare Part A and Part B in order to enroll in or continue with any of the retiree plan options if you are:

- Eligible for group health plan (retiree) coverage from a former employer, and
- Approaching or older than 65.

Exercising your option to enroll in the retiree plan once you are Medicare-eligible will most likely have a deadline. Check with your employer's plan administrator for eligibility timelines and rules. Not enrolling on time may prohibit you from enrolling in the future.

Once you are retired and have Medicare and group health plan (retiree) coverage from a former employer, be sure you know whether your group health plan:

- Pays after Medicare (secondary), or
- Is a managed care plan that pays primary.

How your retiree group health plan coverage works depends on the terms of your specific plan. Group health plan coverage after you retire may have different rules and might not work the same way after you have Medicare.

Five things to know about retiree coverage

1. Find out if you can continue your employer coverage after you retire. Generally, when you have retiree coverage from an employer or union, it controls this coverage. Employers are not required to provide retiree coverage; they can change benefits or premiums, or even cancel coverage.
2. Find out the price and benefits of the retiree coverage, including whether it includes coverage for your spouse. Your employer or union may offer retiree coverage for you, your spouse or both that limits how much it will pay. It might provide only "stop loss" coverage, which starts paying your out-of-pocket costs only when they reach a maximum amount.
3. Find out what happens to your retiree coverage when you are eligible for Medicare. For example, retiree coverage might not pay your medical costs during any period in which you were eligible for Medicare but did not sign up for it. When you become eligible for Medicare, you may need to enroll in both Medicare Part A and Part B to get full benefits from your retiree coverage.
4. Find out what effect your continued coverage as a retiree will have on both your and your spouse's health coverage. If you are not sure how your retiree coverage works with Medicare, get a copy of your plan's benefit booklet or look at the summary plan description provided by your employer or union. You can also call your employer's benefits administrator to ask how the plan pays when you have Medicare. You may want to talk to a SHIBA counselor for advice about whether to buy a Medicare Supplement Insurance (Medigap) policy.
5. If your former employer discontinues your coverage, Oregon law gives you

the right to buy a Medigap policy with guaranteed issue within 63 days. This applies even if you are no longer in your Medigap open enrollment period.

Medicare pays first after you retire. As a result, your retiree coverage is likely similar to coverage under Medicare Supplement Insurance (Medigap). Retiree coverage is not the same thing as a Medigap policy; however, similar to a Medigap policy, it usually offers benefits that fill in some of Medicare's gaps in coverage, such as co-insurance and deductibles. Sometimes, retiree coverage includes extra benefits, such as coverage for extra days in the hospital, routine vision exams or dental benefits.

COBRA and Medicare

If your Medicare benefits (Part A or Part B) become effective on or before the day you elect COBRA coverage, you can continue COBRA coverage as well as having Medicare. This is true even if your Part A benefits begin before you elect COBRA but you don't sign up for Part B until later. In this situation, Medicare is always primary to COBRA coverage. COBRA is not active work group health and will not protect from the Part B late enrollment penalty. Medicare A and B will be required in most circumstances.

If you become entitled to Medicare after you have signed up for COBRA, your COBRA benefits end when Medicare begins. However, if COBRA covers your spouse and/or dependent children, their coverage may be extended for up to 36 months because you qualified for Medicare.

Medicare and employer group health plans (EGHPs)

When you or your spouse are still working and covered by an employer group health plan, you can delay enrolling into Medicare without penalty. However, if the employer has fewer than 20 employees, Medicare typically pays first (primary). The employer plan would then pay second, whether or not you are enrolled in Medicare. If you or your spouse are on Medicare due to disability (younger than age 65), Medicare pays first for companies with fewer than 100 employees.

When you are covered by active-work group health, you may generally enroll in Medicare Part A and Part B at any time while you are working or up to the eighth month from the date work stopped.

When your EGHP ends, you will have a special enrollment period (SEP) to enroll in Medicare and additional Medicare-related insurance plans. You could choose to enroll into a:

- Retiree plan if available (page 20)
- Medicare Advantage Plan (health and drug combined) (page 50)
- Secondary policy, called a Medicare Supplement Insurance (Medigap) (Pages page 32)
- Stand-alone prescription drug plan (page 30)

Time is limited to make a choice on your enrollment to avoid any late enrollment penalties, so do not delay. A chart with the timelines is on page 13 of this guide.

Employer high-deductible health plans with health savings accounts (HSAs)

You must choose between continuing to contribute to the HSA or enrolling in Medicare Part A if:

- You are covered by a high-deductible health plan (HDHP) through your employer, and
- You and/or your employer are making contributions to a health savings account (HSA).

Once you enroll in Medicare at all, you are no longer eligible to contribute or receive contributions to your HSA. There are tax consequences and penalties if contributions continue.

If you choose to continue working past age 65 and contribute to the HSA, contributions must stop six months before enrolling in Medicare. This is because Part A, if premium-free, will become effective six months retroactively, or to your 65th birth month, whichever occurs first. Calling Social Security to set an appointment is called a "protective filing date" and Part A will have an effective date six months retroactive from the date of the call.

Time is limited to make a choice on your enrollment to avoid any late enrollment penalties, so do not delay. A chart with the timelines is on **page 13** of this guide.

Medicare and the Marketplace

If you have Medicare, you should not need to buy coverage through the Health Insurance Marketplace (healthcare.gov).

The Marketplace is for individuals, families and employees of small businesses to get health coverage — either through private insurance companies or the Oregon Health Plan. Below are frequently asked questions about Medicare and the Marketplace.

Can I get a Marketplace plan in addition to Medicare?

No. It is against the law for someone who knows you have Medicare to sell you a health plan through the Marketplace or an insurance company. This is true even if you have only Part A or Part B. Instead of a Marketplace plan, there are plans specifically designed to work with Medicare. Go to **page 32** to learn about Medigap policies and **page 50** to learn about Medicare Advantage plans. You can also call SHIBA or visit medicare.gov for more information.

Can I choose the Marketplace coverage instead of Medicare?

Generally, no. However, there are a few exceptions:

- You may be able to get a plan through the Marketplace:
  - » If you are eligible for Medicare but have not enrolled because you would have to pay a premium for Part A, or

because you are not collecting Social Security benefits
  - » If you are paying a premium for Part A (you can drop your Part A and Part B coverage)
  - » If you do not have five years of documented legal resident status to qualify for Medicare or Medicaid.

Your household income will determine whether you qualify for financial help to pay for the plan through the Marketplace. For more information about Marketplace coverage, visit healthcare.gov or call **800-318-2596** (toll-free).

Before making a choice, there are two points to consider:

- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.
- Outside the initial enrollment period, you can usually enroll in Medicare only during the Medicare general enrollment period (from Jan. 1 to March 31). Your coverage will begin the month following the enrollment request.
- See **page 14** for enrollment periods and deadlines.

What if I become eligible for Medicare after I join a Marketplace plan?

You can get a health insurance plan through the Marketplace before your Medicare begins. You can then cancel your Marketplace plan when your Medicare coverage starts.

Once you are eligible for Medicare, you will have an initial enrollment period to sign up. For most people, this period starts three months before their 65th birth month and ends three months after their 65th birth month.

In most cases, it is to your advantage to sign up when you are first eligible because:

- Once you are eligible for Medicare, you will not be able to get lower costs for a Marketplace plan based on your income.
- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.

Note: You can keep your Marketplace plan after your Medicare coverage starts. However, once your eligibility for premium-free Part A coverage starts, any financial help you get through the Marketplace will stop. This is true whether or not you were enrolled in Medicare.

Additionally, your Marketplace plan will not renew once you are eligible for premium-free Part A.

Can I get a stand-alone dental plan through the Marketplace?

No, you cannot buy a dental plan through the Marketplace if you have Medicare. However, you may purchase a dental plan directly from a health insurance company. Contact your agent.

Where can I get dental insurance to go with Medicare?

SHIBA offices have a list of stand-alone dental insurance companies that sell policies in Oregon. Also, some Medicare Advantage plans include preventive dental in their core benefits. These plans can add a dental rider to cover comprehensive services.

Drug coverage

Part D prescription drug coverage

Medicare Part D

Medicare offers prescription drug insurance to all Medicare beneficiaries, regardless of income or health. Medicare Part D plans cover most self-administered drugs, as well as some pharmacy-administered vaccines such as the shingles vaccine.

Private insurance companies contracted with Medicare offer the plans, which may require monthly premiums, copays, co-insurance and deductibles.

Part D coverage is available through stand-alone prescription drug plans (PDPs) that cover only drugs, as well as from Medicare Advantage with Prescription Drug (MAPD) plans that combine health and drug coverage.

If you want prescription drug coverage, you must be enrolled in Medicare Part A or Part B, and take an action to enroll in a plan.

Do I need prescription drug coverage?

Medicare Part D is like all insurance. It covers you if you need it now and it protects you against future prescription costs. If you do not enroll in Part D when you are first eligible, you may have to pay a late enrollment penalty later.

What if I have prescription coverage?

If you already have a Part D stand-alone prescription plan, your insurance company must send you a packet in early October describing the changes for the coming year. Carefully read the documents.

If you already have prescription coverage through an employer, a union or a government agency (such as the VA), you may want to stay with your existing plan if the drug benefits are creditable – as good as or better than Medicare's standard Part D benefit. If you do

Tips and Hints

Save your Medicare Summary Notices (MSNs) and Medicare Advantage and Part D Explanations of Benefits (EOBs). Keep a Personal Health Care Journal, available from your local Senior Medicare Patrol, so you can double-check that your records match the notices you receive. Shred any documents you decide to no longer store in a secure place.

not have a letter telling you whether your coverage is creditable, contact your benefits administrator and request one. Always save any proof of creditable coverage.

The late penalty

If you are eligible for Part D and do not have other creditable coverage, you may face a penalty when you enroll in the future. In 2023, the penalty is ~33 cents times the number of months without creditable drug coverage, added to the premium of the chosen plan (PDP or MAPD). If you have other drug coverage, that plan's benefits administrator must issue a letter stating whether your coverage is as good as or better than Medicare's basic PDP benefit.

The late penalty will be waived if you qualify for Extra Help (see **page 28**), or you have Medicare due to disability and you turn 65.

Where do I get help choosing a prescription drug plan?

- Visit medicare.gov.
- Call SHIBA (Senior Health Insurance Benefits Assistance program) at **800-722-4134** (toll-free).
- Call Medicare at **800-633-4227** (toll-free).

Can I switch plans?

Yes. Plans change every year. Medicare recommends that you review your prescription drug plan each fall. You may join, drop or switch plans during the annual enrollment period (AEP) from **Oct. 15** to **Dec. 7**.

If you start the year with a Medicare Advantage (MA) plan, you can use the MA open enrollment period from Jan. 1 to March 31 to make changes to drug coverage. (See **page 51** for details.)

To switch plans:

- Enroll in a new prescription drug plan or a Medicare Advantage plan that includes prescription drug coverage. Your new plan will replace your old plan starting Jan. 1. **You do not need to take any other action to end your prior plan**.
- If you take more than one enrollment action during the fall annual enrollment period, the last action received by Medicare before the period closes will become effective. Do not make more than one enrollment action on the same day.

If you move to a new state, you must enroll in a new plan in your new state, even if you are enrolled in a national plan.

Things to look for in a drug plan

Drug list: Also known as a "formulary," each drug plan has a list of prescription drugs it covers. Plans differ by formularies, rules governing access and costs.

Restrictions: All the plans are allowed to apply restrictions to their drug formulary. Types of restrictions and limitations imposed are:

- Prior authorization: Your prescriber must contact the plan to show the drug is medically necessary for the plan to cover it. A 30-day supply is available while this is processed.

- Quantity limits: For cost, safety or legal reasons, some plans limit the quantity of drugs they cover over a period of time. If you require more than the allowed amount, your doctor must submit proof it is medically necessary. Your plan may then grant an exception to the limit.
- Step therapy: The plan requires that you must first try certain less-expensive drugs on its formulary before it covers a more expensive brand-name drug. The doctor can contact the plan to request an exception:
  - » If you have previously tried the drug and it did not work, or
  - » If your doctor believes, due to your medical condition, it is medically necessary for you to be on a specific drug.

  If the plan approves the request, the drug will be covered.

Picking a plan with the fewest or no restrictions – even if you pay a somewhat higher price overall – may be a good choice. It will lessen the amount of delay and paperwork to receive your preferred drugs.

What are the out-of-pocket costs for Part D?

Drug plan premiums have a wide range of costs. Higher premium plans do not necessarily cover your medications better than lower premium plans. The real determining factor is the specific medications on your personal list. The Plan Finder on medicare.gov is the best tool for doing a cost comparison and choosing the plan that works best for you.

All medications on a plan's formulary are assigned a "tier" level, indicating the cost share a member will pay at the pharmacy. There are two ways of determining the cost share paid for each medication:

- Copays, a set dollar amount, tend to be on the lower-tiered drugs. Copays will be a consistent cost share throughout the year.
- Co-insurance, a percentage of cost, is often applied to the higher-tiered drugs. Co-insurance cost shares change along with market fluctuation.

Medicare.gov Plan Finder drug plan detail (under "+ View more drug coverage", Other Drug Information) tells you whether your drug list requires copays or co-insurance.

Cost share is also greatly affected by whether the pharmacy you use is a preferred pharmacy.

Drug plan benefits are not available if you use an out-of-network pharmacy. You pay the retail cost, as if you had no insurance. If you travel out of state, be sure you are enrolled in a plan that works nationally.

Can I have more than one prescription drug plan at a time?

It depends. If you are enrolled with Veterans Affairs drug benefits or Indian Health Service pharmacy, you are in a special group that has creditable coverage; you can have one or both types of coverage. Whether it will be a benefit to have both options depends on your drug list. However, people with creditable union, employer or retiree coverage could end up canceling their benefits by signing up for a Medicare Part D plan.

With the exception of Medicare Medical

Savings Account (MSA) plans, you cannot have a Medicare Advantage (MA) plan (HMO or PPO) and a separate stand-alone drug plan. Your drug coverage must be included with the MA plan you choose.

Inflation Reduction Act

Starting in 2023, Part D and Medicare Advantage plans must limit monthly copays for a 30-day supply of insulin to $35. Use the Medicare.gov Plan Finder to review if your diabetic medication is included.

More ways to pay for prescription drugs

- **Drug manufacturers' discount programs or patient-assistance programs**. Some are available if you enrolled in Part D and still cannot afford your drugs. For a list of programs and links to applications, visit needymeds.org (**800-503-6897**).
- **Employer group health plans**. Many employer group health plans cover prescription drugs. Check with your benefits administrator for your coverage information.
- **Oregon Prescription Drug Program** (OPDP), a bulk-purchasing pool, is **free** to anyone living in Oregon. Apply at https://www.oregon.gov/oha/HPA/dsi-opdp/Pages/index.aspx. Most major pharmacy chains, except Walgreens, are included in the bulk-purchasing pool network. You may have both Part D and an OPDP discount card; however, you can use only one for a purchase. The OPDP discount card is not insurance. Call **800-913-4284** to sign up for the discount card.

Other discounts or coupons, such as GoodRX.com, are sometimes available. Discount cards do not protect from a late enrollment penalty because they are not insurance.

Part D standard benefit terms

Monthly premium: Plans have a premium. This is the amount you pay every month, even if you do not buy any prescription drugs. Oregon stand-alone drug plan premiums in 2023 range from $1.60 to $113 monthly.

Yearly deductible: Some plans have a yearly deductible. You pay this amount before the insurance plan pays its part of your prescription drug costs. This amount can be up to $505. After you have paid your plan's deductible, the plan pays an average of 75 percent of your drug costs up to a certain dollar amount.

Initial benefit period: When the insurance plan starts to pay for covered drugs, you still pay a percentage or a copay amount (such as a $15 copay at the pharmacy). Note: Tier 3 and 4 drugs can be a cost share of 33 percent to 44 percent.

Coverage gap: Health care reform has phased out the "donut hole." In 2023, after your total drug value reaches $4,660, you will pay 25 percent of the cost of brand-name drugs and 25 percent of generic drug costs. The donut-hole does not apply to people receiving Extra Help.

Catastrophic coverage: Once you have spent $7,400 out of pocket in 2023, you are out of the coverage gap and automatically receive catastrophic coverage. When you reach catastrophic coverage, you pay the higher amount of 5 percent or $4.15 for generics or $10.35 for other drugs for the rest of the year.

Extra Help and the Medicare Savings Program

Help with Part D

The federal government's Extra Help program, also called the Low Income Subsidy (LIS), saves qualifying beneficiaries money on their Medicare Part D plans.

Extra Help:

- Reduces the monthly premium, often to $0
- Cuts the yearly deductible, often to $0, but to no more than $104
- Greatly reduces pharmacy copays, even on expensive medications
- Reduces the coverage gap ("donut hole") cost sharing to no more than 15 percent for brand-name and generic drugs.

You must be enrolled in a Part D plan. Your level of assistance depends on your income and resources. Once approved for Extra Help, you must choose a plan. If you do not choose a plan, you will be automatically enrolled in a random $0 premium plan that may not cover your specific needs.

How to apply:

- Call your local SHIBA counselor at **800-722-4134** (toll-free)
- Online at BenefitsCheckUp benefitscheckup.org/Oregon
- Call Oregon Medicare Savings Connect at **855-447-0155** (toll-free)

In addition, you can find a variety of **patient-assistance programs** online for help with drug costs or for specific diseases or conditions. A good place to start is needymeds.org. (**800-503-6897**).

Help with the Part B premium and other Medicare costs

The Medicare Savings Program (MSP) can help pay for the Medicare Part B premium, co-insurance, and deductible depending on your level of income. MSP automatically qualifies you for Extra Help.

The Employed Persons with Disabilities (EPD) program provides financial assistance to those on Medicare due to disability who are also working. To see if you qualify, apply at your local office of Aging and People with Disabilities, part of the Oregon Department of Human Services (ODHS). To find your local office, call **800-282-8096** (toll-free) or go to www.oregon.gov/DHS/Offices/Pages/Seniors-Disabilities.aspx.

