

Wisconsin Guide

to Health Insurance for People with Medicare

Wisconsin Office of the COMMISSIONER OF INSURANCE

2026 Guide to Health Insurance for People with Medicare in Wisconsin

This guide gives an overview of the Medicare program and the health and prescription drug insurance available to those on Medicare in Wisconsin.

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Free Health Insurance Counseling for Seniors

The following statewide toll-free phone numbers are set up by the Wisconsin Board on Aging and Long-Term Care and funded by the Office of the Commissioner of Insurance (OCI) to answer questions about health insurance, other healthcare benefits, and prescription drug benefits for people with Medicare. They have no connection with any insurance company.

- Medigap Helpline: 1-800-242-1060
- Medigap Part D and Prescription Drug Helpline: 1-855-677-2783

Disclaimer

This guide is intended as a general overview of current law in this area but is not intended as a substitute for legal advice. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be the most up to date information available. Publications are available at oci.wi.gov/Publications. If you need a printed copy, use the online order form oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx or call 1-800-236-8517. One copy of this publication is available free to the public. This document may be printed or copied without permission.

File a Complaint

If you have a complaint (pages 4-5) about your insurance, first contact the insurance company or agent involved. If the problem isn't resolved, contact the Office of the Commissioner of Insurance (OCI).

- Reach out to OCI (1-800-236-8517, ocicomplaints@wisconsin.gov) to speak with our staff. If sending an email, please include your name and phone number.
- File a complaint with OCI. You can file a complaint online at oci.wi.gov/complaints. Or, to file your complaint by mail, visit oci.wi.gov/complaints, email ocicomplaints@wisconsin.gov, or call 1-800-236-8517 for a form.

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Introduction

This publication provides a general overview of the Medicare program and describes the health and prescription drug insurance available to individuals on Medicare. A list of Medicare Supplement Insurance Policies marketed in Wisconsin is available on the OCI website at oci.wi.gov/Pages/Consumers/PI-010.aspx or the Medicare website at medicare.gov/plan-compare.

If you have a complaint about your insurance, first contact the insurance company or agent involved. If the problem isn't resolved, contact OCI. A complaint form is available on the OCI website at oci.wi.gov/complaints.

To file a complaint with OCI:

Visit the OCI website at oci.wi.gov/Complaints or call :
1-800-236-8517 (Statewide)

(608) 266-0103 (Madison)
Deaf and hearing or speech-impaired callers may reach OCI through WI TRS.

Medicare Advantage and Prescription Drug Plans (PDPs) are regulated by Medicare, not OCI. Complaints about these plans or appeals of plan decisions must be made through the federal Centers for Medicare & Medicaid Services (CMS). Visit Medicare.gov. or call 1-800-MEDICARE (1-800-633-4227) for more information.

Important Notice

The State of Wisconsin has received a waiver from the federal A-N standardization regulations on Medicare Supplement insurance. This means policies sold in Wisconsin are somewhat different from those available in other states. This publication describes only those policies available in Wisconsin.

What is Medicare?

Medicare is the health insurance program administered by CMS for people 65 years of age or older, people of any age with permanent kidney failure or Lou Gehrig's disease (ALS), and some individuals under 65 with disabilities. Although Medicare may pay a large part of your health care expenses, it does not pay for all your expenses. Some services and medical supplies are not fully covered. A publication titled Medicare & You is available at Medicare.gov in several different formats (English and Spanish) including large print, eBook, audio, and braille versions: medicare.gov/forms-help-resources/medicare-you-handbook/download-medicare-you-in-different-formats. You can also request a paper handbook by calling 1-800-MEDICARE (1-800-633-4227) or from any Social Security office. The publication provides a detailed explanation of Medicare.

Medicare is divided into four types of coverage: Part A, Part B, Part C, and Part D.

Medicare Part A

Medicare Part A is commonly known as hospitalization insurance. For most people, Part A is available without paying a monthly premium for coverage. It pays your hospital bills and certain skilled nursing facility expenses. It also provides very limited coverage for skilled nursing care after hospitalization, rehabilitative services, home health care, and hospice care for the terminally ill. It does not pay for your personal (custodial) care, such as help with eating, dressing, or moving around.

Under Medicare Part A, a period of hospitalization is called a benefit period.

A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a nursing facility for 60 consecutive days. If you are re-admitted within 60 days, you are still in the same benefit period and would not pay another deductible. If you are admitted to a hospital after the benefit period ends, an entirely new benefit period begins, and a new deductible must be paid.

If you do not qualify for premium-free Medicare Part A, you may be able to buy it. Visit ssa.gov or call Social Security at 1-800-772-1213 for more information.

Medicare Part B

Medicare Part B is commonly known as medical insurance. It helps pay your doctors' bills and certain other charges, such as surgical care, diagnostic tests and procedures, some hospital outpatient services, preventive services, laboratory services, physical and occupational therapy, and durable medical equipment. It does not cover your prescription drugs, dental care, physicals, or other services not related to the treatment of an illness or injury. The premium is automatically taken out of your Social Security check each month if you receive Social Security benefits. If not, you may be billed for it.

Medicare Part C/Medicare Advantage

Medicare Part C is the Medicare program more commonly known as Medicare Advantage providing Medicare coverage through private insurance plans.

Medicare Advantage plans bundle all Medicare health benefits (with or without drug coverage) and may include extra services such as vision, hearing, dental, and more. You do not need to purchase a Medicare Supplement policy if you enroll in a Medicare Advantage plan.

However, your Medicare Advantage plan may include deductibles and copayment and/or coinsurance (out-of-pocket expenses) that don't apply to Wisconsin standardized Medicare Supplement policies. You may also be limited to using doctors in the plan's network or going to certain hospitals for services. Additional information is available in the OCI publication Medicare Advantage in Wisconsin: oci.wi.gov/Pages/Consumers/PI-099.aspx.

Effective Jan. 1, 2021, people with End-Stage Renal Disease (ESRD) may enroll in Medicare Advantage plans.

Medicare Part D/Prescription Drug

Medicare Part D is the Medicare program that helps you pay for outpatient prescription drug costs. It is an optional program available to you because you are eligible for Medicare Part A and/or enrolled in Medicare Part B. See pages 8-10 for additional information about Medicare Part D.

What Are Specific Limitations Under Medicare?

Medicare was not designed to pay all your health care expenses. It does not cover long-term care expenses. Medicare provides limited coverage for skilled nursing care and home health care. Medicare does not pay for personal care, such as eating, bathing, dressing, or getting into or out of bed. Most nursing home care is not covered by Medicare**.**

Skilled Nursing Care Limitations

If you need skilled nursing care (as defined by Medicare), Medicare pays limited benefits in a Medicare-approved skilled nursing facility. For more information, visit oci.wi.gov or contact OCI to request a copy of Guide to Long-Term Care: oci.wi.gov/Pages/Consumers/PI-047.aspx.

Home Health Limitations

Medicare pays limited benefits for your home health care services considered medically necessary by Medicare. For more information, visit oci.wi.gov or contact OCI and request a copy of the publication Guide to Long-Term Care: oci.wi.gov/Pages/Consumers/PI-047.aspx.

What Preventive Care Is Covered Under Medicare?

Medicare helps cover some of your preventive care services to help maintain your health and keep certain illnesses from getting worse. You may be required to pay a portion of the costs for these services. Information regarding Medicare preventive services is available in your Medicare & You publication (medicare.gov/medicare-and-you).

What Is Meant by Out-of-Pocket Expenses?

Out-of-pocket expenses are the costs you must pay yourself. Out-of-pocket expenses occur when there is a cost-share for a service, or you receive a service not covered by Medicare.

There are three types of out-of-pocket expenses you typically must pay yourself:

1. Medicare deductibles, coinsurance, and copayments.
2. Fees that exceed the Medicare-approved amount (depending on whether the provider accepts Medicare assignment or not – see below).
3. Services not covered by Medicare.

There are insurance policies you can purchase to cover some of your out-of-pocket expenses not covered by Medicare called supplement policies. Medicare Supplement policies are described in the Individual Policy Options section of this publication.

What Does Accepting Assignment Mean?

Some doctors and other providers accept Medicare assignment. This means the doctor or provider is paid directly by Medicare and accepts the Medicare-approved amount.

A doctor or other provider who does not accept assignment can charge you 15% over Medicare's approved amount. In this case, you are responsible not only for the usual cost-sharing of 20% of the approved charge for the service but also for the full 15% excess charge.

What is Medicare Part D?

