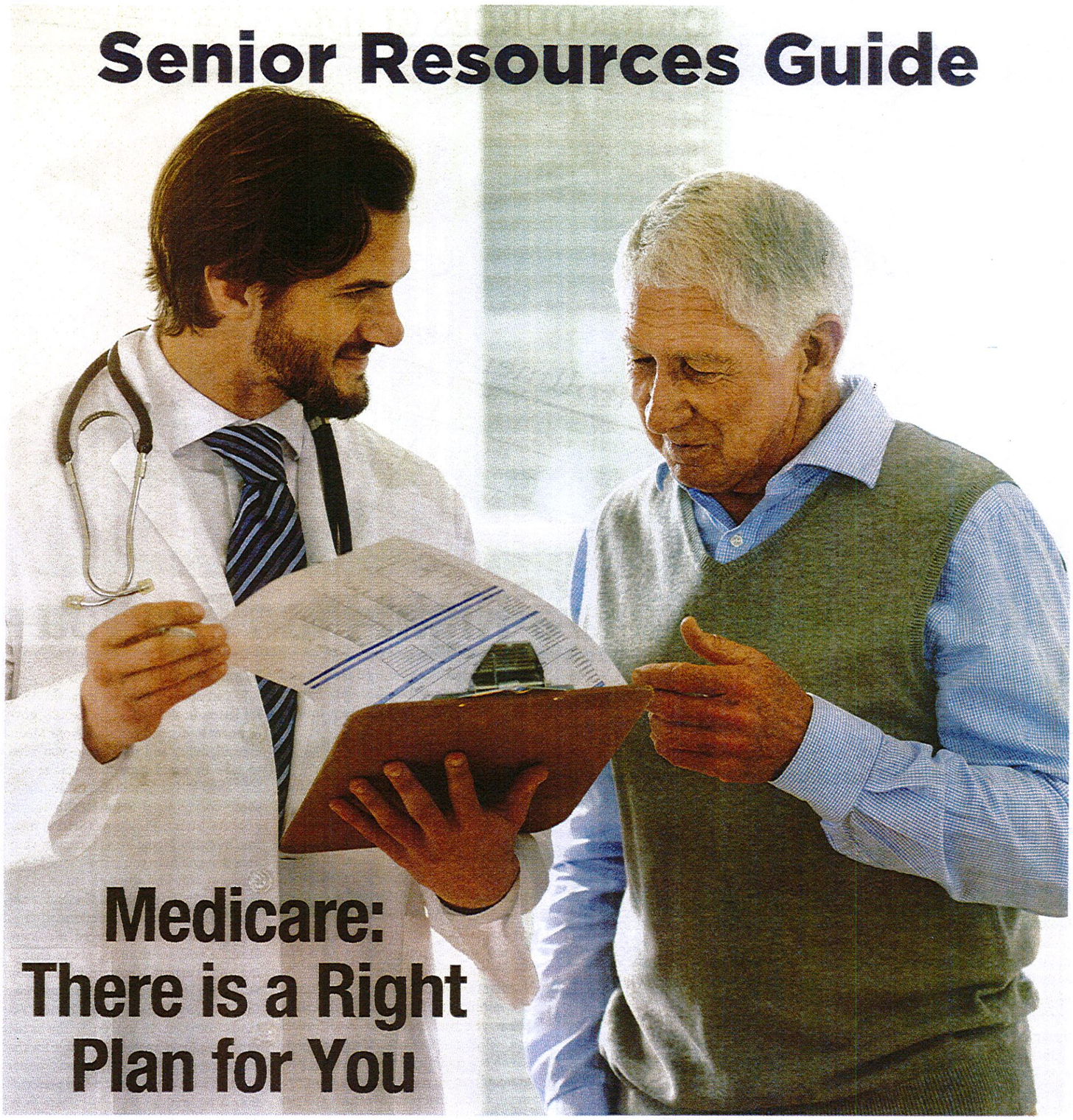
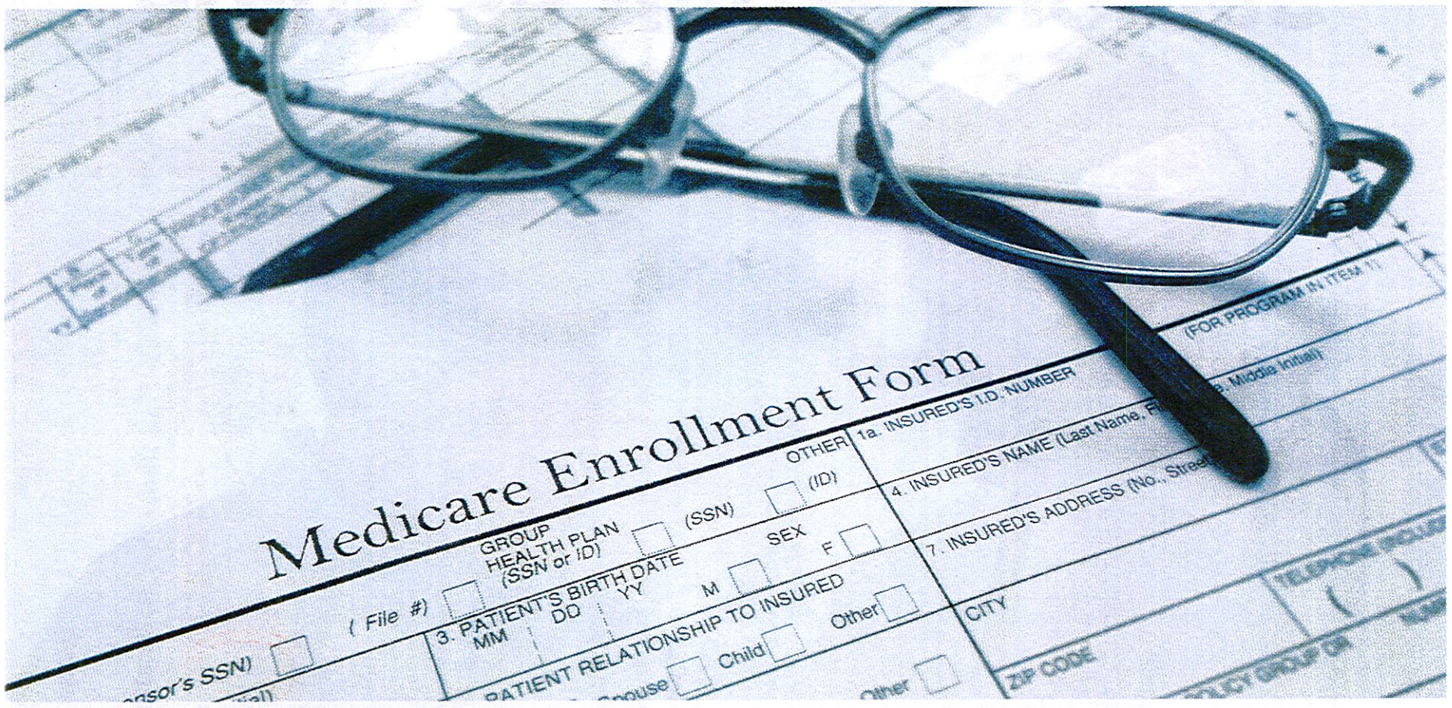
Senior Resources Guide



