

**Arkansas Insurance Department
Senior Health Insurance Information Program
(AR SHIIP) Division**

AR SHIIP

Quick Guide

to

MEDICARE

2025



**Senior Health Insurance
Information
Program (AR SHIP) Division**

AR SHIP's Mission Statement:

Our mission is to empower, educate, and assist Medicare-eligible individuals through objective outreach, counseling, and training.

AR SHIP's vision is to become your trusted resource in the community for reliable Medicare information.



1 Commerce Way

Little Rock, AR 72202

Toll Free: 1-800-224-6330

FIND US ON FACEBOOK

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MEDICARE

Health insurance for:

- People 65 or older
- Certain people who are under 65 with disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

★ **NOTE:** To get Medicare you must be a U.S. citizen or lawfully present in the U.S. Must reside in the U.S. for 5 continuous years.



**Medicare
& You**
The official U.S. government
Medicare handbook
2024



CMS Product No. 10050

What Agencies Are Responsible for Medicare?



Social Security
Enrolls most people in Medicare



Railroad Retirement Board (RRB)
Enrolls both railroad retirees and active employees in Medicare



Office of Personnel Management (OPM)
Handles federal retirees' premiums



Centers for Medicare & Medicaid Services (CMS)
Forms Medicare policy and administers Medicare coverage, benefits, and payments

Getting Started with Medicare

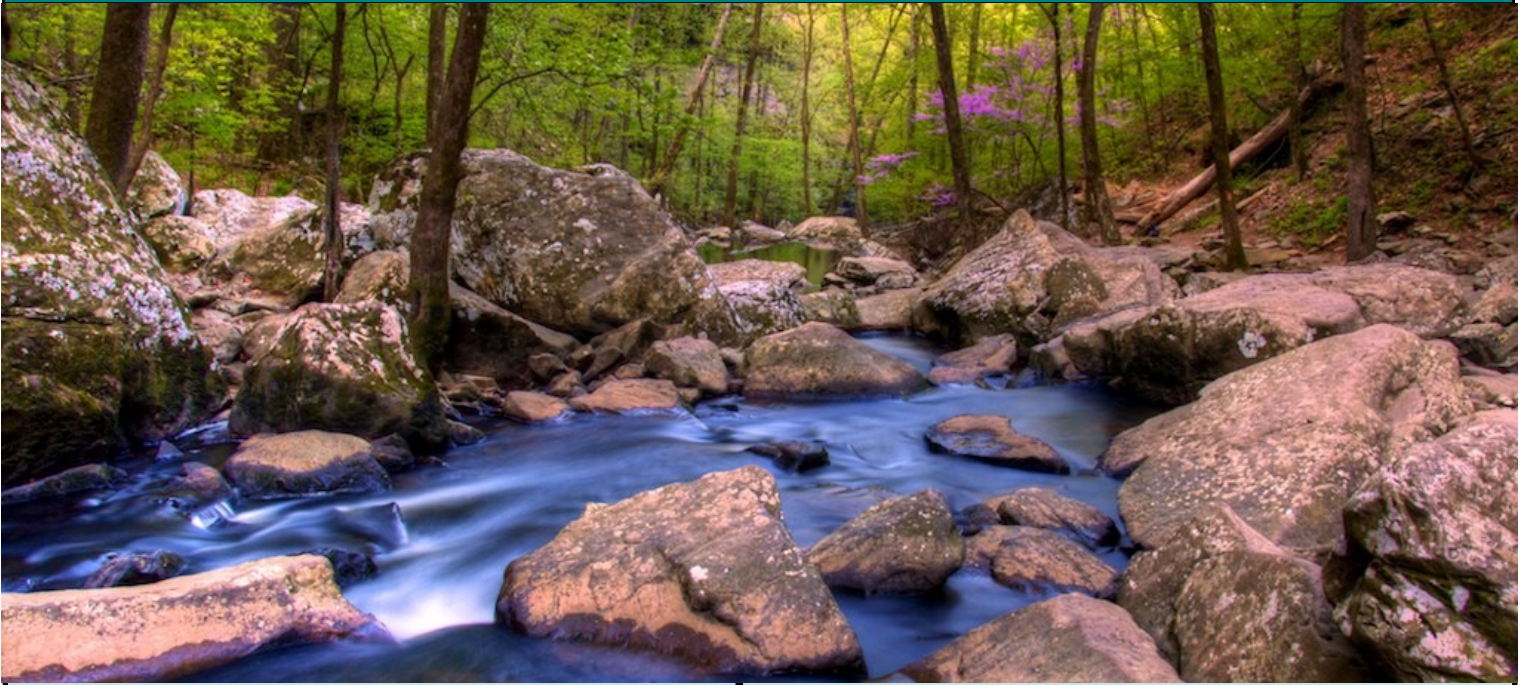
Receiving Medicare is a major milestone. Listed below are 5 important facts to help you on your Medicare journey.

1. Some people receive Medicare automatically, and some have to sign up. You may have to sign up if you're 65 (or almost 65) and not receiving Social Security.
2. There are certain times of the year when you can sign up or change Medicare coverage.
3. If you sign up for Medicare (Part B) when you're first eligible, you will avoid a penalty.
4. You may be able to receive help with your Medicare costs.
5. Shop and compare plans each year.

If you have questions regarding Medicare AR SHIP has the answers. Call AR SHIP and we will connect you with a certified Medicare counselors in your area. Call toll free at:

1-800-224-6330

How and when should you enroll in Medicare?



If you're close to 65, and not getting Social Security or Railroad Retirement Board (RRB) benefits, you will have to sign up for Medicare. Contact Social Security 3 months before you turn 65.

Medicare enrollment is automatic **only** if you are already receiving Social Security or a RRB benefits check. A red, white and blue Medicare card will be sent to you 3 months before your 65th birthday or the 25th month of

When you are first eligible for Medicare, you have a 7-month **Initial Enrollment Period** to sign up for (Part A) and/or (Part B) (3 months before, your birthday month and 3 months after your 65th birthday).

When you apply for Medicare, you can sign up for Parts A & B. You must pay a premium for (Part B). If you decide to enroll in (Part B) later on, you may have to pay a **monthly late enrollment penalty for as long as you have (Part B) coverage** and could have a gap in your health coverage.

Initial Enrollment Period (IEP) 2025

7-Month Period



If you sign up **before** you turn 65, your coverage starts the 1st day of your birthday month.



If you sign up during the last 4 months of your IEP, your coverage begins the 1st day of the month after you sign up.



If you don't enroll during your IEP, you may have to wait to enroll and possibly pay late enrollment penalty

★ NOTE: Your 6-month Medigap OEP starts when you're both 65 and have Part B.

General Enrollment Period (GEP) 2025

3-Month GEP each year



You can sign up for:

- Part A (if you have to buy it)
- Part B

Coverage begins the 1st day of the month after you sign up



May have late enrollment penalties

Special Enrollment Period (SEP) 2025

Starts after Medicare IEP if you have GHP coverage based on current employment

Continues for 8 Months after GHP Coverage Ends



You can sign up for Part A (if you have to pay for it) and/or Part B:

- ✓ Anytime you're still covered by the GHP
- ✓ During the 8-month period that begins the month after the employment ends or the coverage ends

Usually, no late enrollment penalties



★ NOTE: You have 6 months from the Part B effective date to buy a Medigap policy (must have Part A and Part B).

New Beneficiary Enrollment Simplification

- ◆ Section 120 of the Consolidated Appropriations Act (CAA) of 2021
- ◆ Special Enrollment Periods (SEP) with no late enrollment penalties may be established for individuals who meet exceptional conditions specified by the Secretary of the U. S. Department of Health & Human Services (HHS)
- ◆ People may qualify for one of the new SEP if:
 - ◆ They're impacted by an emergency or disaster
 - ◆ They get inaccurate or misleading information from their health plan or employer
 - ◆ They were formerly incarcerated
 - ◆ They lose Medicaid coverage
 - ◆ They experience other exceptional conditions

Beneficiary Enrollment Simplification

New Special Enrollment Periods (SEP)

Special Enrollment Periods (SEP)	Starts	Ends	Coverage Starts
Once individual is or was impacted by a disaster or emergency.	The Date the State, Federal or local Disaster is declared.	6 months after one of the following: <ul style="list-style-type: none"> ▪ The end date of declaration. ▪ The last day of extension of declaration. ▪ The date the government revokes or announces the end of the declaration. 	The month after the individuals signs up.
Health Plan or Employer Error	The day the individual notifies Social Security that their health plan or employer misrepresented or provided incorrect information.	6 months after the individual notifies Social Security.	The month after they sign up.
Formerly Incarcerated	The day the person is released from custody	The last day of the 12th month after the month the person is released	The month after the person signs up or, the person can choose retroactive back to their release date (not to exceed 6 months)
Termination of Medicaid	The day the person is notified that Medicaid coverage is ending	6 months after Medicaid coverage ends	The month after the person signs up, unless the person elects a start date of the first day of the month they lost Medicaid and agrees to pay all prior premiums.
Other exceptional conditions	One Social Security decides whether the person qualifies for a SEP.	Minimum 6-month duration.	The month after the person signs up.

The Four Parts of Medicare

(Part A) (Hospital Insurance)



Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

(Part B) (Medical Insurance)



Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)




(Part C) (Medicare Advantage)

Medicare Advantage (MA) Plans are considered an all in one alternative plan to Original Medicare



(Part D) (Drug coverage)

- Helps cover the cost of prescription drugs (including some shots and vaccines)
- Plans that offer Medicare drug coverage (Part D) are offered through private insurance companies that follow rules set by Medicare

 MEDICARE HEALTH INSURANCE	
Name/Nombre JOHN L SMITH	
Medicare Number/Número de Medicare 1EG4-TE5-MK72	
Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	03-01-2016
MEDICAL (PART B)	03-01-2016

Replacing your Medicare card

If you need to replace your Medicare card because it's damaged or lost, log into (or create) your secure Medicare account at [Medicare.gov](https://www.Medicare.gov) to print or order an official copy of your Medicare card. You can also call 1-800-MEDICARE (1-800-633-4227) and ask for a replacement card to be sent in the mail. TTY users can call 1-877-486-2048.

Medicare (Part A) Premium and Cost

Premium-free (Part A)

You usually don't pay a monthly premium for **Medicare (Part A) (Hospital Insurance)** coverage if you or your spouse paid Medicare taxes for while working. This is sometimes called "premium-free (Part A)."

Most people receive premium-free (Part A).

