Delaware Medicare Supplement Insurance Guide 2023

State Health Insurance Assistance Program
A Program of the Delaware Department of Insurance

DMAB
Delaware Medicare Assistance Bureau

INSURANCE COMMISSIONER TRINIDAD NAVARRO

A Message From Delaware's Insurance Commissioner

Dear fellow Delawarean,

As a service to all residents, our office puts together this Delaware Medicare Supplement Insurance Guide each year. The 2023 edition contains the most up-to-date information for those shopping for insurance to supplement Medicare coverage.

As you review plans, keep in mind that gender and tobacco use will influence your premiums, and rates may change during the year. People eligible for Medicare are not, in most cases, eligible for Affordable Care Act coverage.

Medicare is a Federal program, but our Delaware Medicare Assistance Bureau (DMAB) division can provide you with individualized Medicare counseling. **DMAB services are free of charge**, and I have to say that I believe our team is one of the best in the country. I hear from so many residents that DMAB helped educate and empower them to take charge of their health insurance choices.

While the guide no longer publishes annual rates, DMAB can provide you with a free, personalized Medicare Supplement plan search, help you compare prices, and provide other company information, and I urge you to connect with them. DMAB can be reached toll-free at **(800) 336-9500** and **(302) 674-7364**. Call if you have any questions regarding Medicare, Medicaid, Medigap, long-term care, or the new Federal reforms. Our team is here to help.

Kind regards,

Trinidad Navarro
Insurance Commissioner

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DMAB Counseling Sites

While Medicare is a Federal program, DMAB can help Delawareans with Medicare make sense of the complex health insurance system. All DMAB services are completely free.

Below is a listing of participating DMAB counseling sites throughout Delaware. For the name of the counselor and counseling hours at the site nearest you, please call (302) 674-7364. If you are not able to visit the site, a counselor will call you to answer your questions.

DMAB counselors are volunteers who have completed extensive training on health insurance. Counselors provide one-on-one assistance in an objective and confidential manner.

New Castle County

M.O.T. Senior Center
300 S. Scott Street
Middletown

*Jewish Family Services
99 Passmore Rd
Wilmington

Newark Senior Center
200 White Chapel Road
Newark

Kent County

Milford Senior Center
111 Park Avenue
Milford

Modern Maturity Center
1121 Forrest Ave.
Dover

Sussex County

**Dept. of Insurance
28 The Circle, Suite #1
Georgetown

Are you Interested in helping others within your community with questions regarding medicare?

Free Medicare training for volunteers. No experience is necessary. Call today to learn about volunteer opportunities (302) 674-7364

*Please do not contact counseling sites directly.
**By appointment only.

About Medicare

What is Medicare?

Medicare is a Federal health insurance program for people 65 years of age or older, people of any age with permanent kidney failure, and certain disabled people under age 65. The Centers for Medicare & Medicaid Services and part of the U.S. Department of Health and Human Services manages Medicare.

Medicare was never intended to pay 100% of medical bills. It forms the foundation for beneficiaries' protection against heavy medical expenses. There are "gaps" in Medicare coverage where the beneficiary must pay a portion of expenses. Medicare supplement insurance, also called Medigap, can help cover these expenses. The Delaware Insurance Department regulates this type of plan.

How is Medicare divided?

Medicare has four parts:

- Hospital insurance (Part A)
- Medical insurance (Part B)
- Medicare Advantage Plans (Part C)
- Medicare prescription drug coverage (Part D)

Part A

Medicare Part A helps pay for medically necessary care in the following areas: inpatient hospital care; inpatient stays in a skilled nursing facility following a hospital stay **(not custodial or long-term care)**; home health care services; hospice care and blood. Limitations exist on the number of hospital or skilled-nursing facility care days Medicare helps pay for in a benefit period. Most people do not pay a premium for this coverage – it is generally covered by the federal government.

Part B

Medicare Part B includes doctors' services; outpatient hospital services; emergency room care; diagnostic tests; durable medical equipment; ambulance services; and many other services and supplies not covered by Medicare Part A.

Medicare Part B has a monthly premium. In 2023, most people will pay the standard monthly Part B premium of $164.90. If you file an individual tax return and your annual income is more than $97,000, or if you are married filing a joint tax return and your annual income is more than $194,000 you will pay a higher Part B premium on your modified adjusted gross income.