Medicare: There is a Right Plan for You

Jewish Council for the Aging
Helping All Seniors Thrive®

WashingtonJewishWeek
October 4, 2018



Medicare: There is a Right Plan For You

You've seen the advertisements, heard about the deadlines and probably wondered about such phrases as Medicare Part B and prescription drug plan. Now, believe it or not, your senior years have arrived and despite feelings of intimidation, it's time to learn about Medicare.

The alphabet soup of Medicare Plans A, B, C and optional plans D and supplemental Medigap plans, can be difficult to understand, but it is important to recognize that Medicare really is just health care insurance. For years, you've probably agonized over the annual ritual of picking an employer health care plan or finding one for yourself. Now, you can review what the federal government and additional health care providers offer, and then pick what's right for you.

This Jewish Council for the Aging Senior Resources Guide details what Medicare is, what your options are, when to begin exploring those options and where to turn for help. At the end of the guide is a glossary to help ease your way through this information.

Who can answer my questions?

For Medicare information, call 1-800-633-4227. TTY users should call 1-877-486-2048. For more detailed information, visit the Medicare.gov website. You can also read the annual "Medicare & You" handbook for updated information, which each fall the federal government mails to all Medicare-eligible households.

Where to turn for local help?

Each state has a State Health Insurance Assistance Program (SHIP), which offers free personalized counseling on Medicare coverage, claims and appeals as well as help for people with limited income and resources. Call 1-800-MEDICARE for the phone number of your local SHIP office or visit shiptacenter.org. Just click on your state, and information concerning your local SHIP office will pop up.

Some SHIPs operate through government agencies. The SHIP office in Montgomery County operates through JCA — the Jewish Council for the Aging of Greater Washington — in Rockville with support from the County's Health and Human Services Department. Expert volunteers and staff there help inform your Medicare decisions.

What is Medicare?

Medicare is the federal program that provides health care coverage and insurance for people 65 years old or older as well as those under 65 who receive Social Security Disability Insurance (for at least 24 months) or those under 65 with a diagnosis of End-Stage Renal Disease.

Medicare is funded by the federal budget and taxes Americans pay on their income as well as through premiums that people with Medicare pay.

After becoming Medicare-eligible and enrolling in the system as described below, you must choose coverage. Seniors can select the Original Medicare plan, which is a traditional fee-for-service program offered directly through the government. Under that plan, Medicare will pay a fee for each covered service.

Alternatively, those eligible for Medicare could choose Medicare Part C, a Medicare Advantage Plan, which is a kind of private insurance offered by private companies. Part C plans include prescription drug coverage as well as vision, dental and hearing benefits.

When should I enroll?

If you are turning 65 years old, look for letters in the mail from the U.S. government informing you about your Medicare eligibility and the actions you need to take to avoid gaps in coverage and late enrollment penalties. In addition, some county-level State Health Insurance Assistance Programs (SHIPs) offer free monthly Medicare seminars in your area that will help you learn about Medicare and how and when to enroll in the various Medicare plans. Contact your local SHIP office for more information.

If you are an experienced Medicare enrollee and are thinking about changing your current Medicare Prescription Drug Plan D or Medicare Advantage Plan, the 2018 Open Enrollment Period extends from Oct. 15 to Dec. 7. This is the time to make changes in coverage for the year beginning Jan. 1, 2019. Your county SHIP office probably offers free prescription drug analysis to help inform your 2019 Part D coverage decisions.

There is a seven-month window for enrolling in Medicare. You can apply about three months before your 65th birthday, the month of your 65th birthday or three months after your birthday through the

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Social Security Administration, either online at ssa.gov or by phone at 1-800-772-1213. If you do not apply during that seven-month timeframe, you may end up paying a penalty and delaying your enrollment date.

If you or your spouse worked a minimum of 10 years and paid taxes, then you are eligible for premium-free Medicare Part A coverage. Even if you are still working and have health care coverage from your employer, you should sign up and receive some of the benefits of Original Medicare. Medicare Part A helps pay for hospital inpatient care, skilled nursing facility care (though not custodial or long-term care), home health care and hospice care.

