2025 Medicare Options Guidebook

Advocate Health Care® | Aurora Health Care®

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About this guidebook

This guidebook is designed to help you with the basics of Medicare. No single Medicare plan is right for everyone. Use this guidebook to help identify your Medicare insurance needs and select the plan most suitable for you.

Main resources:

Advocate Health Care®

advocatehealth.com/medicare

Aurora Health Care®

aurora.org/medicare

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Understanding Medicare

Classifications of Medicare Insurance

The following information represents the most common classifications of Medicare insurance.

Original Medicare

Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). Original Medicare pays for most, but not all costs for covered health services and supplies. To help pay for your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can shop for and buy a Medigap plan. If you want drug coverage, you can shop for and buy a separate Part D plan.

Medigap

Medigap plans are sold by private insurance companies and can help pay some of the remaining health care costs for covered services and supplies. Medigap provides coverage that is secondary to Medicare (Part A & B), meaning Medicare pays first and the Medigap pays second. **See pages 8-11** for more information on Medigap.

Medicare Advantage Plan

Also referred to as Medicare Part C, a Medicare Advantage plan incorporates your Part A, Part B and often Part D Prescription Drug coverage into one plan. **See pages 15-16** for more information on Medicare Advantage Plans.

Employer-sponsored Medicare plan

Employer-sponsored Medicare plans are available to those who receive some form of Medicare insurance from a current or former employer (or their spouse's employer). This category includes corporate Medicare plans, union member plans, military plans (TRICARE for Life) and Medicare plans offered to federal, state and municipal retirees. This type of insurance may be a plan that works secondary to Medicare or it may function as a Medicare Advantage Plan. Employer-sponsored Medicare plans often feature premiums that include drug coverage and may be more expensive than comparable individual Medicare plans available to the general Medicare population. If you are considering cancelling an employer-sponsored Medicare plan and joining a regular Medigap or Medicare Advantage Plan, be sure to carefully consider your options, as employers often will not allow retirees to return to the plan after cancelling coverage.

Medicare/Medicaid

Medicare and Medicaid are available to those who qualify for both Original Medicare and Medicaid benefits simultaneously. Often referred to as being "dual-eligible," Medicare/Medicaid beneficiaries meet state-specific income requirements for Medicaid eligibility, in addition to being qualified for Original Medicare. In basic terms, these individuals have Medicare as their primary insurance and Medicaid as secondary insurance.

Source: medicare.gov/basics/costs/help/medicaid

Understanding your options *(cont.)*

Medicare is...

A federal government program that offers health insurance to:

- Individuals at age 65 and older or under age 65, disabled, and on Social Security for 24 months
- Any age with end-stage renal disease or ALS (amyotrophic lateral sclerosis)
- U.S. citizens or permanent legal residents in the U.S. for a minimum of five consecutive years, including five years just before applying to Medicare

Medicare is managed by the Centers for Medicare and Medicaid Services (CMS).

Note:

- You (or your spouse's) work history affects Medicare premiums, but not eligibility
- A divorced spouse can apply for Medicare benefits on the work record of their former spouse if married a minimum of 10 years (certain rules apply)
  - Social Security processes your application for Original Medicare (Part A and Part B), and can give you general information about the Medicare program
  - Other parts of Medicare are run by private insurance companies that follow rules set by Medicare

Source: medicare.gov/basics/costs/help/medicaid

Medicare basics

Original Medicare is comprised of **Part A** (hospital insurance) and **Part B** (medical insurance). These plans are made available directly through the federal government.

PART A HOSPITAL INSURANCE

Part A helps pay for hospital, skilled nursing facility, home health and hospice care. In most cases, you will usually have a $0 Medicare Part A premium if you or your spouse paid Medicare taxes long enough while working – generally at least 10 years. You are first eligible for Medicare Part A at age 65 or earlier if you have been drawing Social Security due to disability for 24 months.

PART B MEDICAL INSURANCE

Part B helps pay for physician services, outpatient services, durable medical equipment and other medical services. You are first eligible for Medicare Part B at age 65 or earlier if you have been drawing Social Security due to disability for 24 months. You are required to have both Part A and Part B to purchase a Medigap or a Medicare Advantage Plan.

PART C MEDICARE ADVANTAGE PLAN

Part C also known as Medicare Advantage Plan is an all in one alternative to Original Medicare and often includes Part D - prescription drug coverage. For these plans, Medicare pays a private insurance company to provide your health care coverage with a Medicare Advantage Plan. These plans must, at minimum, provide the same level of coverage as Original Medicare, and may include a monthly plan premium. Medicare Advantage Plans often include additional benefits not offered by Original Medicare. You must have Part A and Part B to be eligible to select a Part C plan.