If you have group insurance, check with your employer to see if you are required to select Part B. Your group benefits may be reduced if you do not enroll in Part B when you are eligible.

Part C

Medicare Advantage Plans are health plan options that are approved by Medicare and run by private companies. **The Department of Insurance has no jurisdiction over these health plans.** These plans are part of Medicare and sometimes called "Part C." They provide all of your Part A and Part B covered services. Medicare Advantage Plans provide Medicare covered benefits to Medicare members through the plan and may offer prescription drug benefits as well

as extra benefits that Medicare doesn't cover, such as vision or dental services. If you join one of these plans, you generally get all your Medicare-covered health through the plan and will use the health care card that you receive from your Medicare Advantage Plan. You may need a referral to see a specialist. In some plans, you can only see doctors who belong to the plan or go to certain hospitals to get covered services. If you're in a Medicare Advantage Plan, you generally don't need a Medigap policy because they cover many of the same benefits.

Part D

Medicare offers prescription drug coverage (Part D) for everyone with Medicare. This coverage may help you lower your prescription drug costs and help you protect against higher costs in the future. It can give you greater access to drugs that you can use to prevent complications of diseases and stay well. To get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered. If you join a Medicare drug plan, you usually pay a monthly premium. If you decide not to join a Medicare drug plan when you are first eligible, you may pay a penalty if you choose to join later. If you have limited income and resources, you might qualify for extra help paying your Part D costs. For more information about extra help with prescription drug costs and how to apply, call DMAB at (302) 674-7364.

What is Not Covered By Medicare

Medicare does not cover everything. You are responsible for paying uncovered medical expenses, sometimes called "gaps." Items and services **not covered** include but are not limited to the following:

- Acupuncture.
- Deductibles, coinsurance or co-payments when you obtain certain health care services.
- Dental care and dentures (with a few exceptions).
- Cosmetic surgery.
- Long-term care, like custodial care (help with bathing, dressing, using the bathroom and eating) at home or in a nursing home.
- Eye care (routine exam), eye refractions.
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing tests that haven't been ordered by your doctor.
- Orthopedic shoes (with a few exceptions).
- Prescription drugs (with a few exceptions).
- Routine foot care, such as cutting of corns or calluses (with a few exceptions).
- Vaccinations (exception influenza, Hepatitis B and pneumococcal).
- Diabetic supplies (like syringes or insulin, unless the insulin is used with a pump or it may be covered by Medicare Part D).
- Chiropractic services exception to correct a subluxation (when bones in your spine move out of position) using manipulation of the spine. You are responsible for coinsurance, and the Part B deductible applies.

Gaps in Medicare

Part A Inpatient hospital coverage, you pay:

- $1,600 deductible on first admission to hospital in each benefit period.*
- $400 daily coinsurance for days 61 through 90.*
- All charges for coverage after 90 days in any benefit period unless you have and use lifetime reserve days.
- $800 daily coinsurance for each lifetime reserve day used.*
- For a private hospital room, unless medically necessary, and for a private duty nurse.
- For nonemergency care in a hospital that does not participate in the Medicare program.
- For care received outside the United States and its territories, except under limited circumstance in Canada and Mexico.

Psychiatric hospital coverage, you pay:

- For all care after you have received 190 days of specialized treatment in a psychiatric hospital during your lifetime.
- The gaps in general hospital coverage.

Skilled-nursing facility coverage (SNF), you pay:

- $200.00 daily coinsurance for days 21 through 100 in each benefit period.
- All cost for care after 100 days in a benefit period.
- All costs if you were not transferred to the SNF in a timely manner after a qualifying hospital stay.
- For care in a SNF not approved by Medicare.
- For custodial care in a Medicare-approved SNF.
- For care in a general nursing home.

Home health coverage, you pay:

- For full-time nursing care.
- For meals delivered to your home.
- For prescription drugs.
- 20% of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims (claims submitted for a service or supply by a provider who doesn't accept assignment).
- For homemaker services that primarily assist you in meeting personal care or housekeeping needs.

Hospice coverage, you pay:

- Limited charges for inpatient respite care and outpatient drugs.
- Deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than terminal illness.