If, you are working and already covered by a group health plan with 20 or more participants or you are covered under your spouse's health insurance with 20 or more participants, you should still enroll in Medicare Part A. You do not need make all the decisions about prescription and medical insurance, and you do not need to enroll in Medicare Part B or Part D.

The federal government will enroll you automatically in Medicare Part A if you receive Social Security benefits or Railroad Retirement Board benefits before you turn 65 or if you have a disability or such diseases at Amyotrophic Lateral Sclerosis or End-Stage Renal Disease.

There are two pathways to obtaining Medicare coverage: through Original Medicare Plans and through Medicare Advantage Plans.

Original Medicare

Original Medicare includes Part A (hospital insurance), and Part B (medical insurance). If you are enrolled in Original Medicare, the government contracts with Medicare Administrative Contractors to pay for the provision of health care services. You will get a red, white and blue Medicare card to show doctors or other health care providers when they ask for proof of insurance.

Having Original Medicare means that there are set limits on how much you must pay when visiting participating and non-participating doctors and providers. When choosing hospitals and doctors, make sure they are Medicare participants. If the provider only takes Medicare payments but is not a Medicare participant, you may be required to pay an additional co-payment of 15 percent above the 20 percent that you normally pay for Part B.

Original Medicare does not limit how much you will be charged if you visit providers that opt out of the Medicare program. Generally, a Medicare beneficiary is responsible for cost sharing with the federal government for plan premiums, deductibles and coinsurance charges, so the final tally could be substantial.

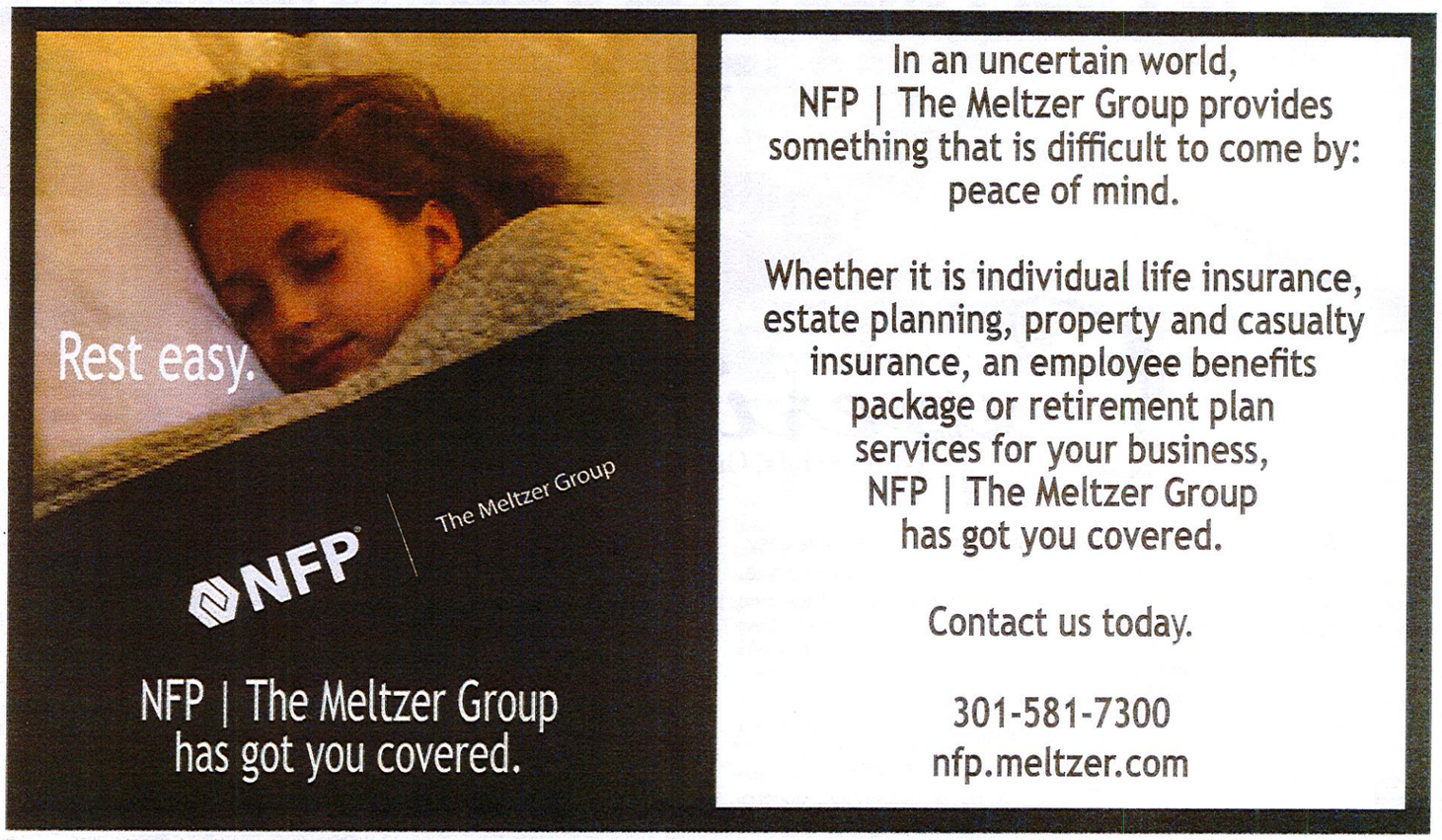
To help reduce your Medicare Part A and Part B out-of-pocket expenses for hospital and provider services, you might consider enrolling in an optional Medicare Supplemental policy (Medigap). The government guarantees enrollees the right to Medigap coverage for the period of six months immediately after Part B enrollment.

