

Choosing A Medigap Policy

To Supplement The Original Medicare Plan

NEW!

**6 Easy Steps To Buying A
Medigap Policy**



HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

Welcome to the 2001 Guide To Health Insurance For People With Medicare

“Choosing A Medigap Policy”

This Guide has 6 easy steps to buying a Medigap policy and other important tips to help you buy the Medigap policy that’s right for you (see pages 20-32).

Don’t feel like you have to read everything in this Guide all at once.

Section 1, which starts on page 9, has the basics you need to know about Medigap policies. Look over the list of topics in “What’s In This Guide” on pages 2 and 3, and pick the one that you want to read. Then, work your way through the rest of Section 1 a page at a time.

Section 2, which starts on page 33, gives more details about Medigap policies for those who want them.

How This Guide Can Help You

Medicare is a federal health insurance program for people 65 years of age or older, and certain people with disabilities or **End-Stage Renal Disease** (permanent kidney failure). **It pays for much of your health care, but not all of it. There are some costs that you will have to pay yourself.** These costs are called your out-of-pocket costs.

There are other kinds of health insurance, like Medigap policies, that may help pay the costs that Medicare doesn't. This Guide is about "Medigap Policies," which are also called "Medicare Supplement Insurance." A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in the **Original Medicare Plan** coverage.

This Guide helps you understand:

- What Medigap policies are,
- How Medigap policies can help you, and
- What to do before you buy a Medigap policy.

Whether you need a Medigap policy is a decision only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a **Medicare managed care plan**, or a **Private Fee-for-Service plan**. You may also want to think about your long-term care needs (see page 37).

Words in **red** are defined on pages 77-79.

- ▶ Read over "A Quick Look At Medicare" on pages 4-8. This will help you understand what Medicare does and does not cover.
- ▶ Section 1, which starts on page 9, gives you the basics you need to know about Medigap policies.
- ▶ Section 2, which starts on page 33, has more details for those who want them.
- ▶ If you want information about other kinds of health insurance other than Medigap policies, see pages 34-39.

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Important: At the time of printing, the phone numbers listed were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD:1-877-486-2048 for the hearing and speech impaired) or look on the Internet at www.medicare.gov and select "Helpful Contacts."

Words You Should Know

Where words in red are defined	77-79
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The 2001 Guide To Health Insurance For People With Medicare "Choosing A Medigap Policy" is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

A Quick Look At Medicare

Medicare has two parts:

1. Part A (Hospital Insurance)
2. Part B (Medical Insurance)

1. Part A (Hospital Insurance) helps pay for:

- Inpatient hospital care,
- Some **skilled nursing facility** care,
- **Hospice care**, and
- Some **home health care**.

For more information on what Medicare Part A covers, see the Part A coverage chart on page 68.

How To Get Medicare Part A

Most people get Medicare Part A automatically when they turn age 65. They do not have to pay a monthly payment called a **premium** for Part A because they or a spouse paid Medicare taxes while they were working.

If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you still may be able to buy Part A. If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show “Hospital Part A” on the lower left corner of the card. You can also call the Social Security Administration toll-free at 1-800-772-1213 or call your local Social Security office for more information about buying Part A. If you get benefits from the Railroad Retirement Board, call your local RRB office or 1-800-808-0772.

Words in **red** are defined on pages 77-79.

A Quick Look At Medicare

2. Part B (Medical Insurance) helps pay for:

- Doctors' services,
- Outpatient hospital care, and
- Some other medical services that Part A doesn't cover (like some **home health care**).

Part B helps pay for these covered services and supplies when they are **medically necessary**.

You pay the Medicare Part B **premium** of \$50.00 per month in 2001. Rates can change every year. For some people, this amount may be higher if they did not choose Part B when they first became eligible at age 65. The cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases (see pages 6-7, "Special Enrollment Period For Part B"). You will have to pay this extra amount for the rest of your life.

For more information on what Medicare Part B covers, see the Part B coverage charts on pages 69-71.

How To Get Medicare Part B

You are automatically eligible for Part B if:

- You are eligible for **premium-free** Part A.
- You are a United States citizen or permanent resident age 65 or older.

Just before you turn 65 years old, you have to decide whether or not to take Part B. You should keep in mind that the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see pages 6-7 "Special Enrollment Period For Part B"). You will have to pay this extra amount for the rest of your life. If you choose to take Part B, Medicare takes this monthly **premium** out of your Social Security, Railroad Retirement, or Civil Service Retirement payment. If you don't get any of these payments, you will get a bill for the Part B premium every 3 months.

A Quick Look At Medicare

How To Get Medicare Part B (continued)

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods:

1. The General Enrollment Period
2. The Special Enrollment Period

1. The General Enrollment Period For Part B

This period runs from January 1 through March 31 of each year. During this time, you can sign up for Part B at your local Social Security office. Your Part B coverage will start on July 1 of that year. Remember, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see below). You will have to pay this extra amount for the rest of your life.

2. The Special Enrollment Period For Part B

You can sign up during this period if you didn't take Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union.

You can sign up for Part B during the Special Enrollment Period:

- Anytime you are still covered by an employer or union group health plan through your or your spouse's **current or active** employment, or
- Within 8 months of the date when the employer or union group health plan coverage ends or when the employment ends (whichever is first).

Note: If you are still working and plan to keep your employer's group health coverage, you should talk to an expert to help you decide what is the best time to enroll in Part B. When you sign

A Quick Look At Medicare

2. The Special Enrollment Period For Part B (continued)

up for Part B, you automatically begin your Medigap **open enrollment period**. Once your Medigap open enrollment period begins, it cannot be changed or restarted. See page 18 to learn more about your Medigap open enrollment period.

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible but do not sign up for Part B during the Special Enrollment Period, the cost of Part B may go up.

Call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) for more information about signing up for Medicare Parts A and B.

A Quick Look At Medicare

Medicare Health Plan Choices

Depending on where you live, you may be able to get your health care in one of 3 ways:

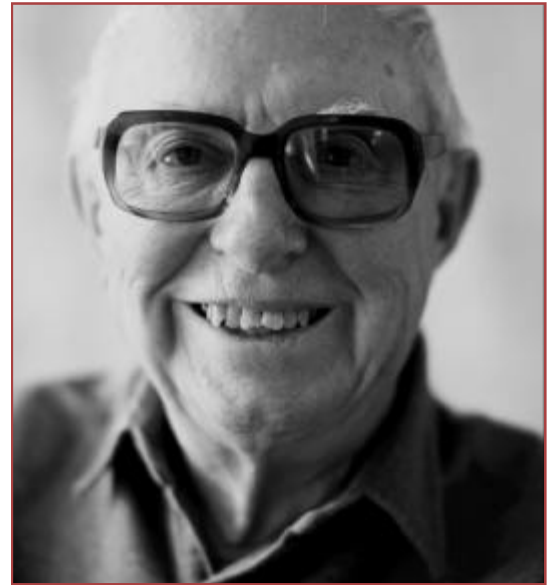
1. The **Original Medicare Plan** (also known as fee-for-service),
2. A **Medicare managed care plan** (like an HMO), or
3. A **Private Fee-for-Service plan**.

Note: Medigap policies only help pay health care costs if you are in the Original Medicare Plan.

For more information about your Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). Ask for a FREE copy of the “**Medicare & You**” handbook. You can also read or print a copy of this handbook at www.medicare.gov on the Internet. Select “Publications.”

Words in red are defined on pages 77-79.

Section 1: The Basics



Section 1: The Basics

Learning About Medigap Policies

What Is A Medigap Policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the “gaps” in **Original Medicare Plan** coverage. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

There are 10 standardized Medigap plans called “A” through “J.” **Each plan A through J has a different set of standardized benefits.** Plan A offers the least amount of benefits and Plan J offers the most benefits. **The chart on page 15 lists the benefits in the 10 standardized Medigap plans.**

If you live in **Massachusetts, Minnesota, or Wisconsin**, there are different types of Medigap plans that are sold in your state. For more information about the Medigap plans that are sold in your state, see pages 72-74.

When you buy a Medigap policy, you pay a **premium** to the insurance company. As long as you pay your premium, a policy bought after 1990 is automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium. You still must pay your monthly Medicare Part B premium.

However, in some states, insurance companies may refuse to renew Medigap policies that you bought before 1990. The law in these states did not say these policies had to be automatically renewed each year (guaranteed renewable) at the time these policies were sold.

Section 1: The Basics

What Is A Medigap Policy? (continued)

Medigap policies only help pay health care costs if you have the **Original Medicare Plan**. You don't need to buy a Medigap policy if you are in a:

- **Medicare managed care plan**, or
- **Private Fee-for-Service plan**.

In fact, it is illegal for anyone to sell you a Medigap policy if they know you are in one of these plans.

