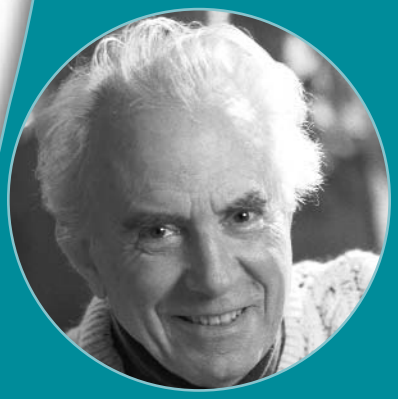
2004

Choosing A Medigap Policy:

A Guide To Health Insurance For People With Medicare



Use this Guide to learn about an important way to help you cover health care costs.

This official government guide can help you:

- Learn what a Medigap policy is.
- Decide if you want to buy a Medigap policy.
- Understand when you can buy a Medigap policy.
- Choose the Medigap policy that best meets your needs.
- Know where to go if you have questions.

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

How to use this Guide

There are two ways to find the information you need:

1. The "Table of Contents" on pages 1–2 can help you find the sections you need to read.

2. The "Index" on pages 88–89 lists every topic in this Guide and the page number to find it on.

Tip: Pages 6, 30, 40, and 86 are **"Notes Pages."** Use these pages to write down any questions you might have or information you gather.

The *2004 Choosing A Medigap Policy: A Guide To Health Insurance For People With Medicare* isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

The information in this Guide was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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Welcome

This guide was written to help people with Medicare make good health care coverage decisions. When you first enroll in Medicare, or if you later want to change how you get your Medicare benefits or other health care coverage (such as buying a Medigap policy), you need to look at all the options you have to help you:

- Get the best coverage you can afford, and
- Reduce your out-of-pocket health care costs.

Words in green are defined on pages 82–85.

This guide explains in detail how Medigap (Medicare Supplement Insurance) policies work with the Original Medicare Plan. A Medigap policy is private insurance that supplements, or helps you pay for some of the costs that Medicare doesn't pay for.

Before you decide whether or not to buy a Medigap policy, there are a few things you should know about Medicare and Medicare health plans. Below is a quick look at how Medicare health plans work with Medigap policies.

If you already know about Medicare and Medicare health plans, turn to Section 1 "Medigap Overview," which starts on page 7.

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has:

- Medicare Part A (Hospital Insurance), and
- Medicare Part B (Medical Insurance)

For more information about Medicare Part A and Part B, see pages 56–64.

Welcome

What are Medicare Health Plans?

Medicare health plans provide different ways to get your health care coverage in the Medicare program. Your Medicare health plan choices include:

- The Original Medicare Plan - Available nationwide. If you have this plan, you may want to buy a Medigap policy.
- Medicare Advantage (formerly Medicare + Choice) Plans - Available in many areas. If you have one of these plans, you don't need a Medigap policy. Medicare Advantage Plans include:
  - Medicare Managed Care Plans
  - Medicare Preferred Provider Organization Plans (PPO)
  - Medicare Private Fee-for-Service Plans
  - Medicare Specialty Plans

Words in green are defined on pages 82–85.

The Medicare health plan that you choose affects many things like cost, benefits, doctor choice, convenience, and quality. No matter how you choose to get your health care, you are still in the Medicare program.

For help comparing your Medicare health plan choices, use the "Medicare Personal Plan Finder" at www.medicare.gov on the web. See page 36 for details. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Original Medicare Plan and Medigap Policies at a glance

If you get your health care from the Original Medicare Plan, you use your red, white, and blue Medicare card (see sample card on page 19) to get your health care. Usually you don't have to pay a monthly premium for Medicare Part A. If you want to get Medicare Part B covered services, you **must** pay the monthly premium of $66.60 in 2004 for Medicare Part B. However, you don't need Medicare Part B to be in the Original Medicare Plan. Generally, you must have Medicare Part A and Part B to buy a Medigap policy.

The Original Medicare Plan pays for many health care services and supplies, but it doesn't pay **all** of your health care costs. There are costs that you **must** pay, like coinsurance, copayments, and deductibles. These costs are called "gaps" in Medicare coverage.

