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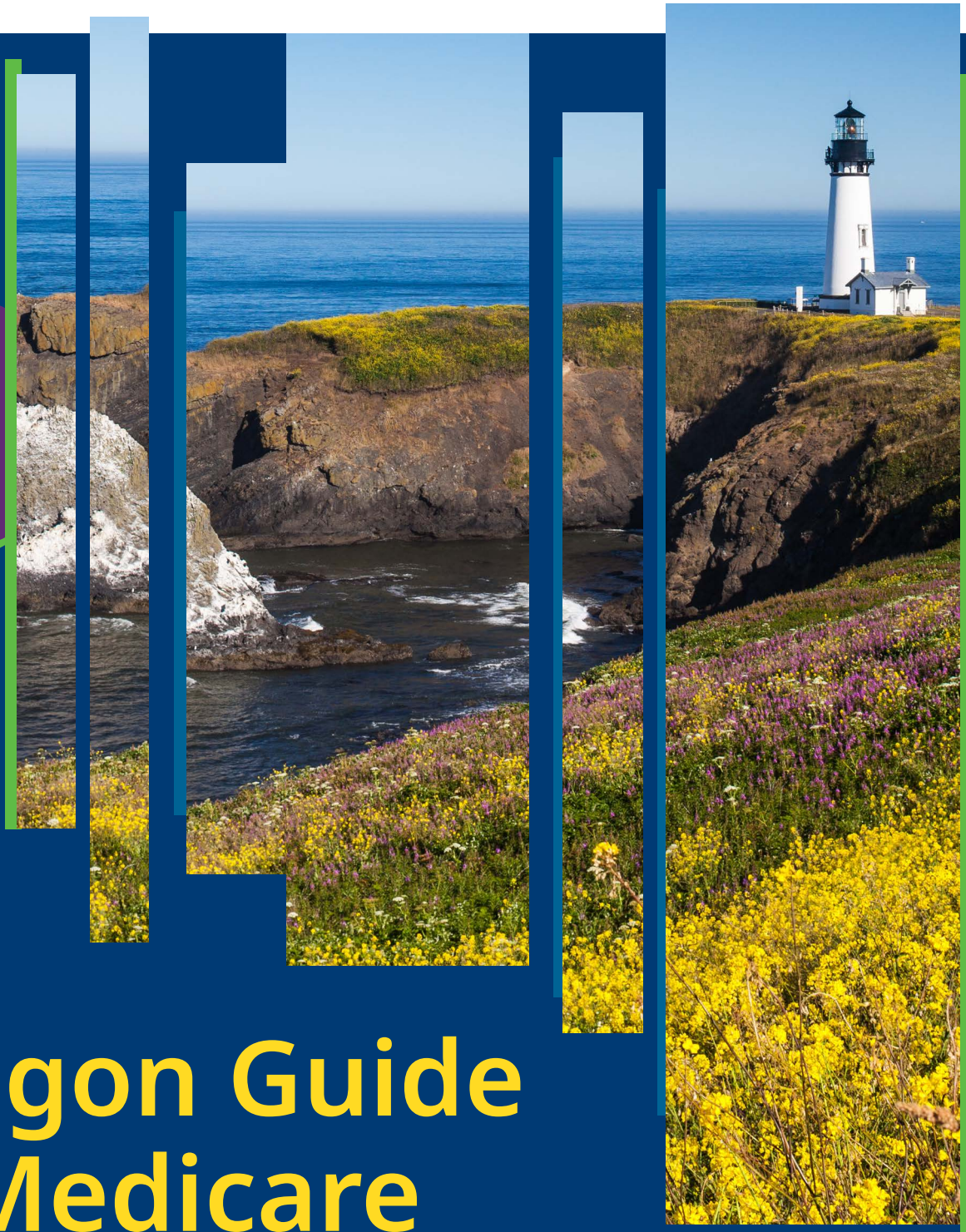

Oregon Guide to Medicare Insurance Plans

OREGON DEPARTMENT OF
Human Services
Aging and People with Disabilities

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 in this guide are defined in the glossary on **page 65**.

You can get this document in other languages, large print, braille, or a format you prefer free of charge. Contact the Senior Health Insurance Benefits Assistance (SHIBA) program at **shiba.oregon@odhs.oregon.gov** or **800-722-4134** (voice/text). We accept all relay calls.

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Introduction

What is SHIBA?

Senior Health Insurance Benefits Assistance (SHIBA) 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 "2026 Oregon Guide to Medicare Insurance Plans" to decide what plan works best for them. Learn more about SHIBA at **shiba.oregon.gov.**

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. Each location has different hours of availability. State SHIBA staff are available Monday through Friday between 8 a.m. and 5 p.m.

- 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.

New to Medicare?

Medicare is available to start 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**.

Getting started:
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 the representative with whom you spoke, and what was said.

- For Social Security, call **800-772-1213** (available 8 a.m. to 7 p.m. Monday through Friday). To find a local office, visit **ssa.gov/locator** for Medicare Part A and Part B enrollment questions.
- Call **800-MEDICARE (800-633-4227)** with questions about your Part A (Hospital), Part B (Medical), Part D (drug plan) questions, and Medicare Advantage coverage.

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 **shiba.oregon.gov/becomeacounselor/Pages/default.aspx.**

Medicare agent locator tool

While the SHIBA program offers Medicare counseling services through a statewide network of certified counselors, 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 completed a state certification process. Be sure to scroll down the page to "Find Local Help" and select "Medicare Agents" when you search.

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 **immigrationadvocates.org/nonprofit/legaldirectory/search?state=OR**.

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 by checking **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 **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** at **855-673-2372** or visit **adrcoforegon.org**.

Basics of Medicare

Medicare explained

What is Medicare?

Medicare is health insurance for:

- People **age 65 years and older**
- People **younger than 65 who have had Social Security Disability Insurance (SSDI) for more than 24 months**
- People with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS, also called Lou Gehrig's disease)

The ABCs — and D — of Medicare

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

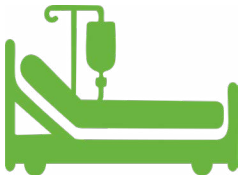
- **Part A: Hospital insurance**
- **Part B: Medical insurance**
- **Medicare supplements (Medigap plans):** Extra coverage to help pay costs not covered by Parts A and B
- **Part C: Medicare Advantage:** Private plans that include Parts A and B and often D
- **Part D: Prescription drug coverage**

Because Medicare is health insurance, you pay a share of the costs of your care. The amount depends on the coverage you choose.

Your Medicare options

When you first sign up for Medicare, and during certain times of the year, you can choose how you get your Medicare coverage. **There are two ways to get Medicare:**

Original Medicare
Part A and Part B



Part A

Hospital insurance

Part B

Medical insurance

You can use any doctor or hospital that takes Medicare, anywhere in the U.S.

Part D

Prescription drug plan (PDP)

You can add:
A separate Medicare drug plan to get prescription coverage (Part D)

Medicare supplement insurance

"Medigap"

You can add:
Supplemental coverage that helps pay your out-of-pocket costs like your 20% coinsurance or help paying costs that Original Medicare doesn't

Go to page 11 to learn more about Original Medicare, and page 39 for information about Medigap.

Medicare Advantage Plan
Part C

Combines Parts A and B

Available with or without prescription coverage (Part D)

A Medicare-approved plan from a private company, **secondary insurance**, that offers an alternative to Original Medicare for health and drug coverage. These plans bundle together Part A, Part B, and usually Part D

Secondary insurance can also include:

- **Retiree benefits (for example PERS)**
- **COBRA (in some cases)**
- **TRICARE for Life or CHAMPVA**
- **Medicaid**
- **Indian Health Service (IHS)**

Secondary insurance may:

- Provide lower out-of-pocket costs depending on the plan
- Include plans offering additional benefits not covered by Original Medicare

Go to page 53 to learn more about Medicare Advantage.

Getting started

Already getting Social Security or Railroad Retirement Board benefits?

If you are turning 65 and already get Social Security or Railroad Retirement Board (RRB) benefits, you should get your Medicare card and packet in the mail about **three months before your birthday.** Make sure your address is up to date with Social Security so you get your packet on time.

Not getting retirement benefits?

Suppose you do not yet get Social Security or RRB benefits. In that case, you **must contact Social Security** at **800-772-1213** or go to **medicare.gov/plan-compare** to sign up for Medicare or to find out if you can delay enrolling without penalty.

When can you enroll?

You have **seven months** to sign up. This is called the **initial enrollment period (IEP)**. It includes:

- Three months **before** the month you turn 65.
- The **month** you turn 65.
- Three months **after** that month.

When does coverage start?

- If you sign up **before or during** your birth month, coverage can **start as early as the first day of your birth month.**
- If you sign up in the **last three months** of your IEP, coverage starts on the **first day of the following month.**

Did you miss your first chance to enroll?

You can still sign up during the General Enrollment Period (GEP):

- It goes from **January 1 to March 31** each year.
- Your coverage will start on the **first day of the month after you sign up.**
- You may have to pay a **late enrollment penalty.**
- If you retire or lose an **employer group health plan (EGHP)** after age 65, you may qualify for a **special enrollment period (SEP).** This may let you sign up for Medicare **without a late fee**. Go to **page 27** for details.

For more information about special enrollment periods, go to **page 18** through page 22.

Still working at 65?

You may delay enrolling in Medicare without penalty if both of the following are true:

- You or your legal spouse **is still working.**
- You **have health coverage through an employer group plan.**

Note: If your employer has fewer than 20 employees, Medicare will likely be your **primary insurance**, not the employer plan. Go to page 27 for details.

Contact your benefits administrator at your job to find out how Medicare works with your job-based coverage.

Questions about Medicare?

The **Social Security Administration** determines who qualifies for Medicare, the costs and if there are any late penalties.

If you have questions or need to enroll, **call Social Security at 800-772-1213** (toll-free). They are open Monday to Friday, 8 a.m. to 7 p.m. local time.

Other coverage options

Contact these options if they are available to you:

- **Employer or union group plan:** Call your plan's customer service
- **Military benefits:** Call your county Veteran Services Office, **800-692-9666**
- **Medicaid:** Contact your Medicaid case manager, **one.oregon.gov or 800-699-9075 (711 TTY)**

Ready to sign up for Medicare?

- Call Medicare at **800-MEDICARE** or (**800-633-4227**, toll-free) for help with benefits, claims or drug coverage (Part D).
- Make sure any place you get medical care **accepts your Medicare plan** and **is in-network.**
- Go to Medicare.gov. Under **"Find health & drug plans,"** use the **"Find Plans Now" button**, or call your plan to learn what's covered.

Keep good records. Write down the following:

- The **date** you called
- The **time** you called
- The **number** you called from
- The **name** of the person you spoke to

Part A — Original Medicare hospital insurance

2026 costs were not available at the time of publication. Look for updated costs at Medicare.gov.

Part A Premiums

Work credits	Monthly premium
40 or more	$0 (No premium)
30 to 39	$285 per month
Fewer than 30	$518 per month

To find out how many work credits you have, visit the Social Security Credits page.