Ask about the Medicare Savings, QMB (Qualified Medicare Beneficiary) or EPD (employed persons with disabilities) Programs.

If you get Supplemental Security Income (SSI), you automatically receive this financial help.

Estate recovery

- No estate recovery for MSP (partial Medicaid)
- No estate recovery for Extra Help
- Estate recovery continues for full Medicaid
- For more information, call Estate Administration, **800-826-5675** (toll-free).

Part D standard benefit, what you pay for drugs

This diagram shows the standard prescription drug plan benefit. Coverage begins Jan. 1, 2023. The costs shown below are in addition to any monthly premium charged by the drug plan. Total value of $4,660 includes beneficiary cost and plan payment.

<table>
<tr><th colspan="5">Standard Benefit 2023</th></tr>
<tr><th rowspan="2">1
Deductible period</th><th rowspan="2">2
Initial benefit period</th><th colspan="2">3
Coverage gap (aka “donut hole”)</th><th rowspan="2">4
Catastrophic coverage</th></tr>
<tr><th>Brand name drug</th><th>Generic drug</th></tr>
<tr><td colspan="2">$4,660 total value of drugs</td><td>5%</td><td rowspan="2">75%</td><td rowspan="2">Plan pays %
Medicare pays %

95% covered by Medicare and plan</td></tr>
<tr><td rowspan="2">100% ($505) maximum (can be less)</td><td>Plan pays 75% on average (~$3,116)</td><td>70% manufacturer discount</td></tr>
<tr><td>Co-insurance 25% on average (~$987)</td><td>25%</td><td>25%</td><td>Greater of 5% co-insurance or $4.15/$10.35 minimum</td></tr>
<tr><td>$505</td><td>$1,038.75</td><td colspan="2">$5,856.25</td><td rowspan="2">Beneficiary pays</td><td rowspan="2">Plan pays</td></tr>
<tr><td colspan="4">$7,400 TrOOP</td></tr>
</table>

Yellow cells = the dollar amounts coming out the member’s pocket.

Blue cells = what is paid by either the plan or by Medicare.

Green cell = yellow + blue. The green bar represents all the dollars paid by both the member and the plan in the first three squares (2 yellow and 1 blue).

Orange cell = all the yellow squares plus the pink square (yellow + pink = orange). The dollar amount shown, $7,400, includes all the money paid out of pocket by the member (yellow cells) plus any brand name manufacturers’ discounts (pink cell).

In 2023, 95 percent of the full price of a brand name and 25 percent of a generic goes toward True Out Of Pocket expense (TrOOP). Once this amount reaches $7,400, then Stage 4 — Catastrophic Coverage is reached.

2023 stand-alone prescription drug plans

Parent company name, contract and phone numbers	Plan name and plan number	Premium	Annual deductible	Tiers exempt from deductible	Additional coverage in gap	Plan premium with 100% Extra Help
Aetna Medicare S5601* M - **866-235-5660** NM - **833-526-2445**	SilverScript SmartSaver (E) - 205	$1.60	$505.00	Tier 1	No	$1.60
	SilverScript Choice (B) - 060	$40.50	$505.00		No	$0.00
	SilverScript Plus (E) - 061	$73.50	$0.00		Yes	$56.80
Asuris Northwest Health S5609 M - **800-541-8981** NM - **888-369-3172**	Asuris Medicare Script Basic (B) -001	$84.00	$455.00	Tiers 1, 2	No	$43.00
	Asuris Medicare Script Enhanced (E) - 002	$113.00	$0.00		Yes	$72.00
Cigna-HealthSpring Rx S5617* M - **800-222-6700** NM - **800-735-1459**	Cigna Secure Rx (B) -148	$38.70	$505.00	Tiers 1, 6	No	$0.00
	Cigna Saver Rx (B) -380	$12.30	$505.00	Tiers 1, 2	No	$12.30
	Cigna Extra Rx (E) - 275	$54.70	$100.00	Tiers 1, 2, 3, 6	Yes	$50.30
Clear Spring Health S6946 M - **877-317-6082** NM - **877-317-6082**	Clear Spring Health Premier Rx (E) - 054	$22.60	$505.00	Tiers 1, 2	No	$13.00
	Clear Spring Health Value Rx (B) - 025	$28.50	$505.00		No	$0.00
Elixir Insurance S7694* M - **866-250-2005** NM - **888-377-1439**	Elixir RxPlus (E) - 136	$58.30	$505.00	Tiers 1, 2	No	$17.30
	Elixir RxSecure (B) - 030	$39.60	$505.00		No	$0.00

*** Nationwide plans**
(B) = Basic drug benefit (see glossary)
(E) = Enhanced drug benefit (see glossary)
Key: NM - nonmember, M - member, TTY - teletypewriter

Parent company name, contract and phone numbers	Plan name and plan number	Premium	Annual deductible	Tiers exempt from deductible	Additional coverage in gap	Plan premium with 100% Extra Help
Humana S5884* M - **800-281-6918** NM - **800-706-0872**	Humana Walmart Value Rx Plan (E) - 209	$30.60	$505.00	Tiers 1, 2	No	$3.10
	Humana Basic Rx Plan (B) - 113	$40.60	$505.00		No	$0.00
	Humana Premier Rx Plan (E) - 176	$81.30	$505.00	Tiers 1, 2	Yes	$40.30
Mutual of Omaha Rx S7126 M - **855-864-6797** NM - **800-961-9006**	Mutual of Omaha Rx Essential (E) - 132	$18.30	$505.00	Tier 1	No	$18.30
	Mutual of Omaha Rx Premier (E) - 099	$59.40	$505.00	Tiers 1, 2	No	$56.00
	Mutual of Omaha Rx Plus (B) - 029	$98.00	$505.00		No	$57.00
UnitedHealthcare S5820* M - **888-867-5575** NM - **888-867-5564**	AARP MedicareRx Preferred (E) - 029	$110.20	$0.00		Yes	$69.20
UnitedHealthcare S5921* M - **866-870-3470** NM - **800-753-8004**	AARP MedicareRx Walgreens (E) - 411	$28.20	$350.00	Tier 1	No	$4.90
UnitedHealthcare S5921* M - **866-460-8854** NM - **888-867-5564**	AARP MedicareRx Saver Plus (B) - 374	$36.50	$505.00		No	$0.00
WellCare S4802* M - **888-550-5252** NM - **866-859-9084**	WellCare Value Script (E) - 135	$11.10	$505.00	Tiers 1, 2	No	$11.10
	WellCare Classic (B) - 020	$35.70	$505.00		No	$0.00
	WellCare Medicare Rx Value Plus (E) 233	$71.40	$0.00		No	$49.70

*** Nationwide plans**

(B) = Basic drug benefit (see glossary)

(E) = Enhanced drug benefit (see glossary)

Key: NM - nonmember, M - member, TTY - teletypewriter

Medigap

About Medicare Supplement (Medigap) policies

What is Medigap?

Medigap is another name for Medicare Supplement Insurance. With Original Medicare, Medicare beneficiaries must pay some of the costs (deductibles and co-insurance) of their medical care. Because of these gaps in Part A and Part B coverage, private insurance companies sell Medicare Supplement Insurance policies, also known as "Medigap." **You must have Medicare Part A and Part B to purchase a Medigap.**

If you are in Original Medicare (Part A and Part B) and buy a Medigap policy, Medicare will pay its portion of the claim, then your Medigap policy will pay its portion.

Medigap policies are named by letter, Plan A through Plan N. (These are not to be confused with Medicare parts A, B, C, and D; they are different.) Medigap benefits are standardized and regulated by the Division of Financial Regulation. **A Medigap cannot pay if you also enroll in a Medicare Advantage plan**.

What do Medicare Supplement SELECT plans offer?

These are essentially limited versions of standardized Medigap insurance that cost less. SELECT plans are almost identical to regular Medigap policies, but they limit which clinics, doctors and hospitals are covered for nonemergency and nonurgent care.

If you use only the in-network providers, a SELECT plan can give you Medigap coverage at a lower cost. If you need an out-of-network specialist, Medicare will still pay for 80 percent of its predetermined amount. However, your SELECT plan may not pay for any of the remaining 20 percent or deductibles.

What is a Medicare Supplement Innovative plan?

Medicare Supplement Innovative plans must follow federal and state laws and must be clearly identified as Medicare Supplement Insurance on the policy and attached documents. The insurance company can offer some additional benefits at no extra cost to the Medicare beneficiary. With the approval of the Oregon Division of Financial Regulation (DFR), Innovative plan benefits cannot be used to change or reduce the standardized benefits, including a change of any cost-sharing provision.

Medicare Supplement Innovative plan benefits can include, but are not limited to:

- Nurse hotline
- Annual physical exam
- Preventive dental care
- Preventive vision care
- Routine hearing exam
- Drug discount card

Insurance companies that offer the Innovative plan will determine which benefits are offered.

Policy costs differ

The monthly premium for the same policy varies by insurance company. Factors that affect premium rates include age, gender, health history, tobacco use, direct bill, electronic funds transfer (EFT), ZIP code and, most importantly, the number of members in the insurance policy pool.

Areas

When a company states that its rates vary by ZIP code, the pool of members with that policy is divided into smaller sizes. Smaller pool groups may have more volatile premium increases because plans can increase rates once a year based on medical claims payments for the entire membership pool, but not for individuals. Plans may increase premiums only once in a 12-month period for the pool medical loss ratio.

Type

The majority of Medigap policies available in Oregon are age-rated. This means your policy premium may also increase each year because you are a year older.

A few policies available in Oregon are community-rated or issue-age-rated. The issue-age-rated policies never increase due to aging. Both may increase each year based on medical cost payments within the membership pool.

When can I buy a Medigap policy?

You can apply for a Medigap policy at any time. Insurance companies may consider your medical history (underwrite) and may refuse your application. **However, you are guaranteed a policy regardless of** pre-existing conditions **during one of the protected periods on page 36 and below:**

- **Medigap open enrollment period:** Your open enrollment period for Medigap begins the day your Medicare Part B begins and ends six months later.
- **Guaranteed issue:** Certain special circumstances trigger guaranteed issue (GI) situations. At these times, you are entitled to purchase a Medigap policy with no underwriting. These GI protections last for 63 days. See **page 36** for all GI situations available.
- **Loss of Medicaid:** If you lose full Medicaid or Qualified Medicare Beneficiary (QMB) Medicaid eligibility, you have 63 days to buy a Medigap policy. You might want to do this to afford expensive medical treatments such as dialysis, chemotherapy treatments and infused medications or immunosuppressants.

- **Your birthday:** In Oregon, if you are an existing Medigap policyholder, you have a 30-day shopping period with GI beginning on your birthday if you want to compare different companies' prices for the same (or lesser) Medigap benefits under the Oregon birthday rule.

Medigap for enrollees younger than age 65

People younger than 65 who receive Medicare due to a disability and those with ESRD (end-stage renal disease or permanent kidney failure) have additional opportunities for guaranteed issue open enrollment rights for Medigap insurance:

- When they turn 65, for six months
- Keep the notice of retroactive Medicare enrollment during the first six months after receiving it. Guaranteed issue protection begins with the date of that notice and ends after six months.

Will I have to wait to use my Medigap?

Medigap policies can have a pre-existing condition look-back/waiting period of up to six months before the policy will pay certain benefits or before the policy covers previously diagnosed conditions. On the plan rate pages, a 0/0, 6/6 or 2/6 refers to how many months back the company looks for pre-existing conditions and how many months you must wait before the Medigap policy will cover those pre-existing conditions. Not all companies' policies have waiting periods. Look-back/waiting periods are not imposed if eligible for guaranteed issue.

Medigap waiting periods

Can I get credit for my prior coverage?

If you apply for a Medigap policy that has a waiting period for pre-existing conditions during your open enrollment period, your previous insurance may qualify for credit.

Qualifying coverage must be from one of the following:

- A group or individual health care program, including an employer plan or COBRA policy
- Medicare or Medicaid
- A military-sponsored health care program
- Indian Health Service benefits
- Certain public health plans
- Federal Employees Health Benefits Program (FEHB)
- A Peace Corps health benefit plan

Tips and Hints

Elder financial abuse is estimated to cost between $2.8 billion and $36.5 billion every year. Protect your Medicare number, check your statements for accuracy, and report any concerns of fraud or abuse.

Medigap coverage outside the United States

Except in limited situations, Medicare does not pay for health care services you get outside the United States. However, Medigap plans C, D, F, F high deductible, G, G high deductible, M and N will cover emergency care outside the United States in certain circumstances.

Medigap plans C, D, E, F, F high deductible, G, G high deductible, M and N pay 80 percent of the billed charges for certain medically necessary emergency care outside the United States after you meet the plan's deductible, plus a $250 deductible for the year. These Medigap policies cover foreign travel emergency care if it begins during the first 60 days of your trip, and if Medicare does not otherwise cover the care, but would if the policyholder had been in the United States. Foreign travel emergency coverage with Medigap policies has a lifetime limit of $50,000. The intent of this benefit is not to provide robust coverage. Anyone planning extensive traveling should research travel insurance. Remember, when traveling on a cruise ship, you are in a foreign country. Cruise ships sail under foreign flags.

The rates published on page 42 are starting rates at the time of publication. They are the lowest rate available in the state and include rate factors such as gender, ZIP code, nonsmoking status or electronic funds transfer (EFT). Contact the insurance companies or a SHIBA counselor for specific individual quotes.

Tips and Hints

Ask questions

Ask your provider or plan*:

- When you don't understand the charges billed
- When you don't think you received the service
- When you think the service was unnecessary.

*If your provider or plan does not help you, contact your local Senior Medicare Patrol at **855-673-2372** (toll-free).

Medigap guaranteed issue periods and plan choices

Guaranteed issue	Medigap plan choices
You joined a Medicare Advantage plan (not an MSA) or Program of All-inclusive Care for the Elderly (PACE) program **when you were first enrolled in Medicare, but within the first 12 months of joining the plan**, you want to leave (trial right). (N)	All plans
You are awarded retroactive Medicare enrollment due to disability. The six-month open enrollment period begins on the first day of the first month after you receive written notice of retroactive enrollment. (OR)	All plans
You terminated a Medigap policy to enroll in a Medicare Advantage (MA) plan, Medicare Select policy, or PACE program **for the first time** and now you want to terminate the MA plan **after no more than 12 months of enrollment**. (trial right) (N)	Original plan. If not available then all plans.
Your Medicare Advantage plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area.* (N)	All plans
Your employer group health plan coverage (including COBRA and retiree coverage) (N/OR), or Medicaid (OR) terminates or ceases to provide all health benefits.	All plans
You are enrolled under a Medigap policy and the enrollment ceases because of insolvency of the company or other involuntary termination of coverage or enrollment under the policy.	Same plan as current policy or one with fewer benefits
Your employer group health plan, Medicare Advantage plan, PACE, Medigap or Medicare Select health coverage ends because you move out of the plan's service area.* (N)	All plans
You leave any plan — Medicare Advantage plan, PACE, Medicare Select, or Medigap — because the plan committed fraud. For example, marketing materials were misleading or quality standards were not met.* (N)	All plans
Your Medicare Select insurer had its certification terminated, stopped offering the plan in your area, substantially violated a material provision of the organization's contract in relation to the individual, or misrepresented the plan's provisions.* (N)	All plans
Birthday rule: You are a current Medigap policyholder wanting to change to a different Medigap insurance company within 30 days following your birthday. (OR) https://shiba.oregon.gov/Documents/2021-4845-INS-birthday-Rule.pdf.	Same plan as current policy or one with fewer benefits

* 63-day deadline to take an action

(N) National rule

(OR) Oregon-only rule

Crater Lake, Oregon

What Medigap plans cover

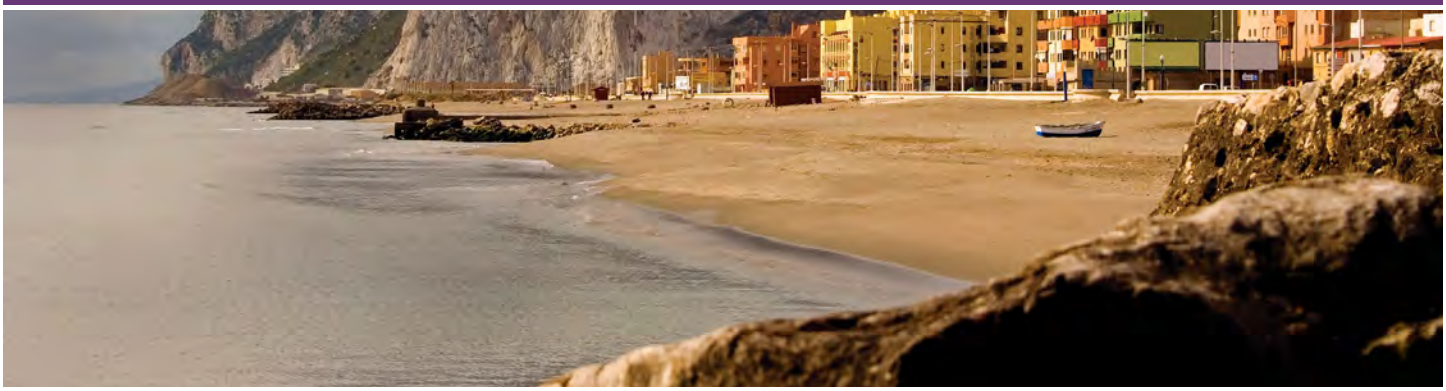
Note: The following include starting rates available at the time of publication and do not include future rate adjustments.

Medigap plans help pay the deductibles, copayments and co-insurance in Medicare Part A and Part B. These standardized plans offer the same benefits from company to company. Costs may vary by ZIP code; call for a rate quote. Rate comparisons begin on page 42.

