Wisconsin Guide to Health Insurance for People with Medicare

2016

Free health insurance counseling for seniors:

Medigap Helpline
1-800-242-1060

Medigap Part D and Prescription Drug Helpline
1-855-677-2783

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

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's Web Site:
oci.wi.gov

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

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Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

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Introduction

This booklet briefly describes the Medicare program. It also describes the health and prescription drug insurance available to those on Medicare. A list of companies that offer Medicare supplement insurance to Wisconsin Medicare beneficiaries, and have chosen to be included in the list, is available on the OCI Web site at oci.wi.gov/pub_list/pi-010.htm.

Our Web site also includes information and booklets regarding other types of consumer insurance policies, including long-term care insurance, life insurance, automobile, and homeowner's insurance.

You may also find companies that offer Medicare supplement insurance and Prescription Drug Plans (PDPs) on the Medicare Web site at https://www.medicare.gov/find-a-plan/questions/home.aspx.

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers, you can file a complaint with our Office.

You can find information on filing a complaint with the Office of the Commissioner of Insurance:

OCI's Web site at oci.wi.gov

or call the Insurance Complaint Hotline
1-800-236-8517 (Statewide)
(608) 266-0103 (Madison)

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103

IMPORTANT NOTICE

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

What is Medicare?

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (CMS) for people 65 years of age or older, people of any age with permanent kidney failure, and some disabled individuals under age 65. Although Medicare may pay a large part of your health care expenses, it does not pay for all of your expenses. Some services and medical supplies are not fully covered. A handbook titled *Medicare & You* is available free from any Social Security office. The handbook provides a detailed explanation of Medicare.

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

Medicare Part A

Medicare Part A is commonly known as hospitalization insurance. For most people, Part A is premium-free, meaning that you do not have a monthly payment for the coverage. It pays your hospital bills and certain skilled nursing facility expenses. It also provides very limited coverage for skilled nursing care after hospitalization, rehabilitative services, home health care, and hospice care for the terminally ill. It does not pay for personal (custodial) care, such as help with eating, dressing, or moving around. Under Medicare Part A, a period of hospitalization is called a benefit period. A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a nursing facility for 60 consecutive days. If you are re-admitted within that 60 days, you are still in the same benefit period and would not pay another deductible. If you are admitted to a hospital after that benefit period ends, an entirely new benefit period begins and a new deductible must be paid.

If you do not automatically get premium-free Medicare Part A, you may be able to buy it. For more information, visit www.ssa.gov or call Social Security at 1-800-772-1213.

Medicare Part B

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

Medicare Part C/Medicare Advantage

Medicare Part C is the Medicare program more commonly known as Medicare Advantage that provides Medicare coverage through private insurance plans. Medicare Advantage plans provide the same coverage as Medicare and also provide supplemental health insurance coverage. You do not need to purchase a Medicare supplement policy if you enroll in a Medicare Advantage plan. However, Medicare Advantage plans may include deductibles and copayment and/or coinsurance amounts (out-of-pocket expenses) that do not apply to Wisconsin standardized Medicare supplement policies. You may also have to see doctors that belong to the plan or go to certain hospitals to get services. Additional information regarding these plans is available in our booklet *Medicare Advantage in Wisconsin*.

Medicare Part D/Prescription Drug

Medicare Part D is the Medicare program to provide assistance for Medicare beneficiaries to pay for outpatient prescription drug costs. It is an optional program available to Medicare beneficiaries eligible for Medicare Part A and/or enrolled in Medicare Part B. Additional information about Medicare Part D is included on pages 8-10 of this booklet.

What Are Specific Limitations Under Medicare?

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

Skilled Nursing Care Limitations

Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as defined by Medicare. For more information, visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

Home Health Limitations

Medicare pays limited benefits for home health care services that are considered "medically necessary" by Medicare. For more information, visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

What Preventive Care Is Covered Under Medicare?

Medicare helps cover some preventive care services to help maintain your health and to keep certain illnesses from getting worse. **You may be required to pay a portion of the costs for these services.** Your Medicare handbook provides more details regarding these costs. Information regarding Medicare preventive services is available in your *Medicare & You* booklet.

What Is Meant by Out-of-Pocket Expenses?

Out-of-pocket refers to costs, bills, fees, or expenses you will have to pay yourself. Out-of-pocket expenses occur when you receive a service not covered by Medicare. There are three types of out-of-pocket expenses. First, you will have to pay out-of-pocket expenses to cover the Medicare deductibles, coinsurance, and copayments. In other cases you will have out-of-pocket expenses when you choose a provider whose fees exceed Medicare-approved amounts. Finally, you may receive services not covered by Medicare; in those cases you will have to pay the entire cost of the services. There are insurance policies you can purchase that will cover some out-of-pocket expenses not covered by Medicare called supplement policies. Medicare supplement policies are described in the "Individual Policy Options" of this guide.

What Does Accepting Assignment Mean?

Sometimes a doctor or other provider accepts "assignment." This means that the doctor or provider is paid directly by Medicare and accepts the "Medicare-approved" amount.

A doctor or other provider who does not accept assignment can charge 15% over Medicare's approved amount. In this case, you are responsible not only for the usual cost-sharing of 20% of the approved charge for the service but also for 100% of the excess charges, which is the portion of the fee that exceeds the approved amount.

What is Medicare Part D?

Medicare Part D is the program created by the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to provide some assistance for Medicare beneficiaries to pay for outpatient prescription drug costs. It is an optional program available to Medicare beneficiaries eligible for Medicare Part A and/or enrolled in Part B.

Enrollment

Medicare Part D includes an annual open enrollment period of October 15 through December 7, during which you can enroll or choose to change to another Prescription Drug Plan (PDP). Your coverage will begin on January 1 of the following year. Individuals not yet on Medicare will be able to join a PDP whenever they become eligible for Medicare.

Enrollment in Medicare Part D is voluntary, and you are not required to participate. <u>However, you may have to pay a penalty if you decide to sign up after your eligible enrollment period ends.</u> Currently, the late enrollment penalty is equal to one percent of the national base beneficiary premium for every month that you waited to join. This penalty amount changes every year and you will have to pay it as long as you have Medicare prescription drug coverage.

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

The cost of your Medicare Part D coverage will vary based on the PDP that you choose. PDP plans may have deductible, coinsurance and copayment amounts (out-of-pocket expenses) that must be met before the PDP pays for your outpatient prescription drug costs.

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

Premiums

The cost of your Medicare Part D coverage will vary based on the PDP that you choose. If you are not eligible for low-income assistance (referred to as Limited

Income Subsidy), you will pay a monthly premium, an annual deductible, and a percentage of your drug costs. Your PDP will pay for your outpatient prescription drug expenses after you have met deductible and coinsurance amounts. Deductible and coinsurance amounts are those expenses you must pay out-of-pocket before Medicare Part D will pay any money for your outpatient prescription drugs.

Coverage

The prescription drugs covered by your PDP will vary based on the plan that you choose. If you enroll in a Medicare Part D prescription drug plan, it is important that you understand that your PDP will pay for only those prescriptions in the PDP's formulary. A formulary is a list of specific drugs a Medicare PDP will cover. Only the cost of drugs covered by your PDP will count toward the deductible and out-of-pocket limits. Outpatient prescription drug expenses not covered by the PDP or drugs covered by a drug discount card that you have will not count toward the out-of-pocket expense requirement of your PDP.

The Donut Hole

Medicare Part D PDPs have a coverage gap or "donut hole." A coverage gap means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay out-of-pocket all costs for your drugs while you are in the gap.

If you reach the "donut hole" gap, you may get a discount on brand name prescription drugs when you buy them. There will be additional savings in the "donut hole" gap each year through 2020 when the "donut hole" is closed completely.

Out-of-Pocket Limit

Once you have reached your plan's out-of-pocket limit, you will have catastrophic coverage. Catastrophic coverage assures that once you have reached your plan's out-of-pocket limit for covered drugs, you pay a smaller coinsurance amount or smaller copayment for the drug for the rest of the year.

Extra Help for People with Limited Income and Resources

If your income is low, you may qualify for Extra Help, also called Low Income Subsidy or LIS. This is a federal program that helps you pay for most of the costs of Medicare prescription drug coverage. If your income is below $17,655 ($23,895 for couples) and your resources are less than $13,640 ($27,250 for couples), you may qualify for Extra Help. The amount of assistance you qualify for will depend on your income.

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

Tips to Remember

- Participation in the Medicare Part D program is voluntary. However, if you do not enroll in a Part D plan when you are first eligible and you decide to join later, you may have to pay a late enrollment penalty unless you have had creditable drug coverage.
- You do not have to pay an enrollment fee or pay for assistance to enroll in Medicare Part D.
- You will have to pay for Medicare Part D coverage, which may include monthly premiums and cost-sharing, such as annual deductibles, coinsurance and copayments.
- You may be eligible for help to pay for your Medicare Part D prescription drug coverage based on your income.
- You do not have to enroll in Medicare Part D in order to keep your Medicare Part A and Part B coverage.
- You do not have to buy any additional insurance products to be eligible to enroll in Medicare Part D and should be wary of any individual who uses a Part D sales pitch to sell other insurance products.

Contacts

Information regarding Medicare Part D can be obtained by contacting a prescription drug helpline listed on page 48 of this booklet.

Coverage Options Available When You Are Eligible for Medicare

Finding the right coverage at an affordable price may be difficult as no one policy is right for everyone. Coverage options include:

- Group insurance, including
  - Employer group plans
  - Association group plans
- Individual Medicare supplement policies
- Individual Medicare cost-sharing policies
- Individual Medicare high-deductible policies
- Individual managed care Medicare supplement policies, including
  - Medicare select policies
  - Medicare cost policies
- Medicare Advantage, including
  - Medicare managed care plans
  - Medicare preferred provider organization plans (PPO)
  - Medicare private fee-for-service plans (PFFS)

There are many options available under employer groups, retirement groups, and voluntary association plans. This booklet focuses on the coverage options available under individual Medicare supplement insurance policies, Medicare select insurance policies, Medicare cost insurance policies, Medicare cost-sharing policies, Medicare high-deductible policies, and Medicare Advantage plans.

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

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

Generally, if you are eligible for Medicare, you are not eligible for coverage on the Federally Facilitated Marketplace (FFM). Information regarding Medicare and FFM coverage can be found at www.healthcare.gov/medicare/.

What Are Wisconsin Mandated Benefits?

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

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

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

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

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

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

Medicare supplement and Medicare select policies issued prior to January 1, 2006, for individuals who do not enroll in Medicare Part D cover prescription medication, insulin, and supplies associated with the injection of insulin. Prescription drug

expenses are subject to the $6,250 deductible for drug charges. This deductible does not apply to insulin.