Hospital stays

Inpatient care (not observation) includes semiprivate room, meals, nursing and miscellaneous hospital services and supplies

Days in hospital	What you pay
First 60 days	$1,676 deductible for each benefit period. **You may have to pay this more than once in a calendar year.** This can happen if you are admitted to the hospital or a skilled nursing facility again **after being out for 60 days in a row**
Days 61 to 90 days	$419 a day
Days 91 to 150 days (uses lifetime reserve days — you get only 60 days to use over your lifetime)	$838 a day
More than 150 days	All costs

Skilled nursing facility (SNF)

You must have had a three-midnight inpatient hospital stay and enter the Medicare-approved SNF within 30 days of discharge.

Days in SNF	What you pay
Days 1 to 20	$0
Days 21 to 100	Up to $209.50 a day
More than 100 days	All costs

Other services covered by Part A

Service	What's covered	What you pay
Home health care	Part-time or short-term skilled nursing care from a Medicare-certified agency	$0 for covered services
Hospice care	For terminal illness, if a doctor certifies the medical need	Small cost-sharing option for drugs and respite care
Blood	If the hospital has to buy blood	You must pay for the first three units unless it is donated

Note:

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

The **Centers for Medicare & Medicaid Services (CMS)** sets the costs, which may change yearly.

Go to Medicare.gov for the most current rates and deductible information.

Part B — Original Medicare medical insurance

2026 costs were not available at the time of publication. Look for updated costs at Medicare.gov.

Part B Premiums

Income level	Monthly premium
Most people	$185
Higher income	May pay more

Annual deductible

Cost	Details
$257	After paying the deductible, Medicare pays 80 percent of approved charges. You pay the other 20 percent
No maximum limit	There is no out-of-pocket maximum

Note: You must first pay your annual deductible for most services listed below.

Service	What you pay
• Doctor visits • Emergency room • Urgent care	20 percent of the Medicare-approved amount
Diagnostic tests, such as MRIs, CT scans and X-rays	20 percent of the Medicare-approved amount
Lab tests	$0 if Medicare approves the tests
Drugs given in an outpatient facility	20 percent of the Medicare-approved amount

Service	What you pay
Ambulance services (if it's an emergency)	**20 percent of the Medicare-approved amount**
Diabetes supplies	$0 for covered supplies if the **"Provider Accepted Assignment:" on** page 70; otherwise, 20 percent. For more information, visit **medicare.gov/coverage/durable-medical-equipment-dme-coverage** for details
Durable medical equipment, prosthetics or orthotics	$0 for covered equipment if the provider accepts assignment (**medicare.gov/basics/costs/medicare-costs/provider-accept-Medicare**); otherwise, 20 percent. For more information visit **medicare.gov/coverage/durable-medical-equipment-dme-coverage** for details
Hospital observation stay	**Copayment or copay** based on Medicare payment rules
Occupational, physical and speech therapy	20 percent of the Medicare-approved amount
Acupuncture (for chronic low back pain)	20 percent of the Medicare-approved amount
Home health care (same as in Part A)	$0 for covered services
Preventive services, some clinical lab services (blood tests, urinalysis)	$0 for Medicare-approved services. Fees for office visits or other costs may apply
Mental health	20 percent of the Medicare-approved amount

Note:

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

The **Centers for Medicare & Medicaid Services (CMS)** sets the costs, which may change yearly.

Go to Medicare.gov for the most current rates and deductible information.

What Medicare Part A and Part B don't cover

- ✘ Long-term care (help with daily activities, such as bathing and dressing)
- ✘ Dental care and dentures
- ✘ Most outpatient prescription drugs
- ✘ Hearing aids and exams for fitting them
- ✘ Routine vision care and glasses
- ✘ Annual physical exams with lab tests
- ✘ Medical care outside the United States, with limited exceptions
- ✘ Alternative care, such as naturopathy or therapeutic massage
- ✘ Non-emergency ambulance rides

Have questions?

Confused by your Medicare Summary Notice (MSN) or Medicare Advantage or Part D Explanation of Benefits (EOB)?

Call your provider or Medicare plan **first.** If they can't help, contact your local SHIBA for free assistance.

Notes

Medicare enrollment periods

What's an Initial enrollment period (IEP)?

You have seven months to sign up. This is called the initial enrollment period (IEP). It includes:

- Three months **before** the month you turn 65.
- The **month** you turn 65.
- Three months **after** that month.

If you are not automatically enrolled or must pay a premium for Part A coverage, you can sign up for Medicare during this time.

To qualify, you must have lived legally in the United States for at least five years. If you are age 65 or older but have not yet met the five-year legal residency requirement:

- Your IEP starts in month 57 of your legal residency.
- It ends in month 63 of your legal residency.

Missed your IEP?

If you missed your IEP and are not covered by you or your spouse's **employer group health plan (EGHP)**, you can sign up for Medicare during the:

General enrollment period (GEP)

- **When:** January 1 to March 31 each year.
- **How:** Call Social Security at **800-772-1213** to make an appointment to sign up.

- **Part A:**
  - If you qualify for premium-free Part A coverage, it may retroactively start up to six months before you enroll.
  - If you must pay for Part A coverage, it starts the month after you enroll.
- **Part B:** Starts the month after you enroll.
- **Next step:** You have 60 days after your **Part A** and **Part B** coverage starts to enroll in a Medicare Advantage or **Part D** drug plan.
- **Late enrollment penalties:** May apply if you delay enrollment in Part B or Part D drug plans.

Initial enrollment period and when coverage starts

Medicare coverage start dates are based on when you enroll.

Month of the IEP	When you sign up	Your Medicare coverage starts the first day of this month:
1	3 months before your birthday month	Your 65th birthday month
2	2 months before your birthday month	Your 65th birthday month
3	1 month before your birthday month	Your 65th birthday month
4	Your birthday month	The month after your birthday month
5	1 month after your birthday month	The month after you sign up
6	2 months after your birthday month	The month after you sign up
7	3 months after your birthday month	The month after you sign up

Note: If your birthday is on the first day of the month, your IEP starts one month earlier.

Have questions?

Get important Medicare information faster by getting your "Medicare and You" handbook electronically: Medicare.gov/go-digital

Find and compare providers near you: Medicare.gov/care-compare/

You can talk or live chat with a real person, 24 hours a day, 7 days a week (except for some federal holidays): Medicare.gov/talk-to-someone

Medicare enrollment periods and deadlines

Medicare Part A enrollment

Period	Details
IEP/OEP Initial enrollment period **(IEP)** and open enrollment period **(OEP)**	Auto-enrolled if you've received SSDI for 24 months **or** if you're receiving Social Security retirement benefits **at least three months before turning 65.** If not, you can enroll during your **seven-month** initial enrollment period (IEP): • Three months **before** the month you turn 65 • The **month** you turn 65 • Three months **after** that month
AEP/GEP Annual enrollment period **(AEP)** and general enrollment period **(GEP)**	**GEP (general enrollment period): January 1–March 31.** Coverage starts the month after you enroll • If you qualify for **premium-free** Part A, you can enroll at **any time** • If you must **pay a premium** for Part A, you must enroll during GEP
SEP/GI Special enrollment period **(SEP)** and guaranteed issue (GI)	• If you qualify for **premium-free** Part A, you can enroll at any time • If you must **pay a premium,** you can enroll any time while covered by an EGHP (your or your spouse's) **while still working or within eight months starting the month after you or your spouse stops working**
MAOEP Medicare Advantage Open Enrollment Period	Only applies to enrolling in Medicare Advantage plans
Late penalty	• None, if you qualify for **premium-free** Part A • If you must **pay a premium**, 10 percent of the premium for **each year** enrollment was delayed. The penalty lasts **for twice the number of years** enrollment was delayed

Medicare Part B enrollment

Period	Details
IEP/OEP Initial enrollment period **(IEP)** and open enrollment period **(OEP)**	Auto-enrolled if you've received SSDI for 24 months **or** if you're receiving Social Security retirement benefits **at least three months before turning 65.** If not, you can enroll during your **seven-month** initial enrollment period (IEP): • Three months **before** the month you turn 65 • The **month** you turn 65 • Three months **after** that month
AEP/GEP Annual enrollment period **(AEP)** and general enrollment period **(GEP)**	**GEP: January 1–March 31.** Coverage starts the month after you enroll
SEP/GI Special enrollment period **(SEP)** and guaranteed issue **(GI)**	You can enroll any time while covered by an EGHP (you or your spouse's) **while still working or within eight months starting the month after you or your spouse stops working**
MAOEP Medicare Advantage Open Enrollment Period	Only applies to enrolling in Medicare Advantage plans
Late penalty	10 percent of the current Part B premium for each full year during which enrollment was delayed. The **penalty lasts for life unless you qualify for a Medicare Savings Program (MSP).** For more information about the late penalty visit medicare.gov/publications/10050-medicare-and-you.pdf

Medigap (Medicare supplement plans) enrollment

Period	Details
IEP/OEP Initial enrollment period **(IEP)** and open enrollment period **(OEP)**	You can buy when you have both Part A and Part B. Open enrollment with **GI (guaranteed issue): on page 68** for **six months** after Part B starts, **regardless of age (younger or older than 65)**
AEP/GEP Annual enrollment period **(AEP)** and general enrollment period **(GEP)**	You can apply at any time, but at the plan's discretion. Plans can deny coverage or charge more unless the GI applies
SEP/GI Special enrollment period **(SEP)** and guaranteed issue **(GI)**	You have GI rights to switch plans for **63 days** from the date the previous health coverage ends or for **60 days** around your birthday **(30 before, 30 after)**. It also includes a **trial right** to switch to Medigap if you try a Medicare Advantage plan for the first time and disenroll within 12 months. Go to **page 43**
MAOEP Medicare Advantage Open Enrollment Period	Only applies to enrolling in Medicare Advantage plans
Late penalty	None, but plans may deny or charge more if outside OEP or GI periods

Will Medicare call and offer free genetic testing?

No. 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 (Part C) enrollment

Period	Details
IEP/OEP Initial enrollment period **(IEP)** and open enrollment period **(OEP)**	The seven-month period that starts three months before turning 65 **or** before qualifying for Medicare due to SSDI
AEP/GEP Annual enrollment period **(AEP)** and general enrollment period **(GEP)**	**AEP: October 15–December 7;** coverage starts January 1 **GEP:** If you enroll in Part A and Part B during GEP, Medicare Advantage begins when you apply for Part B. It lasts for the first two months of Part B. Coverage starts the month after your enrollment request
SEP/GI Special enrollment period **(SEP)** and guaranteed issue **(GI)**	**60 days** after losing other coverage. Includes **5-star plan SEP** and **low-performing plan SEP.** Go to page 54
MAOEP Medicare Advantage Open Enrollment Period	January 1–March 31 **or** the first three months of Medicare Advantage enrollment if new to Medicare. You can **make only one change** during this period — for example, switch to another Medicare Advantage plan or drop Medicare Advantage and return to Original Medicare (with optional Part D). Go to page 54
Late penalty	None for Medicare Advantage health coverage. But if you delay enrolling in a drug plan, **you may face a Part D late enrollment penalty** added to your premium

Medicare Part D (prescription drug plans) enrollment

Period	Details
IEP/OEP Initial enrollment period **(IEP)** and open enrollment period **(OEP)**	The **seven-month** period that starts three months before turning 65 or before qualifying for Medicare due to SSDI
AEP/GEP Annual enrollment period **(AEP)** and general enrollment period **(GEP)**	**AEP: October 15–December 7**, coverage starts January 1 **GEP:** If you enroll in Part A during GEP, Part D enrollment begins when you apply for Part A. It lasts for the first two months of enrollment. Coverage starts the month after your enrollment request
SEP/GI Special enrollment period **(SEP)** and guaranteed issue (**GI**)	**60 days** after losing other drug coverage. Includes **5-star plan SEP** and **low-performing plan SEP.** For more information go to: medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods
MAOEP Medicare Advantage Open Enrollment Period	**January 1–March 31 each year**, if you're in a Medicare Advantage plan on January 1. You can make only one change during this period — for example, switch to another Medicare Advantage plan with drug coverage or drop Medicare Advantage and join a standalone drug plan. Go to page 32
Late penalty	1 percent of the national base premium for each month that enrollment was delayed. For example, a 24-month delay results in a 24 percent monthly penalty. This penalty lasts for life unless you qualify for Extra Help. Go to page 37

Veterans' benefits and Medicare

If you are a veteran, it's important to understand how the U.S. Department of Veterans Affairs (VA) health benefits and Medicare work together.