Medicare Part D is the Medicare Prescription Drug Plan (PDP). A program created by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide prescription drug cost assistance to people on Medicare. It is an optional program available when you are eligible for Medicare Part A and/or enrolled in Part B.

Enrollment

Medicare Part D includes an annual open enrollment period from October 15 through December 7, when you can enroll or change to another PDP. Your coverage begins on January 1 of the following year. If you are not yet on Medicare, you can join a PDP when you become eligible for Medicare.

Although your enrollment in Medicare Part D is voluntary, you may have to pay a penalty if you don't sign up when you are first eligible, and there were 63 days or more in a row when you did not have either Medicare drug coverage or other creditable prescription drug coverage such as SeniorCare, a group employer plan, or veterans benefits. Currently, the late enrollment penalty is equal to one percent of the national base beneficiary premium **($38.99 for 2026)** for every month you wait to enroll. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage.

Medicare Part D coverage is offered by approved PDPs. The PDP benefits are administered by private companies, some of which may be insurance companies. There are two types of Medicare PDPs. One is a stand-alone PDP, which offers you only prescription drug coverage. The other is a Medicare Advantage plan with prescription drugs (MA-PD), which provides all your Medicare-covered services as well as prescription drug coverage.

You should review your drug coverage during every annual open enrollment period to make sure you have the best plan for your prescription drug needs.

Premiums

The cost of your Medicare Part D coverage will vary based on the PDP you choose. If you are not eligible for low-income assistance (referred to as Limited Income Subsidy), you will pay a monthly premium, an annual deductible, and a percentage of your drug costs. Your PDP will pay for your outpatient prescription drug expenses after you have met deductible, copayment, and coinsurance amounts.

Coverage

The prescription drugs covered by your PDP will vary based on the plan you choose. If you enroll in a Medicare Part D PDP, it is important to understand your PDP will pay for only those prescriptions in the plan's formulary. A formulary is a list of specific drugs your Medicare PDP will cover. Only the cost of drugs covered by your PDP will count toward the deductible and out-of-pocket limits.

Outpatient prescription drug expenses not covered by your PDP or drugs covered by a drug discount card will not count toward the out-of-pocket expense requirement of your PDP.

Extra Help for People with Limited Income and Resources

If your income is low, you may qualify for Extra Help, also called Low Income Subsidy (LIS): medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d This is a federal program to help you pay for most of the costs of Medicare prescription drug coverage. The amount of assistance you qualify for depends on your income. Income and resources standards are adjusted annually, and the amounts are released in January of each year. **For example, in 2026, if your resources are less than $17,600 for individuals or $35,130 for married couples living together, you may qualify for Extra Help.**

You can apply for Extra Help to assist in paying for your Medicare prescription drug coverage with the Social Security Administration (SSA) through paper or online application. You may contact the SSA at ssa.gov or by phone at 1-800-772-1213. You may also apply for Extra Help at your local Medicaid office.

Tips to Remember

- Your participation in the Medicare Part D program is voluntary. However, if you don't enroll in a Part D plan when you are first eligible and you decide to join later, you may have to pay a late enrollment penalty unless you have had creditable drug coverage, such as Wisconsin's SeniorCare Prescription Drug Assistance Program.
- You do not have to pay an enrollment fee or pay for assistance to enroll in Medicare Part D.
- You will have to pay for Medicare Part D coverage, which may include monthly premiums and cost-sharing, such as annual deductibles, coinsurance, and copayments.
- You may be eligible for Extra Help to pay for your Medicare Part D prescription drug coverage based on your income.
- You do not have to enroll in Medicare Part D to keep your Medicare Part A and Part B coverage.

- You do not have to buy any additional insurance products to be eligible to enroll in Medicare Part D and you should be wary of any individual who uses a Part D sales pitch to sell other insurance products.

Contact

You can get information about Medicare Part D by calling the Part D Helpline: 1-855-677-2783.

Coverage Options Available When You are Eligible for Medicare

Finding the right coverage at an affordable price may be difficult as no one policy is right for everyone. Although there are many options available, this publication focuses on the coverage options under individual Medicare Supplement insurance policies, Medicare SELECT insurance policies, Medicare Cost insurance policies, Medicare cost-sharing policies, Medicare high-deductible policies, and Medicare Advantage plans.

Before you decide to purchase a policy to help fill Medicare gaps, you should familiarize yourself with Medicare options, benefits, and rules.

CMS, which administers the Medicare Program, produces several guides, all of which are free and can be obtained by writing to CMS or contacting 1-800-MEDICARE (1-800-633-4227) or Medicare.gov.

Generally, when you become eligible for Medicare, you are not eligible to purchase a new plan on the Federally Facilitated Marketplace (FFM). Information regarding Medicare and FFM coverage can be found at HealthCare.gov/medicare.

Individual Policy Options

If you are eligible for Medicare, many insurance companies offer individual policies supplementing the benefits available under Medicare. Options include Medicare Supplement (aka Medigap), Medicare SELECT, and Medicare Advantage policies.

Medicare Supplement Policies

Medicare Supplement policies provide coverage for some of the costs not covered by Medicare Part A and Medicare Part B. You are eligible for open enrollment in an individual Medicare Supplement plan for six months starting with the first day you are enrolled in Medicare Part B, regardless of your health history.

Medicare was never intended to pay 100% of your medical bills but was created to offset your medical expenses by providing basic benefits. While it will pay a significant portion of your medical bills, Medicare does not cover all the services you might need. Even those services covered are not covered in full.

Your Medicare Supplement policy does not restrict your ability to receive services from the doctor of your choice. However, these policies may require you to submit your claim to the insurance company for payment.

Your individual Medicare Supplement policy includes a basic core of benefits. In addition to the basic benefits, your Medicare Supplement insurance company offers specified optional benefits. Each of the options the insurance company offers you must be priced and sold separately from the basic policy.

Medicare requires you to pay deductibles and many Part B expenses are paid at 80% of the Medicare-approved amount. Medicare Supplement policies may be purchased from insurance companies to cover the remaining 20% of Medicare-approved expenses not covered by Medicare.

Outline of Coverage

The Outline of Coverage is a summary of your benefits provided by Medicare Parts A and B and your Medicare Supplement policy. The outline includes a chart showing your expenses both covered and not covered by either Medicare or the Medicare Supplement policy. An agent or insurance company must give you an Outline of Coverage when selling you a new policy or replacing the one you already own.

Some insurance companies offer Medicare Supplement or Medicare SELECT cost-sharing policies. These plans require you to pay a portion of the costs for Medicare-covered services until you reach an out-of-pocket limit. **For 2026, the out-of-pocket limit for 25% cost-sharing plans is $4,000 and the out-of-pocket limit for 50% cost-sharing plans is $8,000.** The out-of-pocket limits for Medicare Supplement or Medicare SELECT cost-sharing policies are updated each year and are based on estimates of the United States Per Capita Costs of the Medicare program published by the Centers for Medicare & Medicaid Services.

Some insurance companies may offer you a Medicare Supplement high-deductible plan. **High-deductible Medicare Supplement plans offer benefits after you have paid a calendar year deductible of $2,950 for 2026**. You pay the expenses ordinarily paid by the policy until you reach that amount. As of January 1, 2020, Medicare Supplemental high-deductible plans sold to people who are new to Medicare are not allowed to cover the Part B deductible. As a result of this, the Part B deductible is not covered (reimbursed) if you are newly eligible for Medicare on or after January 1, 2020, however, it does count towards your High-Deductible plan's deductible. If, in the rare circumstance, your Plan's High Deductible is met with all Part A expenses and Part B Deductible expenses are then incurred, these expenses will not be covered expenses until you meet the Medicare Part B deductible.

Medicare SELECT Policies

Medicare SELECT policies are supplemental policies paying benefits only if your covered services are obtained through network providers selected by the insurance company or health maintenance organization (HMO). Each insurance company offering a Medicare SELECT policy contracts with its own network of doctors or other providers to provide services. Each of these insurance companies has a provider directory listing the doctors and other providers you can use.

If you buy a Medicare SELECT policy, each time you receive covered services from a plan provider, Medicare pays its share of the approved charges, and the insurance company pays the full supplemental benefits provided for in the policy. Medicare SELECT insurers must pay supplemental benefits for emergency health care furnished by providers outside the plan provider network.

In general, Medicare SELECT policies will deny payment or pay less than the full benefit if you go outside the network for nonemergency services. However, still pays its share of approved charges if the services you receive outside the network are services covered by Medicare.