If you have Medicaid, it is illegal for an insurance company to sell you a Medigap policy, except in certain situations (see page 39).

Can I keep seeing my same doctor if I buy a Medigap policy?

In most cases, yes. If you are in the **Original Medicare Plan** and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider who accepts Medicare. But if you have the type of Medigap policy called **Medicare SELECT**, you must use specific hospitals and, in some cases, doctors to get your full insurance benefits.

What is Medicare SELECT?

Medicare SELECT is a type of Medigap policy available in some states. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J. With a Medicare SELECT policy, generally you must use specific hospitals and, in some cases, doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally cost less.

Words in red are defined on pages 77-79.

If you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay what the **Original Medicare Plan** doesn't pay. The Original Medicare Plan will pay its share of approved charges no matter what hospital or doctor you choose.

Section 1: The Basics

Medigap Is Not...

- Coverage you get from your employer or union.
- A Medicare managed care plan (like an HMO).
- A Private Fee-for-Service plan.
- Medicare Part B.

Why Do I Need A Medigap Policy?

If you are in the Original Medicare Plan, a Medigap policy may help you:

- Lower your out-of-pocket costs.
- Get more health insurance coverage.

You may want to buy a Medigap policy because Medicare does not pay for all of your health care. There are “gaps” or costs that you must pay in the Original Medicare Plan. The chart on page 13 gives some examples of these gaps.

What you pay out-of-pocket in the Original Medicare Plan will depend on:

- Whether your doctor or supplier accepts “assignment” or takes Medicare’s approved amount as payment in full.
- How often you need health care.
- What type of health care you need.
- Whether you buy a Medigap policy.
- Which Medigap policy you buy.
- Whether you have other health insurance.

Words in red are defined on pages 77-79.

Section 1: The Basics

Gaps In The Original Medicare Plan

Examples Of Gaps In Medicare Covered Services (What You Pay)	A Medigap Policy May Help Pay These Costs
Hospital Stays ▶ \$792 for days 1-60 ▶ \$198 per day for days 61-90 ▶ \$396 per day for days 91-150	✓
Skilled Nursing Coinsurance ▶ Up to \$99 per day for days 21-100	✓
Blood ▶ The first 3 pints	✓
Part B yearly deductible ▶ \$100 per year	✓
Part B covered services ▶ 20% of Medicare-approved amount (coinsurance) for most covered services ▶ 50% coinsurance for outpatient mental health treatment ▶ copayment for outpatient hospital services	✓

Note: Some Medigap policies also cover other extra benefits that are not covered by Medicare like:

- Routine yearly check-ups.
- At-home recovery.
- Medicare Part B **excess charge** (the difference between your doctor's charge and **Medicare's approved amount**). The excess charge only applies if your doctor doesn't accept **assignment**.
- And more (see page 15).

You don't need a Medigap policy if you are in a Medicare health plan other than the Original Medicare Plan.

Section 1: The Basics

What Medigap Policies Cover

Each standardized Medigap policy must cover basic (core) benefits (see the chart on page 15). Medigap policies pay most, if not all, of the **Original Medicare Plan coinsurance** and outpatient **copayment** amounts. These policies may also cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to help pay more of those things that Medicare doesn't cover, like prescription drugs. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74.

What Medigap Policies Don't Cover

- Long-term care
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Unlimited prescription drugs

Who Can Buy A Medigap Policy?

To buy a Medigap policy, you generally must have Medicare Part A and Part B. If you are under age 65 and disabled or have ESRD (**End-Stage Renal Disease**), you may not be able to buy a Medigap policy until you turn 65.

See pages 44-45 if you want to know more about Medigap policies for people under age 65.

Words in red are defined on pages 77-79.

Remember, Medigap policies only work with the **Original Medicare Plan.**

Section 1: The Basics

Your Medigap Plan Choices - Medigap Plans A Through J

Medigap policies (including Medicare SELECT) can only be sold in 10 standardized plans. This chart gives you a quick and easy look at all the Medigap plans and their benefits. Read down to find out what benefits are in each plan. **For details about the Medigap plan extra benefits in the chart below, see pages 27-28. Note:** This chart does not apply if you live in Massachusetts, Minnesota, or Wisconsin (see pages 72-74).

Basic Benefits: (Included in All Plans)

- **Inpatient Hospital Care:** Covers the Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount) or copayment amount which may vary according to the service.
- **Blood:** Covers the first 3 pints of blood each year.

	A	B	C	D	E	F*	G	H	I	J*
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery	At-Home Recovery
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
Extended Drug Benefit (\$3,000 Limit)									Basic Drug Benefit (\$1,250 Limit)	Extended Drug Benefit (\$3,000 Limit)
Preventive Care										Preventive Care

* Plans F and J also have a high deductible option (see page 17).
Call your State Insurance Department for more information (see page 76).

Section 1: The Basics

How Much Do Medigap Policies Cost?

The cost for Medigap policies will be different depending on your age, where you live, and the insurance company from which you buy the policy. There can be big differences in the **premiums** that insurance companies charge for exactly the same coverage. When you compare premiums, be sure you are comparing the same Medigap policies.

Insurance companies have 3 different ways of pricing policies based on your age. In general, no-age-rated (also called community-rated) policies are the least expensive over your lifetime. For more details, see pages 40-41.

Other Factors That May Affect Your Cost:

- **Whether you are male or female.** Some companies offer discounts for females.
- **Whether you smoke or not.** Some companies offer discounts for non-smokers.
- **Whether you are married or not.** Some companies offer discounts for married couples.
- **Medical Underwriting.** This is a process that a company uses to review your health status and medical history, and decide whether to accept your application for insurance.

With medical underwriting, you usually must answer medical questions on an application. You need to fill out this application carefully. Some companies may want to review your medical record before they sell you a policy. The company may use this information to add a waiting period for **pre-existing conditions** if your state law allows. The company may also use this information to decide how much to charge you for a Medigap policy.

Insurance companies may “medically underwrite” any Medigap policy at times other than your open enrollment period or when you have the right to buy a Medigap policy (see page 18).

Section 1: The Basics

How Much Do Medigap Policies Cost? (continued)

Other Factors That May Affect Your Cost: (continued)

The company can not deny you coverage or charge you more for a policy if you are in your Medigap **open enrollment period** or when you have the right to buy a Medigap policy.

- **Buying A High Deductible Policy**

Insurance companies may offer a “high deductible option” on Medigap Plans F and J (see chart on page 15). If you choose this option, you must pay a \$1,580 **deductible** for the year 2001 before the plan pays anything. This amount can go up each year.

High deductible option policies often cost less, but if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

In addition to the \$1,580 deductible that you must pay for the high deductible option on Plans F and J, you must also pay deductibles for:

- Prescription drugs (\$250 per year for Plan J), and
- Foreign travel emergency (\$250 per year for Plans F and J).

- **Buying A Medicare SELECT Policy**

Medicare SELECT is a type of Medigap policy available in some states. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J. With a Medicare SELECT policy, you must use specific hospitals and, in some cases, doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally cost less.

Words in red are defined on pages 77-79.

If you don't use a Medicare SELECT hospital or doctor for non-emergency services, you will have to pay what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what hospital or doctor you choose.

Section 1: The Basics

When Is The Best Time To Buy A Medigap Policy?

The best time to buy a Medigap policy is during your Medigap **open enrollment period**.

Your Medigap **open enrollment period** lasts for 6 months. It starts on the first day of the month in which you are both:

1. Age 65 or older, **and**
2. Enrolled in Medicare Part B.

Once the 6 month Medigap open enrollment period starts, it can't be changed.

During this period, an insurance company cannot:

- Deny you insurance coverage,
- Place conditions on a policy (like making you wait for coverage to start), or
- Change the price of a policy because of past or present health problems.

If you buy a policy during your Medigap **open enrollment period**, the insurance company must shorten the waiting period for **pre-existing conditions** by the amount of previous health coverage (creditable coverage) you have. See page 42 for more information about pre-existing conditions.

If you want to know more about creditable coverage, see page 43. If you are disabled or have ESRD (**End-Stage Renal Disease**), see pages 44-45.

Section 1: The Basics

When Is The Best Time To Buy A Medigap Policy? (continued)

Medigap Open Enrollment Period Example:

Mr. Smith is 65 and has heart disease. He has just enrolled in Medicare Part B and his coverage starts on March 1, 2001. His Medigap **open enrollment period** is from March 1 through August 31. Mr. Smith has until August 31, 2001 to buy a Medigap policy without his heart disease affecting the cost or type of policy he can choose. After August 31, 2001, Mr. Smith will not have this guarantee.