Additionally, you might want to purchase optional Original Medicare Part D prescription drug coverage, which is available only through private companies. Please read the section called Part D to understand your coverage choices for prescription drugs.

Medicare Advantage Plans

Most Medicare Advantage Plans offer specific kinds of extra coverage, covering such things as vision, hearing, dental, or health and wellness programs or often covering various combinations of such things. Most include Medicare prescription drug coverage (Part D). However, you will need to pay not only your Medicare Part B premium but also a monthly premium for the Medicare Advantage Plan.

You would still have Medicare if you enroll in an Advantage Plan. Each Medicare Advantage Plan must provide all Part A and Part B services covered by Original Medicare. Be aware, however, that Advantage plans could have unique rules, costs and restrictions that affect how and when you receive coverage. Often, these plans have network restrictions, meaning that you will be more limited to particular doctors and hospitals. On the upside, these plans could provide additional benefits including coverage for hearing,



vision and dental care.

Medicare Part A

Included in Medicare Part A are benefits for hospital inpatient care, skilled nursing facility care that is neither custodial nor long-term care, home health care and hospice care. Part A is usually premium free as long as either you or your spouse have worked and paid Social Security taxes for at least 40 quarters, or 10 years.

Under the inpatient hospital care portion of Part A, your benefits are free beginning the day you are admitted to the hospital for up to 60 consecutive days. After that, you will be responsible for various costs.

Skilled nursing facility care is covered if you meet the following requirements:

You need daily skilled services;

You have been hospitalized for at least three consecutive inpatient overnights prior to going to skilled nursing facility care or;

You are admitted into a skilled nursing care facility within 30 days of leaving the hospital. The facility must participate in Medicare.

To receive home health care benefits, you must be under a doctor's care, need skilled services or be homebound and use a Medicare-approved provider. Prior hospitalization is not required.

Hospice care is special care for people who are terminally ill. It also provides family respite care. Medicare pays for a maximum of 210 days in a Medicare-approved hospice program. There are no deductibles or copayments, except for covered prescription drugs and inpatient respite care. You must choose hospice care to receive these benefits.

Medicare Part B

Items covered under Part B include inpatient and outpatient physician services, durable medical equipment and supplies, home health care, diagnostic and lab tests, Medicare preventive services and a first physical exam. Part B also covers bone mass measurement, colorectal cancer screening, diabetic screening as well as services and testing supplies, glaucoma testing, prostate cancer screening, mammograms and pap test screenings, vaccinations for flu, pneumonia and hepatitis B, cardiovascular screening, smoking cessation and a yearly wellness exam.

The standard Medicare Part B premium cost for 2018 is $134, and that amount changes yearly. The rate of your Part B premium is income-related, the more income you earn, the higher your Part B premiums will be. You will also need to pay a $183 deductible for Original Medicare Part B as well as 20 percent copayment.

Medicare Part C

These plans, also called Medicare Advantage Plans, cover the same approved services as Part A and Part B. There are deductibles and copayments and you generally will need a referral to see specialists. Advantage Plans, however, may include the added benefits of prescription drugs, limited dental care, hearing and vision care.

Think carefully about your needs and budget accordingly. Some Advantage plans have higher up-front costs but fewer out-of-pocket costs throughout the year. However, if you see specialists frequently, you may face co-payments and co-insurance costs.

Unlike Original Medicare, Medicare Advantage plans usually have annual out-of-pocket limits. In other words, once you reach a certain out-of-pocket dollar amount, the plan will pay the remaining costs.

"Each person has to consider their own health insurance needs. Some costs you may be able to predict such as monthly doctor visits and prescription drugs, and knowing your annual out-of-pocket limits give you a better understanding of your budget range," said Rafael Espinoza, the Montgomery County SHIP director. Espinoza is a Medicare and Medicaid expert. He handles the most complex issues faced by clients, and he especially encourages our readers to learn the differences between Medicare and Medicaid. (Later in this guide, you will find a section on that very topic.)

Unlike Original Medicare's A, B, D and Medigap supplemental insurance option, Medicare Advantage plans have no supplemental policy available.

Medicare Part D

Under the Original Medicare plan, those enrolled in Medicare Part A and/or Part B may opt to purchase Part D plans, which are offered by Medicare-approved private insurance companies. These plans vary in premiums and coverage. You do not need to enroll in a Part D plan if you have drug coverage through an employer policy, Veterans Administration benefits or TriCare for Life, which is Medicare wraparound coverage for those who