Original Medicare Plan and Medigap policies at a glance (continued)

You might want to consider buying a Medigap policy to cover these gaps in Medicare coverage. Some Medigap policies also cover other extra benefits that aren't covered by Medicare, like routine yearly check-ups, at-home recovery, and emergency health care while traveling outside the U.S. A Medigap policy may help you save on out-of-pocket costs. If you buy a Medigap policy you will also have to pay a monthly premium to the private insurance company.

Medigap policies only help pay health care costs if you are in the Original Medicare Plan. For a list of Medicare-covered services, see pages 57–60. To learn what Medigap policies cover, see pages 33–35.

Medicare Advantage Plans at a glance

Medicare Advantage is the new name for Medicare + Choice. If you decide to join a Medicare Advantage Plan, then you will use the health care card that you get from your Medicare Advantage Plan (provider) for your health care. These plans often give you more choices and, sometimes, extra benefits, like extra days in the hospital.

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of $66.60 (in 2004) to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer. You should call the Medicare Advantage Plan that you're interested in to find out what extra benefits they offer and how much your monthly premium will be.

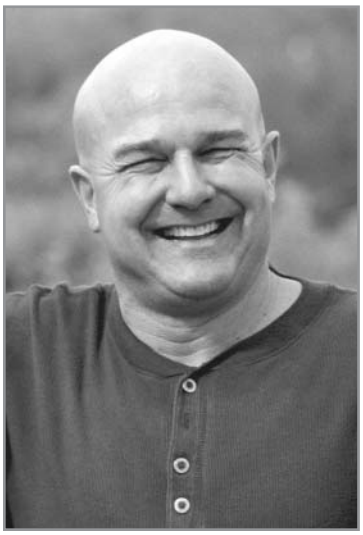
Note: Medicare Advantage Plans aren't Medigap policies.

If you're in a Medicare Advantage Plan, you don't need a Medigap policy because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover, like extra days in the hospital after you used the number of days that Medicare pays for.

Need more information?

For more information about Medicare health plans, get a free copy of the *Medicare & You* handbook (CMS Pub. No. 10050) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Notes



"I keep this book on my shelf so I know where to find it if I have a question."

section 1

Medigap Overview

This section includes information about what Medigap policies are, what they cover and don't cover, cost information, and more.

What is a Medigap policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in the Original Medicare Plan. Medigap policies help you pay some of the health care costs that the Original Medicare Plan doesn't cover. If you are in the Original Medicare Plan and have a Medigap policy, then Medicare will pay its share and your Medigap policy will pay its share of your health care costs.

Important: Starting January 1, 2006, there will be changes to some Medigap policies. See page 20 for more information.

Currently, there are ten standardized Medigap plans called "A" through "J." Medigap policies must follow Federal and State laws. These laws protect you. The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance." **Each plan, A through J, has a different set of benefits**. Plan A covers only the basic (core) benefits, listed on page 12. These basic benefits are included in all the Medicare plans (A through J). Medigap Plans B through J offer extra benefits (see page 13). Plan J offers the most benefits.

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, different types of standardized Medigap policies are sold in your State (see pages 74–76).

Insurance companies can only sell you one of the ten standardized Medigap policies. Medigap policies are standardized so you can compare them easily. Two of the standardized Medigap policies may have a high deductible option (see page 16). In addition, any standardized Medigap policy may be sold as a "Medicare SELECT" policy (see page 17). No matter where you live (except for Massachusetts, Minnesota, and Wisconsin) Medigap policies must offer the same benefits within Medigap plans (A through J). See page 13 for a list of the ten standardized Medigap policies.

It's important to compare Medigap policies because costs can vary. Remember, the standardized Medigap policies that insurance companies offer must provide the same benefits. The only difference between Medigap policies sold by different insurance companies might be the cost. Also, insurance companies that sell Medigap policies don't have to offer each Medigap plan (A through J). Each insurance company decides which Medigap policies they want to sell. Make sure the insurance company offers the Medigap policy that you want.