Gaps in Medicare Part B You will be responsible for:

- $226 annual deductible.*
- Generally, 20% coinsurance and permissible charges in excess of Medicare-approved amount.
- All charges for most services that are not reasonable and necessary for the diagnosis or treatment of all illness or injury.
- All charges for most self-administered prescription drugs and immunizations.
- All charges for non-covered services listed on Page 5 of this booklet ("What is Not Covered By Medicare").

About Medicare supplement coverage

What is a Medigap policy?

A Medigap policy (also called "Medicare Supplement Insurance") is private health insurance that's designed to supplement Original Medicare. This means it helps pay some of the health care costs ("gaps") that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share. A Medigap policy is different from a Medicare Advantage Plan (like an HMO or PPO) because those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits. **Note:** Medicare doesn't pay any of the costs for you to get a Medigap policy.

WHEN IS THE BEST TIME TO BUY A MEDIGAP POLICY?

The best time to buy a Medigap policy is during your Medigap open enrollment period. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B. During this period, an insurance company can't use medical underwriting. This means the insurance company can't do any of the following because of your health problems:

- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except as explained below)

While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition. A pre-existing condition is a health problem you have before the date a new insurance policy starts. In some cases, the Medigap company can refuse to cover your out-of-pocket costs for these pre-existing health conditions for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition. Coverage for a pre-existing condition can only be excluded in a Medigap policy if the condition was treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy. This is called the "look-back period." After the 6-month pre-existing waiting period, the Medigap policy will cover the condition that was excluded. Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket costs, but you're responsible for the coinsurance or copayment.

If you have a pre-existing condition and you buy a Medigap policy during your Medigap open enrollment period and you're replacing certain kinds of health coverage that counts as "creditable coverage," it's possible to avoid or shorten waiting periods for pre-existing conditions. Prior creditable coverage is generally any other health coverage you recently had before applying for a Medigap policy. If you have had at least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing conditions.

There are many types of health care coverage that may count as creditable coverage for this purpose. If you buy a Medigap policy when you have guaranteed issue right (also called "Medigap protection"), the insurance company can't use a pre-existing condition waiting period.

It's very important to understand your Medigap open enrollment period. Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the Medigap policy. However, if you apply during your Medigap open enrollment period, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health.

If you apply for Medigap coverage **after** your open enrollment period, there is no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements, **unless** you're eligible based on Medigap protections listed on the next page.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap open enrollment period begins when you enroll in Part B **and** can't be changed or repeated. In most cases, it makes sense to enroll in Part B when you're first eligible, because you might otherwise have to pay a Part B late enrollment penalty.

If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare. You may want to wait to enroll in Part B. This is because employer plans often provide coverage similar to Medigap, so you don't need a Medigap policy.

When your employer coverage ends, you will be able to enroll in Part B without a late enrollment penalty. This means your 6-month Medigap open enrollment period will start when you're ready to take advantage of it. If you enrolled in Part B while you still had the employer coverage, your Medigap open enrollment period would be limited to 63 days.

MEDIGAP OPTIONS FOR BENFICIARIES UNDER AGE 65

Senate Bill 42 (SB 42) requires insurance companies that offer Medigap (Medicare supplemental insurance) policies to people 65 and older to also offer the same policies to anyone under the age of 65 who qualifies for Medicare due to a disability.

Newly enrolled Medicare recipients under age 65 have six months to purchase one of these plans, from the time benefits begin.

Premium rates for the pre-65 Medigap policies may differ from the premium rates for the post-65 Medigap policies, and that the risks assumed by carriers with respect to the pre-65 Medigap policies may not be subsidized by purchasers of the post-65 Medigap policies. SB 42 requires two different ratings pools for the pre-65 Medigap policies: one for end-stage renal disease and another for all other.

Medigap Protection

If you lose your health coverage under certain circumstances, you will have a right to purchase a Medigap policy (Plan A, B, C*, D*, F*, G*, K or L) as long as you apply within 63 days of losing your coverage. Special protections apply with regard to pre-existing conditions and for the disabled. The circumstances include:

- You are in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.
- You were in an employer health plan that terminated coverage.
- You move outside the plan's service area.
- You join a Medicare Advantage plan when you first become eligible for Medicare at age 65 and you leave the plan within one year.
- You drop your Medigap policy to join a Medicare Advantage plan for the first time and you leave within one year of joining.
- You leave a plan because it failed to meet its obligations to you.
- Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.