Using VA and Medicare

If you have VA benefits and Medicare, you may get services through either program. However, **you cannot use both at the same time. You must choose which benefit to use each time you see a doctor or get health care, such as a hospital stay.** The VA and Medicare do **not** coordinate payments:

- Medicare will not pay for the same service that the VA has already approved.
- The VA will not pay for the same service covered by Medicare.

Some veterans get free health care and prescriptions. Others may need to make **copayments.** Medicare does not pay or reimburse these copayments.

To get VA benefits, you must get care at a VA facility or get approval from the VA to use a non-VA facility.

Medicare enrollment

For **Medicare Part B**, a **late penalty** may apply if you sign up after you're first eligible. It doesn't matter if you get care through the VA. That won't avoid this penalty.

Medicare considers VA prescription drug coverage as **creditable coverage***, so you won't get a late enrollment penalty if you join a Medicare drug plan later. However, you'll need to show proof of your VA drug coverage. To get a letter of creditable coverage, contact the VA health benefits hotline at **877-222-VETS (8387)** (toll-free).

Using VA with Medicare Part D drug coverage

If you have both VA benefits and Medicare Part D:

- VA drug benefits only work at VA pharmacies and VA medical facilities. Medicare Part D only works at pharmacies in its network.
- The VA does not repay you for costs your Medicare plan does not cover.
- As an exception, Medicare may act as a secondary payer if VA services are not available or delayed.
- **VA and Medicare don't work together.** You'll need to use the right pharmacy for each type of coverage.

***Creditable means your current drug plan is as good or better than Medicare's standard drug plan.**

Need help?

Every county is assigned a veterans service officer (VSO) who can help you with your VA benefits. To find your local VSO, go to **oregon.gov/odva/services/pages/county-services.aspx** or call **800-692-9666** (toll-free).

TRICARE for Life

This program is for military retirees. To qualify, you must have Medicare Part A and Part B.

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

Secondary Insurance Options

Program	Medicare required?	How it works with Medicare
Federal Employee HealthBenefits (FEHB)	**No**, but Medicare late enrollment penalty (LEP) may still apply if you delay	Works with Medicare Parts A and B if enrolled
TRICARE For Life (TFL)	**Yes**, both Parts A and B	Medicare pays first; TFL pays second
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)	**Yes**, both Parts A and B	Medicare pays first; CHAMPVA pays second
Veterans Affairs (VA)	**No**, but Medicare late enrollment penalty (LEP) may still apply if you delay	You choose: Either VA or Medicare pays, not both
Indian Health Service (IHS)	**No**, but Medicare late enrollment penalty (LEP) may still apply if you delay	Saves Tribal dollars if Medicare enrolled. Medicare pays first; IHS pays second

Retiree plans and Medicare

In most cases, you must be signed up for Medicare Part A and Part B to enroll in or keep your retiree health plan if both of the following are true:

- You are eligible for retiree group health coverage from a former job.
- You are almost 65, or are 65 or older.

Once you are Medicare eligible, there is often a deadline to enroll in the retiree plan. Check with your former employer's plan administrator for timelines and rules. If you miss the deadline, you may not be able to enroll later.

If you're retired and have Medicare and retiree group health coverage from a former employer, be sure you know how it works:

- Does it pay **after Medicare** as a secondary payer?
- Is it a managed care plan that becomes your only payer?

The way your retiree group health plan coverage works with Medicare depends on your plan. Your group health plan coverage might not work the same way after you retire and have Medicare.

Five things you should know about retiree coverage

1. **Find out if you can continue your coverage through your employer after you retire.**

   Employers don't have to offer retiree coverage. They can change benefits or premiums or even cancel it.

2. **Find out the cost and benefits.**

   Ask if there is coverage for your spouse. Also, ask how much you will pay and what the plan will pay. Some plans limit the amount they will pay. For example, "stop-loss" coverage only starts paying your out-of-pocket costs when they reach a maximum amount.

3. **Find out what happens when you become eligible for Medicare.**

   Some retiree plans may not pay anything if you are eligible for Medicare but did not sign up. You may also need to enroll in both Medicare Part A and Part B to get full benefits from your retiree coverage.

Tips

Protect your Medicare number. Check your statements for accuracy, and report any concerns of fraud or abuse.

4. **Find out how your retiree coverage will affect you and your spouse.**

   Get a copy of your plan's benefit booklet or summary plan description from 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 to find out if you should get a Medicare Supplement Insurance (Medigap) policy.

5. **If your retiree coverage ends, you have Medigap rights.**

   Oregon law gives you the right to buy a Medigap policy with **guaranteed issue** within **63 days.** This applies even if you are not in your Medigap open enrollment period.

   Medicare usually pays first after you retire. Your retiree coverage may pay some of the costs Medicare doesn't cover. This is similar to how coverage works with a Medicare supplement insurance plan (Medigap). However, Retiree coverage is not the same thing as a Medigap policy.

   Sometimes, retiree coverage includes extra benefits, such as coverage for:

   - Extra days in the hospital
   - Routine vision exams
   - Dental benefits.

COBRA and Medicare

You may be able to have both COBRA and Medicare at the same time. However, it depends on when your Medicare starts.

- **If your Medicare Part A or Part B starts on or before the day you choose COBRA:**
  You can keep both. Medicare will pay claims first. COBRA may help pay some of the costs Medicare doesn't cover.
- **If you sign up for COBRA first and become eligible for Medicare later:**
  Your COBRA coverage usually ends when your Medicare starts. However, if your spouse or children are on your COBRA, they may be able to keep it for up to 36 months.

What to know about late enrollment penalties

Most people don't pay a late penalty for **Medicare Part A** if they don't have to pay a monthly premium. However, you **may get a Part B penalty** if you wait to sign up and don't have insurance from a current job.

COBRA is not the same as having group health coverage while you are still working.

It does **not** let you delay signing up for Part B without a penalty. If you're on COBRA and want Medicare Parts A and B, you usually need to sign up for both when you first qualify to avoid late penalties.

Employer group health plans (EGHPs) and Medicare

When you or your spouse are still working and covered by an **employer group health plan (EGHP)**, you can delay enrolling into Medicare without penalty.

If you do enroll in Medicare while covered by an EGHP, who pays first depends on the number of employees:

- **If the employer has 20 or more employees:** The EGHP pays first (primary), and Medicare pays second (secondary).
- **If the employer has fewer than 20 employees:** Medicare pays first (primary), and the EGHP pays second (secondary).
- **If you or your spouse are on Medicare due to disability:** Medicare pays first when the employer has fewer than 100 employees.

If you have health insurance from a current job, you may generally sign up for Medicare Part A and Part B anytime. You also have up to eight months from the date you stopped working.

When your EGHP ends, you have a special enrollment period (SEP) to sign up for Medicare and other Medicare related coverage. You could choose:

- A retiree plan, if available (**page 25**)
- A Medicare Advantage Plan (health and drug coverage together) (**page 53**)
- A Medigap policy, which is Medicare supplement insurance **(page 39)**
- A stand-alone drug plan **(page 31)**

Time is limited. To avoid late enrollment penalties, do not delay. Timelines are on **page 18.**

Employer high-deductible health plans (HDHP) with health saving accounts (HSAs) and Medicare

You must choose between continuing to contribute to the HSA or signing up for Medicare Part A if both of these are true:

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

Once you sign up for any part of Medicare, you must stop putting money into your HSA. Your employer must stop adding money, too. You may have to pay a penalty if money continues to go into the HSA.

If you keep working after age 65 and want to keep adding money to your HSA, plan ahead. You must stop HSA contributions six months before you sign up for Medicare. This is because if Part A is premium-free to you, it can become effective six months before you enroll. If you enroll close to your 65th birthday, it may start that month.

When you sign up for Medicare Part A, through Social Security, it may be backdated up to six months.

If you are covered by an employer EGHP, you won't get a late fee for signing up for Medicare Part A or Part B later. However, if your employer plan has prescription drug coverage, it must be **creditable coverage** to avoid a Medicare Part D late enrollment penalty.

Protective Filing Date and Medicare

You can contact the Social Security Administration (SSA) to set a protective filing date if you plan to apply for benefits. But you still need to submit a full application to actually get those benefits.

If you're applying for premium-free Medicare Part A after age 65, SSA might be able to start your coverage up to six months earlier, based on when you first contacted them.

You can set a protective filing date by:

- Writing a note to SSA saying you plan to apply (signed is best)
- Calling SSA
- Visiting an SSA office
- Mailing or faxing a request
- Scheduling an appointment to talk about benefits

The Marketplace and Medicare

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

The Marketplace is where persons, families and employees of small businesses can get health coverage.

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 made to work with Medicare. To learn more about your Medicare options:

- Go to **page 39** to learn about Medigap policies. Go to **page 53** to learn about Medicare Advantage plans.
- You can also call **SHIBA** or go to **Medicare.gov** for more information.

If I have a Marketplace plan, 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're eligible for Medicare but have not enrolled because of either of the following:

- You'd have to pay a premium for Part A.
- You're not receiving Social Security benefits.

- You're paying a premium for Part A and choose to drop both Part A and Part B.
- You're 65 or older and don't have five years of documented legal residency, so you're not eligible for Medicare. You may buy a plan through the Oregon Health Insurance Marketplace at **healthcare.oregon.gov**.
- You may get help to pay for a Marketplace plan. However, this depends on your household income. For more information go to **healthcare.gov** or call **800-318-2596** (toll-free).

If you meet income and resource limits, you may also qualify for the Oregon Health Plan (Medicaid). To apply, go to **one.oregon.gov** or call your **local** Aging and People with Disabilities (APD) or Area Agency on Aging (AAA) office. You can find your local APD or AAA office at **oregon.gov/odhs/pages/office-finder.aspx.**

Before you decide, think about these two things:

1. If you sign up for Medicare after your initial enrollment period, you may have to pay a late enrollment penalty for as long as you have Medicare.
2. Outside the initial enrollment period, you can usually enroll in Medicare only during the Medicare general enrollment period (January 1 to March 31). Your coverage will start the month after you enroll.

Go to page 18 for enrollment periods and deadlines.

What if I get Medicare after a Marketplace plan?

You can get a Marketplace plan before your Medicare starts. When your Medicare begins, **you can cancel your Marketplace plan. However, it's important to understand how Medicare affects your Marketplace plan.**

You can keep your Marketplace plan after Medicare starts. However, you'll pay full price for it. Also, your Marketplace insurance company may end your plan.