Generally, when you buy a Medigap policy you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of $66.60 (in 2004) to Medicare. In addition, you will have to pay a premium to the Medigap insurance company. As long as you pay your premium, your Medigap policy is guaranteed renewable. This means it is automatically renewed each year. Your coverage will continue year after year as long as you pay your premium.

You and your spouse must buy separate Medigap policies. **Your Medigap policy won't cover any health care costs for your spouse**.

Important: In some States, insurance companies may refuse to renew a Medigap policy bought before 1990. At the time these Medigap policies were sold, State law might not have required that Medigap policies be guaranteed renewable.

Words in green are defined on pages 82–85.

Medigap policies only help pay health care costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you are in a Medicare Advantage Plan (like a Medicare Managed Care Plan). In fact, it is illegal for anyone to sell you a Medigap policy if they know you are in one of these plans.

It is also illegal for an insurance company to sell you a Medigap policy if you have health insurance coverage through your State Medicaid program. There are certain exceptions (see page 69).

What isn't a Medigap policy?

A Medigap policy isn't:

- Coverage you get from your employer or union,
- A Medicare Advantage (formerly Medicare + Choice) Plan,
- Medicare Part B, or
- Medicaid.

Why would I want to buy a Medigap policy?

You may want to buy a Medigap policy because Medicare doesn't pay for all of your health care. There are "gaps" or costs that you must pay in the Original Medicare Plan. The chart on the next page gives some examples of these gaps. A Medigap policy will cover some, but not all the gaps in the Original Medicare Plan.

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

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

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

- Whether your doctor or supplier accepts "assignment" (This means he or she takes the Medicare-approved amount as payment in full),
- How often you need health care,
- What type of health care you need,
- Whether you buy a Medigap policy,
- Which Medigap policy you buy, and
- Whether you have other health insurance.

Some examples of gaps in Medicare-covered services What YOU Pay in 2004 (These amounts can change each year.)		A Medigap policy may help pay these costs
Hospital Stays	**For each benefit period YOU PAY:** • $876 for the first 60 days • $219 per day for days 61–90 • $438 per day for days 91–150	✓
Skilled Nursing Facility Stays	**For each benefit period YOU PAY:** • Nothing for the first 20 days • Up to $109.50 per day for days 21–100	✓
Blood	**YOU PAY** the cost of the first three pints.	✓
Medicare Part B Yearly Deductible	**YOU PAY** the $100 per year deductible. This will go up to $110 in 2005.	✓
Medicare Part B Covered Services	**YOU PAY:** • 20% of Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment* • Copayment for outpatient hospital services	✓

Note: Some Medigap policies also cover other extra benefits that aren't covered by Medicare. Some examples of these benefits include the following:

- Routine yearly check-ups,
- At-home recovery,
- Medicare Part B excess charges (the difference between your doctor's charge and the Medicare-approved amount) that only apply if your doctor doesn't accept assignment,
- Prescription drugs,**
- And more (see page 13).

* All Medigap policies sold today must pay 50% coinsurance for outpatient mental health treatment services.

** Starting January 1, 2006, there will be a change in Medigap policies that cover prescription drugs. Medigap Plans H, I, and J may still be sold, but without the prescription drug benefit.

Who can buy a Medigap policy?

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

More information about Medigap policies for people under age 65 starts on page 51.

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

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

What is Medicare SELECT?

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

You don't need a Medigap policy if you are in a Medicare Advantage Plan.

What isn't covered by Medigap policies?

- Long-term care,
- Vision or dental care,
- Hearing aids,
- Private-duty nursing, or
- "Unlimited" outpatient prescription drugs.

Note: Medigap Plans H, I, and J currently cover some outpatient prescription drugs (see page 13). This will change in 2006 (see page 20).

What do Medigap policies cover?

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 74–76.

Each standardized Medigap policy **must** cover basic (core) benefits (see below). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance and outpatient copayment amounts. These policies may also cover Original Medicare Plan deductibles. Some Medigap policies cover extra benefits to help pay for things Medicare doesn't cover (see page 13).

Note: Medigap Plans F and J have a high deductible option (see page 16). You must pay the deductible first before the Medigap policy pays anything.