You can receive premium-free (Part A) at 65 if:

- ◆ You already receive retirement benefits from Social Security or the Railroad Retirement Board
- ◆ You're eligible to receive Social Security or Railroad benefits
- ◆ You or your spouse worked and paid Medicare taxes for at least 10 years

If you're under 65, and eligible to receive premium-free (Part A) if:

- ◆ You received Social Security or Railroad Retirement Board disability benefits for 24 months
- ◆ You have End-Stage Renal Disease (ESRD) and meet certain requirements

(Part A) premiums

\$0 per month for those with 10+ years (40 quarters of work history)

If you don't qualify for premium-free (Part A), you can buy (Part A).

If you buy (Part A), you may pay up to \$518 each month. If you paid Medicare taxes for 30-39 quarters, the standard (Part A) premium is \$285.

In most cases, if you choose to buy (Part A), you must also:

- ◆ Have Medicare (Part B) (Medical Insurance)
- ◆ Pay monthly premiums for both (Part A) and (Part B)

Contact Social Security for more information about the (Part A) premium.

Medicare (Part B) Premium and Cost

(Part B) Premium

You pay a premium each month for (Part B). Your (Part B) premium will be automatically deducted from your benefit payment if you receive benefits from one of these:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If you don't receive these benefit payments, you will receive a bill. Most people will pay the standard premium amount. If your modified adjusted gross income is above a certain amount, you may pay an **Income Related Monthly Adjustment Amount** (IRMAA). Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago. This is the most recent tax return information provided to Social Security by the IRS.

The standard (Part B) premium amount in **2025 is \$185**. Most people pay the standard (Part B) premium amount. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

Based on your IRS tax return from 2023 the following table will show what you may pay for (Part B) total premiums each month in 2025.			You pay each month (in 2025)
File individual tax return	File joint tax return	File married & separate tax return	
\$106,000 or less	\$212,000 or less	\$106,000 or less	\$185.00
above \$106,000 up to \$133,000	above \$212,000 up to \$266,000	Not applicable	\$259.00
Above \$133,000 up to \$167,000	above \$266,000 up to \$334,000	Not applicable	\$370.00
above \$167,000 up to \$200,000	above \$334,000 up to \$400,000	Not applicable	\$480.90
above \$200,000 and less than \$500,000	above \$400,000 and less than \$750,000	above \$106,000 and less than \$394,000	\$591.90
\$500,000 or above	\$750,000 and above	\$394,000 and above	\$628.90

2025 Services Covered by Medicare

(PART A) HOSPITAL INSURANCE COVERED SERVICES			
SERVICES	BENEFITS	MEDICARE PAYS	YOU PAY
Hospitalization Semiprivate room, general nursing, misc. services	First 60 days 61st to 90th day 91st and Beyond	All but \$1,676 All but \$419 per day All but \$838 per day	\$1,676 deductible \$419 per day \$838 per day
Skilled Nursing Facility Care (SNF) after a 3 night hospital stay	First 20 days 21st to 100th day Beyond 100 days	100% of approved All but \$209.50 per day Nothing	Nothing if approved \$209.50 per day All costs
Home Health Care Medically necessary skilled care, therapy	Part-time care as long as you meet guidelines	100% of approved	Nothing if approved
Hospice Care For the terminally ill	As long as doctor certifies need	All but limited costs for drugs & respite care	Limited costs for drugs & respite care
Blood	Blood	All but first 3 pints	First 3 pints
(PART B) MEDICAL INSURANCE COVERED SERVICES			
SERVICES	MEDICARE PAYS	YOU PAY	
Medical Expense Physician services and medical supplies in and out of the hospital	80% of approved amount (after \$257 deductible)	20% of approved amount (after \$257 deductible)	
Clinical Laboratory diagnostic tests	100% of approved	<u>Nothing</u> if approved	
Home Health Care Medically necessary skilled care, home health aide services, medical supplies etc. after a 3-day inpatient hospital stay, Requires a prescription	100% of approved	<u>Nothing</u> if approved	
Outpatient Hospital Treatment Unlimited if medically necessary	80% of approved	20% of approved amount (after \$257 deductible)	
Durable Medical Equipment Prescribed by a doctor for use in home	80% of approved amount (after \$257 deductible)	20% of approved amount (after \$257 deductible)	
Blood	80% of approved amount (after \$257 deductible and after the first 3 pints)	20% of approved amount (after \$257 deductible and after payment of the first 3 pints)	

How does my other insurance work with Medicare?

When you have other insurance (like employer group health coverage) and Medicare, there are rules that decide whether Medicare or your other insurance pays first.

Who Pays First?

If you have retiree insurance from your or your spouse's former employment	Medicare pays first
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees	Your group health plan pays first
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees	Medicare pays first
If you are under 65 and disabled, have group health plan coverage based on your, a spouse's, or a family member's current employment, and the employer has 100 or more employees	Your group health plan pays first
If you are under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees	Medicare pays first
If you have Medicare because of your group health plan and have End-Stage Renal Disease (ESRD)	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Then Medicare will pay first after this 30-month period

Facts to remember:

- ⇒ The insurance that pays first (primary payer) pays up to the limits of its coverage.
- ⇒ The insurance that pays second (secondary payer) only pays if there are costs the primary insurer did not cover.
- ⇒ The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- ⇒ If your employer insurance is the secondary payer, you might need to enroll in (Part B) before your insurance will pay.
- ⇒ Medicare might pay second if you are in an accident or have a workers' compensation case in which other insurance covers your injury and pays first. In these situations, you or your lawyer should tell Medicare as soon as possible.
- ⇒ Tricare for Life (TFL) requires the Medicare Beneficiary to enroll in (Part A) and (Part B).

New (Part B) Preventive & Screening Services

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings & counseling
- Blood-based biomarker test
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy, one-time visit)
- Cervical & vaginal cancer screening
- **Colorectal cancer screenings:**
 - Multi-target stool DNA tests
 - Screening barium enemas
 - Screening colonoscopies
 - Screening fecal occult blood tests
 - Screening flexible sigmoidoscopies
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Hepatitis B Virus infection screenings
- Hepatitis C screening test
- HIV screening



- Lung cancer screening
- Mammograms (screening)
- Medicare Diabetes Prevention Program
- Nutrition therapy services
- Obesity screenings and counseling
- One-time "Welcome to Medicare" preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Tobacco use cessation counseling
- Yearly "Wellness" visit
Shots:
 - COVID-19 vaccines
 - Flu shots
 - Hepatitis B shots
 - Pneumococcal shots

For the complete Preventive Care list or more information on Medicare (Part B) visit [Medicare.gov](https://www.Medicare.gov)

What is Medicare (Part C)

Medicare (Part C) is known as **Medicare Advantage (MA)**. Medicare approved private companies that must follow rules set by Medicare.

How Medicare Advantage Plans work?

Medicare Advantage Plans, sometimes called "(Part C)" or "MA Plans," are considered an "all in one" alternative to Original Medicare. They are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have **Medicare**. However, you will receive most of your (Part A) and (Part B) coverage from your Medicare Advantage Plan, and includes Medicare prescription drug (Part D).

Medicare pays a fixed amount for your care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you receive services.

What are the different types of Medicare Advantage Plans?

- Health Maintenance Organization (HMO) plan
- HMO Point-of-Service (HMOPOS) plan: This HMO plan may allow you to receive some services out-of-network for a higher copayment or coinsurance
- Medical Savings Account (MSA) plans
- Preferred Provider Organization (PPO) plan
- Private Fee-for-Service (PFFS) plan
- Special Needs Plan (SNP)

Covered services in Medicare Advantage Plans

Medicare Advantage Plans cover all Medicare services. Some Medicare Advantage Plans also offer extra coverage, such as vision, hearing and dental coverage.

Medicare Advantage Plans cover Medicare (Part A) and (Part B) benefits. Plans must cover all emergency and urgent care, and almost all medically necessary services Original Medicare covers. However, if you're in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.



(Part C) - Medicare Advantage

Your out-of-pocket costs in a Medicare Advantage Plan (Part C) depend on:

1	Many Medicare Advantage Plans have a \$0 monthly premium. If you enroll in a plan that does charge a premium, you pay that amount in addition to the (Part B) premium.
2	Whether the plan pays any of your monthly Medicare premiums—Some Medicare Advantage Plans will help pay all or part of your (Part B) premium. This benefit is sometimes called a “Medicare (Part B) premium reduction.”
3	If the plan has a yearly deductible or any additional deductibles for certain services.
4	How much you pay for each visit or service (copayments or coinsurance).
5	Medicare Advantage Plans can’t charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
6	The type of health care services you need and how often you receive the services.
7	Whether you receive services from a network provider or a provider that doesn’t contract with the plan. If you go to a doctor, other health care provider, facility, or supplier that doesn’t belong to the plan’s network for non-emergency or non-urgent care services, your plan may not cover your services, or your costs could be higher. In most cases, this applies to Medicare Advantage Plans, Health Maintenance Organizations and Preferred Provider Organizations.
8	Whether you go to a doctor or supplier who accepts Medicare assignment (if you’re in a Preferred Provider Organization or Private Fee-for-Service plan, or Medical Savings Account plan and you go out of network).
9	The plan’s yearly limit on your out of pocket costs for all (Part A) and (Part B) medical services. Once you reach this limit, you’ll pay nothing for (Part A) and (Part B) covered services.
10	Whether you have Medicaid or receive help from your state through a Medicare Savings Program.

Medicare (Part D) Drug Coverage

Medicare prescription drug coverage (Part D) helps pay for medications your doctor prescribes. Even if you don't take prescription drugs now, you should consider enrolling in a Medicare drug plan. Medicare drug coverage is optional and is offered to everyone with Medicare. If you decide not to enroll when you're first eligible, and do not have other creditable prescription drug coverage (such as drug coverage from a union or employer) or receive Extra Help, you will likely **pay a late** enrollment penalty if you join a plan later. Generally, you may **pay this penalty** for as long as you have Medicare drug coverage. To enroll in Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered. Visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare) to find and compare plans in your area or contact your AR SHIIP office **1-800-224-6330**.

There are 2 ways to receive Medicare drug coverage:

1

Medicare drug plans. These plans add drug coverage to Original Medicare, some Medicare Cost Plans, some Private Fee-for-Service plans, and Medical Savings Account plans. You must have (Part A) and/or (Part B) to join a separate Medicare drug plan.

2

Medicare Advantage Plans or other Medicare health plans with drug coverage. You receive all of your (Part A), (Part B), and drug coverage, through these plans. Remember, you must have (Part A) and (Part B) to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

What is a Formulary?

