PERS Health Insurance Program (PHIP) Medicare Enrollment Guide

A comprehensive guide to PHIP and Medicare

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

The PERS Health Insurance Program (PHIP) offers health insurance coverage for all retirees, their spouses and dependents who meet the eligibility requirements.

Mission Statement

The PERS Health Insurance Program (PHIP) provides PERS retirees with high-quality, comprehensive coverage (or benefits) at the most cost-effective rates possible to meet retiree benefit needs.

Our core values are:

- Maintain stability of premiums
- Maintain stability of coverage
- Maintain stability of Contracted Health Plans

Medicare Enrollment Guide

The PERS Health Insurance Program (PHIP) Medicare Enrollment Guide is designed to help you understand how your PHIP benefits work with Medicare. To participate in a PHIP Medicare plan, you must live in the United States and maintain a permanent residence (not mailing address) within a health plan's service area, and be enrolled in both Medicare Part A and Part B.

Your PHIP Medicare health plan options include a Medicare Supplement plan and Medicare Advantage plans. All PHIP Medicare health plans include a Medicare Part D Prescription Drug Plan (PDP). You can find program-specific information through the following additional PHIP member materials:

- PERS Health Insurance Program (PHIP) Member Guide
- PHIP Benefit Guide (includes premium rates)

For more information about your PHIP health benefits, please visit pershealth.com or call customer service at 800-768-7377. To view the complete PHIP eligibility and enrollment Oregon Administrative Rules (OAR) visit sos.oregon.gov/archives.

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Understanding Medicare

Medicare is the federal health insurance program for individuals who:

- Are 65 years of age or older
- Are under age 65 but have been receiving Social Security Disability Insurance for more than 24 months
- Have End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)

The Social Security Administration (SSA) is the federal agency responsible for Medicare eligibility determination, enrollment and premiums. The Centers for Medicare and Medicaid Services (CMS) regulates the Medicare program. Every year, CMS publishes the Medicare and You handbook. This handbook provides information about Medicare.

The following section provides basic information about the federal Medicare program. For more information, you can visit medicare.gov.

Here are specific timelines for enrolling in Medicare. For general information on enrollment and eligibility, you can contact the Social Security Administration (SSA). See Additional Medicare Resources on page 14.

Medicare Part A (Hospital)

Medicare Part A is hospital insurance that helps pay for inpatient hospital care, limited home health services, skilled nursing care and hospice expenses.

In general, you are eligible for Medicare Part A if you:

- Are age 65 or older and have worked for at least 40 quarters (10 years) in Social Security/Medicare-covered employment
- Are disabled and are receiving Social Security disability benefits
- Have End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)

In most cases, you pay no premium to have this coverage. If you delay enrollment into Medicare Part A after you first become eligible, you may have to pay a federal late enrollment penalty.

Medicare Part B (Medical)

Medicare Part B is medical insurance that helps pay for outpatient expenses, including doctor visits, lab work and diagnostic services.

Generally, if you are eligible for Medicare Part A, you are eligible for Medicare Part B.

If you do not enroll in Medicare Part B when you are first eligible, you may have to pay the federal late enrollment penalty. If so, your premium may be 10 percent higher for each 12-month period that you were eligible, but did not enroll in Medicare Part B. This also may lead you to be ineligible for PHIP.

You must pay a premium each month to maintain your enrollment in Medicare Part B. Every year, the SSA determines the base monthly Medicare Part B premium amount. If your income is above certain thresholds, you may need to pay a higher premium amount.

Premiums for Medicare Part A (if applicable) and Medicare Part B are automatically deducted from your Social Security benefits. If you do not yet receive a Social Security benefit, you will be billed quarterly by Social Security.

You must pay for and maintain enrollment in Medicare Part A and Part B to remain enrolled in a PHIP Medicare health plan.