PART D PRESCRIPTION DRUG COVERAGE

Part D refers to Medicare prescription drug coverage. People with Original Medicare and Medigap will need to purchase a Medicare Part D prescription plan separately. For people considering a Medicare Advantage Plan, in addition to Medicare Part A and B, they often include Medicare Part D prescription coverage. Please note, if you decide to enroll late for Part D prescription drug coverage, a penalty may be assessed.

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium.

For Medicare costs and estimates visit medicare.gov/basics/costs/medicare-costs

Information Source

The Medicare & You book published annually by the Centers for Medicare & Medicaid Services includes additional information pertaining to **Parts A, B, C and D.** You can request a copy by calling 800-MEDICARE (TTY 877-486-2048) or download a copy by going to medicare.gov/medicare-and-you**.**

Your Medicare coverage choices

Original Medicare Part A + Part B with the option of adding Part D and a Medigap plan or you can choose a Medicare Advantage plan.

1 Choose a coverage plan.

ORIGINAL MEDICARE

PART A — HOSPITAL INSURANCE

+

PART B — MEDICAL INSURANCE

2 Add prescription drug coverage.

PART D — PRESCRIPTIONS

3 Add supplemental coverage.

MEDIGAP — SUPPLEMENTAL COVERAGE

or

MEDICARE ADVANTAGE

PART C — PART A + PART B + USUALLY PART D

2 Add prescription drug coverage if not already included.

PART D — PRESCRIPTIONS

MEDIGAP: Cannot be purchased if you already have a Medicare Advantage plan.

MEDIGAP — SUPPLEMENTAL COVERAGE

Understanding your Medigap options

Medigap always functions secondary to Medicare. This means Medicare will pay its portion of the health care claim first and Medigap will pay second.

Useful facts about Medigap

The federal government has authorized 10 different standardized Medigap plan designs, named with letters from A to N for all states except Wisconsin, Minnesota, and Massachusetts, which are considered waiver states and have a different set of standardized plans. Every policy must follow federal and state laws designed to protect you. Please note: these letters have no relationship to the Medicare Part A, B, C and D designations.

All Medigap policies with the same letter offer the same benefits, regardless of insurance company selling the policy. Some policies offer additional benefits so select the plan that best suits your needs. The chart on page 10 shows the standard benefits for each plan type.

In Massachusetts, Minnesota and Wisconsin, Medigap policies are standardized in a different way. Wisconsin offers a Basic Medigap Plan and additional insurance riders are available to enhance your supplemental coverage. The choice for you depends on your budget and needs. The chart on page 11 shows the standard benefits for each plan type and additional information regarding Medigap coverage in Wisconsin.

Medigap plans are sold by private insurance companies and are not part of Medicare. Medigap plans being sold today do not include Part D Prescription Drug coverage.

Premiums for Medigap plans can vary greatly by company and plan. Medigap plans provide coverage nationwide.

Understanding your Medigap options (cont.)

Medigap Open Enrollment Period is your 6 month period starting the first month you have Medicare Part B and you're 65 or older to enroll in a Medigap policy without being subject to medical underwriting (known as guarantee issue) by the insurance company.

Medigap plans may require the prospective policy holder to answer a series of health-related questions to qualify for coverage if purchased outside of the guaranteed issue period. This is called medical underwriting.

Most Medigap plans will allow the policyholder to receive care from any Medicare-certified healthcare provider that accepts Original Medicare, but some require the use of a contracted network of providers.

Most plans cover a limited dollar amount for foreign travel emergencies.

IL Medigap Birthday Rule states individuals between 65-75 years of age that have an existing Medigap policy may switch to any Medigap policy with the same company/issuer that offers benefits equal to or less than those provided by the previous coverage.

This Illinois Medigap Birthday Rule Enrollment period begins on the individual's birth date each year and lasts for 45 days.

During this period, the policy cannot deny or place conditions on the individual holding the policy or effectiveness of Medigap 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.

Plans cannot be cancelled nor charge a higher premium due to health conditions or claims filed.

Source: medicare.gov/health-drug-plans/medigap/ready-to-buy

Medigap plan types available in Illinois

Medigap Plans

Benefits	A	B	C	D	F*	G*	K**	L**	M	N***
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-pocket limit**							Available Nov 2024	Available Nov 2024		

*Plans F and 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 before your policy pays anything.

**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 department visits that don't result in an inpatient admission.

Note: Plan C, F and FHD (high deductible) are only available to those eligible for Medicare before Jan. 1, 2020.