A **FORMULARY** is a list of drugs covered by a Medicare prescription drug plan. *Each plan has its own formulary and the formulary can change from year to year.*

Shop and compare plans every year. Drug costs (premiums, deductibles and formularies) change every year. Contact the plan to find out its current formulary or visit the plan's website. Your plan should notify you if there are any formulary changes.

Use the Medicare Plan Finder at www.medicare.gov/find-a-plan

OR

Call 1-800-MEDICARE (1-800-633-4227)

TTY users should call 1-877-486-2048

OR

Call AR SHIP for help 1-800-224-6330

Many Medicare drug plans place drugs into different "tiers" or "levels" with different costs. Generally, the higher the tier, the higher the cost. **HOWEVER**, if your doctor thinks you need a drug in a higher tier instead of a similar drug in a lower tier, he/she can ask your plan for an exception to receive a lower copayment for that drug.

Each month that you fill a prescription, your drug plan will mail you an **Explanation of Benefits (EOB) notice**. This will give you a summary of your prescription drug claims and your costs. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes.

Medicare Coverage Gap (Donut Hole)

Coverage Gap. Starting in **2025** the 5% coinsurance will be eliminated, and beneficiaries will have **\$0 cost-sharing**. In 2025, annual out-of-pocket Part D cost will be capped at \$2,000. The coverage for generic drugs works differently from the discount for brand-name drugs. Once your total out-of-pocket drug cost reaches the catastrophic coverage threshold (\$2,000 in 2025) you will have no co-pays.

Catastrophic Coverage. Beneficiary enters catastrophic coverage after spending **\$2,000** out of pocket in 2025. Out-of-pocket costs include: Deductible; What beneficiary paid during initial coverage period; Almost the full cost of brand-name drugs (including the manufacturer's discount) purchased during the coverage gap; Amounts paid by others, including family members, most charities, and other persons on beneficiary's behalf; and Amounts paid by State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs, and the Indian Health Service.

When to Join, Switch or Drop a Medicare Plan

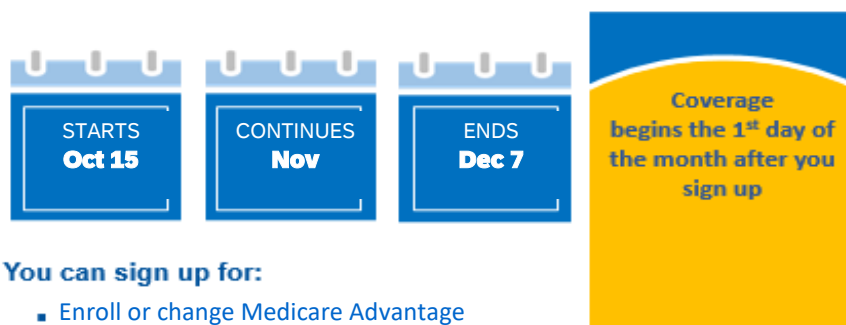
You can join, switch, or drop a Medicare drug plan or a Medicare Advantage Plan with drug coverage during these times:

- **Initial Enrollment Period.** During the first three months in which you become eligible for Medicare, you can join a plan
- **Medicare Annual Open Enrollment Period.** October 15 – December 7 each year, you can join, switch, or drop a plan. Your coverage will begin on January 1 (as long as the plan receives your request by December 7)
- **Medicare Advantage Open Enrollment Period.** January 1 – March 31 You can switch to another Medicare Advantage Plan, with or without drug coverage. You can drop your Medicare Advantage Plan and return to original Medicare. If you do, you can join a Medicare drug plan. Coverage begins the first of the month after you join the plan.

If you have to pay a premium for (Part A) and enroll in (Part B) for the first time during the General Enrollment Period, you can also join a plan, April 1 – June 30. Your coverage will begin the month after you sign up.

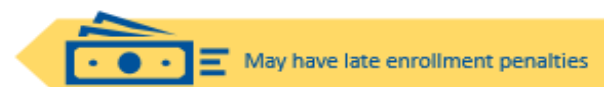
Annual Enrollment Period 2025

Medicare Open Enrollment Period (OEP)



You can sign up for:

- Enroll or change Medicare Advantage
- Part D Drug Plan



When to Join, Switch or Drop a Medicare Plan (Continued)

Special Enrollment Periods

You must stay enrolled in your plan for the entire year. But when certain events happen in your life, like if you move or lose other insurance coverage, you may qualify for a Special Enrollment Period (SEP). You may be able make changes to your plan mid-year if you qualify. Check with your plan for more information.

How do I switch plans?

You can switch to a new Medicare drug plan or Medicare Advantage Plan by joining another plan during one of the times listed above. Your old drug coverage will end when your new drug coverage begins. You should receive a letter from your new plan letting you when your coverage begins, so you don't need to cancel your old plan. You can switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Call AR SHIP 1-800 224-6330



ARKANSAS
SHIP
Senior Health Insurance
Information Program

Have Medicare Questions? We Have Answers!



- **Helps Arkansans navigate through the Medicare maze**
- **AR SHIP Certified Counselors assist Medicare recipients with free, unbiased, confidential, educational information**
- **NO sales pitch, just informative counseling that will empower you to make good decisions for your Healthcare Coverage**



SHIP
State Health Insurance
Assistance Program

1-800-224-6330

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Read the “Evidence of Coverage” and “Annual Notice of Change” you receive from your plan

You will receive the plan information each year. The Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. If you don't receive these important documents in early fall, contact your plan.

How much do I pay?

Your drug costs will vary based on the plan you choose. Remember, plan coverage and costs can change each year. You may have to pay a premium, deductible, copayments, or coinsurance throughout the year.

Your prescriptions may change from year to year be sure to have your (Part D) coverage reviewed during Open Enrollment



Individuals who have limited income and resources may qualify for Medicare Assistance Programs

There are 4 types of Medicare Savings Programs:

1. **AR Seniors** - helps pay for (Part A) and/or (Part B) premiums, deductibles, coinsurance, copayments, and full Medicaid benefits (must be 65 or older).
2. **Qualified Medicare Beneficiary (QMB) Program** – helps pay for (Part A) and/or (Part B) premiums, deductibles, coinsurance, copayments, copays for managed care, and a Medicaid card.
3. **Specified Low-Income Medicare Beneficiary (SMB) Program**– helps pay (Part B) premiums and the (Part B) late enrollment penalty.
4. **Qualifying Individual (QI-1) Program** – helps pay (Part B) premiums and late enrollment penalty.

These programs are different in every state and each has different income and asset levels to qualify.

Call AR SHIP - 1- 800 - 224 - 6330

Extra Help (a Federal Program) that lowers (Part D) costs

If you qualify for **Extra Help** and enroll in a Medicare drug plan, you will receive help paying your Medicare drug plan's monthly premium, yearly deductible, coinsurance, and copayments.

With **Extra Help**, there will be no coverage gap (donut hole) and no late enrollment penalty. You can switch drug plans quarterly.

Medicare will mail you a **LETTER** if you are qualified for **Extra Help**. Keep the letter for your records. You will not need to apply.

You automatically qualify for **Extra Help** if you have Medicare and meet any of these conditions:

- ⇒ You have both Medicare and Medicaid
- ⇒ You are in a Medicare Savings Program
- ⇒ You receive Supplemental Security Income (SSI) benefits

Income and asset levels can change every year.

Call AR SHIP – 1-800-224-6330

Drug Coverage Rules

Plans may have coverage rules for certain drugs

- **Prior authorization:** You and/or your prescriber must contact your plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it. Plans may also use prior authorization when they cover a drug for only certain medical conditions it is approved for, but not others. When this occurs, plans will likely have alternative drugs on their list of covered drugs (formulary) for the other medical conditions the drug is approved to treat.
- **Quantity limits:** Limits on how much medicine you can receive at a time.
- **Step therapy:** You may need to try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.
- **Prescription safety checks at the pharmacy (including opioid pain medicine):** Before the pharmacy fills your prescriptions, your Medicare drug plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages. These safety checks also include checking for possible unsafe amounts of opioids, limiting the days supply of a first prescription for opioids, and use of opioids at the same time as benzodiazepines (commonly used for anxiety and sleep). Opioid pain medicine (like oxycodone and hydrocodone) can help with certain types of pain, but have risks and side effects (like addiction, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.
- **Drug Management Programs:** Medicare drug plans and health plans with drug coverage have a program in place to help you use these opioids and benzodiazepines safely. If you receive opioids from multiple doctors or pharmacies, your plan will contact the doctors who prescribed these drugs to make sure they're medically necessary and you're using them appropriately.
- If your plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan will send you a letter in advance. This letter will tell you if the plan will limit coverage of these drugs for you, or if you'll be required to receive the prescriptions for these drugs only from one doctor or pharmacy you select. You and your doctor have the right to appeal these limitations if you disagree with the plan's decision. The letter will also tell you how to contact the plan if you have questions or would like to appeal.
- **The opioid safety reviews at the pharmacy and the Drug Management Programs generally don't apply** if you have cancer, are receiving palliative or end-of-life care, are in hospice, or live in a long-term care facility.

If you or your prescriber believes that your plan should waive one of these coverage rules, you may be able to ask for an exception.

Drug Coverage Cost

Your actual drug coverage costs will vary depending on:

- Your prescriptions and whether they're on your plan's list of covered drugs (a "formulary")
- Each plan has its own formulary.
- What "tier" the drug is in (Medicare health plans with drug coverage place drugs into different levels).
- Which drug benefit phase you're in (such as, whether you've met your deductible, or if you're in the catastrophic coverage phase).
- Which pharmacy you use and whether that pharmacy offers preferred or standard cost sharing, is out of network, or if your prescription is a mail order. Your out-of-pocket drug costs may be less at a preferred pharmacy that has an agreement with your plan to charge less.
- Whether you receive Extra Help paying your drug coverage costs (**see box below**).

You may be able to lower the cost of your drugs, by choosing generics over brand name or paying the non-insurance cost of a drug, ask your pharmacist if there's a less expensive option available or check with your doctor to make sure the generic option is best for you.