Medicare Part C (Medicare Advantage)

Medicare Part C, also known as Medicare Advantage (MA) is CMS-approved health coverage in which private health insurance companies contract with Medicare to coordinate care. Medicare Advantage plans include Medicare Part A and Part B. When you join a MA plan, you agree to that plan's terms and conditions. You will still pay the Medicare Part B premium, in addition to the health plan premium.

PHIP MA plans include a Medicare Part D Prescription Drug Plan (PDP).

Medicare Part D (Prescription Drug Plan)

Medicare Part D Prescription Drug Plan (PDP) covers Medicare-approved prescription medications. If you are enrolled in Medicare Part A and Part B, you are usually eligible to enroll in a Medicare Part D plan.

Medicare Part D is offered by health insurance companies and other private companies that are approved by Medicare.

Premiums for Medicare Part D plans are in addition to your Medicare Part A and Part B premiums. If you or your dependent are Medicare-eligible when you enroll in a PHIP health plan, you may need to show proof from your prior employer or health plan that the prior plan's prescription drug coverage was creditable (equal to or more than the basic Medicare Part D prescription drug benefit). If the coverage was not creditable, Medicare could impose a penalty of 1 percent per month for each month you did not have creditable coverage.

Part D Late Enrollment Penalty

The late enrollment penalty (LEP) is an amount added to your Medicare Part D premium. You may owe a late enrollment penalty if, at any time after your initial enrollment period (IEP) is over, there's a period of 63 or more days in a row when you do not have Medicare Part D or other creditable prescription drug coverage.

If you are required to pay the LEP, Medicare will notify PHIP of that amount. It will be added to your monthly premium.

You will need to pay this penalty to protect your eligibility to stay enrolled in a PHIP Medicare health plan.

Part D-IRMAA

Part D Income Related Monthly Adjustment Amount (Part D-IRMAA) is an assessment required by Medicare for individuals whose income is above the Medicare-defined income threshold and who are enrolled in a Medicare Part D Prescription Drug Plan. If you are receiving a Social Security benefit, the assessment will be deducted from your monthly benefit. If not, you will be billed quarterly.

To be eligible for PHIP coverage, you must pay your Part D-IRMAA assessment. If you do not pay it, Medicare will notify your plan of non-payment and your PHIP coverage will end.

If you have questions about Part D-IRMAA, please contact either Medicare or the Social Security Administration.

Your PHIP coverage will end if you enroll in a second Medicare Part D prescription plan or Medicare Advantage plan. After that, you cannot re-enroll in PHIP, unless you experience a new enrollment opportunity.

Medicare Enrollment

You will become eligible for Medicare at age 65, regardless of whether you are receiving a Social Security benefit at the time. You are entitled to Medicare the first day of the calendar month in which you turn 65.

If your birthday falls on the first day of the month, you are entitled to Medicare the first day of the prior month.

Medicare eligibility could occur earlier than age 65 if you are awarded Social Security Disability Insurance. Medicare eligibility due to disability would become effective the first day of the 25th month after your Social Security disability benefits began.

You should receive your Medicare information, including your Medicare Part A and Part B card, approximately three months prior to your 65th birthday or when you become eligible for Medicare due to disability.

If you do not receive your Social Security benefit prior to age 65, you will need to contact the Social Security Administration (SSA) or visit your local Social Security office approximately three months prior to your 65th birthday and apply for Medicare Part A and/or Part B.

Medicare due to End-Stage Renal Disease

End-stage renal disease (ESRD) is the stage of kidney impairment that appears irreversible and permanent. It needs a regular course of dialysis or a kidney transplant. If you have ESRD, coverage is available through Original Medicare (Supplement Plan) or beginning January 1, 2021, a Medicare Advantage plan. Prior to January 2021, Medicare Advantage enrollment due to ESRD was only available in certain situations. Eligibility for Medicare coverage based on ESRD works differently than other types of Medicare eligibility. Please contact either Medicare or the Social Security Administration for more information.