Most people qualify for Medicare around age 65. Your **initial enrollment period** starts three months before your 65th birthday month and ends three months after.

It is usually best to sign up when you are first eligible because:

- **Once you qualify for Medicare**, you can't get help paying for a Marketplace plan based on your income.
- **If you sign up for Medicare late**, you may have to pay a penalty for as long as you have it.

It's illegal for someone to sell you a Marketplace plan if they know you have Medicare. You can keep a Marketplace plan you had before Medicare. However, you can't buy one after Medicare starts.

If you pay a premium for Part A, you can compare the costs of staying on your Marketplace plan versus signing up for Medicare. However, be aware that there may be penalties, and you may lose financial help.

For more information, go to **healthcare.gov/medicare/changing-from-marketplace-to-medicare/** or call the Marketplace at **800-318-2596**.

Tips

Optional supplemental benefits such as dental, vision and hearing are covered by some Medicare Advantage plans. For more information visit: **medicare.gov/basics**

Dental plans and Medicare

Can I get dental insurance with Medicare?

Medicare Parts A, B and D **do not** cover dental services. However, there are several other ways to get dental insurance:

- Buy a dental plan directly from an insurance company.
- Work with a licensed agent to help you compare and choose a stand-alone dental plan.
- Join a Medicare Advantage plan that includes dental benefits or offers extra dental coverage.

Ask your provider or plan:

- When you don't understand the charges billed
- If you don't think you got the service
- If you think the service was not needed

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

Drug coverage

Part D prescription drug coverage

Medicare Part D

Everyone who has Medicare can get drug coverage, regardless of income or health conditions.

Medicare Part D plans cover most drugs you take yourself. It also covers some vaccines you get at the pharmacy, such as the shingles shot.

Insurance companies work with Medicare to offer these plans. You may have to pay some things, such as:

- Monthly premiums
- **Copays**
- **Coinsurance**
- **Deductibles**

You can get a Part D plan that only covers your prescriptions, without any healthcare coverage. These are called **prescription drug plans (PDPs)**. You can also choose a **Medicare Advantage Plan with prescription drug (MAPD)**, which includes both health and drug coverage.

If you want to sign up for a prescription drug coverage, you need to also have Medicare Part A or Part B, or both. Unlike some parts of Medicare, you won't be automatically enrolled in a Part D plan.

Do I need prescription drug coverage?

Medicare Part D works like other insurance by covering prescription costs. Enrolling in a Part D plan (PDP) when you are first eligible will protect you from having a late enrollment penalty.

What if I have prescription coverage?

If you already have Part D coverage only, your insurance company must send you a packet in early October with updates for the next year. **Be sure to read it!**

If you get drug coverage through one of the following:

- A job
- A union
- A government agency (such as the VA)

You might want to keep your current plan if its drug benefits are as good as or better than Medicare's standard Part D benefit, called **creditable coverage**.

If you didn't get a letter stating that your coverage meets that standard, check with your benefits office. Be sure to keep any letter or document that proves your coverage is creditable. It could save you from a late penalty later.

Is there a late penalty?

If you can get Part D but don't have other creditable drug coverage, you may have to pay a penalty if you sign up later. In 2026, the penalty is about 34 cents for each month you went without creditable drug coverage. This amount gets added to the monthly premium of your plan (PDP or MAPD).

If you have other drug coverage, your plan's benefits administrator must provide a letter stating whether your coverage is as good as or better than Medicare's basic Part D plan.

You won't have to pay the late penalty if you qualify for **Extra Help** (go to **page 37**), or if you have Medicare due to disability and then turn 65.

Where do I get help choosing a prescription drug plan?

- Visit **Medicare.gov prescription coverage** and search for **"Your Guide to Medicare Drug Coverage"**.
- 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 can change every year. Medicare recommends that you check your drug plan each fall. You may join, drop or switch plans during the annual enrollment period (AEP) from **October 15 to December 7**.

If you start the year with a Medicare Advantage **(MA)** plan, you can make changes to drug coverage from **January 1 to March 31** during the MA open enrollment period. Go to **page 22** for details.

How do I switch plans?

Sign up for a new drug plan or a Medicare Advantage plan with drug coverage during the annual enrollment period. Your new plan will start January 1 and replace your old plan. **You do not need to do anything else to end your old plan; it will end automatically.**

- If you make more than one enrollment change during the fall open enrollment period (AEP), the last enrollment Medicare gets before the period ends on December 7th will count. **Don't make more than one change on the same day.**

If you move to a new state, you **must sign up for a new plan there**, even if you have a national plan.

What should I look for in a drug plan?

You want to look for a few different things in a drug plan that will work best for you.

Drug list: Also known as a formulary, each drug plan has a list of prescription drugs it covers. Plans have different drug lists and rules about how you get drugs and what they cost.

Restrictions: Plans can limit how and when you get drugs they cover. Here are some common limits:

- **Prior authorization:** Your doctor must ask the plan to approve the drug. The doctor must show it's **medically necessary** for the plan to cover it. You can get a 30-day supply while the plan reviews the request.
- **Quantity limits:** Some plans limit how many of a drug they cover over a period. This can be for cost, safety or legal reasons.

If you need more than the limit, your doctor must submit proof that it is medically necessary. Your plan may then need to approve the request.

- **Step therapy:** Some plans require that you try cheaper drugs before they cover more expensive ones. Your doctor can ask for an exception if:
  - You tried the drug before, and it did not work.
  - Your doctor thinks you need a specific drug due to your medical condition.
  - 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 little more—may be a good choice. It can help you avoid delays and paperwork in getting the drugs you need.

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

Drug plan premiums have a wide range of costs. A higher monthly premium doesn't always mean better coverage. What matters most is that your plan covers the drugs you take. The **Plan Finder** on **Medicare.gov** is the best tool to compare costs and choose a plan that works best for you.

Each covered drug is placed in a **tier** go to **page 72** that affects how much you pay. Plans use two types of costs:

- **Copays:** You pay a set dollar amount, usually for cheaper drugs. Copays stay the same throughout the year.
- **Coinsurance:** You pay a percentage of the drug's cost, usually for more costly drugs. The amount changes if the drug's price changes.

To check copays or coinsurance for your medications:

- Go to **Medicare.gov** and use the **Find Plans Now tool**. You'll need to:
  - Choose the type of plan you want to compare.
  - Enter your ZIP Code and medications.
  - Review the plans and click on a plan name to see more details.

The pharmacy you use affects your drug costs:

- Prices can vary a lot, so compare a few.
- If you use an **out-of-network** pharmacy, your plan won't pay. You'll pay the full retail cost, as if you had no insurance.
- If you travel out of state, be sure your plan works in other states.

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

It depends on your situation. If you get drug benefits through Veterans Affairs or the Indian Health Service (IHS) pharmacy, you have creditable coverage and can have one or both types of coverage. Whether it helps to keep both depends on the drugs you take.

However, if you have drug coverage from a union, employer or retiree plan, signing up for a Medicare Part D plan could cancel that coverage.

You cannot have a Medicare Advantage (MA) plan and a separate stand-alone drug plan. If you choose an MA plan, your drug coverage must be included.

Coverage for insulin costs

Medicare Part D and Medicare Advantage plans must cap the cost of a 30-day supply of insulin at $35. If you take insulin, use the **Medicare.gov Plan Finder** and contact the insurance plan directly to confirm your insulin is covered.

More ways to pay for prescription drugs

- **Drug manufacturers' discount programs or patient-assistance programs.** Help may be available if you have enrolled in Part D and still cannot afford your drugs. For a list of programs and links to applications, visit **needymeds.org** or call **800-503-6897.**
- **Employer group health plans.** Many employer group health plans cover prescription drugs. Check with your benefits administrator for your coverage information.
- **The Medicare Prescription Payment Plan.** Part D plans must let you pay out-of-pocket drug costs in monthly payments throughout the plan year. You can do this instead of paying all at once at the pharmacy. For more information, go to **medicare.gov/prescription-payment-plan.**
- **Oregon Prescription Drug Program (OPDP)**, also known as ArrayRX, a bulkpurchasing pool, is **free** to anyone living in Oregon. You can apply at **oregon.gov/oha/HPA/dsi-opdp.** Most major pharmacy chains take part in the pool. You may have both Part D and an OPDP discount card, but you can only use one at a time. The OPDP discount card is not insurance. Call **800-913-4146** to sign up for the card.
- **Other discounts or coupons**, such as **GoodRX.com,** are sometimes available. Discount cards do not protect you from a late enrollment penalty because they are not insurance.

Tips

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

Medicare drug costs, step by step

Coverage starts on Jan. 1, 2026
These costs are in addition to your monthly premium.

Monthly premium (paid every month)

- You must pay your drug plan's premium, even if you don't get any prescriptions.
- Premiums vary by plan. In 2026 they range from **$0 to $127** for stand-alone plans in Oregon.

Step 1: Deductible period

You pay 100 percent of your drug costs until you reach your deductible (**up to $615**).

Step 2: Initial benefit period

- Once you pay your deductible, cost-sharing begins.
- You pay 25% of the cost for all drugs covered by your plan.

Here is how the rest is paid:

- For drugs with drug company discounts (for applicable drugs)
  - Your plan pays 65%
  - The drug company gives a 10% discount
- For other covered drugs without drug company discounts (non-applicable drugs)
  - Your plan pays 75%

Step 3: Catastrophic coverage

After you spend **$2,100 out-of-pocket**, you get catastrophic coverage.

- You pay nothing for the rest of the year.

Others cover the full cost of your drugs:

- For drugs with drug company discounts (for applicable drugs)
  - Drug company pays 20%
  - Government pays 20%
  - Your plan pays 60%
- For other covered drugs without drug company discounts (non-applicable drugs)
  - Government pays 40%
  - Your plan pays 60%

See the Medicare drug costs at a glance chart to find out who pays what in each step.

Medicare drug costs at a glance

Coverage step	What you pay	What others pay
Step 1: **Deductible*** (not all drugs are subject to deductible)	**100%** up to **$615**	$0
Step 2: **Initial benefit** (after deductible is met)	**25%** for applicable or non-applicable drugs up to **$2,100** (coverage may depend on drug tier)	**Applicable drugs** • Plan pays **65%** • Drug company pays **10%** **Non-applicable drugs** • Plan pays 75%
Step 3: **Catastrophic coverage**	**$0** for all covered drugs	**Applicable drugs** • Plan pays **60%** • Government pays **20%** • Drug company pays **20%** **Non-applicable drugs** • Plan pays **60%** • Government pays 40%

Note:

Applicable drugs: Drugs that are approved by the Food and Drug Administration (FDA) or are licensed under the Public Health Service Act (PHSA), and are either on the plan's formulary or approved by the plan if not on the formulary. These can be generic or brand name drugs.

Non-Applicable Drugs: Drugs that are not approved by the FDA or licensed under the PHSA, or are not part of the plan's formulary. These can be generic or brand name drugs.

***Part D and Medicare Advantage plans** must limit monthly copays for a 30-day supply of insulin to $35. If you take insulin, use the Medicare.gov Plan Finder to check if yours is included.

Ways to save on Medicare and prescriptions

Help with Part D

The federal government's **Extra Help** program, also called the Low Income Subsidy (LIS), helps people with limited income save money on their Medicare Part D plans.

