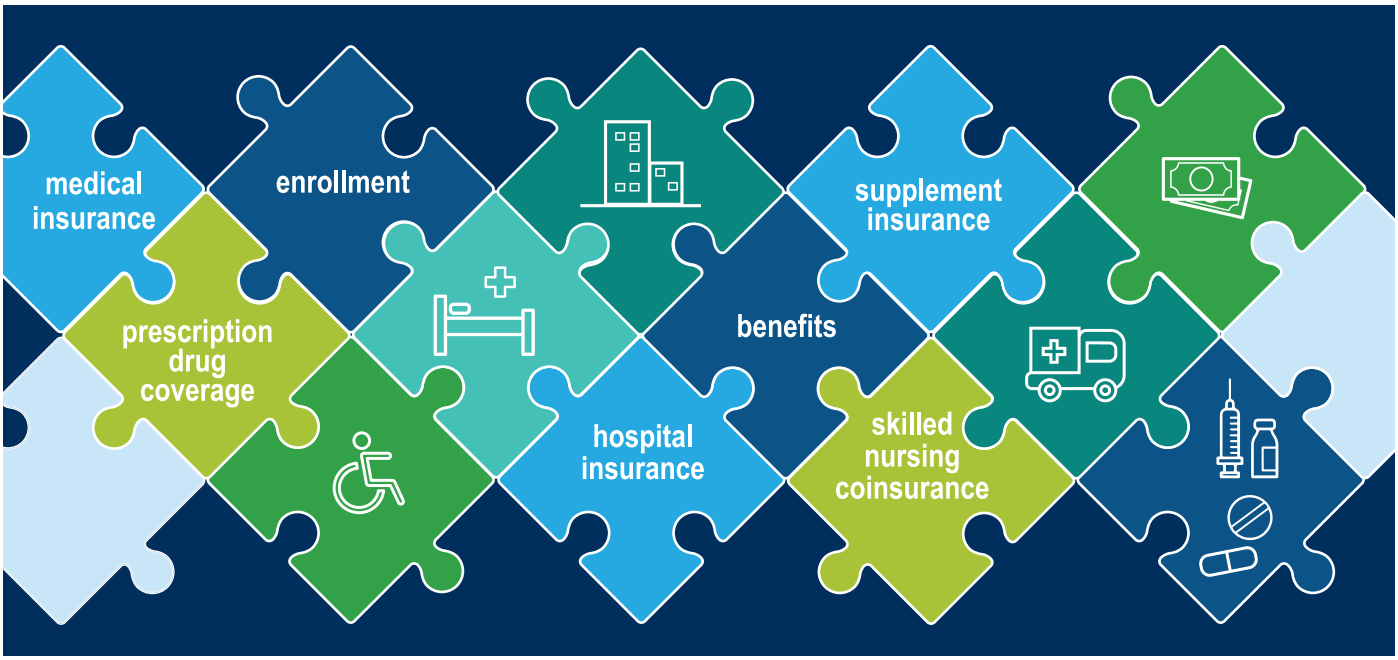
IDoA
Illinois Department on Aging

2025

MEDICARE CHOICES

Because the best choice is an educated choice



SHIP
State Health Insurance Assistance Program

Senior Health Insurance Program
Illinois Department on Aging

SMP
Senior Medicare Patrol

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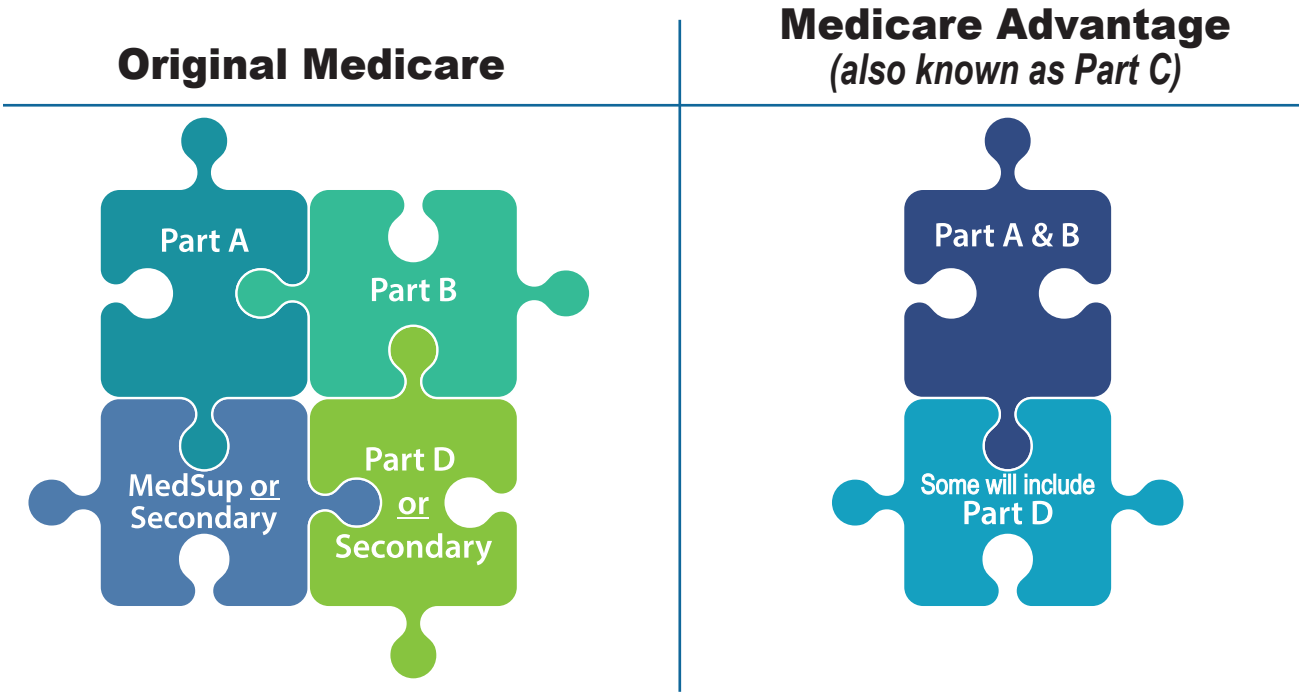
IMPORTANT PHONE NUMBERS

IL Department on Aging Senior Health Insurance Program (SHIP)	1-800-252-8966; 711 (TRS)	Free Medicare counseling; Aging-related information and referral services
Social Security Administration	1-800-772-1213	Medicare eligibility and enrollment
Medicare (24 hours/day, 7 days/week)	(1-800-MEDICARE) 1-800-633-4227	Medicare claims, appeals, drug plan information
Office of Consumer Health Insurance (OCHI)	1-877-527-9431	Consumer complaints, information and referral services
Healthcare & Family Services Health Benefits Hotline	1-800-226-0768	Medicaid questions
Illinois Senior Medicare Patrol (AgeOptions)	1-800-699-9043 (ask for "SMP")	The Senior Medicare Patrol (SMP) Free Hotline to report Medicare fraud

HOW TO USE THIS GUIDE

This guide is made available to beneficiaries by the Illinois Department on Aging SHIP (Senior Health Insurance Program). SHIP Counselors are people who objectively counsel Medicare beneficiaries, their caregivers or representatives who have problems and/or questions with Medicare, Medicare Supplement, Medicare managed care or other insurance related questions. This guide is here to break down the pieces of Medicare and help beneficiaries understand what the differences are between Original Medicare (Parts A and B), Medicare Advantage plans (Part C), Prescription Drug Plans (Part D) and Medicare Supplement plans also sometimes called Medigap plans.

THE PIECES OF MEDICARE



Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care following a hospital stay
- Hospice care
- Home health care

Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits—you typically pay 20% of the Medicare approved amounts for most of these services.)

Additional Coverage

Part D (Drug coverage): Helps cover the cost of prescription drugs (including many recommended shots or vaccines). Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

Medicare Supplement Policy also known as Medigap: A Medicare supplement policy is insurance coverage sold by a private insurance company designed to pay the major benefit gaps in Original Medicare, such as deductibles and copayments.

Medicare Advantage (also known as Part C): Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D and may include additional benefits such as vision, hearing and dental. In some cases, you'll need to use doctors who are in the plan's network.

Who is Eligible for Medicare?

Generally, a person is eligible for Medicare if they are:

a. age 65 years or older; and
b. Persons deemed disabled by the Social Security Administration
   - Persons become eligible after the 24th month.
c. End-Stage Renal Disease (ESRD)
d. ALS (Lou Gehrig's Disease)
e. a U.S. Citizen or a lawfully admitted non-citizen with 5 years continuous residence at time of filing.

Enrollment into Medicare is automatic for those receiving Social Security benefits or Railroad Retirement Board benefits.

The initial enrollment packet for auto enrollees will be mailed 3 months before the person turns 65 or on the 25th month of disability.

There are many people who do not receive benefits from Social Security or RRB, such as people who have not reached their full SSA retirement age, are still working and have employer group health coverage or certain retired municipal employees. These people are **not automatically** enrolled and will need to contact SSA or RRB to sign up for Part A and/or Part B to enroll during one of the enrollment periods.

NOTE* If a person does not want to be enrolled into Medicare Part B, they should follow the instructions that come with the card and send back the form to delay enrollment. Should they keep the card, Medicare Part B will begin on their eligibility month and premiums will be charged.

ENROLLMENT PERIODS

- Enrollment and/or changes to Medicare are limited to certain times.
- You can't always sign up when you want, so it is important to know when you can enroll in different parts of Medicare.
- Medicare has specific types of enrollment periods.