Medigap Plans A through J basic (core) benefits include:

Basic (core) benefit	What Medigap policies pay in 2004 (These amounts can change each year.)
Medicare Part A coinsurance and hospital benefits	**Medigap policies pay:** • $219 per day for days 61–90 of a hospital stay. • $438 per day for days 91–150 of a hospital stay. • Up to 365 more days of a hospital stay during your lifetime after you use all Medicare hospital benefits.
Medicare Part B coinsurance or copayment	**Medigap policies** cover you after you meet the Part B $100 yearly deductible. This will go up to $110 in 2005.
Blood	**Medigap policies pay** for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.

See page 13 for more information about Medigap Plans A through J.

Types of Medigap policies: Medigap Plans A through J

Medigap policies (including Medicare SELECT) can only be sold in ten standardized plans. This chart gives you a quick look at all the Medigap plans and their benefits. Read down to find out what benefits are in each plan. If you need more information, call your State Insurance Department (see pages 79–80).

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible
		Medicare Part B Deductible			Medicare Part B Deductible				Medicare Part B Deductible
					Medicare Part B Excess Charge (100%)	Medicare Part B Excess Charge (80%)		Medicare Part B Excess Charge (100%)	Medicare Part B Excess Charge (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	Extended Drug Benefit ($3,000 Limit)
				Preventive Care **					Preventive Care **

* Plans F and J also have a high-deductible option (see page 16).

** Medigap policies cover some preventive care that isn't covered by Medicare.

Important Notes

- All Medigap plans must cover the basic benefits listed on **page 12.**
- For details about the Medigap plan extra benefits listed in the chart (Skilled Nursing Coinsurance, Medicare Part A and Part B Deductible, Medicare Part B Excess Charge, Foreign Travel Emergency, At-Home Recovery, Prescription Drugs, and Preventive Care), see **pages 34–35**.
- This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin, see **pages 74–76**.
- Starting January 1, 2006, you won't be able to buy Medigap policies covering prescription drugs (see page 20). For more information about Medigap policies or the new Medicare prescription drug benefit, look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder" or "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227).

How much do Medigap policies cost?

The cost of Medigap policies can vary widely. **There can be big differences in the premiums that insurance companies charge for exactly the same coverage**. As you shop for a Medigap policy, be sure you are comparing the same Medigap policy (Plans A through J). Although this Guide **can't** give actual costs of Medigap policies, you can get this information by calling insurance companies, or by looking at the "Medicare Personal Plan Finder" at www.medicare.gov on the web. For more information about the Medicare Personal Plan Finder, see page 36.

How do insurance companies set the price of Medigap premiums?

Each insurance company sets the price of their policy premiums. How they set the price affects how much you pay. The **examples** below and on the next page help show how costs may vary based on how insurance companies set their premiums. Monthly premiums may vary by insurance company and by Medigap policy (Plans A through J). The amounts in the examples **aren't** actual costs.

1. Pricing based on one price for everyone who buys the same policy.

Some insurance companies charge the same monthly premium for everyone with the same Medigap policy, regardless of age. Insurance companies call these "community-rated (or no-age-rated) policies."

Premiums for these Medigap policies remain the same except for inflation. Premiums may be higher for younger buyers at first than for policies priced by age. However, if you keep this policy for a while, the premiums will eventually be lower than those policies priced by age.

Example: Premium based on same premium for everyone

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 policy, everyone pays the same price.

2. Pricing based on your age when you first buy the policy.

An insurance company can base your monthly premium on the age you are when you buy their Medigap policy. Insurance companies call these "issue-age-rated policies." Premiums are lower for younger buyers. Premiums for these policies won't go up each year as you get older except for inflation.

Example: Premium based on your age when you first buy the policy

Mr. Han is 66. He buys a Medigap policy and pays a $160 monthly premium.

Mrs. Wright is 73. She buys the same Medigap policy as Mr. Han. Since she is older at the time of purchase, her monthly premium is $175.

3. Pricing based on your current age.

Note: Look at page 24 if you are thinking about switching Medigap policies to save money.