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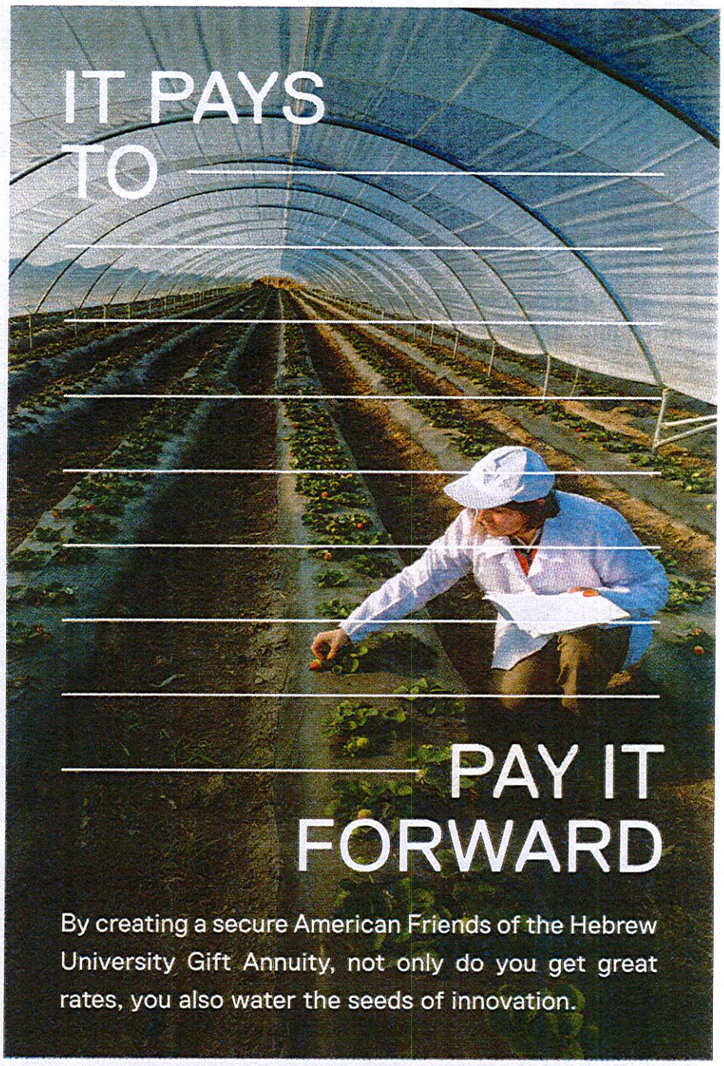

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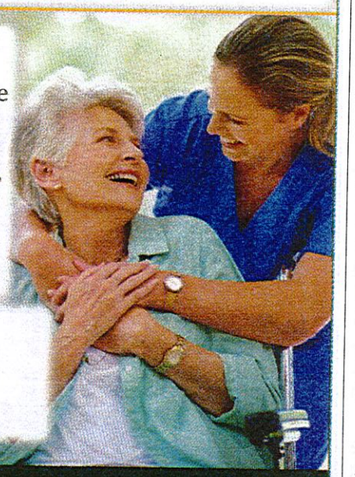

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have both Medicare Part A and B and can use Tricare for Life. If an individual wants Medicare prescription drug coverage (Part D) with Original Medicare, in most cases he or she will need to actively choose and join a stand-alone Medicare private drug plan.

If you are new to Medicare, you must enroll in Part D during your initial enrollment period. If you are already a Medicare beneficiary, there is a window when you can enroll in a Part D plan. This is "the Open Enrollment Period." This year, the Open Enrollment Period runs from Oct. 15 to Dec. 7. Your plan coverage then begins on Jan. 1, 2019.

Medicare Supplemental Insurance (Medigap)

Medigap plans cover certain gaps in out-of-pocket expenses in Medicare Parts A (hospital) and B (doctor and provider services).

There are many Medigap plans. Some cover deductibles, others coinsurance and still others, copayments. It is important to pay close attention to your Medigap plan choice because you may be committed to this plan for life. You are only guaranteed the right to a Medigap plan (regardless of pre-existing conditions) during the first six months after enrolling in Medicare Part B.

What Medicare does not cover

Some services not covered by Medicare include long-term custodial care, private hospital rooms and private nursing and ambulance services unless medically necessary, cosmetic surgery, acupuncture, most chiropractic services, Christian Science practitioners and Naturopath services, and most services provided outside the United States.

Need help paying for Medicare?

Some federal and state programs help pay medical costs if you have a limited income and meet certain other requirements. Some people qualify for both Medicare and Medicaid; they are dual eligible. These programs include Qualified Medicare Beneficiary Program (QMB) and Specified Low Income Medicare Beneficiary Program (SLMB).

Other state and federal programs help cover Medicare prescription drug costs. The federal government's Low Income Subsidy, also known as "Extra Help," is administered by the Social Security Administration. Some states also offer the Senior Prescription Drug Assistance Program, which helps eligible Medicare beneficiaries pay premiums and provides some cost sharing.

Medicare vs Medicaid

Although they sound alike and are both federal programs, Medicare and Medicaid are quite different from one another.

The federal government funds Medicaid in partnership with states to cover health needs of people with limited incomes. Depending on where you live, Medicaid could be available to those who fall below a certain income level. Some states also impose other criteria including age, blindness, disability and pregnancy.

Medicare coverage, on the other hand, is not income-dependent and is uniform throughout the United States.

Tips to protect you from fraud

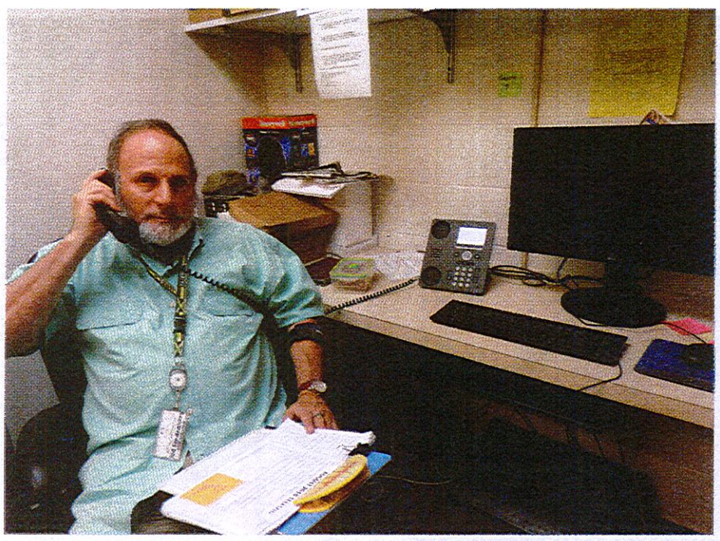
Medicare fraud and abuse is on the rise. This year, Medicare produced a new Medicare Card to help address this, but you play an important role in protecting your personal information and Medicare coverage.