How To Tell If You Are In Your Medigap Open Enrollment Period

Your red, white, and blue Medicare card shows the dates that your Part A and Part B coverage started. If you are age 65 or older, add 6 months to the date that your Part B coverage starts to figure out if you are in your Medigap **open enrollment period**. If that date is in the future, you are still in your Medigap open enrollment period. If that date is in the past, you have missed your Medigap open enrollment period.

Should I Enroll In Medicare Part B And Start My Medigap Open Enrollment Period If I Am Age 65 Or Over And Still Working?

You may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your or your spouse's **current or active** employment. Your Medigap open enrollment period won't start until after you sign up for Medicare Part B. Remember, once you're age 65 or older **and** enrolled in Medicare Part B, the Medigap open enrollment period starts and cannot be changed.

Section 1: The Basics

What If I Enrolled In Part B and Did Not Use My Medigap Open Enrollment Period To Buy A Medigap Policy?

If you apply for a Medigap policy after your open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept your application, and how much to charge you for the policy. If you are in good health, the insurance company is likely to accept your application, but there is no guarantee that you will get the policy.

Steps To Buying A Medigap Policy

Buying a Medigap policy is an important decision. Only you can decide if a Medigap policy is the right kind of health insurance coverage for you. If you decide to buy a Medigap policy, shop carefully. Look for a policy that you can afford and that gives you the coverage you need most. As you shop for a Medigap policy, keep in mind that insurance companies may charge different amounts for the same Medigap policy.

To buy a Medigap policy, follow steps 1-6 on pages 21-32.

Words in red are defined on pages 77-79.

Section 1: The Basics

Steps To Buying A Medigap Policy (continued)



Step 1. Look At How Much You're Spending On Health Care Each Year.

Use the worksheet on page 23 to write down your yearly out-of-pocket costs for health care. If you don't know your yearly out-of-pocket costs, use the worksheet to check off the health care costs and services you paid out-of-pocket (see "How To Use The Worksheet" below and on page 22). This will help you decide which benefits you need. It will also help you when you begin to shop for the Medigap policy that's right for you.

Important: You should also think about your future health care needs. As you get older, your health care costs may increase.

How To Use The Worksheet

- Column 1 lists types of health care costs and services that you may have paid out-of-pocket last year. You can also add other health care costs or services that you used last year (or previous years) that you may want to think about when choosing a Medigap policy. Write those costs or services in the rows marked "Other."

If you use Column 2:

- Write down the cost for the services you used last year. If you don't know how much you paid out-of-pocket, ignore this column and use Column 3 (see page 22).
- Look at the amounts in Column 2. Rows with the largest amounts are most likely the benefits you may need in a Medigap policy right now. Remember, you should also think about your future health care needs (see pages 24-25). For example:

Let's say you did not have a hospital stay last year, so you did not have to pay a Medicare Part A hospital **deductible**. Next year, or sometime in the future, you may end up in a

(continued on page 22)

Section 1: The Basics

How To Use The Worksheet (continued)

hospital. If you did not buy a Medigap policy that covers the Part A hospital **deductible**, you will have to pay this cost (\$792 in 2001) for each **benefit period**.

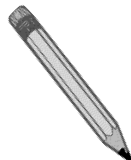
If you use Column 3:

- Check off the costs and services you paid out-of-pocket last year (or previous years) using the list in Column 1. If some costs and services are not listed, write them in Column 1 in the rows marked “Other.”
- Look at the costs and services you checked off. These are the benefits you may want to think about when choosing a Medigap policy.

Words in red are defined on pages 77-79.

Section 1: The Basics

Yearly Health Care Cost Worksheet



Column 1	Column 2	Column 3
Health Care Costs and Services	Amount Spent Last Year	Health Care Costs and Services Paid Out-of-Pocket (✓)
Medicare Part A Hospital Deductible	\$	
Medicare Part B Yearly Deductible	\$	
Prescription Drugs	\$	
Skilled Nursing Coinsurance (Skilled care or rehabilitation services you received.)	\$	
Foreign Travel Emergency (Any emergency care you received outside of the U.S.)	\$	
At-Home Recovery (Help you received at home with daily activities like bathing and dressing if you are already getting Medicare covered home health visits.)	\$	
Medicare Part B Excess Charge (The difference between your doctor's charge and Medicare's approved amount.)	\$	
Preventive Care (Such as yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function test.)	\$	
Other:	\$	
Other:	\$	

Section 1: The Basics



Step 1. Look At How Much You're Spending On Health Care Each Year. (continued)

Now that you have completed the chart (see page 23), you should have a good idea of the types of benefits you want to look for in a Medigap policy. But don't stop here. **You should also think about benefits you may need in the future.**

Below is a list of health care benefits. Next to each benefit is a reason why you might need that benefit. Check off the benefits that you think you may need in the future. Add the benefits you checked off below to your list of benefits you may want in a Medigap policy.

Consider your medical history, your family medical history, and health risks when thinking about future health care costs.

- Medicare Part A Hospital Deductible:** You may need this benefit if you have to stay in the hospital. The Part A deductible for 2001 is \$792. This amount can change every year. You have to pay this deductible for each **benefit period**.
- Medicare Part B Yearly Deductible:** You may want to consider this benefit (which is \$100 in 2001) if you have Medicare Part B. Each year you must pay the Part B deductible before Medicare starts to pay its share. If you have this benefit, the Medigap plan would pay this amount each year.
- Prescription Drugs:** You may think about this benefit if you have high prescription drug costs. Because it covers half your drug costs after the yearly **deductible**, to get the full benefit under Plans H and I, you should have at least \$2,750 in drug costs in a year (you pay \$1,250 plus \$250; plan pays \$1,250). To get the full benefit under Plan J, you should have at least \$6,250 in drug costs in a year (you pay \$3,000 plus \$250; plan pays \$3,000). See page 28 for more information on which Medigap plans cover prescription drugs.

Section 1: The Basics

Step 1. Look At How Much You're Spending On Health Care Each Year. (continued)

- Skilled Nursing Coinsurance:** You may want to consider this benefit if you need to go to a Skilled Nursing Facility (SNF) after a hospital stay and stay in the SNF longer than 20 days.
- Foreign Travel Emergency:** If you travel outside the United States, this benefit could save you money for emergency care.
- At-Home Recovery:** This benefit covers additional care at home if you are already getting Medicare-covered home health services. It pays up to \$40 a visit and \$1,600 a year. This benefit may cost a lot and may not be worth the additional premiums you pay for it.
- Medicare Part B Excess Charge:** Under federal law, doctors who don't accept "assignment" (take Medicare's approved amount as payment in full) may charge up to 15% more than the approved amount. You might want to think about this benefit if your doctors don't accept assignment. You may also want this benefit if you have to stay in the hospital and can't control whether the doctors you see accept assignment.
- Preventive Care:** This benefit helps pay for routine yearly check-ups and tests that may be important to you to keep you healthy.

Section 1: The Basics



Step 2. Review The Medigap Plans And Decide Which Benefits You Want Or Need.

If you decide to buy a Medigap policy, make sure it covers the benefits you want or need. If you need help, call your State Health Insurance Assistance Program (see page 75). This program will give you free counseling to help you decide which Medigap policy is best for you.

Note: If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74 for the Medigap plans that are sold in your state.

Remember, all Medigap policies cover these Basic (Core) Benefits:

- The Part A **coinsurance** amount for days 61-90 (\$198 per day in 2001) and days 91-150 (\$396 per day in 2001) of a hospital stay.
- 100% of the cost for up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits.
- The first 3 pints of blood or equal amounts of packed red blood cells per calendar year, unless this blood is replaced.
- The **coinsurance** or **copayment** amount for Part B services after you meet the \$100 yearly **deductible**.

Most Medigap policies also cover extra benefits. The chart on pages 27-28 lists those extra benefits in the first column and the Medigap plans that cover those benefits in the second column.

1. Put a check next to the extra benefits you need or want (from worksheet in Step 1).
2. Turn to the chart on page 15 that lists all the Medigap plans and their benefits. On that chart, circle the benefits you checked off in the chart on pages 27-28.
3. Based on the benefits you circled, find the plan that has most, if not all, of the benefits you need. **The plan you choose may not match your needs exactly. You may have to give up or buy extra benefits to get a plan that is close to what you want.**

(continued on page 27)

Section 1: The Basics

Medigap Policy Extra Benefits

Note: If you live in Massachusetts, Minnesota, or Wisconsin, see pages 72-74 for the Medigap plans that are sold in your state.

Medigap Policies pay for:

through plans:

Medicare Part A Hospital **Deductible**

- \$792 in 2001. This amount can change every year.

B, C, D, E, F, G, H, I, and J

Skilled Nursing **Coinsurance**

- Up to \$99 a day for days 21-100 in a **Skilled Nursing Facility**.

C, D, E, F, G, H, I, and J

Medicare Part B **Deductible**

- \$100 per year.