Original Medicare gaps	A	B	*C	D	*F	*F high	G	G high	K	L	M	N
Hospital cost share — 2023 Cost share for days 61-90 ($400 a day), 91-150 ($800 a day); payment in full for 365 additional lifetime days. See page 9 for details.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B co-insurance — Covers the 20 percent co-insurance for Part B services. See page 10 for details.	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓†
First three pints of blood, per calendar year.	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice care — Co-insurance for respite care and other Part A-covered services.	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospital (Part A) deductible Covers deductible in each benefit period. ($1,600 in 2023)		✓	✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Skilled Nursing Facility (SNF) daily co-insurance — Covers co-insurance ($200 per day) for days 21–100 each benefit period.			✓	✓	✓	✓	✓	✓	50%	75%	✓	✓

* In accordance with the Medicare Access and CHIP Reauthorization Act of 2015, effective Jan. 1, 2020, Plan C, F and FH are not available to "newly eligible" Medicare applicants.

† Pays the Part B co-insurance, except you pay up to a $20 copay per physician visit and a $50 copay per emergency room visit.



Original Medicare gaps	A	B	*C	D	*F	*F high	G	G high	K	L	M	N
Part B deductible — Covers the annual deductible. ($226 in 2023)			✓		✓							
Part B excess charges — Covers the 15 percent excess charge when a physician or hospital does not accept Medicare's full charge as payment in full.					✓	✓	✓	✓				
Emergency care outside the United States — See page 35 for more information.			80%	80%	80%	80%	80%	80%			80%	80%
Out-of-pocket maximum — Pays 100 percent of Part A and Part B co-insurance after annual out-of-pocket maximum has been spent.									$6,940	$3,470		
High deductible — Once you have paid the deductible in cost sharing, the coverage will begin.						$2,700		$2,700				

* In accordance with the Medicare Access and CHIP Reauthorization Act of 2015, effective Jan. 1, 2020, Plan C, F and FH are not available to "newly eligible" Medicare applicants.

Medicare Supplement (Medigap) policy information

Insurer	Phone	Website	Available plan types	Rate factors*
AARP Medicare Supplement Plans, by UnitedHealthcare	800-523-5800	aarpmedicaresupplement.com	A, B, C, F, G, G(S), K, L, N, N(S)	Nonsmoker, EFT, HH
Accendo Insurance Company (A CVS Company and Aetna Affiliate)	855-335-1407	aetnaseniorproducts.com	A, F, G, N	Female, non-smoker, EFT
Allstate Health Solutions (National Health Ins. Co.)	855-224-6271	allstatehealth.com	A, F, FHD, G, N	Preferred female, rates vary by ZIP, HH
Cigna Life and Health Ins. Co.	855-891-9368	cigna.com/medicare/supplemental/	A, F, FHD, G, N	Preferred female, bank draft, rates vary by ZIP
Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	800-264-4000	aetnaseniorproducts.com	A, B, F, FHD, G, N	Preferred female, rates vary by ZIP, HH
Everence Association, Inc.	800-348-7468	everence.com	A, C, F, G, L, N	Female nonsmoker
Globe Life and Accident Ins. Co.	800-801-6831	globecaremedsupp.com	A, B, C, F, FHD, G, GHD, N	Female non-smoker, rates vary by ZIP
GPM Health and Life Ins. Co.	877-844-1036	gpmhealthandlife.com	A, F, G, N	Female nonsmoker, rates vary by ZIP, HH
Humana Ins. Co.	800-866-0581	humana.com	A, B, C, F, FHD, G, GHD, K, L, N	Preferred female, rates vary by ZIP, HH
Lumico Life Ins. Co.	800-750-2407	lumico.com	A, F, G, N	Female preferred, rates vary by ZIP, HH
The Manhattan Life Ins. Co.	800-877-7703	https://www.manhattanlife.com/Seniors/Medicare-Supplement	A, F, G, N	Preferred female, rates vary by ZIP, HH
Moda Health Plan, Inc.	877-277-7073	modahealth.com	A, F, FHD, G, GHD, N	Preferred female
Mutual of Omaha (United World Life Ins. Co.)	800-667-2937	mutualofomaha.com	A, F, G, GHD, N	Female nonsmoker, EFT, rates vary by ZIP, HH

Key: I (Innovative), S (SELECT), PAC (preauthorized check), EFT (electronic funds transfer), FH (F High), GH (G High), HH (Household discount)

To find a local Medicare agent, visit our Agent Locator Tool at healthcare.oregon.gov/Pages/find-help.aspx. The tool also is described on page 6.

* Rate factors are explained on page 33 and page 35.

Insurer	Phone	Website	Available plan types	Rate factors*
Providence Health Assurance	**866-365-4324**	providencemedicaresupplement.com	A, G, N	Nonsmoker
Puritan Life Ins. Co. of America	**888-474-9519**	puritanlifeinsurance.com/medsupp	A, F, G, N	Female preferred, rates vary by ZIP, HH
Regence BlueCross BlueShield of Oregon	**844-734-3623**	https://www.regence.com/medicare/plans/medigap	A, C, F, G, K, N	EFT, nonsmoker, HH
State Farm Mutual Automobile Ins. Co.	866-855-1212	statefarm.com/insurance/health/medsupp.asp	A, C, D, F, G, N	Female nonsmoker, territory 1, contact local agent, rates vary by ZIP
Transamerica Life Ins. Co.	**800-752-9797**	transamerica.com	A, B, C, D, F, G, K, L, M, N	Female nonsmoker, PAC
United American Ins. Co.	**800-755-2137**	unitedamerican.com	A, B, C, D, F, FHD, G, GHD, K, L, N	Preferred female
United Commercial Travelers of America (The Order of)	**800-848-0123**	uct.org	A, F, G, N	Female nonsmoker, EFT, rates vary by ZIP
USAA Life Ins. Co.	**800-515-8687**	usaa.com	A, F, G, N	Nonsmoker, PAC

Key: I (Innovative), S (SELECT), PAC (preauthorized check), EFT (electronic funds transfer), FH (F High), GH (G High), HH (Household discount)

To find a local Medicare agent, visit our Agent Locator Tool at healthcare.oregon.gov/Pages/find-help.aspx. The tool also is described on **page 6**.

* Rate factors are explained on **page 33** and **page 35**.

Medigap policies by plan type

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Appli-cation fee
		0–65	70	75	80	85				
Plan A	Accendo Insurance Company	$137	$146	$171	$202	$236	5/1/2022	0/0	A	$25
	Allstate Health Solutions	$163	$173	$201	$233	$269	7/12/2021	0/0	A	$25
	Cigna Health and Life Ins. Co.	$220	$248	$301	$358	$425	6/1/2022	6/6	A	None
	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$167	$189	$221	$243	$259	6/1/2022	0/0	A	$20
	Everence Association, Inc.	$169	$183	$192	$203	$212	4/1/2022	0/0	I	None
	Globe Life & Accident Ins. Co.	$118	$160	$170	$172	$172	1/1/2023	2/2	A	None
	GPM Health and Life Ins. Co.	$261	$287	$346	$408	$466	11/15/2022	0/0	A	$25
	Humana Insurance Company	$177	$209	$242	$275	$304	5/1/2022	6/3	A	None
	Lumico Life Ins. Co.	$155	$177	$212	$241	$266	3/1/2022	0/0	A	$25
	Manhattan Life Assurance Co.	$139	$152	$179	$213	$255	7/19/2021	0/0	A	$25
	Moda Health Plan, Inc.	$110	$130	$155	$173	$190	1/1/2023	6/6	A	None
	Mutual of Omaha (United World Life Insurance Company)	$138	$155	$187	$222	$262	10/1/2022	0/0	A	None
	Providence Health Assurance	$143	$159	$197	$235	$236	4/1/2022	0/0	A	None
	Puritan Life Ins. Co. of America	$141	$143	$167	$192	$214	2/1/2022	0/0	A	$25
	Regence BlueCross BlueShield of Oregon	$143	$164	$198	$233	$267	1/1/2023	0/0	A	None
	State Farm Mutual Automobile Ins. Co.	$106	$133	$154	$173	$181	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$137	$172	$210	$247	$279	5/1/2022	6/6	I	None
	United American Ins. Co.	$94	$113	$120	$120	$120	1/15/2022	2/2	A	None
	United Commercial Travelers of America, The Order of	$185	$231	$270	$298	$317	12/1/2019	0/0	A	None
	USAA Life Ins. Co.	$144	$169	$202	$234	$259	7/1/2022	0/0	A	None
	UnitedHealthcare Ins. Co. (AARP)	$91	$105	$131	$160	$189	1/1/2023	3/3	A	None

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Application fee
		0–65	70	75	80	85				
Plan B	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$210	$238	$278	$306	$326	6/1/2022	0/0	A	$20
	Globe Life & Accident Ins. Co.	$176	$232	$257	$263	$263	1/1/2023	2/2	A	None
	Humana Insurance Company	$169	$200	$232	$264	$291	5/1/2022	6/3	A	None
	Transamerica Life Ins. Co.	$181	$228	$277	$327	$368	5/1/2022	6/6	I	None
	United American Ins. Co.	$164	$204	$223	$226	$226	1/15/2022	2/2	A	None
	UnitedHealthcare Ins. Co. (AARP)	$146	$169	$210	$257	$304	1/1/2023	3/3	A	None
Plan C	Everence Association, Inc.	$249	$295	$332	$358	$380	4/1/2022	0/0	I	None
	Globe Life & Accident Ins. Co.	$203	$260	$298	$315	$315	1/1/2023	2/2	A	None
	Humana Insurance Company	$233	$275	$319	$362	$400	5/1/2022	6/4	A	None
	Regence BlueCross BlueShield of Oregon	$217	$278	$330	$370	$400	1/1/2023	0/0	A	None
	State Farm Mutual Automobile Ins. Co.	$183	$231	$267	$300	$313	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$214	$269	$328	$386	$436	5/1/2022	6/6	I	None
	United American Ins. Co.	$166	$209	$235	$258	$258	1/15/2022	2/2	A	None
	UnitedHealthcare Ins. Co. (AARP)	$168	$195	$242	$296	$351	1/1/2023	3/3	A	None
Plan D	State Farm Mutual Automobile Ins. Co.	$132	$162	$191	$217	$240	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$168	$211	$257	$303	$342	5/1/2022	6/6	I	None
	United American Ins. Co.	$161	$206	$234	$258	$258	1/15/2022	2/2	A	None
Plan F	Accendo Insurance Company	$214	$227	$267	$315	$367	5/1/2022	0/0	A	$25
	Allstate Health Solutions	$206	$219	$253	$294	$339	7/12/2021	0/0	A	$25
	Cigna Health and Life Ins. Co.	$197	$222	$270	$320	$380	6/1/2022	6/6	A	None
	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$272	$306	$351	$380	$404	6/1/2022	0/0	A	$20
	Everence Association, Inc.	$211	$229	$243	$263	$283	4/1/2022	0/0	I	None
	Globe Life & Accident Ins. Co.	$204	$262	$299	$317	$317	1/1/2023	2/2	A	None

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Application fee
		0–65	70	75	80	85				
Plan F	GPM Health and Life Ins. Co.	$339	$373	$450	$530	$606	11/15/2022	0/0	A	$25
	Humana Insurance Company	$241	$285	$330	$375	$414	5/1/2022	6/3	A	None
	Lumico Life Ins. Co.	$207	$235	$282	$322	$355	3/1/2022	0/0	A	$25
	Manhattan Life Assurance Co.	$155	$184	$221	$260	$302	7/19/2021	0/0	A	$25
	Moda Health Plan, Inc.	$183	$216	$257	$289	$316	1/1/2023	6/6	A	None
	Mutual of Omaha (United World Life Insurance Company)	$200	$224	$271	$322	$381	10/1/2022	0/0	A	None
	Puritan Life Ins. Co. of America	$200	$202	$238	$283	$330	2/1/2022	0/0	A	$25
	Regence BlueCross BlueShield of Oregon	$218	$280	$331	$372	$402	1/1/2023	0/0	A	None
	State Farm Mutual Automobile Ins. Co.	$185	$233	$270	$303	$316	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$215	$271	$330	$389	$438	5/1/2022	6/6	I	None
	United American Ins. Co.	$194	$243	$274	$300	$300	1/15/2022	2/2	A	None
	United Commercial Travelers of America, The Order of	$313	$382	$439	$474	$503	12/1/2019	0/0	A	None
	UnitedHealthcare Ins. Co. (AARP)	$169	$196	$243	$297	$352	1/1/2023	3/3	A	None
	USAA Life Ins. Co.	$167	$195	$232	$269	$297	7/1/2022	0/0	A	None
Plan F High (Plan FH)	Allstate Health Solutions	$61	$65	$76	$88	$101	7/12/2021	0/0	A	$25
	Cigna Health and Life Ins. Co.	$47	$53	$64	$76	$90	6/1/2022	6/6	A	None
	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$89	$100	$115	$124	$132	6/1/2022	0/0	A	$20
	Globe Life & Accident Ins. Co.	$39	$52	$65	$71	$71	1/1/2023	2/2	A	None
	Humana Insurance Company	$53	$63	$73	$83	$91	5/1/2022	6/3	A	None
	Moda Health Plan, Inc.	$41	$48	$58	$65	$71	1/1/2023	6/6	A	None
	United American Ins. Co.	$27	$35	$44	$48	$48	1/15/2022	2/2	A	None

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Application fee
		0–65	70	75	80	85				
Plan G	Accendo Insurance Company	$169	$179	$211	$248	$290	5/1/2022	0/0	A	$25
	Allstate Health Solutions	$175	$186	$215	$249	$287	7/12/2021	0/0	A	$25
	Cigna Health and Life Ins. Co.	$146	$164	$199	$237	$281	6/1/2022	6/6	A	None
	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$203	$227	$261	$283	$300	6/1/2022	0/0	A	$20
	Everence Association, Inc.	$151	$164	$175	$187	$195	4/1/2022	0/0	I	None
	Globe Life & Accident Ins. Co.	$180	$237	$275	$292	$292	1/1/2023	2/2	A	None
	GPM Health and Life Ins. Co.	$267	$294	$355	$419	$478	11/15/2022	0/0	A	$25
	Humana Insurance Company	$226	$267	$310	$352	$389	5/1/2022	6/3	A	None
	Lumico Life Ins. Co.	$156	$178	$213	$243	$268	3/1/2022	0/0	A	$25
	Manhattan Life Assurance Co.	$121	$138	$168	$199	$233	7/19/2021	0/0	A	$25
	Moda Health Plan, Inc.	$145	$171	$204	$229	$250	1/1/2023	6/6	A	None
	Mutual of Omaha (United World Life Insurance Company)	$142	$160	$192	$229	$270	10/1/2022	0/0	A	None
	Providence Health Assurance	$165	$189	$248	$306	$322	4/1/2022	0/0	A	None
	Puritan Life Ins. Co. of America	$151	$154	$184	$221	$259	2/1/2022	0/0	A	$25
	Regence BlueCross BlueShield of Oregon	$177	$203	$246	$288	$331	1/1/2023	0/0	A	None
	State Farm Mutual Automobile Ins. Co.	$132	$162	$191	$217	$241	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$168	$211	$257	$303	$342	5/1/2022	6/6	I	None
	United American Ins. Co.	$157	$200	$227	$250	$250	1/15/2022	2/2	A	None
	United Commercial Travelers of America, The Order of	$225	$282	$329	$363	$387	12/1/2019	0/0	A	None
	UnitedHealthcare Ins. Co. (AARP)	$140	$163	$202	$248	$293	1/1/2023	3/3	A	None
	UnitedHealthcare Ins. Co. (AARP) (Select)	$126	$147	$182	$223	$264	1/1/2023	3/3	A	None
	USAA Life Ins. Co.	$132	$143	$172	$213	$273	7/1/2022	0/0	A	None

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Application fee
		0–65	70	75	80	85				
Plan G High (Plan GH)	Globe Life & Accident Ins. Co.	$39	$52	$65	$71	$71	1/1/2023	2/2	A	None
	Humana Insurance Company	$50	$59	$69	$78	$86	5/1/2022	6/3	A	None
	Moda Health Plan, Inc.	$38	$45	$53	$60	$66	1/1/2023	6/6	A	None
	Mutual of Omaha (United World Life Insurance Company)	$44	$51	$61	$71	$83	10/1/2022	0/0	A	None
	United American Ins. Co.	$27	$35	$44	$48	$48	1/15/2022	2/2	A	None
Plan K	Humana Insurance Company	$91	$108	$125	$142	$157	5/1/2022	6/3	A	None
	Regence BlueCross BlueShield of Oregon	$107	$123	$148	$174	$200	1/1/2023	0/0	A	None
	Transamerica Life Ins. Co.	$75	$94	$115	$136	$153	5/1/2022	6/6	I	None
	United American Ins. Co.	$89	$119	$132	$139	$139	1/15/2022	2/2	A	None
	UnitedHealthcare Ins. Co. (AARP)	$47	$54	$67	$82	$97	1/1/2023	3/3	A	None
Plan L	Everence Association, Inc.	$93	$101	$108	$117	$126	4/1/2022	0/0	I	None
	Humana Insurance Company	$130	$153	$178	$202	$223	5/1/2022	6/3	A	None
	Transamerica Life Ins. Co.	$111	$140	$171	$201	$227	5/1/2022	6/6	I	None
	United American Ins. Co.	$125	$167	$186	$195	$195	1/15/2022	2/2	A	None
	UnitedHealthcare Ins. Co. (AARP)	$94	$109	$136	$166	$196	1/1/2023	3/3	A	None
Plan M	Transamerica Life Ins. Co.	$137	$173	$210	$248	$279	5/1/2022	6/6	I	None
Plan N	Accendo Insurance Company	$116	$130	$154	$180	$211	5/1/2022	0/0	A	$25
	Allstate Health Solutions	$131	$139	$161	$187	$215	7/12/2021	0/0	A	$25
	Cigna Health and Life Ins. Co.	$104	$127	$154	$183	$217	6/1/2022	6/6	A	None
	Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	$169	$192	$225	$247	$264	6/1/2022	0/0	A	$20
	Everence Association, Inc.	$97	$116	$131	$143	$154	4/1/2022	0/0	I	None
	Globe Life & Accident Ins. Co.	$128	$169	$199	$215	$215	1/1/2023	2/2	A	None
	GPM Health and Life Ins. Co.	$205	$225	$272	$321	$367	11/15/2022	0/0	A	$25

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Note: The following include starting rates available at the time of publication and do not include future rate adjustments. For a real time rate quote for your specific age and ZIP code, go to https://Medicare.gov/medigap-supplemental-insurance-plans/ or contact your local SHIBA (see page 6 for contact information) or SHIBA statewide staff at **800-722-4134**.