* Never give your Medicare number to anyone except your doctor or other Medicare providers.
* Do not accept free medical services or equipment in exchange for your Medicare or Social Security number.
* Never give your Medicare number to telephone or door-to-door solicitors. Medicare does not call or go door-to-door.
* Keep records of the dates you received medical services.
* Carefully review each Medicare Summary Notice and make sure you received all the services and products listed.
* If you are charged for a service you did not receive, alert Medicare or your Medicare Advantage provider. This will help you avoid future misunderstandings. For example, if you are charged for a wheelchair you did not receive, you may be denied wheelchair coverage in the future because you did not alert Medicare of an erroneous charge.
* Carry your medical and Social Security cards with you only when you must.
* If you suspect fraud or abuse, call Medicare immediately.

SHIP volunteers are here for you

Sid Lindenberg spent his career working for the federal government's Centers for Medicare and Medicaid Services. When it came time to retire, the Calverton, Md., resident asked himself, "How am I going to give back, and what do I

SENIOR RESOURCES GUIDE



Sid Lindenberg is a volunteer for Maryland's State Health Insurance Program.

Photo provided

have to offer?"

Thankfully for the 10,000 baby boomers turning 65 every day, Lindenberg chose to become a volunteer for Maryland's State Health Insurance Program (SHIP).

SHIP is a federal program, sometimes supported by federal, state and county funds, too, that provides free local health coverage counseling people on Medicare individually by phone or in groups at community-wide outreach and educational events. Its goal it to help seniors understand Medicare and its various parts.

SHIP offers information on Medicare, Medigap plans, Managed Care plans called Medicare Advantage, Part D drug plans and Medicare fraud and abuse.

SHIP is the number one place to contact for individualized Medicare information and counseling. Most employee handbooks list it, and many politicians distribute their state SHIP phone number and website as a go-to resource for accurate, up-to-date information.

Lindenberg is one of 20 SHIP volunteer experts in Montgomery County who work at Jewish Council for the Aging's office in Rockville.

To Lindenberg, it's all about helping others. At the end of each call, he always asks, "Have I helped you or hindered you?" He finds great satisfaction when the caller gives him a verbal "thumbs up." He particularly appreciates it when the person thanks him "or when the people of faith say, 'God bless you,'" he said. "I really believe I help people."

When he begins his shift, Lindenberg picks up a telephone-messaging log, which lists recent calls and what the callers' questions were. Often, those who are about to turn 65 have general questions about what they could and should do. Others, however, call for their parents who are seeking a better plan. Still others might have begun using an expensive medication and need help determining how they can afford it and which drug plan would be best for them.

Sometimes, Lindenberg does a little research before returning a call, but generally, there are so many choices that he finds it best to return a call and learn exactly what the caller is wondering about. Then, he researches their questions before he calls back at a particular time. Even returning a call can be a challenge, however People don't want to talk about personal matters when they are at work or when someone else is in the room, Lindenberg said.

"The first goal is to reach the person, which is difficult," he said.

SHIP volunteers must determine if they are speaking with the person who is looking for a plan or if the person needs information for a parent or other relative. If it's not for themselves, "I ask: 'Do you have power of attorney?'" Lindenberg said.

It is imperative for all personal information to remain confidential, and SHIP volunteers need to ensure they are talking with the person able to give permission.

"We are very protective of situations where we are not talking to the person who needs help," he said, so he is likely to require the actual client, and not merely

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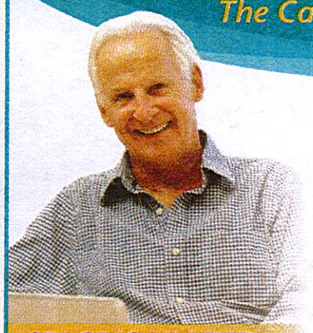

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the client's loved one, to affirm that it is OK to discuss his or her income, medications and other personal matters.

Once he is sure it's OK to proceed, Lindenberg reviews his checklist of questions, working to narrow down what the caller needs and is eligible to consider. There are retired federal employee programs, teacher association programs and so on, he said, adding most people aren't aware of what they can and cannot consider.

"It's time consuming" to look into all the options, "but it's better not to work off false assumptions," he said. "That's always a fight, getting the right information."

Lindenberg's goal is to match that person with the most cost-effective plan and then to review all the steps on how they should sign up.