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

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

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

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

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

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

Catastrophic Prescription Drugs—Medicare supplement and Medicare select policies issued prior to January 1, 2006, to Medicare beneficiaries who do not enroll in Medicare Part D cover at least 80% of the charges for outpatient prescription drugs after a drug deductible of no more than $6,250 per calendar year. Medicare supplement policies issued beginning January 1, 2006, do not include catastrophic prescription drug coverage as these policies are not allowed to duplicate benefits available under Medicare Part D. This coverage does not qualify as Medicare Part D creditable coverage.

Individual Policy Options

Many insurance companies offer to individuals eligible for Medicare individual policies that supplement the benefits available under Medicare. These policies are referred to as Medicare supplement or Medigap policies. Common names for these policies include Medicare select or supplemental and Medigap policies.

The federal government has expanded the options available to include managed care plans that require that you see only network providers to receive optimum benefits, and plans whereby the insurance company agrees to provide all Medicare benefits. These policies are referred to as Medicare Advantage policies.

What are Medicare Supplement Policies?

Medicare supplement policies provide coverage for some of the costs not covered by Medicare Part A and Medicare Part B.

Medicare was never intended to pay 100% of your medical bills but instead was created to offset your most pressing medical expenses by providing a basic foundation of benefits. Thus, while it will pay a significant portion of your medical bills, Medicare does not cover all services that you might need. Even those services that are covered are not covered in full. Medicare requires that you pay deductibles and pays many Part B expenses at 80% of the Medicare-approved amount. Insurance companies sell policies that pay some of these expenses if you are enrolled in both Part A and Part B of Medicare. These policies are referred to as “Medicare supplement” or “Medigap” policies and provide a way to fill the coverage gaps left by Medicare. You are automatically eligible for individual Medicare supplement coverage for six months starting with the first day you are enrolled in Medicare Part B, regardless of your health history.

Outline of Coverage

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

Medicare Supplement Policies

Individual Medicare supplement policies are designed to supplement the benefits available under the original Medicare program. Medicare supplement policies pay the 20% of Medicare-approved charges that Medicare does not pay. These Medicare supplement policies do not restrict your ability to receive services from the doctor of your choice. However, these policies may require that you submit your claim to the insurance company for payment.

Individual Medicare supplement policies include a basic core of benefits. In addition to the basic benefits, Medicare supplement insurance companies offer specified optional benefits. Each of the options that an insurance company offers must be priced and sold separately from the basic policy.

Some insurance companies offer Medicare supplement or Medicare select cost-sharing policies. These plans require that you pay a portion of the costs for Medicare-covered services until you reach an out-of-pocket limit. For 2016, the out-of-pocket limit for 25% cost-sharing plans is $2,480, and the out-of-pocket limit for 50% cost-sharing plans is $4,960. The out-of-pocket limits for Medicare supplement or Medicare select cost-sharing policies are updated each year and are based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program published by CMS.

Some insurance companies offer Medicare supplement high-deductible plans. High-deductible Medicare supplement plans offer benefits after you have paid a calendar year deductible of $2,180. This deductible consists of expenses that would ordinarily be paid by the policy.

Medicare Select Policies

Medicare select policies are supplemental policies that pay benefits only if covered services are obtained through network medical providers selected by the insurance company or health maintenance organization (HMO). Each insurance company that offers a Medicare select policy contracts with its own network of doctors or other providers to provide services. Each of these insurance companies has a provider directory that lists the doctors and other providers with whom they have contracts.

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

In general, Medicare select policies will deny payment or pay less than the full benefit if you go outside the network for nonemergency services. However, this will not impact Medicare payments. Medicare still pays its share of approved charges if the services you receive outside the network are services covered by Medicare.

Medicare Cost Policies

Medicare cost policies are offered by certain HMOs that have entered into a special arrangement with the federal Centers for Medicare & Medicaid Services (CMS). Insurers that market Medicare cost policies offer both basic Medicare cost policies and enhanced Medicare cost policies. The basic Medicare cost policies supplement only those benefits covered by Medicare and do not provide the benefits mandated under Wisconsin insurance law.

You must live in the plan's geographic service area to apply for Medicare cost insurance. The HMO plan doctors or other providers are selected by the HMO. The HMOs agree to provide Medicare benefits and may provide additional benefits at additional cost. Medicare cost insurance will only pay full supplemental benefits if covered services are obtained through HMO plan doctors or other providers, called the plan's "network."

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

Medicare Advantage Plans (Medicare Part C)

Medicare Advantage plans are offered by certain HMOs and insurance companies that have entered into special arrangements with the federal Centers for Medicare & Medicaid Services (CMS). Under these arrangements the federal government pays the HMO or insurance company a set amount for each Medicare enrollee. The HMO or insurance company agrees to provide Medicare benefits and may provide some additional benefits, which may be at an additional cost.

It is important to note that your Medicare Advantage plan can terminate at the end of the contract year if either the plan or CMS decides to terminate their agreement.

Medicare Advantage plans may include deductibles and copayment/coinsurance amounts (out-of-pocket expenses) that do not apply to Wisconsin standardized Medicare supplement policies.

Medicare Advantage plans are not regulated by the State of Wisconsin, Office of the Commissioner of Insurance. Therefore, these plans are **NOT** required to cover Wisconsin mandated benefits, nor are the plans guaranteed renewable for life like Medicare supplement policies. Information regarding benefits mandated by Wisconsin insurance laws is available on pages 12-13 of this booklet or by contacting OCI at oci.wi.gov or the phone numbers listed on page 47 of this booklet.

You can obtain more information by requesting a copy of OCI's booklet *Medicare Advantage in Wisconsin*. You may also call CMS at 1-800-MEDICARE (1-800-633-4227) or (312) 353-7180 for information.

You may also find private companies that contract with Medicare to offer Medicare Advantage Plans on the Medicare Web site at https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html.

Medicare Advantage Health Maintenance Organization Plans

If you enroll in a Medicare Advantage plan through a health maintenance organization (HMO) that has contracted with CMS, you are required to seek care from plan providers. This means that, except for emergency or urgent care situations away from home, you must receive all services from HMO-contracted medical providers. If you go to a doctor or other provider who does not have a contract with your HMO without a referral from your doctor, you will be responsible for the entire cost of the services you receive, **including Medicare costs.** To be eligible for a Medicare Advantage plan through an HMO, you must live in the HMO's geographic service area.

Medicare Advantage Preferred Provider Organization Plans

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

Medicare Advantage Private Fee-For-Service Plans

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

Group Insurance Options

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

Employer Group Plans

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

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

Employer Plans

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

Employers With 20 or More Employees

If you continue to work past age 65, you are considered an active employee, and your employer has at least 20 employees, your group plan will be the primary payer over Medicare. If you are 65, retired, covered under your actively employed spouse's group plan, and your spouse's employer has at least 20 employees, the group plan will be the primary payer.

In either of these cases, when the employee (you or your spouse) retires and is no longer considered an active employee, each Medicare eligible beneficiary (you and/or your spouse) will have a Special Enrollment Period and should enroll in Medicare Part B (if not already enrolled). If you don't enroll in Medicare Part B and are allowed to continue your employer's group health plan, the group policy may pay only the 20% and you will be responsible for paying the 80%. This is because your group policy may calculate its benefit payment as if you are enrolled in Medicare Part B regardless of whether you sign up for Medicare Part B. Also, to apply for a Medicare supplement or Medigap policy, most insurance companies require that you have both Medicare Part A and Part B.

Employers With Less Than 20 Employees

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

You should contact your local Social Security office for the publication *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You may view this publication online at www.medicare.gov and key in the title of the publication.

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

COBRA Coverage

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

Special Enrollment

If you didn't take Medicare 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 Medicare Part B during a Special Enrollment Period. You can sign up anytime you are still covered by the employer or union group health plan through your or your spouse's current or active employment during the eight months following the month the employer or union group health plan coverage ends or when the employment ends (whichever is first).

If you are age 65 or older and are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. The best time to sign up for Medicare Part B is before your employment ends or you lose your employer's coverage. If you wait to sign up for Medicare Part B during the eight months after your employment or coverage ends, your employer may make you pay for services that Medicare would have paid for if you had signed up earlier.

If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if your first Medicare enrollment is after the date you elected COBRA coverage.

Additional information regarding COBRA coverage and Medicare Part B is available in the booklet *Medicare & You*, available at your Social Security office or go to the Medicare Web site www.medicare.gov.

Voluntary Association Plans

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

Basic Benefits Included in Medicare Supplement Policies

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

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

Optional Riders
Insurance companies are allowed to offer these seven riders to a Medicare supplement policy. • Medicare Part A Deductible • Medicare 50% Part A Deductible • Additional Home Health Care (365 visits including those paid by Medicare) • Medicare Part B Deductible • Medicare Part B Copayment or Coinsurance • Medicare Part B Excess Charges • Foreign Travel Emergency

Basic Benefits Included in Medicare Select Policies

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

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

Policy Description

The charts on pages 25 - 30 provide a brief description of benefits of Medicare supplement and Medicare select policies offered in Wisconsin. Check the Outline of Coverage that you receive from the company and the policy itself for details. A booklet entitled *Medicare & You* is available free from your Social Security office and explains Medicare benefits in detail.

For information on Medicare supplement insurance policies approved by the Office of the Commissioner of Insurance (OCI), visit our Web site or contact OCI and request a copy of the booklet *Medicare Supplement Insurance Approved Policies*. The booklet includes only policies offered by companies that have agreed to be listed in the booklet and is updated on an annual basis.

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

POLICY BENEFITS—TRADITIONAL INSURERS

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

Basic Benefits

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
4. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
5. First 3 pints of blood
6. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
7. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments
8. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction . The care also must meet the insurance company's standards as medically necessary.
9. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

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

Optional Benefits

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

1. Part A deductible **($1,288)**
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less
5. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
6. Medicare 50% Part A deductible
7. Part B copayment or coinsurance rider

POLICY BENEFITS—TRADITIONAL INSURERS COST-SHARING 50% AND 25%

Medicare supplement cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. The out-of-pocket limits for 2016 are $4,960 or $2,480 for 50% or 25% cost-sharing policies, and the 2016 Part B deductible is $166.

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

Basic Benefits

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)** (50% or 25%)
4. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
5. First 3 pints of blood (50% or 25%)
6. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
7. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments
8. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
9. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

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

Optional Benefits

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

1. Part A deductible **($1,288)** (50% or 25%)
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less

5. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.

POLICY BENEFITS—MEDICARE SELECT

All **Medicare select** policies provide the following benefits:

Basic Benefits

1. Part A deductible **($1,288)**
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood
7. Part B deductible **($166)**
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Optional Benefits

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

1. Medicare 50% Part A deductible
2. Part B copayment or coinsurance rider

POLICY BENEFITS—MEDICARE SELECT COST-SHARING 50% AND 25%

Medicare select cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. The out-of-pocket limits for 2016 are $4,960 or $2,480 for 50% or 25% cost-sharing policies, and the 2016Part B deductible is $166.