	Insurance company name See separate spreadsheet for 2023 info.	Age at time of purchase					Effective date	Pre-ex LB/ waiting period	Type	Application fee
		0–65	70	75	80	85				
Plan N	Humana Insurance Company	$132	$156	$181	$206	$227	5/1/2022	6/3	A	None
	Lumico Life Ins. Co.	$123	$140	$167	$191	$210	3/1/2022	0/0	A	$25
	Manhattan Life Assurance Co.	$98	$112	$135	$162	$192	7/19/2021	0/0	A	$25
	Moda Health Plan, Inc.	$132	$155	$185	$208	$228	1/1/2023	6/6	A	None
	Mutual of Omaha (United World Life Insurance Company)	$109	$122	$148	$178	$210	10/1/2022	0/0	A	None
	Providence Health Assurance	$153	$170	$211	$252	$266	4/1/2022	0/0	A	None
	Puritan Life Ins. Co. of America	$104	$121	$143	$160	$195	2/1/2022	0/0	A	$25
	Regence BlueCross BlueShield of Oregon	$151	$173	$210	$246	$282	1/1/2023	0/0	A	None
	State Farm Mutual Automobile Ins. Co.	$100	$123	$146	$168	$190	3/1/2022	0/0	A	None
	Transamerica Life Ins. Co.	$129	$162	$198	$233	$263	5/1/2022	6/6	I	None
	United American Ins. Co.	$154	$198	$227	$253	$253	1/15/2022	2/2	A	None
	United Commercial Travelers of America, The Order of	$189	$231	$265	$287	$304	12/1/2019	0/0	A	None
	UnitedHealthcare Ins. Co. (AARP)	$110	$127	$158	$193	$229	1/1/2023	3/3	A	None
	UnitedHealthcare Ins. Co. (AARP) (Select)	$102	$119	$147	$180	$213	1/1/2023	3/3	A	None
	USAA Life Ins. Co.	$118	$138	$164	$190	$210	7/1/2022	0/0	A	None

Key: A – Attained age, C – Community rated, I – Issue age; explained on page 33.
Pre-ex LB/WP – Pre-existing look back/waiting periods explained on page 34.

Medigap vs. Medicare Advantage comparison chart

Original "fee-for-service" Medicare with a Medigap (Example: Plan G)	Comparison point	Medicare Advantage: HMO or PPO (private Medicare plans)
Must have Part A and Part B. Companies may deny, but must accept all applicants and all ages during Medigap open enrollment and guaranteed issue periods. (refer to **page 36**)	Eligibility	Must have Part A and Part B and live in service area. Takes all applicants.
Premium may vary with gender and health, and may go up with age. Companies may underwrite (add to premium). No copay costs, with some exceptions, at time of service. Out-of-pocket maximum for K and L only.	Costs: Premiums, copay, co-insurance and out-of-pocket max	All plan members pay same premium, regardless of age, gender or health. Cost sharing (copays) must be paid for most medical services. Plans have an out-of-pocket annual maximum.
No network: Go to any provider that accepts Medicare. No referrals required for specialist visits. May be hard to find providers accepting new patients with Original Medicare in some areas. May be used for treatments at specialty medical facilities, such as Mayo Clinics, OHSU.	Provider choice and availability Always ask your providers what insurance they accept.	Maintain provider networks; they must have available providers in order to accept new members. **HMOs:** Generally cover in-network only. Referrals may be required for specialist visits. **PPOs:** Cover out-of-network, but costs may be higher. Provider must agree to bill the plan. No referrals required. **MSAs:** No provider network. Provider must agree to bill the plan. Provides funds to use during deductible.
Not included. If you want drug coverage, you may enroll in any stand-alone Medicare PDP (prescription drug plan) available.	Prescription drug coverage To make sure your plan covers your drug, use medicare.gov.	If you want drug coverage, you must enroll in the drug coverage bundled with the HMO or PPO plan (VA-eligible excepted). With MSAs, you may choose a stand-alone Medicare prescription drug plan.

Original "fee-for-service" Medicare with a Medigap (Example: Plan G)	Comparison point	Medicare Advantage: HMO or PPO (private Medicare plans)
Yes, guaranteed renewable, as long as you pay the premium and the application was correct. Benefits never change. No election season for Medigaps. May change company each year on birthday with guaranteed issue.	Is it renewable?	No, benefits may change yearly. However, you usually remain in a plan unless you disenroll at election times or your plan terminates in your area.
Covers only same as Original Medicare. No routine dental, vision, except "Innovative" plans; no alternative medicine.	Extras	Some plans include routine dental, hearing or vision. Some offer additional benefits such as alternative therapy, gym membership, medical transportation, meal delivery and medical alert systems.
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.	For whom it may be best	Network plans may be good for people who otherwise can't find a Medicare provider. May save money unless you need frequent appointments or treatments. Having a packaged plan may simplify choices.
Because Medigaps are standardized, price and customer service are the only difference. Try calling a few competitively priced plans.	How to comparison shop	Plans are not standardized. To compare, see the chart starting on **page 57** of this guide or the medicare.gov Plan Finder.
Regulated by Oregon Division of Financial Regulation. Contact a SHIBA counselor for a rate quote based on your specific information or go to http://www.medicare.gov/medigap-supplemental-insurance-plans/.	Who regulates it?	Plans regulated by Medicare; agents licensed by Oregon Division of Financial Regulation.

Medicare Advantage

Medicare Advantage plans

Private insurance companies contract with Medicare to offer coordinated care and private fee-for-service health insurance plans. Medicare pays these plans to provide all your Medicare-approved services. When you join a Medicare Advantage (MA) plan, you agree to that plan's terms and conditions.

- You will receive the same benefits as in Original Medicare, but not at the same payment rates.
- You will still pay the Part B premium, plus a premium to the plan (unless the plan has a $0 premium) and copayments or co-insurance for certain services.
- Medicare Advantage plans may offer additional coverage, such as routine annual physicals, preventive vision or dental.

Medicare Advantage plans renew their contracts annually with the Centers for Medicare and Medicaid Services (CMS). This means the policies are not guaranteed renewable. However, if you join a plan that decides to not renew its contract with CMS, you have protection under the law that enables you to join another plan or purchase a Medigap policy.

Where you live (based on your ZIP code) often determines which Medicare Advantage plans are available to you.

You can find out if a plan covers your area by calling the company or by reviewing the plans on Medicare's website, medicare.gov, or on the chart that starts on **page 57**.

Who can join a Medicare Advantage plan?

Anyone who has both Medicare Part A and Part B and lives in the plan's service area can join a plan.

Medicare Advantage election periods and enrollment actions

If you take more than one action during any of the enrollment periods, Medicare will take the last action received before the effective date ends the enrollment period. Once the plan takes effect, the enrollment period ends. You may join, leave or switch Medicare Advantage plans during:

- Initial enrollment period (IEP) when you are new to Medicare; usually the three months before, the month of and three months after your 65th birthday
- Annual enrollment period (AEP), Oct. 15 to Dec. 7, also referred to as Fall Open Enrollment. Enroll in your new plan; you will be automatically taken off your old plan.

Special enrollment periods (SEPs)

Special enrollment periods are opportunities to make plan changes outside of the standard enrollment periods. These include:

- Moving permanently outside your plan's service area, and
- Qualifying for any limited-income assistance.

SEPs are generally 60 days, but may vary. At these times, you may use your SEP to:

- Join a different Medicare Advantage plan
- Switch to using only Original Medicare, and
- Switch to Original Medicare and purchase a Medigap plan. Insurance companies may require that you undergo underwriting unless you have guaranteed issue.

Star-rated SEPs – Medicare uses a star rating system based on complaints that they receive. Five stars is excellent and one star is poor.

- Five-star SEP – You may enroll in a plan with five stars once per year from Dec. 8 to Nov. 30, if available.
- Low-performing plan SEP – If you are in a low-performing plan you will receive a letter in late October. You must call 800-MEDICARE (**800-633-4227**) or SHIBA to enroll in another plan.

Medicare Advantage open enrollment period (MA OEP)

The MA OEP is from Jan. 1 to March 31 or, if you're new to Medicare, in the first three months of an MA plan. Your coverage will start the first day of the month after you enroll. You must have an MA plan on Jan. 1 to use this enrollment period.

You can:

- Switch MA plans (with or without drug coverage)
- Enroll in a stand-alone Part D plan (which returns you to Original Medicare).

Getting Part D is not guaranteed unless you were in an MA plan on Jan. 1.

There is only one change during this enrollment period.

You cannot switch from one stand-alone PDP to another stand-alone PDP.

Help comparing plans

A SHIBA counselor can help you understand plan options and plan rules, such as how and when you may make changes.

For a SHIBA contact in your area:

- Call 800-722-4134 (toll-free)
- Visit shiba.oregon.gov, or
- Call 800-MEDICARE (**800-633-4227**).

How do I select a plan?

- **What plans are offered in my area?**

  Refer to the plan by county starting on page 57 to see which plans are available to you.

- **Will my doctor and hospital accept the plan?**

  Ask the business 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. In some plans, if your provider is not part of the preferred network, you will have to pay more to see that provider. It is **very important** to know if the plan you are considering includes your doctors and hospital of choice.

  Call for the above information yourself. Webpages and printed materials can be incorrect and an agent wanting to sell you a plan may be misinformed.

- **Can I afford the plan?**

  Make sure you understand the coverage, including premiums and copays. The plan description pages list some of your costs. Here are some of the words you need to understand:

  - **Premiums:** The amount you pay monthly for a plan. A few plans have a $0 premium.
  - **Deductible:** The amount you pay before the plan starts paying (some exceptions apply).
  - **Maximum out-of-pocket costs:** This is the most you would have to pay in a year for covered services, excluding the premium and Part D drugs, before the plan starts paying 100 percent.

    Caution: Not all covered services may count toward the out-of-pocket maximum.
  - **Copays:** A fixed amount you pay for a service
  - **Co-insurance:** A percentage of the cost of a service.

Prescription drug coverage

- **Do I want prescription drug coverage with my Medicare Advantage plan?**

  Most HMO/PPO plans include integrated prescription drug coverage (MAPD). Your drug coverage **must** be part of this "bundled" package.

  Medicare Medical Savings Account (MSA) plans allow you to choose a stand-alone prescription drug plan.

  Exception: If you have VA drug coverage available, you can use it with the health-only MA plan, if the plan allows.

What's a Medicare MSA plan?

Medicare works with private insurance companies to offer you ways to get your health care coverage. These companies can choose to offer a consumer-directed Medicare Advantage plan, called a Medicare Medical Savings Account (MSA) plan. These plans are similar to health savings account plans available outside of Medicare. You can choose your health care services and providers.

Medicare MSA plans have two parts

Medicare MSA plans combine a high-deductible insurance plan with a medical savings account that you can use to pay for your health care costs.

- High-deductible health plan: The first part is a special type of high-deductible Medicare Advantage plan (Part C). The plan will begin to cover your costs after you meet a high yearly deductible, which varies by plan.
- Medical Savings Account (MSA): The second part is a special type of savings account. The Medicare MSA plan deposits money into a special account. You can use money from this savings account to pay your health care costs before you meet the deductible. Those who enroll in MSA plans are required to file IRS tax returns showing how deposited funds were used. Tax consequences if not used for qualified medical or dental expenses.

About Medicare Advantage dental coverage

Original Medicare **does not** cover routine dental care. There are limited dental services you may get when you are in the hospital, but these are rare.

Some Medicare Advantage (MA) plans have dental coverage included in the plan or as an additional rider. Other MA plans choose to cover preventive care, such as cleanings and X-rays, up to a capped limit.

For more information, contact the plan. Contact SHIBA for a list of stand-alone dental plans or for other community resources go to oregondental.org.

Tips and Hints

Be suspicious of anyone who offers you "free" genetic testing and then requests your Medicare number. If your personal information is compromised, it may be used in other fraud schemes. A physician you know and trust should assess your condition and approve any requests for genetic testing.

Medicare Advantage plan types:

HMO: Health maintenance organization

HMO-POS: HMO with point-of-service option

PPO: Preferred provider organization

SNP: Special needs plan

MSA: Medicare Medical Savings Account

(See Glossary for definitions)

Medicare special needs plans (SNPs)

These are specially designed HMO-MA plans with membership limited to the following groups of people:

- Those who have both Medicare and Medicaid (dual eligible), or
- Those who also reside in institutions such as nursing homes, or
- Those who are both Medicare and Medicaid (dual eligible) and are living in institutions such as nursing homes.

Dual eligible (Medicaid)		
Company/plan	**Contact information**	**Available counties**
AllCare Advantage H3810-023 AllCare Advantage Redwood Rx (HMO D-SNP)	Nonmember and member **888-460-0185**; TTY **711** allcarehealth.com	Curry, Jackson, Josephine counties and Glendale and Azalea in Douglas County
Atrio Health Plans H3814-007 Atrio Special Needs Plan (HMO D-SNP)	Nonmember and member **877-672-8620**; TTY **711** atriohp.com	Douglas, Klamath (select ZIP codes)
Atrio Health Plans H5995-001 Atrio Special Needs Plan (Willamette) (HMO D-SNP)		Marion and Polk
CareOregon Advantage H5859-001 CareOregon Advantage Plus (HMO-POS D-SNP)	Nonmember and member **888-712-3258**; TTY **711** careoregonadvantage.org	Clackamas, Columbia, Jackson, Multnomah, Tillamook, Washington
PacificSource Medicare PacificSource Dual Care H3864-043 (HMO D-SNP)	Nonmember **866-282-8814**; Member **888-530-1428** medicare.pacificsource.com	Clackamas, Crook, Deschutes, Hood River, Jefferson, Lane, Multnomah, Wasco, or Washington Counties, or northern Klamath zip codes 97731, 97733, 97737, and 97739
Providence Health Assurance (H9047-043) Providence Medicare Dual Plus (HMO D-SNP)	Nonmember **800-603-2340** Member **800-603-2340** providencehealthassurance.com	Clackamas, Multnomah, Washington
Samaritan Advantage Health Plan H3811-003 Samaritan Advantage Special Needs Plan (HMO D-SNP)	Nonmember and member **800-832-4580**; TTY **711** medicare.samhealthplans.org	Benton, Lincoln, Linn
Wellcare by Trillium H2174-001 Wellcare Dual Select (HMO D-SNP)	Nonmember **844-917-0175**, Member **844-867-1156**; TTY **711** trilliumadvantage.com	Lane

Institutional (Nursing homes or skilled nursing facilities)

Company/plan	Contact information	Available counties
AgeRight Advantage Health Plan H1372-001 AgeRight Advantage Health Plan (HMO I-SNP)	Nonmember and member **844-854-6885**; TTY **711** agerightadvantage.com	Benton, Clackamas, Jackson, Josephine, Klamath, Lane, Lebanon, Linn, Marion, Medford, Multnomah, Washington, and Yamhill
AgeRight Advantage Health Plan H1372-002 AgeRight Advantage Health Plan (HMO I-SNP)		Benton, Clackamas, Jackson, Josephine, Klamath, Lane, Lebanon, Linn, Marion, Medford, Multnomah, Washington, and Yamhill
UnitedHealthcare H0710-036 UnitedHealthcare Nursing Home Plan 2 (PPO I-SNP)	Nonmember **888-834-3721**; Member **877-370-3249**, TTY **711** uhcmedicaresolutions.com	Benton, Clackamas, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
UnitedHealthcare H0710-037 UnitedHealthcare Assisted Living Plan 2 (PPO I-SNP)		Benton, Clackamas, Jackson, Josephine, Linn, Marion, Multnomah, Polk, Washington, Yamhill
UnitedHealthcare H2228-017 UnitedHealthcare Assisted Living Plan 1 (PPO I-SNP)		Clackamas, Linn, Multnomah, Washington, Yamhil
UnitedHealthcare H2228-016 UnitedHealthcare Nursing Home Plan 1 (HMO I-SNP)		Clackamas, Lane, Linn, Multnomah, Washington
UnitedHealthcare H3113-008 UnitedHealthcare Assisted Living Plan (HMO-POS I-SNP)		Lane

Beneficiary must meet eligibility requirements. Must be certified as needing assistance with care.
Will pay a premium unless the beneficiary qualifies for Medicaid and then the premium is paid by the state.
Health and drug deductibles and co-pays for services may apply for those without financial asisstance.

PACE (Program of All Inclusive Care for the Elderly)

Company/plan	Contact information	Available counties
AllCare PACE, LLC H0247-001 AllCare PACE - Dual Eligible (PACE)	**844-950-7223** allcarehealth.com	These ZIP codes in Jackson and Josephine counties: 97501, 97502, 97504, 97525, 97526, 97527, 97535, 97537, 97543
AllCare PACE, LLC H0247-002 AllCare PACE - Medicare Only (PACE)		
Providence Elder Place Portland H3809-001 Providence ElderPlace Portland (dual eligible)	**855-415-6048** providence.org/elderplace	All of Multnomah and Clatsop; select ZIP codes in Clackamas, Tillamook and Washington
Providence Elder Place Portland H3809-002 Providence ElderPlace Portland (private pay)		

Beneficiary must meet eligibility requirements. Must be certified as needing nursing home level of care. Will pay a premium unless the beneficiary qualifies for Medicaid and then the premium is paid by the state. Costs do not change if medical / social care needs increase. There are no out-of-pocket costs or deductibles. All necessary medical and social services are covered. Chiropractic, podiatry, prosthetic devices, and acupuncture are covered only if identified as beneficial / necessary.