Extra Help paying for drug cost

- Medicare drug cost assistance program administered by Social Security
- Also known as Low-Income Subsidy (LIS)
- **Full Extra Help: Up to 135%-150% FPL**

Extra Help

2025 Changes

In 2025, income eligibility for full Extra Help will be expanded to 150% FPL

- *Limit was previously 135% FPL*
- *Partial Extra Help will be eliminated*
- *Anyone previously eligible for partial Extra Help will be entitled to the full benefit*
- *\$0 premium in benchmark plans*
- *\$0 deductible*

Extra Help cost in 2025

- **Copayments:** *\$4.50 for generics and \$11.20 for brand names*
 - ◆ *For those with Medicaid and income below 100% FPL, copays are \$1.55 and \$4.60*
 - ◆ *Those who are institutionalized and/ or who receive home and community based services do not have prescription drug copays*
- *No copay after reaching \$8,000 in out of pocket drug costs*

Low-Income Subsidy (LIS)/Extra Help (2025) - 48 STATES + DC

Beneficiary Group	Annual Income Eligibility Requirement	Monthly Income Eligibility Requirement	Asset Eligibility Requirement	Need to apply for LIS?	Monthly Premium	Annual Deductible	Copay/Coinsurance Plan's Formulary Drugs
Full-Benefits Duals: Institutionalized or receiving Home and Community-based Services	Meet State Medicaid financial eligibility	Meet State Medicaid financial eligibility	Meet State Medicaid financial eligibility	No, receive it automatically	No	No	None
Full-Benefit Duals: income ≤ 100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	Copay: \$1.60 generic/\$4.80 brand Catastrophic Copay: \$0
Full-Benefit Duals: income > 100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	Copay: \$4.90 generic/\$12.15 brand Catastrophic Copay: \$0
Non-duals: income ≤ 135% FPL	Single: \$20,331/\$20,571* Couple: \$27,594/\$27,834*	Single: \$1,695/\$1,714* Couple: \$2,300/\$2,320*	Single: \$16,100/\$17,600** Couple: \$32,130/\$35,130**	No, if receiving SSI; otherwise, yes	No	No	Copay: \$4.90 generic/\$12.15 brand Catastrophic Copay: \$0
Non duals with income between 135-150% FPL	Single: \$22,590/\$22,830* Couple: \$30,660/\$30,900*	Single: \$1,883/\$1,903* Couple: \$2,555/\$2,575*	Single: \$16,100/\$17,600** Couple: \$32,130/\$35,130**	Yes	No	No	Coinsurance: 0% Catastrophic Copay: \$4.90 generic/\$12.15 brand

* Income amounts reflect threshold without/with the \$20 monthly income disregard (annually = \$240); income is rounded to the nearest whole dollar.

** Asset limits include amount without/with \$1,500/person burial allowance.

Income Levels Source: <https://aspe.hhs.gov/poverty-guidelines>

Asset/Resource Levels: <https://www.cms.gov/files/document/lis-memo.pdf>

Part D Cost-Sharing Source: <https://www.cms.gov/files/document/2024-announcement-pdf.pdf>

2025 Medicare Savings Program

	ARSENIORS	QMB	SMB	QI-1				
Benefits Package	<ul style="list-style-type: none"> Provides full range of Health Care Services including Personal care services in the home when prescribed by a physician. Pays monthly Medicare premiums and co-payments.* <p>NOTE: Only for Seniors 65 and over.</p>	<ul style="list-style-type: none"> Pays monthly Medicare premiums. Pays Medicare deductibles. Pay co-insurance payments. Pays co-payments for Medicare managed care (HMOs). Recipient receives Health Care Card. 	<ul style="list-style-type: none"> Pays monthly Medicare Part B premium only.* Recipient does not receive a Health Care Card. Recipient CAN be certified in another Health Care Category at the same time. 	<ul style="list-style-type: none"> Pays monthly Medicare part B Premium only.* Recipient cannot be certified in another Health Care category at the same time. Recipient does not receive a Health Care Card. 				
Monthly gross income	Individual \$1,043.33	\$1,304.17	Greater than \$1,304.17 but less than \$1,565.00	At least \$1,565.00 but less than \$1,760.63				
Eligibility Requirement**	Couple \$1,410.00	\$1,762.50	Greater than \$1,762.50 but less than \$2,115.00	At least \$2,115.00 but less than \$2,379.38				
Asset Eligibility Requirement	<table border="1"> <tr> <td>Individual</td> <td>\$9,660.00</td> </tr> <tr> <td>Couple</td> <td>\$14,470.00</td> </tr> </table>	Individual	\$9,660.00	Couple	\$14,470.00	Your home and one (1) vehicle are not counted as an asset. We also do not count some burial funds as an asset.		
Individual	\$9,660.00							
Couple	\$14,470.00							

*The Medicare premium rate for 2025 is \$185.00

**Current income Limits for 4/01/2025-03/31/2026

You will not be required to visit the county office. If there are any questions about your application, a caseworker may contact you. You will be placed in the Medicare Savings benefit package with the most coverage based on your eligibility. You will receive a notice in the mail within 45 days telling you if you qualify for Medicare Savings benefits and when your eligibility will begin.

New in 2025

Postal Service Health Benefit (PSHB)

- PSHB Program requires certain retirees to enroll in Medicare Part B to continue PSHB coverage
- Retirees as of January 1, 2025 who did not enroll in Part B:
 - NOT required to enroll in Part B to continue coverage in PSHB
- Retirees as of January 1, 2025 who are already enrolled in Part B as of that date:
 - Required to remain enrolled in Part B to continue coverage in PSHB

PSHB and Part B enrollment

- Retirees entitled to Part A as of January 1, 2024 who did not enroll in Part B may be able to participate in a Special Enrollment Period (SEP) for Part B that starts on April 1, 2024
 - Those who enroll during this SEP will not owe a late enrollment penalty
 - Eligibility letters will be sent to retirees and eligible family members in early 2024
- Those who retire between October 31, 2024 and December 31, 2024, and are entitled to Medicare Part A, will have the option to enroll in Part B using the Part B SEP for job-based insurance

Access to Mental Health Care Services

- Licensed Mental Health Counselors and Licensed Marriage and Family Therapists can enroll for the first time in Medicare and bill Part B directly for their services
- Intensive outpatient program (IOP) services can be billed and covered by Medicare in hospital outpatient departments, community mental health centers, RHCs, and FQHCs
 - IOP services may also be covered in OTPs for the treatment of opioid use disorder
- New CMS policies for Medicare Advantage Plans
 - Extend network adequacy requirements to mental health professionals, including Clinical Psychologists and Licensed Clinical Social Workers
 - Specify that emergency behavioral health services should not be subject to prior authorization

What is Medicare Supplement Insurance (Medigap)?

Medigap is Medicare's Supplement Insurance that helps fill "**gaps**" in Original Medicare and is sold by private companies. Original Medicare pays for some of the cost for covered health care services and supplies. A Medicare Supplement Insurance (Medigap) policy can help pay some of the remaining health care costs, such as:

- Copayments
- Coinsurance
- Deductibles

8 things to know about Medigap policies

1. You must have Medicare (Part A) and (Part B).
2. You pay the private insurance company a monthly Premium for your Medigap policy. You pay this monthly premium in addition to the monthly (Part B) premium that you pay to Medicare.
3. A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you'll each have to buy separate policies.
4. You can buy a Medigap policy from any insurance company that's licensed in your state.
5. Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can not cancel your Medigap policy as long as you pay the premium.
6. Some Medigap policies sold in the past covered prescription drugs. However, Medigap policies sold after January 1, 2006 are not allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D).
7. It's illegal for anyone to sell you a Medigap policy if you have a Medicare Advantage Plan, unless you're switching back to Original Medicare.
8. Medigap policy covers you if you travel outside the country.

Medicare Supplement (Medigap)

Predictable Out-of-Pocket Costs

Low or no out-of-pocket copay, coinsurance or deductible plan options available.

More Complete Coverage

Prescription drug (Part D) plans work with Medicare Supplement plans to provide you with more complete coverage.

Keep Your Doctor

Choose any doctor or hospital that accepts Medicare patients—no referrals needed.

Coverage When You Travel

A Medicare Supplement plan goes with you when you travel anywhere in the U.S.

Guaranteed Coverage for Life*

Plan features stay the same from year to year, and your coverage will never change, even if your health does.

***Coverage guaranteed for life as long as you pay your premiums when due and you do not make any material misrepresentation when you apply for this plan. Rates are subject to change. Any change will apply to all members of the same class insured under your plan who reside in your state.**

TYPES OF MEDICARE SUPPLEMENT INSURANCE (MEDIGAP)

Most companies offer two rates: Preferred and Standard. The monthly premium amount is based on medical underwriting. Underwriting is the method insurance companies use to evaluate your health status to determine risk and insurability (to determine if they will sell you a policy).

Preferred Premium

The Preferred insurance premium is typically lower than the standard premium. Insurance companies base their decision to offer a preferred premium on a variety of factors including but not limited to: smoking/tobacco use, weight, cholesterol, blood pressure, substance abuse, etc. Preferred Premiums are offered to those purchasing during the Medigap Open Enrollment Period (OEP).

Vs.

Standard Premium

The standard rates apply outside the Medigap Open Enrollment Period and for those with less favorable medical histories.

Medigap Select Policy

A select policy has a NETWORK or specific list of providers (hospitals) an insured person can use. In general, Medicare SELECT policies are not required to pay any benefits (claims/bills) if you do not use a preferred/network provider for non-emergency services. Medicare, however, will still pay its share of approved charges regardless of the provider you choose.

The select policy usually offers the lowest cost premium. In Arkansas, three companies offer select policies:

1. AARP/United Healthcare Insurance Company
2. Marquette National Life Insurance Company
3. Sterling Life Insurance Company

If you choose a Medicare Select Policy, be sure your hospital is in-network.

Difference between Medigap & Medicare Advantage Plans

- Medigap and Medicare Advantage offer different options. What is best for a person depends on their particular needs.
- Medigap also known as (Supplemental) insurance can help pay some of the remaining health care costs for covered services and supplies, like copayments, coinsurance, and deductibles not covered by Original Medicare. Medicare Advantage also known as (Medicare Part C) is an alternative to Original Medicare you can receive all of the Medicare-covered services if you have both (Part A) and (Part B). MA plans may offer extra benefits that Original Medicare does not.
- The key factors that a person will need to compare to decide which option best suits their needs include coverage, flexibility in choosing doctors, and costs.

In the state of Arkansas it is illegal for anyone to sell you a Medigap policy unless you are switching back to Original Medicare. If you have a Medigap policy and join a [Medicare Advantage Plan \(Part C\)](#), you must drop your Medigap policy. You are not permitted to use Medigap policy to pay your Medicare Advantage Plan copayments, deductibles, and premiums because MA plans provide other protections that Medigap does not.

Special Rights under Advantage Plans

If you join a Medicare Advantage Plan for the first time, when you are first eligible for Medicare and you are not happy with the plan, you'll have special rights under federal law to buy a Medigap policy and a separate [Medicare Prescription Drug Plan \(Part D\)](#), if you return to Original Medicare within 12 months of joining the Medicare Advantage.

If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to receive the same policy back.