An insurance company can base your monthly premium on your current age so your premium goes up each year. Insurance companies call these "attained-age-rated polices." They may also go up because of inflation.

Premiums for these Medigap policies are usually the lowest at first for younger buyers. However, the premiums go up every year and can eventually become the most expensive.

Example: Premium based on current age

Mrs. Anderson buys a Medigap policy at age 65. She pays a $140 monthly premium. Her premium will go up every year.

- At age 66 her premium will go up to $146.
- At age 67 her premium will go up to $152.

Mr. Dodd buys his Medigap policy at age 72. He pays a $180 monthly premium. His premium is higher than Mrs. Anderson's because it is based on his current age. Mr. Dodd's premium will go up every year as he gets older.

- At age 73 his premium will go up to $185.
- At age 74 his premium will go up to $190.

Are there other factors that may affect the cost of my Medigap policy?

Yes. The cost of your Medigap policy may be affected

- **By Discounts:** Insurance companies may offer discounts to females, non-smokers, and/or if you are married.
- **By Medical Underwriting:** Some insurance companies may use medical underwriting. You must answer medical questions on an application. Fill it out carefully and completely or your Medigap policy could be voided. The insurance company uses this information to decide whether to sell you a Medigap policy, how much they will charge you, and whether you will have to wait for coverage to start. Some companies may add a waiting period for pre-existing conditions if your State law allows (see page 21).

  Insurance companies can't use medical underwriting if you are in your Medigap open enrollment period (see pages 18–20) or you have special rights (called Medigap protections) to buy a Medigap policy (see page 42).
- **If you buy a high-deductible option:** Insurance companies may offer a "high-deductible option" on Medigap Plans F and J (see chart on page 13). If you choose this option, you must pay the first $1,690 in Medigap-covered costs (the deductible in 2004) before the Medigap policy pays anything. This amount can change each year.

  High-deductible option policies often have lower premiums, but if you need a lot of Medicare covered health care services, supplies, and equipment, your out-of-pocket costs will be higher. You may not be able to change plans.

  In addition to the $1,690 (in 2004) deductible that you must pay for the high-deductible option for Plans F and J, you must **also** pay deductibles for:

  - Prescription drugs ($250 per year for Plan J only, because Plan F doesn't cover prescription drugs), and
  - Foreign travel emergency ($250 per year for Plans F and J).

Words in green are defined on pages 82–85.

Are there other factors that may affect the cost of my Medigap policy? (continued)

- **If you buy a Medicare SELECT policy:** Medicare SELECT is a type of Medigap policy sold by some insurance companies in some States. If you buy a Medicare SELECT policy, you are buying one of the ten standardized Medigap Plans A through J. Medigap SELECT policies require you to use specific hospitals and, in some cases specific doctors to get full insurance benefits (except in an emergency). Generally, Medicare SELECT policies cost less than other Medigap policies.

  If you have a Medicare SELECT policy and you don't use a Medicare SELECT hospital or doctor for non-emergency services, your costs will be higher. You will 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.

Words in green are defined on pages 82–85.

When is the best time to buy a Medigap policy?

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

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

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

Once your six-month Medigap open enrollment period starts, it can't be changed.

During this period, an insurance company can't:

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

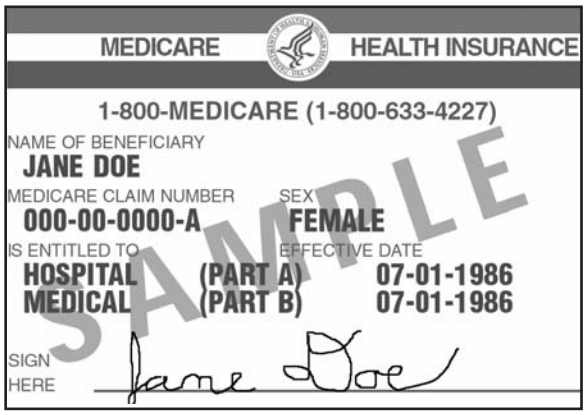
If you buy a Medigap policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions (see page 21) by the amount of previous health coverage you have. This is called "creditable coverage" (see page 22).