If you qualify, Extra Help:

- Reduces the monthly premium, often to $0
- Removes the yearly deductible
- Limits pharmacy **copays**, even on expensive medications

You must be enrolled in a Part D plan. How much help you get depends on your income and resources. After you're approved for **Extra Help**, you must choose a plan. If you don't pick one, Medicare will put you in a random $0 premium plan. That plan may not cover what you need.

How to apply:

Do either of the below:

- Call your local SHIBA counselor at **800-722-4134** (toll-free)
- Call Oregon Medicare Savings Connect at **855-447-0155** (toll-free)

If you're already enrolled in a Medicare Savings Program (MSP) or get Supplemental Security Income (SSI), **you'll be automatically signed up for Extra Help.** You don't need to apply separately.

Help with the Part B premium and other Medicare costs

The **Medicare Savings Program (MSP)** may help if your income is low. Depending on your situation, it can:

- Pay for the Part B premium
- Help with your Medicare deductibles
- Lower your copays and coinsurance

If you qualify for MSP, you'll be automatically enrolled in Extra Help to help with your drug costs. You don't need to apply for Extra Help separately.

QMB (Qualified Medicare Beneficiary) is a part of MSP. QMB helps people with low income and limited resources pay for Medicare Part A and Part B costs. These costs include premiums, deductibles and coinsurance.

How to apply:

- Contact the Aging and People with Disabilities program through the Oregon Department of Human Services (ODHS) — or your local office that serves older adults and people with disabilities. Here's how to contact them:
  - Call **800-282-8096** (toll-free)
  - Online at **oregon.gov/odhs/pages/office-finder.aspx**

Ask about:

- Medicare Savings Program (MSP)
- Qualified Medicare Beneficiary (QMB)

Help for working people with disabilities

The Employed Persons with Disabilities (EPD) program helps people who:

- Have a disability
- Are working
- Have Medicare

If you qualify, EPD lets you keep your Medicaid while working. Medicaid may help pay for Medicare costs, such as premiums, deductibles and other medical expenses.

How to apply:

- Contact the Aging and People with Disabilities program through the Oregon Department of Human Services (ODHS) — or your local office that serves older adults and people with disabilities. Reach them by:
  - Call **800-282-8096** (toll-free)
  - Online at **oregon.gov/odhs/pages/office-finder.aspx**

Ask about:

- Employed Persons with Disabilities (EPD)

More help with drug costs

You can find a variety of patient-assistance programs online that help with drug costs or for specific health conditions.

A good place to start is NeedyMeds. Here's how to contact them:

- Online at **needymeds.org**
- Call **800-503-6897**

What to know about estate recovery

Estate recovery is when the state asks to be paid back from a person's estate after they die. This only applies if a person got certain benefits from Medicaid services or General Assistance.

Here's what's important to know:

- No estate recovery for MSP (partial Medicaid)
- No estate recovery for Extra Help
- Estate recovery applies if you get full Medicaid or General Assistance

For more information, call Estate Administration at **800-826-5675** (toll-free).

Tips

Use the Medigap Plan Finder tool on: https://www.medicare.gov/basics/get-started-with-medicare/other-paths for specific individual quotes by ZIP code, age and gender, or contact your local SHIBA counselor for assistance.

Medigap

About Medicare Supplement (Medigap) policies

What is Medigap?

Medigap is another name for Medicare Supplement Insurance.

With Original Medicare, you must pay some of the costs, such as deductibles and coinsurance. Because of these gaps in Part A and Part B, insurance companies sell Medicare Supplement policies, also known as Medigap.

You must have Medicare Part A and Part B to purchase a Medigap.

If you have Original Medicare (Part A and Part B) and a Medigap plan, Medicare will pay its share of your costs first. Then your Medigap policy will pay its part.

Medigap plans are named by letter — Plan A through Plan N. (These are different from Medicare Parts A, B, C, and D.)

All Medigap plans are standardized by the federal government. They are regulated by the Oregon Division of Financial Regulation (DFR).

You cannot have a Medigap plan and a Medicare Advantage plan at the same time.

What do Medicare Supplement SELECT plans offer?

Medicare SELECT plans are a type of Medigap plan. They offer the same basic benefits of standard Medigap plans, but usually cost less because you're limited to a provider network for routine care.

Network providers:

- You use clinics, doctors and hospitals in the plan's network for nonemergency care.
- You get the same coverage as a standard Medigap policy, for these in-network visits, but at a lower cost.

Out-of-network specialist:

- Medicare will still pay its approved cost, which is usually 80 percent.
- Your SELECT plan may not pay the rest, such as coinsurance or deductibles.

Emergency or urgent care:

- You can go to any hospital or doctor, even if they aren't in network.
- Your SELECT plan will still cover the care, just like a standard Medigap plan.

How do policy costs differ?

The monthly premium for the same type of Medigap plan (such as Plan G or Plan N) can vary between insurance companies. The cost may depend on your age, gender, health history, tobacco use, and ZIP Code. It can also depend on how many people are enrolled in that company's Medigap plan. How you pay, such as direct bill or electronic funds transfer (EFT), can also affect the price.

Areas

If an insurance company says its prices vary by ZIP Code, it means they group people based on where they live. Smaller groups have fewer people to share the cost of care. So, if just a few people in the group have high medical bills, prices can go up for everyone in the group. This is why smaller groups often see bigger changes in what they pay each year. Insurance companies can only raise prices once a year. It's based on the total costs for the whole group, not on you alone.

Type

Most Medigap policies in Oregon are age-rated. That means the price is based on your age. It usually goes up each year as you get older.

Some policies in Oregon are **issue age-rated.** These start at a price based on how old you are when you first buy the plan. The cost doesn't go up just because you get older. However, it can still go up if the medical costs for the group go up.

Other policies are "**attained age**" rated. These policies have premiums that increase as you age.

When can I buy a Medigap plan?

You can apply for a Medigap policy at any time. But keep these points in mind:

- Outside of protected times, an insurance company may review your health history and could turn you down.
- **The good news:** there are several times when insurance companies can't turn you down, no matter your health.

Medigap open enrollment period

This is your best time to buy a Medigap plan.

- During this time, insurance companies can't ask you about your health or deny you a plan.
- It starts the day your Medicare Part B starts and lasts for six months.

Guaranteed Issue (GI)

- GI gives you the right to buy a Medigap plan without answering health questions.
- The insurance company can't deny you, charge you more, or delay coverage because of your health.
- You qualify for GI in certain situations, such as:
  - You lose Medicaid coverage.
  - You move out of your Medicare Advantage plan's area.
  - You have another reason listed on **page 43** and **page 44.**
  - Under GI rules, you have 63 days from the date of the event to buy a Medigap plan.

Loss of Medicaid

- If you lose either of the following, you qualify for GI:
  - Full Medicaid
  - Qualified Medicare Beneficiary (QMB)

- You have 63 days after you lose your full Medicaid or QMB to buy a Medigap plan without answering health questions.
- You may want a plan to help cover costly medical treatments, such as:
  - Dialysis
  - Chemotherapy
  - Infused medications
  - Immunosuppressant drugs

Oregon birthday rule

- If you already have a Medigap plan in Oregon, you get a 60-day period to shop each year.
- The time starts 30 days before your birthday.
- You can switch to a plan with the same or lesser benefit plan with the same or a different company. There won't be any health questions.

Medigap for enrollees younger than age 65

If you are younger than 65 and get Medicare due to a disability, end-stage renal disease (ESRD) or permanent kidney failure, you can enroll in a Medigap plan, with guaranteed issue rights. You can find more information about guaranteed issue on page 40.

- You also have a six-month enrollment period that starts at age 65, also with guaranteed issue rights.
- If you get a retroactive Medicare enrollment notice, save it. Medigap coverage can't be denied for six months from the date of the notice.

Will I have to wait to use my Medigap?

Medigap policies may delay coverage for prior health issues for up to six months. Some plans have waiting periods. Contact the plan for more information. If you have guaranteed issue rights, no waiting period will be added.

It's a good idea to check with an insurance agent who sells Medigap plans for details.

Medigap waiting periods

Can I get credit for my prior coverage?

If you get a Medigap plan during open enrollment, it may not cover prior health issues for a time. Your former coverage may qualify to shorten or skip that period.

To count, the former coverage must be from one of the following:

- An employer plan, **COBRA**, or other group or individual health plan
- Medicare or Medicaid
- TRICARE or other military health care plan
- Indian Health Service
- Some public health programs
- Federal Employees Health Benefits (FEHB) program
- Peace Corps health plan

Medigap coverage outside the United States

In most cases, Medicare will not pay for health care services you get outside the United States. However, some Medigap plans may cover emergency care in other countries. You can find a list of plans with emergency care in other countries on page 47.

These plans pay 80 percent of the cost for **medically necessary** emergency care outside the United States. The plan's regular **deductible** (if it has one) must be paid, plus a $250 yearly deductible for foreign emergency care. Both deductibles must be paid before other costs are covered.

These Medigap policies cover emergency care if it begins during the first 60 days of your trip. Medicare will not pay for the care otherwise. There is a lifetime limit of $50,000 for this kind of coverage.

This benefit is not meant to cover everything. If you plan to spend a lot of time outside the United States, you should look into travel insurance.

Remember that traveling on a cruise ship is like being in a foreign country. Many cruise ships are registered in other countries. Make sure you know what your insurance covers and if you need travel insurance.

If you research travel insurance, consider evacuation coverage. It can help you return quickly to the closest United States medical facility, if needed.

Tips

- Save your Medicare Summary Notices (MSNs) and Medicare Advantage and Part D Explanations of Benefits (EOBs)
- Keep a My Health Care Tracker, 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

Medigap coverage

Medigap coverage is based on the plan you choose, and there are many plans. Go to **"What Medigap plans cover"** on page 45.

Medigap guaranteed issue periods and plan choices

Note: Some guaranteed issue (GI) rules are national and some are specific to Oregon. Some GI rules also have a 63-day deadline to take an action.

(N) = National rule
(OR) = Oregon-only rule
***63-day deadline to take an action**

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). For more information about PACE go to: oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/pace-fact-sheet.pdf **(N)**	All plans
You are awarded r**etroactive 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 Medicaid **(OR)** terminates or ceases to provide all health benefits.	All plans

Guaranteed issue	Medigap plan choices
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 before to 30 days after your birthday each year. **(OR)** **shiba.oregon.gov/Documents/4845-ins-birthday-rule-2023.pdf**	Same plan as current policy or one with fewer benefits
You qualify for Medicare by reason of disability and move to Oregon from a state that does not permit Medicare Supplement policies be issued to persons under age 65.* **(OR)**.	All plans

What Medigap plans cover

Medigap plans help pay for what Medicare doesn't. This includes such things as deductibles, copayments and coinsurance for Medicare Part A and Part B.

These plans offer the same benefits no matter which company sells the plan. Costs may vary by ZIP code, so it's a good idea to call for a rate quote.

What Medigap covers and doesn't cover

Premiums, deductibles and cost sharing amounts for 2026 were not available at the time of publication. The amounts listed are from 2025.

Note: Check marks mean the Medigap plan covers the service. Horizontal bars mean the Medigap plan does not cover the service.