Deferred Enrollment in Medicare Part B

You or your spouse can defer enrollment in Medicare Part B if either of the following apply:

- You are currently working for an employer that has 20 or more employees and have active employer-sponsored group coverage through your job.
- You have employer-sponsored group coverage through your spouse who is currently working for an employer that has 20 or more employees.

If your employer has fewer than 20 employees, you may not be able to defer your Medicare Part A and Part B.

Enrolling After Deferred Medicare Part B - Special Enrollment Period (SEP)

Once your employer-sponsored group coverage ends, you will have eight months to sign up for Medicare Part B without a penalty. If you do not sign up for Medicare Part B during that time, you may have to pay a penalty for as long as you are enrolled in Medicare Part B.

Additionally, if you do not sign up during this time, you will not be able to enroll in Medicare Part B until the General Enrollment Period which is from Jan. 1 — March 31. Your coverage will not begin until July 1 of that year. This may cause a gap in healthcare coverage and you may lose your enrollment opportunity with PHIP.

PHIP recommends you enroll in your Medicare Part B approximately 90 days before your employer-sponsored group coverage ends. Submit your PHIP Enrollment Request Form and copy of your Medicare Card showing enrollment in Medicare Part A and Part B prior to your group coverage ending: This avoids a gap in coverage. PHIP allows up to 30 days to enroll after loss of employer-sponsored group coverage ends. Any Enrollment Request Form received after 30 days of loss of employer-sponsored group coverage is considered outside of the PHIP enrollment opportunity and will be ineligible. See "Work After Retirement" on page 9 for more information on your PHIP enrollment opportunity.

When to Enroll in a PHIP Medicare Plan

Eligibility for PHIP Medicare Plans

OAR 459-035-0070

A completed PHIP Enrollment Request Form must be submitted when you are initially enrolling, adding a dependent or making a change to your PHIP coverage either at plan change or due to a family status change.

PERS retirees can enroll within 90 days of initial Medicare eligibility, if enrolled in both Medicare Part A and Part B, whether due to age or disability.

Your eligibility to enroll in Medicare Part A and Part B due to Social Security Disability is effective the first day of the 25th month after your Social Security Disability benefits began. In this instance, becoming Medicare-eligible due to disability is considered your initial Medicare eligibility. Becoming Medicare-eligible at age 65 will not be a new opportunity to enroll in a PHIP Medicare health plan, unless you have had 24 months of continuous employer-sponsored group coverage immediately before enrollment in PHIP.

If you or your dependents are enrolled in a PHIP non-Medicare plan and become Medicare eligible, you must enroll in a PHIP Medicare plan within 30 days of your initial Medicare enrollment date in order to continue in PHIP.

OPSRP disability benefit recipients are not eligible for PHIP until they are an eligible retiree under ORS 238.305, 238.315, 238.195, or 238A.400

Enrollment in a PHIP Medicare Plan

OAR 459-035-0080

In order to avoid a gap in coverage or forfeiting your enrollment opportunity, please submit all requested information and/or documentation with the completed Enrollment Request Form prior to your requested effective date.

If your Enrollment Request Form is missing information or additional documentation, your application will be considered incomplete.

If you are unable to provide the necessary information and/or documentation prior to your requested effective date, your effective date will change to the first of the next month, as long as you are still within the PHIP enrollment opportunity period.

You will receive enrollment information from PHIP approximately 90 days prior to the month you turn 65. This information provides you with the requirements needed to enroll in a PHIP Medicare health plan.

During peak enrollment times (e.g., plan change, peak retirement periods, end of month), delays may occur.

Please allow time for PHIP to process your application and notify your selected health plan. If you need immediate access to your health plan information, please contact PHIP customer service.