The terminating plan is required to provide you with written proof of coverage as evidence of continuous insurance for enrolling in another plan. Do not destroy or lose this notification.

***Note:** Plans C and F are no longer available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

Financial assistance

Medicare Savings Programs (MSP)

For certain low-income individuals entitled to Medicare Part A, the MSP may pay some or all of Medicare's premiums, deductibles and coinsurance. The programs that help pay Medicare's premiums are called the QMB program, the SLMB program, and the QI-1 program. For eligibility requirements, please contact DMAB at (302) 674-7364.

Deductible and coinsurance amounts are set by CMS and change at the start of each calendar year. You are responsible for these amounts and uncovered medical expenses.

Extra Help (low-income subsidy/ LIS)

Medicare beneficiaries are eligible for extra help if they have limited income and resources. You may be able to get extra help to pay for the monthly premiums, annual deductibles, and co-payments related to the Medicare Prescription Drug program. However, you must be enrolled in a Medicare Prescription Drug plan to get this extra help. The extra help is estimated to be worth an average of $5,100 per year.

Delaware prescription assistance program (DPAP)

The Delaware Prescription Assistance Program, (DPAP) provides a $3,000 prescription benefit per year for low-income senior or low-income disabled person. Eligible individuals are responsible for a minimum co-pay of $5 or 25% whichever is greater. You must be enrolled in a Medicare Part D drug plan to receive DPAP assistance.

Medigap Plans

How to read the chart:

If a checkmark appears in a column of this chart, the Medigap policy covers 100% of the described benefit. If a column lists a percentage, the policy covers that percentage of described benefit. If a column is blank, the policy doesn't cover that benefit.

Note: The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

Medigap Benefits										
Medigap Benefits	A	B	C	D	F*	G*	K	L	M	N
Medigap Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	√	√	√	√	√	√	√	√	√	√
Medicare Part B Coinsurance or Copayment	√	√	√	√	√	√	50%	75%	√	√***
Blood (First 3 Pints)	√	√	√	√	√	√	50%	75%	√	√
Part A Hospice Care Coinsurance or Copayment	√	√	√	√	√	√	50%	75%	√	√
Skilled Nursing Facility Care Coinsurance			√	√	√	√	50%	75%	√	√
Medicare Part A Deductible		√	√	√	√	√	50%	75%	50%	√
Medicare Part B Deductible			√		√					
Medicare Part B Excess Charges					√	√				
Foreign Travel Emergency (Up to Plan Limits)			√	√	√	√			√	√
							Out-of-Pocket Limit**			
							$6,940	$3,470		

*Plan F and G also offer a high-deductible plan. This means you must pay for Medicare covered costs up to the deductible amount $2,700 in 2023 before your Medigap plan pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly part B deductible ($226 in 2023), the Medigap plan pays 100% of covered services for the rest of the calendar year. Out-of-pocket limit is the maximum amount you would pay for coinsurance and copayments.

***Plan N pays 100% of the Part B co-insurance except up to $20 copayment for office visits and up to $50 for emergency department visits.

Guide for Standard and High-Deductible Plans

Rates are determined in one of three ways:

- Issue Age - The premium is based on the age you are when you buy (are "issued") the Medigap policy.
- Attained Age - The premium is based on your current age (the age you have "attained"), so your premium goes up as you get older.
- Community Rated - Generally the same monthly premium is charged to everyone who has the Medigap policy, regardless of age.

Remember: All companies must offer Plan A, the basic Benefits. All other plans build upon Part A.

Plan A (Basic Benefits)

- Coverage for the Part A coinsurance amount ($400 per day in 2023) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($800 per day in 2023) for each of Medicare's 60 nonrenewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage under Medicare Part A and B for the reasonable cost of the first three pints of blood or equivalent quantities of pack red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 20% of approved charges for outpatient mental health services) after $226 annual deductible is met.
- Hospice.
- Coverage for Medicare-covered preventative care.

Plan B

Includes the basic benefits under Plan A plus

- Coverage for the Medicare Part A inpatient hospital deductible ($1,600 per benefit period 2023).

Plan C

Includes the basic benefits under Plan A and Plan B plus:

- Coverage for the skilled-nursing facility care coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- Coverage for the Medicare Part B deductible ($226 per calendar year in 2023).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for Medicare Preventive Care Part B Coinsurance.