Source: ilaging.illinois.gov/content/dam/soi/en/web/aging/ship/documents/medicare-choices.pdf

Medigap plan types available in Wisconsin

Medigap Plans

Basic Benefits Included in Medigap Policies

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount)
- **Blood:** Covers the first three pints of blood each year
- **Part A** hospice coinsurance or co-payment

Medigap	Basic Plan
Basic Benefits	✓
Inpatient Mental Health Coverage	175 days per life-time in addition to Medicare's benefits
Home Health Care	40 visits in addition to those paid by Medicare
Other Wisconsin Mandated Benefits. Visit oci.wi.gov for more information	✓

Optional Medigap Riders
Insurance companies are allowed to offer riders to a Medigap policy holder.
1. Medicare Part A Deductible
2. Medicare Part B Deductible*
3. Additional Home Health Care (365 visits including those paid by Medicare)
4. Medicare Part B Co-payment or Coinsurance
5. Medicare Part B Excess Charges
6. Foreign Travel Emergency

50% Cost Sharing plan is similar to the national standardized Plan K.
25% Cost-Sharing Plan is similar to the national standardized Plan L.
See page 10 for more information on these 2 plan types.

* Wisconsin cannot permit a Medicare Part B medical deductible rider to be issued to those who are newly eligible for Medicare on or after January 1, 2020 as that is contrary to MACRA. However, a Medicare Part B medical deductible rider can be offered or renewed to those first eligible for Medicare prior to January 1, 2020.

Part D: Medicare prescription drug coverage

Medicare prescription drug coverage

- Medicare prescription drug coverage is an optional benefit available to everyone with Medicare
- These plans are offered by Medicare approved private insurance companies
- You must have Part A and/or Part B to enroll in Part D

Coverage

- Coverage is available through:
  - Stand-alone Medicare prescription drug plans
  - Included in most Medicare Advantage plans
  - Make sure your prescription drugs are covered before you enroll in a plan
    - The list of covered prescription drugs can change each year
    - Every plan has a tiered drug formulary, a list of prescription drugs covered by a plan
    - Medicare sets standards for the types of prescription drugs Part D plans must cover

Costs

- You may join a Part D plan approved by Medicare which may include deductibles and copayments. Prescription drugs covered vary from plan to plan
- The prescription Part D monthly plan premium varies by plan and may be higher* depending on your income
- Prescription Drug assistance programs are available for Medicare eligible individuals that meet certain requirements.

Enrollment

- Coverage is not automatic; you must enroll in a Part D plan during the appropriate enrollment period
- You must live in the service area of the Part D drug plan you want to join
- Penalties may apply if you enroll late

*For more information, visit, medicare.gov/drug-coverage-part-d

Part D: Medicare prescription drug coverage (cont.)

Do you have creditable drug coverage?

- How does your coverage compare to Medicare's?
  - For example, you may have coverage through an employer group plan, when you are still employed
  - No penalty if you have creditable drug coverage and delay enrolling in a Medicare drug plan
- Compare current drug costs on your current creditable plan vs. premium and drug costs of Medicare Part D plans

Without creditable coverage

- You may pay a late enrollment penalty if you do not sign up when first eligible or go without drug coverage for more than 63 consecutive days

Insulin savings through the Part D Senior Savings Model

INSULIN BENEFIT: The cost of a one-month supply of each Part D-covered insulin is capped at $35, and you don't have to pay a deductible. If you get a 60 or 90-day supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin.

To search for participating plans in your area, go to medicare.gov/plan-compare
You can filter and compare participating plans to help you find the one that's right for you.

For frequently asked questions on this program, visit medicare.gov/coverage/insulin

Help with drug costs–Extra Help program

"Extra Help" is a Medicare program to help people with limited income and resources pay Medicare drug coverage (Part D) premiums, deductibles, coinsurance, and other costs.

For more information on Extra Help, call Social Security at 800-772-1213 TTY:800-325-0778

medicare.gov/basics/costs/help/drug-costs

How is the Medicare Part D Benefit Changing in 2025?

Out-of-pocket drug spending will be capped at $2,000

Beginning in 2025, Part D enrollees' out-of-pocket drug costs will be capped at $2,000. This amount will be indexed to rise each year after 2025 at the rate of growth in per capita Part D costs. (This cap does not apply to out-of-pocket spending on Part B drugs.)