Important Notice

Coverage Changes to Part B Deductible - The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed Medicare Supplement policies' coverage of Part B deductibles for those who became "newly eligible" Medicare Beneficiaries on or after January 1, 2020, prohibiting first dollar Part B coverage. This means a Part B Deductible Rider, Medicare SELECT policy, or High-Deductible Plan (which covers the Part B deductible as part of the plan) cannot be sold to you if you are "newly eligible" for Medicare. If you either became eligible for or were enrolled in Medicare before January 1, 2020, you may keep or purchase a Part B Deductible Rider, Medicare SELECT policy, or High-Deductible Plan (which covers the Part B deductible as part of the plan) after December 31, 2019.

Medicare Cost Policies

Medicare Cost policies are offered by certain HMOs through a special arrangement with CMS. Insurers marketing Medicare Cost policies offer both basic and enhanced Medicare Cost policies. The basic Medicare Cost policy supplements only those benefits covered by Medicare and does not provide the benefits mandated under Wisconsin insurance law.

You must live in the plan's geographic service area to apply for Medicare Cost insurance. The doctors or other providers are selected by the HMO, and agree to provide your Medicare benefits, or may provide you with additional benefits at additional cost. Medicare Cost

insurance will only pay your full supplemental benefits if covered services are obtained through HMO plan doctors or other providers, called the plan's "network."

If you purchase a Medicare Cost policy, Medicare pays its share of approved charges if you receive services from outside the plan's network area. **If you go to a doctor or other provider who does not belong to your HMO without a referral from your HMO doctor, you will pay for your Medicare deductibles and copayments. The HMO will not provide your supplemental benefits.**

Medicare Advantage Plans (Medicare Part C)

Medicare Advantage plans are offered by certain HMOs and insurance companies that have special arrangements with CMS. Under these arrangements, the federal government pays the HMO or insurance company a set amount for each Medicare enrollee. The HMO or insurance company agrees to provide all Medicare benefits and may provide some additional benefits, which may be at an additional cost. To receive the most benefits, you must receive services from only network providers.

It is important to note your Medicare Advantage plan can terminate at the end of the contract year if either the plan or CMS decides to terminate their arrangement. Medicare beneficiaries may also make changes to their Medicare coverages between October 15 – December 7 during the Medicare Annual Enrollment. Those already covered by a Medicare Advantage plan have another opportunity to switch Advantage plans between January 1 – March 31 during the Medicare Advantage Open Enrollment.

Your Medicare Advantage plan may include deductibles and copayment/coinsurance amounts that do not apply to Wisconsin standardized Medicare supplement policies.

Medicare Advantage plans are not regulated by OCI. Therefore, these plans are **NOT** required to cover Wisconsin mandated benefits, nor is your plan guaranteed renewable for life, like Medicare Supplement policies. You can find information regarding Wisconsin Mandated Benefits on page 17 of this publication or by contacting OCI at oci.wi.gov or the phone numbers listed in this publication.

You may obtain more information by requesting a copy of the OCI publication Medicare Advantage in Wisconsin: oci.wi.gov/Pages/Consumers/PI-099.aspx. You may also call CMS at 1-800-MEDICARE (1-800-633-4227) for information.

Medicare Advantage Health Maintenance Organization Plans

If you enroll in a Medicare Advantage plan through a health maintenance organization (HMO) contracting with CMS, you are required to seek care from plan providers. This means, except for emergency or urgent care situations away from home, you must receive all services from HMO contracted medical providers. If you go to a doctor or other provider who

does not have a contract with your HMO without a referral from your doctor, you are responsible for the entire cost of the services you receive, including Medicare costs. To be eligible for a Medicare Advantage plan through an HMO, you must live in the HMO's geographic service area.

Medicare Advantage Preferred Provider Organization Plans

If you enroll in a Medicare Advantage plan through a preferred provider organization plan (PPO), to receive full coverage under the PPO option, you must receive all services, except for emergency or urgent care situations away from home, from plan providers. You may also enroll in a Medicare Advantage plan through an insurance company with a preferred provider organization plan contracted with CMS. However, you may receive services from providers outside the plan at an additional cost.

Medicare Advantage Private Fee-For-Service Plans

Medicare Advantage private fee-for-service (PFFS) plans differ from Medicare Advantage HMO and PPO plans because they allow you to go to any doctor, hospital, or health care provider who agrees to accept the PFFS plan's terms of payment. PFFS plans do not have contracts with doctors, hospitals, or health care providers. You do not have to obtain a referral from the plan to go to a doctor, hospital, or specialist of your choice. However, it is your responsibility to verify the doctor or other provider will accept the PFFS plan's payment terms. Doctors and other providers can stop accepting the Medicare Advantage PFFS plan's terms and reimbursement rates at any time they choose.

Group Insurance Options

If you are covered under an employer group plan, you may still be eligible for coverage after you reach 65 years old, either as an active employee or as a retiree. You may also be eligible to purchase coverage through a voluntary association.

Employer Group Plans

If you are currently covered under an employer's group insurance plan, you should determine if you have the option of continuing coverage or converting to suitable coverage that will supplement Medicare before you decide to retire, become eligible for Medicare, or reach age 65. State and federal laws require many employers to offer continued health insurance benefits for a limited time if your group coverage ends because of divorce, death of a spouse, or termination of employment for reasons other than a discharge for misconduct.

You should check with your employer for more information. You should also submit a written request to your insurance company regarding the benefits you will have under the group insurance policy after you or your spouse become eligible for Medicare.

If either you or your spouse plan to continue working after age 65, you need to take extra care in making insurance decisions. Your group insurance plan may not provide the same coverage you received before you turned 65.

Employer Plans

Federal law determines when Medicare is the primary payer and when it is the secondary payer. This determination is based on whether you meet the definition of employee or dependent under the group insurance policy and whether the group insurance policy is offered by an employer with 20 or more employees. In some cases, your employer may offer a supplement to Medicare through a group retiree plan.

Employers with 20 or More Employees

If you continue to work past age 65, and your employer has at least 20 employees, your group plan is the primary payer over Medicare. If you are 65, retired, covered under your actively employed spouse's group plan, and your spouse's employer has at least 20 employees, the group plan is the primary payer. **In either of these cases, when the employee (you or your spouse) retires and is no longer considered an active employee, each Medicare-eligible beneficiary (you and/or your spouse) may have a Special Enrollment Period (SEP) and should enroll in Medicare Part B (if not already enrolled).**

If you do not enroll in Medicare Part B and are allowed to continue your employer's group health plan, the group policy may pay only 20% of covered expenses and you are responsible for paying the remaining 80%. This is because your group policy may calculate its benefit payment as if you are enrolled in Medicare Part B regardless of whether you sign up for Medicare Part B. Also, to apply for a Medicare Supplement or Medigap policy, most insurance companies require you to have both Medicare Part A and Part B.

Employers with Less Than 20 Employees

If you continue to work past age 65 and are considered an active employee but your employer has fewer than 20 employees, Medicare is the primary payer, and your group policy is the secondary payer. If you do not enroll in Medicare Part B when you become eligible, your group policy may pay only 20% of covered expenses and you are responsible for paying the remaining 80%. This is because your group policy may calculate its benefit payment as if you are enrolled in Medicare Part B regardless of whether you sign up for Medicare Part B. If your spouse is covered under your employer's plan and becomes eligible for Medicare because of disability or retirement, your group policy may change to paying only 20% because Medicare is primary as soon as your spouse becomes eligible for Medicare.

You can search for the publication *How Medicare Works with Other Insurances* online at medicare.gov/publications (or view it online by clicking here). You can also contact your local Social Security office to request the publication.

Remember: Employer group coverage is often available regardless of your health and usually does not include any waiting periods for preexisting conditions.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is the law allowing some people to keep their group health coverage for a limited time after they leave their employment. However, there are important time frames affecting COBRA coverage when you are eligible for Medicare and Medicare Supplement policies.

Additional information regarding COBRA coverage and Medicare Part B is in the publication Medicare & You, available on the Medicare website or by contacting your local Social Security office.

Special Enrollment Period

If you did not enroll in Medicare Part B when you were first eligible because you or your spouse were working and had group health plan coverage through you or your spouse's employer or union, you may be eligible to enroll in Medicare Part B during a Special Enrollment Period (SEP). You or your spouse (or your family member if you are disabled), also have an eight-month SEP to sign up for Part B that starts at one of these times (whichever happens first):

1. The month after employment ends.
2. The month after group health plan insurance based on current employment ends.

COBRA and retiree health plans aren't considered coverage based on current employment. **Details regarding more events that trigger a SEP are available from the Social Security Administration:** ssa.gov/pubs/EN-05-10043.pdf.