What Medigap covers	A	B	*C	D	*F	*F high	G	G high	K	L	M	N
Hospital stays after day 60 • $408 a day for days 61-90 • $816 a day for the next 60 lifetime reserve days (days 91-150) • You pay all costs after the lifetime reserve days or after day 150. Go to page 11 for details	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Part B coinsurance 20 percent coinsurance for Part B services. Go to page 13 for details.	✔	✔	✔	✔	✔	✔	✔	✔	**50%**	**75%**	✔	✔
First three pints of blood, per calendar year.	✔	✔	✔	✔	✔	✔	✔	✔	**50%**	**75%**	✔	✔

What Medigap covers	A	B	*C	D	*F	*F high	G	G high	K	L	M	†N
Hospice care coinsurance Respite care and other Part A-covered services.	✔	✔	✔	✔	✔	✔	✔	✔	**50%**	**75%**	✔	✔
Hospital (Part A) deductible Deductible per benefit period. ($1,676 in 2025)	—	✔	✔	✔	—	✔	✔	✔	**50%**	**75%**	**50%**	✔
Skilled nursing facility (SNF) daily coinsurance $209.50 per day for days 21-100 each benefit period.	—	—	✔	✔	✔	✔	✔	✔	50%	75%	✔	✔

***Plan C, F and F-high deductible** are **not** available to people who became eligible for Medicare on or after January 1, 2020. This change is part of the Medicare Access and CHIP Reauthorization Act of 2015.

†**Plan N covers Part B coinsurance.** However, you pay up to a $20 copay per office visit and up to $50 copay per emergency room visit, if you're not admitted to the hospital. Go to page 13.

Tips

Medicare cards will **never use** these letters because they are easily confused with numbers: **B, I, L, O, S,** or **Z.**

What Medigap covers	A	B	*C	D	*F	*F high	G	G high	K	L	M	†N
Part B deductible The annual deductible. ($257 in 2026)	—	—	✔	—	—	✔	—	—	—	—	—	—
Part B excess charges Covers 15% extra charge when a doctor or hospital doesn't accept Medicare's full payment.	—	—	—	—	✔	✔	✔	✔	—	—	—	—
Emergency care outside the United States Go to page 42 for more information.	—	—	80%	80%	80%	80%	80%	80%	—	—	80%	80%
Out-of-pocket maximum All Part A and Part B coinsurance after you reach the yearly out-of-pocket limit.	—	—	—	—	—	—	—	—	$7,220	$3,610	—	—
High deductible Once you have paid the deductible in cost sharing, the coverage will begin.	—	—	—	—	—	$2,870	—	$2,870	—	—	—	—

***Plan C, F and F-high deductible** are **not** available to people who became eligible for Medicare on or after January 1, 2020. This change is part of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015.

†Plan N covers Part B coinsurance. However, you pay up to a $20 copay per office visit and up to $50 copay per emergency room visit, if you're not admitted to the hospital. Go to page 13.

Medigap (Medicare Supplement) plan information

To find a local Medicare agent, go to our Agent Locator Tool at **healthcare.oregon.gov/Pages/find-help.aspx**. For more information on how to use the tool go to **page 6**.

Plan premiums can vary based on different factors listed on **page 39** through **page 40** under "Policy Costs Differ."

Plan Types

Key

- **A,B, C, D, F, G, K, L, N =** Types of Medigap plans
- **FHD =** F high deductible
- **GHD =** G high deductible
- **G(S) =** Type of Select Medigap plan
- **N(S) =** Type of Select Medigap plan

Insurance company	Phone	Website	Plan types
Cigna Life and Health Ins. Co.	**855-891-9368**	cigna.com/medicare	A, F, FHD, G, N
Continental Life Ins. Co. of Brentwood, Tennessee (Aetna)	**800-358-8749**	aetnaseniorproducts.com	A, B, F, FHD, G, N
Everence Association, Inc.	**800-348-7468**	everence.com	A, F, G, L, N
Globe Life and Accident Ins. Co.	**888-678-3403**	globecaremedsupp.com	A, B, C, F, FHD, G, GHD, N
GPM Health and Life Ins. Co.	**866-242-7573**	gpmhealthandlife.com	A, F, G, N
Humana Ins. Co.	**877-426-1269**	humana.com	A, B, C, F, FHD, D, G, GHD, K, L, N
Moda Health Plan, Inc.	**877-299-9062**	modamedicare.com	A, F, FHD, G, GHD, N

Insurance company	Phone	Website	Plan types
Providence Health Assurance	888-231-9287	providencemedicare supplement.com	A, G, N
Regence BlueCross BlueShield of Oregon	888-319-4181	regence.com/medicare/plans	A, C, F, G, K, N
State Farm Mutual Automobile Ins. Co.	800-782-8332	statefarm.com/insurance/health/medicare-supplemental	A, C, D, F, G, N
Tier One Ins. Co. (Aflac)	866-990-2668	aflacmedicaresupplement.com	A, F, G, N
Transamerica Life Ins. Co.	866-205-9120	transamerica.com/agent-locator	A, B, C, D, F, G, K, L, M, N
United American Ins. Co.	800-331-2512	unitedamerican.com/medicare-supplement-policies	A, B, C, D, F, FHD, G, GHD, K, L, N
UnitedHealthcare Ins. Co. (AARP)	888-378-0849	aarpmedicaresupplement.com	A, B, C, F, G, G(S), K, L, N, N(S)
United World Life Ins. Co.	855-977-6312	mutualofomaha.com/states	A, F, G, GHD, N
USAA Life Ins. Co.	800-531-8722	usaa.com/inet/wc/insurance	A, F, G, N
Washington National Ins. Co.	800-621-3724	washingtonnational.com	A, F, G, GHD, N
Woodmen Life	402-449-7771	woodmenlife.org/insurance/medicare-supplement-insurance/	A, F, G, GHD, N

Medigap plans by type

Use the online tool to find Medigap rates for your age and ZIP code. Go to **Medicare.gov/medigap-supplemental-insurance-plans/**.

A Medicare insurance agent can help you choose a Medigap plan that is right for you and get you enrolled. To find a certified agent, go to **shiba.oregon.gov/get-help/Pages/help-near-you.aspx**.

For basic Medigap information, contact either:

- Your local SHIBA (see "To get help with Medicare decisions" on **page 5** for contact information)
- SHIBA statewide staff at **800-722-4134**

Tips

Only licensed Medicare Insurance Agents can enroll you into a Medigap plan.

Go to **shiba.oregon.gov/get-help/Pages/help-near-you.aspx** to find an agent in your area. If you need assistance finding a Medicare Insurance Agent, call SHIBA at **800-722-4134** or email **shiba.oregon@odhs.oregon.gov**

Medicare Advantage plan types

HMO:
Health maintenance organization

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

PPO:
Preferred provider organization

SNP:
Special needs plan

(See **Glossary** for definitions)

Medigap vs. Medicare Advantage comparison chart

How coverage works: Example using Plan G

Comparison point	Medigap (Plan G)	Medicare Advantage (HMO or PPO)
Eligibility	You need Medicare Part A and Part B. Plans may not be available in all areas. Check if plans are offered in your ZIP Code. Companies **must accept all applicants of any age during Medigap open enrollment and guaranteed issue periods.**	You need Medicare Part A and Part B and you must live in the plan's service area. Availability varies by location.
Premium	You pay your Medigap monthly premium **plus** the Medicare Part B premium. What you pay varies by age, gender, ZIP Code and health.	You pay the Medicare Part B premium, **plus** any Medicare Advantage plan premium. Plan members in the same Medicare Advantage plan pay the same premium. However, premiums vary between plans and by location.
Copay	After you meet the Part B deductible, you usually don't pay copays for covered care.	You usually pay a copay for most medical services, including prescriptions.
Coinsurance	After you meet the Part B deductible, your plan generally pays for almost all covered care.	You pay coinsurance for some services. The amount varies by plan.
Out-of-pocket maximum	No yearly limit on your total spending.	Plans set a yearly limit on what you pay for covered medical services. Once you reach that amount, the plan pays 100 percent for covered care.

Comparison point	Medigap (Plan G)	Medicare Advantage (HMO or PPO)
Provider choice	You can go to any doctor in the U.S. who takes Medicare. No referrals are needed. **Always confirm a provider accepts Medicare before getting care.**	You may have to stay in the plan's network. Some plans need referrals for specialists. PPOs let you go out of network. However, it may cost more. **Always confirm a provider accepts your plan before getting care.**
Drug coverage	Not included. You need to buy a separate Medicare drug plan (Part D).	Drug coverage is usually included in the plan.
Ongoing coverage	Your benefits don't change year to year. You can keep the plan as long as you pay your premium.	Benefits can change each year. You stay in the plan unless you switch or the plan leaves your area.
Extra benefits	It only covers what Medicare covers. Most plans don't include dental, vision or hearing.	Some plans offer extras, such as dental, vision, hearing, gym memberships, or rides to appointments.
Best for	People who travel, see specialists often, or want to pay little or nothing at the time of care.	People who want a lower monthly cost and don't mind using a provider network.
How to compare	Plans with the same letter (such as Plan G) have the same benefits. This is true no matter which insurance company you choose. Only the prices and customer service are different.	Plans are all different. Compare by using the plan comparison tool at **medicare.gov/plan-compare.**
Who regulates it	Oregon Division of Financial Regulation.	Medicare

Medicare Advantage

Medicare Advantage plans

Medicare Advantage plans are run by insurance companies that work with Medicare. These plans give you all your Medicare-approved care. When you join a Medicare Advantage (MA) plan, you agree to follow the plan's rules.

- You get the same benefits as Original Medicare, but the costs may be different.
- You will still pay your Part B premium. You may also pay the plan's premium (unless the plan has a $0 premium). You may also pay copayments or coinsurance for certain services.
- Some plans cover extras, such as yearly checkups, basic vision or dental care.

Medicare Advantage plans need new contracts with the Centers for Medicare and Medicaid Services (CMS) each year. A plan may choose not to renew its contract. If that happens, you can join another plan or buy a Medigap plan.

Your ZIP Code affects which Medicare Advantage plans you can get. You can check if a plan is in your area by calling the company or by going to **Medicare.gov**.

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.

When can you join, leave or switch Medicare Advantage plans?

You can take different actions during enrollment periods. These actions include:

- Joining a plan
- Leaving a plan
- Switching from one plan to another

If you take more than one action during an enrollment period, Medicare uses the last plan you sign up for before the period ends. When your plan starts, the enrollment period ends.

You may join, leave or switch Medicare Advantage plans during:

- **Initial enrollment period (IEP):** This is when you are new to Medicare. It's three months before, the month of, and three months after your 65th birthday.
- **Annual enrollment period (AEP):** This runs from October 15 to December 7. It's also called Fall Open Enrollment. You can join a new plan during this time, and Medicare will automatically take you off your old plan.

Medicare Advantage special enrollment periods (SEPs)

Special enrollment periods let you change plans outside of the usual periods. They happen when you:

- Move permanently outside your plan's service area
- Qualify for limited-income help. Go to page 37 and page 69 for more information.

SEPs are usually 60 days, but may vary. During a SEP, you can:

- Join a different Medicare Advantage plan
- Switch to using only Original Medicare
- Switch to Original Medicare and buy a Medigap plan.

You may have to go through underwriting, unless you have guaranteed issue rights.

Star-rated SEPs: Medicare gives plans star ratings based on complaints and quality. Plans range from five stars to one. Five stars mean excellent. One star means poor.