C, F, and J

Foreign Travel **Emergency**

(Emergency Care Outside the United States)

- 80% of the cost of emergency care during the first 60 days of each trip (after you pay the \$250 deductible).
- Up to \$50,000 in your lifetime.

C, D, E, F, G, H, I, and J

At-Home **Recovery**

- The cost of at-home help with daily activities like bathing and dressing if you are already getting Medicare-covered **home health** visits.
- Up to 8 weeks of at-home help after skilled care is no longer needed.
- Will pay up to \$40 each visit and \$1,600 each year.

D, G, I, and J

Section 1: The Basics

Medigap Policy Extra Benefits (continued)

Medigap Policies pay for:

through plans:

Medicare Part B **Excess Charge**

- The difference between your doctor's actual charge and Medicare's **approved amount**.
- Plans F, I, and J pay all of the excess charges.
- Plan G pays 80% of the excess charges.

F, G, I, and J

Preventive Care

(such as routine yearly check-ups, serum cholesterol screening, hearing tests, diabetes screening, and thyroid function test)

- Up to \$120 each year.

E and J

Prescription Drugs

- 50% of the drug costs that Medicare doesn't cover (after you pay a \$250 per year **deductible**).
- Up to \$1,250 each year under Plans H and I.
- Up to \$3,000 each year under Plan J.

H, I, and J

Note: In most states, if you are not in good health, you may not be able to get policies with a prescription drug benefit unless you enroll during your Medigap **open enrollment period**.

Insurance companies may offer a high **deductible** option on Plans F and J. For more information on this option, see page 17.

Section 1: The Basics



Step 3. Find Out Which Insurance Companies Sell Medigap Policies In Your State.

To find out which insurance companies sell Medigap policies in your state:

- Call your State Health Insurance Assistance Program (see page 75). Ask if they have a Medigap comparison shopping guide for your state. These types of guides usually list the insurance companies that sell Medigap policies in your state and compare the costs of policies for each company.
- Call your State Insurance Department (see page 76).
- Look at www.medicare.gov on the Internet. Select “Medigap Compare” (see page 46).

This website has information on:

- ✓ Which Medigap policies are sold in your state.
- ✓ Tips on shopping for a Medigap policy.
- ✓ What the policies must cover.
- ✓ How insurance companies decide what to charge you for a Medigap policy **premium**.
- ✓ Your Medigap rights and protections.

If you don’t have a computer, your local library or senior center may be able to help you look at this information.

You should plan to call more than one insurance company that sells Medigap policies in your state. Make sure the ones you choose to call are honest and reliable (see page 66).

Section 1: The Basics

Step 4. Call The Insurance Companies And Compare Costs.



Call different insurance companies and ask questions. Shopping around will help you find the best Medigap policy for you at a price you can afford.

It may not be good to **only** talk to a friend or relative about their Medigap policy when you are shopping for a policy. This is because the policy your friend has may not be the policy that best fits your needs or that you can afford. That's why it's important to call different insurance companies to shop around. Ask each insurance company:

- Is this insurance company licensed in this state? (The answer should be yes.)
- Which Medigap policies do you sell? (Make sure they sell the plan you want.)
- What is the cost of the Medigap policy I am interested in?
- How is this price decided?
 - ▶ What is the type of pricing used by the insurance company?
 - ▶ Does it make a difference if I am male or female?
 - ▶ Does it make a difference if I smoke or don't smoke?
 - ▶ Does it make a difference if I am married or single?
- Are there any additional benefits or discounts included in this policy?

If you are not in your Medigap **open enrollment period, ask:**

- Do you review my health records or application to decide how much to charge me for a Medigap policy?
- Will I have to wait for my pre-existing conditions to be covered if I already have a health problem?

Words in red are defined on pages 77-79.

Make sure you get the agents' and the companies' names, addresses, and telephone numbers.

Section 1: The Basics

Step 5. Choose The Best Medigap Policy For You.



After you call the insurance companies and compare their costs, choose the Medigap policy that is best for you.

But, before you make your final choice, make sure:

- You carefully review the Medigap policy benefits.
- You can afford the cost of the policy.
- The policy covers the benefits you need and want.
- You feel good about and trust your insurance company and/or the insurance agent.
- You have talked with someone you trust, like a family member or friend, about your choice.

Once you've checked the items above, you are now ready to move on to Step 6.

Section 1: The Basics

Step 6. Buy The Medigap Policy.



Once you have decided on the insurance company and the Medigap policy you want, you can buy your policy. When you buy your Medigap policy:

- Fill out your application carefully and completely. Answer all of the medical questions. If the insurance agent fills out the application, review it to make sure it's correct.
- Make sure the insurance company gives you a clearly worded summary of your Medigap policy. Read it carefully.
- Don't buy more than one Medigap policy. If you already have a Medigap policy, it is illegal for an insurance company to sell you a second policy unless you put in writing that you are going to cancel the first Medigap policy. Do not cancel your first Medigap policy until the second one is in place, and you decide to keep the second Medigap policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.
- Do not pay cash. Pay for your policy by check, money order, or bank draft.
- Ask for your Medigap policy to become effective whenever you want coverage to start, or when your previous policy's coverage ends. If for any reason the insurance company will not give you the start date you want, call your State Insurance Department (see page 76).
- Get a receipt with the insurance company's name, address, and telephone number for your records.
- Make sure you get your policy within 30 days. If you don't get your policy in 30 days, call your insurance company. If you don't get your policy in 60 days, call your State Insurance Department (see page 76).

Section 2: If You Want To Know More



Section 2: If You Want To Know More

Other Kinds Of Health Insurance

There are other kinds of health coverage, besides Medigap, that may pay for some of your health care costs not covered by Medicare. They include:

1. Employee or Retiree Coverage From an Employer or Union (see below)
2. COBRA Coverage (see pages 35-36)
3. The **PACE** Program (see page 36)
4. Federally Qualified Health Centers (see page 37)
5. Hospital Indemnity Insurance (see page 37)
6. Specified Disease Insurance (see page 37)
7. Long-Term Care Insurance (see page 37)
8. Medicaid (see pages 38-39)

1. Employee Or Retiree Coverage From An Employer Or Union

Call your benefits administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment. Since this kind of health coverage is not a Medigap policy, the rules that apply to Medigap policies do not apply.

Note: When you have retiree coverage from an employer or union, they have control over this coverage. They may change the benefits or **premiums**, and may also cancel the coverage if they choose.

Caution: If you drop your employer or union group health coverage, you may not be able to get it back. For more information, call your benefits administrator.

Note: If your coverage ends, you may have the right to buy a Medigap policy. Your employer or union should tell you within 60 days after the date your coverage ends. In some cases, the notice that your coverage has ended could be a letter telling you that your claim for payment has been denied, or that a claim your doctor sent in for payment was denied (see **Situation #2 on page 52**).

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

2. COBRA Coverage (Consolidated Omnibus Budget Reconciliation Act Of 1985)

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called “continuation coverage.” You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents keep the group coverage for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Insurance Department to make sure (see page 76). In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefits administrator. If you don't get a notice, or if you get divorced, you should call your benefit administrator as soon as possible.

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare.

However, if you elect COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. If you only have Medicare Part A when your group health plan coverage ends (based on **current or active** employment), you can enroll in Medicare Part B during a special enrollment period without having to pay a Part B premium penalty. This means you have to sign up for Part B within 8 months of your group health coverage ending (see page 6). You will not get another Special Enrollment Period once COBRA coverage ends.

Section 2: If You Want To Know More

Remember, once you're age 65 or older and enrolled in Medicare Part B, the Medigap open enrollment period starts and cannot be changed (see page 18).

State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law. For more information about group health coverage under COBRA, call your State Insurance Department (see page 76).

3. The PACE Program (Programs Of All-Inclusive Care For The Elderly)

This program combines both inpatient and outpatient medical and long-term care services for eligible persons. To be eligible, you must:

- Be at least 55 years old,
- Live in the service area of a **PACE** program, and
- Be certified as eligible for nursing home care by the appropriate state agency.

The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

To find a PACE site near you, or for more information, call your state, county, or local medical assistance office - not a federal office. You can also look on the Internet at www.medicare.gov for PACE locations and telephone numbers. Select "Nursing Home Compare."

Section 2: If You Want To Know More

4. Federally Qualified Health Centers (FQHCs)

These are special health centers that can give you routine health care at a lower cost. FQHCs may include:

- A community health center,
- Tribal health clinic,
- Migrant health service, and
- Health center for the homeless.

To find the FQHC nearest you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired). Ask for the phone number of the Primary Care Association in your state. You can also look at www.medicare.gov on the Internet. Select “Helpful Contacts.”