Chronic conditions special need plans		
Company/plan	**Contact information**	**Available counties**
AgeRight Advantage Health Plan H1372-003 AgeRight Advantage Health Plan (HMO C-SNP)	Nonmember and member **844-854-6885**; TTY **711** agerightadvantage.com	Benton, Clackamas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Washington and Yamhill
Humana (H1036-306) Humana Gold Plus - Diabetes (HMO C-SNP)	Nonmember **800-833-2364**	Clackamas, Columbia, Deschutes, Jefferson, Multnomah, and Washington
UnitedHealthcare H0271-036 UnitedHealthcare Chronic Complete Assure (PPO C-SNP)	Nonmember **800-555-5757**; Member **877-370-3249**; TTY **711** uhcmedicaresolutions.com	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill

Medicare Advantage plan contact information

Insurer	Nonmember number	Member number	TTY	Website
AARP from United Medicare	**800-555-5757**	**800-643-4845**	**711**	aarpmedicareplans.com
Aetna Medicare	**855-275-6627**	**833-570-6670**	**711**	aetnamedicare.com
Ageright Advantage	**844-854-6885**		**711**	agerightadvantage.com
Allcare Advantage	**888-460-0185**		**711**	allcarehealth.com/advantage
ATRIO Health Plans	**877-672-8620**		**711**	atriohp.com
Cigna	**800-313-0973**	**800-997-1654**	**711**	cigna.com/medicare
Devoted Health	**866-548-1418**	**800-385-0916**	**711**	devoted.com
Humana	**800-833-2364**	**800-457-4708**	**711**	humana.com/medicare
Kaiser Permanente	**877-408-3496**	**877-221-8221**	**711**	kp.org/medicare
Lasso Health Care	**866-766-2583**		**711**	lassohealthcare.com
Moda Health Plan, Inc.	**888-217-2375**	**877-299-9062**	**711**	modahealth.com/medicare
PacificSource Medicare	**888-863-3637**		**800-735-2900**	medicare.pacificsource.com
Providence Health Assurance	**800-475-6064**	**800-603-2340**	**711**	providencehealthplan.com/medicare
Regence BlueCross BlueShield of Oregon	**888-369-3171**	**800-541-8981**	**711**	regence.com/medicare
Samartitan Advantage Health Plan	**800-832-4580**		**800-735-2900**	samhealthplans.org/medicare
Summit Health	**844-931-1781**	**844-827-2355**	**711**	yoursummithealth.com
UnitedHealthcare	**844-530-2951**	**800-643-4845**	**711**	uhc.com/medicare
Wellcare	**844-917-0175**	**888-445-8913**	**711**	wellcare.healthnetoregon.com

Medicare Advantage plans, by county

Plan name	Plan & contract number	Plan type	Annual deductible	Annual deposit	Cost-sharing after deductible	MOOP (maximum out-of-pocket)	Drug plan type
All Oregon counties							
Lasso Healthcare Growth (MSA)	H1924-001	MSA	$5,000	$2,000	$0	$5,000	No Rx
Lasso Healthcare Growth Plus (MSA)	H1924-004	MSA	$8,000	$3,000	$0	$8,000	No Rx

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Baker, Gilliam, Harney, Lake, Morrow, Umatilla, Union, and Wallowa Counties									
HumanaChoice H5525-054 (PPO) (Baker/Wallowa only)	H5525-054	PPO	$70	NA	$6,700/$12,450	$0	$250	Enhanced	$28
Summit Health Core (HMO-POS)	H2765-001	HMO	NA	$19	$4,990	$0	NA	No Rx	No Rx
Summit Health Value + Rx (HMO)	H2765-002	HMO	$59	NA	$6,990	$0	$235	Enhanced	$18
Summit Health Standard + Rx (HMO-POS)	H2765-003	HMO	$89	NA	$5,880/$8,990	$0	$185	Enhanced	$48
Summit Health Premier + Rx (HMO-POS)	H2765-004	HMO	$139	NA	$4,850/$7,990	$0	$135	Enhanced	$98
Benton County	*Available only in ZIP codes: 97330, 97331, 97333, 97339, 97370								
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Plan 1 (HMO)	H3805-007	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO)	H3805-023-1	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
Kaiser Permanente Senior Advantage Enhanced (HMO)*	H9003-001	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO)*	H9003-006	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Benton County	*Available only in ZIP codes: 97330, 97331, 97333, 97339, 97370								
Kaiser Permanente Senior Advantage Value (HMO)*	H9003-009	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health Mid-valley PPORX (PPO)	H3813-014	PPO	$96	NA	$6,025/$9,500	$0	$285	Enhanced	$55
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Providence Medicare Extra + Rx (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
Samaritan Advantage Conventional Plan (HMO)	H3811-001	HMO	NA	$50	$5,200	$0	NA	No Rx	No Rx
Samaritan Advantage Premier Plan (HMO)	H3811-002	HMO	$19	NA	$5,000	$0	$175	Enhanced	$0
Samaritan Advantage Premier Plan Plus (HMO)	H3811-009	HMO	$129	NA	$4,800	$0	$0	Enhanced	$89
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare No Premium (HMO)	H6815-038-0	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,500/$7,500	$250	$200	Enhanced	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare Low Premium Open (PPO)	H5439-018	PPO	$30	NA	$6,900/$6,900	$225	$150	Enhanced	$11.40
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Clackamas, Multnomah, and Washington Counties									
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
Aetna Medicare Choice Plan (PPO)	H9431-005	PPO	$24	NA	$5,600/$8,950	$0	$0	Enhanced	$7.70
Aetna Medicare Elite Plan (HMO-POS)	H2056-003	HMO	$0	NA	$5,200	$1,000	$0	Enhanced	$0
Aetna Medicare Value Plan (HMO-POS)	H2056-004	HMO	$0	NA	$6,100	$0	$0	Enhanced	$0
Aetna Medicare Eagle Plan (PPO)	H9431-015	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	No Rx
AgeRight Advantage Premier Health Plan (HMO C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
Cigna True Choice Savings Medicare (PPO)	H7849-055	PPO	$0	NA	$5,600/$8,950	$0	$0	Enhanced	$0
Cigna Preferred Medicare (HMO)	H7389-002	HMO	$0	NA	$4,900	$0	$0	Enhanced	$0
Devoted CORE Oregon (HMO)	H2923-001	HMO	$0	NA	$5,200	$0	$0	Enhanced	$0
Devoted CHOICE Oregon (PPO)	H7199-001	PPO	$0	NA	$5,900/$8,950	$0	$225	Enhanced	$0
Devoted CHOICE PLUS Oregon (PPO)	H7199-002	PPO	$36.20	NA	$5,400/$8,950	$0	$150	Enhanced	$0
Humana Gold Plus H1036-153 (HMO)	H1036-153	HMO	$0	NA	$5,200	$0	$0	Enhanced	$0
Humana Gold Plus - Diabetes (HMO C-SNP)	H1036-306	HMO	$0	MA	$6,900	$0	$250	Enhanced	$0
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	No Rx
Humana Honor (PPO)	H5216-315	PPO	NA	$0	$8,300/$11,300	$0	NA	No Rx	No Rx
HumanaChoice H5216-247 (PPO)	H5216-247	PPO	$0	NA	$6,500/$11,000	$0	$175	Enhanced	$0
Humana Value Plus H5216-294 (PPO)	H5216-294	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Clackamas, Multnomah, and Washington Counties									
Kaiser Permanente Senior Advantage Enhanced (HMO-POS)	H9003-001	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO-POS)	H9003-006	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1
Kaiser Permanente Senior Advantage Value (HMO-POS)	H9003-009	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health Metro PPORX (PPO)	H3813-013	PPO	$88	NA	$5,090/$8,500	$0	$225	Enhanced	$47
Moda Health + Fred Meyer PPORX (PPO)	H3813-016	PPO	$39	NA	$6,920/$10,950	$0	$285	Enhanced	$0
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
PacificSource Medicare MyCare Rx 40 (HMO)	H3864-040	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
PacificSource Medicare MyCare Choice 30 (HMO-POS)	H3864-030	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare MyCare Choice Rx 34 (HMO-POS)	H3864-034	HMO	$0	NA	$5,700	$0	$0	Enhanced	$0
Providence Medicare Bridge + RX (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Choice + RX (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra + RX (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Prime + RX (HMO)	H9047-037	HMO	$0	NA	$4,500	$0	$150	Enhanced	$0
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$0	$4,500/$10,000	$0	NA	No Rx	No Rx
Regence BlueAdvantage HMO (HMO)	H6237-007-1	HMO	$0	NA	$5,500	$0	$200	Enhanced	$0
Regence BlueAdvantage HMO Plus (HMO)	H6237-008-1	HMO	$45	NA	$4,900	$0	$100	Enhanced	$32.60

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Clackamas, Multnomah, and Washington Counties									
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-1	PPO	$47	NA	$5,700/$8,950	$0	$150	Enhanced	$16.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-1	PPO	$172	NA	$5,000/$8,300	$0	$0	Enhanced	$131
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-1	PPO	$0	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (HMO)	H6237-006	HMO	NA	$0	$4,900	$0	NA	No Rx	No Rx
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-018	PPO	$30	NA	$6,900/$6,900	$225	$150	Enhanced	$11.40
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Clatsop County — see all Oregon counties									
Columbia County									
AARP Medicare Advantage Choice (PPO)	H2228-029-0	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084-0	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088-0	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	$0
AARP Medicare Advantage Plan 1 (HMO)	H3805-001-0	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO)	H3805-036-0	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
Aetna Medicare Eagle Plan (PPO)	H9431-015-0	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	$0

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Columbia County									
Aetna Medicare Choice Plan (PPO)	H9431-005-0	PPO	$24	NA	$5,600/$8,950	$0	$0	Enhanced	$8
Aetna Medicare Elite Plan (HMO-POS)	H2056-003-0	HMO	$0	NA	$5,200	$1,000	$0	Enhanced	$0
Aetna Medicare Value Plan (HMO-POS)	H2056-004-0	HMO	$0	NA	$6,100	$0	$0	Enhanced	$0
Cigna Preferred Medicare (HMO)	H7389-002-0	HMO	$0	NA	$4,900	$0	$0	Enhanced	$0
Cigna True Choice Savings Medicare (PPO)	H7849-055-0	PPO	$0	NA	$5,600/$8,950	$0	$0	Enhanced	$0
Devoted CORE Oregon (HMO)	H2923-001-0	HMO	$0	NA	$5,200	$0	$0	Enhanced	$0
Devoted CHOICE Oregon (PPO)	H7199-001-0	PPO	$0	NA	$5,900/$8,950	$0	$225	Enhanced	$0
Devoted CHOICE PLUS Oregon (PPO)	H7199-002-0	PPO	$0	NA	$5,400/$8,950	$0	$150	Enhanced	$0
Humana Gold Plus H1036-153 (HMO)	H1036-153-0	HMO	$0	NA	$5,200	$0	$0	Enhanced	$0
Humana Honor (PPO)	H5216-315-0	PPO	NA	$0	$8,300/$11,300	$0	NA	No Rx	$0
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	$0
Humana Value Plus H5216-294 (PPO)	H5216-294-0	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0
HumanaChoice H5216-247 (PPO)	H5216-247-0	PPO	$0	NA	$6,500/$11,000	$0	$175	Enhanced	$0
Humana Gold Plus - Diabetes (HMO C-SNP)	H1036-306	HMO	$0	MA	$6,900	$0	$250	Enhanced	$0
Kaiser Permanente Senior Advantage Enhanced (HMO)	H9003-001-0	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO)	H9003-006-0	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1
Kaiser Permanente Senior Advantage Value (HMO)	H9003-009-0	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health NW PPORX (PPO)	H3813-011-0	PPO	$89	NA	$5,990/$8,950	$0	$225	Enhanced	$48
Moda Health PPO (PPO)	H3813-001-0	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	$0
Moda Health + Fred Meyer PPORX (PPO)	H3813-016-0	PPO	$39	NA	$6,920/$10,950	$0	$285	Enhanced	$0
Providence Medicare Bridge + Rx (HMO-POS)	H9047-059-0	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Columbia County									
Providence Medicare Choice + RX (HMO-POS)	H9047-065-0	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra + Rx (HMO)	H9047-064-0	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Focus Medical (HMO)	H9047-033-0	HMO	NA	$128	$3,400	$0	NA	No Rx	$128
Providence Medicare Timber + RX (HMO)	H9047-054-0	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Providence Medicare Reverence (HMO-POS)	H9047-035-0	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	$51
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010-0	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	$0
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037-0	HMO	$14.90	NA	$5,600	$0	$400	Enhanced	$0
Wellcare No Premium (HMO)	H6815-038-0	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Coos and Curry counties	*Available in Curry County only **Available in Coos County only								
AllCare Advantage Madrone Rx (HMO)*	H3810-024	HMO	$41	NA	$8,300	$226	$505	Basic	$0
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Moda Health Southern PPORX (PPO)	H3813-012	PPO	$85	NA	$5,400/$8,950	$0	$200	Enhanced	$44
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
PacificSource Medicare Essentials Rx 41 (HMO)	H3864-041	HMO	$74	NA	$5,500	$0	$0	Enhanced	$37.30

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Coos and Curry counties	*Available in Curry County only **Available in Coos County only								
PacificSource Medicare Explorer 8 (PPO)	H4754-008	PPO	NA	$0	$6,700/$8,950	$0	NA	No Rx	No Rx
PacificSource Medicare Explorer Rx 7 (PPO)	H4754-007	PPO	$134	NA	$6,950/$10,000	$0	$150	Enhanced	$93
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$5.90
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
Wellcare Assist (HMO)**	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare No Premium (HMO)**	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Crook and Jefferson counties	*Available only in Jefferson County								
Humana Gold Plus H1036-219 (HMO)*	H1036-219	HMO	$55	NA	$5,900	$0	$100	Enhanced	$55
Humana Gold Plus H2486-009 (HMO)*	H2486-009	HMO	$0	NA	$5,900	$0	$100	Enhanced	$0
Humana Gold Plus - Diabetes (HMO C-SNP)*	H1036-306	HMO	$0	MA	$6,900	$0	$250	Enhanced	$0
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	No Rx
Humana Value Plus H5216-294 (PPO)	H5216-294	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0
HumanaChoice H5216-044 (PPO)	H5216-044	PPO	$14	NA	$6,000/$8,950	$0	$200	Enhanced	$0
HumanaChoice H5216-047 (PPO)	H5216-047	PPO	$99	NA	$6,700/$10,000	$0	$320	Enhanced	$91.40
Moda Health Central PPORX (PPO)	H3813-010	PPO	$89	NA	$5,950/$5,950	$0	$200	Enhanced	$48
Moda Health Value PPORX (PPO	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Crook and Jefferson counties	*Available only in Jefferson County								
PacificSource Medicare Essentials Choice 2 (HMO-POS)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Choice Rx 36 (HMO-POS)	H3864-036	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Providence Medicare Timber + Rx (HMO)	H9047-054	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Providence Medicare Bridge + Rx (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	No Rx
Providence Medicare Choice + RX (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Extra + RX (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Curry County — see Coos County									
Deschutes County									
Humana Gold Plus H1036-219 (HMO)	H1036-219-0	HMO	$55	NA	$5,900	$0	$100	Enhanced	$55
Humana Gold Plus H2486-009 (HMO)	H2486-009-0	HMO	$0	NA	$5,900	$0	$100	Enhanced	$0
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	No Rx

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Deschutes County									
Humana Value Plus H5216-294 (PPO)	H5216-294-0	PPO	$38	NA	$8,300/$11,300	Not Avail	$425	Basic	$0
HumanaChoice H5216-044 (PPO)	H5216-044-0	PPO	$14	NA	$6,000/$8,950	$0	$200	Enhanced	$0
HumanaChoice H5216-047 (PPO)	H5216-047-0	PPO	$99	NA	$6,700/$10,000	$0	$320	Enhanced	$91.40
Humana Gold Plus - Diabetes (HMO C-SNP)	H1036-306	HMO	$0	MA	$6,900	$0	$250	Enhanced	$0
Moda Health Central PPORX (PPO)	H3813-010-0	PPO	$89	NA	$5,950/$5,950	$0	$200	Enhanced	$48
Moda Health Value PPORX (PPO)	H3813-017-0	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health PPO (PPO)	H3813-001-0	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice RX 36 (HMO-POS)	H3864-036-0	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Choice 2 (HMO-POS)	H3864-002-0	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014-0	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027-0	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006-0	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Providence Medicare Choice + Rx (HMO-POS)	H9047-065-0	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra + Rx (HMO)	H9047-064-0	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Focus Medical (HMO)	H9047-033-0	HMO	$128	NA	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Reverence (HMO-POS)	H9047-035-0	HMO	$51	NA	$4,500/$10,000	$0	NA	No Rx	No Rx
Providence Medicare Bridge + Rx (HMO-POS)	H9047-059-0	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Timber + RX (HMO)	H9047-054-0	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Regence Valiance (PPO)	H3817-010-0	PPO	$0	NA	$5,000/$8,950	$0	NA	No Rx	No Rx