Initial Enrollment Period (IEP)

The Initial Enrollment Period is a seven-month period when beneficiaries can enroll into Medicare A & B, Part C (if have Part A and Part B), or Part D (if have Part A and/or Part B). It is known as the **3-1-3 rule**.

- 3 months prior to the 65th birthday (or 25th month of disability payment); or
- Month of the 65th birthday (or 25th month of disability payment); and
- 3 months after the 65th birthday (or 25th month of disability payment).

Example:

Birth Month = July						
Apr	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**
Coverage begins 1st day of July	Coverage begins 1st day of July	Coverage begins 1st day of July	**Coverage begins 1st day of August**	Coverage begins 1st day of September	Coverage begins 1st day of October	Coverage begins 1st day of November
Individual must be enrolled by the end of Oct. or they will have to wait until the General Enrollment Period (GEP) to enroll unless they qualify for a SEP. If using the GEP, coverage begins the 1st day of the month following enrollment.						

Deferring Part B Enrollment Due to Current Employment Health Coverage

Some people do not take Part B during their Initial Enrollment Period (IEP) because they, or their spouse, are still working and have primary health insurance from a current employer (20 or more employees). They should always talk to their employer's Human Resources (HR) or health benefit advisor to see how their employer insurance will work with Medicare.

If an individual works for a small employer (fewer than 20 employees) and has an Employer Group Health Plan (EGHP), they typically need to take Medicare when they first qualify. Health care coverage from small employers pays secondary to Medicare. The employer will normally advise the individual that they "must" enroll in Medicare to continue their EGHP. This means that if they fail to enroll in Medicare when they are first eligible, they may have no health coverage.

General Enrollment Period (GEP)

If you do not sign up for Parts A and/or B during your Initial Enrollment Period (IEP) or any available Special Enrollment Period (SEP) you may use the General Enrollment Period (GEP) to enroll.

- You may have to pay a lifetime late enrollment penalty if you did not sign up during the IEP and use the GEP.

The effective date for enrollment into Medicare Parts A and B in the GEP is the month following the month of enrollment.

Special Enrollment Period (SEP)

A beneficiary can enroll or make changes to their Medicare coverage when certain special circumstances or events happen in their life. These chances to make changes are called Special Enrollment Periods. Rules about when they can make changes and the type of changes they can make are different for each SEP.

Some examples:

- Loss of active employment health insurance coverage
- SEP for Individuals Impacted by an Emergency or Disaster
- SEP for Health Plan or Employer Misrepresentation or Incorrect Information
- SEP for Formerly Incarcerated Individuals
- SEP to Coordinate with Termination of Medicaid Coverage
- SEP for Other Exceptional Circumstances

For a full list of SEP's https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods

Annual Open Enrollment Period

October 15 – December 7

Medicare health (Part C) and drug plans (Part D) can make changes each year – due to things like cost, coverage, and what providers and pharmacies are in their networks. October 15 to December 7 is when all people with Medicare can change their Medicare health plans and prescription drug coverage for the following year to better meet their needs.

People in a Medicare health or prescription drug plan should always review the materials their plans send them, like the "Evidence of Coverage" (EOC) and "Annual Notice of Change" (ANOC). If their plans are changing, they should make sure their plans will still meet their needs for the following year. If they're satisfied that their current plans will meet their needs for next year and it's still being offered, they don't need to do anything.

MEDICARE SAVINGS PROGRAM

The Medicare Savings Program assists with Medicare costs for those with limited income and savings. Qualifying for an MSP stops the deduction of Medicare Part B premiums from Social Security checks and enrolls you in Extra Help for Part D prescription drug costs. Enrollment is based on income, assets, and application details.

Your monthly income needs to be less than ($1,761 individual) ($2,380 couple) and have no more than ($9,660 individual) ($14,470 couple) in resources/assets

To learn more about the Medicare Savings Program (MSP) and how to apply contact a SHIP counselor in your area.

You can apply at: https://abe.illinois.gov/abe/access/

Reference: https://www.medicare.gov/medicare-savings-programs

MEDICARE ENROLLMENT PERIODS QUICK CHART

<table>
<tr><th>Part A & B (Original Medicare)</th><th>Medigap/Medicare Supplement</th><th>Part C (Advantage)</th><th>Part D (Prescription Drugs)</th></tr>
<tr><td>Medicare Initial Enrollment Period (IEP)
7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare</td><td>Medigap Open Enrollment Period (OEP) for guaranteed issue
One-time 6-month window after a person first enrolls in Part B</td><td>Medicare Initial Enrollment Period (IEP)
7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare</td><td>Medicare Initial Enrollment Period (IEP)
7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare</td></tr>
<tr><td>General Enrollment Period (GEP)
(If missed IEP)
Jan 1- Mar 31</td><td rowspan="2">A person on Medicare age 65 and above can purchase or change Medigap policies at any time, but it is <u>not</u> guaranteed that the company will issue one.
In Illinois, an additional Medigap guaranteed Special Enrollment Period, for people on Medicare due to disability, is available. This protection exists for those individuals who did not purchase a Medigap during their initial Medigap Open Enrollment Period when they first went on Medicare Part B.
Beneficiaries under 65 & on Medicare due to disability do not have the same right as the Age 65 people above BUT have a Medigap Special Enrollment Period (SEP) (Oct 15-Dec 7) an Illinois guaranteed Issue Company.</td><td>If use GEP,
Can sign up for Part C at the same time you sign up for Part B and extends for 2 months after Part B begins</td><td>If use GEP,
Can sign up for Part D at the same time you sign up for Part B & extends for 2 months after Part B begins</td></tr>
<tr><td></td><td>Medicare Annual Open Enrollment Period
(AOEP) for Parts C & D
Oct 15 – Dec 7</td><td>Medicare Annual Open Enrollment Period
(AOEP) for Parts C & D
Oct 15 – Dec 7</td></tr>
<tr><td></td><td></td><td>Medicare Advantage Open Enrollment Period
(MA-OEP)
<u>One-time change</u> between January 1- March 31. Must already be enrolled in a MA plan on Jan 1st. Can switch to a different MA Plan, with or without drug coverage. Can return to Original Medicare and enroll in Part D. <u>Cannot</u> switch from one PDP to another.</td><td></td></tr>
<tr><td>Special Enrollment Period (SEP)
Granted by Medicare in certain situations</td><td>Note: May have Special Rights and Guaranteed Issue Rules</td><td>Special Enrollment Period (SEP)
Granted by Medicare in certain situations</td><td>Special Enrollment Period (SEP)
Granted by Medicare in certain situations</td></tr>
</table>

Note: if you do not sign up during the IEP, coverage may be delayed, and lifetime late penalties may apply.

2025 ORIGINAL MEDICARE PART A & B BASIC COSTS

Monthly Part A and Part B Costs	
Part A Costs	
Part A Monthly Premium for beneficiaries with 40 quarters of coverage	$0.00
Part A Monthly Premium for beneficiaries with 30-39 quarters of coverage	$285.00
Part A Monthly Premium for beneficiaries with less than 30 quarters of coverage	$518.00

Contact Social Security by phone or by creating a My Social Security account https://www.ssa.gov/ to find out if you are eligible for premium free Part A.

Beneficiaries 65 and older, and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium in order to voluntarily enroll in Medicare Part A. https://www.medicare.gov/basics/costs/medicare-costs

Part B Costs	
Part B Monthly Premium	$185.00
Part B Annual Deductible	$257.00
Part B Copays or Coinsurance	normally 20%
Part B Monthly Premium for 36-month post kidney transplant immunosuppressive drug eligibility	$110.40

If you are a Medicare beneficiary with a high annual income, your Medicare Part B premiums can be higher. This difference in premium reflects your Income Related Monthly Adjustment Amount (IRMAA).
https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles

Original Medicare Part A - Inpatient Hospital Insurance (Without Medigap or Secondary coverage)			
Service	**Benefit**	**Medicare Pays**	**Beneficiary Pays (Per Benefit Period)**
Inpatient Hospitalization Semi–private room and board, general nursing, inpatient drugs and miscellaneous hospital services and supplies *(You begin a new Part A benefit period after you have been home for 60 consecutive days.)*	First 60 days	All but $1,676.00	**$1,676.00**
	61st to 90th day	All but $419.00 a day	**$419.00** a day
	Lifetime Reserve Days		
	91st to 150th day (these 60 reserve days may be used only once in your lifetime)	All but $838.00 a day	**$838.00** a day
	Beyond 150 days	Nothing	**All Costs**
Skilled Nursing Facility Care (SNF)* (Custodial care not covered)	First 20 days	Full cost of services	**Nothing**
	21st day through 100th day	All but $209.50 a day	**$209.50** a day
	Beyond 100 days	Nothing	**All costs**
Home Health Care (After a prior inpatient hospital stay; up to 100 visits)	Visits limited to medically necessary part-time skilled care of a homebound individual	Full cost of services (See Durable Medical Equipment)	**Nothing**
Hospice Care Available to terminally ill	Unlimited renewable benefit period	All but limited costs for outpatient drugs and inpatient respite care	$5.00 for each outpatient prescription drug and 5% of Medicare-approved amount for respite care
*Beneficiary must be hospitalized under Part A inpatient hospital coverage for at least three consecutive days for the same illness prior to admission to the Medicare–approved SNF.			