Health Savings Account

If you have a Health Savings Account (HSA) with a High-Deductible Health Plan (HDHP) through current employment, you may be eligible for a SEP. To avoid a tax penalty, you should stop contributing to your HSA for at least six months before you apply for Medicare. We suggest you consult a tax professional regarding your specific situation to discuss necessary changes to avoid excess contributions. You can withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses (like deductibles, premiums, coinsurance, or copayments).

Voluntary Association Plans

Many associations offer group health insurance coverage to their members. Association plans are not necessarily less expensive than comparable coverage under an individual policy. Be sure you understand the benefits included and then compare prices. Association groups offering Medicare Supplement insurance must comply with the same rules applying to other Medicare Supplement policies.

What Are Wisconsin Mandated Benefits?

Wisconsin insurance law requires that individual Medicare Supplement policies, Medicare SELECT policies, and some Medicare Cost policies contain the following mandated benefits. These benefits are available even when Medicare does not cover these expenses. **Medicare Advantage plans are NOT required to provide these benefits.**

Skilled Nursing Facilities—Medicare Supplement and Medicare SELECT policies cover 30 days of skilled nursing care in a skilled nursing facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care. No prior hospitalization may be required. The facility must be a licensed skilled care nursing facility. The care must also meet the insurance company's standards as medically necessary.

Home Health Care—Medicare Supplement and Medicare SELECT policies cover up to 40 home care visits per year in addition to those provided by Medicare **if you qualify**. Your doctor must certify that you would need to be in the hospital or a skilled nursing home if the home care was not available to you. Home nursing and medically necessary home health aide services are covered on a part-time or intermittent basis, along with physical, respiratory, occupational, or speech therapy.

Medicare Supplement insurance companies are required to offer an option to purchase coverage for 365 home health care visits in a policy year. Insurance companies may charge an additional premium for the additional coverage. Medicare provides coverage for all medically necessary home health visits. However, "medically necessary" is narrowly defined, and you must meet certain other criteria.

Kidney Disease—Medicare Supplement and Medicare SELECT policies cover inpatient and outpatient expenses for dialysis, transplantation, or donor-related services of kidney disease in an amount not less than $30,000 in any calendar year. Policies are not required to duplicate Medicare payments for kidney disease treatment.

Diabetes Treatment—Medicare Supplement and Medicare SELECT policies cover the usual and customary expenses incurred for the installation and use of an insulin infusion pump or other equipment or nonprescription supplies for the treatment of diabetes. Self-management services are also considered a covered expense. This benefit is available even if Medicare does not cover the claim.

Medicare Supplement and Medicare SELECT policies issued beginning January 1, 2006, do not cover prescription medication, insulin, and supplies associated with the injection of insulin as policies are prohibited from duplicating coverage available under Medicare Part D.

Chiropractic Care—Medicare Supplement and Medicare SELECT policies cover the usual and customary expense for services provided by a chiropractor under the scope of the chiropractor's license. This benefit is available even if Medicare does not cover the claim. The care must also meet the insurance company's standards as medically necessary.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care—Medicare Supplement and Medicare SELECT policies cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care for an individual with a chronic disability or an individual with a medical condition requiring hospitalization or general anesthesia for dental care. The care also must meet the insurance company's standards as medically necessary.

Breast Reconstruction—Medicare Supplement and Medicare SELECT policies cover breast reconstruction of the affected tissue incident to a mastectomy.

Colorectal Cancer Screening—Medicare Supplement and Medicare SELECT policies cover colorectal cancer examinations and laboratory tests. Coverage is subject to any cost-sharing provisions, limitations, or exclusions applying to other coverage under the policy.

Coverage of Certain Health Care Costs in Cancer Clinical Trials—Medicare Supplement and Medicare SELECT policies cover certain services, items, or drugs administered in cancer clinical trials in certain situations. Coverage is subject to all terms, conditions, and restrictions applying to other coverage under the policy, including the treatment under the policy of services performed by participating and nonparticipating providers.

Catastrophic Prescription Drugs—Medicare Supplement policies issued beginning January 1, 2006, do not include catastrophic prescription drug coverage as these policies are not allowed to duplicate benefits available under Medicare Part D. This coverage does not qualify as Medicare Part D creditable coverage.

Basic Facts About Medicare Supplement Policies

Open Enrollment

Medicare Supplement and Medicare SELECT insurance companies must make coverage available to you, regardless of your age, for six months beginning with the date you enroll in Medicare Part B. This six-month period is called the **open enrollment period**. Insurance companies may not deny or place conditions on the policy (such as a waiting period) based on your health status, claims experience, receipt of healthcare, or medical condition and may not charge you an additional premium because of your use of tobacco. The policy may still have waiting periods before preexisting health conditions are covered. In addition, if you are under

65 years old and enrolled in Medicare due to disability or end-stage renal disease, you are entitled to another six-month open enrollment period upon reaching age 65.

Medicare Cost and Medicare Advantage insurance plans accept applicants who live in the plan's geographic service area and have Medicare Part A and Part B.

Guaranteed Issue

In addition to the open enrollment period, in some situations, you have the right to enroll in a Medicare Supplement or Medicare SELECT policy regardless of your health status if your other health coverage terminates. The insurance company must offer you one of these Medicare Supplement policies if:

- Your Medicare Advantage or Medicare Cost plan stops participating in Medicare or providing care in your service area; or
- You move outside the plan's geographic service area; or
- You leave the health plan because it failed to meet its contractual obligations to you; or
- Your employer group health plan ends some or all your coverage; or
- You terminate your employer group plan to join a Medicare Advantage plan but leave the Medicare Advantage plan within 12 months of enrollment; or
- Your insurance company ends your Medicare Supplement or Medicare SELECT policy and you are not at fault (for example, the company goes bankrupt); or
- You drop your Medicare Supplement policy to join a Medicare Advantage plan, a Medicare Cost plan, or buy a Medicare SELECT policy for the first time and then leave the plan or policy within one year after joining. You may return to your previous plan or to any available Medicare supplement plan if your prior plan is no longer available; or
- You join a Medicare Advantage plan or a Medicare Cost plan when you first become eligible for Medicare Parts A and B at age 65 and within one year of joining you decide to leave the health plan; or
- You have Medicare Parts A and B and are covered under Medical Assistance and lose eligibility in Medical Assistance; or
- Your employer group plan increases your cost from one 12-month period to the next by more than 25% and the new payment for the employer-sponsored coverage is greater than the premium charged under the Medicare Supplement plan for which the individual is applying.

If you qualify for a guaranteed issue plan, you must apply for your new Medicare Supplement policy no later than 63 calendar days after your health plan or policy ends. The Medicare Supplement insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (such as a waiting period),
- Must cover you for all preexisting conditions, and
- It cannot charge you more for a policy because of past or present health problems.

If your policy was terminated, the insurance company must provide a notification explaining individual rights to the guaranteed issue of Medicare Supplement policies. You must submit a copy of this notice (creditable coverage) or other evidence of termination with the application for the new policy.

Suspension of Medicare Supplement Policy

Medicare Supplement and Medicare SELECT policies must allow Medicare beneficiaries with coverage the right to suspend their Medicare Supplement coverage when they have employer group health plan coverage. This option was created by federal law and is referred to as a Ticket to Work provision. If you are a Medicare beneficiary with Medicare Supplement coverage and you want to suspend your Medicare Supplement policy, you may do so by calling your Medicare Supplement insurance company. If you later lose your employer group health plan coverage, you may contact the Medicare Supplement insurance company within 90 days of losing your employer coverage and receive your Medicare Supplement policy back.

30-Day Free Look

All Medicare Supplement and Medicare SELECT insurance policies sold in Wisconsin have a 30-day free-look period. If you are dissatisfied with a policy, you may return it to the insurance company within 30 days and get a full refund if no claims have been made. You should use the time to make sure the policy offers the benefits you expect. Check your application for accuracy and check the policy for any limitations, exclusions, or waiting periods.

Renewability

All Medicare Supplement and Medicare SELECT policies sold today must be guaranteed renewable for life. This means you can keep the policy as long as you pay the premium. It does not mean the insurance company cannot raise the premium. Policies that are guaranteed renewable offer added protection. Be sure to ask the insurance agent or company about the renewability of the policy.