All **Medicare select cost-sharing** policies provide the following benefits:

1. Part A deductible **($1,288)** (50% or 25%)
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)** (50% or 25%)
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood (50% or 25%)
7. Part B deductible **($166)**
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

POLICY BENEFITS—COST INSURANCE - BASIC AND ENHANCED

Basic Plan

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
4. First 3 pints of blood
5. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
6. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments

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

Enhanced Plan

Insurance companies may offer additional benefits for an additional premium:

1. Part A deductible **($1,288)**
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
7. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
8. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet medical necessity requirements. The care also must meet the insurance company's standards as medically necessary.

POLICY BENEFITS—HIGH-DEDUCTIBLE PLAN

High-deductible Medicare supplement plans offer benefits after you have paid a calendar year deductible of $2,180. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the separate foreign travel emergency deductible of $250.

Benefits

1. Part A deductible included
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood
7. Part B deductible included
8. Part B excess charges up to the actual charge or the limiting charge, whichever is less, included
9. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
10. 365 home health care visits including those paid by Medicare. he care also must meet the insurance company's standards as medically necessary.
11. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
12. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
13. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Basic Facts About Medicare Supplement Policies

Open Enrollment

Medicare supplement and Medicare select insurance companies must make coverage available to you, regardless of your age, for six months beginning with the date you enroll in Medicare Part B. This six-month period is called the **open enrollment period**. Insurance companies may not deny or condition the issuance of a policy on your health status, claims experience, receipt of health care, or medical condition and may not charge you additional premium because of your use of tobacco. The policy may still have waiting periods before preexisting health conditions are covered. In addition, if you are under age 65 and enrolled in Medicare due to disability or end stage renal disease, you are entitled to another six-month open enrollment period upon reaching age 65.

Medicare cost and Medicare Advantage insurance plans accept applicants who live in the plan's geographic service area, have Medicare Part A and Part B, and do not have permanent kidney failure.

Guaranteed Issue

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

- Your Medicare Advantage or Medicare cost plan stops participating in Medicare or providing care in your service area; or
- You move outside the plan's geographic service area; or
- You leave the health plan because it failed to meet its contract obligations to you; or
- Your employer group health plan ends some or all of your coverage; or
- You terminate your employer group plan to join a Medicare Advantage plan but leave the Medicare Advantage plan within 12 months of enrollment; or
- Your Medicare supplement insurance company ends your Medicare supplement or Medicare select policy and you're not at fault (for example, the company goes bankrupt); or

- You drop your Medicare supplement policy to join a Medicare Advantage plan, a Medicare cost plan, or buy a Medicare select policy for the first time, and then leave the plan or policy within one year after joining. However, you may only return to the policy under which you were originally covered, if available; or

- You join a Medicare Advantage plan or a Medicare cost plan when you first become eligible for Medicare Parts A and B at age 65 and within one year of joining you decide to leave the health plan; or

- You have Medicare Parts A and B and are covered under Medical Assistance and lose eligibility in Medical Assistance; or

- Your employer group plan increases your cost from one 12-month period to the next by more than 25% <u>and</u> the new payment for the employer-sponsored coverage is greater than the premium charged under the Medicare supplement plan the individual is applying for.

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

- Cannot deny you insurance coverage or place conditions on the policy (such as a waiting period),

- Must cover you for all preexisting conditions, and

- Cannot charge you more for a policy because of past or present health problems.

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

Suspension of Medicare Supplement Policy

Medicare supplement and Medicare select policies must allow Medicare beneficiaries with coverage the right to suspend their Medicare supplement coverage when they have employer group health plan coverage. This option was created by federal law and is referred to as a Ticket to Work provision. If you are a Medicare beneficiary with Medicare supplement coverage and you want to suspend your Medicare supplement policy, you can do so by calling your Medicare supplement insurance company.

If you later lose your employer group health plan coverage, you can contact the Medicare supplement insurance company within 90 days of losing your employer coverage and get your Medicare supplement policy back.

30-day Free Look

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

Renewability

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

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

Midterm Cancellation

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

Waiting Periods, Limitations, and Exclusions

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

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

Creditable Coverage

Health Creditable Coverage

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

Prescription Drug Creditable Coverage

The Medicare Modernization Act (MMA) imposes a late enrollment penalty if you do not maintain creditable drug coverage (coverage that is at least as good as Part D coverage) for a period of 63 days or longer following your initial enrollment period for the Medicare prescription drug benefit. MMA mandates that certain entities offering prescription drug coverage disclose to all Medicare-eligible individuals with prescription drug coverage whether such coverage is creditable. You should retain this document for your records. CMS does not request or require a copy of this creditable coverage documentation. Therefore, you should not be instructed to send the certificate to CMS. For more information on creditable coverage as it relates to Part D, go to www.cms.hhs.gov/CreditableCoverage/01_Overview.asp.

Common Exclusions

No insurance policy will cover everything that is not covered by Medicare. Medicare excludes certain types of medical expenses. So do many Medicare supplement, Medicare select, Medicare cost policies, and Medicare Advantage plans.

Some services that are frequently excluded under these policies are:

- private duty nursing,
- routine check-ups,
- eye glasses,
- hearing aids,
- dental work,
- cosmetic surgery, and
- prescription drugs.

Medicare supplement policies include two other exclusions that are frequently misunderstood:

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

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

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

   Medicare select and Medicare cost policies cover the entire charge for covered services if you use doctors and hospitals connected to the plan. Medicare Advantage plans may charge a copayment for doctor office and emergency room visits.

2. **Custodial Care—**Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare **if your doctor certifies that it is medically necessary and the care meets the insurance company's standards as medically necessary.** There are **no** benefits for custodial care. In general, Medicare supplement, Medicare select, Medicare cost, and Medicare Advantage plans cover only skilled care and do not cover custodial or intermediate care. Skilled nursing care is quite narrowly defined.

Your Grievance and Appeal Rights

Medicare Supplement Mandated Benefits

Grievance Procedure

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

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

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

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

Benefit Appeal

If you are not satisfied with the denial of a benefit by your Medicare supplement insurance company, you may appeal the decision. The insurance company must offer you the opportunity to submit a written request that the insurance company review the denial of benefits. Your policy or group insurance certificate and Outline of Coverage describe the benefit appeal procedure. If the insurance company denies any benefit under your Medicare supplement policy, the insurance company must, at the time of denial, provide you with a written description of its appeal process.

Independent Review

For Wisconsin mandated benefits under Medicare supplement policies, if you are not satisfied with the outcome of a grievance and the grievance involves a dispute regarding medical necessity or experimental treatment, you or your authorized

representative may request that an independent review organization (IRO) review your insurance company's decision. The independent review process provides you with an opportunity to have medical professionals who have no connection to the insurance company review the dispute. The IRO has the authority to determine whether the treatment should be covered by the insurance company.

Your insurance company will provide you with information on the availability of this process whenever it makes a determination that is eligible for the independent review process. Information regarding the IRO process is also available on OCI's Web site at oci.wi.gov/company/iro.htm.

Original Medicare Part A and Part B and Medicare Prescription Drug Coverage

Information can be found at https://www.medicare.gov/claims-and-appeals/.

Prescription Drug Discount Options

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

SeniorCare Prescription Drug Assistance Program

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

SeniorCare's eligibility requirements include:

1. Must be a Wisconsin resident.

2. Must be 65 years of age or older.

3. You must be a U.S. citizen or qualifying immigrant.

4. Must pay a $30 annual enrollment fee per person.

5. Only income is measured. Assets, such as bank accounts, insurance policies, home, property, etc., are not counted.

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

If you think you might be eligible, contact your county or tribal aging office for more information or call the SeniorCare Customer Service Helpline at 1-800-657-2038.

Consumer Buying Tips

Cost of Policies

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

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

Attained Age. In addition to medical inflation and increased Medicare deductibles and copayments, your premium will also increase as you age. This is due to the fact that you tend to use more medical services as you age. Premiums may be less expensive than issue age policies at first but can eventually become the most expensive.

Issue Age. Your premium will increase due to medical inflation and increased Medicare deductibles and copayments. It will not increase due to your age. Your initial premium will be higher than under the Attained Age approach because a portion of the initial premium is used to prefund the increased claims cost in later years.

No Age Rating. Your premium is the same as for all customers who buy this policy, regardless of age.

Under Age 65. Your premium is calculated for individuals who, due to a disability, are eligible to enroll in Medicare under age 65. (If you are under age 65 and enrolled in Medicare due to disability or end stage renal disease, you are entitled to another six-month open enrollment period upon reaching age 65.)

Policy Delivery and Refunds

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

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

Policy Storage

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

Duplicate Coverage

Before buying additional, duplicate coverage, evaluate your current policy. Buying one comprehensive health insurance policy is much better than buying several limited policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

Health History

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

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

Payment

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

Replacing Existing Coverage

Make sure you have a good reason for switching from one policy to another. You should only replace existing coverage for different benefits, better service, or more affordable premiums. Do not terminate your existing policy until your new policy is in effect. You should also make sure to cancel the policy you are replacing. An agent generally cannot cancel your existing policy. If you have questions about the process, you should contact the company.

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

Insurance Agents and Companies

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

You can check with the Office of the Commissioner of Insurance Web site at oci.wi.gov to see if they are licensed.

What if I Can't Afford a Medicare Supplement Policy?

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

Medicaid Program

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

If you lose your eligibility for Medicaid, you are allowed to reinstate your Medicare supplement or Medicare select insurance.

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

If you are a low-income Medicare beneficiary but don't qualify for the standard Medicaid program, you may be eligible for either the QMB or the SLMB program. While these programs do not necessarily eliminate your need for private insurance to supplement your Medicare benefits, they could save you hundreds of dollars each year in health care costs if you qualify for assistance.

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

The SLMB program pays your Medicare Part B premium if you are entitled to Medicare Part A and your income does not exceed the national poverty level by

more than 20%. If you qualify for assistance under the SLMB program, you will be responsible for Medicare's deductibles, coinsurance, and other related charges.

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

Limited Policies

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

Long-Term Care Coverage—These policies cover long-term nursing home and/or home health care. Visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

Hospital Confinement Indemnity Insurance—These policies pay a fixed amount per day for a specific number of days during the time you are hospitalized. These policies are not related to Medicare and only pay a limited amount of any hospital bill. You should review these policies carefully to determine the number of days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage—These policies provide benefits for a single disease or group of specified diseases, such as cancer, and are not Medicare supplement or Medicare supplement policies. These policies only provide coverage for the specified disease and therefore should not be bought as alternatives to more comprehensive coverage. *A Shopper's Guide to Cancer Insurance* prepared by the National Association of Insurance Commissioners is available on our Web site.