2025 Original Medicare (Part B): Medical (Without Medigap or Secondary coverage)			
Service	**Benefit**	**Medicare Pays**	**You Pay in 2025**
Medical Expenses	Physician's services, some diagnostic tests, physical and speech therapy, ambulance, etc.	80% of approved amount (after $257.00 deductible)	**$257.00** deductible* plus 20% of approved amount (plus any charge above approved amount) **
Home Health Care	Visits limited to medically necessary part–time skilled care of a homebound individual	Full cost of services (See Durable Medical Equipment)	**Nothing**
Outpatient Hospital Services	Medically necessary treatment such as outpatient surgery, diagnostic procedures, emergency room, etc.	A set amount for each specific procedure	Subject to deductible **plus copayment or coinsurance for each procedure**
Durable Medical Equipment (DME)	Medically necessary equipment and supplies such as walkers, wheelchairs, hospital beds, etc.	80% of approved amount (after **$257.00** deductible)	20% of approved amount plus **$257.00** deductible, plus charges above approved amount unless supplier accepts assignment

*Once you have had $257.00 of expenses for covered services, the Part B deductible is met for the rest of the calendar year.

** You pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as payment in full (accepts assignment). Excess charges for physician services cannot exceed 15% of the Medicare-approved amount.

Medicare Supplements

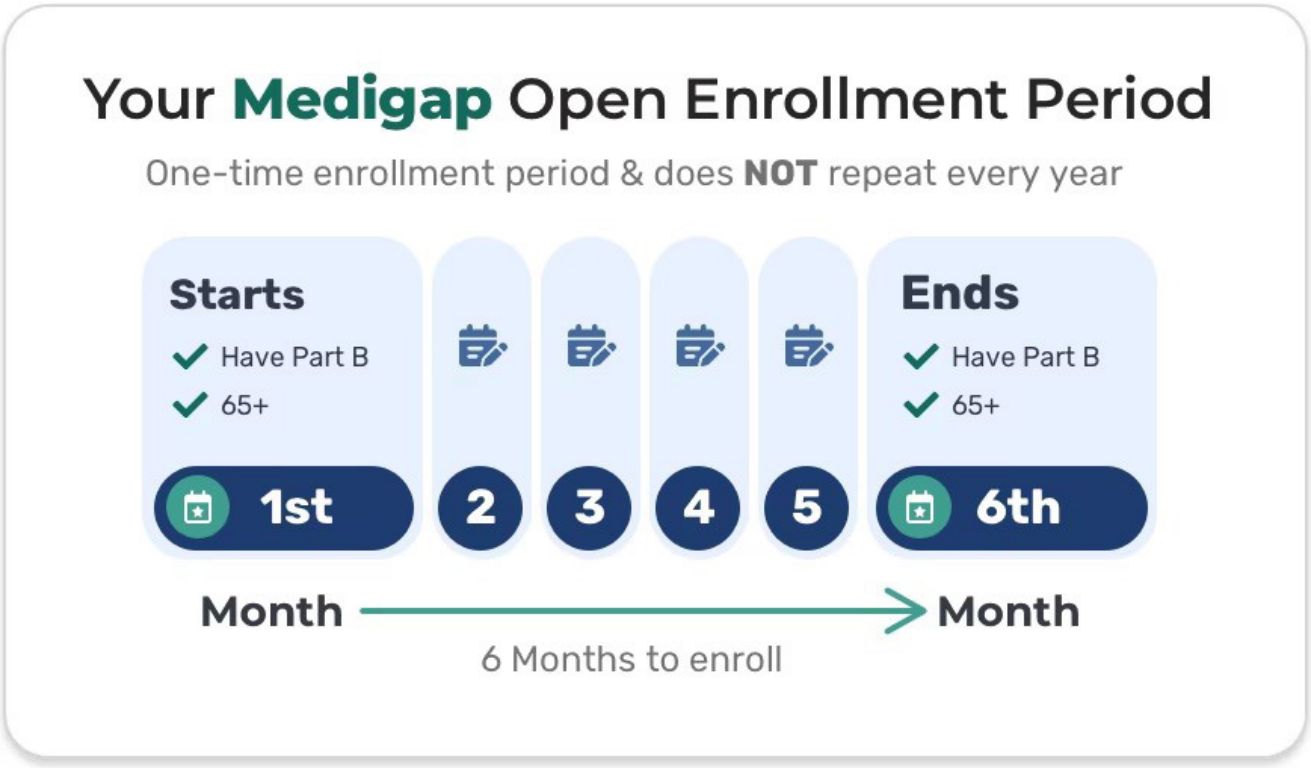
A Medicare supplement policy sometimes referred to as "Medigap" or "MedSup" is insurance coverage sold by a private insurance company designed to pay the major benefit gaps in Original Medicare, such as deductibles and copayments. A Medicare supplement is NOT managed care, such as an HMO, PPO, etc., or coverage provided by an employer. By law, all Medicare supplement plans currently available must follow a standardized benefit structure, but may offer enhanced benefits if approved by the Illinois Department of Insurance (IDOI). So, comparison for price is important! Not all insurance companies sell all plans.

Medigap law changed on June 1, 2010. Therefore, if you purchased a Medigap plan prior to June 1, 2010, your plan benefits may look different than the current benefits offered for sale today. You do NOT have to replace an older Medigap policy. You may keep your current Medigap policy and it will continue to pay benefits according to its policy guidelines. Medicare Supplement Plans A through N are currently being sold. Plan F and Plan G are also available as High-Deductible plans. Additionally, you may have the option of choosing a Medicare SELECT plan that requires you to use specific hospitals and doctors.

Medigap policies currently sold cannot contain prescription drug benefits because of Medicare's prescription drug coverage, Medicare Part D, which began in 2006. However, if you had a Medigap policy with prescription drug coverage prior to 2006, you may keep that policy. Medicare Part D coverage is provided through private insurance companies and/or Medicare Advantage plans offering prescription drugs.

Medigap Open Enrollment Period

Open enrollment period begins when first enrolled in Part B. There is a 6-month guaranteed issue period when insurance companies must sell a policy with no underwriting (cannot be denied coverage).



The IL Medigap "Birthday Law"

If an individual is at least 65 years of age, but no more than 75 years of age, and has an existing Medicare supplement policy the individual is entitled to a New Medicare Supplement Annual Open enrollment period. This New Medicare Supplement Annual Open Enrollment period begins on the individuals birthdate each year and lasts for 45 days. The individual may purchase any Medicare Supplement policy with the same company/issuer that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, if an individual currently has a Medicare supplement policy then the policy cannot deny or place conditions on the individual holding the policy or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual.

Example: Sam purchased a Medicare Supplement plan G when they turned 65, Sam is now turning 70 and feels that their supplement plan is getting too expensive. Because of the "Birthday Law" Sam can now purchase a lesser plan within their supplement company without underwriting. Sam has 45 days from their birthdate each year to purchase any Medicare Supplement policy with the same company/issuer that offers benefits equal to or lesser than those provided by the previous coverage. Sam discussed the options with a SHIP counselor and went with a Plan N.

Information for Disabled Individuals on Medicare:

In Illinois, people under the age of 65 on Medicare due to a disability have the same Open Enrollment rights as people 65 and older. **Additionally, when you turn 65 you will be eligible for another six (6) month Medicare supplement open enrollment period due to age**. This will give you the opportunity to purchase a Medigap policy based on the age of 65, which may reduce your monthly premium.

PLEASE NOTE: If you are under 65 and receive notification of your Medicare Part B eligibility retroactively, your six (6) month Open Enrollment Period starts on the date you receive that notification.

Please note if you are under 65, disabled and on Medicare and did not purchase a Medigap policy during your initial six (6) month open enrollment period, you will be able to purchase a Medigap policy from **Blue Cross/Blue Shield** from October 15 to December 7.

Guaranteed Issue Policies from a Guaranteed Issue Company

For persons aged 65 or older and NOT in their Open Enrollment Period or any Special Enrollment Periods there is still an option to get a Supplemental plan. In Illinois, we have one Medicare Supplement insurer that offers policies to anyone over the age of 65 in ANY health condition, throughout the year at the same premium rate as anyone in the same policy class. That company is Blue Cross Blue Shield of Illinois. **NOTE:** BC/BS also has some plans with underwriting.

Medicare SELECT Policies

Medicare Select policies must conform to the A-N standardized Medicare supplement guidelines. However, Medicare Select differs from the standardized A-N plans in that MedSelect policies require the policyholder to **use specific hospitals**, and in some cases specific doctors (except in emergency situations). The beneficiary must **live within 30 miles** of the contracted hospital to enroll in a MedSelect plan.

If a policyholder chooses to receive inpatient hospital care **outside the MedSelect network**, and the care does not constitute an emergency, Medicare will still pay the approved amount, **but** the MedSelect company will pay nothing toward the inpatient deductible.

MEDICARE SUPPLEMENT BENEFITS

This chart indicates the benefits included in each of the standardized Medicare Supplement plans. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

2025 Medicare Supplement Plans

Benefits	A	B	*C	D	*F	*FHD	G	GHD	K	L	M	N
Medicare Part A coinsurance and inpatient hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	100%	100%	**50%	**75%	100%	100% ***
Blood (first 3 pints, if charged)	100%	100%	100%	100%	100%	100%	100%	100%	**50%	**75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	100%	100%	**50%	**75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	100%	100%	**50%	**75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	100%	100%	**50%	**75%	50%	100%
Part B deductible			100%		100%	100%						
Part B excess charges					100%	100%	100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%	80%	80%			80%	80%
2025 Out-of-Pocket Limits									$7,220	$3,610		

Plans F & G are also offered as a high-deductible plan by some insurance companies. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,870 in 2025 before your policy pays anything.