The coverage gap phase will be eliminated

This means that Part D enrollees will no longer face a change in their cost sharing for a given drug when they move from the initial coverage phase to the coverage gap phase, which is the case in most Part D plans today, since most plans charge varying cost-sharing amounts, rather than the standard 25% coinsurance, in the initial coverage phase.

Part D plans and drug manufacturers will pay a larger share of costs for catastrophic coverage, and Medicare will pay a smaller share

Medicare's share of total costs in the catastrophic phase (reinsurance) will decrease from 80% to 20% for brand-name drugs and from 80% to 40% for generic drugs beginning in 2025.

Part D plans and manufacturers will face changes to their share of total drug costs paid in the initial coverage phase

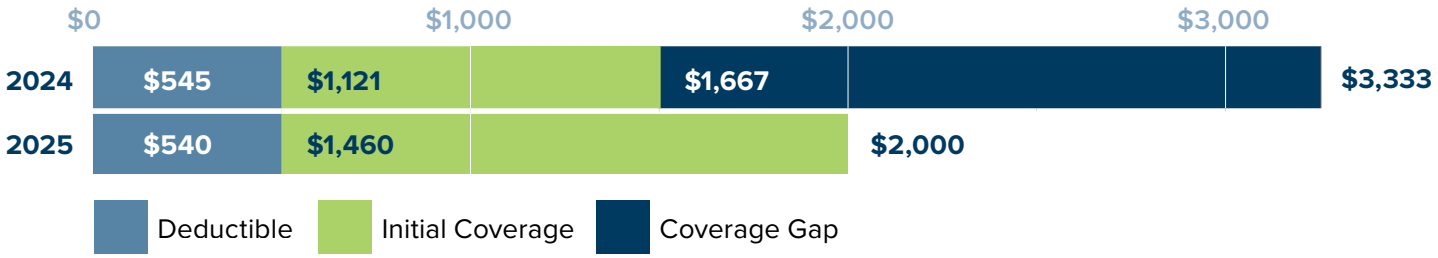
Drug manufacturers will be required to provide a 10% discount on brand-name drugs in the initial coverage phase beginning in 2025, replacing the 70% price discount in the coverage gap phase under the current benefit design. Part D plans will pay 65% of brand-name drug costs.

What Other Changes Are Being Made to Part D?

Starting in 2025, Part D enrollees will have the option of spreading out their out-of-pocket costs over the year rather than face high out-of-pocket costs in any given month.

For Medicare Part D enrollees who use only brands, out-of pocket drugs costs at the catatrosphic threshold will fall from about $3,300 in 2024 to $2,000 in 2025.

Out of pocket drug costs under the standard benefit for Part D enrollees without low-income subsidies.



NOTE: 2024 out-of-pocket amounts based on Part D benefit parameters from the 2024 Advance Notice. Deductible amount for 2025 is from 2023 Medicare Trustees report, Table V.E2.
SOURCE: KFF estimates based on Part D benefit parameters.
kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/

For a complete list of costs, visit: medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage

Understanding Medicare Advantage

Medicare Advantage facts

Medicare Advantage also known as Medicare Part C Plans work differently than Original Medicare. It is an alternate way to receive your medical and hospital benefits from a private health insurance company contracted with Medicare.

In many cases, **you can only use doctors and other providers who are in the plan's network and service area.** *If you are allowed to go out-of-network for the plan, you may have higher out of pocket costs. Contact the plan for further details.*

Medicare Advantage Plans usually include member coinsurance and copayments.

A Summary of Benefits and Coverage is an official document from the Medicare Advantage plan, summarizing member cost-sharing requirements and should be reviewed carefully prior to applying for coverage. These are available on most insurance company websites.

Some Medicare Advantage Plans charge a monthly premium, which vary considerably by insurer, plan and market. Medicare Advantage Plans cannot adjust plan premiums based on the member's age, health or claims experience.

Medicare Advantage plans require A and B of Medicare to be in effect and you must continue to pay your Part B monthly premium. You must also reside within the county (plan service area) the Medicare Advantage Plan is offered.

Medicare Advantage plans may include Part D prescription drug coverage. All Medicare Advantage Plans must include out of service emergency and urgently needed care. Contact your plan for more information on coverage while out of your plan's service area.

Some Medicare Advantage Plans feature additional plan benefits that are not included with Original Medicare, such as dental, vision care, telehealth visits, annual hearing exam, gym membership, transportation for health care services and more.

People who already have a Medicare Advantage Plan should receive an Annual Notice of Change (ANOC) letter from their Medicare Advantage Plan no later than September 30. The ANOC letter indicates how their Medicare Advantage benefits will change for the upcoming plan year. Medicare Advantage members are strongly encouraged to carefully review their ANOC letter.