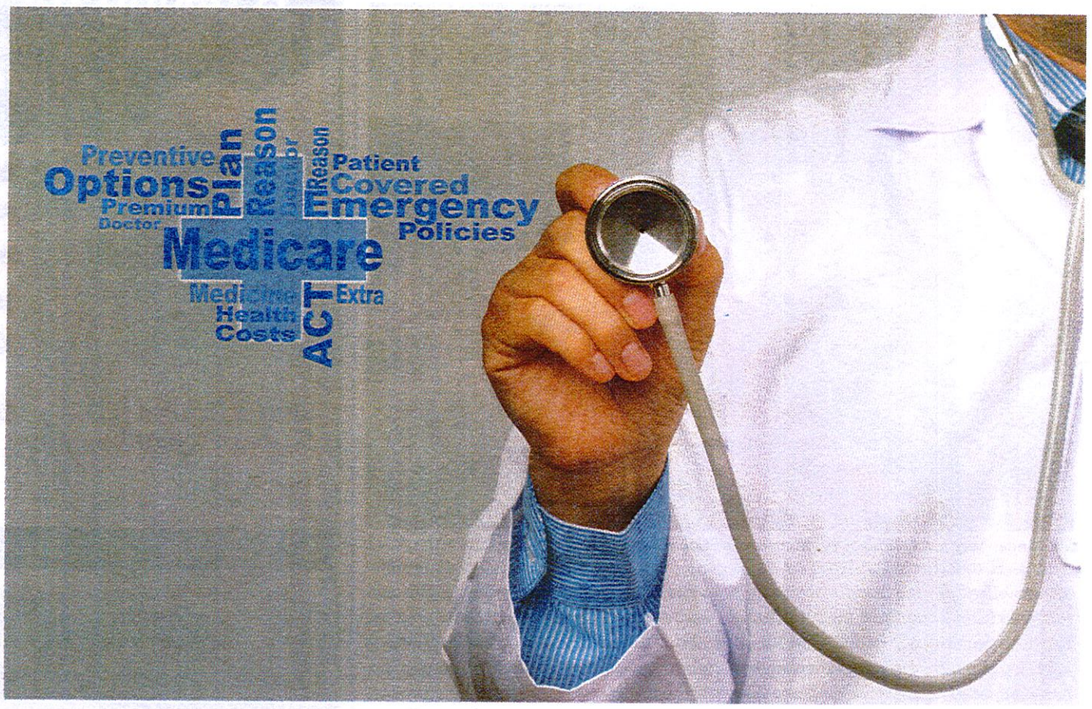
One client said this about Lindenberg's assistance: "SHIP sent me in the right direction to obtain help. It's a wonderful program and our family is so grateful for the guidance and support. Mr. Lindberg, you are amazing! One million thank you's!"

It is common for a SHIP volunteer to receive a call from someone who was just put on a new medicine that his or her current plan either does not cover or barely covers. With some prescription costs in the thousands of dollars per month, a person exhaust savings in no time at all. But often, it is just a matter of finding another drug plan that covers that medicine.

"We analyze their drugs and where they live and give them three choices" of economical plans, Lindenberg said. One thing SHIP volunteers don't do is make recommendations. They offer advice and choices but no recommendations.

This fiscal year, callers to the Jewish Council for the Aging's SHIP office saved an average of $482 per person on prescription drugs, thanks to advice from SHIP's staff and volunteers. Although some had no changes to their plans and thus no cost savings, others may have benefitted a great deal from SHIP's prescription drug analysis.

A recent review of the analysis provided to clients concerning the Part D drug plan enabled one caller to save a whopping $87,911. Twelve people saved at least $5,000. Collectively, the advice given to callers during the 2017 Part D Open Season enabled 167 clients to save a total of $366,652, according to Espinoza.



October marks the beginning of the open enrollment period; this is the time for people who are 65 years or older to change plans. As soon as seniors receive the government handbook or plan notices in the mail and the television and magazine advertisements begin appearing, SHIP phone lines begin lighting up.

SHIP volunteers work hard to stay current to keep up with what can be a huge volume of inquiries as people become overwhelmed with choices, advertisements and all the abbreviations being thrown at them, like SSA (Social Security Administration) and LIS (Limited Income and Resources) while trying to understand the difference between Medicare and Medicaid.

Lindenberg strives to ensure people realize that advertised come-ons are not from the government but from companies trying to make money. During open enrollment, some of the information is strictly marketing, he said.

SHIP volunteers charge nothing and have no stake in any plan.

During the Open Enrollment Period, SHIP volunteers and staff receive and document prescription drug worksheets that they receive for analysis. A core group of prescription drug analysis experts dedicates their time to finding the best plan for clients. It is complicated, detailed work that is mired in minutiae, and the volunteers must convey the proper information to people who may be unsure of what questions to ask or who are confused by medical jargon and misinformation they acquired from marketing materials or well-meaning friends.

"There is a lot of anxiety," Lindenberg. "Very educated people often don't know what is available to them," he said.

It is important to understand that low premium costs are not the only consideration when choosing a Part D plan. There are also deductibles, copays and out of pocket costs to consider. Additionally, each Part D plan has a different drug formulary; they are likely to cover only certain branded prescription drugs, to limit the quantity of drugs covered, and to require stepped therapies — those that begin with generic drugs and step up to branded drugs only as medically necessary.

SHIP mails the drug analyses to clients, and then the clients must declare their Medicare plan decisions by Dec. 7, the last day of the open enrollment period. They accomplish this by calling or going online to enroll in their selected Medicare Part D plan or their Medicare Advantage Plan.

A Montgomery County survey sent by SHIP seeks feedback on client services, and staff and volunteers take seriously what respondents say. One commented, "Everyone I ever spoke with is very knowledgeable and helpful. This is the best agency/program I have ever dealt with." Another said, "Your program is excellent and the only one I have found that so effectively assists in navigating this complex minefield. Please continue the good work."

TERMS TO KNOW

Ambulatory Surgical Center — This is a facility in which certain surgeries may be performed for patients who aren't expected to need more than 24 hours of care.

Appeal — This is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, your Medicare Prescription Drug Plan, a private insurer or Medicaid.

Benefit period — This is the way that original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you are admitted as an impatient in a hospital or skilled nursing facility for 60 days. The benefit period ends when you haven't received any inpatient hospital or skilled nursing facility care for 60 consecutive days.

BCRC — The Benefits Coordination & Recovery Center is the company that acts on behalf of Medicare to collect and manage information on other kinds of insurance or coverage that a person with Medicare may have and determine whether the coverage pays before or after

Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment and the other payer is determined to be primary.