To enroll in a PHIP Medicare health plan you must:

- Meet a PHIP Medicare enrollment opportunity
- Be an eligible PERS Retiree, spouse or dependent
- Be enrolled in and maintain Medicare Part A and Part B

- Complete the PHIP Enrollment Request Form: Include spouse or dependent information only if they are enrolling in PHIP
- Submit a photocopy of either the Medicare card or Letter of Entitlement (Letters of Eligibility are not accepted) showing Medicare effective dates for Part A and Part B for each Medicare-eligible individual applying
- Provide your Medicare Beneficiary Identifier (MBI). This is found on your Medicare card

The retiree, spouse and dependent (if over 18) must sign if enrolling. Enrollment Request Forms will need to be signed and received prior to the requested effective date of coverage.

Additional documentation may be required. This may include a dependent's birth certificate, adoption paperwork, PERS disability approval letter, Affidavit of Domestic Partnership or marriage certificate (if last names are different).

Work After Retirement

If you chose to work following your PERS retirement, and have employer-sponsored group health coverage (your own or with your spouse) you may enroll in PHIP at any time as long as you have been covered under another employer-sponsored group health plan for 24 consecutive months immediately preceding enrollment in PHIP.

Employer-sponsored group coverage can be:

- Employer-sponsored group coverage you had as an active or retired employee that is terminating
- Employer-sponsored group coverage you had under an eligible spouse's active employment or as a retired employee that is terminating
- Employer-sponsored group coverage continued through COBRA following termination of employment:
  - COBRA coverage is secondary to Medicare, except when the Medicare beneficiary has ESRD
  - COBRA coverage is primary to Medicare during the 30-month ESRD coordination period

For the purposes of PHIP, healthcare coverage under worker's compensation, Medicare or any other government entitlement program (including foreign healthcare) does not qualify as employer-sponsored group health coverage.

To ensure you are selecting the correct PHIP effective date, verify your current health plan coverage end date with your employer. To avoid a gap in coverage, select the first of the month after your employer-sponsored group coverage ends as the PHIP effective date.

To enroll, submit your completed PHIP Enrollment Request Form **30 days prior to your employer-sponsored group coverage ending** to prevent a gap in coverage. PHIP allows up to 30 days to enroll after loss of employer-sponsored group coverage ends. However, if the Enrollment Request Form is received after your group coverage ends (or is incomplete), your PHIP effective date will be the first of the month after PHIP receives your completed Enrollment Request Form. Any Enrollment Request Form received after 30 days of loss of employer group coverage is considered outside of the PHIP enrollment opportunity and will be ineligible.

Medicare Health Plan Options

To qualify for a PHIP Medicare health plan, you must live in the United States and maintain a permanent residence (not mailing address) within a health plan's service area, and be enrolled in Medicare Part A and Part B.

PHIP Medicare Supplement Plan

The PHIP Medicare Supplement with a Medicare Part D Prescription Drug Plan (PDP) plan covers medical and prescription drugs. It is similar to a Medigap plan in that it fills the gaps in Original Medicare. Original Medicare will process the claim first and pay its share and the PHIP Medicare Supplement with Medicare Part D PDP plan will then pay its portion.

You can live anywhere in the United States, travel outside the U.S. for up to six months and still maintain coverage. You will have to pay the monthly Medicare Part B premium in addition to your PHIP Medicare Supplement premium. The PHIP Medicare Supplement plan allows you to choose any physician who is a Medicare participating provider.

PHIP Medicare Advantage (MA) Plans

The PHIP Medicare Advantage (MA) plans cover medical and prescription drugs. MA plans contract with hospitals and physicians to provide care. When you enroll in any MA plan, that plan becomes the administrator of your Medicare Part A and Part B benefits. You will have to pay the monthly Medicare Part B premium in addition to your PHIP Medicare Advantage premium.

To be enrolled in a MA plan, you must reside in that health plan's service area. All available plans have some limitations and exclusions.