5. Hospital Indemnity Insurance

This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. **It does not fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any hospital stay you have.**

6. Specified Disease Insurance

This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. **It does not fill gaps in your Medicare coverage. Remember, Medicare and any Medigap policy you have will very likely cover costs from any specific disease you have.**

You may also get a FREE copy of “**Your Guide to Choosing A Nursing Home**” by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

7. Long-Term Care Insurance

This kind of insurance policy may cover medical care and non-medical care to help you with your daily needs, such as bathing, dressing, using the bathroom, and eating. Generally, **Medicare does not pay for long-term care**. For more information about long-term care insurance, get a copy of “**A Shopper’s Guide to Long-Term Care Insurance**” from either your State Insurance Department (see page 76) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

Section 2: If You Want To Know More

8. Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most of your health care costs are covered if you qualify for both Medicare and Medicaid. People on Medicaid may also get coverage for nursing home care and outpatient prescription drugs which are not covered by Medicare.

States also have programs that pay some or all of Medicare's **premiums** and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a low income. To qualify for these programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than \$1,273 for an individual or \$1,714 for a couple. These income limits are slightly higher in Hawaii and Alaska. These income limits will change slightly in 2002.
- Have savings of \$4,000 or less for an individual or \$6,000 or less for a couple. Savings include money in a checking or savings account, stocks, or bonds.

If you think you qualify, call your state medical assistance office. To get this phone number, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also ask for information on "**Savings for Medicare Beneficiaries.**"

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

8. Medicaid (continued)

Can An Insurance Company Sell Me A Medigap Policy If I Already Have Medicaid?

If you have Medicaid, an insurance company can sell you a Medigap policy only in certain situations (see chart below).

If...	Then you can buy...
Medicaid pays your Medigap premium	Any Medigap policy
Medicaid pays your Medicare premiums, deductibles, or coinsurance	Medigap plans H, I, or J
Medicaid only pays all or part of your Medicare Part B premium	Any Medigap policy

In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you have Medicaid.

Section 2: If You Want To Know More

The Cost Of Medigap Policies: Ways Of Pricing Policies

Insurance companies have 3 different ways of pricing Medigap policies based on your age:

1. No-age-rated (also called community-rated)
2. Issue-age-rated
3. Attained-age-rated

1. No-age-rated (also called community-rated) policies

These policies charge everyone the same rate no matter how old they are.

Example*: Mrs. Smith pays the same monthly **premium** at each age plus any premium increases the company may charge because of inflation.

Monthly Premium at Age 65	\$155
Monthly Premium at Age 75	\$155
Monthly Premium at Age 85	\$155

2. Issue-age-rated policies

The monthly **premium** for these policies is based on your age when you first buy the policy. The cost does not automatically go up as you get older. Your premium will be the same as any one buying a policy for the first time at your age.

Example*: Mrs. Smith pays the same monthly **premium** depending on how old she is when she buys the policy plus any additional premium increases the company may charge because of inflation.

Buy Policy at Age 65

Monthly Premium at Age 65	\$130
Monthly Premium at Age 75	\$130
Monthly Premium at Age 85	\$130

Buy Policy at Age 75

Monthly Premium at Age 65	--
Monthly Premium at Age 75	\$165
Monthly Premium at Age 85	\$165

(continued on page 41)

* Remember, **all** monthly **premiums** may change and go up each year because of inflation and rising health care costs.

Section 2: If You Want To Know More

The Cost Of Medigap Policies: Ways Of Pricing Policies (continued)

Buy Policy at Age 85

Monthly Premium at Age 65	--
Monthly Premium at Age 75	--
Monthly Premium at Age 85	\$195

* Remember, **all** monthly **premiums** may change and go up each year because of inflation and rising health care costs.

3. Attained-age-rated policies

The monthly **premiums** for these policies are based on your age each year. These policies generally cost less at age 65, but their costs go up automatically as you get older.

Example*: Mrs. Smith pays higher monthly **premiums** as she gets older plus any additional premium increases the company may charge because of inflation.

Monthly Premium at Age 65	\$115
Monthly Premium at Age 75	\$160
Monthly Premium at Age 85	\$190

Caution: In general, attained-age-rated policies cost less when you are 65 than issue-age-rated or no-age-rated policies. However, beginning somewhere between the ages of 70 and 75, attained-age-rated policies usually cost more than issue-age-rated or no-age-rated policies.

Section 2: If You Want To Know More

Medigap Coverage Of Pre-existing Conditions

What Is A Pre-existing Condition?

A **pre-existing condition** is a health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

Will My Pre-existing Condition Be Covered If I Buy A Medigap Policy?

If you buy a Medigap policy during your Medigap open enrollment period, the insurance company can refuse to cover care for **pre-existing conditions** for up to 6 months. This only applies to conditions that were diagnosed or treated during the 6 months immediately before the start of your Medigap policy. This 6-month period is called the pre-existing condition waiting period. However, they cannot refuse to cover pre-existing conditions if you have at least 6 months of **creditable coverage**. Any new health problem would be covered immediately, regardless of whether you had creditable coverage.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Creditable Coverage

What Is Creditable Coverage?

Creditable coverage is any previous health coverage that can be used to shorten the **pre-existing condition** waiting period, such as coverage under:

- A group health plan (like an employer plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool
- TRICARE (the health care program for military dependents and retirees)
- The Federal Employees Health Benefit Plan
- A public health plan
- A health plan under the Peace Corps Act

Note: Whether you can use creditable coverage depends on whether you had any “breaks in coverage.” If there was any time that you had no health coverage of any kind, and during that time you were without coverage for more than 63 days in a row, you can only count creditable coverage that you had after that break in coverage.

Creditable Coverage Example:

Mr. Smith is 65 and has heart disease. His Medicare Part A and B started November 1, 2000. Before this date, he had no health insurance coverage. On March 1, 2001, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for 6 months (the **pre-existing condition** waiting period). However, Mr. Smith can use his 4 months of Medicare coverage to shorten this 6 month period. Now his waiting period will only be 2 months instead of 6 months. During these 2 months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease.

Section 2: If You Want To Know More

Medigap Policies For People Under Age 65 With A Disability Or End-Stage Renal Disease (ESRD)

You may have Medicare Part B benefits before age 65 due to a disability or ESRD (permanent kidney failure treated with dialysis or a kidney transplant). If you are under age 65 and disabled or have ESRD, you may not be able to buy the Medigap policy you want until you turn 65 because not all states require insurance companies to sell Medigap policies to people under age 65. You will have the right to choose and buy any Medigap policy when you turn age 65. It does not matter that you had Medicare Part B before you turned age 65.

For 6 months after you turn age 65 **and** are enrolled in Medicare Part B:

- You can buy any Medigap policy (including those policies that help pay the cost of prescription drugs), and
- Insurance companies cannot refuse to sell you a Medigap policy due to a disability or other health problem.

When you buy a policy during your Medigap **open enrollment period**, the insurance company must shorten the waiting period for **pre-existing conditions** by the amount of **creditable coverage** you have. If you had Medicare for more than 6 months, you will not have a pre-existing condition waiting period because Medicare counts as creditable coverage.

Several states require Medigap insurance companies to offer a limited Medigap open enrollment period for people with Medicare Part B who are under age 65. At the time of this printing, the following states require insurance companies to offer at least one

Section 2: If You Want To Know More

Medigap Policies For People Under Age 65 With A Disability Or End-Stage Renal Disease (ESRD) (continued)

kind of Medigap policy during a special open enrollment period to people with Medicare under age 65:

- California
- Connecticut
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- Texas
- Wisconsin

Also, some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Remember, if you live in a state that has a Medigap **open enrollment period** for people under age 65, you will still get another Medigap open enrollment period when you turn age 65.

Also, if you join a Medicare health plan and your coverage ends, you may have the right to buy a Medigap policy (see Situations #1 and #2 on pages 50-53).

If you have questions, you should call your State Health Insurance Assistance Program (see page 75).

Words in red are defined on pages 77-79.



Section 2: If You Want To Know More

Medigap Compare On The Internet

What Is Medigap Compare?

Medigap Compare is part of www.medicare.gov, a government website that has information on Medigap policies. It helps you find insurance companies in your state that sell Medigap policies, gives you information on how to contact the insurance companies, and, in some cases, gives you information to compare Medigap policies. This website has information on:

- Which Medigap policies are sold in your state.
- Tips on shopping for a Medigap policy.
- What the policies must cover.
- How insurance companies decide what to charge you for a Medigap policy **premium**.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

How To Use Medigap Compare

First, look on the Internet at www.medicare.gov and select "Medigap Compare." To compare Medigap policies in your state, follow these 4 steps:

1. Enter the zip code or state/territory where you live.
2. Select the insurance companies in your area that you want to compare.
3. See which insurance companies sell the plans you are interested in and how they price their plans based on what rating method they use (see pages 40-41).
4. Call the insurance company to get more information.