All Medicare Advantage Plans are required to set maximum out-of-pocket costs for health-related services each year. Remember, this does not include Part D prescription drug expenses. Many Medicare Advantage Plans have lower maximum out-of-pocket limits. Contact your Medicare Advantage Plan for more information on coverage limits. *You cannot be enrolled in a Medicare Advantage and Medigap plan at the same time.*

Source: medicare.gov/health-drug-plans/health-plans/your-health-plan-options

Understanding your Medicare Advantage options

Medicare Advantage extra benefits

Many Medicare Advantage Plans have some of the following extra benefits included. Review plans in the state and county you reside in for specific benefit details.

Telehealth

Fitness

Dental

Eye exams and glasses

Hearing aids

Over-the-counter benefits

Meal benefit

Transportation

Bathroom safety

Home healthcare and caregiver support

Flex allowance

Some MA (Part C) plans offer additional dollars on a pre-paid card that can be used towards plan identified services

Original Medicare and Medicare Advantage comparison summary

Doctor & Hospital Choice

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you can **only use doctors and other providers who are in the plan's network and service area** (for non-emergency care).
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
For Part B-covered services, y**ou usually pay 20% of the Medicare-approved amount** after you meet your deductible. This amount is called your coinsurance.	**Out-of-pocket costs vary.** Plans may have different out-of-pocket costs for certain services.
You **pay the monthly premium** for Part B. If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out-of-pocket, unless you have supplemental coverage – like Medicare Supplement Insurance (Medigap), Medicaid, employer, retiree, or union coverage.	Plans have a **yearly limit** on what you pay for covered Part A and Part B services (with different limits for in-network and out-of-network services). Once you reach your plan's limit, you'll pay nothing for covered services for the rest of the year.
You **can choose to buy** Medigap to help pay your out-of-pocket costs that Medicare doesn't cover (like your 20% coinsurance). Or, you can use coverage from a current or former employer or union, or Medicaid.	You **can't buy** Medigap to cover your out-of-pocket costs.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

Original Medicare and Medicare Advantage comparison summary

Coverage

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some services, like routine physical exams, eye exams, and most dental care.	Plans must cover all medically necessary services that Original Medicare covers. For some services, plans may use their own coverage criteria to determine medical necessity. Plans may also offer some **extra benefits that Original Medicare doesn't cover.**
In most cases, you **don't need approval** (prior authorization) for Original Medicare to cover your services or supplies	In many cases, you may need to **get approval** (prior authorization) from your plan before it covers certain services or supplies.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans.** In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.

Foreign travel

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Original Medicare generally **doesn't cover medical care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally **don't cover medical care outside the U.S**. Some plans may offer an extra benefit that covers emergency and urgently needed services when traveling outside the U.S.

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

Medicare Advantage comparison at a glance

PLAN TYPE	HMO Health Maintenance Organization	PPO Preferred Provider Organization	PFFS Private Fee-for-Service (PFFS) Plan	SNP Special Needs Plan	MSA Medicare Savings Account
Premium Do most plans charge a monthly premium?	**Yes** Many charge a premium in addition to the monthly Part B premium.	**Yes** Many charge a premium in addition to the monthly Part B premium.	**Yes** Many charge a premium in addition to the monthly Part B premium.	**Yes** Many charge a premium in addition to the monthly Part B premium.	**No** You won't have to pay a separate monthly premium, but you'll continue to pay your Part B premium.
Drugs Does the plan offer Medicare prescription drug coverage (Part D)?	**Usually** If you join an HMO plan that doesn't offer drug coverage, you can't get a separate Medicare drug plan.	**Usually** If you join a PPO plan that doesn't offer drug coverage, you can't get a separate Medicare drug plan.	**Usually** If your PFFS Plan that doesn't offer drug coverage, you can get a separate Medicare drug plan.	**Yes** All SNPs must provide Medicare drug coverage (Part D).	**No** You may join a separate Medicare drug plan.
Providers Can I use any doctor or hospital that accepts Medicare for covered services?	**Sometimes** You generally must get your care and services from doctors, other providers, or hospitals in the plan's network (except emergency or urgent care or out-of-area dialysis). In an HMO Point-of-Service (HMOPOS) Plan you may be able to get some services out of network for a higher copayment or coinsurance.	**Yes** Each plan has a network of doctors, hospitals, and other providers that you may go to. You may also go out of the plan's network, but your costs may be higher.	**Yes** You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. If the plan has a network, you can use any of the network providers. (If you go to an out-of-network provider that accepts the plan's terms, you may pay more.)	**Sometimes** If your SNP is an HMO, you must get your care and services from doctors or hospitals in the SNP's network (except for emergency, urgent care, or out-of-area dialysis). However, if your SNP is a PPO, you can get Medicare-covered services out of network.	**Yes** MSA plans generally don't have network providers. You may go to any Medicare-approved provider for services that Original Medicare covers.
Primary Care Do I need to choose a primary care doctor?	**Usually**	**No**	**No**	**Varies by plan** Some SNPs require you to choose a primary care doctor and others don't.	**No**
Referrals Do I need a referral from my doctor to use a specialist?	**Yes**	**No**	**No**	**Maybe** If the SNPs is an HMO, you need a referral. If the SNP is a PPO, you don't need a referral.	**No**