Medicare Advantage plans are not guaranteed renewable. Medicare Advantage plans are a special arrangement between federal CMS and certain HMOs or insurance companies. CMS, HMOs, or insurance companies may choose to terminate plans at the end of any calendar year.

Midterm Cancellation

All Medicare Supplement and Medicare SELECT policies include the right to a prorated refund of premium if you want to cancel a policy before the end of a term. All you need to do is send a letter requesting cancellation to the insurance company. The right to midterm cancellation does not apply to Medicare Cost or Medicare Advantage plans.

Waiting Periods, Limitations, and Exclusions

Many Medicare Supplement insurance policies have waiting periods before coverage begins. If your policy excludes coverage for preexisting conditions for a limited time, it must provide this information on the first page of the policy. The waiting period for preexisting conditions may not be longer than six months, and only conditions treated during the six months before the effective date of the policy may be excluded.

Insurance companies are required to waive any waiting periods for preexisting conditions if you buy a Medicare Supplement policy during the open enrollment period and have been continuously covered with creditable coverage for at least six months before applying for the Medicare Supplement policy. Insurance companies are also required to waive any waiting periods for preexisting conditions when one Medicare Supplement policy is replaced with another.

Creditable Coverage

Health Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health insurance issuers, group health plans, and/or employers to issue a HIPAA certificate of creditable coverage when your health coverage ends. The certificate indicates the date your coverage ends and how long you had the coverage. You should keep this document for your records because the certificate provides evidence of your prior coverage. If certain conditions are met, evidence of prior coverage may entitle you to a reduction or total elimination of a preexisting condition exclusion period under future health benefits coverage you may obtain. CMS does not request or require a copy of this HIPAA certificate of creditable coverage. Therefore, you should not be instructed to send the certificate to CMS.

Prescription Drug Creditable Coverage

The Medicare Modernization Act imposes a late enrollment penalty if you do not maintain creditable drug coverage (coverage at least as good as Part D coverage) for 63 days after your initial enrollment period is over. Wisconsin's SeniorCare Prescription Drug Assistance Program (dhs.wisconsin.gov/seniorcare/index.htm) qualifies as creditable drug coverage. The Medicare Modernization Act mandates certain entities offering prescription drug coverage disclose to all Medicare-eligible individuals with prescription drug coverage whether such coverage is creditable. You should keep this document for your records. CMS does not request or require a

copy of this creditable coverage documentation during the Initial Enrollment Period. Therefore, you should not be instructed to send the certificate to CMS unless challenging a penalty.

For more information on creditable coverage as it relates to Part D, go to cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html.

Common Exclusions

No insurance policy will cover everything not covered by Medicare. Medicare excludes certain types of medical expenses and so do many Medicare Supplement, Medicare SELECT, Medicare Cost, and Medicare Advantage plans.

Some services frequently excluded under these policies are:

- private duty nursing
- routine check-ups
- eyeglasses
- hearing aids
- dental services
- cosmetic surgery
- prescription drugs

Medicare Supplement policies include two other frequently misunderstood exclusions:

1. **Approved Charges** — Medicare pays only for charges considered reasonable and services considered necessary. Medicare's determination of a reasonable or "approved" charge may be much less than the actual charge for a covered service. For example:

Doctor's bill	$115
Medicare-approved amount	100
Medicare pays (80% coinsurance)	80

In the example above, Medicare pays 80% of the approved charge ($80). Medicare Supplement policies pay only the 20% difference between what Medicare approves and what Medicare pays ($20). If your doctor accepts assignment, you aren't charged the difference between what Medicare approves and the doctor's bill. If your doctor does not accept assignment, you are responsible for that portion of the bill. If you have the Medicare Part B Excess Charges Rider, the policy pays the difference between what Medicare approves and what the doctor charges.

Medicare SELECT and Medicare Cost policies cover the entire charge for covered services if you use doctors and hospitals connected to the plan. Medicare Advantage plans may charge a copay for doctor's office and emergency room visits.

2. **Custodial Care** — Medicare pays for skilled nursing care in a facility approved by Medicare if your doctor certifies it is medically necessary and the care meets the insurance company's

standards as medically necessary. There are no benefits for custodial care. In general, Medicare Supplement, Medicare SELECT, Medicare Cost, and Medicare Advantage Plans cover only skilled care and do not cover custodial or intermediate care. Skilled nursing care is narrowly defined. Read more about Medicare's coverage of skilled nursing care at medicare.gov/what-medicare-covers/what-part-a-covers/medicare-part-a-coverage-skilled-nursing-facility-care

Basic Benefits Included in Medicare Supplement 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.

Medicare Supplement Benefits	Basic Plan
Basic Benefits	√
Medicare Part A: Skilled Nursing Facility Coinsurance	√
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Medicare Part B: Coinsurance	√*
Outpatient Mental Health	√
Other Wisconsin Mandated Benefits	√

Optional Riders

Insurance companies are allowed to offer these seven riders to a Medicare supplement policy.

1. Medicare Part A Deductible
2. Medicare 50% Part A Deductible
3. Additional Home Health Care (365 visits including those paid by Medicare)
4. Medicare Part B Deductible**
5. Medicare Part B Copayment or Coinsurance*
6. Medicare Part B Excess Charges
7. Foreign Travel Emergency

* Except if Part B Copayment or Coinsurance Optional Rider is purchased.
** Not available to people who are newly eligible for Medicare on or after January 1, 2020.

Basic Benefits Included in Medicare SELECT 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.

Medicare Select Benefits	Basic Plan
Basic Benefits	√
Medicare Part A: Deductible	√
Medicare Part A: Skilled Nursing Facility Coinsurance	√
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	365 visits including those paid by Medicare
Medicare Part B: Deductible*	√*
Medicare Part B: Coinsurance	√
Other Wisconsin Mandated Benefits	√
Outpatient Mental Health	√
Foreign Travel Emergency	√

* Not reimbursed for people who are newly eligible for Medicare on or after January 1, 2020.

Policy Description

The information on the upcoming pages provides a brief description of the benefits of Medicare Supplement and Medicare SELECT policies offered in Wisconsin. Check the Outline of Coverage you receive from the company and the policy itself for details. The publication Medicare & You (medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf) is available at Medicare.gov or free of charge from your Social Security office and explains Medicare benefits in detail.

For information on Medicare Supplement insurance policies approved by OCI, visit oci.wi.gov/Pages/Consumers/PI-010.aspx or contact OCI and request a copy of the publication Medicare Supplement Insurance Policies List. The publication includes only policies offered by companies that agree to be listed in the publication and is updated on an annual basis.

Medicare Supplement insurance companies can only sell standardized Medicare Supplement policies. Each standardized Medicare Supplement policy must offer the same basic benefits, no matter which insurance company sells it. The optional benefits and cost are the major differences among the Medicare Supplement policies sold by different insurance companies.

Policy Benefits – Traditional Insurers

All Medicare Supplement policies offered by traditional insurance companies provide the following benefits:

Basic Benefits

1. Copayment for days 61 to 90 of hospitalization **($419 a day)**
2. Copayment for days 91 to 150 of hospitalization **($838 a day for "lifetime reserve days")** – full coverage after Medicare days are exhausted
3. Copayment for days 21 to 100 of skilled nursing care in a skilled nursing facility **($209.50 a day)**
4. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
5. First three pints of blood
6. 40 home health care visits in addition to Medicare – must also meet the insurance company's standards as medically necessary
7. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments

8. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction – must also meet the insurance company's standards as medically necessary.
9. Coverage for 30 days non-Medicare skilled nursing facility care – no prior hospitalization required but must meet the insurance company's standards as medically necessary.

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Optional Benefits

Insurance companies may offer the following optional benefits as a separate benefit for an additional premium:

1. Part A deductible **($1,736 for 2026)**
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B excess charges up to the actual charge or the limiting charge, whichever is less
4. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
5. Medicare 50% Part A deductible
6. Part B copayment or coinsurance rider. The policy covers Part B services after the Part B deductible is met and Medicare has paid. The insured then pays a 20% coinsurance copay (up to a maximum of $20) per doctor's office visit or a 20% coinsurance copay (up to $50 maximum) per emergency room visit. The emergency room copayment or coinsurance is waived if the emergency room visit results in hospitalization.

Policy Benefits – Traditional Insurers Cost-Sharing 50% and 25%

Medicare Supplement cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. The out-of-pocket limits for 2026 are $8,000 for 50% and $4,000 for 25% cost-sharing policies, and the 2026 Part B deductible is $283.00.