PHIP offers the following types of MA plans:

Health Maintenance Organization (HMO)

HMO plans offer healthcare services through a closed network of providers and hospitals at a fixed price (copay). Most HMO plans require you to select a primary care provider (PCP) who will work with you to manage your healthcare needs through an integrated care system. Under an HMO plan, you may need a referral to see a specialist and out-of-network services may not be covered.

HMO-Point-of-Service (POS)

POS plans work similar to an HMO plan with a more flexible network that allows care outside of the traditional HMO network. You may have a higher copay or coinsurance for using services outside of the traditional HMO network. A primary care provider (PCP) may be required and often a referral will be necessary to see a specialist.

Preferred Provider Organization (PPO)

PPO plans give you access to a network of healthcare providers known as preferred (in-network) providers. It also allows you the option of seeing non-preferred (out-of-network) providers at a higher coinsurance rate. Typically, a PPO plan will not require you to select a primary care provider (PCP) and you may get services without requiring a referral.

You can be enrolled in only one MA plan at a time. By enrolling in a PHIP Medicare Advantage plan, any prior MA coverage will be terminated.

Frequently Asked Questions

Q: My spouse will be Medicare-eligible before me and will no longer be able to stay on my retiree plan. Can my spouse enroll in PHIP while I stay on my retiree plan?

A: Yes. Your spouse may enroll in PHIP during their initial Medicare eligibility while you stay on your group-sponsored retiree plan.

Q: What happens if I cancel my Medicare Part B benefits? How does this affect my PHIP Medicare plan?

A: You must have Medicare Part B in order to continue your enrollment in a PHIP Medicare plan. If you stop paying your Medicare Part B premiums or cancel your Medicare Part B coverage, you will lose all your PHIP medical, pharmacy and dental coverage. After that, you may not re-enroll in PHIP unless you experience a new enrollment opportunity.

Q: I am Medicare-eligible, but my spouse is still working and I am covered under my spouse's active employer-sponsored group health plan. When should I enroll in Medicare Part B?

A: You may enroll in Medicare Part B when eligible due to age or Social Security Disability while your spouse is employed and you are covered under their active employer-sponsored group health plan, or you may defer your Medicare Part B enrollment until your spouse retires and loses employer-sponsored group coverage. When loss of active employer-sponsored group coverage ends, your Medicare Part B enrollment should be the first of the month after your active employer-sponsored group coverage ends.

Example: *Active employer-sponsored group coverage ends March 31; your Medicare Part B enrollment should be effective April 1.*

This will also be your PHIP Medicare effective date. You may submit your completed PHIP Enrollment Request Form up to 30 days prior to your active employer-sponsored group coverage ending to prevent a gap in coverage. You will need to provide proof of Medicare enrollment (copy of your Medicare Part A and Part B card or Letter of Entitlement) and 24 months of continuous employer-sponsored group coverage immediately before your PHIP requested enrollment effective date. Any Enrollment Request Form received after 30 days of loss of employer-sponsored group coverage is considered outside of the enrollment opportunity and will be ineligible.

Q: I am under 65 and currently enrolled in a PHIP non-Medicare plan. I have been approved for Medicare due to Social Security Disability. Do I need to enroll in a PHIP Medicare plan?

A: Your eligibility to enroll in Medicare Part A and Part B, due to Social Security Disability, becomes effective the first day of the 25th month after your Social Security Disability benefits began. In this situation, becoming Medicare-eligible due to disability is considered your initial Medicare eligibility.

If you are currently enrolled in a PHIP non-Medicare plan, you must complete a new Enrollment Request Form 30 days prior to your Medicare eligibility date in order to make your PHIP Medicare health plan selection. Failure to submit a new Enrollment Request Form for Medicare coverage will result in cancellation of your non-Medicare health plan coverage under PHIP, upon Medicare eligibility. You will not have any future opportunities to enroll.