ATTENTION

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

State Health Insurance Assistance Program (SHIP)

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

The Medigap Helpline is provided by the State of Wisconsin Board on Aging and Long Term Care at no cost to you. There is no connection with any insurance company. The program is funded by a grant from the federal government Centers for Medicare & Medicaid Services and the Wisconsin Office of the Commissioner of Insurance.

Filing a Claim

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

- Keep an accurate record of all your health care expenses. Store this information with your Medicare supplement insurance or other health insurance policies.
- Whenever you receive treatment, present your Medicare card and any other insurance card you have.
- File all claims promptly. You will receive a Medicare Summary Notice (MSN) in the mail every 3 months. If the insurance company requests a copy of the Medicare Summary Notice, make a copy of the MSN and record the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.
- You do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare provider must submit claims to Medicare for you.
- If you enroll in a health maintenance organization (HMO), you will not have to file claims for services covered by HMO providers. All claims for covered services will be handled by the HMO.
- Some Medicare supplement insurance companies have an automatic claims filing program. This means that the insurance company receives a copy of your claim as soon as it is processed by Medicare. There may be a charge for this service.
- For more information on filing claims, you may want to contact the benefit specialist at your county or tribal aging office.

NOTE

Under Wisconsin law, all Medicare supplement and Medicare select insurance policies must include a benefit appeal procedure for claim denials. This procedure will be explained in your policy and Outline of Coverage.

What if I Have Additional Questions?

If you have questions or complaints about:

Health Insurance

- **Board on Aging and Long Term Care (BOALTC)**

  This is the Wisconsin Senior Health Insurance Assistance Program (SHIP) with a statewide toll-free number staffed by the Wisconsin Board on Aging and Long Term Care (BOALTC) and funded by the Office of the Commissioner of Insurance. BOALTC provides free insurance counseling services to Medicare beneficiaries and can answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

  Address
  Board on Aging and Long Term Care
  1402 Pankratz Street, Suite111
  Madison, WI 53704-4001

  Medigap Helpline: 1-800-242-1060 - (toll-free)
  (608) 246-7001 Fax
  longtermcare.wi.gov

- **Office of the Commissioner of Insurance (OCI)**

  OCI publishes several consumer guides to assist seniors in shopping for insurance. The publications should be used only as a guide. These guides are not legal documents and do not represent your rights under any insurance policy or government program. Your policy, contract, or federal or state laws establish your rights. Consult an attorney for legal guidance about your specific rights. Legal assistance may also be available through your county or tribal aging office which can be found at https://www.dhs.wisconsin.gov/benefit-specialists/index.htm.

  If you are having a problem with your insurance, you should first check with your agent or with the insurance company that sold you the policy. If you do not get satisfactory answers, you may file a complaint with OCI.

Web Site
oci.wi.gov

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

Street Address
125 South Webster Street
Madison, WI 53703

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

Elder Benefit Specialists
Disability Benefit Specialists

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

All local contact information can be found on https://www.dhs.wisconsin.gov/benefit-specialists/index.htm.

Medicare

- **Centers for Medicare & Medicaid Services (CMS)**

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

  Address
  7500 Security Boulevard
  Baltimore MD 21244-1850

  1-800-633-4227 (toll-free)
  www.cms.gov

- **Medicare Claim Appeal for Part A and Part B**

  The Medicare contractor that processed your Medicare claim(s) appears on your Medicare Summary Notice (MSN). Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. You will get an MSN in the mail every 3 months, and you must file your appeal within 120 days of the date you get the MSN. For more information about filing a Medicare appeal, visit the Medicare Web site https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html.

- **SeniorCare**

  SeniorCare is Wisconsin's prescription drug assistance program for Wisconsin residents who are 65 years of age or older and who meet eligibility requirements.

  SeniorCare Customer Service: 1-800-657-2038 (toll-free)
  TTY and translations services are available
  www.dhs.wisconsin.gov/seniorcare/index.htm

- **Prescription Drug Helplines for Medicare Beneficiaries**

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

  Wisconsin Board on Aging and Long Term Care
  1402 Pankratz Street, Suite 111
  Madison, WI 53704-4001

  1-855-677-2783 (toll-free)
  E-mail: BOALTC@wisconsin.gov

  Disability Drug Benefit Helpline
  Toll-free information line that provides free counseling to Wisconsin Medicare beneficiaries under age 60 with a disability.

  Disability Rights Wisconsin
  1-800-926-4862
  www.disabilityrightswi.org

Glossary of Terms

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

Appeal: A special kind of complaint you make if you disagree with any decision about your health care services. This complaint is made to your Medicare health plan or to Medicare. There is usually a special process you must use to make your complaint.

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

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

Attained age: This means that as you age, your premiums will change to meet your age range and your premiums will become higher.

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

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

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

Carrier: A private company that has a contract with Medicare to process your Medicare Part B bills.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program.

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. If you have supplemental coverage, this is the balance of a covered health expense that you are required to pay after insurance has covered the rest.

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

Creditable coverage: Previous health/drug coverage that reduces the time you have to wait before preexisting health conditions are

covered by a policy you buy during your Medicare supplement open enrollment period or guarantee-issue period.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medically necessary: Services or supplies that are 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 local area; and are not mainly for the convenience of you or your doctor.

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

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

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

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

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

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

Open enrollment period: A one-time only six-month period when you can buy any Medicare supplement policy you want that is sold in Wisconsin. It starts when you sign up for Medicare Part B and you are age 65 or older.

You cannot be denied coverage or charged more due to present or past health problems during this time period.

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

Preexisting condition: A medical condition diagnosed or treated up to 6 months prior to the purchase of an insurance policy. Medicare supplement policies may impose up to a 180-day waiting period before coverage for that condition begins.

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

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

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

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

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

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

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

Acronyms

We have tried to limit the use of acronyms and initials, but some terms are used so often, the acronyms are practical and of assistance to you. The term has been spelled when first used in the text with the acronym or initials following in parentheses. For your convenience, the following is a listing of acronyms and initials that appear in the *Wisconsin Guide to Health Insurance for People with Medicare* booklet:

ADRC Aging and Disability Resource Center

BOALTC Board on Aging and Long Term Care

CMS Centers for Medicare & Medicaid Services

COB Coordination of Benefits

COBRA Consolidated Omnibus Budget Reconciliation Act

DME Durable Medical Equipment

EOB Explanation of Benefits

EOMB Explanation of Medicare Benefits

HMO Health Maintenance Organization

IRO Independent Review Organization

MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MSN Medicare Summary Notice

OCI Office of the Commissioner of Insurance

PDP Prescription Drug Plan

PFFS Private Fee for Service Plan

PPO Preferred Provider Organization Plan

QMB Qualified Medicare Beneficiary Program

SHIP State Health Insurance Assistance Program

SLMB Specified Low-Income Medicare Beneficiary Program

SNF Skilled Nursing Facility

CENTERS FOR MEDICARE & MEDICAID SERVICES

2016

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

- Medicare Supplement Insurance (Medigap) policies
- What Medigap policies cover
- Your rights to buy a Medigap policy
- How to buy a Medigap policy

This guide can help if you're thinking about buying a Medigap policy or already have one.

Developed jointly by the Centers for Medicare & Medicaid Services (CMS)
and the National Association of Insurance Commissioners (NAIC)

Who should read this guide?

This guide helps people with Medicare understand Medicare Supplement Insurance policies (also called Medigap policies). A Medigap policy is a type of private insurance that helps you pay for some of the costs that Original Medicare doesn't cover.

Important information about this guide

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

The "2016 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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SECTION

1

Medicare Basics

A brief look at Medicare

A Medicare Supplement Insurance (Medigap) Policy is a health insurance sold by private insurance companies which can help pay some of the health care costs that Original Medicare doesn't cover, like coinsurance, copayments, or deductibles. Some Medigap policies also cover certain benefits Original Medicare doesn’t cover like emergency foreign travel expenses. Medigap policies don’t cover your share of the costs under other types of health coverage, including Medicare Advantage Plans (like HMOs or PPOs), stand-alone Medicare Prescription Drug Plans, employer/union group health coverage, Medicaid, or TRICARE. Insurance companies generally can’t sell you a Medigap policy if you have coverage through Medicaid or a Medicare Advantage Plan.

Before you learn more about Medigap policies, the next few pages provide a brief look at Medicare. If you already know the basics about Medicare and only want to learn about Medigap, skip to page 9.

Words in blue are defined on pages 49–50.

What's Medicare?

Medicare is health insurance for:

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

The different parts of Medicare

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance) helps cover

- Inpatient care in hospitals
- Skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance) helps cover

- Services from doctors and other health care providers, hospital outpatient care, durable medical equipment, and home health care
- Preventive services to help maintain your health and to keep certain illnesses from getting worse

Medicare Part C (Medicare Advantage)