COMPARE MEDIGAP PLANS AND BENEFITS

Medigap Plan Benefits	A	B	C	D	F*	G*	K	L	M	N
Medicare (Part A) eligible hospital costs up to an additional 365 days after all Medicare hospital benefits are exhausted	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare (Part B) Coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (First 3 Pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
(Part A) Hospice Care Coinsurance or Copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled Nursing Facility Care Copayment			100%	100%	100%	100%	50%	75%	100%	100%
Medicare (Part A) Deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Medicare (Part B) Deductible			100%		100%					
Medicare (Part B) Excess Charges					100%	100%				
Foreign Travel Emergency (Up to Plan Limits)			80%	80%	80%	80%			80%	80%
							Out-of-Pocket limit in 2025**			
							\$7,060	\$3,530		

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,800 in 2025 before your policy pays anything. (Plans C and F aren't available to people who are newly eligible for Medicare on or after January 1, 2020.)

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly (Part B) deductible (\$257 in 2025), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

Medigap Policies Do Not Cover Everything

Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Insurance plans that are not Medigap

This list include the following insurance plans:

- Medicare Advantage Plans (like an HMO, PPO, or Private Fee-for-Service Plan)
- Medicare Prescription Drug Plans
- Medicaid
- Employer or union plans, including the Federal Employees Health Benefits Program (FEHBP)
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans

Important Information to Remember

➡ Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

➡ Contact your private insurance company for more information on your coverage and your monthly premium for Medigap in addition to the monthly (Part B) premium you pay to Medicare. Also, if you buy Medigap and a separate Medicare drug plan from the same company, you may need to make 2 separate premium payments. Contact the company to find out how to pay your premiums.

➡ A Medigap policy only covers one person. Spouses must buy separate coverage.

BUYER BEWARE

For Quotes And Exact Premium Cost. Contact a company or agent to purchase.

SHOP WITH CAUTION. Do not just buy the cheapest policy without weighing other factors and determining the company's financial stability and reputation for resolving complaints.

AVOID HIGH PRESSURE SALES TACTICS. Take time and avoid being pushed into buying an insurance policy. Be wary of agents and sales material that imply a policy is connected with or endorsed by the government. Medicare Supplement Insurance and Long-term Care insurance are not connected with or endorsed by the federal government.

DON'T BE MISLED BY ADVERTISING. Do not buy a policy because celebrities endorse it on television, radio, newspaper, or other advertisements. Ask questions before buying a policy.

BE CAREFUL HOW YOU PAY FOR POLICIES. Do not pay in cash. When purchasing Medicare Supplement Insurance, it is always best to pay by check, money order, or bank draft. Premium payments should always be made payable to the insurance company instead of the agent selling the policy. If you must pay in cash, be sure to get a company-authorized receipt.

KEEP YOUR POLICY IN A SAFE PLACE. Select a friend or relative in advance to handle your medical affairs in case of illness and let that person know where to locate your policy.

KEEP RECORDS. Write down the names, phone numbers and address of the insurance company and the agent who is selling you the policy.

BUYER BEWARE

When describing the benefits of Medicare Supplement Plans, all insurers use the same format, language, and definitions. They are required to use a uniform chart and outline of coverage to summarize the benefits of the plans they offer. These requirements make it easier to compare policies from different insurers. As you shop for a policy, keep in mind that each company's products are standard, products compete based on price, service, and reputation.

PRICE. While the benefits are identical for all Medicare Supplemental Plans of the same type, the premiums vary from one company to another and from area to area. The plan with the lowest price is not necessarily the best plan. The price should not be the only concern. You may prefer a particular schedule of payments. Some companies bill the premium each month, while others bill each quarter or once a year. In addition, prices are based in part on the services a company provides and on their reputation. Some plans add benefits but remember the basic coverage is the same from plan to plan based on federal law.

CUSTOMER SERVICES. You should ask about the insurer's customer services. For example, some companies link their computers with the computers at the federal Medicare office to process your health insurance claims without additional paperwork. This is called Medicare Crossover. This and other available customer services may be important considerations in making a decision.

REPUTATION. You should consider the reputation of the insurer before buying a policy. Find out about the company by asking for referrals, asking others about their experiences, and check out the number of complaints filed at this website:

<https://eapps.naic.org/cis/>.

VARIABLES

POLICY FEE: Some policies add a one-time policy fee. **These are not allowed in Arkansas.**

UNDERWRITING: Most companies underwrite. However, a few policies are "guaranteed issue."

PREMIUM TYPE: The premium for your policy may increase every year, primarily due to inflation in medical costs and the use of more advanced technology. The amount your premium goes up may depend upon the manner in which the company has reflected the aging of its policyholders in its rates. The general approach that companies use are described below. **In Arkansas, the "no age rating method" is used.**

1. Attained Age: In addition to medical inflation and advancing technology, your premium will also rise due to the increased use of medical services as people age.

2. Issue Age: The premium you pay will initially be somewhat 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. As a result, in subsequent years your premiums should be somewhat less than they would be under an attained age approach.

3. No Age Rating or Community Rated Age: Under this approach, the premium is the same for all customers who buy this policy, regardless of age.

DIRECT RESPONSE/AGENT: Premiums are basically the same when comparing a direct response sale to an agent-marketed sale.

NON-SMOKER: Few companies have non-smoker discounts.

MEDICARE CROSSOVER: This is one of the more significant service enhancements that companies can offer. A "crossover" company has a contract with Medicare requiring Medicare to send the policyholder's balance bills directly to the Medicare Supplement Insurance Company.

SPECIAL CIRCUMSTANCES FOR GUARANTEED ISSUE FOR MEDIGAP

Federal and state laws guarantee acceptance into Medicare Supplement insurance (Medigap), if a Medicare beneficiary qualifies in one of seven categories listed below. This means the insurance company can not deny a policy nor impose a pre-existing waiting period based on medical history. There is a strict time limit! The Medicare beneficiary has **ONLY 63 days** from the date of loss of coverage to apply for a Medigap policy and be granted a guaranteed issue.

The Arkansas Insurance Department is committed to seeing that your rights are upheld in all circumstances pertaining to guaranteed acceptance into Medicare Supplement Insurance.

CATEGORY 1:

If a Medicare beneficiary is enrolled in an employer-sponsored plan and the plan terminates or ceases to provide some or all supplemental benefits to Medicare, or the insured chooses to leave the plan.

Then guarantee issue of Medigap Plans A, B, C, F, K or L with any company selling these plans.

CATEGORY 2:

If a Medicare beneficiary is enrolled in a Medicare Advantage Plan and

- the plan's certification is terminated
- the plan ceases to provide all services
- the enrollee moves out of the service
- the plan violates the contract, misrepresents during marketing
- there are other circumstances as determined by HHS Secretary

Then guarantee issue of Medigap Plans A, B, C, F, K or L with any company selling these plans.

CATEGORY 3:

If a Medicare beneficiary is enrolled in a Medicare Risk, Cost, Demonstration, HCPP, or select plan, and

- the plan's certification is terminated
- the plan ceases to provide all services
- the enrollee moves out of the service
- the plan violates the contract, misrepresents during marketing
- there are other circumstances as determined by HHS Secretary

Then guarantee issue of Medigap Plans A, B, C, F, K or L with any company selling these plans.

CATEGORY 4:

If a Medicare beneficiary is enrolled in a Medigap policy and any of the following occur:

- the Insurer becomes insolvent or bankrupt

- there is involuntary termination of coverage or enrollment
- there is material violation of the policy
- there is material misrepresentation during marketing

Then guarantee issue of Medigap Plans A, B, C, F, K or L with any company selling these plans.

CATEGORY 5:

If a Medicare beneficiary is enrolled in a Medigap policy, terminates it and enrolls for the first time in a Medicare Advantage Plan, Risk, Cost, Demonstration, HCPP, or Select plan, and disenroll from the chosen coverage within the first 12 months as permitted under federal law,

Then guarantee issue of Medigap Plans A, B, C, F, K or L with any company selling these plans or his/her prior Medigap plan, if it is still available.

CATEGORY 6:

If an individual is first eligible for Medicare (Part A) at the age of 65, and

- enrolls in a Medicare Advantage plan
- disenroll within the first 12 months after enrollment as permitted by federal law

Then guarantee issue of any Medigap plan sold by any insurer.

CATEGORY 7:

If an individual leaves a Medicare Advantage Plan or drop a Medigap policy because the company has not followed the rules or misled the individual,

Then guarantee issue of Medigap Plans A, B, C, F, K, L, M, or N sold by any insurer.

If you believe you meet the criteria in one of these categories and have been denied a policy, contact Arkansas SHIP 1-800-224-6330 or email: insurance.shiip@arkansas.gov



Hugh McDonald
SECRETARY OF COMMERCE

Alan McClain
COMMISSIONER,
ARKANSAS INSURANCE
DEPARTMENT

BULLETIN NO. 5-2023

DATE: APRIL 3, 2023

TO: ALL LICENSED INSURERS AUTHORIZED TO TRANSACT HEALTH INSURANCE BUSINESS IN THE STATE OF ARKANSAS WRITING MEDICARE SUPPLEMENT INSURANCE AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: **THE FEDERAL PUBLIC HEALTH EMERGENCY AND MEDICARE SUPPLEMENT GUARANTEED ISSUE ELIGIBILITY**

During the Federal Public Health Emergency, Arkansas consumers were permitted to remain enrolled in Medicaid without a redetermination of income or other eligibility requirements. Consequently, some Medicare eligible consumers may have missed the guaranteed issue period for obtaining a Medicare Supplement plan in Arkansas.

Pursuant to Arkansas Insurance Department Rule 27, Sections Eleven (11) and Twelve (12), Arkansans aged sixty-five (65) or older, and who are enrolled in Medicare Part B receive a Medicare Supplement “open enrollment” and “guaranteed issue” period of six months wherein insurers must offer Medicare Supplement policies to applicants. During this period insurers also cannot discriminate in the pricing of Medicare Supplement policies due to the health status of the applicant.

Arkansas’s Medicaid program required Medicaid recipients eligible for Medicare to enroll in Medicare Part B and in some cases auto enrolled the consumer. Some consumers may have been dual enrolled for multiple years.

To ensure low- and moderate-income Arkansas seniors have access to Medicare Supplement plans, the Commissioner directs all health insurers writing Medicare Supplement business in Arkansas to offer a guaranteed issue Medicare Supplement plan to all applicants who have exhausted their open enrollment period as a result of their continued enrollment in Medicaid and who can show verification of an Arkansas Medicaid eligibility change. Insurers should treat applicants as “eligible persons” pursuant to Arkansas Insurance Department Rule 27, Section Twelve (12) and permit applicants to enroll in a Medicare Supplement plan with a guaranteed issue period of sixty-three (63) days starting on the date of a Medicaid eligibility change.