All Medicare Supplement cost-sharing policies offered by traditional insurance companies provide the following benefits:

Basic Benefits

1. Part A deductible **($1,736)** (50% or 25%)
2. Copayment for days 61 to 90 of hospitalization **($419 a day)**
3. Copayment for days 91 to 150 of hospitalization **($838 a day for "lifetime reserve days")** – full coverage after Medicare days are exhausted
4. Copayment for day 21 to 100 of skilled nursing care in a skilled nursing facility **($209.50 a day)** (50% or 25%)
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First three pints of blood (50% or 25%)
7. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
8. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments
9. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
10. Coverage for 30 days non-Medicare skilled nursing facility care – no prior hospitalization required but must meet the insurance company's standards as medically necessary

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Optional Benefits

Insurance companies may offer the following optional benefit as a separate benefit for an additional premium:

1. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.

Policy Benefits – Medicare SELECT

All Medicare SELECT policies provide the following benefits:

Basic Benefits

1. Part A deductible **($1,736)**

2. Copayment for days 61 to 90 of hospitalization **($419 a day)**
3. Copayment for days 91 to 150 of hospitalization **($838 a day)** – full coverage after Medicare days are exhausted
4. Copayment for days 21 to 100 of skilled nursing care in a skilled nursing facility **($209.50 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First three pints of blood
7. Part B deductible **($283 for 2026)**-- not reimbursed for people who are newly eligible for Medicare on or after January 1, 2020
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid for by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary.

Policy Benefits – Medicare SELECT Cost-Sharing 50% and 25%

Medicare SELECT cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. **The out-of-pocket limits for 2026 are $8,000 for 50% and $4,000 for 25% cost-sharing policies, and the 20265Part B deductible is $283**.

All Medicare SELECT cost-sharing policies provide the following benefits:

1. Part A deductible **($1,736)** (50% or 25%)
2. Copayment for 61st to 90th day of hospitalization **($419 a day)**

3. Copayment for 91st to 150th day of hospitalization **($838 a day)** – full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($209.50 a day)** (50% or 25%)
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First three pints of blood (50% or 25%)
7. Part B deductible **($283 for 2026)**
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid for by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care – no prior hospitalization required but must meet the insurance company's standards as medically necessary.

Policy Benefits – Cost Insurance – Basic and Enhanced

Basic Plan

1. Copayment for days 61 to 90 of hospitalization **($419 a day)**
2. Copayment for days 91 to 150 of hospitalization **($838 a day)** - full coverage after Medicare days are exhausted
3. Copayment for days 21 to 100 of skilled nursing care in a skilled nursing facility **($209.50 a day)**
4. First three pints of blood
5. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.

6. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments.

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Enhanced Plan

Insurance companies may offer additional benefits for an additional premium:

1. Part A deductible **($1,736)**
2. Additional home health care (up to 365 visits per year) – must also meet the insurance company's standards as medically necessary.
3. Part B deductible **($283)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less.
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S.; emergency care must begin during the first 60 days of a trip outside the U.S.; benefit limit must be at least $50,000 per lifetime.
7. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
8. Coverage for 30 days non-Medicare skilled nursing facility care – no prior hospitalization required but must meet medical necessity requirements; must meet the insurance company's standards as medically necessary.

Policy Benefits – High-Deductible Plan

High-deductible Medicare Supplement plans offer benefits after you have paid a calendar year deductible of **$2,950 for 2026**. This deductible consists of expenses ordinarily paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the separate foreign travel emergency deductible of $250.

Benefits

1. Part A deductible included.

2. Copayment for days 61 to 90 of hospitalization **($419 a day)**
3. Copayment for days 91 to 150 of hospitalization **($838 a day)** – full coverage after Medicare days are exhausted
4. Copayment for days 21 to 100 of skilled nursing care in a skilled nursing facility **($209.50 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First three pints of blood
7. Part B deductible included - The Part B deductible is not covered (reimbursed) for people who are newly eligible for Medicare on or after January 1, 2020, however it does count towards the High Deductible plan's deductible.
8. Part B excess charges up to the actual charge or the limiting charge, whichever is less, included.
9. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
10. 365 home health care visits including those paid by Medicare. The care also must meet the insurance company's standards as medically necessary.
11. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
12. Coverage for full usual and customary cost of non-Medicare-covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges, anesthetics for dental care, and non-Medicare-covered breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
13. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary.

Filing a Claim

It is important to file claims properly. The following list will help:

- Keep an accurate record of all your health care expenses. Store this information with your Medicare Supplement insurance or other health insurance policies.

- Whenever you receive treatment, present your Medicare card and any other insurance card you have.
- File all claims promptly. You will receive a Medicare Summary Notice (MSN) in the mail every three months or log into MyMedicare.gov. If the insurance company requests a copy of the Medicare Summary Notice, make a copy of the MSN and record the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and who provided the services.
- You do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare provider must submit claims to Medicare for you.
- If you enroll in a health maintenance organization (HMO), you don't have to file claims for services covered by HMO providers. All claims for covered services are handled by the HMO.
- Most Medicare Supplement insurance companies have an automatic claim filing program. This means the insurance company receives a copy of your claim as soon as it is processed by Medicare.
- For more information on filing claims, contact the benefits specialist at your county or tribal aging office, dhs.wisconsin.gov/benefit-specialists/index.htm

Your Grievance and Appeal Rights

Medicare Supplement Mandated Benefits

Grievance Procedure

If you have a complaint or question, you may wish to first contact your insurance company. Many complaints can be resolved quickly and require no further action. However, you do not have to file a complaint with your insurance company before you file a complaint with the appropriate state agency.

Medicare Supplement insurance companies are required to have an internal grievance procedure to resolve issues involving Wisconsin mandated benefits. If you are not satisfied with the service you receive, your insurance company must provide you with complete and comprehensible information about how to use the grievance procedure. You have the right to participate in the grievance committee's meeting and present additional information.

Insurance companies are required to have a separate expedited grievance procedure for situations where your medical condition might require immediate medical attention.

Medicare Supplement insurance companies are required to file a report with OCI listing the number of grievances they had in the previous year.

Independent Review
For Wisconsin mandated benefits under Medicare Supplement policies, if you are not satisfied with the outcome of a grievance and the grievance involves a dispute regarding medical necessity or experimental treatment, you or your authorized representative may request that an independent review organization (IRO) review your insurance company's decision. The independent review process provides you with an opportunity to have medical professionals who have no connection to the insurance company review the dispute. The IRO has the authority to determine whether the treatment should be covered by the insurance company.

Your insurance company will provide you with information on the availability of this process whenever it makes a determination that is eligible for the independent review process. Information regarding the IRO process is available on the OCI website at oci.wi.gov/Pages/Consumers/IROConsumer.aspx.

Original Medicare Part A and Part B and Medicare Prescription Drug Coverage
Information can be found at medicare.gov/claims-and-appeals.

Prescription Drug Discount Options

In Wisconsin, Medicare beneficiaries have access to discounted drugs through the SeniorCare program and can obtain discounted drugs through drug manufacturers, the internet, and mail-order pharmacies.

SeniorCare Prescription Drug Assistance Program

The Wisconsin legislature created the SeniorCare prescription drug assistance program for residents 65 years or older and who meet certain requirements. SeniorCare is designed to make prescription drugs more affordable and to make it easier to obtain needed prescription medications.

SeniorCare's eligibility requirements include:

1. Must be a Wisconsin resident.
2. Must be 65 years of age or older.
3. Must be a U.S. citizen or qualifying immigrant.
4. Must pay a $30 annual enrollment fee per person.

Under SeniorCare, you will need to pay out-of-pocket expenses based on your annual income. There are different expense requirements and benefits based on your income and your spouse's income if your spouse lives with you.

If you think you are eligible, contact your county or tribal aging office for more information or call the **SeniorCare Customer Service Helpline** at **1-800-657-2038**. You may also visit their website, dhs.wisconsin.gov/seniorcare/index.htm.

Consumer Buying Tips

Cost of Policies

When buying a Medicare Supplement policy, you should find out exactly what the premium is. A few insurance companies charge everyone the same amount. Most companies charge different premiums based on your age at the time of application. Several companies also use other factors, such as different rates for men and women or different rates in different parts of the state. Companies also charge different premiums if you use, or have a history of using, tobacco (if you are not applying during your open enrollment period).