Enrollment periods

At a glance

	Part A & B	Part D	Part C	Medigap
Medicare initial enrollment period	7 month window, starting 3 months before an individual turns 65, and ending 3 months after the month they turn 65, allowing eligible individuals to enroll into a Medicare plan.	7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare	7-month window surrounding month of entitlement to Medicare when eligible individuals can sign up for Medicare	Guaranteed issue 1-time 6-month window after a person first enrolls in Part B
General enrollment period	3 month window from Jan. 1-March 31 annually where you can enroll in Medicare Part A and B for the 1st time if you missed signing up when you were first eligible and you are not eligible for a special enrollment period. GEP coverage begins the month after you sign up for A & B. You may be subject to late penalties.			
Medicare annual open enrollment period		Oct. 15-Dec. 7	Oct. 15-Dec. 7	
Medicare Advantage open enrollment period			One-time change between January 1-March 31. Must already be enrolled in a Medicare Advantage 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. Cannot switch from one Prescription Drug Plan to another. No guaranteed issue right for Medigap.	
Special enrollment period	Granted by Medicare in certain situations	Granted by Medicare in certain situations	Granted by Medicare in certain situations	May have special rights and guaranteed issue rules

IL Medigap birthday rule: Please go to page 7 for more information on this benefit.

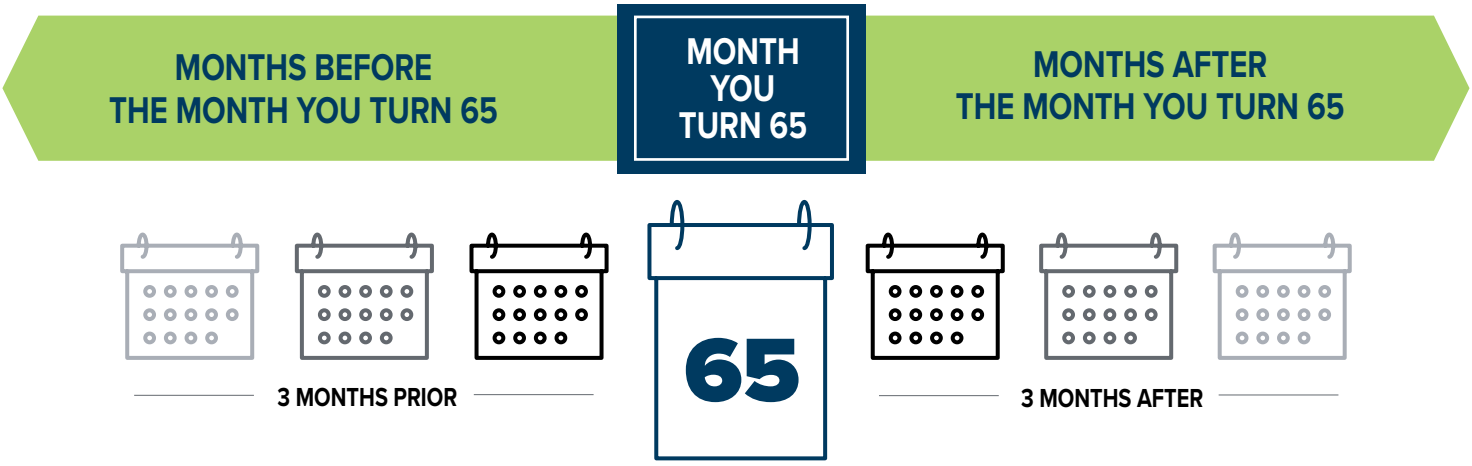
Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Signing up for Medicare

Just turning 65? Understand the Medicare initial enrollment period and Medigap open enrollment period

The Medicare initial enrollment period is a 7-month period that begins three months before you turn age 65, the month you turn 65 and ends the third month after your 65th birthday. To sign up for Medicare Part A and B benefits, contact Social Security Administration or visit www.ssa.gov/benefits/medicare/. If you sign up for Medicare Part B during the initial enrollment period, there is no late enrollment penalty. However, for Part B coverage to start by your 65th birthday, you must sign up during the three months prior to your birthday. Note: if you become eligible for Medicare due to a disability, your eligibility begins on the 25th month of receiving Social Security Disability Insurance.