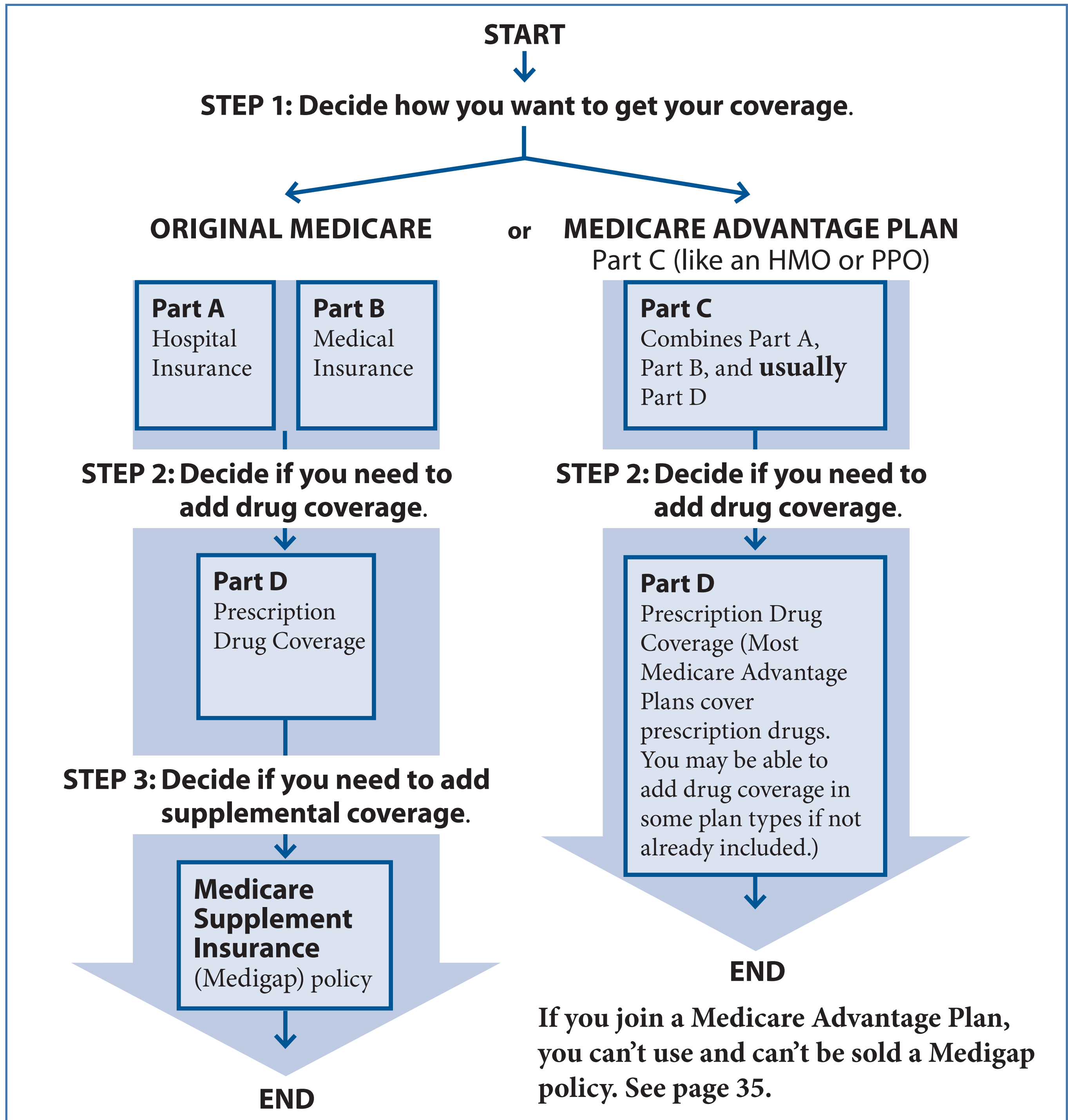
- Includes all benefits and services covered under Part A and Part B
- Run by Medicare-approved private insurance companies
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of outpatient prescription drugs
- Run by Medicare-approved private insurance companies
- May help lower your prescription drug costs and help protect against higher costs in the future

Your Medicare coverage choices at a glance

There are 2 main ways to get your Medicare coverage — Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide which way to get your coverage. See page 35 for information about Medicare Advantage Plans and Medigap policies.



Medicare and the Health Insurance Marketplace

The Health Insurance Marketplace is a way for qualified individuals, families, and employees of small businesses to get health coverage. **Medicare isn't part of the Marketplace.**

Is Medicare coverage "minimum essential coverage?"

Minimum essential coverage is coverage that you need to have to meet the individual responsibility requirement under the Affordable Care Act.

As long as you have Medicare Part A (Hospital Insurance) coverage or are enrolled in a Medicare Advantage Plan, you have minimum essential coverage and you don't have to get any additional coverage.

If you only have Medicare Part B (Medical Insurance), you aren't considered to have minimum essential coverage. This means you may have to pay a fee for not having minimum essential coverage. You'd pay this fee when you file your federal income tax return.

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

Generally, no. In most cases, it's against the law for someone who knows you have Medicare to sell you a Marketplace plan, because that would duplicate your coverage. However, if you're employed and your employer offers employer-based coverage through the Marketplace, you may be eligible to get that type of coverage.

Note: The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies, Medicare Advantage Plans, or Medicare drug plans (Part D).

For more information

Remember, this guide is about Medigap policies. To learn more about Medicare, visit Medicare.gov, look at your "Medicare & You" handbook, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION

2

Medigap Basics

What's a Medigap policy?

A Medigap policy is private health insurance that helps supplement Original Medicare. This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). These are "gaps" in Medicare coverage.

If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share. A Medigap policy is different from a Medicare Advantage Plan (like an HMO or PPO) because those plans are ways to get Medicare benefits, while a Medigap policy only supplements the costs of your Original Medicare benefits.

Note: Medicare doesn't pay any of your costs for a Medigap policy.

All Medigap policies must follow federal and state laws designed to protect you, and policies must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies in most states can only sell you a "standardized" Medigap policy identified by letters A through N. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. **Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies.**

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. See pages 42–44. In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. Medicare SELECT plans are standardized plans that may require you to see certain providers and may cost less than other plans. See page 20.

What Medigap policies cover

The chart on page 11 gives you a quick look at the standardized Medigap Plans available. You'll need more details than this chart provides to compare and choose a policy. Call your State Health Insurance Assistance Program (SHIP) for help. See pages 47–48 for your state's phone number.

Notes:

- Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Plan C or Plan F. Not all types of Medigap policies may be available in your state. See pages 42– 44 if you live in **Massachusetts**, **Minnesota**, or **Wisconsin**.
- Plans D and G effective on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- Plans E, H, I, and J are **no longer sold**, but, if you already have one, you can generally keep it.

This chart shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Medicare Part B coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%** ***
Blood (first 3 pints)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A hospice care coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Skilled nursing facility care coinsurance			**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A deductible		**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	50%	**100%**
Part B deductible			**100%**		**100%**					
Part B excess charges					**100%**	**100%**				
Foreign travel emergency (up to plan limits)			**80%**	**80%**	**80%**	**80%**			**80%**	**80%**
							Out-of-pocket limit in 2016**			
							$4,960	$2,480		

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,180 in 2016 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($166 in 2016), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

What Medigap policies don't cover

Generally, Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Types of coverage that are NOT Medigap policies

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

What types of Medigap policies can insurance companies sell?

In most cases, Medigap insurance companies can sell you only a "standardized" Medigap policy. All Medigap policies must have specific benefits, so you can compare them easily. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

Words in blue are defined on pages 49–50.

Insurance companies that sell Medigap policies don't have to offer every Medigap plan. However, they must offer Plan A if they offer any Medigap policy. If they offer any plan in addition to Plan A, they must also offer Plan C or Plan F. Each insurance company decides which Medigap plan it wants to sell, although state laws might affect which ones they offer.

In some cases, an insurance company must sell you a Medigap policy, even if you have health problems. Here are certain times that you're guaranteed the right to buy a Medigap policy:

- When you're in your Medigap Open Enrollment Period. See pages 14–15.
- If you have a guaranteed issue right. See pages 21–23.

You may be able to buy a Medigap policy at other times, but the insurance company can deny you a Medigap policy based on your health. Also, in some cases it may be illegal for the insurance company to sell you a Medigap policy (like if you already have Medicaid or a Medicare Advantage Plan).

What do I need to know if I want to buy a Medigap policy?

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to buy a Medigap policy.
- If you have a Medicare Advantage Plan (like an HMO or PPO) but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the Plan. Ask that the new Medigap policy start when your Medicare Advantage Plan enrollment ends, so you'll have continuous coverage.
- You pay the private insurance company a premium for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, **you each will have to buy separate Medigap policies**.
- When you have your Medigap Open Enrollment Period, you can buy a Medigap policy from any insurance company that's licensed in your state.
- If you want to buy a Medigap policy, see page 11 for an overview of the basic benefits covered by different Medigap policies to review the benefit choices. Then, follow the "**Steps to Buying a Medigap Policy**" on pages 25–30.
- If you want to drop your Medigap policy, write your insurance company to cancel the policy and confirm it's cancelled. Your agent can't cancel the policy for you.
- Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you pay the premium.
- Different insurance companies may charge different premiums for the same exact policy. As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).
- Some states may have laws that may give you additional protections.

What do I need to know if I want to buy a Medigap policy? (continued)

- Although some Medigap policies sold in the past covered prescription drugs, Medigap policies sold after January 1, 2006, aren't allowed to include prescription drug coverage.
- If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D) offered by private companies approved by Medicare. See pages 6–7.

To learn about Medicare prescription drug coverage, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When's the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods including those for people under 65. During this period, an insurance company can't use medical underwriting. This means the insurance company can't do any of these because of your health problems:

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

Words in blue are defined on pages 49–50.

While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition. A pre-existing condition is a health problem you have before the date a new insurance policy starts. In some cases, the Medigap insurance company can refuse to cover your out-of-pocket costs for these pre-existing health problems for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

When's the best time to buy a Medigap policy? (continued)

Coverage for a pre-existing condition can only be excluded if the condition was treated or diagnosed within 6 months before the coverage starts under the Medigap policy. This is called the "look-back period." After the 6-month pre-existing condition waiting period, the Medigap policy will cover the condition that was excluded. Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't, but you're responsible for the Medicare coinsurance or copayment.

Creditable coverage

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

There are many types of health care coverage that may count as creditable coverage for Medigap policies, but they'll only count if you didn't have a break in coverage for more than 63 days.

Your Medigap insurance company can tell you if your previous coverage will count as creditable coverage for this purpose. You can also call your State Health Insurance Assistance Program. See pages 47– 48.

If you buy a Medigap policy when you have a guaranteed issue right (also called "Medigap protection"), the insurance company can't use a pre-existing condition waiting period. See pages 21–23 for more information about guaranteed issue rights.

Note: If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65. See page 39 for more information.

Why is it important to buy a Medigap policy when I'm first eligible?

When you're first eligible, you have the right to buy any Medigap policy offered in your state. In addition, you generally will get better prices and more choices among policies. It's very important to understand your Medigap Open Enrollment Period. Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the Medigap policy. However, if you apply during your Medigap Open Enrollment Period, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health. If you apply for Medigap coverage **after** your Open Enrollment Period, there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements, **unless** you're eligible because of one of the limited situations listed on pages 22–23.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap Open Enrollment Period begins when you enroll in Part B and it can't be changed or repeated. In most cases, it makes sense to enroll in Part B and purchase a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty and you might miss your Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Employer coverage

Words in blue are defined on pages 49–50.

If you have group health coverage through an employer or union, because either you or your spouse is currently working, you may want to wait to enroll in Part B. This is because benefits based on current employment often provide coverage similar to Part B, so you would be paying for Part B before you need it, and your Medigap Open Enrollment Period might expire before a Medigap policy would be useful. When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty which means your Medigap Open Enrollment Period will start when you're ready to take advantage of it. If you enrolled in Part B while you still had employer coverage, your Medigap Open Enrollment Period would start, and unless you bought a Medigap policy before you needed it, you would miss your Medigap Open Enrollment Period entirely. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare. See page 24 for more information.

How do insurance companies set prices for Medigap policies?

