WILLOW VALLEY COMMUNITIES

Medical Insurance Review and Willow Valley Communities Lifecare Agreement

Residents often have questions about how their *Willow Valley Communities (WVC) Resident's Agreement* and their current medical insurance plans apply to Supportive Living. Since individual Resident contracts and medical insurance plans vary, it is important to read your *WVC Resident's Agreement* and medical insurance plans to review what type of accommodations, medical supplies, and prescription drugs are covered if you were to enter Supportive Living.

The *WVC Resident's Agreement* requires Residents to carry Medicare Part A and Part B coverage, or insurance coverage with equivalent benefits. WVC also requires Residents to carry a Medigap plan with a rating of "C" or higher (a Medigap plan is also referred to as a Medicare Supplement Plan).

Medicare Advantage Plans, sometimes referred to as Medicare Part "C", may initially look inexpensive and usually have smaller monthly premiums, but often have little or no coverage in skilled nursing care settings. Each Advantage Plan is different; if you have an Advantage Plan, please read the fine print for requirements regarding co-pays and deductibles. In addition, you should confirm if WVC is considered an "in-network" provider with your Advantage Plan. Your *WVC Resident's Agreement* does NOT cover these co-pays and deductibles when you are receiving Medicare qualified benefits in Skilled Care.

Willow Valley Communities cautions Residents who have Medicare Advantage Plans because if their plan is not "in-network," the Resident could experience high out-of-pocket expenses when living in Skilled Care.

Lifecare and the Resident's Agreement

In Personal Care, basic room accommodations (additional costs may be incurred for upgraded rooms), meals, and nursing care are covered by your *WVC Resident's Agreement*. Please note that Medicare Part A does not pay for any part of a stay in Personal Care. Medicare Part B may cover such things as outpatient procedures, outpatient therapy, physician appointments, medical equipment, or oxygen while you are in Personal Care.

In Skilled Care, when Medicare Part A coverage is <u>not</u> applied, the *WVC Resident's Agreement* covers basic room accommodations (additional costs apply for upgraded rooms), meals, and nursing care. If you are admitted to Skilled Care and have not had a three night qualifying hospital stay (three consecutive overnights in the hospital), you are not eligible to receive Medicare Part A Skilled Care coverage. In cases such as this, your WVC *Resident's Agreement* coverage would apply. Please note, Individual *Resident Agreements* reflect the amount of coverage, if any, provided for medical supplies and prescription medications during temporary admissions or permanent transfers in Skilled Care.

Medicare Coverage

If you are <u>admitted</u> to the hospital and have a three night qualifying stay, and are then in need of Skilled Care, Medicare Part A would cover up to 100 days per illness. For days 1 through 20, Medicare Part A pays in full. For days 21 through 100, there is a mandatory co-pay, currently $204 per day (2024 rate), applies if the required insurance is not carried. This is why Willow Valley Communities require Residents to maintain a Medigap Plan with a rating of "C" or higher.

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If, after several days, weeks, or months in Skilled Care, you no longer meet the criteria for Medicare Part A, you will be notified that Medicare A will no longer cover your stay. At that point, your *WVC Lifecare* coverage would apply. Please refer to your *WVC Resident's Agreement* to familiarize yourself with the accommodations and supplies that are covered. One of the benefits of being covered by Medicare Part A is that Medicare will pay for all of your prescription medications during a Medicare Part A qualified stay in Supportive Living. When your stay is no longer Medicare Part A qualifying, it is your responsibility to pay out-of-pocket for prescription medications, unless:

- You participate in a prescription drug insurance plan. PharMerica, our contracted pharmacy, works with most prescription drug insurance plans. Your specific coverage will determine your out-of-pocket expenses.

We encourage you to contact your insurance carrier to verify this information as it applies to your specific policy. You will need to ask the following questions:

- Does my (our) insurance policy cover the Medicare coinsurance of $204 per day for days 21-100 in 2024?
- Does my (our) insurance policy cover outpatient physical, occupational, and speech therapy?
- Is my (our) insurance contracted with Willow Valley Communities to provide outpatient physical, occupational, and speech therapy?
- What is the deductible amount for which I/we am/are responsible prior to my insurance paying for any services?
- What is my (our) maximum annual "out of pocket expense"?

Attached is a glossary of terms and information that you may find useful as you speak to your insurance carrier. You may find additional information at www.medicare.gov or you may call 1.800.Medicare or 1.800.633.4227.

GLOSSARY OF INSURANCE TERMS

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or Skilled Care in a SNF) for 60 days in a row. If you go into the hospital or a SNF after one benefit period has ended, a new benefit begins. If you are in the Original Medicare Plan, you must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefits periods you can have.