Five-star SEP: You can join a five-star plan once per year from December 8 to November 30, if one is available.

Low-rated SEP: If you are in a plan with a low rating of one or two stars, you will get a letter in late October. You must call **800-MEDICARE (800-633-4227)** or SHIBA (**800-722-4134**) to sign up for another plan.

Medicare Advantage open enrollment period (MA OEP)

There are two kinds of Medicare Advantage open enrollment periods:

- **January 1 to March 31**: You can use this if you already have a Medicare Advantage plan on January 1.
- **New to Medicare**: You can use this if you are new to Medicare and start a Medicare Advantage plan during your initial enrollment period. This period lasts for the first three months you have the plan and Medicare Part B. It lets you make a one-time change if the first plan you choose doesn't meet your needs.

When coverage starts:

- Your new coverage will start the first day of the month after you enroll.

What you can do during an MA OEP:

- Switch from one Medicare Advantage plan to another (with or without drug coverage).
- Return to Original Medicare and join a stand-alone Part D plan.
- Get Part D drug coverage only if you were in a Medicare Advantage plan on January 1.

What you cannot do during an MA OEP:

- Make more than one change.
- Switch from one stand-alone Part D plan to another stand-alone Part D plan.

Why this period exists:

- It is meant to give you a second chance if your plan isn't working for you.
- It is not meant for comparing and changing plans multiple times.

Help comparing plans

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

For a SHIBA contact in your area:

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

How do I select a plan?

What plans are offered in my area?

- Go to **Medicare.gov** and type in your ZIP code to find plans available in your county. You can enroll in a plan on **Medicare.gov**. You may also visit **SHIBA.Oregon.gov** for a list of plans in your county.

Will my doctor and hospital accept the plan?

- Ask the business offices of your doctors and hospital if they are in-network for a plan you are thinking about. Even if a plan is offered in your area, providers do not have to take part. Some plans may charge you more if your provider is not in the preferred network. It is very important to check if the plan you want includes your doctors and hospital.
- Call to get the information yourself. Websites and printed materials can be wrong. An agent trying to sell you a plan may also not have the right information.

Can I afford the plan?

- Make sure you understand the coverage, including premiums and copays. Here are some words you need to understand:
  - **Premiums:** The amount you pay each month for a plan. A few plans have a $0 premium.
  - **Deductible**: The amount you pay before the plan starts paying (with some exceptions).
  - **Maximum out-of-pocket costs:** This is the most you will pay in a year for covered services, excluding the premium and Part D drugs, before the plan starts paying 100 percent. **Not all covered services may count toward the out-of-pocket maximum.**
  - **Copays:** A fixed amount you pay for a service.
  - **Coinsurance:** A percentage of the cost of a service.

Prescription drug coverage

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

- Most **HMO** and **PPO** plans come with built-in prescription drug coverage (**MAPD**). In these plans, the drug coverage is part of the “bundle.”
- **Exception:** If you have VA drug coverage available, you can use it with the health-only MA plan, **if the plan lets you**.

Medicare Advantage dental coverage

Original Medicare **does not** cover regular dental care. It may cover some dental work if you are in the hospital for a related illness or injury. However, that is rare.

Medicare Advantage plans offer dental coverage in different ways:

- Some plans have coverage as part of the plan. This may be just basic care or include more comprehensive services.
- Others offer preventive care, such as cleanings and X-rays, up to a set limit.
- Some let you add extra coverage as a "dental rider" for more services, such as crowns or dentures.

To find a dental plan, contact a local licensed insurance agent.

Medicare special needs plans (SNPs)

These are specially designed HMO and PPO Medicare Advantage plans for certain groups of people:

- People who have both Medicare and Medicaid (dual eligible).
- People who also live in nursing facilities or assisted living communities.
- People who are both Medicare and Medicaid (dual eligible) and live in nursing facilities or assisted living communities.
- People who have certain chronic conditions, such as diabetes or a heart condition. These plans focus on helping that condition.

For more information, go to **Medicare.gov**.

Have summary notice questions?

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.

Appeals

Appeals and Medicare

Medicare, Medicare Advantage, and Part D plans have five levels of appeals. The main differences are in the time frames for filing an appeal and receiving a decision. An expedited process might be available.

Appeals can be started by the beneficiary, provider, or representative. Be sure to include **only copies** of any relevant information. **Do not send your original documents.** Always appeal a denial of service from the insurance plan or Medicare. For details, go to **medicare.gov/providers-services/claims-appeals-complaints/appeals**.

You can also go to **Medicare.gov** for more information about Medicare, Medicare Advantage and Part D appeals.

Links for appeals

Original Medicare Appeals: https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/original-medicare

Medicare Advantage plan appeals: https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/medicare-health-plans

Prescription Drug plan appeals: https://www.medicare.gov/providers-services/claims-appeals-complaints/appeals/drug-plans

What if I get a denial letter?

If your Medicare Advantage or prescription drug plan denies a service, contact your insurance plan or check your insurance plan's Evidence of Coverage for more information on filing an appeal.

If Medicare denies a service, follow the instructions on the denial letter or contact Medicare at **800-633-4227**.

Your right to a fast appeal

You have the right to a fast appeal if you think your Medicare-covered services are ending too soon.

This includes services you get from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility or hospice.

Your provider will send a written notice before your services end that tells you how to ask for a fast appeal.

Find out how fast appeals work: **medicare.gov/providers-services/claims-appeals-complaints/appeals/fast-appeals**

Resources and publications

About SHIBA

The Senior Health Insurance Benefits Assistance (SHIBA) program is part of the Oregon Department of Human Services Office of Aging and People with Disabilities. SHIBA is also part of the Administration for Community Living (ACL/HHS) 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 informed decisions about health insurance by providing confidential and objective counseling.

Contact the SHIBA program:

- To get free help:
  - Filing claims
  - Comparing Medicare Advantage plans, Medigap policies and prescription drug plans
  - Ordering free brochures
- To become a SHIBA certified counselor

Contact information

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

SHIBA
Senior Health Insurance Benefits Assistance

Tips

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 the Aging and Disability Resource Connection of Oregon

What is the Aging and Disability Resource Connection (ADRC) of Oregon?

The Aging and Disability Resource Connection of Oregon (ADRC) is a partnership between Oregon Department of Human Services and local service providers. When you are looking for information about services to address aging or disability needs, the ADRC of Oregon can help you learn about local public and privately paid options. The ADRC has trained professional staff who can help you and your family with immediate needs, or help you plan for the future.

How can the ADRC help?

The ADRC provides information and referral services to older adults, people with disabilities, and their families and care providers, regardless of income. Oregonians are able to learn about more than 5,000 resources through ADRCofOregon.org or the toll-free number: **1-855-ORE-ADRC (1-855-673-2372).**

Contact information

You can reach the ADRC of Oregon by:

- Going to the website ADRCofOregon.org
- By calling toll-free **1-855-673-2372**
- Contacting a local ADRC office. You can find your local office at adrcoforegon.org/consumersite/connect/

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."

Resources and publications

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

You do not need to give your Medicare number to receive plan information from a licensed insurance agent. However, you will need to provide it to enroll in a plan.

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: **oregon.benefitscheckup.org**
- Health Insurance Marketplace: **healthcare.gov**
- Division of Financial Regulation: **dfr.oregon.gov**
- Social Security Administration: **ssa.gov**

Tips

In 2026, Medicare covers the COVID-19 vaccine at no cost. Contact Medicare or your plan for more information or go to **medicare.gov/coverage/coronavirus-disease-2019-covid-19-vaccine**

Helpful phone numbers

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

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

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

Acentra Health (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. to 7 p.m., Monday through Friday) **800-772-1213**

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

Acronyms

ABN . . . . . Advance Beneficiary Notice

ACA. . . . . Affordable Care Act

ACL/HHS Administration for Community Living /Health and Human Services

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

FDA. . . . . Food and Drug Administration

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

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

PDP. . . . . Prescription drug plan

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

PHSA. . . . . Public Health Service Act

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

TTY . . . . . Teletypewriter

VA . . . . . Veterans' Affairs

VSO . . . . . Veterans Service Officer

5 tips for using Medicare

1. Create your secure Medicare account
2. **Give Medicare permission to talk to someone you trust**
3. Find out if you qualify for help with costs
4. **Go digital**
5. Get your free "Welcome to Medicare" visit

medicare.gov/basics/get-started-with-medicare/using-medicare/5-tips-for-using-medicare

Glossary

ABN (Advance Beneficiary Notice):
A notice given to people with Medicare that shows the cost of an item or service that Medicare might not pay for.

AEP (Annual Enrollment Period):
The time from Oct. 15 to Dec. 7 when people with Medicare can join or leave a Part D drug plan or a Medicare Advantage plan. Changes start on Jan. 1. Also known as “Fall Open Enrollment” or Open Enrollment Period (OEP).

Alternative care:
Health care practices like homeopathy, naturopathy, chiropractic, and herbal medicine that might not follow usual medical methods.

Annual physical exam:
A yearly check-up with your doctor to assess your overall health. This exam may include tests for weight, blood pressure, and cholesterol. Note that Medicare does not cover this expense.

Areas:
How a Medigap insurance company sets premium rates across the state. They may divide the state into different areas (by ZIP code), with each area having its own premium rate.

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

Attained age:
Insurance policies where the cost goes up as you get older.

Basic drug plan:
A Medicare Part D plan that might have a lower or no deductible. It can use different copayments or coinsurance levels and may adjust the initial coverage limit. It still provides the same overall value as the standard benefit.

Beneficiary:
A person who gets payments for medical services from an insurance company.

Benefit period:
The time during which benefits are paid. For example, if you are hospitalized and have Original Medicare Part A, the benefit period starts on the first day you're in the hospital. It ends when you've been out of the hospital or a skilled nursing facility for 60 straight days.

Benefits:
Items covered by an insurance plan.

Birthday rule:
In Oregon, if you already have a Medigap policy, you get a 60-day period to shop around for better prices starting 30 days before your birthday. You can compare prices for the same or lesser Medigap benefits.

Catastrophic coverage:
The maximum amount you pay out of pocket before your health plan starts covering most or all of your copayments.

CHAMPVA:
A health program for veterans and their families.

Chronic:
A long-lasting and recurring health issue. A person with a chronic condition is not expected to fully recover or significantly improve.

Claim:
A request for payment for medical services under an insurance policy, usually made by a healthcare provider or the insured person.

CMS (Centers for Medicare and Medicaid Services):
A part of the U.S. Department of Health and Human Services that runs the Medicare and Medicaid programs.

COBRA (Consolidated Omnibus Budget Reconciliation Act):
A law that lets you keep your health insurance after you leave a job.

Coinsurance:
A set percentage you pay for each medical service or prescription.

Community rating:
A way of setting Medigap policy prices where everyone pays the same rate, no matter their age or health.

Copayment or copay:
A fixed amount you pay for each service or prescription.

Creditable coverage:
Prescription drug insurance that is as good as or better than Medicare's drug coverage.

Deductible:
The amount you have to pay for covered services before your insurance, including Medicare, starts paying.

Diagnostic tests:
Tests that a doctor orders to help diagnose a condition when you have symptoms.

Direct bill:
A way to pay your insurance premium directly to the insurance company. They send you a bill or a coupon book to collect the payment.