Each insurance company decides how it'll set the price, or premium, for its Medigap policies. It's important to ask how an insurance company prices its policies. The way they set the price affects how much you pay now and in the future. Medigap policies can be priced or "rated" in 3 ways:

1. Community-rated (also called "no-age-rated")
2. Issue-age-rated (also called "entry-age-rated")
3. Attained-age-rated

Each of these ways of pricing Medigap policies is described in the chart on the next page. The examples show how your age affects your premiums, and why it's important to look at how much the Medigap policy will cost you now and in the future. The amounts in the examples aren't actual costs. Other factors like where you live, medical underwriting, and discounts can also affect the amount of your premium.

How do insurance companies set prices for Medigap policies? (continued)

Type of pricing	How it's priced	What this pricing may mean for you	Examples
Community-rated (also called "no-age-rated")	Generally the same premium is charged to everyone who has the Medigap policy, regardless of age or gender.	Your premium isn't based on your age. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Smith is 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because, with this type of Medigap pricing, everyone pays the same price regardless of age.
Issue-age-rated (also called "entry age-rated")	The premium is based on the age you are when you buy (are "issued") the Medigap policy.	Premiums are lower for people who buy at a younger age and won't change as you get older. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is 72. She buys the same Medigap policy as Mr. Han. Since she is older when she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you've "attained"), so your premium goes up as you get older.	Premiums are low for younger buyers but go up as you get older. They may be the least expensive at first, but they can eventually become the most expensive. Premiums may also go up because of inflation and other factors.	Mrs. Anderson is 65. She buys a Medigap policy and pays a $120 monthly premium. Her premium will go up each year: • At 66, her premium goes up to $126. • At 67, her premium goes up to $132. • At 72, her premium goes up to $165. Mr. Dodd is 72. He buys the same Medigap policy as Mrs. Anderson. He pays a $165 monthly premium. His premium is higher than Mrs. Anderson's because it's based on his current age. Mr. Dodd's premium will go up each year: • At 73, his premium goes up to $171. • At 74, his premium goes up to $177.

Comparing Medigap costs

As discussed on the previous pages, the cost of Medigap policies can vary widely. **There can be big differences in the premiums that different insurance companies charge for exactly the same coverage**. As you shop for a Medigap policy, be sure to compare the same type of Medigap policy, and consider the type of pricing used. See pages 17–18. For example, compare a Plan C from one insurance company with a Plan C from another insurance company. Although this guide **can't** give actual costs of Medigap policies, you can get this information by calling insurance companies or your State Health Insurance Assistance Program. See pages 47–48.

You can also find out which insurance companies sell Medigap policies in your area by visiting Medicare.gov.

The cost of your Medigap policy may also depend on whether the insurance company:

- Offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses medical underwriting, or applies a different premium when you don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. See page 20.
- Offers a "high-deductible option" for Plan F. If you buy Plan F with a high-deductible option, you must pay the first $2,180 of deductibles, copayments, and coinsurance (in 2016) not paid by Medicare before the Medigap policy pays anything. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

If you bought your Medigap Plan J before January 1, 2006, and it still covers prescription drugs, you would also pay a separate deductible ($250 per year) for prescription drugs covered by the Medigap policy. And, if you have a Plan J with a high deductible option, you must also pay a $2,180 deductible (in 2016) before the policy pays anything for medical benefits.

What's Medicare SELECT?

Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be any of the standardized Medigap plans (see page 11). These policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT hospital or doctor for non-emergency services, you'll have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

How does Medigap help pay my Medicare Part B bills?

In most Medigap policies, when you sign the Medigap insurance contract you agree to have the Medigap insurance company get your Medicare Part B claim information directly from Medicare, and then they pay the doctor directly whatever amount is owed under your policy. Some Medigap insurance companies also provide this service for Medicare Part A claims.

If your Medigap insurance company **doesn't** provide this service, ask your doctors if they participate in Medicare. Participating providers have signed an arrangement to accept assignment for all Medicare-covered services. If your doctor participates, the Medigap insurance company is required to pay the doctor directly if you request. If your doctor doesn't participate but still accepts Medicare, you may be asked to pay the coinsurance amount at the time of service. In these cases, your Medigap insurance company will pay you directly according to policy limits.

If you have any questions about Medigap claim filing, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

As explained on pages 14–16, the best time to buy a Medigap policy is during your Medigap Open Enrollment Period, when you have the right to buy any Medigap policy offered in your state. However, even if you aren't in your Medigap Open Enrollment Period, there are several situations in which you may still have a guaranteed right to buy a Medigap policy.

Guaranteed issue rights are rights you have in certain situations when insurance companies must offer you certain Medigap policies. In these situations, an insurance company must:

- Sell you a Medigap policy
- Cover all your pre-existing health conditions
- Can't charge you more for a Medigap policy regardless of past or present health problems

If you live in Massachusetts, Minnesota, or Wisconsin, you have guaranteed issue rights to buy a Medigap policy, but the Medigap policies are different. See pages 42–44 for your Medigap policy choices.

When do I have guaranteed issue rights?

In most cases, you have a guaranteed issue right when you have certain types of other health care coverage that changes in some way, like when you lose the other health care coverage. In other cases, you have a "trial right" to try a Medicare Advantage Plan and still buy a Medigap policy if you change your mind. For information on trial rights, see page 23.

This chart describes the situations, under federal law, that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issue rights.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
You're in a Medicare Advantage Plan (like an HMO or PPO), and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. **Note:** In this situation, you may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. Call the Medicare SELECT insurer for more information about your options.	Medigap Plan A, B, C, F, K, or L that's sold by any insurance company in your state or the state you're moving to.	As early as 60 calendar days before the date your Medicare SELECT coverage will end, but no later than 63 calendar days after your Medicare SELECT coverage ends.

This chart describes the situations, under federal law, that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issue rights. (continued)

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
(**Trial right**) You joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	Any Medigap policy that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
(**Trial right**) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medigap policy **isn't** available, you can buy Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.
You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.

Can I buy a Medigap policy if I lose my health care coverage?

Yes, you may be able to buy a Medigap policy. Because you may have a guaranteed issue right to buy a Medigap policy, make sure you keep these:

- A copy of any letters, notices, emails, and/or claim denials that have your name on them as proof of your coverage being terminated.
- The postmarked envelope these papers come in as proof of when it was mailed.

You may need to send a copy of some or all of these papers with your Medigap application to prove you have a guaranteed issue right.

If you have a Medicare Advantage Plan (like an HMO or PPO) but you're planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the plan. Ask that the new policy take effect when your Medicare Advantage enrollment ends, so you'll have continuous coverage.

For more information

If you have any questions or want to learn about any additional Medigap rights in your state, you can:

- Call your State Health Insurance Assistance Program to make sure that you qualify for these guaranteed issue rights. See pages 47–48.
- Call your State Insurance Department if you're denied Medigap coverage in any of these situations. See pages 47– 48.

Important: The guaranteed issue rights in this section are from federal law. These rights are for both Medigap and Medicare SELECT policies. Many states provide additional Medigap rights.

There may be times when more than one of the situations in the chart on pages 22–23 applies to you. When this happens, you can choose the guaranteed issue right that gives you the best choice.

Some of the situations listed include loss of coverage under Programs of All-inclusive Care for the Elderly (PACE). PACE combines medical, social, and long-term care services, and prescription drug coverage for frail people. To be eligible for PACE, you must meet certain conditions. PACE may be available in states that have chosen it as an optional Medicaid benefit. If you have Medicaid, an insurance company can sell you a Medigap policy **only** in certain situations. For more information about PACE, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 4

Steps to Buying a Medigap Policy

Step-by-step guide to buying a Medigap policy

Buying a **Medigap policy** is an important decision. Only you can decide if a Medigap policy is the way for you to supplement Original Medicare coverage and which Medigap policy to choose. Shop carefully. Compare available Medigap policies to see which one meets your needs. As you shop for a Medigap policy, keep in mind that different insurance companies may charge different amounts for exactly the same Medigap policy, and not all insurance companies offer all of the Medigap policies.

Below is a step-by-step guide to help you buy a Medigap policy. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

STEP 1: Decide which benefits you want, then decide which of the standardized Medigap policies meet your needs.

STEP 2: Find out which insurance companies sell Medigap policies in your state.

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs.

STEP 4: Buy the Medigap policy.

STEP 1: Decide which benefits you want, then decide which of the Medigap policy meets your needs.

You should think about your current and future health care needs when deciding which benefits you want because you might not be able to switch Medigap policies later. Decide which benefits you need, and select the Medigap policy that will work best for you. The chart on page 11 provides an overview of Medigap benefits.

STEP 2: 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 pages 47– 48. Ask if they have a "Medigap rate comparison shopping guide" for your state. This guide usually lists companies that sell Medigap policies in your state and their costs.
- Call your State Insurance Department. See pages 47– 48.
- Visit Medicare.gov/find-a-plan:

  This website will help you find information on all your health plan options, including the Medigap policies in your area. You can also get information on:

  ✔ How to contact the insurance companies that sell Medigap policies in your state.

  ✔ What each Medigap policy covers.

  ✔ How insurance companies decide what to charge you for a Medigap policy premium.

  If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227). A customer service representative will help you get information on all your health plan options including the Medigap policies in your area. TTY users should call 1-877-486-2048.

Words in blue are defined on pages 49–50.

STEP 2: (continued)

Since costs can vary between companies, you should plan to call more than one insurance company that sells Medigap policies in your state. Before you call, check the companies to be sure they're honest and reliable by using one of these resources:

- Call your State Insurance Department. Ask if they keep a record of complaints against insurance companies that can be shared with you. When deciding which Medigap policy is right for you, consider these complaints, if any.
- Call your State Health Insurance Assistance Program. These programs can give you help with choosing a Medigap policy at no cost to you.
- Go to your local public library for help with:
  - Getting information on an insurance company's financial strength from independent rating services like weissratings.com, A.M. Best, and Standard & Poor's.
  - Looking at information about the insurance company online.
- Talk to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy from the same Medigap insurance company.

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs.

Before you call any insurance companies, figure out if you're in your Medigap Open Enrollment Period or if you have a guaranteed issue right. Read pages 14–15 and 22–23 carefully. If you have questions, call your State Health Insurance Assistance Program. See pages 47–48. This chart can help you keep track of the information you get.