Plan D

Includes the basic benefits under Plan A and Plan B plus:

- Coverage for the skilled-nursing facility care coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- 80% coverage for medically necessary emergency care in foreign country, after a $250 deductible.

Plan F

Includes the basic benefits under Plan A and Plan B plus:

- Coverage for the skilled-nursing facility care coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- Coverage for the Medicare Part B deductible ($226 per calendar year in 2023).
- Coverage for the 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan F*

High-deductible plan:

- This high-deductible plan offers the same benefits as Plan F after you have a paid a calendar-year $2,700 deductible.
- Benefits will not begin until your out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductible for Parts A and B, but not the plan's separate foreign travel emergency deductible.

Plan G

Includes the basic benefits under Plan A and Plan B plus:

- Coverage for the skilled-nursing facility care Coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for Medicare Preventive Care Part B Coinsurance.

About Plans K and L

Plans K and L provide different cost-sharing for items and services than Plan A-G. Once you reach the annual limit, the plan plays for 100% of the Medicare co-payments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include provider charges that exceed Medicare-approved amounts, called "excess charges." You will be responsible for paying excess charges.

Plan K Includes:

- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end.
- 50% of hospice cost-sharing.
- 50% of Medicare-eligible expenses for the first three pints of blood.
- 50% of Part B coinsurance.
- 100% coinsurance for Part B preventive services.
- 50% skilled-nursing facility coinsurance.
- 50% Part A deductible.
- $6,940 out-of-pocket annual limit.

Plan L Includes:

- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits ends.
- 75% hospice cost-sharing.
- 75% of Medicare eligible expenses for the first three pints of blood.
- 75% of Part B coinsurance.
- 100% coinsurance for Part B preventive services.
- 75% skilled-nursing facility coinsurance.
- 75% Part A deductible.
- $3,470 out-of-pocket annual limit.

Plan M

Includes the basic benefits under Plan A plus:

- Coverage for the skilled-nursing facility care coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- 50% Part A deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan N

Includes the basic benefits under Plan A and Plan B plus:

- 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.
- Coverage for the skilled-nursing facility care coinsurance amount ($200.00 per day for days 21 through 100 per benefit period in 2023).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Tips From The Commissioner

- You only need one Medigap policy.
- The lowest price is not always the best deal. If the policy is priced too low, you could be hit with a big price hike in the future.
- Don't be fooled by sales hype. All plans are identical from one insurance company to another - and must be labeled with the letters A, B, C, D, F, G, K, L, M or N.
- Your premiums are not guaranteed for life. They may (and probably will) go up.
- Medical conditions you had before purchasing the policy can be excluded, but not for longer than six months.
- All policies have a 30-day free look period. During this time, you may review the policy, cancel, and get a full refund.
- Pay by check. Make the check out to the insurance company, not the agent. Never pay with cash.
- If you are switching policies, do not cancel your current plan until you have received your new policy.

Call DMAB at 302-674-7364 for a free, personalized plan comparison search with up-to-date rates.

Resources Available to You

Delaware Medicare Assistance Bureau
(302) 674-7364 or (800) 336-9500 or www.insurance.delaware.gov/DMAB

Delaware Medicare Assistance Bureau "DMAB", Delaware's State Health Insurance Assistance Program (S.H.I.P), a division of the Delaware Department of Insurance, offers free, objective information about Medicare, Medicare Advantage plans, Medicare claims, Medicare supplement insurance, Medicare prescription drug plans and long-term care insurance. Trained SHIP volunteer counselors are available for one-on-one counseling in every county in the state.

Medicare
(800) 633-4227 or www.medicare.gov

Medicare provides information 24 hours a day, seven days a week about eligibility, enrollment and coverage.

Social Security Administration
(800) 772-1213 or www.socialsecurity.gov

Contact the Social Security Administration to enroll in Medicare Part A or B, or to request a replacement Medicare card.

Employer Benefits Representative

See your representative for information about Employer Group Health Plan coverage.

Delaware Department of Health and Social Services (DHSS)
(800) 372-2022 or https://dhss.delaware.gov/dhss/

State DHSS offices have information about Medicaid and Medicare Savings Program eligibility and applications.

TRICARE for Life
(877) 874-2273 or www.tricare.mil

TRICARE for Life representatives can assist military retirees with questions on eligibility and coverage.