Coinsurance - The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Co-payment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A co-payment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Co-payments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible - The amount you must pay for health care or prescriptions, before Medicare or your prescription drug plan begins to pay. For example, either for each benefits period for Part A, or each year for Part B. These amounts can change every year.

Medically Necessary - Services or supplies that:

- Are proper and needed for the diagnosis or treatment of your medical condition;
- Are provided for the diagnosis, direct care, and treatment of your medical condition;
- Meet the standards of good medical practice in the local area; and
- Are not mainly for the convenience of you or your doctor.

Medicare-approved Amount - In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. There are 12 standardized plans labeled Plan A through Plan L, except in Massachusetts, Minnesota, and Wisconsin. These states have different standardized plans. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you cannot be denied coverage or charged more due to past or present health problems.

Original Medicare Plan - A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more that the Medicare-approved amount. The Original Medicare Plan has Part A (Hospital Insurance) and Part B (Medical Insurance).

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Skilled Nursing Facility Care - A level of care that requires the daily involvement of skilled nursing or rehabilitation staff and cannot be done on an outpatient basis. Examples of skilled nursing care include getting intravenous injections and physical therapy. A need for custodial care, such as help with bathing and dressing, cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for skilled nursing or rehabilitation care, Medicare covers the majority of your care needs in the facility.

Skilled Nursing Facility - A nursing facility with the staff and equipment to give skilled nursing care and/or other related health services.

WILLOW VALLEY COMMUNITIES

Medical Insurance Responsibility Form

The *Willow Valley Communities (WVC) Resident's Agreement* requires Residents to carry Medicare Part A and Part B coverage, or insurance coverage with equivalent benefits. WVC also requires Residents to carry a Medigap plan (rating of C or higher). A Medigap plan is sometimes also referred to as a Medicare Supplemental Plan.

An alternative to Medicare A and B is a "Medicare Advantage Plan". Medicare Advantage Plans, sometimes referred to as Medicare Part "C", may initially look inexpensive and usually have smaller monthly premiums, but often have little or no coverage in skilled nursing care settings. Each Advantage Plan is different; if you have an Advantage Plan, please read the fine print for requirements regarding co-pays and deductibles. In addition, you should confirm if WVC is considered an "in-network" provider with your Advantage Plan. Your *WVC Resident's Agreement* does NOT cover these co-pays and deductibles when you are receiving Medicare qualified benefits in Skilled Care. WVC cautions those who have Medicare Advantage Plans because if their plan is not "in-network," they could have high out-of-pocket expenses when in Skilled Care.

Medicare Part A covers hospital stays and a limited number of days in a Skilled Nursing Facility for those who meet the Medicare requirements. Medicare B covers medical services that are outpatient related, including, but not limited to, physical, occupational and speech therapy, medical supplies, clinical lab services, etc.

WVC also requires Residents to carry a Medigap plan with a rating of "C" or higher, as rated by the Commonwealth of Pennsylvania. A Medigap plan is sometimes also referred to as a Medicare Supplemental Plan. Medigap plans are rated with the letters of the alphabet (A – N). A plan rating of "C" or higher is required, as these plans cover the Skilled Nursing Facility coinsurance.

When a Resident is in a Skilled Nursing Facility under Medicare Part A, he/she may be responsible for a daily coinsurance if the required insurance coverage is not carried. The requirement for Residents to maintain a Medigap plan with a rating of "C" or higher may offset all or part of this coinsurance amount. The *Willow Valley Communities Resident's Agreement* does <u>not</u> cover the payment of the coinsurance.

Medicare offers prescription drug coverage to everyone eligible for Medicare. Medicare Prescription Drug coverage, also referred to as Medicare Part D, is an outpatient prescription drug plan. At WVC, the expense of prescription drugs is the responsibility of the Resident.

The ability to control Resident fees at Willow Valley Communities is dependent on a variety of actuarial projections of revenue. Among these revenue sources is reimbursement for eligible services provided to Lifecare Residents. For this reason, compliance on the part of every Resident with Medicare and Medigap insurance requirements is extremely important to the overall operation of the community. All insurance coverage discussed above must be maintained throughout residency at Willow Valley Communities. You should contact your insurance carrier to verify this information as it applies to your specific policies.

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The above information is an accurate statement of my health and medical insurance. I verify that I have read and understand my responsibilities as outlined in this Medical Insurance Responsibility Form.

Signature(s)

1. _____ **Date:** _____

2. _____ **Date:** _____