Ask each insurance company…	Company 1	Company 2
"Are you licensed in ___?" (Say the name of your state.) **Note:** If the answer is NO, STOP here, and try another company.		
"Do you sell Medigap Plan ___?" (Say the letter of the Medigap Plan you're interested in.) **Note:** Insurance companies usually offer some, but not all, Medigap policies. Make sure the company sells the plan you want. Also, if you're interested in a Medicare SELECT or high-deductible Medigap policy, tell them.		
"Do you use medical underwriting for this Medigap policy?" **Note:** If the answer is NO, go to step 4 on page 30. If the answer is YES, but you know you're in your Medigap Open Enrollment Period or have a guaranteed issue right to buy that Medigap policy, go to step 4. Otherwise, you can ask, "Can you tell me whether I'm likely to qualify for the Medigap policy?"		
"Do you have a waiting period for pre-existing conditions?" **Note:** If the answer is YES, ask how long the waiting period is and write it in the box.		
"Do you price this Medigap policy by using community-rating, issue-age-rating, or attained-age-rating?" See page 18. **Note:** Circle the one that applies for that insurance company.	Community Issue-age Attained-age	Community Issue-age Attained-age
"I'm ___ years old. What would my premium be under this Medigap policy?" **Note:** If it's attained-age, ask, "How frequently does the premium increase due to my age?"		
"Has the premium for this Medigap policy increased in the last 3 years due to inflation or other reasons?" **Note:** If the answer is YES, ask how much it has increased, and write it in the box.		
"Do you offer any discounts or additional benefits?" See page 19.		

STEP 3: (continued)

Watch out for illegal practices.

It's illegal for anyone to:

- Pressure you into buying a Medigap policy, or lie to or mislead 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.
- Sell you a Medigap policy if they know you're in a Medicare Advantage Plan (like an HMO or PPO) unless your coverage under the Medicare Advantage Plan will end before the effective date of the Medigap policy.
- Claim that a Medigap policy is a part of Medicare or any other federal program. Medigap is private health insurance.
- Claim that a Medicare Advantage Plan is a Medigap policy.
- Sell you a Medigap policy that can't legally be sold in your state. Check with your State Insurance Department (see pages 47–48) to make sure that the Medigap policy you're interested in can be sold in your state.
- Misuse the names, letters, or symbols of the U.S. Department of Health & Human Services (HHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare. (For example, they can't suggest the Medigap policy has been approved or recommended by the federal government.)
- Claim to be a Medicare representative if they work for a Medigap insurance company.
- Sell you a Medicare Advantage Plan when you say you want to stay in Original Medicare and buy a Medigap policy. A Medicare Advantage Plan isn't the same as Original Medicare. See page 5. If you enroll in a Medicare Advantage Plan, you can't use a Medigap policy.

If you believe that a federal law has been broken, call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950. Your State Insurance Department can help you with other insurance-related problems.

STEP 4: Buy the Medigap policy.

Once you decide on the insurance company and the Medigap policy you want, you should apply. The insurance company must give you a clearly worded summary of your Medigap policy. Read it carefully. If you don't understand it, ask questions. Remember these when you buy your Medigap policy:

- **Filling out your application.** Fill out the application carefully and completely, including medical questions. The answers you give will determine your eligibility for an Open Enrollment Period or guaranteed issue rights. If the insurance agent fills out the application, make sure it's correct. If you buy a Medigap policy during your Medigap Open Enrollment Period or provide evidence that you're entitled to a guaranteed issue right, the insurance company can't use any medical answers you give to deny you a Medigap policy or change the price. The insurance company can't ask you any questions about your family history or require you to take a genetic test.
- **Paying for your Medigap policy.** You can pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. If buying from an agent, get a receipt with the insurance company's name, address, and phone number for your records. Some companies may offer electronic funds transfer.
- **Starting your Medigap policy.** Ask for your Medigap policy to become effective when you want coverage to start. Generally, Medigap policies begin the first of the month after you apply. If, for any reason, the insurance company won't give you the effective date for the month you want, call your State Insurance Department. See pages 47– 48.

  Note: If you already have a Medigap policy, ask for your new Medigap policy to become effective when your old Medigap policy coverage ends.
- **Getting your Medigap policy.** If you don't get your Medigap policy in 30 days, call your insurance company. If you don't get your Medigap policy in 60 days, call your State Insurance Department.

If you already have a Medigap policy, it's illegal for an insurance company to sell you a second policy unless you tell them in writing that you'll cancel the first Medigap policy. However, don't cancel your old Medigap policy until the new one is in place, and you decide to keep it. See pages 29 and 32.

SECTION

5

If You Already Have a Medigap Policy

You should read this section if any of these situations apply to you:

- You're thinking about switching to a different Medigap policy. See pages 32–35.
- You're losing your Medigap coverage. See page 36.
- You have a Medigap policy with Medicare prescription drug coverage. See pages 36–38.

If you just want a refresher about Medigap insurance, turn to page 11.

Switching Medigap policies

If you're satisfied with your current Medigap policy's cost, coverage, and customer service, you don't need to do anything. If you're thinking about switching to a new Medigap policy, see below and pages 33–35 to answer some common questions about switching Medigap policies.

Can I switch to a different Medigap policy?

In most cases, you won't have a right under federal law to switch Medigap policies, unless you're within your 6-month Medigap Open Enrollment Period or are eligible under a specific circumstance for guaranteed issue rights. But, if your state has more generous requirements, or the insurance company is willing to sell you a Medigap policy, make sure you compare benefits and premiums before switching. If you bought your Medigap policy before 2010, it may offer coverage that isn't available in a newer Medigap policy. On the other hand, Medigap policies bought before 1992 might not be guaranteed renewable and might have bigger premium increases than newer, standardized Medigap policies currently being sold.

If you decide to switch, don't cancel your first Medigap policy until you've decided to keep the second Medigap policy. On the application for the new Medigap policy, you'll have to promise that you'll cancel your first Medigap policy. You have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look period." The 30-day free look period starts when you get your new Medigap policy. You'll need to pay both premiums for one month.

Words in blue are defined on pages 49–50.

Switching Medigap policies (continued)

Do I have to switch Medigap policies if I have a Medigap policy that's no longer sold?

No. But you can't have more than one Medigap policy, so if you buy a new Medigap policy, you have to give up your old policy (except for your 30-day "free look period," described on page 32). Once you cancel the policy, you can't get it back.

Do I have to wait a certain length of time after I buy my first Medigap policy before I can switch to a different Medigap policy?

No. If you've had your old Medigap policy for less than 6 months, the Medigap insurance company may be able to make you wait up to 6 months for coverage of a pre-existing condition. However, if your old Medigap policy had the same benefits, and you had it for 6 months or more, the new insurance company can't exclude your pre-existing condition. If you've had your Medigap policy less than 6 months, the number of months you've had your current Medigap policy must be subtracted from the time you must wait before your new Medigap policy covers your pre-existing condition.

If the new Medigap policy has a benefit that isn't in your current Medigap policy, you may still have to wait up to 6 months before that benefit will be covered, regardless of how long you've had your current Medigap policy.

If you've had your current Medigap policy longer than 6 months and want to replace it with a new one with the same benefits and the insurance company agrees to issue the new policy, they can't write pre-existing conditions, waiting periods, elimination periods, or probationary periods into the replacement policy.

Switching Medigap policies (continued)

Why would I want to switch to a different Medigap policy?

Some reasons for switching may include:

- You're paying for benefits you don't need.
- You need more benefits than you needed before.
- Your current Medigap policy has the right benefits, but you want to change your insurance company.
- Your current Medigap policy has the right benefits, but you want to find a policy that's less expensive.

It's important to compare the benefits in your current Medigap policy to the benefits listed on page 11. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42– 44. To help you compare benefits and decide which Medigap policy you want, follow the "**Steps to Buying a Medigap Policy**" in Section 4. If you decide to change insurance companies, you can call the new insurance company and arrange to apply for your new Medigap policy. If your application is accepted, call your current insurance company, and ask to have your coverage end. The insurance company can tell you how to submit a request to end your coverage.

As discussed on page 32, you should have your old Medigap policy coverage end **after** you have the new Medigap policy for 30 days. Remember, this is your 30-day free look period. You'll need to pay both premiums for one month.

Switching Medigap policies (continued)

Can I keep my current Medigap policy (or Medicare SELECT policy) or switch to a different Medigap policy if I move out-of-state?

In general, you can keep your current Medigap policy regardless of where you live as long as you still have Original Medicare. If you want to switch to a different Medigap policy, you'll have to check with your current or the new insurance company to see if they'll offer you a different Medigap policy.

You may have to pay more for your new Medigap policy and answer some medical questions if you're buying a Medigap policy outside of your Medigap Open Enrollment Period. See pages 14–16.

If you have a Medicare SELECT policy and you move out of the policy's area, you can:

- Buy a standardized Medigap policy from your current Medigap policy insurance company that offers the same or fewer benefits than your current Medicare SELECT policy. If you've had your Medicare SELECT policy for more than 6 months, you won't have to answer any medical questions.
- Use your guaranteed issue right to buy any Plan A, B, C, F, K, or L that's sold in most states by any insurance company.

Your state may provide additional Medigap rights. Call your State Health Insurance Assistance Program or State Department of Insurance for more information. See pages 47–78 for their phone numbers.

What happens to my Medigap policy if I join a Medicare Advantage Plan?

Words in blue are defined on pages 49–50.

Medigap policies can't work with Medicare Advantage Plans. If you decide to keep your Medigap policy, you'll have to pay your Medigap policy premium, but the Medigap policy can't pay any deductibles, copayments, coinsurance, or premiums under a Medicare Advantage Plan. So, if you join a Medicare Advantage Plan, you may want to drop your Medigap policy. Contact your Medigap insurance company to find out how to disenroll. However, if you leave the Medicare Advantage Plan you might not be able to get the same Medigap policy back, or in some cases, any Medigap policy unless you have a "trial right." See page 23. Your rights to buy a Medigap policy may vary by state. You always have a legal right to keep the Medigap policy after you join a Medicare Advantage Plan. However, because you have a Medicare Advantage Plan, the Medigap policy would no longer provide benefits that supplement Medicare.

Losing Medigap coverage

Can my Medigap insurance company drop me?

If you bought your Medigap policy **after 1992**, in most cases the Medigap insurance company can't drop you because the Medigap policy is guaranteed renewable. This means your insurance company can't drop you unless one of these happens:

- You stop paying your premium.
- You weren't truthful on the Medigap policy application.
- The insurance company becomes bankrupt or insolvent.

If you bought your Medigap policy **before 1992**, it might not be guaranteed renewable. This means the Medigap insurance company can refuse to renew the Medigap policy, as long as it gets the state's approval to cancel your Medigap policy. However, if this does happen, you have the right to buy another Medigap policy. See the guaranteed issue right on page 23.

Medigap policies and Medicare prescription drug coverage

If you bought a Medigap policy **before** January 1, 2006, and it has coverage for prescription drugs, see below and page 37.

Medicare offers prescription drug coverage (Part D) for everyone with Medicare. If you have a Medigap policy with prescription drug coverage, that means you chose not to join a Medicare Prescription Drug Plan when you were first eligible. However, you can still join a Medicare drug plan. Your situation may have changed in ways that make a Medicare drug plan fit your needs better than the prescription drug coverage in your Medigap policy. It's a good idea to review your coverage each fall, because you can join a Medicare drug plan between October 15–December 7. Your new coverage will begin on January 1.