Section 2: If You Want To Know More

Your Rights To Buy A Medigap Policy In Certain Situations

If you lose certain types of health care coverage, you have the right to buy a Medigap policy outside of your Medigap **open enrollment period**. These rights are called “Medigap Protections.” They are also called “guaranteed issue” rights because the law says that insurance companies must issue you a policy.

Medigap protections are important because without them, if you do not buy a Medigap policy during your Medigap open enrollment period, an insurance company can refuse to sell you a policy, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back except in very limited circumstances.

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Summary of Medigap Protections

There are a few situations involving health coverage changes where you may have a **guaranteed issue right** to buy a Medigap policy.

For example:

1. Your **Medicare managed care plan, Private Fee-for-Service plan**, PACE provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see **Situation #1 on pages 50-52**), or
2. Your health coverage ends because of reasons other than a plan leaving the Medicare program (see **Situation #2 on pages 52-53**), or

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

3. You dropped your Medigap policy to join a **Medicare managed care plan**, **Private Fee-for-Service plan**, or PACE program and then leave the plan within one year after joining. Or you buy a **Medicare SELECT** policy for the first time and drop the policy within one year after buying (see **Situation #3 on page 54-55**).
4. You joined a Medicare health plan (like a **Medicare managed care plan** with a Medicare + Choice contract, or **Private Fee-for-Service plan**) or PACE program when you first became eligible for Medicare at age 65 and you leave the plan within one year of joining (see **Situation #4 on page 55-56**).
5. A change in your circumstances gives you the right to leave (disenroll from) your plan (see **Situation #5 on pages 56-57**).

The following pages have a summary of these situations and the protections that apply. In order to get these Medigap protections, you must meet certain conditions (see the summary for more details). All rights to buy Medigap policies under the following situations include **Medicare SELECT** policies since they are a type of Medigap policy.

The Medigap protections in this section are from federal law. Many states provide more Medigap protections than federal law. Call your State Health Insurance Assistance Program or State Insurance Department for more information (see pages 75-76).

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the right to buy a Medigap policy that is similar to the standardized policies you have a right to buy in other states. Call your State Insurance Department (see page 76).

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Note: There may be times when more than one of these situations applies to you. When this happens, you can choose the protection that gives you the best choice of policies.

For example:

If both situations #1 and #4 apply to you, you may have the right to buy any Medigap policy.

- Situation #1 limits your choices to only Medigap plans A, B, C, or F that are sold in your state.
- Situation #4 offers you the best choice by allowing you to buy **any** Medigap policy that is sold in your state.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #1

Your Medicare managed care plan, Private Fee-for-Service plan, PACE provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

You have the right to buy Medigap plans A, B, C, or F that are sold in your state. You can apply for a Medigap policy as soon as you get the final notification letter from your plan.

However, to protect your rights, you must apply no later than 63 calendar days after your health coverage ends.

You can choose to leave your plan any time after you get your final notification letter, or wait until your coverage ends. You can apply for your Medigap policy early, and ask for it to start when your plan coverage ends.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all **pre-existing conditions**.
- Can't charge you more for a policy because of past or present health problems.

If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. Remember, there is no federal law that says insurance companies must sell Medigap plans to people under age 65.

Words in red are defined on pages 77-79.

Important: When your health coverage ends, your health plan will send you a final notification letter telling you that your

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Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #1 (continued)

coverage is ending. Keep a copy of this letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

If you get a final notification letter telling you that your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or will no longer give care in your area, you may have 3 choices:

- 1. Switch to another Medicare managed care plan or Private Fee-for-Service Plan in your area.** The final notification letter will tell you if there are other plans available in your area. In some cases, you may have to wait until the new plan you want to join is accepting new members. If you join a new Medicare health plan when your current plan coverage ends, you will not need (or be able to use) a Medigap policy.
- 2. Leave your plan (disenroll) anytime between the date you get your final notification letter and when your health coverage ends.** Unless you join another Medicare health plan, you will automatically return to the Original Medicare Plan when you leave (disenroll from) your plan. You still have 63 calendar days from the day you leave your plan (disenroll) to apply for a Medigap policy.
- 3. Stay in your plan until the date your coverage ends.** Unless you join another Medicare health plan, you will automatically return to the Original Medicare Plan when your coverage ends. You still have 63 calendar days after your health coverage ends to apply for a Medigap policy.

Another Option

If you joined a Medicare managed care plan or Private Fee-for-Service plan for the first time and you were in the plan less

(continued on page 52)

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

than one year before the plan left the Medicare program or stopped giving care in your area, you have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to return to your old Medigap policy if you dropped it to join the plan under Situation #3 (see page 54) or to buy any Medigap policy under Situation #4 (see page 55).

If you have ESRD:

A new law lets you join another Medicare managed care plan or Private Fee-for-Service plan if your plan left the Medicare program or stopped giving care in your area anytime after December 31, 1998.

Situation #2

Your health coverage ends because of reasons other than a plan leaving the Medicare program. This includes the following:

- Your Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, or PACE program ends your coverage because you move out of the plan's service area. You can apply for a Medigap policy after you get the termination notice, but must apply no later than 63 calendar days after the coverage ends.
- You are in an employer group health plan that pays some of the costs not paid for by Medicare, and the plan ends your coverage. If you are notified by your employer plan, you have 63 calendar days after you get the termination notice to apply for a Medigap policy.

Note: In some cases, the notice that your coverage has ended could be a letter telling you that your claim for payment has been denied, or that a claim your doctor sent in for payment was denied because your coverage has ended. If this happens, you have 63 calendar days after the date you get the notice to buy Medigap plans A, B, C, or F that are sold in your state.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #2 (continued)

- Your Medigap policy terminates because the insurance company goes bankrupt or is insolvent, and State law does not provide for you to get conversion coverage. You can apply for a new Medigap policy any time after you are notified in some way that the insurer is insolvent or that your coverage will be ending, or after your coverage actually ends, but you must apply no later than 63 calendar days after your coverage ends.

In these cases, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. **You must apply no later than 63 calendar days after your health coverage ends.**

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare.

Important: Keep a copy of any letters, notices, claims, or denials (make sure that your name is on it) and the postmarked envelopes to prove that you lost coverage from your health plan/policy. Keep a copy of any insurance company or provider claim denial letters. Make sure that your name is on the letter, and the postmarked envelope to prove that you lost coverage from your health plan/policy.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #3

You dropped your Medigap policy to join a Medicare managed care plan, Private Fee-for-Service plan, PACE program, or buy a Medicare SELECT policy, then leave the plan or policy, and:

- This is the first time that you have ever been enrolled in a Medicare managed care plan, Private Fee-for-Service plan, PACE program, or Medicare SELECT policy, and
- You leave the Medicare managed care plan, Private Fee-for-Service plan, PACE program, or Medicare SELECT policy within one year after joining.

You have the right to return to your former Medigap policy if the same insurance company still sells it.

If your former Medigap policy is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You have from 60 days before your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

Note: If you are still in your Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

Words in red are defined on pages 77-79.

Another Option

If you dropped a Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan for the first time and you were in the plan less than one year before the plan left the Medicare program or stopped giving care in your area, you

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #3 (continued)

have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to return to your old Medigap policy under this situation.

Caution: If you bought a Medigap policy before 1992, your policy is probably not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.

Situation #4

You joined a Medicare health plan when you first became eligible for Medicare at age 65, and you leave the health plan within one year after joining. This includes health plans like a Medicare managed care plan with a Medicare + Choice contract, a Private Fee-for-Service plan, or a PACE program.

You must be allowed to buy **any** Medigap policy sold in your state. You have from 60 days before your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

The insurance company:

- Can't deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Can't charge you more for a policy because of past or present health problems.

Note: If you are still in your Medigap open enrollment period when you leave your Medicare health plan, your right to buy any Medigap policy sold in your state lasts until the end of your open enrollment period. That may be longer than 63 calendar days after your coverage ends.

Section 2: If You Want To Know More

Summary of Medigap Protections (continued)

Situation #4 (continued)

Another Option

If you joined a Medicare managed care plan or Private Fee-for-Service plan for the first time at age 65, and you were in it less than one year before the plan left the Medicare program or stopped giving care in your area, you have the right to join another Medicare managed care plan or Private Fee-for-Service plan for up to another year and still keep the right to buy any Medigap policy under this situation.

Situation #5

A change in your circumstances gives you the right to leave (disenroll from) your plan. This includes the following:

- You move out of the service area of your Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, or PACE program.
- You leave the health plan because it failed to meet its contract obligations to you (for example, the marketing materials were misleading or quality standards were not met).

You have the right to buy Medigap plans A, B, C, or F that are sold in your state or the new state if you are moving. You have from 60 days before you leave your plan and your coverage ends until 63 calendar days after your coverage ends to apply for a Medigap policy.