Disenrollment:
Canceling your enrollment in a health plan.

DME (durable medical equipment):
Medically necessary equipment prescribed by a doctor for use at home, like oxygen equipment, wheelchairs, and other essential items.

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

Effective date:
The date when your insurance policy starts and coverage begins.

EFT (electronic funds transfer):
Moving money from one account to another using a computer. It's also called "AFT" (Automatic Funds Transfer).

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

Election period:
The time when you can join or leave Medicare, a Medicare Advantage plan, or a prescription drug plan.

Equitable relief:
Federal employees must provide correct and complete information. If they give wrong or incomplete information that causes harm (like delayed benefits or penalties), and the client has proof of the contact, the agency must fix the problem under the equitable relief rule.

Enhanced drug plan:
A Medicare Part D plan that offers more value than the standard coverage. It includes basic prescription drug coverage and extra benefits like lower costs in the coverage gap, reduced or no deductible, lower coinsurance or copayments during the initial coverage phase, a higher initial coverage limit, and additional drugs.

Enrollee:
A person who gets benefits from an insurance plan. Sometimes called "member" by insurance plans.

EOC (evidence of coverage):
A document from your insurance plan that explains what is covered, how much you pay, and other important details. It's also called a "Certificate of Benefits."

ESRD (end-stage renal disease):
A condition where the kidneys no longer work, requiring dialysis or a transplant.

Excess charge:
The amount you might have to pay if your doctor charges more than the Medicare-approved amount. This extra charge can't be more than 15% above the Medicare-approved amount. It's also called a "limiting charge."

Extra Help:
A Medicare program that helps people with limited income and resources pay for Medicare prescription drug costs, like premiums, deductibles, and coinsurance. It's also called "LIS" (Low-Income Subsidy).

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

Fee for service:
Original Medicare pays healthcare providers for each service they provide, like office visits, tests, or procedures, based on what they consider medically necessary.

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

GEP (general enrollment period):
The time from January 1 to March 31 each year when people can sign up for Medicare Part A or Part B if they didn't do it when they first could. They can also sign up again if they stopped their Part A or Part B benefits. Coverage starts the month after you enroll.

GI (guaranteed issue):
A Medigap insurance company cannot refuse to sell you a policy due to pre-existing conditions, nor can they charge you more because of your past or current health issues.

HMO (health maintenance organization):
A Medicare Advantage plan where you must get care from the plan's network of providers. You might need referrals from your primary care doctor to see specialists.

IEP (initial enrollment period):
A seven-month period around your 65th birthday when you can sign up for Medicare. It includes the three months before your birthday month, your birthday month, and the three months after.

Inpatient care:
Care given to someone admitted to a hospital or other medical facility.

Institutional care:
Care given in a hospital, skilled or intermediate nursing home, or other state-certified or licensed facility. This care includes diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services.

Issue age:
Insurance policies where premiums are based on your age when you buy the policy. The premiums won't go up just because you get older, but they might increase for other reasons.

Late enrollment penalty:
An extra amount added to your Medicare premium if you don't sign up when first eligible.

Lifetime reserve days:
After Medicare covers 90 days of hospitalization, you get 60 extra days. These extra days can only be used once and do not renew.

Limiting charge:
Go to "**Excess charge**."

LIS (Low or Limited Income Subsidy):
A program run by the Social Security Administration that offers Extra Help with prescription drug costs for people who meet income and asset requirements. See "**Extra Help**" for more details.

Look-back:
Go to "**Waiting period**."

LTC (long-term care):
Services that help with the health, medical, personal, and social needs of people with long-term illnesses, disabilities, or cognitive disorders like Alzheimer's. LTC services can include skilled nursing care in a nursing home, in-home health and personal care, assisted living, adult day care, and other options. Medicare does not cover LTC.

MA (Medicare Advantage):
These plans provide your Medicare benefits through private companies that manage your care. Medicare pays these companies a set amount per person, and you pay part of the costs through copays, coinsurance, deductibles, and premiums. These plans are also known as “managed care,” or “Part C.”

MA-OEP (Medicare Advantage open enrollment period):
From January 1 to March 31 each year. During this time, people in a Medicare Advantage (MA) plan, including those newly eligible, can switch to another MA plan or go back to Original Medicare.

MAPD (Medicare Advantage with Prescription Drug coverage):
A Medicare Advantage plan that includes drug coverage.

Medicaid:
A federal-state program that helps ensure older, sick, and low-income people in America get the care they need. It provides medical services to those who fall below the state-established poverty line. There are strict income and asset guidelines to qualify. In Oregon, Medicaid programs include the “Medicare Savings Program,” “Medical Assistance (MA),” “Title 19 (XIX),” and the Oregon Health Plan.

Medically necessary:
Services or supplies needed to diagnose or treat a medical condition, following standard medical practices. Also called “reasonable and necessary.”

Medigap:
A policy from private companies that helps cover health care costs not paid by Original Medicare, like copayments, coinsurance, and deductibles. Plans are standardized and named by letters A–N. Plans with the same letter offer the same coverage, but premiums may vary by company.

Medigap Open Enrollment Period (OEP):
A six-month period starting the month you first enroll in Part B. During this time, a Medigap company must sell you a policy, no matter your health status.

MOOP (maximum out of pocket):
The most money an MA plan member has to pay for deductibles, copays, and coinsurance in a calendar year.

MSP (Medicare Savings Program):
A federal-state partnership that helps Medicare beneficiaries with out-of-pocket costs like deductibles, copays, and coinsurance.

ODHS (Oregon Department of Human Services):
The state agency that provides services for aging and disabled people.

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

PDP (prescription drug plan):
Adds prescription drug coverage to Original Medicare. It can be a stand-alone plan or part of a Medicare Advantage plan. Also called “Part D.”

POS (point of service):
An option in some HMO plans that lets you use doctors outside the plan for an extra cost.

PPO (preferred provider organization):
A Medicare Advantage plan where you pay less if you use doctors, hospitals, and providers in the network. Using providers outside the network may cost more.

Pre-existing condition:
A medical condition that was diagnosed, treated, or needed to be treated before you bought an insurance policy.

Preferred drug list:
A list of prescription drugs that is preferred by a plan. Drugs not on a plan's preferred drug list may require extra authorization.

Preferred pharmacy:
A pharmacy that has an agreement with an insurance plan to offer lower costs for covered prescription drugs. Out-of-pocket costs may be lower for these drugs.

Premium:
The monthly cost of an insurance plan.

Prescription drug:
A drug that requires a doctor's written order.

Preventive care:
Health care that helps keep people from getting sick, like checkups, mammograms, vaccines, and tests.

Prior authorization:
Approval needed from the insurance plan before filling a prescription. If a drug requires prior authorization, you must work with the plan and your doctor to get approval before the pharmacy can provide the medication. Check the plan's website for specific requirements and forms.

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

Provider Accepted Assignment:
If your doctor accepts assignment, your out-of-pocket costs may be lower. The doctor will only charge you the Medicare deductible and coinsurance amount after Medicare pays its share of the cost.

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

QMB (Qualified Medicare Beneficiary):
A program that helps pay for Medicare Part B premiums, as well as Medicare Part A and Part B deductibles and coinsurances. It's a partnership between the federal and state governments. Your local Aging and People with Disabilities office decides if you qualify based on your income and assets.

Quantity limits:
The limit a plan may place on the amount of covered drugs you can get over a certain period. If a drug has a quantity limit, contact the plan for details. For example, if you take one pill per day and the limit is 30 pills per month, you may only refill a few days before running out. If you need more than the limit, work with the plan to get approval.

Referral:
A written order from your primary care doctor to see a specialist or get certain medical services. In many HMOs, you need a referral to get care from anyone other than your primary doctor. Without a referral, the claim may not be paid.

Reserve days:
Go to "**Lifetime reserve days**."

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

Rx:
An abbreviation for prescription.

Screening tests:
Tests that help find a disease early, even when there are no obvious signs or symptoms.

SEP (special enrollment period):
A time when you can join or leave a plan outside regular enrollment periods.

Service area:
The geographic area that an insurance plan covers.

SHIBA (Senior Health Insurance Benefits Assistance):
Oregon's program with certified counselors who educate, assist, and advocate for Medicare beneficiaries about their health insurance rights and options, helping them make informed choices.

SHIP (State Health Insurance Assistance Program):
A nationwide program offering local one-on-one counseling and assistance to people with Medicare and their families. Funded by ACL/HHS grants, SHIPs provide free help via phone, face-to-face sessions, public education, and media activities. SHIBA is Oregon's SHIP.

Skilled care:
Care for an illness or injury that needs the training and skills of a licensed professional, prescribed by a doctor, and is medically necessary.

SMB/SMF (Specified Low-Income Beneficiary):
A program that helps pay for Medicare Part B premiums. It's a partnership between the federal and state governments. Your local Aging and People with Disabilities office decides if you qualify based on your income and assets.

SMP (Senior Medicare Patrol):
A national volunteer group that helps seniors learn about health care fraud, errors, and abuse, and helps resolve complaints.

SNF (skilled nursing facility):
A place where licensed health care professionals provide medically necessary care, as prescribed by a doctor.

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

Specialist:
A doctor who provides expert care in a specific area, like a surgeon, oncologist, dermatologist, or allergist.

SSI (Supplemental Security Income):
Monthly payments from Social Security to people with limited income and resources who have disabilities, are blind, or are 65 or older. This money helps them pay for basic needs like food, clothing, and shelter.

SSA (Social Security Administration):
The government agency that runs Social Security.

SSDI (Social Security Disability Insurance):
Monthly payments from Social Security for people who can't work due to a disability.

Stand-alone drug plan:
Go to "**PDP**."

Supplement insurance:
Private health insurance that pays for medical costs after Medicare. Also called "Medigap."

Suppressed:
Medicare plans that don't show up on the Medicare Plan Finder until corrected.

Step therapy:
Sometimes, your plan will make you try a cheaper drug first before they cover a more expensive one. For example, if both Drug A and Drug B can treat your condition, the plan might require your doctor to prescribe Drug A first. If Drug A doesn't work, then the plan will cover Drug B. If a drug has step therapy rules, you and your doctor will need to work with the plan to get an exception.

Tier:
Pricing levels for prescription drug plans. Each drug is placed in a tier based on its type and cost. The lowest copayment is for generic drugs, followed by brand-name drugs on the plan's list.

Total drug costs:
The full price of prescription medicines, including what you pay and what your drug plan pays.

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

TRICARE:
Health insurance for active-duty military personnel.

TRICARE For Life:
Health insurance for retired military personnel.

TTY (teletypewriter):
A service that helps people using TTYs (teletypewriters) to make phone calls. Specially trained agents help complete the calls and relay messages between TTY users and hearing people. This service is available 24/7 with no limits on call length or number of calls. It's also called "TDD" (Telecommunications Device for the Deaf).

Underwriting:
The process an insurance company uses to decide if they will accept your application for insurance and under what terms.

Waiting period:
The time you have to wait before your health insurance starts paying benefits or covering pre-existing conditions and specific illnesses.

Work credit:
Credits are earned when you work and pay Social Security taxes. 40 Social Security credits must be earned to be eligible for Social Security benefits.

Notes

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SHIBA
Senior Health Insurance Benefits Assistance

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OREGON DEPARTMENT OF
Human Services
Aging and People with Disabilities

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