Because consumers were enrolled in both Medicaid and Medicare, this approach will most closely match the intent of Medicare Supplement regulations related to other insurance coverage under Arkansas Insurance Department Rule, Section 12. This approach also aligns with Medicare’s decision to not apply a Medicare Part B penalty to late Medicare enrollees.

The Commissioner encourages consumers with questions about this bulletin to contact Carroll Astin at carroll.astin@arkansas.gov or (501) 371-2785. Questions from insurers and other interested parties should be directed to Jimmy Harris at jimmy.harris@arkansas.gov or (501) 671-1621.



ALAN MCCLAIN
INSURANCE COMMISSIONER
STATE OF ARKANSAS

4-3-2023

DATE

2025-2026 Med Supps Closed Block	A	B	C	D	E	FHD-F	G	HD-G	H	I	J	K	L	M	N
Accendo Insurance Company	\$159					\$235	\$210								\$165
Aetna Health and Life Insurance Company	\$191	\$220				\$253	\$199								\$125
American Continental Insurance Company	\$330					\$479	\$412								\$285
American Family Life Assurance Company of Columbus	\$186		\$376	\$235		\$404	\$362								\$238
American National Life Insurance of Texas - Plan G only							\$341								
American Republic Corp Insurance Company						\$436	\$87			\$318					
Atlantic Coast Life Insurance Company		\$410				\$323	\$293								\$216
Cigna National Health Insurance Company						\$541									
Colonial Penn Life Insurance Company				\$281		\$423	\$431	\$60		\$107	\$0	\$275		\$314	
Continental General Insurance Company						\$393	\$340								
Family Life Insurance Company	\$139	\$170	\$197	\$406	\$179	\$572	\$508					\$160		\$401	
Garden State Life Insurance Company							\$247	\$201						\$81	
Gerber Life Insurance Company						\$608	\$510								
Guarantee Trust Life Insurance Company						\$267									
Heartland National Life Insurance Company						\$553								\$401	
Humana Insurance Company						\$412	\$97			\$124					
Liberty National Life Insurance Company							\$74								
Loyal American Life Insurance Company						\$320									
Nassau Life and Annuity Company AP			\$386			\$567									
Nassau Life Insurance Company of Kansas		\$408	\$541	\$426		\$514	\$439								
Oxford Life Insurance Company				\$324		\$495				\$505					
Philadelphia American Life Insurance Company			\$297			\$369	\$311							\$239	
Physicians Life Insurance Company						\$445	\$362								
Physicians Mutual Insurance Company						\$557	\$134							\$403	
Physicians Mutual Insurance Company	\$221	\$280	\$451			\$414									
Principal Life Insurance Company	\$311	\$366	\$511	\$415	\$440	\$447	\$333		\$518	\$465	\$658				

2025-2026 Med Supps Closed Block	A	B	C	D	E	F	FHD-F	G	HD-G	H	I	J	K	L	M	N
S. USA Life Insurance Company, Inc.	\$295					\$376		\$257								
Sentinel Security Life Insurance Company						\$414	\$340									
Southern Guaranty Insurance Company						\$405		\$314								\$208
Standardized Life and Accident Insurance Company							\$36									\$119
Sterling Investor Life Insurance Company						\$299		\$290								\$156
Sterling Investors Life Insurance Company				\$540		\$729		\$554								
The Manhattan Life Insurance Company	\$310	\$0	\$370			\$410		\$302								\$253
Thrivent Financial for Lutherans	\$267		\$326	\$290		\$372	\$56	\$297		\$419	\$425					
Transamerica Life Insurance Company	\$149			\$261		\$284				\$630	\$638	\$825				
United Commercial Travelers of America	\$421	\$645	\$0		\$446	\$520		\$456								
United National Life Insurance Company	\$184			\$214		\$352		\$309								\$213
United World Life Insurance Company	\$229	\$264				\$304	\$106	\$239								\$150
UnitedHealthcare Insurance Company	\$312	\$381	\$522			\$556		\$501					\$163	\$288		\$477
UnitedHealthcare Insurance Company	\$267	\$325	\$444	\$417	\$418	\$447		\$420		\$412	\$414	\$432	\$139	\$247		
USABLE Mutual Insurance Company	\$227	\$275	\$374	\$374		\$378		\$293			\$390	\$419				

Medicare and the Health Insurance Marketplace

The Health Insurance Marketplace provides a way for people who do not have health insurance through a job or a federal program to receive health coverage. **The Marketplace does not offer Medicare health plans, Medicare drug plans (Part D), or Supplement Insurance policies. Medicare is not part of the Marketplace.**

What is considered “minimum essential coverage”?

As long as you have Medicare (Part A) coverage (or coverage from a Medicare Advantage Plan), you have minimum essential coverage and you do not have to receive any additional coverage. If you only have Medicare (Part B), you are not considered to have minimum essential coverage. ***This means you may have to pay a fee for not having minimum essential coverage when you file your federal income tax return.***

Can I get a Marketplace plan instead of Medicare, or can I get a Marketplace plan in addition to Medicare?

Generally, no. It is against the law for someone who knows you have Medicare to sell you a Marketplace plan because that would duplicate your coverage. HOWEVER, if you are employed and your employer offers employer-based coverage through the Marketplace, you may be eligible for this type of coverage.

What if I become eligible for Medicare after I join a Marketplace plan?

If you have a Marketplace plan, you can keep it until your Medicare coverage starts. Then, you can terminate the Marketplace plan without penalty. Visit **HealthCare.gov** to find out how to terminate your Marketplace plan.

Note: If you have been receiving premium tax credits or other savings on a Marketplace plan, your eligibility for these savings will end once your Medicare (Part A) coverage starts.

***To learn more about how Medicare works with the Marketplace,
visit [HealthCare.gov](https://www.healthcare.gov) and [Medicare.gov](https://www.medicare.gov).***

Medicare Rights and Protections

What are my Medicare rights?



- Be treated with dignity and respect at all times
- Be protected from discrimination
- Your personal and health information kept confidential
- Have questions about Medicare answered
- Have access to doctors, other healthcare providers, specialists, hospitals, and receive emergency care when needed
- Receive information from Medicare, healthcare providers, and Medicare contractors about your treatment choices in clear language, in a format you understand, and to participate in treatment decisions
- Request a review (appeal) of certain decisions about healthcare payments, coverage of services, or prescription drug coverage
- File complaints (or grievances), including complaints about the quality of your care
- Receive a decision about a healthcare payment, coverage of services, or prescription drug

What is an Advanced Beneficiary Notice of Noncoverage (ABN)?

To protect you from unexpected bills, Medicare requires healthcare providers to give you in a written notice if they think Medicare will not pay for an item or service. It will give you the cost of the item or service so you can decide whether to pay for it or not.

How do I file an Appeal?

You can appeal a denied item or service if you think Medicare should pay but did not or if you think Medicare did not pay the right amount.

Review your Medicare Summary Notice (MSN) that shows the item or service you are appealing and follow the directions on the MSN to appeal within 120 days of the date you receive the MSN in the mail. You should receive a decision from the Medicare Administrative Contractor (MAC) within 60 days after they receive your request. If Medicare will cover the item (s) or service (s), it will be listed on your next MSN.

What if I think my services are ending too soon or I am denied admission to the hospital?

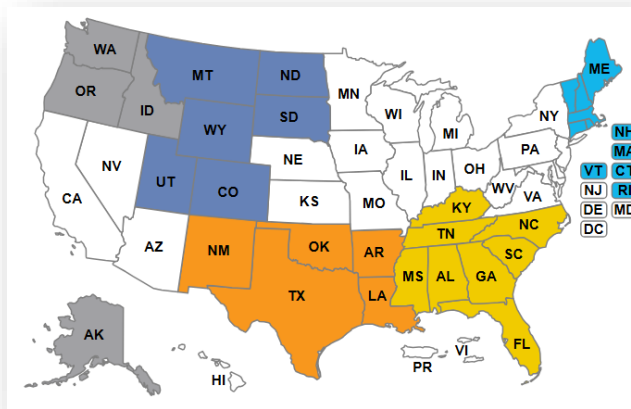
You can ask for a **fast appeal** – an immediate review by the BFCC-QIO.

For more information, visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals) or

Call AR SHIP – 1-800-224-6330

Acentra Health is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for the 29 states highlighted in the map below. As a BFCC-QIO, Acentra health helps people who are on Medicare-and their families and caregivers-to file quality of care complaints and hospital discharge and skilled service termination appeals. We also offer immediate Advocacy services to quickly resolve medical concerns. For additional information: See the [teal boxes](#) under the US map.

- | | | | | | |
|--|-------------------------------------|--|-------------------------------------|--|--------------------------------------|
| | Region 1
Toll-free: 888-319-8452 | | Region 6
Toll-free: 888-315-0636 | | Region 10
Toll-free: 888-305-6759 |
| | Region 4
Toll-free: 888-317-0751 | | Region 8
Toll-free: 888-317-0891 | | |



Information for People Who Have Medicare and Their Families

- Overview of Services
- How to File a Quality of Care Complaint
- How to File an Appeal
- Immediate Advocacy
- Additional Resources
- Newsletter: On the Healthcare Front
- Podcast: Aging Health Matters
- En Español
- Check Status of an Appeal

- Not sure where to begin?
Click here to start on our overview page.

Information for Healthcare Providers

- Overview
- Appeals
- Beneficiary Complaints
- Other Reviews
- Medical Record Electronic Submission
- Educational Resources
- Newsletter: Case Review Connections
- Physician Acknowledgement Monitoring
- QJO Liaison
- Memorandum of Agreement
- Update Your Contact Information
- Become a Peer Reviewer
- CMS Beneficiary Notices Initiative
- Check Status of an Appeal

Information for Our Partners and Stakeholders

- Overview
- Educational Resources
- Newsletters
- Podcast: Aging Health Matters
- Advocacy Resources
- Request a Speaker
- Annual Reports

Medicare Fraud, Waste & Abuse

What is Senior Medicare Patrol?

Senior Medicare Patrol projects are federally funded grant programs of the U.S. Department of Health and Human Services Administration for Community Living. The Arkansas SMP program is administered through the Arkansas Insurance Department in Little Rock. The goal of the SMP program is twofold:



- To educate and protect Medicare recipients, their caregivers and families, as well as professionals in the aging industry, from fraud and scams.
- To protect the Medicare trust fund, which is made up of taxpayer money and loses approximately \$90 billion annually to fraud, waste and abuse.

The SMP message is simple: “protect, detect and report.” These three steps work together to combat fraud and errors.