As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start).
- Must cover you for all pre-existing conditions.
- Cannot charge you more for a policy because of past or present health problems.

Section 2: If You Want To Know More

Situation #5 (continued)

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Where To Get More Information About Medigap Protections

- Call your State Health Insurance Assistance Program (see page 75) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that's right for you.
- Call your State Insurance Department (see page 76) if you are denied Medigap coverage.

Section 2: If You Want To Know More

Losing Medigap Coverage

Can My Medigap Insurance Company Drop Me?

In most cases, no. If you bought your Medigap policy after 1990, the law says the policy is **guaranteed renewable**. This means that your insurance company must let you renew your Medigap policy unless you do not pay the **premiums**, you lie (for example, you don't tell the insurance company everything about your health), or you commit fraud under the policy. There is only one situation where you may lose a Medigap **guaranteed renewable** policy: if the insurance company goes bankrupt. If this happens, and state law does not make some other coverage available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see Medigap Protections, Situation #2 on pages 52-53).

Insurance companies in some states may refuse to renew Medigap policies that you bought before 1990. The law, in some states, did not say these policies had to be **guaranteed renewable** at the time they were sold. If an insurance company refuses to renew one of these older Medigap policies, the company must cancel all policies of this type that they sell in your state. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see example below and Medigap Protections, Situation #2, on pages 52-53).

Example:

In 1987, Mr. Jones bought a Medigap policy from Company A. The Medigap policy Mr. Jones bought is not guaranteed renewable because he bought it before 1990, and it did not say it was guaranteed renewable. Company A will not renew Mr. Jones's policy because it is no longer being offered. The company is canceling all policies of this type in the state. Therefore, Mr. Jones has the right to buy Medigap policies A, B, C, or F that are sold in his state.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Switching Medigap Policies

Do I Have To Switch If I Have An Older Medigap Policy?

No. If you have an older Medigap policy, you can keep it. You don't have to switch it for one of the newer standardized Medigap plans. But, if you decide to switch your Medigap policy, you will not be able to go back to your older Medigap policy if you bought it before 1992 when standardized policies were first sold.

What Should I Do Before Switching My Medigap Policy?

Before switching policies, compare benefits and **premiums**. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and **long-term care**. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies.

Do I Have To Wait A Certain Length Of Time Before I Can Switch To A Different Medigap Policy?

No. But the length of time you had your policy will affect how your new policy covers you for **pre-existing conditions**.

If you've had a Medigap policy for at least 6 months and you decide to switch, your new Medigap policy generally must cover you for all pre-existing conditions. If you have had a Medigap policy for less than 6 months, the new policy must give you credit for the time the older policy covered you (see "What is creditable coverage?" on page 43).

Words in red are defined on pages 77-79.

If there is a benefit in the new Medigap policy that was not in your older policy, the company can make you wait up to 6 months before covering that benefit.

Section 2: If You Want To Know More

Medigap Coverage If You Move

What Happens To My Medigap Policy If I Move?

Because your Medigap policy is **guaranteed renewable**, you will still have coverage if you move. However, if you move to a new state, the company may charge you a different **premium**.

If you have a **Medicare SELECT** policy and you move out of the plan's service area, you have to change your insurance coverage. You have the right to buy Medigap plans A, B, C, or F that are sold in the new state where you move (see Situation #5 on pages 56-57).

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

How Your Bills Get Paid

Does The Medigap Insurance Company Pay My Doctor or Provider Directly?

The insurance company must pay your doctor or provider directly when:

- Your doctor or provider has signed an agreement with Medicare to accept **assignment** of all Medicare claims for all people with Medicare,
- Your policy is a Medigap policy, and
- You tell your doctor's office to put on the Medicare claim form that you want Medigap insurance benefits paid to the doctor or supplier. Your doctor should put your Medigap policy number and the company name on the Medicare claim form. You will need to sign the claim form. Make sure this information is correct.

When these conditions are met, the Medicare carrier will process the claim and send it to the Medigap insurance company. The carrier will send you an Explanation of Medicare Benefits (EOMB) or a Medicare Summary Notice (MSN). Your Medigap insurance company will pay your doctor or provider directly and then send you a notice. If you don't get this notice, you may ask your Medigap insurance company for it.

In most cases, Medicare claims are sent directly to the insurance company, even if the doctor does not accept **assignment** on all claims.

If Your Doctor Is Not Paid Directly

If the Medigap insurance company does not pay your doctor directly when the above three conditions are met, you should report this to your State Insurance Department (see page 76). For more information on Medigap claim filing by the carrier, call your Medicare carrier. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get the telephone number of the Medicare carrier in your state.

Section 2: If You Want To Know More

Private Contracts

What Is A Private Contract?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. It only applies to the services given by the doctor who asked you to sign it.

If I Sign A Private Contract With My Doctor, Will Medicare And My Medigap Policy Pay?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services given by the doctor who asked you to sign it. This means that Medicare and Medigap will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. **Note:** You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor:

- Medicare will not pay for any of the services this doctor gives you.
- Your Medigap policy, if you have one, will not pay anything for services this doctor gives you.
- You will have to pay whatever this doctor or provider charges you. (The **limiting charge** will not apply.)
- **Medicare managed care plans** or **Private Fee-for-Service plans** will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- Many other insurance plans will not pay for these services either. (Call your insurance company before you get the service.)
- The doctor must tell you if he or she has been excluded from the Medicare program.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

You Can Pay On Your Own For Services That Medicare Doesn't Cover

You may choose to pay on your own for services the **Original Medicare Plan** doesn't cover. In this case, your doctor does not have to stop giving services through Medicare or ask you to sign a private contract. You are always free to get services that Medicare doesn't cover, but you must pay for the services yourself.

Medicare may refuse to pay for services that aren't **medically necessary**. If that happens, a Medigap policy will not pay any **coinsurance** or **deductible** amounts on the cost of these services.

Some of the 10 standardized Medigap policies have certain benefits that pay for limited types of services that Medicare never covers. For example:

- The foreign travel emergency benefit in plans C, D, E, F, G, H, I, and J,
- The prescription drug benefit in plans H, I, and J,
- The at-home recovery benefit in plans D, G, I, and J, and
- The preventive care benefit in plans E and J.

Words in red are defined on pages 77-79.

Section 2: If You Want To Know More

Watch Out for Illegal Insurance Practices

It is illegal for anyone to:

- Pressure you into buying a Medigap policy, or lie to you or mislead you to get you to switch from one company or policy to another.
- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have Medicaid, except in certain situations (see page 39).
- Sell you a Medigap policy if they know you are enrolled in a **Medicare managed care plan** with a Medicare + Choice contract or **Private Fee-for-Service plan**.
- Claim that a Medigap policy is part of the Medicare program or any other federal program.
- Sell you a Medigap policy that can't be sold in your state. Some Medigap insurance companies use direct mail advertising to sell policies. You should make sure that the Medigap plan you are interested in can be sold in your state.
- Misuse the names, letters, symbols, or emblems of the U. S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs like Medicare.

If you believe that a federal law has been broken, you may call 1-800-MEDICARE (1-800-633-4227, TTY/ TDD: 1-877-486-2048 for the hearing and speech impaired). In most cases, however, your State Insurance Department can help you with insurance-related problems (see page 76).

Section 2: If You Want To Know More

Discrimination

Every facility or agency that takes part in the Medicare program must follow the law. It's illegal to discriminate (treat a person differently from everyone else) based on:

- Race,
- Color,
- Sex,
- Disability,
- Age, or
- National origin.

If you believe that you have been discriminated against in any of these 6 categories, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 (TTY/ TDD: 1-800-537-7697 for the hearing and speech impaired).

Section 2: If You Want To Know More

Ways To Check If An Insurance Company Is Reliable

Buying a Medigap policy is an important decision. You want to make sure that you are buying from a reliable insurance company. To help you decide if an insurance company is reliable, you can:

- Call the **State Insurance Department** in your state (see page 76). Ask if they keep a record of complaints against insurance companies and whether these can be shared with you.
- Go to your local public library.

Your local public library can help you:

- ▶ Get information on an insurance company's financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poors.
- ▶ Look at information on the Internet.
- Talk to someone you trust, like your insurance agent or a friend who has a Medigap policy.
- Call the **State Health Insurance Assistance Program** in your state (see page 75). These programs provide free counseling about Medigap policies.

Section 2: If You Want To Know More

Medicare Part A and Part B Coverage Charts

For:	See page(s):
Part A (Hospital Insurance)	68
Part B (Medical Insurance)	69-71

If you have general questions about Medicare Part A, call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your Fiscal Intermediary.

If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). Call 1-800-MEDICARE (1-800-633-4227) to get these phone numbers.

You can also get these phone numbers at www.medicare.gov on the Internet. Select “Helpful Contacts.”