When you consider purchasing a Medicare Supplement policy, you should also research what happens to your premium as you get older. The premium on your policy may increase every year primarily due to inflation in medical costs causing increases in your Medicare deductibles and copayments. The amount your premium increases may also depend on the way the company reflects the aging of its policyholders in the rates charged. Be sure to ask the agent to explain the method the company uses for any Medicare Supplement policy you are considering. In general, insurance companies use one of the methods described below:

- **Attained Age** – In addition to medical inflation and increased Medicare deductibles and copayments, your premium will also increase as you age. This is because you tend to use more medical services as you age. Premiums may be less expensive than issue age policies at first but can eventually become the most expensive.
- **Issue Age** – Your premium will increase due to medical inflation and increased Medicare deductibles and copayments. It will not increase due to your age. Your initial premium is higher than under the Attained Age approach because a portion of the initial premium is used to pre-fund the increased claims cost in later years.
- **No Age Rating** – Your premium is the same as for all customers who buy this policy, regardless of age.
- **Under Age 65** – Your premium is calculated for individuals who, due to a disability, are eligible to enroll in Medicare under age 65. (If you are under age 65 and enrolled in Medicare due to disability, ALS (Lou Gehrig's disease), or end-stage renal disease, you are entitled to another six-month open enrollment period upon reaching age 65.)

Policy Delivery and Refunds

Policy delivery or refunds on policies should be made promptly by insurance companies. If you do not receive your policy within a month or if there is a delay in receiving a refund, call or write to the insurance company.

If you buy from an agent, find a good local insurance agent who can help you buy the right policy and will also assist you with making claims.

Policy Storage

Keep your policy in a safe place. It is a good idea to choose someone ahead of time who can take over your affairs in case of a serious illness. This person should know where your records are kept.

Duplicate Coverage

Before buying additional policies, you should review your current policy to see if the benefits of the additional policies already exist in your current policy. Buying one comprehensive health insurance policy is much better than buying several limited policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

Health History

If you are applying outside of your Medicare open enrollment period and your application for individual Medicare Supplement insurance includes questions about your health, be sure you answer all medical questions completely and accurately. Omitting specific medical information on your application can be very costly. If an agent helps you fill out the application, do not sign the application until you read it. If you omit medical information and the insurance company finds out later, the company may deny your claim and/or terminate your policy.

Since the application is part of the insurance contract, you will receive a copy with the policy. Make sure the application has not been changed and all the medical information in the application is accurate.

Payment

Make checks payable only to the insurance company—**do not pay cash or make a check out to the agent**. Be sure you have the agent's name, address, National Producer Number (NPN), and the name and address of the company from which you are buying the policy.

Replacing Existing Coverage

Make sure you have a good reason for switching from one policy to another. You should only replace existing coverage with different benefits, better service, or more affordable premiums. Do not terminate your existing policy until your new policy is in effect. **You should also make**

sure to cancel the policy you are replacing. An agent generally cannot cancel your existing policy. If you have questions about the process, you should contact the company.

If you are replacing a Medicare Advantage plan, you must follow the plan's cancellation procedure. You are responsible for paying premiums for the Medicare Advantage plan if you do not follow the plan's cancellation procedure. If you have questions about the process, you should contact the company.

Insurance Agents and Companies

Insurance agents and companies must be licensed to sell Medicare Supplement and other insurance products. Keep the agent's business card and information regarding the insurance company's address and telephone number.

Verify on the OCI website, oci.wi.gov, or by phoning 1-800-236-8517 that the agent and company are licensed before providing personal information or payment.

What if I Cannot Afford a Medicare Supplement Policy?

You may find you can no longer afford to pay insurance premiums, and if so, there may be programs to help you pay for your medical care, including Medicaid or other low-income programs. The Medicaid program provides health care coverage for individuals who meet the program's definition of low income. If you do not qualify for the Medicaid program, you may be eligible for either the Qualified Medicare Beneficiary (QMB) program or the Specified Low-Income Beneficiary (SLMB) program (see details below).

Medicaid Program

If you are eligible for Medicaid, you do not need to buy private health insurance. Medicaid pays almost all the health care costs if you are eligible for the program. For more information, contact your county or tribal aging office. If you bought a Medicare Supplement policy after November 5, 1991, and then become eligible for Medicaid, you can suspend your coverage for 24 months while you are enrolled in the Medicaid program.

If you lose eligibility for Medicaid, you can reinstate your Medicare Supplement or Medicare SELECT insurance.

Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs

If you are a low-income Medicare beneficiary but do not qualify for the standard Medicaid program, you may be eligible for either the QMB or the SLMB program. While these programs do not necessarily eliminate your need for private insurance to supplement your Medicare

benefits, they could save you hundreds of dollars each year in health care costs if you qualify for assistance.

The QMB program pays Medicare's premiums, deductibles, and coinsurance amounts if you are entitled to Medicare Part A, your annual income is at or below the national poverty level, and your savings and other resources are very limited. The QMB program, therefore, functions more like a Medicare Supplement policy because it also pays your Part B premium.

The SLMB program pays your Medicare Part B premium if you are entitled to Medicare Part A and your income does not exceed the national poverty level by more than 20%. If you qualify for assistance under the SLMB program, you are responsible for Medicare's deductibles, coinsurance, and other related charges.

In addition, you may be eligible for a Medicaid program requiring states to pay Medicare Part B premium assistance for low-income Medicare beneficiaries. Contact the state or local Medicaid or social services office or your benefits specialist to get more detailed eligibility information.

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a free counseling service for Medicare beneficiaries and their caregivers. SHIP's Medigap Helpline (1-800-242-1060) can help you with questions about health insurance, primarily Medicare supplements, Medicare savings programs, long-term care insurance, employer/retiree group insurance, the Medicaid program, and other health care plans available to Medicare beneficiaries, as well as prescription drug coverage.

The Medigap Helpline is provided by the State of Wisconsin Board on Aging and Long-Term Care (BOALTC), at no cost to you. There is no connection with any insurance company. The program is funded by a grant from CMS and OCI.

Limited Policies

The limited policies listed below should not be bought as substitutes for a comprehensive Medicare Supplement policy.

Long-Term Care Coverage—These policies cover long-term nursing home and/or home health care. Visit our website or contact OCI and request a copy of the publication Guide to Long-Term Care: oci.wi.gov/Pages/Consumers/PI-047.aspx.

Hospital Confinement Indemnity Insurance—These policies pay a fixed amount per day for a specific number of days during the time you are hospitalized. These policies are not related to Medicare and only pay a limited amount of any hospital bill. You should review these policies

carefully to determine the number of days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage—These policies provide benefits for a single disease or group of specified diseases, such as cancer, and are not Medicare Supplement policies. These policies only provide coverage for the specified disease and therefore should not be bought as alternatives to more comprehensive coverage. A Shopper's Guide to Cancer Insurance prepared by the National Association of Insurance Commissioners is available on our website: oci.wi.gov/Pages/Consumers/PI-001.aspx.

Attention

Federal law prohibits the sale of a health insurance policy paying benefits in addition to Medicare unless it pays benefits without regard to other health coverage and it includes a disclosure statement on or together with the application.

What if I Have Additional Questions?

Health Insurance

Board on Aging and Long-Term Care (BOALTC)

This is the Wisconsin State Health Insurance Assistance Program (SHIP) with a statewide toll-free number staffed by BOALTC and funded by OCI. BOALTC provides free insurance counseling services to Medicare beneficiaries and can answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

Board on Aging and Long-Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
Medigap Helpline: 1-800-242-1060 (toll-free) fax: (608) 246-7001
Email: BOALTCMedigap@wisconsin.gov
Website: longtermcare.wi.gov

Office of the Commissioner of Insurance (OCI)

OCI publishes consumer publications (oci.wi.gov/Publications) to assist seniors in shopping for insurance. The publications are only guides. These publications are not legal documents and do not represent your rights under any insurance policy or government program. Your policy, contract, or federal or state laws establish your rights. Consult an attorney for legal guidance about your specific

rights. Legal assistance may also be available through your county or tribal aging office. A list of these can be found at dhs.wisconsin.gov/benefit-specialists/index.htm.

If you have a problem with your insurance, you should first contact your agent or insurance company that sold you the policy. If your problem is not resolved, you may file a complaint with OCI.