The 90-day initial Medicare eligibility enrollment opportunity will apply in this situation. If you miss this opportunity, becoming Medicare-eligible at age 65 will not be a new opportunity to enroll in a PHIP health plan unless you have had 24 months of continuous employer-sponsored coverage immediately preceding enrollment in PHIP.

Resources

Getting Assistance With Your PHIP Plan

If you are a PERS member and are considering retirement or are already retired and will be turning 65 years of age within the next 12 months, or if you have eligibility and enrollment questions, please contact PHIP:

Online

pershealth.com

By Phone

In Portland: 503-224-7377

Toll-free: 800-768-7377

Monday through Friday, 7:30 a.m. to 5:30 p.m.

TTY: 711

By Mail

PERS Health Insurance Program

P.O. Box 231299

Tigard, OR 97281-1299

By Fax

In Portland: 503-765-3452

Toll-free: 888-393-2943

In Person

Call PHIP and schedule an appointment.

Contacting Your Health Plan

Contact information for your health plan can be found in the PHIP Member Program Guide. You can also visit the PHIP website at pershealth.com.

For questions on plan benefits, limitations and exclusions, or deductibles, please refer to the health plan's Evidence of Coverage (EOC). You can get a copy of the health plan's EOC by contacting the health plan directly or from the health plan's microsite under pershealth.com/benefits/health-plans/.

For Medicare Supplement members, refer to your Medicare & You handbook for plan benefits, limitations and exclusions.

Additional Medicare Information

Centers for Medicare and Medicaid Services (CMS)

Toll-free: 800-633-4227

TTY: 877-486-2048

medicare.gov

Social Security Administration (SSA)

Toll-free: 800-772-1213

TTY: 800-325-0778

ssa.gov

Appeals

PHIP Enrollment or Eligibility Appeals:

Pursuant to Oregon Administrative Rule (OAR) 459-001-0030, if you receive a letter denying PHIP eligibility (program or subsidy) or enrollment and you disagree with that determination, you may request a review by writing to the PERS Director within 60 days after, the date of the letter.

Oregon Revised Statutes are available from the Office of Legislative Counsel, or can be located on the Internet at oregonlegislature.gov/. Oregon Administrative Rules are available from the Oregon State Archives sos.oregon.gov/archives.

Your request must include the following information:

(a) A description of the determination you want reviewed

(b) A short statement describing how and why you think the determination is wrong

(c) A statement of facts that you believe shows the determination is wrong

(d) A list of any statutes, rules, or court decisions that you believe support your position

(e) A statement of the action you seek

(f) A request for review

Mail Appeal to:

Public Employees Retirement System
Attn: Appeals
P.O. Box 23700
Tigard, OR 97281-3700

When the Director receives your request, they may ask a Division Administrator to act on it. Your request for review may be denied if it does not contain the required information listed above. You will be mailed a response letter within 45 days after we receive your request.

Health Plan Appeals:

Appeals, complaints or grievances related to your health plan benefits or claims should be directed to the health plan in which you are enrolled. Refer to your health plan's Evidence of Coverage (EOC) booklet for more information about your health plan's appeal and grievance process. You can get your EOC by contacting your health plan directly or from your health plan's microsite under pershealth.com.

Required Notices

Women's Health and Cancer Rights Act

Beginning in 1999, federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, coinsurance amounts and copayments that are consistent with those that apply to other benefits under the plan.

Power of Attorney/Authorization to Disclose Information

PHIP requires that a Power of Attorney (POA) or Authorization to Disclose Information be on file with the program office for anyone acting on a member's behalf. PHIP is unable to release information to anyone who is not authorized by the PHIP member. To disclose or change information after the death of a member, please provide one of the following: executor, letter of probate or trustee documentation, or Last Will and Testament.

COBRA Continuation of Coverage

In accordance with federal and state of Oregon guidelines, PHIP provides opportunities for the continuation of coverage through COBRA following specific qualifying events.