Section 2: If You Want To Know More

Medicare Part A (Hospital Insurance) Helps Pay For:

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, a private room unless **medically necessary**, or a television or telephone in your room. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.

Skilled Nursing Facility (SNF) Care:**

Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).

Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.

Hospice Care:** Medical and support services from a Medicare-approved **hospice**, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.

Blood: Pints of blood you get at a hospital or **skilled nursing facility** during a covered stay.

What YOU Pay in 2001* in the Original Medicare Plan

For each benefit period YOU pay:

- A total of \$792 for a hospital stay of 1-60 days.
- \$198 per day for days 61-90 of a hospital stay.
- \$396 per day for days 91-150 of a hospital stay. (See **Lifetime Reserve Days** on page 77.)
- All costs for each day beyond 150 days.

For each benefit period YOU pay:

- Nothing for the first 20 days.
- Up to \$99 per day for days 21-100.
- All costs beyond the 100th day in the benefit period.

YOU pay:

- Nothing for home health care services.
- 20% of the **Medicare-approved amount** for durable medical equipment.

YOU pay:

- A **copayment** of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year.

YOU pay:

For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.

** You must meet certain conditions in order for Medicare to cover these services.

Section 2: If You Want To Know More

Medicare Part B (Medical Insurance) Helps Pay For:

Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions.

Also covers outpatient physical and occupational therapy including speech-language therapy.

Outpatient mental health care.

Clinical Laboratory Service: Blood tests, urinalysis, and more.

Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.

Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.

Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.

What YOU Pay in 2001* in the Original Medicare Plan

YOU pay:

- \$100 **deductible** (pay once per calendar year).
- 20% of **Medicare-approved amount** after the deductible, except in the outpatient setting.

- 20% for all outpatient physical, occupational, and speech-language therapy services.

- 50% for outpatient mental health care.

YOU pay:

- Nothing for Medicare-approved services.

YOU pay:

- Nothing for Medicare-approved services.
- 20% of **Medicare-approved amount** for durable medical equipment.

YOU pay:

- A coinsurance or **copayment** amount which may vary according to the service.

YOU pay:

For the first 3 pints of blood, then 20% of the **Medicare-approved amount** for additional pints of blood (after the **deductible**), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2002.

** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept assignment, and you may have to pay the entire cost. Medicare will then send you its share of the costs. If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC).

Section 2: If You Want To Know More

Medicare Part B Covered Preventive Services

Bone Mass Measurements:

Varies with your health status.

Who is covered...

Certain people with Medicare who are at risk for losing bone mass.

What YOU pay in the Original Medicare Plan...

20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B deductible.

Colorectal Cancer Screening:

- Fecal Occult Blood Test - Once every 12 months.
- Flexible Sigmoidoscopy* - Once every 48 months.
- Colonoscopy* - Once every 24 months if you are at high risk for colon cancer. Starting July 1, 2001, once every 10 years but not within 48 months of a screening sigmoidoscopy, if you are not at high risk for colon cancer.
- Barium Enema - Doctor can decide to use instead of sigmoidoscopy or colonoscopy.

All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.

Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. *(For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.)

Diabetes Services:

- Coverage for glucose monitors, test strips, and lancets.
- Diabetes self-management training.

All people with Medicare who have diabetes (insulin users and non-users).

If requested by your doctor or other provider and you are at risk for complications from diabetes.

20% of the Medicare-approved amount after the yearly Part B deductible.

20% of the Medicare-approved amount after the yearly Part B deductible.

Mammogram Screening:

Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)

Starting April 1, 2001, Medicare covers new digital technologies for mammogram screenings.

All women with Medicare age 40 and older.

20% of the Medicare-approved amount with no Part B deductible.

(continued on page 71)

Section 2: If You Want To Know More

Medicare Part B Covered Preventive Services

Pap Smear and Pelvic Examination:

(Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.

Starting July 1, 2001, pap smear and pelvic examinations are covered once every 24 months.

Who is covered...

All women with Medicare.

What YOU pay in the Original Medicare Plan...

Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.

Prostate Cancer Screening:

- Digital Rectal Examination - Once every 12 months.
- Prostate Specific Antigen (PSA) Test - Once every 12 months.

All men with Medicare age 50 and older.

Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.

Shots (vaccinations):

- Flu Shot - Once a year in the fall or winter.
- Pneumonia Shot - One shot may be all you will ever need. Ask your doctor.
- Hepatitis B Shot - If you are at medium to high risk for hepatitis.

All people with Medicare.

Nothing for flu and pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Massachusetts

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A **coinsurance** and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs:** Covers the Part B **coinsurance** (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

Medigap Benefits	Core	Supplement 1	Supplement 2
Basic Benefits	✓	✓	✓
Part A: Inpatient Hospital Deductible		✓	✓
Part A: Skilled-Nursing Facility Coinsurance		✓	✓
Part B: Deductible		✓	✓
Foreign Travel Emergency		✓	✓
Inpatient Days in Mental Health Hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
Prescription Drugs ((\$35 deductible each calendar quarter, then 100% coverage for generic drugs and 80% coverage for brand name drugs)			✓
State-Mandated Benefits (Annual Pap Smear tests and mammograms. Check your plan for other state-mandated benefits.)	✓	✓	✓

For more information on these policies, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select “Medigap Compare.”

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Minnesota

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A **coinsurance**.
- **Medical Costs:** Covers the Part B **coinsurance** (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

Medigap Benefits	Basic	Extended Basic
Basic Benefits	✓	✓
Part A: Inpatient Hospital Deductible		✓
Part A: Skilled-Nursing Facility Coinsurance	✓	✓
Part B: Deductible		✓
Foreign Travel Emergency	80%	80%
Outpatient Mental Health	50%	50%
Usual and Customary Fees		80%
Preventive Care	✓	✓
Prescription Drugs		80%
At-home Recovery		✓
Physical Therapy	20%	20%
Coverage while in a Foreign Country		80%

Optional Riders

- Part A: Inpatient Hospital **Deductible**
- Part A: **Deductible**
- Usual and Customary Fees
- Preventive Care
- Prescription Drugs
- At-home recovery

Insurance companies are allowed to offer six additional riders that can be added to a Basic plan. You may choose any one or all of the riders to design a Medigap plan that meets your needs.

For more information on these policies, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select “Medigap Compare.”

Section 2: If You Want To Know More

Chart Of Standardized Medigap Plans In Wisconsin

Basic Benefits - Included in all plans:

- **Inpatient Hospital Care:** Covers the Part A **coinsurance**.
- **Medical Costs:** Covers the Part B **coinsurance** (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

Medigap Benefits	Basic Plan
Basic Benefits	✓
Part A: Skilled-Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Part B: Coinsurance	✓
Outpatient Mental Health	✓
Prescription Drugs	✓

Optional Riders

- Medicare Part A **Deductible** Rider
- Additional **Home Health Care** Rider (365 visits including those paid by Medicare)
- Medicare Part B **Deductible** Rider
- Medicare Part B **Excess Charges** Rider
- Outpatient Prescription Drug Rider
- Foreign Travel Rider

Insurance companies are allowed to offer additional riders to a Medigap plan.

Wisconsin also has many other state mandated benefits under the Medigap Basic Plan. For more information, call your State Insurance Department (see page 76) or look on the Internet at www.medicare.gov and select “Medigap Compare.”

Pages 75-76 of this publication are intentionally left blank. They contain phone numbers. For the most recent contact information within this section, please visit the [Helpful Contacts](#) section of this site.

Words You Should Know

Assignment: In the Original Medicare Plan, a process in which a doctor or supplier agrees to accept the amount Medicare approves as full payment. You must pay any coinsurance amount.

Benefit Period: The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance: The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Copayment: In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5 or \$10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

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

End-Stage Renal Disease: Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Excess Charges: The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Guaranteed Issue Rights: A right you have in certain situations when insurance companies are required by law to issue you a Medigap policy.

Guaranteed Renewable: A right you have that requires your insurance company to allow you to automatically renew or continue your Medigap policy, unless you do not pay your premiums.

Home Health Care: Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Hospice Care: Is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).

Lifetime Reserve Days: Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$396 in 2001).

Limiting Charge: The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Words You Should Know

Long-term Care: Custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses. Long-term care is not covered by Medicare.

Medical Underwriting: The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medically Necessary: Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare-approved Amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan: These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare SELECT: A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Open Enrollment Period (Medigap): A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your health history during this time.

Original Medicare Plan: A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-existing Condition (Medigap): A health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

Premium: What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan: A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Words You Should Know

Programs of All-Inclusive Care For The Elderly (PACE): PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Skilled Nursing Facility: A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

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

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To get the *2001 Guide To Health Insurance For People With Medicare: Choosing a Medigap Policy* on audio-tape (English and Spanish), in large print (English and Spanish), or in Braille, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

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