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Deschutes County									
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-1	PPO	$47	NA	$5,700/$8,950	$0	$150	Enhanced	$16.40
Regence BlueAdvantage HMO (HMO)	H6237-007-3	HMO	$34	NA	$5,500	$0	$200	Enhanced	$13
Regence BlueAdvantage HMO Plus (HMO)	H6237-008-3	HMO	$88	NA	$4,900	$0	$100	Enhanced	$76
Regence Valiance (HMO)	H6237-006-0	HMO	NA	$0	$4,900	$0	NA	No Rx	$0
Wellcare Assist (HMO)	H6815-037-0	HMO	$14.90	NA	$5,600	$0	$400	Enhanced	$0
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Douglas County	*Available only in ZIP codes 97442 (Glendale) and 97410 (Azalea).								
AllCare Advantage Focus (HMO)*	H3810-021-0	HMO	NA	$0	$7,950	$0	NA	No Rx	$0
AllCare Advantage Focus Rx (HMO)*	H3810-022-0	HMO	$25	NA	$7,950	$0	$295	Enhanced	$0
AllCare Advantage Gold (HMO)*	H3810-001-0	HMO	NA	$31	$5,900	$200	NA	No Rx	$31
AllCare Advantage Gold Rx (HMO)*	H3810-003-0	HMO	$139	NA	$5,900	$200	$175	Enhanced	$98
AllCare Advantage Madrone Rx (HMO)*	H3810-024-0	HMO	$41	NA	$8,300	$226	$505	Enhanced	$0
ATRIO Freedom (PPO)	H6743-024-1	PPO	NA	$0	$4,500/$6,500	$0	NA	No Rx	No Rx
ATRIO Choice Rx (PPO)	H6743-007	PPO	$0	NA	$4,500/$6,500	$0	$100	Enhanced	$0
ATRIO Prime Rx (PPO)	H6743-023-1	PPO	$99	NA	$2,500/$5,000	$0	$0	Enhanced	$58
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health Southern PPORX (PPO)	H3813-012	PPO	$85	NA	$5,400/$8,950	$0	$200	Enhanced	$44
PacificSource Medicare Essentials Choice 2 (HMO-POS)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	$0
PacificSource Medicare Essentials Choice Rx 42 (HMO-POS)	H3864-042	HMO	$0	NA	$6,700	$0	$200	Enhanced	$0
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Douglas County	*Available only in ZIP codes 97442 (Glendale) and 97410 (Azalea).								
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Enhanced	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-019	PPO	$26	NA	$5,900/$5,900	$225	$150	Enhanced	$17.40
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Gilliam County — see Baker County									
Grant and Sherman counties									
PacificSource Medicare Essentials 2 (HMO)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Choice Rx 36 (HMO-POS)	H3864-036	HMO	$0	$0	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Summit Health Core (HMO-POS)	H2765-001	HMO	NA	$19	$4,990/$4,990	$0	NA	No Rx	No Rx
Summit Health Premier + Rx (HMO-POS)	H2765-004	HMO	$139	NA	$4,850/$7,990	$0	$135	Enhanced	$98
Summit Health Standard + Rx (HMO-POS)	H2765-003	HMO	$89	NA	$5,880/$8,990	$0	$185	Enhanced	$48
Summit Health Value + Rx (HMO)	H2765-002	HMO	$59	NA	$6,990	$0	$235	Enhanced	$18

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Harney County — see Baker County									
Hood River County									
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	No Rx
Humana Honor (PPO)	H5216-315-0	PPO	NA	$0	$8,300/$11,300	$0	NA	No Rx	No Rx
Humana Value Plus H5216-294 (PPO)	H5216-294	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0
HumanaChoice H5216-048 (PPO)	H5216-048	PPO	$199	NA	$6,700/$10,000	$0	$375	Basic	$158
Moda Health Central PPORX (PPO)	H3813-010	PPO	$89	NA	$5,950/$5,950	$0	$200	Enhanced	$48
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Moda Health Value PPO RX (PPO)	H3813-017	PPO	$45	NA	$6.960/$9,500	$0	$285	Enhanced	$4
PacificSource Medicare Essentials Choice 2 (HMO-POS)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 36 (HMO-POS)	H3864-036	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	No Rx
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Extra + RX (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Timber + RX (HMO)	H9047-054	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Providence Medicare Bridge + RX (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Choice + RX (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Jackson County									
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicine Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
Aetna Medicare Choice Plan (PPO)	H9431-004	PPO	$52	NA	$6,700/$10,000	$0	$0	Enhanced	$32
Aetna Medicare Eagle Plan (PPO)	H9431-015	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	No Rx
Aetna Medicare Elite Plan (HMO-POS)	H2056-005	HMO	$0	NA	$6,500	$1,000	$0	Enhanced	$0
AllCare Advantage Focus (HMO)	H3810-021	HMO	NA	$0	$7,950	$0	NA	No Rx	No Rx
AllCare Advantage Focus Rx (HMO)	H3810-022	HMO	$25	NA	$7,950	$0	$295	Enhanced	$0
AllCare Advantage Gold (HMO)	H3810-001	HMO	NA	$31	$5,900	$200	NA	No Rx	No Rx
AllCare Advantage Gold Plus Rx (HMO)	H3810-003	HMO	$139	NA	$5,900	$200	$175	Enhanced	$98
AllCare Advantage Madrone Rx(HMO)	H3810-024	HMO	$41	NA	$8,300	$226	$505	Basic	$0
ATRIO Choice Rx (PPO)	H6743-025	PPO	$0	NA	$4,500/$6,500	$0	$100	Enhanced	$0
ATRIO Freedom (PPO)	H6743-024-2	PPO	NA	$0	$4,500/$6,500	$0	NA	No Rx	No Rx
ATRIO Prime RX (PPO)	H6743-023-2	PPO	$99	NA	$2,500/$5,000	$0	$0	Enhanced	$58
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Moda Health Southern PPORX (PPO)	H3813-012	PPO	$85	NA	$5,400/$8,950	$0	$200	Enhanced	$44
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8950	$0	$150	Enhanced	$43.40

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Jackson County									
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-019	PPO	$26	NA	$5,900/$5,900	$225	$150	Enhanced	$17.40
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Jefferson County — see Crook County									
Josephine County									
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
Aetna Medicare Choice Plan (PPO)	H9431-004	PPO	$52	NA	$6,700/$10,000	$0	$0	Enhanced	$32
Aetna Medicare Eagle Plan (PPO)	H9431-015	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	No Rx

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Josephine County									
Aetna Medicare Elite Plan (HMO-POS)	H2056-005	HMO	$0	NA	$6,500	$1,000	$0	Enhanced	$0
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
AllCare Advantage Focus (HMO)	H3810-021	HMO	NA	$0	$7,950	$0	NA	No Rx	No Rx
AllCare Advantage Focus Rx (HMO)	H3810-022	HMO	$25	NA	$7,950	$0	$295	Enhanced	$0
AllCare Advantage Gold (HMO)	H3810-001	HMO	NA	$31	$5,900	$200	NA	No Rx	No Rx
AllCare Advantage Madrone Rx (HMO)	H3810-024	HMO	$41	NA	$8,300	$226	$505	Basic	$0
AllCare Advantage Gold Plus Rx (HMO)	H3810-003	HMO	$139	NA	$5,900	$200	$175	Enhanced	$98
ATRIO Choice Rx (PPO)	H6743-025	PPO	$0	NA	$4,500/$6,500	$0	$100	Enhanced	$0
ATRIO Freedom (PPO)	H6743-024-2	PPO	$0	NA	$4,500/$6,500	$0	NA	No Rx	No Rx
ATRIO Prime Rx (PPO)	H6743-023	PPO	$99	NA	$2,500/$5,000	$0	$0	Enhanced	$58
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health Southern PPORX (PPO)	H3813-012	PPO	$85	NA	$5,400/$8,950	$0	$200	Enhanced	$44
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-019	PPO	$26	NA	$5,900/$5,900	$225	$150	Enhanced	$17.40

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Josephine County									
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Klamath County	*Not available in ZIP codes: 97731, 97733, 97737 and 97739 **Available only in ZIP codes: 97731, 97733, 97737 and 97739								
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
ATRIO Choice Rx (PPO)*	H6743-001	PPO	$0	NA	$4,500/$6,500	$0	$250	Enhanced	$0
ATRIO Prime Rx (PPO)*	H6743-023	PPO	99	NA	$3,500/$5,450	$0	0	Enhanced	$58
ATRIO Freedom (PPO)*	H6743-024	PPO	NA	$0	$4,500/$6,500	$0	NA	No Rx	$0
PacificSource Medical Essentials Choice 2 (HMO)**	H3864-002	HMO	NA	0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medical Essentials Choice Rx 36 (HMO)**	H3864-036	HMO	0	NA	$6,200	$0	200	Enhanced	$0
PacificSource Medical Essentials Choice Rx 27 (HMO)**	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medical Essentials Choice Rx 14 (HMO)**	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medical Essentials Choice Rx 6 (HMO)**	H3864-006	HMO	203	NA	$4,950	$0	0	Enhanced	$162
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500	$0	NA	No Rx	No Rx
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health Southern PPORX (PPO)	H3813-012	PPO	85	NA	$5,400/$8,950	$0	200	Enhanced	$44
Lake County — see Baker County									

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Lane County									
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
Kaiser Permanente Senior Advantage Standard Lane (HMO-POS)	H9003-007	HMO	$47	NA	$3,000	$0	$125	Enhanced	$6
Kaiser Permanente Senior Advantage Value Lane (HMO-POS)	H9003-008	HMO	$0	NA	$3,800	$0	$175	Enhanced	$0
Moda Health Mid-valley PPORX (PPO)	H3813-014	PPO	$96	NA	$6,025/$9,500	$0	$285	Enhanced	$55
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials 2 (HMO-POS)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Rx 36 (HMO-POS)	H3864-036	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Rx 41 (HMO)	H3864-041	HMO	$74	NA	$5,500	$0	$0	Enhanced	$37.30
PacificSource Medicare Explorer 8 (PPO)	H4754-008	PPO	NA	$0	$6,700/$8,950	$0	NA	No Rx	No Rx
PacificSource Medicare Explorer Rx 4 (PPO)	H4754-004	PPO	$114	NA	$5,500/$8,950	$0	$0	Enhanced	$73

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Lane County									
Providence Medicare Choice + RX (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Bridge + RX (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Extra + RX (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	No Rx
Providence Medicare Timber + RX (HMO)	H9047-054	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Regence BlueAdvantage HMO (HMO)	H6237-007-1	HMO	$0	NA	$5,500	$0	$200	Enhanced	$0
Regence BlueAdvantage HMO Plus (HMO)	H6237-008-1	HMO	$45	NA	$4,900	$0	$100	Enhanced	$32.60
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-1	PPO	$47	NA	$5,700/$8,950	$0	$150	Enhanced	$16.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-1	PPO	$172	NA	$5,000/$8,300	$0	$0	Enhanced	$131
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-1	PPO	$0	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (HMO)	H6237-006	HMO	NA	$0	$4,900	$0	NA	No Rx	No Rx
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400.00	Basic	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-018	PPO	$30	NA	$6,900/$6,900	$225	$0	Enhanced	$11.40
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Lane County									
Wellcare No Premium Open (PPO)	H5439-017	PPO	$0	NA	$3,450/$3,450	$0	$225	Enhanced	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011-0	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Lincoln County									
Moda Health NW PPORX (PPO)	H3813-011	PPO	$89	NA	$5,990/$8,950	$0	$225.00	Enhanced	$48
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500	$0	NA	No Rx	No Rx
Moda Health + Fred Meyer PPORX (PPO)	H3813-016-0	PPO	$39	NA	$6,920/$10,950	$0	285	Enhanced	$0
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150.00	Enhanced	$43.40
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250.00	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
Samaritan Advantage Conventional Plan (HMO)	H3811-001	HMO	NA	$50	$5,200	$0	NA	No Rx	No Rx
Samaritan Advantage Premier Plan (HMO)	H3811-002	HMO	$19	NA	$5,000	$0	$175.00	Enhanced	$0
Samaritan Advantage Premier Plan Plus (HMO)	H3811-009	HMO	$129	NA	$4,800	$0	$0	Enhanced	$89
Linn County	*Available only in ZIP codes: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389								
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036-0	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Linn County	*Available only in ZIP codes: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389								
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	No Rx
Humana Value Plus H5216-294 (PPO)	H5216-294	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0
HumanaChoice H5216-048 (PPO)	H5216-048	PPO	$199	NA	$6,700/$10,000	$0	$375	Basic	$158
Kaiser Permanente Senior Advantage Enhanced (HMO-POS)*	H9003-001	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO-POS)*	H9003-006	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1
Kaiser Permanente Senior Advantage Value (HMO-POS)*	H9003-009	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health Mid-valley PPORX (PPO)	H3813-014	PPO	$96	NA	$6,025/$9,500	$0	$285	Enhanced	$55
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Providence Medicare Extra + RX (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
Samaritan Advantage Conventional Plan (HMO)	H3811-001	HMO	NA	$50	$5,200	$0	NA	No Rx	No Rx
Samaritan Advantage Premier Plan (HMO)	H3811-002	HMO	$19	NA	$5,000	$0	$175	Enhanced	$0
Samaritan Advantage Premier Plan Plus (HMO)	H3811-009	HMO	$129	NA	$4,800	$0	$0	Enhanced	$89

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Linn County	*Available only in ZIP codes: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389								
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-018	PPO	$30	NA	$6,900/$6,900	$225	$150	Enhanced	$11.40
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Malheur County									
Humana Honor (PPO)	H5216-301-1	PPO	NA	$0	$5,000/$5,900	$0	NA	No Rx	$0
Humana Honor (PPO)	H5216-315-0	PPO	NA	$0	$8,300/$11,300	$0	NA	No Rx	$0
Humana Value Plus H5216-294 (PPO)	H5216-294-0	PPO	$38	NA	$8,300/$11,300	$226	$425	Basic	$0
HumanaChoice H5216-044 (PPO)	H5216-044-0	PPO	$14	NA	$6,000/$8,950	$0	$200	Enhanced	$0
HumanaChoice H5216-132 (PPO)	H5216-132-0	PPO	$0	NA	$5,500/$5,500	$0	$100	Enhanced	$0
Summit Health Core (HMO-POS)	H2765-001-0	HMO	NA	$19	$4,990/$4,990	$0	NA	No Rx	$19
Summit Health Premier + Rx (HMO-POS)	H2765-004-0	HMO	$139	NA	$4,850/$7,990	$0	$135	Enhanced	$98
Summit Health Standard + Rx (HMO-POS)	H2765-003-0	HMO	$89	NA	$5,880/$8,990	$0	$185	Enhanced	$48
Summit Health Value + Rx (HMO)	H2765-002-0	HMO	$59	NA	$6,990	$0	$235	Enhanced	$18
Marion and Polk counties									
AARP Medicare Advantage Choice (PPO)	H2228-029-0	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088-0	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	$0
AARP Medicare Advantage Plan 1 (HMO)	H3805-001-0	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Plan 2 (HMO)	H3805-036-0	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Walgreens (PPO)	H2228-084-0	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Marion and Polk counties									
Aetna Medicare Choice Plan (PPO)	H9431-005-0	PPO	$24	NA	$5,600/$8,950	$0	$0	Enhanced	$8
Aetna Medicare Eagle Plan (PPO)	H9431-015-0	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	$0
Aetna Medicare Elite Plan (HMO-POS)	H2056-003-0	HMO	$0	NA	$5,200	$1,000	$0	Enhanced	$0
Aetna Medicare Value Plan (HMO-POS)	H2056-004-0	HMO	$0	NA	$6,100	$0	$0	Enhanced	$0
AgeRight Advantage Premier Health Plan (HMO-C-SNP)*	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
ATRIO Choice Rx (PPO)	H7006-007-0	PPO	$0	NA	$4,500/$6,500	$0	$100	Enhanced	$0
ATRIO Special Needs Plan (Willamette) (HMO D-SNP)	H5995-001-0	HMO	$41	NA	$6,700	$0 or $505	$505	Enhanced	$0
ATRIO Select Rx (PPO)	H7006-003-0	PPO	$99	NA	$2,500/$5,000	$0	$0	Enhanced	$58
Kaiser Permanente Senior Advantage Enhanced (HMO)	H9003-001-0	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO)	H9003-006-0	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1
Kaiser Permanente Senior Advantage Value (HMO-POS)	H9003-009-0	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health Mid-valley PPORX (PPO)	H3813-014-0	PPO	$96	NA	$6,025/$9,500	$0	$285	Enhanced	$55
Moda Health PPO (PPO)	H3813-001-0	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	$0
Providence Medicare Bridge + Rx (HMO-POS)	H9047-059-0	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Choice + Rx (HMO-POS)	H9047-065-0	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra Part B Only + Rx (HMO)	H9047-013-0	HMO	$449	NA	$3,400	$0	$0	Enhanced	$408
Providence Medicare Extra + Rx (HMO)	H9047-064-0	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Marion and Polk counties									
Providence Medicare Reverence (HMO-POS)	H9047-035-0	HMO	$51	NA	$4,500/$10,000	$0	NA	No Rx	$51
Providence Medicare Focus Medical (HMO)	H9047-033-0	HMO	NA	$128	$3,400	$0	NA	No Rx	$128
Providence Medicare Timber + RX (HMO)	H9047-054-0	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010-0	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	$0
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037-0	HMO	$14.90	NA	$5,600	$0	$400	Enhanced	$0
Wellcare Giveback Open (PPO)	H5439-015-0	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-018-0	PPO	$30	NA	$6,900/$6,900	$225	$150	Enhanced	$11.40
Wellcare No Premium (HMO)	H6815-038-0	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010-0	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	$0
Wellcare Premium Ultra Open (PPO)	H5439-011-0	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70
Morrow County — see Baker County									
Multnomah County — see Clackamas County									
Polk County — see Marion County									
Sherman County — see Grant County									

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Tillamook County									
Moda Health NW PPORX (PPO)	H3813-011	PPO	$89	NA	$5,990/$8,950	$0	$225	Enhanced	$48
Moda Health + Fred Meyer PPORX (PPO)	H3813-016	PPO	$39	NA	$6,920/$10,950	$0	$285	Enhanced	$0
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Umatilla County — see Baker County									
Union County — see Baker County									
Wallowa County — see Baker County									
Wasco County									
Moda Health Central PPORX (PPO)	H3813-010	PPO	$89	NA	$5,950/$5,950	$0	$200	Enhanced	$48
Moda Health Value PPORX (PPO)	H3813-017	PPO	$45	NA	$6,960/$9,500	$0	$285	Enhanced	$4
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice 2 (HMO)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Choice Rx 36 (HMO-POS)	H3864-036	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Washington County — see Clackamas County									