Why is SMP’s work important for Medicare beneficiaries?

Senior citizens are one of the most vulnerable and valuable populations in our society. SMP outreach and education efforts empower individuals to understand, recognize and report health care fraud, errors and scams targeting seniors. Repeatedly hearing the SMP message helps in protecting and preventing fraud and scams. Our statewide toll-free helpline (866-726-2916) is available for easy communication with our office. We are a local, unbiased and empathetic group ready to listen, consult, support and assist those who contact us by phone or email aid.insurance.smp@arkansas.gov.



Preventing Medicare Fraud

What are the most common types of health care fraud?

Some examples of Medicare fraud include:

- A Medicare number is stolen or obtained deceptively and used to submit fraudulent claims, usually claims for services or supplies that were never provided, not ordered by a provider, or not medically necessary, such as durable medical equipment, glucose monitors, diabetic supplies and genetic testing.
- Double billing: A provider charges Medicare twice for the same service or item that was either not received or only received once.
- Upcoding: filing a Medicare claim for a more expensive product or procedure than was provided.
- Hospice fraud: Someone is signed up on hospice despite no terminal diagnosis or consent, offering medically unnecessary hospice care in exchange for a Medicare number.

In 2023, SMPs nationwide reported expected Medicare recoveries of more than \$111,277,683. The national SMP program also provided OIG with 26 reports of new fraud trends, including those involving COVID-19, remote patient monitoring, urinary catheters, continuous glucose monitors, internal employee complaints, unsolicited annual wellness visits, fraudulent disenrollment and other concerning trends.

How do I know if my loved one on Medicare is being defrauded?

The only way to detect suspected fraud or errors is by reviewing the *Medicare Summary Notice*. If you are a Medicare recipient, caregiver or loved one, it is crucial to review the *MSN* regularly. A good way to quickly know if your loved one has been defrauded is to sign up for an account at [medicare.gov](https://www.medicare.gov), allowing for easier and more readily available monitoring of your loved one’s Medicare account online.

866-726-2916 • insurance.arkansas.gov/SMP

The Arkansas Senior Medicare Patrol (SMP)
can help with suspected Medicare fraud.

Call 1-866-726-2916

Find a doctor or healthcare provider who accepts Medicare Assignment

For a list of providers in your area go to the Medicare.gov Physician Compare website at: <https://www.medicare.gov/physiciancompare>

Next:

- ☀ Enter your zip code in the “My Location” box
- ☀ Next type a “Name or Keyword” of the Specialty, provider name, or group you are searching for (optional)
- ☀ click “Search” button



Search for Forms, booklets, videos and more information from Arkansas Employee Benefits

Division by visiting their website at:

<https://www.transform.ar.gov/employee-benefits/retirees/>

Or call (501)682-9656

Medicare Frequently Asked Questions

Does Medicare pay for glasses and dentures? No, original Medicare does not cover glasses or dentures, some advantage plans offer dental and vision benefits.

Am I automatically enrolled in Medicare when I turn 65?

Many people automatically receive Original Medicare if they're receiving Social Security retirement benefits when becoming eligible for Medicare coverage. Other's need to sign up for Medicare through Social Security.

What is Medicare (Part C)?

Medicare (Part C) is just another name for private Medicare insurance. The Balanced Budget Act of 1977 created (Part C), which is now referred to as Medicare Advantage. Medicare advantage plans are private health plans that you can choose instead of original Medicare. Advantage plans usually have a network of providers from whom Medicare individuals will seek care.

Do I have to enroll in Medicare Part D? No. It is not mandatory, but Medicare individuals are encouraged to enroll in a (Part D) plan to avoid a penalty for not enrolling at the time that the individual is eligible. The penalty is not a one-time penalty. The penalty will exist for the lifetime of Medicare/Social Security.

What parts of Medicare do I need?

If Medicare is your only medical coverage, you need both parts of Original Medicare (Parts A and B). You must have both (A and B) to be eligible to enroll in either a Medicare supplement plan or a Medicare Advantage plan.

What are Medicare Supplemental Plans? Medicare Supplement plans pay **AFTER** Medicare. Medicare (Part B) pays 80% of Medical cost after the Medicare (Part B) deductible has been met. Medicare Supplement will pay the 20% that the individual would normally pay after Medicare pays.

Do I need Medicare if I already have health insurance? You may need Medicare even if you already have other health insurance coverage, or if your current plans don't meet minimum coverage requirements. Most plans that employers offer meet these standards. If you or your spouse has insurance through your job, you probably don't need Medicare. However, by staying on an employer plan, you can delay enrolling in (Part B) without penalty until you or your spouse decide to retire.

Can my doctor insist that I pay for care up front before Medicare pays? Yes, but only if your doctor does not accept assignment. If your doctor participates with Medicare, he or she can collect the deductible and copayment. If your doctor does not accept assignment, he or she cannot charge you more than the Medicare approved amount.

ARBENEFITS RETIREE PROGRAM for all State and Public School Retirees

All retirees are covered under one healthcare program

ARBenefits Retiree

ARBenefits now offers Medicare-eligible retirees their current coverage plus additional services through the new **ARBenefits Group Medicare Advantage (PPO) plan**. Reach out to UnitedHealthcare for more information about the plan and benefits at 1-844-488-3953, and contact the Employee Benefits Division for eligibility questions at 877-815-1017 or ask.ebd@arkansas.gov.

What is different for State and Public School Retirees?

State Retirees:

Medicare Primary Retired State Employees can keep their prescription drug plan and do not need to join Medicare (Part D) for prescription drug coverage.

Public School Retirees:

Medicare Primary Retired Public School Employees must join Medicare (Part D) for prescription drug coverage. There is a 63-day Special Enrollment Period to join Medicare (Part D) when the Public School Retiree's prescription insurance ends. AR SHIP can help you compare (Part D) plans to find the least expensive plan that covers the medications you take. **Medicare Part D** helps cover prescription drug costs. You must be signed up for Parts A & B before enrolling in Part D. If you are a state retiree on the Health Advantage Primary Plan, **you do not need** to sign up for Part D coverage. If you are a public school retiree on the Health Advantage Primary Plan, **you do need** to sign up for Part D coverage.

Call AR SHIP – 1-800-224-6330

2025 AR Arkansas State Medicare Health Advantage Premium Retiree Monthly Premiums Rates Effective January 1, 2025 - December 2025

Contact ARBenefits at 501-682-9656	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree only	\$550.97	\$294.63	\$256.34
Retiree & Non-Medicare Spouse	\$1,579.56	\$773.88	\$805.68
Retiree & Child (ren)	\$933.83	\$396.05	\$537.78
Retiree & Non-Medicare Spouse & Child (ren)	\$1,962.42	\$943.38	\$1,019.04
Retiree & Medicare Primary Spouse	\$1,101.94	\$487.83	\$614.11
Retiree & Medicare Primary Spouse & Child (ren)	\$1,484.80	\$588.26	\$896.54

2025 Arkansas State Medicare UNITED HEALTHCARE (UHC) MAPD GROUP Retirees Monthly Premiums (Medical & Pharmacy)

Medicare Eligible	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
MAPD Retiree Only	\$220.31	\$198.28	\$22.03
MAPD Retiree & NON-Medicare Spouse	\$1,248.90	\$678.71	\$570.19
MAPD Retiree & Child (ren)	\$603.17	\$300.70	\$302.47
MAPD Retiree & Child	\$440.62	\$396.56	\$44.06
MAPD Retiree & NON-Medicare Spouse & MAPD Child (ren)	\$1,631.76	\$848.23	\$783.53
MAPD Retiree & NON-Medicare Spouse & MAPD Child	\$1,469.21	\$876.99	\$592.22
MAPD Retiree & MAPD Medicare Spouse	\$440.62	\$396.56	\$44.06
MAPD Retiree & MAPD Medicare Spouse & MAPD Child (ren)	\$823.48	\$499.44	\$324.04
MAPD Retiree & MAPD Medicare Spouse & MAPD	\$660.93	\$594.84	\$66.09

2025 Arkansas State Non-Medicare Retirees Monthly Premiums Rates Effective January 1, 2025 - December 2025

Plan Premium	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree only	\$1028.60	\$690.74	\$337.86
Retiree & Non-Medicare Spouse	\$2,057.19	\$1,170.43	\$886.76
Retiree & Child (ren)	\$1,411.46	\$792.26	\$619.20
Retiree & Non-Medicare Spouse & Child (ren)	\$2,440.05	\$1,339.89	\$1,100.16
Retiree & Medicare Primary Spouse	\$1,579.57	\$881.97	\$697.60
Retiree & Medicare Primary Spouse & Child (ren)	\$1,962.43	\$983.79	\$978.64
Retiree & MAPD Primary Spouse	\$1,248.91	\$889.42	\$359.49
Retiree & MAPD Primary Spouse & Child (ren)	\$1,631.77	\$991.16	\$640.61
Classic			
Retiree only	\$894.23	\$676.77	\$217.46
Retiree & Spouse	\$1,788.46	\$1,151.94	\$636.52
Retiree & Child (ren)	\$1,227.09	\$783.05	\$444.04
Retiree & Family	\$2,121.32	\$1,326.12	\$795.20
Basic			
Retiree only	\$789.25	\$666.35	\$122.90
Retiree & Spouse	\$1,578.50	\$1,139.54	\$438.96
Retiree & Child (ren)	\$1,083.03	\$779.19	\$305.84
Retiree & Family	\$1,872.28	\$1,318.26	\$554.02

**2025 Public School Medicare HEALTH Advantage (HA)
Premium Retire Monthly Premiums
Rates Effective January 1, 2025 - December 2025**

Contact ARBenefits at 501-682-9656	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree only	\$238.64	\$116.66	\$121.98
Retiree & Non-Medicare Spouse	\$1,139.24	\$374.06	\$765.18
Retiree & Child (ren)	\$578.86	\$58.24	\$520.62
Retiree & Non-Medicare Spouse & Child (ren)	\$1,479.46	\$224.98	\$1,254.48
Retiree & Medicare Primary Spouse	\$477.28	\$179.18	\$298.10
Retiree & Medicare Primary Spouse & Child (ren)	\$817.50	\$80.44	\$737.06

**2025 Public School Medicare UNITED HEALTHCARE (UHC)
MAPD GROUP Retirees Monthly Premium
Rates Effective January 1, 2025 - December 2025**