***Plans C, F, and FHD** are only available to those eligible for Medicare prior to January 1, 2020.
****For Plans K and L**, after you meet your **out-of-pocket yearly limit** and your yearly Part B deductible; the Medigap plan pays 100% of covered services for the rest of the calendar year.

*****Plan N** pays 100% of the Part B coinsurance, except for a **copayment** of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Reference for Plan F-HD and G-HD: https://www.cms.gov/Medicare/Health-Plans/Medigap/FandJ.html
Reference for Plan K & L: https://www.cms.gov/Medicare/Health-Plans/Medigap/KandL.html

Your monthly premium will depend on plan selected, company purchased from, any discounts offered, etc.

MEDICARE SUPPLEMENT: GUARANTEED ISSUE RIGHTS

The chart describes the most common situations under federal law where you may be able to buy a Medigap policy outside your Medigap Open Enrollment Period, the kind of policy you can buy, and when you can or must apply for it. You may have additional rights under state law.

You Have a Guaranteed Issue Right if….	You Have the Right to Buy….	You Can/Must Apply for a Medigap Policy….
You have a **Medicare Advantage Plan**, and: • Your plan is leaving Medicare • Stops giving care in your area, or • You move out of the plan's service area.	Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state. You only have this right if you switch to Original Medicare (rather than join another Medicare Advantage Plan).	• 60 days before the date your Medicare Advantage Plan coverage ends. • No more than 63 days after your Medicare Advantage Plan coverage ends. **Note:** Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.	Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until your COBRA coverage ends.	No more than 63 days after the latest of these 3 dates: 1. Date your current coverage ends. 2. Date on the notice you get telling you that your coverage is ending (if you get one). 3. Date on a claim denial, if this is the only way you know that your coverage ended.
You have Original Medicare and a **Medicare SELECT** policy. You move out of the Medicare SELECT policy's service area. Contact the Medicare SELECT insurance company for more information about your options.	Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state, or the state you're moving to.	• 60 days before your Medicare SELECT coverage ends. • No more than 63 days after your Medicare SELECT coverage ends.
(**Trial right**) You joined a Medicare Advantage Plan (like an HMO or PPO) when you were first eligible for Medicare Part A at or after age 65 and enroll in Part B, and you decide you want to switch to Original Medicare within the first year of joining.	Any Medigap policy that's sold by an insurance company in your state.*	• 60 days before your coverage ends. • No more than 63 days after your coverage ends.

You Have a Guaranteed Issue Right if….	You Have the Right to Buy….	You Can/Must Apply for a Medigap Policy...
(**Trial right**) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If that policy isn't available, you can buy Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state.	No more than 63 days after your coverage ends.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state.	No more than 63 days **after** your current Medigap coverage ends.
You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you	Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold by an insurance company in your state.	No more than 63 days **after** your coverage ends.
*Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plan D or G instead of Plan C or F.		

PREMIUM CALCULATION METHODS

Premium Calculation Methods: Insurance companies use three (3) different methods of pricing policies based on age.

- **Attained Age**: Your premium will increase as you grow older. Additional increases due to higher medical costs or higher than expected claim costs are also possible. For example, if you buy a policy at age 65, when you turn 70, you will pay whatever the company is charging for a person 70 years old. However, any rate increase that occurs must apply to the entire class of policyholders in which you are categorized, not just to you as an individual.
- **Issue Age**: Your premium will always be based on your age at the time you purchased the plan. Any increases will be due to higher medical costs or higher than expected claim costs for the entire class of policyholders you are in. Even though you will have increases in your policy premium, the premium will not increase just because you are growing older.
- **No Age (Community) Rating**: The premium for a specific policy is the same for everyone over the age of 65, regardless of their age.

Wanting more information on Medicare Supplements or feel you have questions and need assistance?

SHIP Counselors have access to real time premium price estimates utilizing the Medigap Plan Finder available exclusively to certified SHIP Counselors. The tool is updated weekly with the latest plan information received directly from the plan via CSG Actuarial, and allows for customized searches based on gender, age, tobacco status and other criteria.

The SHIP TA Center Medigap Comparison tool is made possible by grant funding from the U.S. Administration for Community Living (ACL) and is created and supported by CSG Actuarial in Omaha, Nebraska.

Contact a SHIP counselor near you by calling 1-800-252-8966 or emailing Aging.SHIP@illinois.gov

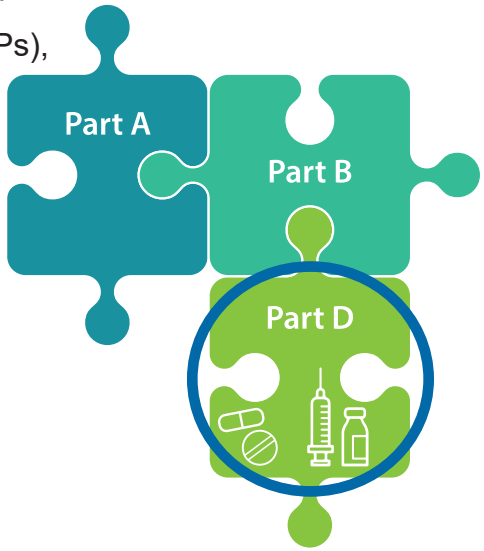
MEDICARE PART D (PRESCRIPTION DRUG) PLANS:

Medicare Part D is prescription drug insurance offered by private insurance companies that are approved by Medicare. It was created by the Medicare Modernization Act (MMA) of 2003 to provide coverage for outpatient drugs and went into effect in 2006. It does not include doctor samples, discount cards, free clinics, or drug discount websites. An individual's decision about Medicare prescription drug coverage will depend upon such things as the medicines they take, type of prescription drug coverage they currently have, if any, and what they can afford, etc.

Part D can be provided by two different types of prescription plans:

a. Stand-alone Medicare Prescription Drug Plans (PDPs), which only provide prescription drug coverage; and

b. Medicare Advantage Prescription Drug Plans (MA-PDs) which offer health benefits as well as prescription drug coverage rolled into one plan.



Who is eligible for Part D?

a. Anyone who is entitled to Medicare Part A (Hospital Insurance); and/or

b. enrolled in Medicare Part B (Medical Insurance); or

c. has both Medicare Part A and Part B; and

d. lives in the service area of a Part D plan.

If you are a Medicare beneficiary with a high annual income, your Medicare Part D premiums can be higher. This difference in premium reflects your Income Related Monthly Adjustment Amount (IRMAA).

https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles?stream=top

Part D Plan Coverage Phases

Deductible period:	Until you meet your Part D deductible, you will pay the full negotiated retail price for your covered prescription drugs. Once you have met the deductible, the plan will begin to help cover the cost of your drugs. While deductibles can vary from plan to plan, a plan's deductible cannot be higher than $590 in 2025, and some plans have no deductible.
Initial coverage period:	After you meet your deductible, your plan will help pay for your covered prescription drugs. Generally, this is 75% plan / 25% beneficiary.
Catastrophic coverage:	In all Part D plans, you enter catastrophic coverage after you reach $2,000 in out-of-pocket costs for covered drugs. During this period, you pay $0 beginning in 2025 for your covered drugs for the remainder of the year.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option in the prescription drug law that works with your current drug coverage to help you manage your out of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option. All plans offer this payment option and participation is voluntary. If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). There's no cost to participate in the Medicare Prescription Payment Plan.

How does it work? When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail order and specialty pharmacies). Instead, you'll get a bill each month from your health or drug plan. Even though you won't pay for your drugs at the pharmacy, you're still responsible for the costs. If you want to know what your drug will cost before you take it home, call your plan or ask the pharmacist.

Visit https://www.medicare.gov/prescription-payment-plan to learn more about this payment option and if it might be a good fit for you.

NOTE: This payment option might help you manage your monthly expenses, but it doesn't save you money or lower your drug costs. You're most likely to benefit from participating in the Medicare Prescription Payment Plan if you have high drug costs earlier in the calendar year. This payment option may not be the best choice for you if your yearly drug costs are low or you are eligible for Extra Help (LIS Low Income Subsidy) from Medicare.

To enroll beneficiaries must contact their health or drug plan's website directly, or call the plan to start participating in the payment option.

Things to Consider

There are important differences between coverage options. Before selecting or making any changes to your coverage, consider things such as:

- Drug plan formulary
- Monthly premium, deductible, copays, etc.
- Prescription plan costs
- Enhanced coverage ($0 generics, lower deductible, lower %)
- Quality of care (Star ratings)
- Prior authorization, quantity limits, step therapy

EXTRA HELP

"Extra Help" is a program from Social Security to help beneficiaries with limited income and resources pay for Medicare Part D prescription drug costs.

Note: 2025 income limits not available as of this printing.

Single = $1,957 Monthly Income for 2025 ($23,484 annually)

Married couple = $2,644.00 Monthly for 2025 ($31,728 annually)

Resources must be limited to $16,100 individual/$32,130 couple in 2025.

Choice of plans that offer $0 premiums / $0 deductibles.

Pay no more than $12.15 for each brand name and for $4.90 for generics in 2025

Apply for Extra Help at the Social Security Website

Note: Medicaid and SSI recipients are auto-enrolled.