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Wheeler County									
PacificSource Medicare Essentials 2 (HMO-POS)	H3864-002	HMO	NA	$0	$3,950	$0	NA	No Rx	No Rx
PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)	H3864-014	HMO	$95	NA	$5,500	$0	$0	Enhanced	$54
PacificSource Medicare Essentials Choice Rx 36 (HMO-POS)	H3864-036	HMO	$0	NA	$6,200	$0	$200	Enhanced	$0
PacificSource Medicare Essentials Rx 27 (HMO)	H3864-027	HMO	$40	NA	$6,200	$0	$399	Enhanced	$0
PacificSource Medicare Essentials Rx 6 (HMO)	H3864-006	HMO	$203	NA	$4,950	$0	$0	Enhanced	$162
Providence Medicare Bridge + Rx (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0
Providence Medicare Choice + Rx (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra + Rx (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	No Rx
Providence Medicare Timber + Rx (HMO)	H9047-054	HMO	$0	NA	$5,500	$0	$0	Enhanced	$0
Summit Health Core (HMO-POS)	H2765-001	HMO	NA	$19	$4,990/$4,990	$0	NA	No Rx	No Rx
Summit Health Premier + Rx (HMO-POS)	H2765-004	HMO	$139	NA	$4,850/$7,990	$0	$135	Enhanced	$98
Summit Health Standard + Rx (HMO-POS)	H2765-003	HMO	$89	NA	$5,880/$8,990	$0	$185	Enhanced	$48
Summit Health Value + Rx (HMO)	H2765-002	HMO	$59	NA	$6,990	$0	$235	Enhanced	$18

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Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Yamhill County									
AARP Medicare Advantage Choice (PPO)	H2228-029	PPO	$32	NA	$4,500/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Patriot (PPO)	H2228-088	PPO	NA	$0	$5,600/$8,500	$0	NA	No Rx	No Rx
AARP Medicare Advantage Plan 1 (HMO-POS)	H3805-001	HMO	$61	NA	$3,500	$0	$0	Enhanced	$23.40
AARP Medicare Advantage Walgreens (PPO)	H2228-084	PPO	$0	NA	$5,600/$8,500	$0	$0	Enhanced	$0
AARP Medicare Advantage Plan 2 (HMO-POS)	H3805-036	HMO	$0	NA	$4,500	$0	$0	Enhanced	$0
Aetna Medicare Choice Plan (PPO)	H9431-005	PPO	$24	NA	$5,600/$8,950	$0	$0	Enhanced	$7.70
Aetna Medicare Eagle Plan (PPO)	H9431-015	PPO	NA	$0	$5,600/$8,950	$0	NA	No Rx	No Rx
Aetna Medicare Elite Plan (HMO-POS)	H2056-003	HMO	$0	NA	$5,200	$1,000	$0	Enhanced	$0
Aetna Medicare Value Plan (HMO-POS)	H2056-004	HMO	$0	NA	$6,100	$0	$0	Enhanced	$0
AgeRight Advantage Premier Health Plan (HMO-C-SNP)	H1372-003	HMO	$42	NA	$6,500	$226	$300	Enhanced	$5
Kaiser Permanente Senior Advantage Enhanced (HMO)	H9003-001	HMO	$127	NA	$3,000	$0	$0	Enhanced	$86
Kaiser Permanente Senior Advantage Standard (HMO)	H9003-006	HMO	$42	NA	$4,900	$0	$0	Enhanced	$1
Kaiser Permanente Senior Advantage Value (HMO-POS)	H9003-009	HMO	$0	NA	$5,300	$0	$0	Enhanced	$0
Moda Health NW PPORX (PPO)	H3813-011	PPO	$89	NA	$5,990/$8,950	$0	$225	Enhanced	$48.00
Moda Health + Fred Meyer PPORX (PPO)	H3813-016	PPO	$39	NA	$6,920/$10,950	$0	$285	Enhanced	$0
Moda Health PPO (PPO)	H3813-001	PPO	NA	$0	$4,500/$4,500	$0	NA	No Rx	No Rx
Providence Medicare Bridge + RX (HMO-POS)	H9047-059	HMO	$35	NA	$4,900/$10,000	$0	$0	Enhanced	$0

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Plan name	Plan & contract number	Plan type	Premium with Rx	Premium without Rx	In-net/in-and-out-of-net MOOP (maximum out-of-pocket)	Health deductible	Drug deductible	Drug plan type – basic or enhanced	Premium with 100% Extra Help
Yamhill County									
Providence Medicare Choice + RX (HMO-POS)	H9047-065	HMO	$89	NA	$4,500/$10,000	$0	$240	Enhanced	$48
Providence Medicare Extra + Rx (HMO)	H9047-064	HMO	$173	NA	$3,400	$0	$0	Enhanced	$132
Providence Medicare Focus Medical (HMO)	H9047-033	HMO	NA	$128	$3,400	$0	NA	No Rx	No Rx
Providence Medicare Prime + RX (HMO)	H9047-037	HMO	$0	NA	$4,500	$0	$150	Enhanced	$0
Providence Medicare Reverence (HMO-POS)	H9047-035	HMO	NA	$51	$4,500/$10,000	$0	NA	No Rx	No Rx
Regence MedAdvantage + Rx Classic (PPO)	H3817-008-2	PPO	$74	NA	$5,700/$8,950	$0	$150	Enhanced	$43.40
Regence MedAdvantage + Rx Enhanced (PPO)	H3817-009-2	PPO	$157	NA	$5,000/$8,300	$0	$0	Enhanced	$116
Regence MedAdvantage + Rx Primary (PPO)	H3817-011-2	PPO	$16.30	NA	$6,200/$10,000	$0	$250	Enhanced	$0
Regence Valiance (PPO)	H3817-010-0	PPO	NA	$0	$5,000/$8,950	$0	NA	No Rx	No Rx
United Healthcare Chronic Complete Assure (PPO C-SNP)	H0271-036	PPO	$13.30	NA	$8,300/$12,450	$0	$505	Basic	$0
Wellcare Assist (HMO)	H6815-037	HMO	$14.90	NA	$5,600	$0	$400	Basic	$0
Wellcare Giveback Open (PPO)	H5439-015	PPO	$0	NA	$7,550/$7,550	$250	$200	Enhanced	$0
Wellcare Low Premium Open (PPO)	H5439-018	PPO	$30	NA	$6,900/$6,900	$225	$150	Enhanced	$11.40
Wellcare No Premium (HMO)	H6815-038	HMO	$0	NA	$4,500	$0	$125	Enhanced	$0
Wellcare Patriot No Premium Open (PPO)	H5439-010	PPO	NA	$0	$2,500/$5,100	$125	NA	No Rx	No Rx
Wellcare Premium Ultra Open (PPO)	H5439-011	PPO	$119	NA	$4,000/$4,000	$175	$95	Enhanced	$97.70

***Note:** Not all plans apply the drug deductible to all drug tiers. See Medicare.gov/plan-compare for drug coverage details.*

Appeals

Appeals

Original Medicare, Medicare Advantage and Part D plans have five levels of appeals. The differences usually are in the time frames involved. There may be an expedited process available. For details, see medicare.gov/claims-and-appeals/file-an-appeal/appeals.html. Appeals can be initiated by the beneficiary, provider or representative. Include copies of any information relative to your case. Always appeal denials.

Appeal level	Medicare Part A and Part B	Medicare Advantage	Part D
1	Medicare contractor	Medicare Advantage plan	Medicare prescription drug plan
2	Qualified independent contractor	Independent review entity	
3	Office of Medicare Hearings and Appeals		
4	Medicare Appeals Council		
5	Judicial review		

Original Medicare appeal steps

Redetermination

- Performed by Medicare carrier, fiscal intermediary or Medicare administrative contractor, depending on the issue.
  - » Appeal information is found on the Medicare Summary Notice.
- 120 days to file with a 60-day time limit for processing.
- Expedited process:
  - » Performed by quality improvement organization.
  - » File by noon the next calendar day with a 72-hour time limit.

Reconsideration

- Performed by qualified independent contractor.
- 180 days to file with a 60-day time limit for processing.
- Expedited process:
  - » Performed by qualified independent contractor.
  - » File by noon the next calendar day with a 72-hour time limit.

Administrative law judge

- Performed by Office of Medicare Hearings and Appeals.
  - » Minimum amount in question must be more than $180 in 2023.
- 60 days to file with a 90-day time limit.

Medicare Appeals Council

- 60 days to file with a 90-day time limit for processing.

Judicial review

- Performed in a federal district court.
  - » Amount in question must be more than $1,850 in 2023.
- 60 days to file.

Medicare Advantage appeal steps

Reconsideration

- Performed by the Medicare Advantage plan.
- 60 days to file, pre-service 30-day time limit, payment 60-day time limit.
- Expedited process:
  - » 60 days to file, 72-hour time limit.
  - » Payment requests cannot be expedited.

Independent review entity reconsideration

- Performed by an independent review entity.
- Automatic if plan upholds denial, pre-service 30-day time limit, payment 60-day time limit
- Expedited process:
  - » 60 days to file, 72-hour time limit.
  - » Payment requests cannot be expedited.

Administrative law judge

- Performed by Office of Medicare Hearings and Appeals.
  - » Minimum amount in question must be more than $180 in 2023.
- 60 days to file, no statutory time limit for processing.

Medicare Appeals Council

- 60 days to file, no statutory time limit for processing.

Judicial review

- Performed in a federal district court.
  - » Amount in question must be more than $1,850 in 2023.
- 60 days to file.

Part D appeal steps

Redetermination

- Performed by the prescription drug plan.
- 60 days to file, seven-day time limit
- Expedited process:
  - » 60 days to file, 72-hour time limit.

Independent review entity reconsideration

- Performed by an independent review entity.
- 60 days to file, seven-day time limit.
- Expedited process:
  - » 60 days to file, 72-hour time limit.

Administrative law judge

- Performed by Office of Medicare Hearings and Appeals.
  - » Minimum amount in question must be more than $180 in 2023.
- 60 days to file, 90-day time limit.
- Expedited process:
  - » 60 days to file, 10-day time limit.

Medicare Appeals Council

- 60 days to file, 90-day time limit.
- Expedited process:
  - » 60 days to file, 10-day time limit.

Judicial review

- Performed in a federal district court.
  - » Amount in question must be more than $1,850 in 2023.
- 60 days to file.

Tips and Hints

Note: Optional supplemental benefits such as dental, vision and hearing are covered under the Medicare Advantage appeals process.

Resources and publications

You can request a free copy of these and other publications or view them on one of the websites listed. **Centers for Medicare and Medicaid Services (CMS)** publication numbers are in parentheses.

SHIBA's five favorite CMS publications

1. "Who Pays First" (02179)
2. "Medicare Basics: A Guide for Families and Friends of People With Medicare" (11034)
3. "Choosing a Medigap Policy: A Guide for People with Medicare" (02110)
4. "Medicare Coverage of Kidney Dialysis and Transplant Services" (10128)
5. "Medicare Coverage of Diabetes and Supplies" (11022)

To order Medicare publications

- Call 800-MEDICARE (**800-633-4227**)
- Website: medicare.gov/publications

Website resources

- Aging and Disability Resource Connection of Oregon (ADRC): adrcoforegon.org
- Medicare Rights Center: medicarerights.org
- Benefits Checkup: https://oregon.benefitscheckup.org
- Health Insurance Marketplace: healthcare.gov
- Division of Financial Regulation: dfr.oregon.gov

Tips and Hints

If anyone besides your health care providers or insurance company requests your Medicare information, do not provide it.

You are not required to provide your Medicare number to receive plan information from a licensed insurance agent. However, your Medicare number **will** be required to enroll in a plan.

About SHIBA

As of July 1, 2021, the Senior Health Insurance Benefits Assistance (SHIBA) program is now a part of the Oregon Department of Human Services Office of Aging and People with Disabilities. SHIBA is part of the Administration for Community Living (ACL) State Health Insurance Assistance Program (SHIP) network. SHIP is a statewide network of certified counselors who provide one-on-one assistance to people with Medicare.

SHIBA's goal is to help people make better decisions about health insurance by providing confidential and objective counseling.

Contact the SHIBA program:

- To order free brochures
- To get free help:
  - » Filing claims or comparing Medicare Advantage plans, Medigap policies and prescription drug plans, or
  - » Understanding long-term care insurance
- To become a SHIBA volunteer.

Contact information

- Toll-free: **800-722-4134**
- Email: shiba.oregon@odhs.oregon.gov
- Website: shiba.oregon.gov

Tips and Hints

For help with Part D Extra Help applications, contact Oregon Medicare Savings Connect at **855-447-0155** (toll-free)

Phone numbers (all are toll-free)

ADRC (Aging and Disability Resource Connection)..... **855-673-2372**

Benefits Coordination & Recovery Center..... **855-798-2627**

HealthCare.gov (Federal Marketplace)..... **800-318-2596**

KEPRO (Quality Improvement Organization)..... **888-305-6759**

Long-Term Care Ombudsman..... **800-522-2602**

Medicare (available 24/7 except Christmas Day) **800-633-4227**

Noridian (DME claims)..... **877-320-0390**

Noridian (Part A and Part B claims)..... **877-908-8431**

Oregon Dental Association **503-218-2010**

Oregon Division of Financial Regulation **888-877-4894**

Oregon Health Insurance Marketplace **855-268-3767**

Oregon Health Plan **800-699-9075**

Oregon Medical Board..... **877-254-6263**

Oregon Medicare Savings Connect **855-447-0155**

Oregon State Bar Lawyer Referral Service..... **800-452-7636**

PERS Health Insurance Program (PHIP) **800-768-7377**

Railroad Retirement Board..... **877-772-5772**

Social Security (available 8 a.m.–7 p.m. M-F)..... **800-772-1213**

U.S. Department of Labor..... **866-487-2365**

Acronyms

ABN ..... Advance Beneficiary Notice

ACA ..... Affordable Care Act

ACL ..... Administration for Community Living

AEP ..... Annual enrollment period

ADRC..... Aging and Disability Resource Connection

ALJ..... Administrative law judge

ALS ..... Amyotrophic lateral sclerosis

ANOC..... Annual Notice of Change

APD ..... Aging and People with Disabilities

CMS ..... Centers for Medicare and Medicaid Services

COBRA ..... Consolidated Omnibus Budget Reconciliation Act

DFR ..... Department of Financial Regulation

DME ..... Durable medical equipment

DMEPOS..... Durable medical equipment, prosthetics, orthotics and supplies

DOB..... Date of birth

EFT..... Electronic funds transfer

EGHP ..... Employer group health plan

EOC ..... Evidence of coverage

ESRD ..... End-stage renal disease

FEHB ..... Federal Employees Health Benefits

FPL..... Federal poverty level

GEP ..... General enrollment period

GI ..... Guaranteed issue

HPV ..... Human papillomavirus

HIV ..... Human immunodeficiency virus

HMO ..... Health maintenance organization

HMO-POS ..... HMO with point-of-service

HSA..... Health savings account

IEP..... Initial enrollment period

IRE..... Independent review entity

LEP..... Late enrollment penalty

LIS..... Low Income Subsidy

LTC..... Long-term care

MA ..... Medicare Advantage

MA-OEP..... Medicare Advantage open enrollment period

MAC ..... Medicare Administrative Contractor

MAPD ..... Medicare Advantage with Prescription Drug

MOOP ..... Maximum out-of-pocket

MSA ..... Medicare Medical Savings Account

MSN ..... Medicare Summary Notice

MSP ..... Medicare Savings Program

ODHS..... Oregon Department of Human Services

OEP ..... Open enrollment period

OHP ..... Oregon Health Plan

OM ..... Original Medicare

OMHA..... Office of Medicare Hearings and Appeals

OPDP..... Oregon Prescription Drug Program

OT ..... Occupational therapy

PAC ..... Preauthorized check

PACE ..... Program of All-Inclusive Care for the Elderly

PDP ..... Prescription drug plan

PFFS..... Private fee-for-service

PPO ..... Preferred provider organization

PT..... Physical therapy

QIC ..... Qualified independent contractor

QIO ..... Quality improvement organization

QMB ..... Qualified Medicare Beneficiary

RRB ..... Railroad Retirement Board

RX ..... Prescription

SEP ..... Special enrollment period

SHIBA..... Senior Health Insurance Benefit Assistance

SHIP ..... State Health Insurance Program

SLMB ..... (SMB/SMF) Specified Low-income Medicare Beneficiary

SMP ..... Senior Medicare Patrol

SNF ..... Skilled nursing facility

SNP ..... Special needs plan

SSA ..... Social Security Administration

SSDI ..... Social Security Disability Insurance

SSI ..... Supplemental Security Income

TrOOP..... True out-of-pocket

TTY ..... Teletypewriter

VA..... Veterans' Affairs

VSO ..... Veterans Service Officer

Glossary

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

AEP (annual enrollment period):
A period of time from Oct. 15 to Dec. 7 in which Medicare beneficiaries may join or disenroll from Part D prescription drug coverage or a Medicare Advantage plan. Changes usually become effective Jan. 1. Also known as "fall open enrollment."

Alternative care:
A variety of therapeutic or preventive health care practices — such as homeopathy, naturopathy, chiropractic and herbal medicine — that may not follow generally accepted medical methods and may not have a scientific explanation for their effectiveness.

Annual physical exam:
Not a Medicare-covered expense. A yearly examination by your physician to check your overall health status. The exam may include tests to monitor vitals such as weight, blood pressure and cholesterol.

Areas:
Also called "area factors." This is how a Medigap insurance company determines the premium rates throughout the state. Some divide the state into multiple areas (by ZIP code) with each area having a specific premium rate.

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

Attained age:
Insurance policies in which premiums increase based on the age of the insured.