If you are eligible for Medicare because you're disabled or have End-Stage Renal Disease (ESRD), see pages 51–54.

Words in green are defined on pages 82–85.

How can I tell if I'm in my Medigap open enrollment period?

You can tell if you are in your Medigap open enrollment period by looking at your red, white, and blue Medicare card (see sample card on the next page). The lower right corner of this card shows the dates that your Medicare Part A and Part B coverage started. If you are age 65 or older, add six months to the date that your Medicare Part B coverage starts. If that date is in the future, you are still in your Medigap open enrollment period. If that date is in the past, you have missed your Medigap open enrollment period (see example on the next page).



Note: There are earlier versions of this card that are slightly different. They are still valid.

Example: Medigap Open Enrollment Period

It is October 1, 2004, and Mr. Rodriguez wants to buy a Medigap policy. He needs to know if he is in his Medigap open enrollment period. He looks at his Medicare card. His Medicare Part B coverage started August 1, 2004. To figure out if he is in his open enrollment period, he must add six months to his Medicare Part B start date and see if it is before or after the current date.

August 1, 2004 + six months = January 31, 2005

Since it is October 1, 2004, he is still in his open enrollment period. Mr. Rodriguez has until January 31, 2005, to buy a Medigap policy during his Medigap open enrollment period.

What if I missed my Medigap open enrollment period?

If you apply for a Medigap policy after your open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting (see page 16) to decide whether to accept your application, and how much to charge you for the policy. If you are in good health, the insurance company is likely to accept your application, but there is no guarantee that you will get the Medigap policy (unless you become eligible for one of the Medigap protections listed on page 43).

Should I enroll in Medicare Part B and start my Medigap open enrollment period if I am age 65 or older and still working or covered under my spouse's plan?

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

However, if your employer group health plan pays after (or "secondary to") Medicare, it may require you to enroll in Medicare Part B in order to get benefits under that plan.

What is the Medicare Modernization Act of 2003 and how will it affect Medigap policies?

The Medicare Modernization Act of 2003 is bringing many new and exciting changes to the Medicare program. These new changes will give you even more choices in how you get your health care benefits, including coverage for prescription drugs.

Starting January 1, 2006, some Medigap policies will change because of the Medicare Modernization Act. After that date, you won't be able to buy Medigap policies that cover prescription drugs. This is because Medicare will offer prescription drug coverage in 2006. Medigap Plans H, I, and J may still be sold, but without the prescription drug benefit. If you already have a Medigap policy that covers prescription drugs, you may be able to keep it under certain conditions. In addition, new types of Medigap policies might be available. More information about these changes will be available in 2005.

If you have questions about Medigap policies or the new Medicare prescription drug benefit, you can look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder" or "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Pre-existing conditions

What is a pre-existing condition?

A pre-existing condition is a health problem you had before the date a new insurance policy starts.

Words in green are defined on pages 82–85.

Will my pre-existing condition be covered if I buy a Medigap policy?

In some cases, if you have a health problem before your Medigap policy started, a Medigap insurance company can refuse to cover that health problem for up to six months. This is called a "pre-existing condition waiting period." The insurance company can only use this kind of waiting period if your health problem was diagnosed or treated during the six months before the Medigap policy started. This means that the insurance company can't make you wait for coverage of a pre-existing condition just because it thinks you should have known to see a doctor for a health problem.

Medigap open enrollment period

If you buy a Medigap policy during your Medigap open enrollment period, and you had at least six months of previous health coverage that qualifies as "creditable coverage" (see page 22), the company can't give you a pre-existing condition waiting period. If you had less than six months of creditable coverage, this waiting period will be reduced by the number of months of creditable coverage you had.

Special Medigap Protections (Guaranteed Issue Rights)

If you buy a Medigap policy when you have special Medigap protections (also called guaranteed issue rights), the insurance company can't use a pre-existing condition waiting period. For more information about Medigap protections, see page 42.

If you want to know if you will have a pre-existing condition waiting period if you switch Medigap policies, see page 24.

Creditable coverage

What is creditable coverage?