Medicare Eligible	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
MAPD Retiree Only	\$140.31	\$126.28	\$14.03
MAPD Retiree & NON-Medicare Spouse	\$1040.91	\$366.63	\$674.28
MAPD Retiree & Child (ren)	\$480.53	\$108.31	\$372.22
MAPD Retiree & Child	\$280.62	\$252.56	\$28.06
MAPD Retiree & NON-Medicare Spouse & MAPD Child (ren)	\$1,381.13	\$274.07	\$1107.06
MAPD Retiree & NON-Medicare Spouse & MAPD Child	\$1,181.22	\$592.91	\$688.31
MAPD Retiree & MAPD Spouse	\$280.62	\$252.56	\$28.06
MAPD Retiree & MAPD Spouse &	\$620.84	\$180.00	\$440.84
MAPD Retiree & MAPD Medicare Spouse & MAPD	\$420.93	\$378.84	\$42.09

2025 Public School Non-Medicare Retirees Monthly Premiums Rates Effective January 1, 2025 - December 2025

Plan Premium	Base Monthly Premium	State & Plan Contribution	Total Monthly Retiree Cost
Retiree only	\$900.60	\$371.64	\$528.96
Retiree & Non-Medicare Spouse	\$1,801.20	\$554.58	\$1,246.62
Retiree & Child (ren)	\$1,240.82	\$269.02	\$971.80
Retiree & Non-Medicare Spouse & Child (ren)	\$2,141.42	\$490.50	\$1,650.92
Retiree & Medicare Primary Spouse	\$1,139.24	\$442.46	\$696.78
Retiree & Medicare Primary Spouse & Child (ren)	\$1,479.46	\$339.82	\$1,139.64
Retiree & MAPD Primary Spouse	\$1040.91	\$497.91	\$543.00
Retiree & MAPD Primary Spouse & Child (ren)	\$1,381.13	\$394.77	\$986.36
Classic			
Retiree only	\$782.96	\$530.78	\$252.18
Retiree & Spouse	\$1,565.91	\$966.37	\$599.54
Retiree & Child (ren)	\$1,078.74	\$617.96	\$460.78
Retiree & Family	\$1,861.69	\$1,101.75	\$759.94
Basic			
Retiree only	\$691.04	\$557.50	\$133.54
Retiree & Spouse	\$1,382.07	\$1,047.67	\$334.40
Retiree & Child (ren)	\$952.09	\$690.41	\$261.68
Retiree & Family	\$1,643.14	\$1,233.58	\$409.56

2025 (Part B) Coverage for Medicare State & Public Retiree

(Part B) Physician and Medical Services	AR Benefits Retirees Plan Covers
(Part B) deductible	AR Benefits pays deductible \$257 deductible
Normally 20% of Medicare-approved amount ((Part B) Coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (DME), after (Part B) deductible is Met	AR Benefits pays 20% of the Medicare-approved amount
Medicare (Part B) excess charges 100% (This benefit would apply when you receive services from a physician that does not accept assignment)	AR Benefits pays 100% of the excess charges when you receive services from a physician that does not accept Medicare



Federal and State

Quick Resource

MEDICARE SAVINGS PROGRAM

WWW.ACCESS.ARKANSAS.GOV

APPLY ONLINE for Medicare Savings Program Assistance.

EXTRA HELP

WWW.SSA.GOV/PRESCRIPTIONHELP

APPLY ONLINE IF INDIVIDUAL QUALIFIES for EXTRA Help with Prescription medications.

www.medicare.gov

- Compare Drug Plans (Part D)
- Compare Medicare Advantage Plans (Part C)
- Compare Hospitals
- Compare Nursing Homes
- Compare Home Health Agencies
- Order a replacement Medicare card

www.mymedicare.gov

- Create an account
- Manage personal Medicare information via a secure website:
- Review eligibility, entitlement and plan information
- Track preventive services
- Keep a prescription drug list
- Complete Authorization Forms Review Claims

Acentra Health

Website: Acentra Health BFCC-QIO

Visit website for your region phone number.
Acentra Health is the Beneficiary and Family Centered Care Quality Improvement Organization

MEDICARE COORDINATION OF BENEFITS 1-855-798-2627

CALL IF PRIMARY AND SECONDARY Insurance IS NOT ACCURATE ON FILE WITH MEDICARE at national level.

MEDICARE

**Website: <http://Medicare.gov>
1-800-633-4227**

UHC Customer Service dedicated to

ARBenefits Group MAPD plan

Website dedicated to ARBenefits
Group MAPD plan [https://
retiree.uhc.com/arbenefits](https://retiree.uhc.com/arbenefits)

CONSUMERS

Website: [www.insurance.arkansas.gov/
consumer-services](http://www.insurance.arkansas.gov/consumer-services)

This agency assists insurance
consumers with complaints and
inquiries regarding insurance
companies, producers, and adjusters.
CSD investigates all complaints.

Having the right
resources starts with
the right
guidance....

Thank you
Mr. Carroll Astin
(AR SHIP Director)
for leading by
example since 2018

SENIOR MEDICARE PATROL (SMP)

[https://Senior Medicare Patrol \(SMP\) - Arkansas Insurance Department](https://SeniorMedicarePatrol(SMP)-ArkansasInsuranceDepartment)

**Fraud Prevention Line
866-726-2916**

MEDICAID

Website: [https://medicaid.mmis.arkansas.gov/
1-800-482-5431](https://medicaid.mmis.arkansas.gov/)
on a wide range of topics.

VETERANS ADMINISTRATION
Website: [http://www.va.gov/
1-800-827-1000](http://www.va.gov/)

SOCIAL SECURITY

Website: [http://
www.socialsecurity.gov/
1-800-772-1213](http://www.socialsecurity.gov/)

**ARKANSAS SENIOR HEALTH
INSURANCE INFORMATION
PROGRAM (AR SHIP)**
800-224-6330

Website: [https://insurance.arkansas.gov/
Website: <http://www.shiipar.com>](https://insurance.arkansas.gov/)

HEALTHY AGING FOR OLDER ADULTS

Website: [http://www.cdc.gov/aging/
Chronic Disease Prevention and Health
Promotion provides
information on a wide range of topics.](http://www.cdc.gov/aging/)

GLOSSARY

Assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period

The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a skilled nursing facility) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Beneficiary

Someone who has healthcare insurance through Medicare or Medicaid.

Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage

Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

GLOSSARY

Critical access hospital

A small facility located in a rural area more than 35 miles (or 15 miles if mountainous terrain or in areas with only secondary roads) from another hospital or critical access hospital. This facility provides 24/7 emergency care, has 25 or fewer inpatient beds, and maintains an average length of stay of 96 hours or less for acute care patients.

Custodial care

Non-skilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible

The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Demonstrations

Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

Durable Medical Equipment (DME)

Reusable medical equipment like wheelchairs, walkers, crutches, hospital beds, home oxygen equipment, diabetic testing meters and supplies.

Extra Help

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary

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

GLOSSARY

Inpatient rehabilitation facility

A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Health Insurance Marketplace

A comparison-shopping area that allows people to buy private health insurance that best meets their needs.

Health Maintenance Organization (HMO)

HMO is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. When you have an HMO, you generally must get your care and services from doctors, other health care providers, and hospitals in the plan's network, except: Emergency care, Out-of-area urgent care, Temporary out-of-area dialysis.

HMO Point-of-Service (HMOPOS)

This HMO plan may allow you to receive some services out-of-network for a higher copayment or coinsurance.

Inpatient rehabilitation facility

A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Lifetime reserve days

In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care hospital

Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

GLOSSARY

Medicare Advantage Plan

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your (Part A) and (Part B) benefits.

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare

Most Medicare Advantage Plans offer prescription drug coverage

Medicare-approved amount. In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and copay.

Medicare health plan

Generally, a plan offered by a private company that contracts with Medicare to provide (Part A) and (Part B) benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide (Part D) and other benefits in addition to (Part A) and (Part B) benefits.

Medicare plan

Any way other than Original Medicare that you can receive your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare drug plans.

GLOSSARY

Medicare Medical Savings Account (MSA)

An MSA is a type of consumer-directed Medicare Advantage Plan (Part C) These plans are similar to Health Savings Account (HSA) Plans like you'd get from an employer or the Marketplace. With MSA Plans, you can choose your health care services and providers (these plans usually don't have a network of doctors, other health care providers, or hospitals).

1. High-deductible health plan: This is a special type of Medicare Advantage Plan. This type of plan only starts to cover your costs once you meet a high yearly deductible , which varies by plan.
2. Medical savings account (MSA): This is a special type of savings account. Medicare gives the plan an amount of money each year for your health care expenses. This amount is based on your plan. The plan deposits money into your MSA account once at the beginning of each calendar year. Or, if you become entitled to Medicare in the middle of the year and join a Medicare MSA Plan at that time, the plan will deposit the money into your account the first month your coverage starts. You can use this money to pay your Medicare-covered costs before you meet the plan's deductible. You can access the money using a checking account or special debit or credit card your bank gives you. Check with your plan for details. The yearly deposit and yearly deductible are pro-rated based on when your enrollment begins.

Minimum essential coverage

Coverage that you must have to meet the individual responsibility requirement under the health care law.

National Provider Identifier (NPI)

A unique identification number for covered health care providers.

Preferred Provider Organization (PPO)

A PPO is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. PPOs have networks of doctors, other health care providers, and hospitals. You pay less if you go to providers and facilities that are belong to the plan's network. You can generally go to out-of-network providers for covered services, but you'll usually pay more.

GLOSSARY

Premium

The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care doctor

The doctor you see first for most health problems. He or she makes sure you receive the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Prior authorization

You and/or your prescriber must contact the drug plan before you can fill certain prescriptions.

Private Fee-for-Service (PFFS)

A PFFS is a type of Medicare Advantage Plan. PFFS plans aren't the same as Original Medicare or Medigap. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.

Referral

A written order from your primary care doctor for you to see a specialist or receive certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can receive medical care from anyone except your primary care doctor. If you don't receive a referral first, the plan may not pay for the services.

Service area

A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can receive routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

GLOSSARY

Special Needs Plan (SNP)

A Special Needs Plan (SNP) provides benefits and services to people with specific diseases, certain health care needs, or who also have Medicaid. SNPs tailor their benefits, provider choices, and list of covered drugs (formularies) to best meet the specific needs of the groups they serve. SNPs are either HMO or PPO plan types, and cover the same Medicare Part A and Part B benefits that all Medicare Advantage Plans cover. However, SNPs might also cover extra services for the special groups they serve. For example, if you have a severe condition, like cancer or congestive heart failure, and you need a hospital stay, an SNP may cover extra days in the hospital. You can only stay enrolled in an SNP if you continue to meet the special conditions of the plan.

Skilled nursing facility care

Skilled nursing care and therapy services provided on a daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.



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