When you sign up for Medicare Part B, you automatically begin your Medigap Open Enrollment Period. The Medigap open enrollment period lasts for six months after you are enrolled in Medicare Part B. During this period, an insurance company cannot deny you any Medigap policy it sells, make you wait for coverage to start, or impose a pre-existing condition.



If you enroll in this month of your initial enrollment period	Your Medicare benefit will begin
1-3 months before you reach age 65	The month you turn 65
The month you reach age 65	1 month after you enroll
1-3 months after you reach age 65	1 month after you enroll

Source: medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Initial enrollment period

You are automatically enrolled if:

- You are collecting Social Security prior to age 65
  - – Medicare Part A & B card mailed two to three months prior
  - – Coverage automatically begins the first day of your 65th birthday month
- You are under age 65 and disabled
  - – Benefits should begin the 25th month after receiving disability benefits
- If you do not want to be enrolled in Medicare Part B, follow instructions on the back of the card and return to delay enrollment Part B

You are not automatically enrolled if:

- Not collecting Social Security before age 65
- You are still working and have employer creditable health coverage
- You have coverage through the Health Insurance Marketplace
- You can enroll with Social Security
  - – Visit your local office, go to SSA.gov or call 800-772-1213 (TTY 800-325-0778)
  - – If retired from the railroad
    - Enroll with the Railroad Retirement Board
    - Call your local Railroad Retirement Board office or 877-772-5772 (TTY 312-751-4701)

You do not have to be retired to receive your Medicare benefits.

Medicare Enrollment Facts

You can sign up for your Medicare benefit at age 65 but you can choose to delay drawing on your Social Security benefits until later.

To avoid paying a late enrollment penalty for Part B (Medical) and Part D (Prescription Drug) you must have creditable health insurance. Check with your employer or current health insurance company to see if their plan is expected to pay, on average, at least as much as Medicare drug coverage or similar in value to Medicare Part B.

Source: medicare.gov/basics/get-started-with-medicare/medicare-basics/working-past-65
medicare.gov/basics/costs/medicare-costs/avoid-penalties

Special Enrollment Period

What if you're working past 65?

You may be eligible for a Special Enrollment Period

If you (or your spouse) already have or are eligible for current employer health insurance or union coverage, check with your benefits administrator or insurer and ask how your current plan works with Medicare.

You may be able to apply for Medicare right away during your initial enrollment period or wait on some parts. Note: If you decline your employer's plan, all family members covered by it, including your spouse and children, would also lose their group benefits and would need to find a new plan.

If you choose to wait to enroll in Medicare after age 65 while you continue to work, you will get a Special Enrollment Period to sign up when you retire.

You may enroll (for Part A and or B)

- Anytime while still covered after your 65th birthday
- Within eight months (within two months for Parts C and D) of loss of coverage or current employment, whichever happens first

Note: Retiree and COBRA coverage are not considered active employment.

Additional Resources

Medicare: medicare.gov **or 800-MEDICARE (800-633-4227) (TTY/TDD 877-486-2048)**

Making changes to your coverage

Medicare Annual Open Enrollment Period also known as Annual Election Period (AEP): Oct. 15-Dec. 7 every year

- Join, drop, or switch to another Medicare Advantage Plan (or add or drop drug coverage).
- Switch from Original Medicare to a Medicare Advantage Plan or from a Medicare Advantage Plan to Original Medicare.
- Join, drop, or switch to another Medicare drug plan if you're in Original Medicare.
- Plan is effective January 1 of next year.

Medicare Advantage Open Enrollment Period (OEP)

Runs from Jan. 1-March 31 every year or within the first 3 months you get Medicare. If you're enrolled in a Medicare Advantage plan, you will have
a one-time opportunity to:

- Switch to a different Medicare Advantage plan
- Drop your Medicare Advantage plan and return to Original Medicare and sign up for a stand-alone Medicare Part D Prescription Drug plan
- Have the new coverage start the first of the month after the plan gets your request.