Medigap policies and Medicare prescription drug coverage (continued)

Why would I change my mind and join a Medicare drug plan?

In a Medicare Prescription Drug Plan, you may have to pay a monthly premium, but Medicare pays a large part of the cost. There's no maximum yearly amount as with Medigap prescription drug benefits in old Plans H, I, and J (these plans are no longer sold). However, a Medicare drug plan might only cover certain prescription drugs (on its "formulary" or "drug list"). It's important that you check whether your current prescription drugs are on the Medicare drug plan's list of covered prescription drugs before you join.

If your Medigap premium or your prescription drug needs were very low when you had your first chance to join a Medicare drug plan, your Medigap prescription drug coverage may have met your needs. However, if your Medigap premium or the amount of prescription drugs you use has increased recently, a Medicare drug plan might now be a better choice for you.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now?

If you qualify for Extra Help, you won't pay a late enrollment penalty.
If you don't qualify for Extra Help, it will depend on whether your Medigap policy includes "creditable prescription drug coverage." This means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard prescription drug coverage.

If your Medigap policy's drug coverage **isn't** creditable coverage, and you join a Medicare drug plan now, you'll probably pay a higher premium (a penalty added to your monthly premium) than if you had joined when you were first eligible. Each month that you wait to join a Medicare drug plan will make your late enrollment penalty higher. Your Medigap carrier must send you a notice each year telling you if the prescription drug coverage in your Medigap policy is creditable. You should keep these notices in case you decide later to join a Medicare drug plan. You should also consider that your prescription drug needs could increase as you get older.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now? (continued)

If your Medigap policy includes creditable prescription drug coverage and you decide to join a Medicare Prescription Drug Plan, you won't have to pay a late enrollment penalty as long as you don't go 63 or more days in a row without creditable prescription drug coverage. So, don't drop your Medigap policy **before** you join the Medicare drug plan and the coverage starts. You can only join a Medicare drug plan between October 15 –December 7 unless you lose your Medigap policy (for example, if it isn't guaranteed renewable, and your company cancels it). In that case, you may be able to join a Medicare drug plan at the time you lose your Medigap policy.

Can I join a Medicare drug plan and have a Medigap policy with prescription drug coverage?

No. If your Medigap policy covers prescription drugs, you must tell your Medigap insurance company if you join a Medicare drug plan so it can remove the prescription drug coverage from your Medigap policy and adjust your premium. Once the drug coverage is removed, you can't get that coverage back even though you didn't change Medigap policies.

What if I decide to drop my entire Medigap policy (not just the Medigap prescription drug coverage) and join a Medicare Advantage Plan that offers prescription drug coverage?

You need to be careful about the timing because in general, you can only join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) during the Open Enrollment Period between October 15 –December 7. If you join during an Open Enrollment Period, your coverage will begin on January 1 as long as the plan gets your enrollment request by December 7.

SECTION 6

Medigap Policies for People with a Disability or ESRD

Information for people under 65

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD)

You may have Medicare before turning 65 due to a disability or ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

If you're a person with Medicare under 65 and have a disability or ESRD, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65. These states are listed on the next page.

Important: This section provides information on the minimum federal standards. For your state requirements, call your State Health Insurance Assistance Program. See pages 47–48.

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD) (continued)

At the time of printing this guide, these states required insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65:

- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Vermont
- Wisconsin

Note: Some states provide these rights to all people with Medicare under 65, while others only extend them to people eligible for Medicare because of disability or only to people with ESRD. Check with your State Insurance Department about what rights you might have under state law.

Words in blue are defined on pages 49–50.

Even if your state isn't on the list above, some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can probably use medical underwriting. Also, some of the federal guarantee rights are available to people with Medicare under 65, see pages 21-24. Check with your State Insurance Department about what additional rights you might have under state law.

Remember, if you're already enrolled in Medicare Part B, you'll get a Medigap Open Enrollment Period when you turn 65. You'll probably have a wider choice of Medigap policies and be able to get a lower premium at that time. During the Medigap Open Enrollment Period, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare (Part A and/or Part B) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, see pages 16–17. If you have questions, call your State Health Insurance Assistance Program. See pages 47–48.

SECTION 7

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Massachusetts benefits 42
Minnesota benefits 43
Wisconsin benefits 44

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

- **Inpatient hospital care:** covers the Medicare Part A coinsurance plus coverage for 365 additional days after Medicare coverage ends
- **Medical costs:** covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice coinsurance or copayment

The check marks in this chart mean the benefit is covered.

Medigap benefits	Core plan	Supplement 1 Plan
Basic benefits	✓	✓
Part A: inpatient hospital deductible		✓
Part A: skilled nursing facility (SNF) coinsurance		✓
Part B: deductible		✓
Foreign travel emergency		✓
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year
State-mandated benefits (annual Pap tests and mammograms. Check your plan for other state-mandated benefits.)	✓	✓

For more information on these Medigap policies, visit Medicare.gov/find-a-plan, or call your State Insurance Department. See pages 47– 48.

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

- **Inpatient hospital care:** covers the Part A coinsurance
- **Medical costs:** covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice and respite cost sharing
- Parts A and B home health services and supplies cost sharing

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan	Extended basic plan
Basic benefits	✓	✓
Part A: inpatient hospital deductible		✓
Part A: skilled nursing facility (SNF) coinsurance	✓ (Provides 100 days of SNF care)	✓ (Provides 120 days of SNF care)
Part B: deductible		✓
Foreign travel emergency	80%	80%*
Outpatient mental health	20%	20%
Usual and customary fees		80%*
Medicare-covered preventive care	✓	✓
Physical therapy	20%	20%
Coverage while in a foreign country		80%*
State-mandated benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)	✓	✓

Mandatory riders
Insurance companies can offer 4 additional riders that can be added to a basic plan. You may choose any one or all of these riders to design a Medigap policy that meets your needs: 1. Part A: inpatient hospital deductible 2. Part B: deductible 3. Usual and customary fees 4. Non-medicare preventive care

*** Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

Minnesota versions of Medigap Plans K, L, M, N, and high-deductible F are available.

Important: The basic and extended basic benefits are available when you enroll in Part B, regardless of age or health problems. If you are under 65, return to work and drop Part B to elect your employer's health plan, you'll get a 6-month Medigap Open Enrollment Period after you retire from that employer when you can elect Part B again.

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

- **Inpatient hospital care:** covers the Part A coinsurance
- **Medical costs:** covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice coinsurance or copayment

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan
Basic benefits	✓
Part A: skilled nursing facility (SNF) coinsurance	✓
Inpatient mental health coverage	175 days per lifetime in addition to Medicare's benefit
Home health care	40 visits per year in addition to those paid by Medicare
State-mandated benefits	✓

Optional riders
Insurance companies are allowed to offer these 7 additional riders to a Medigap policy: 1. Part A deductible 2. Additional home health care (365 visits including those paid by Medicare) 3. Part B deductible 4. Part B excess charges 5. Foreign travel emergency 6. 50% Part A deductible 7. Part B copayment or coinsurance

For more information on these Medigap policies, visit Medicare.gov/find-a-plan or call your State Insurance Department. See pages 47– 48.

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan ($2,180 deductible for 2016) is also available.

SECTION 8

For More Information

Where to get more information

On pages 47–48, you'll find phone numbers for your State Health Insurance Assistance Program (SHIP) and State Insurance Department.

- Call your SHIP for help with:
  - Buying a Medigap policy or long-term care insurance.
  - Dealing with payment denials or appeals.
  - Medicare rights and protections.
  - Choosing a Medicare plan.
  - Deciding whether to suspend your Medigap policy.
  - Questions about Medicare bills.
- Call your State Insurance Department if you have questions about the Medigap policies sold in your area or any insurance-related problems.

How to get help with Medicare and Medigap questions

If you have questions about Medicare, Medigap, or need updated phone numbers for the contacts listed on pages 47– 48:

Visit Medicare.gov:

- For Medigap policies in your area, visit Medicare.gov/find-a-plan.
- For updated phone numbers, visit Medicare.gov/contacts.

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

Customer service representatives are available 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know the language.

State Health Insurance Assistance Program and State Insurance Department

State	State Health Insurance Assistance Program	State Insurance Department
Alabama	1-800-243-5463	1-800-433-3966
Alaska	1-800-478-6065	1-800-467-8725
American Samoa	Not available	1-684-633-4116
Arizona	1-800-432-4040	1-800-325-2548
Arkansas	1-800-224-6330	1-800-224-6330
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7421	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-4422
Illinois	1-217-524-6911	1-888-473-4858
Indiana	1-800-452-4800	1-800-622-4461
Iowa	1-800-351-4664	1-877-955-1212
Kansas	1-800-860-5260	1-800-432-2484
Kentucky	1-877-293-7447	1-800-595-6053
Louisiana	1-800-259-5300	1-800-259-5301
Maine	1-877-353-3771	1-800-300-5000
Maryland	1-800-243-3425	1-800-492-6116
Massachusetts	1-800-243-4636	1-877-563-4467
Michigan	1-800-803-7174	1-877-999-6442
Minnesota	1-800-333-2433	1-800-657-3602
Mississippi	1-800-948-3090	1-800-562-2957
Missouri	1-800-390-3330	1-800-726-7390
Montana	1-800-551-3191	1-800-332-6148
Nebraska	1-800-234-7119	1-800-234-7119

State	State Health Insurance Assistance Program	State Insurance Department
Nevada	1-800-307-4444	1-800-992-0900
New Hampshire	1-866-634-9412	1-800-852-3416
New Jersey	1-800-792-8820	1-800-446-7467
New Mexico	1-800-432-2080	1-888-727-5772
New York	1-800-701-0501	1-800-342-3736
North Carolina	1-800-443-9354	1-800-546-5664
North Dakota	1-800-247-0560	1-800-247-0560
Northern Mariana Islands	Not available	1-670-664-3064
Ohio	1-800-686-1578	1-800-686-1526
Oklahoma	1-800-763-2828	1-800-522-0071
Oregon	1-800-722-4134	1-888-877-4894
Pennsylvania	1-800-783-7067	1-877-881-6388
Puerto Rico	1-877-725-4300	1-888-722-8686
Rhode Island	1-401-462-0510	1-401-462-9500
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 1-340-714-4354 (St. Thomas)	1-340-774-7166
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-994-6272	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION 9

Definitions

Where words in BLUE are defined

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

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

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

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

Excess charge—If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Guaranteed issue rights—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed renewable policy—An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical underwriting—The process that an insurance company uses to decide, based on your medical history, 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.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

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

Medicare prescription drug plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

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, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Medicare Part B, **and** you're 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional Open Enrollment rights under state law.

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

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Insurance Department—A state agency that regulates insurance and can provide information about Medigap policies and other private health insurance.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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