Website: oci.wi.gov

Mailing Address
P.O. Box 7873
Madison, WI 53707-7873

Street Address
125 South Webster Street
Madison, WI 53703

1-800-236-8517 (statewide) or (608) 266-0103 (Madison)
711 TDD (ask for 608-266-3586)

Elder Benefit Specialists

Disability Benefit Specialists
All benefit specialists can help people with Medicare questions and concerns. Elder Benefit Specialists are trained to help anyone 60 years of age or older who is having problems with private or government benefits and are available at either an Aging and Disability Resource Center (ADRC) or a county/tribal aging unit. Disability Benefit Specialists are available at all ADRCs and they serve Medicare beneficiaries ages 18-59.

All local contact information can be found at dhs.wisconsin.gov/benefit-specialists/index.htm.

Medicare

Centers for Medicare & Medicaid Services
The Centers for Medicare & Medicaid Services is the federal agency managing the Medicare and Medicaid programs.

Website: cms.gov
7500 Security Boulevard
Baltimore MD 21244-1850
1-800-633-4227

Medicare Claim Appeal for Part A and Part B
The Medicare contractor processing your Medicare claim(s) appears on your Medicare Summary Notice (MSN). Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. You will get an MSN in the mail every three months, and you must file your appeal within 120 days of the date you get the MSN. For more information about filing a Medicare appeal, visit the Medicare website www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.

SeniorCare
SeniorCare is Wisconsin's prescription drug assistance program for Wisconsin residents who are 65

years of age or older and who meet eligibility requirements.

SeniorCare Customer Service: 1-800-657-2038, TTY and translation services are available dhs.wisconsin.gov/seniorcare/index.htm

Prescription Drug Helplines for Medicare Beneficiaries

Medicare Part D and Prescription Drug Helpline

Toll-free information line providing free counseling to all Wisconsin Medicare beneficiaries age 60 and over on prescription drug coverage options in Wisconsin, including Medicare Part D.

Wisconsin Board on Aging and Long-Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
1-855-677-2783 (toll-free)
Email: BOALTCRXHelpline@wisconsin.gov
Website: longtermcare.wi.gov

Acronyms

For your convenience, the following is a listing of acronyms and initials appearing in the Wisconsin Guide to Health Insurance for People with Medicare (oci.wi.gov/Pages/Consumers/PI-002.aspx) publication:

ADRC	Aging and Disability Resource Center
BOALTC	Board on Aging and Long Term Care
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
DME	Durable Medical Equipment
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
HMO	Health Maintenance Organization
IRO	Independent Review Organization
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSN	Medicare Summary Notice
OCI	Office of the Commissioner of Insurance
PDP	Prescription Drug Plan
PFFS	Private Fee for Service Plan
PPO	Preferred Provider Organization Plan
QMB	Qualified Medicare Beneficiary Program
SHIP	State Health Insurance Assistance Program
SLMB	Specified Low-Income Medicare Beneficiary Program
SNF	Skilled Nursing Facility

Glossary of Terms

Actual charge: The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Appeal: A request you make to your Medicare health plan or Medicare for reconsideration of any decision about your health care services. There is usually a special process you must use to make your appeal.

Approved amount or charge: Also called the allowable, eligible, or accepted charge; this is the maximum approved fee set by Medicare for a particular service or procedure, of which Medicare will reimburse 80%.

Assignment: This means a doctor agrees to accept Medicare's fee as full payment. Accepting assignment means the doctor agrees to bill no more than the approved charge for a service. In other words, a doctor will not charge more than Medicare will approve. Doctors not accepting assignment charge 15% more and you are responsible for 100% of the excess charges.

Attained age: As you age, your premiums will change to meet your age range and your premiums increase.

Beneficiary: A person who has health insurance through the Medicare program.

Benefit appeal: The opportunity for the Medicare beneficiary to submit a written request for review by the insurer of the denial of a claim for Wisconsin mandated benefits under the Medicare Supplement policy.

Benefit period: A designated period of time during and after a hospitalization for which Medicare Part A will pay benefits.

Carrier: A private company contracting with Medicare to process your Medicare Part B bills.

Centers for Medicare & Medicaid Services: The federal agency running the Medicare program.

Coinsurance: The percent of the Medicare-approved amount you have to pay after you pay the deductible for Part A and/or Part B. If you have supplemental coverage, this is the balance of a covered health expense you are required to pay after insurance has covered the rest.

Copayment: A copayment is a set amount you pay for a service.

Creditable coverage: Previous health/drug coverage reducing the time you have to wait before preexisting health conditions are covered by a policy you buy during your Medicare supplement open enrollment period or guarantee-issue period.

Custodial care: Personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of a bed or chair, moving around, and using the bathroom. It may also include care most people do themselves like using eye drops. Medicare does not pay for custodial care.

Deductible: The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A or each year for Part B. These amounts can change every year.

Drug formulary: A formulary is a list of generic and brand name prescription drugs covered by your insurance policy or health plan.

Durable Medical Equipment: Medical equipment ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Excess charge: The difference between a doctor's or other health care provider's actual charge and the Medicare-approved payment amount.

Enrollment period: The six-month period after you turn 65, during which you may enroll in any Medicare supplement insurance plan or policy if you have enrolled in Medicare Part B. During this period, you cannot be denied based on any preexisting medical condition.

Free-look period: The 30-day period of time when you can review a Medicare supplement policy. If you change your mind about keeping the policy during this 30-day period, you may cancel the policy and get your money back.

Grievance: Your right under Wisconsin insurance law to file a written complaint regarding any dissatisfaction with your policy or plan regarding mandated benefits. Medicare also provides you the right to file a grievance if you have a problem regarding calling the plan, staff behavior, or operating hours. Medicare has a separate appeal process for complaints about a treatment decision or a service not covered.

Guaranteed issue rights: Rights you have in certain situations when insurance companies are required to accept your application for a Medicare supplement policy. In these situations, an insurance company cannot deny you insurance coverage or place conditions on a policy, must cover you for all preexisting conditions, and cannot charge you more for a policy because of past or present health problems.

Guaranteed renewable: The right to automatically renew or continue your Medicare supplement policy, unless you commit fraud or do not pay your premiums.

Issue age: Premiums are set at the age you are when you buy the policy and will not increase because you get older. Premiums may increase for other reasons.

Limiting charge: The maximum a doctor or other provider who does not accept assignment may legally charge for a Medicare-covered service. This is 15% over Medicare's approved amount and you are responsible for 100% of the excess charges.

Managed care: A health plan with an established network of providers you must use.

Medically necessary: Services or supplies needed or provided for the diagnosis, direct care, or treatment of your medical condition that meet the standards of good medical practice in the local area. The services or supplies may not mainly be for the convenience of you or your doctor.

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

Medicare Part B (Medical Insurance): Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Part C (Medicare Advantage Plan): A type of Medicare health plan offered by a private company contracting with Medicare to provide you with all your Part A and Part B benefits. Medicare services are covered through the plan and are not paid for under Original Medicare.

Medicare Part D (Prescription Drug Coverage): Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medigap: A term used to refer to Medicare supplement and Medicare select policies designed to fill the "gaps" in Original Medicare plan benefits.

Network: A group of doctors, hospitals, pharmacies, and other health care experts entering into an agreement with a health plan to provide health care services to its members.

Newly eligible for Medicare on or after January 1, 2020: Newly eligible is anyone who: (a) reaches age 65 on or after January 1, 2020, or (b) who first becomes eligible for Medicare benefits due to age, disability, or end-stage renal disease on or after January 1, 2020.

Open enrollment period: A one-time-only six-month period when you can buy any Medicare supplement policy sold in Wisconsin. It starts when you sign up for Medicare Part B and you are age 65 or older. You cannot be denied coverage or charged more due to present or past health problems during this period.

Out-of-pocket costs: Medical costs you must pay on your own because they are not covered by Medicare or other insurance.

Preexisting condition: A medical condition diagnosed or treated up to six months prior to the purchase of an insurance policy. Medicare supplement policies may impose up to a 180-day waiting period before coverage for the condition begins.

Primary payer: An insurance policy, plan, or program paying first on a claim for medical care. This could be Medicare or other health insurance.

Referral: An approval from your primary care doctor and health plan for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Secondary payer: An insurance policy, plan, or program paying second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

Service area: The area where a health plan accepts members. For plans requiring you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

State Health Insurance Assistance Program (SHIP): A state program that receives money from the federal government to give free health insurance counseling and assistance to people with Medicare.

Usual and customary charge: The fee most commonly charged by providers for a particular service, procedure, or treatment, for that specialty, in that geographic area.

Waiting period: The time between when you sign up with a Medicare supplement insurance company or Medicare health plan and when the coverage starts.

SecurityHealth Plan℠

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