Basic drug plan:
A Medicare Part D plan that may have a reduced or $0 deductible, can use tiered copayments or co-insurance and may have a modification to the initial coverage limit. It remains actuarially equivalent to the standard benefit.

Beneficiary:
A person who is receiving payments for medical services through an insurance company.

Benefit period:
The period for which benefits are payable. In Original Medicare Part A, for example, the benefit period begins on the first day of hospitalization and ends when the beneficiary has been out of the hospital or associated skilled nursing facility for 60 consecutive days.

Benefits:
Covered items under an insurance plan, also referred to as coverage.

Birthday rule:
In Oregon, if you are an existing Medigap policyholder, you have a 30-day shopping period with GI beginning on your birthday if you want to compare different companies' prices for the same (or lesser) Medigap benefits. The birthday rule does not apply to employer-sponsored retiree Medigap policies.

Catastrophic coverage:
The highest amount of money paid out of pocket before a health plan pays the majority of or all copayment amounts.

CHAMP VA:
Civilian Health and Medical Program of the Department of Veterans Affairs.

Chronic:
Long-lasting and recurrent condition or characterized by long suffering. A chronically ill person is not expected to recover or get much better.

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.

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

COBRA (Consolidated Omnibus Budget Reconciliation Act):
A law that mandates an insurance program provide employees the ability to continue health insurance coverage after employment ends.

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

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

Copayment or copay:
A fixed dollar amount paid per service received or prescription filled.

Coverage gap:
The stage in Medicare prescription drug coverage when a higher portion of drug costs are paid by the beneficiary. Also known as the "donut hole."

Creditable coverage:
Prescription drug insurance that is determined to be as good as or better than coverage through a Medicare plan.

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.

Direct bill:
Method of paying your insurance plan premium directly to the plan. The insurer sends either a bill or coupon book to collect payment.

Disenrollment:
Cancellation of an individual's enrollment in a health plan.

Donut hole:
See "Coverage gap."

DME (durable medical equipment):
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.

DMEPOS (durable medical equipment prosthetics orthotics and supplies):
See "DME."

Effective date:
The date upon which an insurance policy is in effect and coverage begins.

EFT (electronic funds transfer):
The transfer of funds from one account to another by computer. Also known as "AFT" (automatic funds transfer).

EGHP (employer group health plan):
Health insurance or benefit plan offered through an employer.

Election period:
The period during which an eligible person may join or leave Original Medicare, a Medicare Advantage plan or a prescription drug plan.

Equitable relief:
Federal employees must give adequate and accurate information. If the inadequate or inaccurate information received caused harm (benefits delayed or penalty incurred), and the client has documented the contact, the agency must correct the problem under the equitable relief provision.

Enhanced drug plan:
A Medicare Part D plan with a value exceeding that of the defined standard coverage. The plan design includes the basic prescription drug coverage and has supplemental benefits that may include any or all of the following: a reduction in cost sharing in the "coverage gap," a reduction in or elimination of the initial deductible, a reduction in the co-insurance or copayments applicable during the initial coverage phase, an increase in the initial coverage limit, and supplemental drugs.

Enrollee:
A person eligible for and receiving benefits from an insurance plan or managed care organization. Also called "member" when referring to Medicare Advantage plans.

EOC (evidence of coverage):
The insurance plan document that gives details about what the plan covers, how much you pay and more. Also known as a "Certificate of Benefits."

ESRD (end-stage renal disease):
A medical condition in which a person's kidneys no longer function, requiring dialysis or a kidney transplant to maintain life.

Excess charge:
The difference between the Medicare-approved amount and the limiting charge, which cannot exceed 15 percent more than the Medicare-approved amount. Also known as a "limiting charge."

Extra Help:
A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and co-insurance. Also known as "LIS."

Fall open enrollment period:
Another name for annual enrollment period (Oct. 15 to Dec. 7). See "AEP."

Fee for service:
Original Medicare is a fee-for-service system of payment for health care providers. An amount is billed for each medical service provided (office visits, tests or procedures) as the provider deems is medically necessary for the beneficiary.

Formulary:
A list of prescription drugs covered by an insurance plan.

GEP (general enrollment period):
The period from Jan. 1 through March 31 of each year during which people can enroll in Medicare Part A or Part B, if they did not do so when they were first eligible. They can also re-enroll if they suspended their Part A or Part B benefits. Coverage takes effect July 1.

GI (guaranteed issue):
Rights you have in situations when the law requires insurance companies to sell you a Medigap policy. In these situations, an insurance company cannot deny you a policy for pre-existing conditions, and cannot charge you more for a policy because of past or present health conditions.

HMO (health maintenance organization):
A Medicare Advantage plan in which a member must receive care provided through the plan's network of providers. The member may have to get referrals for specialists through a primary care physician.

IEP (initial enrollment period):
A seven-month period that surrounds a Medicare beneficiary's 65th birthday (qualifying month); three months before, the month of and three months after.

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

Institutional care:
Care provided in a hospital, skilled or intermediate nursing home, or other state facility certified or licensed by the state primarily affording diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services.

Issue age:
Insurance policies with premiums 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:
The 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 charge."

LIS (Low or Limited Income Subsidy):
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. See "Extra Help."

Look-back:
See "Waiting period."

LTC (long-term care):
A general term including 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.

MA (Medicare Advantage):
Medicare Advantage plans offer your Medicare benefits through private companies that manage your care. Medicare pays the companies a set amount per person, plus you pay a share of the costs through copays, co-insurance, deductibles and premiums. Also known as "managed care," "Part C" or "Medicare+Choice."

MA-OEP (Medicare Advantage open enrollment period):
From Jan. 1 through March 31 annually. It allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or Original Medicare.

MAPD (Medicare Advantage with Prescription Drug coverage):
Medicare Advantage plan that includes a Part D plan.

Medicaid:
A federal-state partnership designed to ensure that America's aged, sick and impoverished receive care. This program is a safety net that provides aid in the form of medical services to low-income people who fall below the state-established poverty line. There are strict income and asset guidelines used to qualify people for Medicaid. Administered in Oregon by ODHS. Also known as "Medicare Savings Program," "MA (Medical Assistance)" or "Title 19 (XIX)."

Medically necessary:
Services or supplies needed for the diagnosis or treatment of a medical condition and that meet accepted standards of medical practice. Also known as "reasonable and necessary."

Medigap:
An insurance policy sold by private companies that can help pay some of the health care costs after Original Medicare pays its portion, such as copayments, co-insurance and deductibles. Benefit packages are standardized and plans are named by alphabet letters A–N. Plans with a given letter (for example, F) offer identical coverage, although companies' premiums may differ.

Medigap Open Enrollment Period (OEP):
The six-month period that begins the month you first enroll in Part B during which a Medigap company must sell you a policy regardless of health status.

MOOP (maximum out of pocket):
The maximum amount of money for medical cost share of deductible, copay and co-insurance the MA plan member would have to pay in a calendar year.

MSA (Medicare medical savings account):
Similar to an HSA (health savings account), it combines a high-deductible plan with a savings account to be used for medical costs.

MSP (Medicare Savings Program):
A federal-state partnership program that provides financial assistance to Medicare beneficiaries with the out-of-pocket costs associated with Medicare.

ODHS (Oregon Department of Human Services):
The state agency that houses the Aging and People with Disabilities Office and other assistance programs.

Original Medicare (OM):
Part A and Part B of Medicare.

PAC (preauthorized check):
Checks that are authorized by a payer in advance.

PDP (prescription drug plan):
Prescription drug coverage that adds to Original Medicare. It can be a stand-alone plan or a part of a Medicare Advantage plan. Also known as "Part D."

POS (point of service):
An option available with some HMO plans that allows the beneficiary to use doctors and hospitals outside the plan for an additional cost.

PPO (preferred provider organization):
A type of Medicare Advantage plan in which the beneficiaries pay less if they use doctors, hospitals and providers that belong to the network. If they use doctors, hospitals and providers outside of the network, there could be a higher cost to the beneficiary.

Pre-existing condition:
A medical condition diagnosed, treated or needing treatment before the purchase of an insurance policy.

Preferred drug list:
See "Formulary."

Preferred pharmacy:
A pharmacy that has negotiated with a specific insurance plan to provide lower cost-sharing on covered prescription drugs. Certain out-of-pocket costs may be lower for covered drugs.

Premium:
The monthly charge for insurance plans.

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

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

Prior authorization:
Prior approval is required from the insurance plan before the prescription can be filled. If a drug has a prior authorization, you need to work with the plan and the prescribing doctor to obtain approval before the pharmacy can dispense that medication under your plan's coverage benefit. Go to the plan's website to identify the specific requirements and forms needed.

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

QIC (Qualified Independent Contractor):
An independent entity with which Medicare contracts to handle the reconsideration level of an Original Medicare (Part A or Part B) appeal.

QMB (Qualified Medicare Beneficiary):
A federal-state partnership Medicare Savings Program (MSP) that provides financial help with paying the Medicare Part B premium as well as Medicare Part A and Part B deductibles and co-insurances. Eligibility is determined by local Aging and People with Disabilities offices based on income and assets.

Quantity limits:
For safety and cost reasons, plans may limit the quantity of covered drugs over a certain period. If the drug has a quantity limit restriction, contact the plan for more details. If you take one pill per day and the drug has a 30-day/ month quantity limit, the impact will be minimal (i.e., you may not be able to refill the prescription until a few days before running out of pills). If you currently take two pills per day and the quantity limit is 30 pills per month, you need to work with the plan to get authorization for the higher quantity.

Referral:
A written order from your primary care doctor to see a specialist or get certain medical services. In many HMOs, the beneficiary needs to get a referral before he or she can get medical care from anyone except the primary care physician. If a referral is not obtained before the visit, the claim may not be paid for the services.

Reserve days:
See "Lifetime reserve days."

Restrictions:
Limitations placed on access to drugs on Medicare Part D plans. The three restrictions are prior authorization, step therapy and quantity limits.

Rx:
An abbreviation for prescription.

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

SEP (special enrollment period):
A period of time that provides an opportunity to join or leave a plan outside regular enrollment periods.

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

SHIBA (Senior Health Insurance Benefits Assistance):
Oregon's program that uses its statewide network of certified counselors who educate, assist and advocate for Medicare beneficiaries about their rights and options regarding health insurance so they can make informed choices.

SHIP (State Health Insurance Assistance Program):
A nationwide state-based program that offers local one-on-one counseling and assistance to people with Medicare and their families. Through ACL (Association for Community Living)-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 Oregon's SHIP.

Skilled care:
Care for an illness or injury that requires the training and skills of a licensed professional by physician prescription, and is medically necessary for the condition or illness of the patient.

SMB/SMF (Specified Low-Income Beneficiary):
A federal-state partnership Medicare Savings Program (MSP) that provides financial assistance with paying the Medicare Part B premium. Eligibility is determined by local Aging and People with Disabilities offices based on income and assets.

SMP (Senior Medicare Patrol):
A national volunteer network dedicated to informing seniors about health care fraud, error and abuse, and resolving complaints.

SNF (skilled nursing facility):
A facility at which medically necessary (prescribed) care is provided by licensed health care professionals.

SNP (special needs plan):
Private insurance plans that provide Medicare benefits, including drug coverage, to people eligible for Medicare and Medicaid, those living in certain long-term care facilities, and those with severe chronic or disabling conditions who may qualify to join.

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

SSI (Supplemental Security Income):
Monthly amount paid by Social Security to people with limited income and resources who have disabilities, are blind or are age 65 or older with little or no income to meet basic needs for food, clothing and shelter.

SSA (Social Security Administration):
A government agency responsible for the Social Security system.

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

Stand-alone drug plan:
See "PDP."

Supplement insurance:
Private health insurance designed to pay secondary after Medicare. Also known as "Medigap."

Suppressed:
Medicare Advantage and stand-alone prescription drug plans that do not appear on the Medicare Plan Finder until Medicare issues or reviews corrections.

Step therapy:
In some cases, plans require you to first try one drug to treat your medical condition before they will cover a more expensive drug for that condition. For example, if Drug A and Drug B both treat your medical condition, a plan may require your doctor to prescribe Drug A first. If Drug A does not work for you, then the plan will cover Drug B. If a drug has step therapy restrictions, you need to work with the plan and your doctor to obtain an exception.

Tier:
Pricing levels associated with prescription drug plans. Each drug is assigned a tier level depending on the type and cost of the drug. The lowest copayment is for generics, followed by formulary brands.

Total drug costs:
The total retail value for prescription medicines. It includes what the beneficiary pays and also what the drug plan pays.

Trial right:
You dropped a Medigap policy to join a Medicare Advantage plan (or to switch to a Medicare Select policy) for the first time. You have been in the plan less than a year, and you want to switch back.

TrOOP (true out-of-pocket) costs:
The total amount a beneficiary pays out-of-pocket plus 50 percent of brand-name drugs in a Part D plan.

TRICARE:
A health insurance program offered by the U.S. Department of Defense to active duty military personnel.

TRICARE For Life:
A health insurance program offered by the U.S. Department of Defense to retired military personnel.

TTY (teletypewriter):
Telecommunications relay service that provides voice telephone access to people who use TTYs. Specially trained relay agents complete calls and stay online to relay messages by TTY and verbally to hearing parties. This service is available 24 hours a day with no restrictions to the length or number of calls placed. Also known as "TDD" (telecommunications for the deaf).

Underwriting:
The 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 are paid or before pre-existing conditions or specific illnesses are covered by a health insurance policy.

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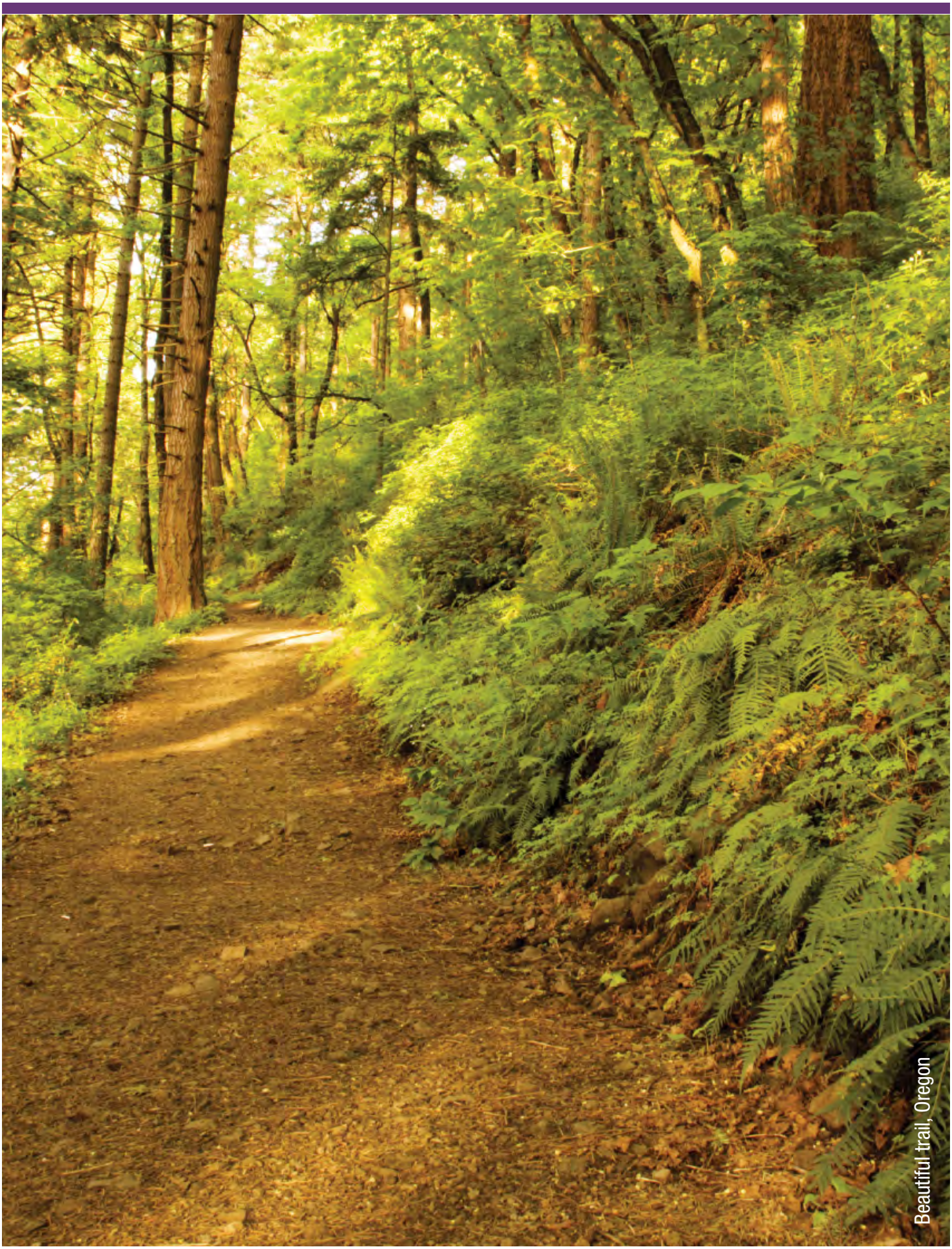

Beautiful trail, Oregon

SHIBA
Senior Health Insurance Benefits Assistance

500 Summer St. NE, E-12
Salem, Oregon 97301
shiba.oregon.gov

ADRC
Aging and Disability Resource Connection of OREGON

The first contact to make for information and resources related to aging or living with a disability

How can the ADRC help?

The Aging and Disability Resource Connection of Oregon provides information and referral services to older adults, people with disabilities, their families and care providers, regardless of income. With a statewide researchable database, Oregonians are able to learn about more than 6,000 resources through www.ADRCofOregon.org or the toll-free number: 1-855-ORE-ADRC (**1-855-673-2372**).

Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES
Senior Health Insurance Benefits Assistance

You can get this document in other languages, large print, braille or a format you prefer. Contact the Senior Health Insurance Benefits Assistance (SHIBA) program at **800-722-4134** or shiba.oregon@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

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