Note: Also known as Low Income Subsidy (LIS)

To learn more about extra Help and how to apply:

https://www.medicare.gov/basics/costs/help/drug-costs

For assistance with applying for "Extra Help" contact a SHIP counselor

Or apply online at https://www.ssa.gov/medicare/part-d-extra-help

The Inflation Reduction Act (IRA) Part D Savings:

<table>
<tr><th colspan="7">Implementation Timeline of the Prescription Drug Provisions in the Inflation Reduction Act</th></tr>
<tr><th>2023</th><th>2024</th><th>2025</th><th>2026</th><th>2027</th><th>2028</th><th>2029</th></tr>
<tr><td rowspan="2">Requires drug companies to pay rebates if drug prices arise faster than inflation</td><td rowspan="2">Eliminates 5% coinsurance for Part D catastrophic coverage</td><td rowspan="2">Adds $2,000 out-of-pocket cap in Part D and other drug benefit changes</td><td colspan="4">Implements negotiated prices for certain high-cost drugs:</td></tr>
<tr><td>• 10 Medicare Part D drugs</td><td>•15 Medicare Part D drugs</td><td>• 15 Medicare Part B and Part D drugs</td><td>20 Medicare Part B and Part D drugs</td></tr>
<tr><td>Limits insulin cost sharing to $35/month in Part B & D</td><td>Expands eligibility for Part D Low-Income Subsidy full benefits up to 150% FPL</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Reduces costs and improves coverage for adult vaccines in Medicare Part D, Medicaid & CHIP</td><td colspan="6">••••••••••2024-2030: Limits Medicare Part D premium growth to no more than 6% per year•••••••••</td></tr>
</table>

Source: https://www.kff.org/medicare/issue-brief/how-will-the-prescription-drug-provisions-in-the-inflation-reduction-act-affect-medicare-beneficiaries/

In 2023: Insulin Costs at $35 Per Month or Less; Medicare drug and health plans must not charge over $35 per insulin prescription, per month as of January 1, 2023.

Includes all insulins in vials, pens, and compounded insulins You must ensure your insulin is on the drug plan's formulary. Insulin is not subject to the plan deductible.

Note: If you use insulin through an insulin pump, it is covered under Part B and the $35 cap began July 1, 2023.

Plans can offer certain insulin at lower than $35 per month through special Senior Savings model plans. Not all insulins may be covered at this lower cost. Check with your plan on costs or do a price comparison on Medicare.gov.

Adult Vaccines: Starting January 1 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles vaccine, will be available to people with Medicare Part D at no cost to them.

In 2024: Starting January 1, people with Medicare prescription drug coverage who fall into the catastrophic phase of the prescription drug benefit won't have to pay any coinsurance or co-payments during that phase for covered Medicare prescription drugs.

Individuals with Medicare Part D who have low incomes will benefit from expanded financial help with prescription drug cost-sharing and premiums. The low-income subsidy program (LIS or "Extra Help") under Medicare Part D will be fully available to certain people with Medicare with limited resources who earn less than 150% of the federal poverty level starting in 2024.
In 2025: $2,000.00 out-of-pocket cap in Part D.

MEDICARE ADVANTAGE PLANS (PART C):

Medicare Advantage (MA) plan, also known as Part C of Medicare, is another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are Medicare-approved plans offered by private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D). In many cases, you’ll need to use health care providers who participate in the plan’s network. These plans set a limit on what you’ll have to pay out-of-pocket each year for covered services. Some plans offer non-emergency coverage out of network, but typically at a higher cost. In many cases, you may need to get approval, also called prior authorization, from your plan before it covers certain drugs or services. Remember, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Please keep your red, white, and blue Medicare card in a safe place because you might need it later. If you join a Medicare Advantage Plan, you’ll still have Medicare, and will need to continue paying your Part B premiums (2025 $185.00) but you’ll get most of your Part A and Part B coverage from your Medicare Advantage Plan, not Original Medicare.

Medicare Advantage Plan Eligibility and Costs

- Must have Part A and Part B
- Beneficiary must continue to pay the $185.00 monthly Part B premium.
- Some plans may charge an additional monthly premium above the Medicare Part B premium.
- In addition, the out-of-pocket costs such as copayments and coinsurances for services may be different than under Original Medicare.
- Live in plan service area
- Agree to provide necessary information to the plan.
- Agree to follow the plan’s rules.
- Belong to only one MA plan at a time.
- You can find a list of these plans in the back of your Medicare & You book.

How do these plans work?

1. All Medicare services (Parts A, B, and most times D) will be provided through the plan. The beneficiary will be issued the plan’s insurance ID card to present to Medicare providers.
2. Medicare pays Medicare Advantage plans a certain amount each month (called a capitation rate) for each beneficiary enrolled in the plan.
3. All MA plans must cover services provided under Medicare Part A and Part B within that dollar amount. Beneficiaries receive the same quality of service a person on Original Medicare could expect.
4. Some plans provide services that Medicare does not cover such as vision, hearing, dental, gym or fitness club memberships, or transportation to the doctor. Please remember not to base your health care needs solely on the “extra benefits” in these Advantage plans.

5. Some plans may charge an additional monthly premium above the Medicare Part B premium. In addition, the out-of-pocket costs for services may be different than under Original Medicare. A person should be aware of the services and costs under each plan.
6. Specifics regarding MA plans and their cost structure can be attained by searching the "Medicare Health Plans in Illinois" tables located in the back of the current Medicare and You Handbook (Illinois version), CMS Publication 10050-23 or by Searching Medicare.gov with Medicare Plan Finder tool for MA plans using your zip code.
   You can join or drop a Medicare Advantage plan only at certain times of the year. Please see page 8 of this guide for the Medicare Enrollment Periods Quick Chart.

IMPORTANT: If you already have a Medicare Supplement plan and decide to switch to a Medicare Advantage Plan, you could be subject to medical underwriting if you decide to switch back to your Medicare Supplement plan. In some situations, Medicare has trial periods that gives you the right to get your Medicare Supplement back without medical underwriting. Please reference the Guaranteed Issue rights chart on pages 14 and 15 for more information on switching from Medicare supplement plans to Medicare Advantage plans and your rights.

Health Maintenance Organizations (HMOs) are only available in certain zip code areas and counties. HMOs utilize a network of providers, doctors, and hospitals, which have contracted with the HMO to provide services to their members. In order to utilize specialists, a referral must be arranged through a primary care physician. Please note that if you use an out-of-network provider in a non-emergency situation, no payment will be made by the HMO or Medicare, which means that you will be responsible for the entire cost of those services.

HMO Point of Service (POS) option is identical to HMOs defined above with the exception of allowing specified health care services outside the HMO network. Enrollees may face higher co-pays for these POS services.

Preferred Provider Organizations (PPOs) A type of medical plan in which coverage is provided to participants through a network of selected health care providers, such as hospitals and physicians. Enrollees may seek care outside the network but pay a greater percentage of the cost of coverage than within the network if the provider agrees to see you and bill your PPO plan.

Private Fee-For-Service (PFFS) plans are available in Illinois and differ from HMOs and PPOs in that they do not utilize a network of contracted providers. People in a PFFS may obtain services from any provider that accepts the plan's terms and conditions. Contact your providers before purchasing a PFFS plan to see if they will accept this type of insurance. If the provider does not agree to accept the plan, the insured person is responsible for all charges associated with the service.

Special Needs Plans (SNPs) are plans which focus on individuals with special needs. Special Needs Plans may target enrollment to people with Medicare and Medicaid; those who are institutionalized; and/or individuals with severe or disabling chronic conditions. All SNP's must have drug coverage.

Medicare Savings Accounts are a non-network high-deductible health plan combined with a savings account that receives an annual tax-free deposit from Medicare. The member can use this account for health expenses until the annual high deductible is met. Any money unused each year rolls over to the next year and can be used for any health-related expense.

Medicare Cost Plan is a type of Medicare health plan available in certain, limited areas of the state. In general, you can join even if you only have Part B. If you have both Part A and B and go to a non-network provider, original Medicare covers the service. You will pay the Part A and B coinsurance and deductibles. You can join anytime the Cost Plan is accepting new members. You can leave any time and return to Original Medicare. You can join a separate Medicare drug plan, or you can get drug coverage.

Things to Consider

Before selecting or making any changes to your Part C coverage, consider things such as:

- Doctor and hospital choice (are they in the network?)
- Cost (premium, co-pays, co-insurance)
- Coverage (prior authorizations, etc.)
- Supplemental coverage (vision, dental, hearing, etc.)
- Prescription drugs (are your prescriptions on plan formulary?)
- Quality of care (Star ratings)