Resources, con't.

Delaware Prescription Assistance Program (DPAP)
(844) 245-9580 ext. 2 or www.dhss.delaware.gov/dhss/dmma/dpap.html

The Delaware Prescription Assistance Program, (DPAP) is funded by tobacco settlement money and provides a $3,000 prescription benefit per year for low-income seniors or low-income disabled persons. To determine if you are eligible for assistance, please contact DPAP for prescription assistance.

Aging And Disability Resource Center (ADRC)
(800) 223-9074 or https://www.dhss.delaware.gov/dhss/dsaapd/adrc.html

The Aging and Disability Resource Center is a one-step access point for information and services for older persons and disabilities with physical disabilities throughout the State.

Nemours Senior Care
(302) 651-4400 (Wilmington) or (302) 424-5420 (Milford)
www.seniorcarenemours.org

The privately funded Nemours Health Clinic provides dental, optometry and ophthalmology (eye) services including eyeglass; audiology (hearing) screenings and tests, and provides hearing aids for qualified senior citizens of Delaware. Some of the services require small co-pays.

Help From Delaware Medicare Assistance Bureau "DMAB"

The issues involved in Medicare, Medigap and other health insurance issues can be complex and confusing. For Delawareans with Medicare, the Insurance Commissioner's DMAB program provides Medicare beneficiaries with information and counseling related to all types of health insurance. To contact DMAB, call 302-674-7364 or go to www.insurance.delaware.gov/DMAB. See back cover for more information.

Important Information About Medicare Advantage (Part C)

Advantages:

- If you are receiving the Qualified Medicare Beneficiary (QMB) benefit, you DO NOT NEED a Medicare Advantage Plan.
- You are still in the Medicare Program; however, the Medicare Advantage plan administers all of your benefits.
- You still have all the rights and protections as original Medicare.
- Most plans include prescription drugs.
- You may receive additional benefits (vision, dental, hearing, which services are not provided by Medicare.)
- If you are unable to purchase a Medigap policy, you may be able to purchase a Medicare Advantage plan.

Disadvantages:

- You no longer use your Medicare card, but the card provided by the Medicare Advantage plan.
- You must live in the plan's service area.
- In some cases, you must use doctors, specialists, and hospitals contracted by the Medicare Advantage plan (except in an emergency situation).
- You still have to pay your Medicare Part B premium.
- You pay deductible, coinsurance, and co-payment different than Original Medicare.
- The plans are offered on an annual contract. Every year you should review your plan to make sure it will be available the following year.
- In some cases, you need a referral to see a specialist.
- If you get healthcare outside the plan's network, you may have to pay the full cost.
- If you currently have or develop a catastrophic or chronic illness that requires you to visit a medical provider frequently, you may experience higher out-of-pocket medical cost.

REMEMBER, MEDICARE PLANS CAN CHANGE EACH YEAR!

IMPORTANT MEDICARE DATES

OCTOBER-REVIEW AND COMPARE

Review: Your plan may change. Review any notices from your plan about changes for next year.

Compare: In October, use Medicare's tools to find a plan that meets your needs.

OCTOBER 15 – OPEN ENROLLMENT BEGINS

This is the one chance each year most people with Medicare have to make a change to their health and prescription drug plans for the next year.

Decide: October 15 is the first day you can change your Medicare coverage for next year. Make your choice as soon as possible to give the plan time to mail your membership card, acknowledgment letter, and welcome package before your coverage begins on January 1.

DECEMBER 7- OPEN ENROLLMENT ENDS

In most cases, December 7 is the last day you can change your Medicare coverage for the next year. The plan has to get your enrollment request (application) by December 7.

JANUARY 1 – COVERAGE BEGINS

Your new coverage begins if you switched to a new plan. If you stay with the same plan, January 1 is the date that any changes to coverage, benefits, or costs for the new year will begin.

JANUARY 1—MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD

Between January 1 and March 31, if you're in a Medicare Advantage Plan (with or without drug coverage), you can switch to another Medicare Advantage Plan (with or without drug coverage). You can disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you'll be able to join a Medicare Prescription Drug Plan. If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.

Delaware Medicare Assistance Bureau "DMAB"

INSURANCE COMMISSIONER TRINIDAD NAVARRO

DMAB provides free, unbiased Medicare counseling to all Delawareans.

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