Centers for Medicare and Medicaid Services — The Centers, also called "CMS," are a part of the federal Department of Health and Human Services (HHS).

COBRA — The Consolidated Omnibus Budget Reconciliation Act protects workers and their families that lose their health benefits. It gives them the right to choose to continue group health benefits provided by their group health plan for limited periods and under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other particular life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

Coinsurance — This is an amount you may be required to pay as your share of the cost of services, after you pay any deductibles. Coinsurance is usually expressed as a percentage.

Copayment — This is an amount that you may be required to pay as your share of the cost of a medical service or supply, like a doctor's visit, hospital outpatient visit or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or a prescription drug.

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

FEHB — Federal Employees Health Benefits is health coverage provided to federal employees.

Group Health Plan — In general, this is a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Health Care Provider — This is a person or organization licensed to give health care. Doctors, nurses and hospitals are examples of health care providers.

Health Insurance Portability and Accountability Act (HIPPA) — This is the federal act that provides for the ability to transfer and continue health insurance coverage for workers and their families when they change or lose their jobs. It also reduces health care fraud and abuse and mandates industry-wide standards for health care information on electronic billing and other processes. HIPPA requires the protection and confidential handling of protected health information.

Large Group Health Plan — In general, a group health plan covers employees of either an employer or an employee organization that has at least 100 employees.

Lifetime Reserve Days — In Original Medicare, Medicare will cover these additional days if you are in a hospital for more than 90 days. You have 60 reserve days that you can use during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medically Necessary — This refers to health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicaid — Wholly distinct from Medicare, this a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary by state but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare — This is federally provided health insurance for people who are 65 years and elder or those under 65 years with certain disabilities.

Medicare Part A (Hospital Insurance) — Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Medicare Part B (Medical Insurance) — Part B covers certain doctors' services, outpatient care, medical supplies and preventive services.

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

Medicare Approved Amount — This is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor

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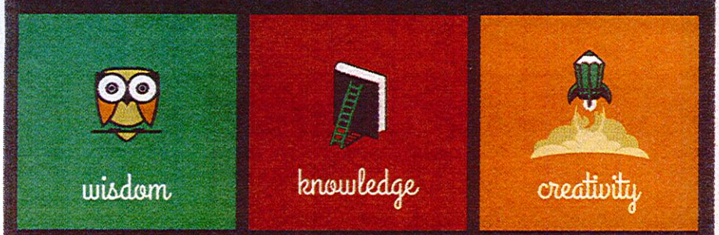

If you're age 50+, we invite you to volunteer with JCA's Heyman Interages Center's high impact programs. Volunteers engage in meaningful service throughout Montgomery County in a variety of programs that help youth unlock their full potential.

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Want to know more?
Contact us at 301-949-3551 or Interages@AccessJCA.org

Special thanks to Montgomery County Public Schools, Montgomery County Department of Health and Human Services, and Montgomery County Council for helping to support Interages programs. JCA is a community partner of The Jewish Federation of Greater Washington and is a beneficiary of the United Way and Combined Federal Campaign. JCA proudly serves people of all faiths, ethnicities and income levels.

SENIOR RESOURCES GUIDE

MEDICARE

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or supplier charges. Medicare pays part of this amount and you are responsible for the difference.

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

Medicare-approved Amount — In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you are responsible for the difference.

Medigap Policy — This is a Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Multi-employer Plan — In general, this is a group health plan that is sponsored jointly by two or more employers.

Open Enrollment — This is the particular time of the year when everyone with Medicare can make changes to their health and prescription drug plans for the coming year.

Protection of Personal Identifiable Information — This is any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means.

Premium — This is the periodic payment to Medicare, an insurance company or a health care plan for health or prescription drug coverage.

Preventative Services — This is health care to prevent illness or detect illness at an early stage, when treatment is likely to work best. It includes Pap tests, flu shots and screening mammograms.

Qualified Medicare Beneficiary Program (QMB) — This is a Medicare savings program that allows you to obtain assistance from your state to pay your Medicare premiums. It helps pay for Part A and B premiums, deductibles, coinsurance and copayments

Referral — This is a written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations, you must have a referral before you can obtain covered medical care from anyone other than your primary care doctor. If you fail to get a referral first, the plan may not pay for the services.

Religious nonmedical health care institution — This is a facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

Specified Low Income Medicare Beneficiary Program (SLMB) — This is one of four Medicare savings programs that allows you to obtain assistance to pay your Medicare premiums. This program helps pay only for Part B premiums.

SHIP — The State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people eligible or soon to be eligible for Medicare.

TTY — This is an abbreviation for "teletypewriter," a communication device used by people who are deaf, hard of hearing or have a severe speech impediment. People who do not have a TTY can communicate with a TTY user through a message relay center (MCR). An MRC has TTY operators available to send and interpret TTY messages.

Workers' compensation — This is an insurance plan that employers are required to have to cover employees who get sick or injured on the job.

AN IMPORTANT FOOTNOTE

Plans change. Moreover, sometimes attempts such as this to explain complicated issues in simple terms and "plain English" may leave out information that is important to you in your particular circumstance. For that reason and others, too, it is essential for you to review the official plan documents related to Medicare, private insurance plans and other benefit plans including the Medicaid provisions for the District of Columbia, Virginia, Maryland and other jurisdictions.

This guide was written by Suzanne Pollak, senior writer/editor at the Jewish Council for the Aging, with assistance from Montgomery County SHIP Director Rafael Espinoza and Montgomery County SHIP Administrative Specialist Suzanne Ross.