Creditable coverage is generally any other health coverage you had before you applied for the Medigap policy. If you buy a Medigap policy during your Medigap open enrollment period, creditable coverage can reduce the time you have to wait before your pre-existing health problems will be covered by the Medigap policy.

These types of coverage count as creditable coverage:

- A group health plan (like an employer or union plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid (see page 69)
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool (sometimes called a state high risk pool)
- TRICARE (the health care program for military dependents and retirees [see page 71])
- A Federal Employees Health Benefit Plan
- A public health plan
- A health plan under the Peace Corps Act

Important: Whether you had creditable coverage depends on whether you had any "breaks in coverage" when you were without health coverage of any kind for more than 63 days in a row. You can only count creditable coverage that you had after that break in coverage. If you have had one or more breaks in coverage, but each break was shorter than 63 days, then you can add the periods of coverage together. This will count towards your creditable coverage.

Note: Hospital indemnity insurance, specified disease insurance, vision or dental policies, and long-term care policies aren't considered creditable coverage.

What is credible coverage? (continued)

Example: Creditable Coverage

Mr. Smith is 65 and is being treated for heart disease. His Medicare Part A and Part B started November 1, 2003. Before this date, he had no health insurance coverage. On March 1, 2004, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for six months (the pre-existing condition waiting period). However, since Mr. Smith had Medicare Part A and Part B from November 1 to March 1, the insurance company must use his four months of Medicare coverage as creditable coverage to shorten this six-month waiting period. Now his waiting period will only be two months instead of six months. During these two months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease. He will also have to pay his Medigap premiums. The Medigap policy will pay for other covered care.

Switching (Changing) Medigap policies

What if I want to switch to a different Medigap policy?

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

Words in green are defined on pages 82–85.

If you decide to switch, don't cancel your first Medigap policy until the second Medigap policy is in place, and you have decided to keep the second Medigap policy. Once you have applied for the second Medigap policy, you have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look" period.

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

No, but the length of time you had your policy will affect how your new policy covers you for pre-existing conditions. Your new Medigap policy generally must cover all pre-existing conditions if you have had your current policy at least six months.

Your new Medigap policy might not cover all pre-existing conditions if you've had your current Medigap policy for less than six months. However, the amount of time you've had your current Medigap policy must count towards the amount of time you must wait before your new policy covers your pre-existing condition.

If there is a benefit in the new Medigap policy that wasn't in your old policy, the company can make you wait up to six months before covering you for that benefit.

Do I have to switch Medigap policies if I have an older Medigap policy?

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

Losing Medigap coverage

Can my Medigap insurance company drop me?

In most cases, no. If you bought your Medigap policy after 1990, the law says that your insurance company must automatically renew your Medigap policy as long as you pay your premium. This means that the policy is guaranteed renewable. Your insurance company can drop you if you lie (for example, you commit fraud under the policy). Other than that, there is only one situation where you may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, and State law doesn't make some other coverage available, you have the right to buy a Medigap Plan A, B, C, or F that is sold in your State (see Medigap Protections, Situation #6 on page 48).

Words in green are defined on pages 82–85.

Insurance companies in some States may refuse to renew Medigap policies that you bought before 1990. This is because these old Medigap policies may not have been required to be guaranteed renewable. In order for an insurance company to refuse to renew one of these older Medigap policies, the company must get the State's approval and cancel all Medigap policies of this type that they sold in your State. If this happens, you have the right to buy a Medigap Plan A, B, C, or F that is sold in your State (see example below and Medigap Protections, Situation #6 on page 48).

Example: Guaranteed renewable

In 1987, Mr. Jones bought a Medigap policy. The Medigap policy Mr. Jones bought isn't guaranteed renewable because he bought it before 1990, and it didn't say it was guaranteed renewable. The insurance company won't renew Mr. Jones's policy because it has decided (and got the State's approval) to cancel all Medigap policies of this type in the State. Therefore, Mr. Jones has the right to buy Medigap Plan A, B, C, or F that is sold in his State from any insurance company that offers them.

How your bills get paid

Does the Medigap insurance company pay my doctor or provider directly?

Words in green are defined on pages 82–85.