If you experience one of the qualifying events listed below, please contact PHIP for additional information. A qualifying event will occur if eligibility for coverage is lost because of:

- Cancellation of PERS retirement status.
- The divorce or legal separation of a retiree's covered spouse; PHIP must be notified within 60 days from the signed Dissolution of Marriage document.
- A spouse or dependent child no longer meeting eligibility requirements (e.g., a child reaches the maximum age limit, or a spouse loses coverage because the retiree does not enroll in PHIP upon the last enrollment opportunity).

Timely COBRA Premium Payments

Once COBRA has been secured, timely payment of premiums is essential. The initial premium must be paid within 45 days of the date COBRA is elected. Thereafter, premiums are due the first day of each month for that month's coverage.

If payment is not postmarked or received on or before the 45th day (for the initial premium) or the 30th day following the monthly due date, coverage will be terminated and cannot be reinstated.

Definition of Terms

Coinsurance

Coinsurance is the portion of cost that a member will pay for healthcare services. It's usually shown as a percentage.

Copay/copayment

A fixed amount that the member pays at the time of receiving a healthcare service. Generally the copayment is the only cost the member will have for a particular service.

Deductible

The amount of money each year that members pay out of their own pocket before their health plan begins to pay.

Employer-Sponsored Group Health Plan

A plan sponsored by an employer, or by an employer in partnership with a union, that provides medical and/or dental care to two or more employees.

Late Enrollment Penalty (LEP)

An amount added to your Medicare Part D monthly premium if you go without Part D or creditable prescription drug coverage for any continuous period of 63 days or more after your Initial Enrollment Period is over.

Low Income Subsidy (LIS)

Assistance from Medicare to pay the costs of Medicare prescription drug coverage if you meet certain income and resource limits.

Maximum Allowable Cost

The most a health plan will pay for a specific service.

Medicare-Approved Amount

The amount a doctor or supplier is paid by Medicare, your supplement plan and/or you for a service or supply. It may be less than the actual amount charged by the doctor or supplier.

Medicare Assignment

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

Medicare Participating Provider

A provider who accepts Medicare patients.

Medigap

Medicare Supplement insurance that conforms to one of the 10 Medicare-approved plans.

Non-Participating Provider

A provider that does not contract with a health plan.

Participating Provider

Providers that are contracted to provide services for specific fees. The fees may or may not be discounted, but the providers are bound to not charge the member for anything above the contracted fee even if they would generally charge someone with other coverage more. This is often referred to as "hold harmless" because the member is not required to pay for charges over the contracted fee.

Preferred Provider Organization (PPO)

Preferred Provider Organization (PPO) providers sign contracts with insurance companies. These providers agree to discount their charges. They cannot charge members more than the contracted fee.

Primary Care Provider (PCP)

A provider who is chosen or assigned to you to coordinate all of your medical care and who may refer you to secondary care, medical or surgical specialists if you need further treatment.

Service Area

The geographic area in which your health plan provides coverage. You must live in the health plan's service area to enroll in and remain enrolled in a plan.

Acronyms

ALS
Amyotrophic Lateral Sclerosis

CMS
Centers for Medicare and Medicaid Services

COBRA
Consolidated Omnibus Budget Reconciliation Act (federal act)

EOC
Evidence of Coverage

ESRD
End-Stage Renal Disease

HMO
Health Maintenance Organization

HMO-POS
An HMO with a Point-of-Service option

IEP
Initial Enrollment Period

IRMAA
Income Related Monthly Adjustment Amount

LEP
Late Enrollment Penalty

LIS
Low Income Subsidy

MA
Medicare Advantage

OAR
Oregon Administrative Rules

ORS
Oregon Revised Statute

PCP
Primary Care Provider

PERS
Public Employees Retirement System

PHIP
PERS Health Insurance Program

PPO
Preferred Provider Organization

SEP
Special Enrollment Period

SSA
Social Security Administration

PERS
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