Comparing Plans on www.medicare.gov

Creating an Account for a Personalized Medicare Plan Finder Experience

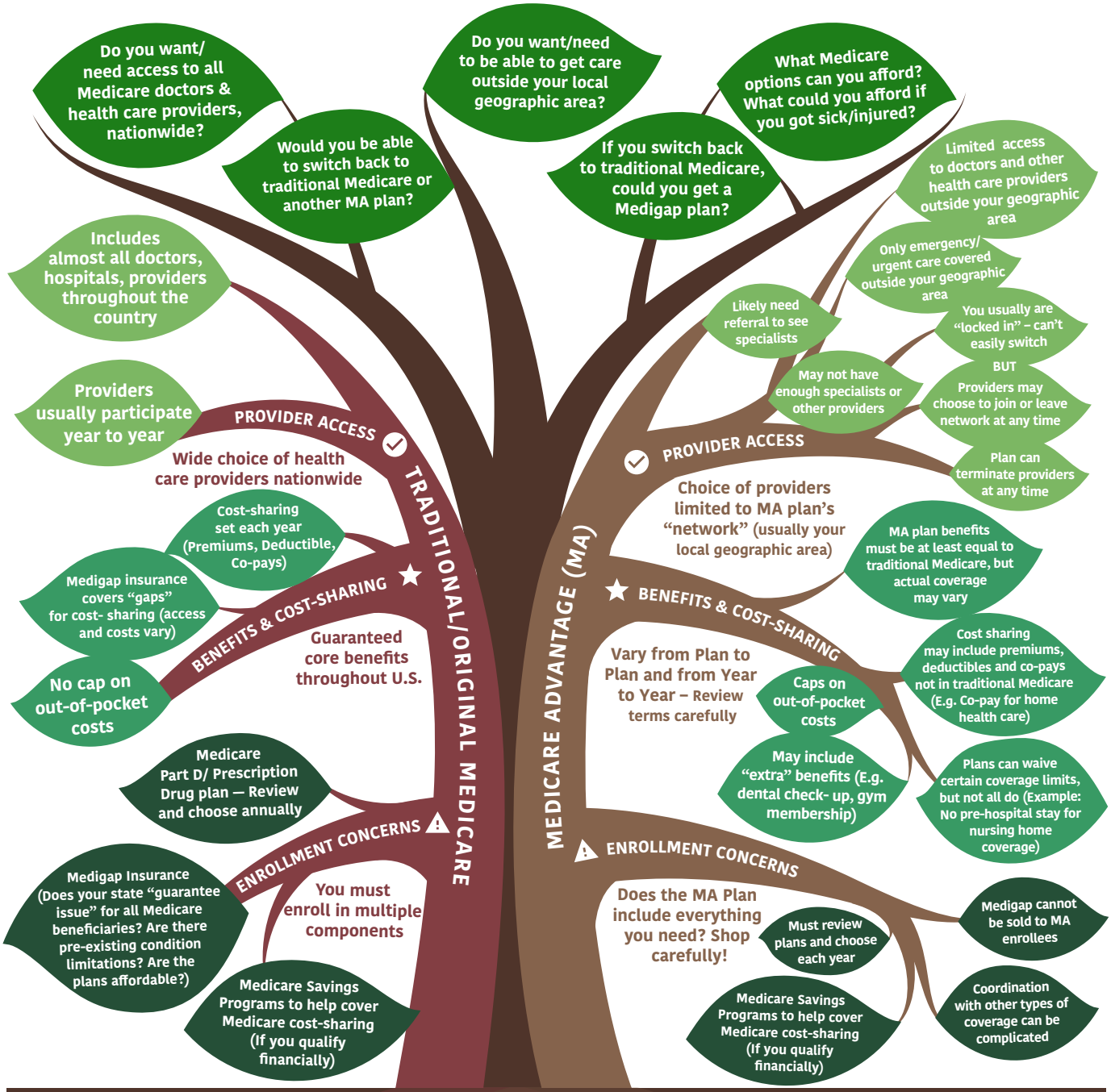
When you create a Medicare account, you can:

- Compare Drug plans and Medicare Advantage plans side-by-side using your personal data and medication list.
- Build a drug list. Medicare makes suggestions based on prescriptions you filled within the last 12 months.
- Modify your drug list and save changes.
- Compare benefits and costs in your current plan to other plans available in your area.
- See prices based on any extra help you get with drug costs.

CMS/Medicare Step-by-Step Guide to using the Medicare Plan Finder Tool on YouTube:
https://www.youtube.com/watch?v=8bLdJoPRiBo

Center for Medicare Advocacy

DECISION TREE: TRADITIONAL MEDICARE OR MEDICARE ADVANTAGE



THE ROOT OF THE DECISION:

If you want access to almost all health care providers, anywhere in the country, and don't want to have to get permission from an insurance company to see specialists, look to traditional Medicare. If you are willing to give up access to a full choice of providers for possible lower cost-sharing and some additional benefits, look at Medicare Advantage.

SENIOR MEDICARE PATROL

If you feel you might be a victim to Medicare fraud the Senior Medicare Patrol can help

The SMP program in Illinois is coordinated by AgeOptions

To prevent healthcare fraud, you first need to know what it looks like. Healthcare fraud happens when someone bills your health insurance, including Medicare, for:

- Something you did not receive
- Something different than what you received
- Something that was not medically necessary

How can you detect healthcare fraud?

The best way to detect healthcare fraud is to read your Medicare Summary Notice (MSN) or your insurance's Explanation of Benefits (EOB). These documents show every claim billed to your insurance.

If you find a claim or charge for something that fits in the categories above, this may be a sign of errors, billing abuse or potential fraud. You can:

- Call the provider to ask about the claim of charge (if you know and trust the provider)
- Call the Illinois SMP at AgeOptions 800-699-9043 (ask for "SMP").

COMMON MEDICARE & MEDICAL DEFINITIONS

Definition of Terms and Special Provisions

Aid for the Aged, Blind and Disabled (AABD): The Aid to the Aged, Blind or Disabled cash program is available through the Illinois Department of Human Services. The program is for people who are elderly, blind or have a disability and need money and medical care to help take care of themselves.

Advance Beneficiary Notice of Non-Coverage: In original Medicare, a notice that a doctor, supplier or provider gives a person with Medicare before furnishing an item or service if the doctor, supplier, or provider believes that Medicare may deny payment.

Amyotrophic Lateral Sclerosis (ALS): Amyotrophic Lateral Sclerosis (also referred to as ALS or Lou Gehrig's disease) is a condition that affects the nerve cells in the brain and spinal cord. These nerve cells control an individual's voluntary muscle movement. When an individual suffers from ALS, these nerve cells die and are no longer able to send messages to the muscles of the body. Over time, the condition gets worse and eventually, the muscles in the chest area stop working. This can make it hard or even impossible for an individual to breathe on his/her own.

Annual Open Enrollment Period: a period from October 15 to December 7 of each year when a person with Medicare can change Medicare Advantage or Part D drug coverage plans.

Appeal: A review of a denied claim or a claim a beneficiary feels has been underpaid.

Area Agencies on Aging (AAA): Local agencies, sponsored by the Illinois Department on Aging, which grant or contract with public and private organizations to provide services for older persons within their area.

Annual Wellness Visit (AWV): Medicare covers the AWV, a preventive wellness visit that provides Personalized Prevention Plan Services at no cost to the Beneficiary.

Assignment Acceptance: The physician or supplier who accepts assignment under Medicare Part B agrees to accept Medicare's approved charge as payment in full. Medicare then pays 80 percent of the approved charge to the physician or supplier. The beneficiary is still responsible for the 20% coinsurance payment.

Best Available Evidence (BAE): The Medicare Part D Best Available Evidence policy is used when clients are eligible for the Low-Income Subsidy (LIS) but their eligibility is not yet reflected on Part D plan files. The Centers for Medicare and Medicaid Services (CMS) require Part D plans to issue members their drugs at the correct LIS cost-sharing amounts when they provide evidence of their LIS eligibility.

Balance Billing: a) the practice of billing a patient the difference between the Medicare approved amount and the actual bill; b) when Private Fee-for-Service plan providers charge 15% more than the plan's payment amount for services.

Beneficiary: Any person who receives benefits through Medicare or Medicaid.

Beneficiary Contact Form (BCF): A Beneficiary Contact Form documents the interactions between SHIP counselors and Medicare or Medicaid beneficiaries, seniors, and individuals working on behalf of a client.

Benefits Coordination & Recovery Center (BCRC): If you have Medicare and other health coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide who pays first. If there are questions about who pays first, or if coverage changes, call the Benefits Coordination & Recovery Center (BCRC) formerly known as the Coordination of Benefits Center (COBC).

Benefit Maximum: The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) a length of time (for example, 60 days), or 2) a dollar amount (for example, $350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. This may refer to specific illness, time frame, or the life of the policy.

Benefit Period: The period for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

Benefit Period under Medicare: A Medicare benefit period begins upon entry to a qualified hospital and ends when the patient has been out of a hospital and not receiving Medicare benefits in a facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days, including the day of discharge.

Biologicals: Substances, such as whole blood, hemophilia clotting factors, tetanus antitoxins vaccines, tumor chemotherapy agent, etc.

Brand Name Drugs: Drugs that have a well-known and usually highly regarded or marketable name. (Not generic)

Carrier: A health insurance company under contract with the Centers for Medicare and Medicaid Services (CMS) to handle claims processing for Medicare Part B.

Catastrophic Coverage: The period of Part D coverage that begins once a beneficiary reaches his or her plan's out-of-pocket limit and comes to the end of the "doughnut hole." The beneficiary then pays the greater of 5% drug coinsurance or the catastrophic coverage copayment amount set each year, and the drug plan pays the balance for the remainder of the calendar year.

Centers for Medicare & Medicaid Services (CMS): A branch of the Department of Health and Human Services, this federal agency is responsible for administering the Medicare and Medicaid programs.

CGS Administrators, LLC: A Celerian Group Company, was awarded administration of the Jurisdiction B Durable Medical Equipment Medicare Administrators Contractor (DME MAC).

COBRA Legislation: From the Consolidated Omnibus Budget Reconciliation Act requiring that workers who end employment for specified reasons have the option of purchasing group health insurance for 18 months.

Coinsurance: The percent of the Medicare payment rate or a hospital's billed charges that a beneficiary will have to pay after meeting the Part B deductible.

Community Care Program: Established in 1979 by Public Act 81-202, the Illinois Department on Aging's Community Care Program helps senior citizens, who might otherwise need nursing home care, to remain in their own homes by providing in-home and community-based services.

Coordination of Benefits (COB): Provisions and procedures used by insurers to avoid duplicate payments for losses insured under more than one policy. One of the insurers is the primary payer assuring that no more than 100% of the costs are covered. This does not usually apply to indemnity (cash payment) policies.