Special Enrollment Period (SEP)

- Granted by Medicare in certain situations. You may have special rights. If you have employer group health plan coverage based on your (or spouse's) active current employment, you may enroll (in Part A and/or B) anytime while still covered or within eight months (within two months for Parts C and D) of loss of coverage or current employment, whichever happens first

To sign up for Part B in a special enrollment period, go to ssa.gov/forms and download two forms: **CMS 40-B** and **CMS L-564**

Trial Period

- For those that have joined a Medicare Advantage Plan for the first time, you can drop your Medicare Advantage Plan and switch to Original Medicare anytime within the first 12 months of plan coverage. You may also have a guaranteed issue opportunity to purchase a Medigap plan

Source: medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Tips and resources

- **Determine which Medicare plans are accepted by your physicians, hospital and other health care providers**

  Beneficiaries should review plans that provide them **the benefits they need to address their health coverage needs.** Within the plans that provide the benefits they need, the should review to see which ones are accepted by their provider.

- **Reflect on your recent health history**

  Do you have any special health care needs, such as receiving outpatient services on a regular basis or a history of frequent hospitalizations? By making a list of health care services you've required in the recent past, you will be able to verify that the Medicare plans you're considering will include these important insurance benefits.

- **Understand the maximum out-pocket benefit**

  Maximum out-of-pocket benefits are included in Medicare Advantage Plans; however, the maximum amount will vary by plan. Original Medicare typically covers 80% and has no maximum out-of-pocket benefit. Choosing an optional Medigap plan would help offset this cost.

- **Consider your prescription medication needs**

  Compare your list against the plan formulary of any Medicare Part D prescription plan of interest, and make sure your prescription medications are covered.

- **Added benefits may be important**

  Many Medicare Advantage Plans include added benefits such as dental, vision, hearing, telehealth, alternative health care, wellness membership and more. Original Medicare and Medigap may not offer these added benefits.

Tips and resources

NATIONAL

CMS – Centers for Medicare and Medicaid Services: cms.gov or 800-633-4227 (TTY 877-486-2048)

Extra Help Prescription Drug Assistance Program available for those with limited income and resources 800-772-1213 or socialsecurity.gov/i1020

Medicare: medicare.gov or 800-633-4227 (TTY/TDD 877-486-2048)

Medicare Benefits Coordination and Recovery Center: 855-798-2627 (TTY 855-797-2627)

Medicare Fraud: 800-633-4227 (TTY 877-486-2048).
If you are in a Medicare Advantage Plan or Medicare drug plan, call the Medicare Drug Integrity Contractor (MEDIC) at 877-772-3379.

Social Security Administration: ssa.gov or 800-772-1213 (TTY 800-325-0778)

National SHIP (State Health Insurance Assistance Program) information: 877-839-2675 shiptacenter.org

ILLINOIS

Advocate Health Care IL Medicare website: advocatehealth.com/Medicare

Illinois Department on Aging: ilaging.illinois.gov/ or 800-252-8966 (TTY 888-206-1327)

SHIP – Senior Health Insurance Program: ilaging.illinois.gov/ship.html or 800-252-8966 (TTY 888-206-1327)

WISCONSIN

Aurora Health WI Medicare website: aurora.org/medicare

Wisconsin Department on Aging: 866-229-9625 dhs.wisconsin.gov/aging

Wisconsin Office of the Commissioner of Insurance: 800-236-8517 OCI.WI.gov

Wisconsin Part D Helpline: 855-677-2783

Disability Rights Wisconsin Medicare Part D Helpline: 800-926-4862

WI Senior Care Prescription Drug Assistance Program: 800-657-2038
dhs.wisconsin.gov/seniorcare/index.htm

Glossary

Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).
Copayment	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. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
Deductible	The amount you must pay for healthcare or prescriptions before Original Medicare, your Medicare Advantage plan, your Medicare drug plan, or your other insurance begins to pay.
Dependent	Any individual, either spouse or child, who is covered by the primary insured customer's plan.
In-Network Provider	A healthcare professional, hospital or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services.
Medigap	Plans offered by private insurance companies to help fill the gap in Medicare coverage.
Network	The group of doctors, hospitals and other healthcare providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.
Out-of-Network Provider	A healthcare professional, hospital or pharmacy that is not part of a health plan's network of providers. You will generally pay more for services received from out-of-network providers.
Out-of-Pocket Maximum	The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.
Payer	The health insurance company (also known as a carrier) whose plan pays to help cover the cost of your care.
Premium	The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.
Provider	Any person (e.g., doctor, nurse, dentist) or institution (e.g., hospital or clinic) that provides medical care.

Notes

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For more information, visit us online at

advocatehealth.com/medicare

or

aurora.org/medicare