Copayment: a) A specified dollar amount or percentage of covered expenses which the beneficiary is required to pay toward medical bills; b) An amount set by a managed care plan that the beneficiary pays at the time specified medical services are received.

Cost Sharing: An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance and/or deductibles.

Coverage Gap also known as the "donut hole", ended December 31, 2024, and is replaced by a $2,000 annual cap on out-of-pocket spending for prescription drugs in 2025.

Creditable Coverage: There are certain types of previous health insurance coverage that can be used to shorten or eliminate a pre-existing condition waiting period under a Medigap policy. However, you cannot have more than a 63-day break in coverage between the previous health insurance coverage and your Medicare coverage.

Creditable Prescription Drug Coverage: Coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Crossover: Crossover is a term which defines the agreement between the Medicare carrier and insurance companies marketing Medicare supplement insurance, who have signed a contract which allows a Medicare beneficiary's claim to automatically "crossover" from Medicare's computer to the med–sup company's computer. This eliminates the need to file paper claims with the Medigap carrier.

Deductible: An initial amount of medical expense for which the beneficiary is responsible before Medicare or an insurance policy will pay.

Dual Eligible: Refers to a situation when an individual is entitled to Medicare Part A and/or Part B and is also eligible for some form of Medicaid benefit.

Durable Medical Equipment (DME): Durable medical equipment is equipment which can 1) withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of an illness or injury; and 4) is appropriate for use in the home.

Drug Formulary: A continually updated list of prescription medications that represents the current covered drugs under a PDP or MA-PDP. The Drug Formulary contains both brand name drugs and generic drugs, all of which have FDA (Food and Drug Administration) approval.

Enrollment Period: A certain period when an eligible person can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Evidence of Coverage and Disclosure Information: The document provided by a Medicare Advantage plan which explains Covered Services and defines the obligations of the plan and the rights and responsibilities of the Member.

Exception: A type of Part D coverage determination that deals specifically with formulary issues; for example, overcoming step therapy requirements, quantity limits or off-formulary drugs.

Extra Help: Also known as Low Income Subsidy, or LIS. Medicare works with drug plans to provide assistance to pay prescription drug costs for people who meet specific income and resource limits. Application is made through the Social Security Administration.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Generic Drugs: A generic drug is a medication created to be the same as an existing approved brand-name drug in dosage form, safety, strength, route of administration, quality, and performance characteristics.

Grievance: A complaint a beneficiary files with a Medicare health plan about its operations, activities or behavior. For example, a grievance may be filed if one is dissatisfied with the customer service or how a plan managed your appeal. An appeal, not a grievance, is the only way to request a reversal of a denial of coverage. Each plan can design its own grievance process with minimal regulation by Medicare.

Group Health Plan: A health plan offered by an employer or employee organization that provides coverage to employees, former employees, and their families.

Group Insurance: A group policy is a written contract between an insurer and a "middle man," usually an employer or group, which provides benefits to the insured persons. The individual receives a certificate of insurance stating the provisions of the coverage for each insured individual or family.

Guaranteed Renewable: The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The premiums for the policy cannot be raised unless it is raised for all policyholders in the same class. The policy cannot be cancelled due to age or deteriorating health unless premiums are not being paid or information on the application is falsified.

Health Maintenance Organization (HMO): An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, diagnosis, and nursing). HMOs are sponsored by large employers, labor unions, medical schools, hospitals, medical clinics, and even insurance companies.

Home & Community-Based Services (Waiver Program): Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

Home Health Care: Health care services provided in the home on a part-time basis for the treatment of an illness or injury. Medicare pays for home health care only if the type of care needed is skilled and required on an intermittent basis and is intended to help people recover or improve from an illness.

Hospice: A public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families in the home in addition to short–term inpatient care.

Indemnity Policy: Type of insurance policy which will pay a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

Initial Coverage Limit: During this period, the beneficiary pays a copayment or coinsurance after any applicable deductible is met and the Part D plan pays their share for each covered prescription until drug costs reach a certain dollar amount.

Initial Enrollment Period: The seven-month period surrounding a person's 65th birthday which is used to enroll for Medicare Parts B and D.

Income Related Monthly Adjustment: If you have higher income, the Medicare law requires an adjustment to your monthly Medicare Part B (out-patient medical insurance) and Medicare prescription drug coverage premiums (Medicare Part D). The Income-Related Monthly Adjustment Amount (or IRMAA) is an additional amount that you pay for your monthly Medicare Part D prescription drug plan premiums and your monthly Medicare Part B (out-patient or doctor visit coverage) premiums.

Inpatient: A person who has been formally admitted (inpatient status) to a hospital or other health facility to receive a diagnosis, treatment, or other health services.

Institutionalization: Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period or indefinitely.

Insured: The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

Limited Income Newly Eligible Transition: The Limited Income NET Program (or LI NET) is designed to eliminate gaps in coverage for low-income individuals transitioning to Medicare Part D drug coverage. The LINET Program ensures that individuals with Medicare's low-income subsidy (LIS), or "Extra Help," who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. Enrollment in the LINET Program is temporary until Medicare enrolls these individuals in a standard Medicare Part D plan.

Long Term Care Insurance: A policy designed to help alleviate some of the costs associated with long-term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered LTC expenses and may exclude or limit certain conditions from coverage.

Long-Term Care Ombudsman: An independent advocate for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.

Long Term Services & Supports (LTSS): Long Term Care Services offered through several vehicles and over a continuum of settings. This includes Institutional Care and Home and Community Based Long Term Services and Supports (known as Home and Community Based waivers).

Managed Care: An arrangement that coordinates your care through a network of health care providers to provide you with all Medicare eligible hospital and medical services.

Maximum Out-Of-Pocket limit: Medicare Advantage plans have a Maximum-Out-Of-Pocket (MOOP) expense, determined by Medicare, to limit the amount of money beneficiaries must pay out of their personal funds. Out-of-pocket expenses are defined as the expenditure of personal funds to cover payment (in full or partial) for a particular service. Once the beneficiary reaches this MOOP, their MA plan is required to pay 100% of the Medicare-approved services performed in their plan's network.

Medicare Advantage: (also referred to as Medicare Part C) includes managed care plans Medicare HMOs, Private Fee-for-Service plans (PFFS), Preferred Provider Organization plans (PPOs) and Medical Savings Accounts (MSAs).

Medicare Advantage Prescription Drug Plan (MA-PD): Medicare Advantage plan that also includes prescription drug coverage.

Medicare Advantage Open Enrollment Period (MA OEP): Lasts from January 1 – March 31. MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP. Individuals must be enrolled in a MA plan as of January 1 to be able to use this MA OEP.

Medicare Medicaid Alignment Initiative (MMAI): A three-year demonstration program that encompasses all Medicare and Medicaid health benefits, administered through a Managed Care organization. In addition to health benefits, prescription drug coverage, long term care institutional care and long-term care services and supports (such as waiver services) are included in one product.

Medicare Medical Savings Account Plan (MSA): A Medicare health plan option which combines a high deductible insurance policy with a special savings account in which Medicare deposits money to be used for medical expenses.

Medicare Savings Program: A state Medicaid program that can help to pay Medicare premiums, deductible and coinsurance for Medicare beneficiaries (elderly or disabled) who qualify. QMB, SLMB and QI

Medicare Select Policy: A standardized Medicare supplement policy that requires the insurer to seek inpatient hospital services through a participating hospital to obtain benefits. Inpatient services rendered in an emergency are exempt from this provision.

Medicare Summary Notice (MSN): The statement that Medicare sends the beneficiary to show what action was taken on a claim. The MSN is replacing the EOMB form.

Medicare Supplemental Policy (Medigap): Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare

Medical Underwriting: The process by which an insurer establishes and assumes risks according to insurability.

Network: The facilities, providers and suppliers your health insurer or plan uses to provide health care services.

Ombudsman: A "citizens' representative'' who protects a person's rights through advocacy, providing information and encouraging institutions or agencies to respect citizens' rights.

Open Enrollment (for Medigap): A one–time, 6-month period when people who first purchase Medicare Part B may elect to enroll in a Medicare Supplement insurance plan and not be turned down. This includes people on Medicare due to disability.

Outpatient: A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

Outpatient Prospective Payment System: The way Medicare will pay for most outpatient services at hospitals or community health centers under Part B.

Pre–existing Condition: Health conditions or problems that were identified and treated before health insurance was purchased. The definition and waiting period before these conditions are covered varies from policy to policy. However, there is a maximum six-month waiting period for Medicare Supplement policies. Usually, treatment must have been received in the preceding six months for the condition to be considered "pre–existing.''

Preferred Provider Organization (PPO): a) A type of Medicare health plan created by the Balanced Budget Act; b) Membership organization that offers members a network of physicians and suppliers who accept assignment. They may also offer additional benefits such as discounts on prescription drugs, transportation discounts and access to health education programs.

Private Fee for Service Plan (PFFS): A Medicare health plan managed by a private company. On this plan, Medicare beneficiaries may go to any doctor or hospital that accepts the plan. The plan, rather than Medicare, decides how much the beneficiary will pay for services.

Quality Improvement Organization (QIO): Groups of doctors paid by the federal government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients.

Qualified Medicare Beneficiaries (QMBs): A federally mandated program that Medicaid must pay the Medicare parts A & B premiums, deductibles and copayments for Medicare beneficiaries who qualify based on income and resources.

Senior Medicare Patrol: A program in Illinois that is coordinated by AgeOptions, the Area Agency on Aging for Suburban Cook County. They empower and assist Medicare beneficiaries, their families and caregivers to prevent, detect and report health care fraud, errors and abuse through outreach, counseling and education.

Social Security Administration (SSA): This federal agency is responsible for determining Medicare eligibility, handling Medicare enrollment and the Extra Help program for Part D.

Social Security Disability Insurance: SSDI refers to the Social Security Disability Insurance program. It is tied to the Social Security retirement program but is for workers who become disabled before retirement age. Only workers who have worked and paid Social Security taxes for many years are insured by the SSDI program.

Special Election Period: Special periods of time in which a person with Medicare can make an election to another Medicare health plan.

Special Enrollment Period: Under Part D, in certain situations, persons are granted this type of enrollment. For instance, if you move out of the service area of a Medicare drug plan or lose creditable prescription drug coverage, you would be granted an SEP.

Special Needs Plan: A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease or who have both Medicare and Medicaid.

Specialty Tier Drugs: Unique, very high cost drugs.

Specific Disease Policy: Type of limited health insurance policy that only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

Spenddown: Medicaid-eligible individuals in some cases must make payments on Medicaid bills until their income, less medical expenses, falls below the state prescribed income level to qualify for Medicaid.

Spousal Impoverishment: The community property and assets of a married nursing home patient may be divided according to CMS standards to protect the property and assets of the spouse.

Supplementary Medical Insurance Benefits (SMIB): are provided by the federal government through Part B of the Medicare Program.

Supplemental Security Income (SSI): A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

Suppliers: Persons or organizations, other than physicians or health care facilities, that furnish medical equipment or services, such as ambulance firms, laboratories, and equipment rental outlets.

Third Party Liability: A party other than a beneficiary who is responsible for payment of part or all of a specific Medicare claim. Medicare supplemental insurance (Medigap) coverage is one example.

Tiered Copayments: Medicare Part D drug plans may group various drugs according to price, and create several price blocks, or tiers.

TRICARE for Life: A medical program run by the Department of Defense to provide medical care to retired members of the military and their dependents.

MY MEDICARE CHECKLIST

MEDICARE PASSWORD INFORMATION (MEDICARE.GOV ACCOUNT):

USERNAME:_____

PASSWORD:_____

SECURITY QUESTION AND ANSWER:_____

Current Plan/ or “New” to Medicare:_____

Primary Care Physician:_____

Specialists (if applicable):

_____

_____

_____

Preferred Hospital:_____

Preferred Pharmacy:_____

Prescription Drug List:

Name	Dosage	Frequency taken

The main choice in Medicare coverage is whether to go with Original Medicare with a Part D (prescription drug plan) and possibly a Supplemental policy, or to go with a Medicare Advantage plan which combines all parts of Medicare together into one plan and may have some additional benefits, but it may also have networks and other restrictions. There are advantages and disadvantages to both options depending on a variety of factors and what is most important to you.

The questions below are intended to help you in determining what your best option for Medicare coverage might be from what your current needs and situation are.

I. Have you had any health changes within the past year? ☐ **Yes** ☐ **No**

a. If yes, what were those changes and did they result in greater costs, new providers, new prescriptions etc.

_____

_____

b. Do you expect the health changes will be ongoing, or remedied in a short period of time? ☐ **Ongoing** ☐ **Remedied**

c. Have you had any increased costs due to the change in health? ☐ **Yes** ☐ **No**

II. Have your finances changed within the past year? ☐ **Yes** ☐ **No**

III. If your finances have decreased, do your current costs fit your budget? ☐ **Yes** ☐ **No**

IV. Do you see more than one doctor?

a. Yes, I see several specialists.
b. Yes, I see 1-2 specialists.
c. No, I only have one.

V. Do you travel frequently?

a. Yes, I am a snowbird.
b. Yes, I vacation often.
c. No, I may take a trip here or there.

VI. Do you live in a rural area? ☐ **Yes** ☐ **No**

WHAT TO KNOW/THINGS TO CONSIDER	
Medicare Supplemental (Medigap) Policies	**Medicare Advantage Plans (Part C)**
Higher Premiums (May have additional out-of-pocket costs depending on choice of plan)	Lower Premiums. Some plans have $0 premiums.
You must purchase a stand-alone Part D plan and pay those premiums and copays.	Prescription drug coverage is usually included.
It is accepted wherever Medicare is accepted throughout the nation. There are no networks or referrals needed.	May have to stay within a network of providers, get referrals for any specialists within the network, and may have to pay all costs of care provided out-of-network. Unless in a PPO plan which may cover out-of-network costs but with higher copays. (Note: It can be difficult to find a network in more rural areas)
Crossover – most plans crossover, which means that the doctor/hospital will bill Medicare and then automatically bill your supplemental plan and you may not even see a bill.	You still must pay your Part B premium.
Still must pay your Part B premium, unless paid by the plan. (ie Plans C & F which are no longer available to those eligible for Medicare after 01/01/2020).	You will only provide your Advantage plan card to your provider.
You will provide both your Medicare card and your Supplemental plan card to your provider.	Advantage plans may have additional Supplemental Benefits such as dental, vision, or hearing as well as others that Medicare does not cover. Usually, these supplemental benefits are not comprehensive, so be sure to check exactly what is covered. For example, it may say it covers dental, but that coverage is for only 1 cleaning per year and nothing else.
Premiums can rise over time, but only if raised on the whole class of beneficiaries.	Though premiums may be low or even $0, do not decide by premium alone. Copays can add up, and if you go out-of-network you may have to pay all costs.
Medicare Supplemental plans may be a good possibility for individuals who see several different providers, those who travel often or may be “snowbirds”, those who live in rural areas or areas with a lack of network providers, and those who may want the ease of crossover, and fewer bills.	

MY MEDICARE "OPEN ENROLLMENT" CHECKLIST

It's important to review your Medicare coverage every year before the Medicare Annual Open Enrollment Period (AOEP), October 15 – December 7. The purpose of this checklist is to help you understand your current coverages and determine if that coverage still meets your current needs, and if not, it will help you to review your Medicare coverage options with more confidence.

I. What is your current plan? (Check your insurance cards and list them here):

_____

_____

_____

II. Do you have any concerns with your current plan? (Is the cost too much? Do your providers accept it? Does it cover your needs? Etc.)

_____

_____

III. Do you have a Medicare Advantage plan? ☐ **Yes** ☐ **No** ☐ **Not Sure**

If No, Skip to next question

If Yes or Unsure – Did you receive an "Annual Notice of Change" (ANOC)?

a) Were there benefits added or removed?
b) Were there any changes to your provider networks?
c) Were there any changes to copays or in- and out—of-network coverage?
d) Were there any changes to Prescription Drug coverage?
e) If applicable, were you able to easily contact your plan and get any issues resolved in a timely manner?

IV. Do you have a stand-alone prescription drug plan? ☐ **Yes** ☐ **No**

If Yes – Did you receive an "Annual Notice of Change" (ANOC)?

a) Are your prescriptions still on the formulary?
b) Is the premium and/or deductible rising?
c) Are copays rising for all, or certain tiers?
d) If applicable, were you able to easily contact your plan and get any issues resolved in a timely manner?

NOTES:

NOTES:

WHAT IS SHIP?

The Senior Health Insurance Program (SHIP) is a **free** insurance counseling service for people with Medicare and their caregivers. The Illinois Department on Aging administers SHIP. This service, offered statewide, is available to people of all ages with Medicare.

- SHIP is **not** affiliated with any insurance company.
- SHIP counselors do **not** sell or solicit any type of insurance.
- SHIP counselors are trained by the Illinois Department on Aging to:
  - ◊ Assist in filing appeals regarding Medicare, Medicare Advantage plans, and Medicare supplement insurance claims;
  - ◊ Assist individuals with the medicare.gov plan finder to compare Medicare Advantage plans or Medicare Part D plans;
  - ◊ Educate and assist consumers with questions about Medicare, Medicare supplement plans, Medicare Advantage plans, Medicare Part D plans, Extra Help for Part D, Medicare Savings Programs, long-term care insurance, and other health insurance plans.

Interested in becoming part of SHIP?

A SHIP Counselor is a person who objectively counsels Medicare beneficiaries, their caregivers or representatives who have issues and/or questions regarding Medicare, Medicare Supplement, Medicare managed care or other insurance related questions. All coordinators and counselors must be affiliated with a sponsoring organization. If you are interested in becoming a counselor, SHIP can put you in touch with a local SHIP sponsoring organization prior to training.

For more information on becoming a SHIP counselor, please visit our website at https://ilaging.illinois.gov/ship/aboutship.html or email Aging.SHIP@illinois.gov

SENIOR HEALTH INSURANCE PROGRAM
Illinois Department on Aging

Illinois Department on Aging
Senior Health Insurance Program (SHIP)
One Natural Resources Way, #100
Springfield, IL 62702-1271

SHIP
State Health Insurance Assistance Program

1-800-252-8966; 711 (TRS)

Website: https://ilaging.illinois.gov/
E-mail: AGING.SHIP@illinois.gov

This Guide replaces our Medicare Supplement Premium Comparison Guide. The Guide has been transformed into a “Choices” publication highlighting traditional Medicare with a Medicare supplement policy versus taking a Medicare Advantage plan. The premium rates are no longer printed in the Guide. **For a real time quote** please contact a SHIP counselor that has access to the SHIP TA Center website that can give ‘real time’ quotes for clients. For more assistance, please call SHIP at 1-800-252-8966; 711 (TRS) or email us at Aging.SHIP@illinois.gov

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