In most cases, Medigap claims are sent directly to the insurance company because most Medigap insurance companies arrange to get your claims information directly from Medicare carriers. A Medicare carrier is a private company that has a contract with Medicare to pay Part B bills.

However, if your Medigap insurance company doesn't have this automatic claims service, you can arrange to have your claims sent directly to your Medigap insurance company so your doctor or provider is paid directly.

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

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

What happens if my Medigap insurance company doesn't pay my doctor or provider directly?

If the Medigap insurance company doesn't pay your doctor directly when the above two conditions are met, you should report this to your State Insurance Department (see pages 79–80). For more information on Medigap claim filing by the Medicare carrier, call your Medicare carrier. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number of the Medicare carrier in your State. TTY users should call 1-877-486-2048.

Private contracts

What is a private contract?

Some doctors don't accept Medicare payments. If you want to get care from a doctor who doesn't accept Medicare payment, you may be asked to sign a private contract.

A private contract is a written agreement between you and a doctor (like a physician, podiatrist, dentist, or optometrist) who has **decided not to give** services through the Medicare program. The private contract only applies to the services you get from the doctor who asked you to sign it. You can't be asked to sign a private contract in an emergency situation or when you get urgently needed care.

Note: You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor:

- You will have to pay whatever this doctor or provider charges you for the services you get. Medicare's limiting charge won't apply.
- No claim will be sent to Medicare, and Medicare won't pay if one is submitted.
- Your Medigap policy, if you have one, won't pay anything for this service.
- Medicare health plans won't pay any amount for the services you get from this doctor.
- Many other insurance plans won't pay for the services either. Call your insurance company before you get the service if you have any questions.
- Your doctor must tell you whether Medicare would pay for the service if you get it from another doctor who participates in Medicare.
- Your doctor must tell you if he or she has opted out of or been excluded from the Medicare program.

It is important that you talk to someone in your State Health Insurance Assistance Program before signing a private contract (see pages 79–80).

You can always choose to get services not covered under Medicare and pay for these services yourself. In this case, you don't have to sign a private contract, and your doctor doesn't have to stop giving services through Medicare.

Watch out for illegal insurance practices

It is illegal for anyone to do the following:

- Pressure you into buying a Medigap policy, or lie 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 (see page 69).
- Sell you a Medigap policy if they know you are in a Medicare Advantage (formerly Medicare + Choice) Plan.
- Claim that a Medigap policy is part of the Medicare program or any other Federal program. Remember, Medigap is private health insurance.
- Sell you a Medigap policy that can't legally be sold in your State. Check with your State Insurance Department (see pages 79–80) to make sure that the Medigap plan you are interested in can be sold in your State.
- Misuse the names, letters, symbols, or emblems of the U. S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare.

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). In most cases, however, your State Insurance Department can help you with insurance-related problems (see pages 79–80).

Ways to check if an insurance company is reliable

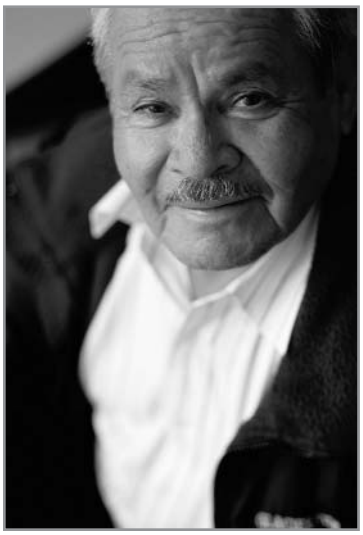
Buying a Medigap policy is an important decision. You want to make sure that you are buying from a reliable insurance company.

Words in green are defined on pages 82–85.

To help you find out if an insurance company is reliable, you can take the following actions:

- Call the State Insurance Department in your State (see pages 79–80). Ask if they keep a record of complaints against insurance companies and ask whether these can be shared with you.
- Call the State Health Insurance Assistance Program in your State (see pages 79–80). These programs can give you free help with choosing a Medigap policy.
- Go to your local public library. Your local public library can help you:
  - Get information on an insurance company's financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poors, and
  - Look at information on the web.
- Talk to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy.

Notes



"I used this section to learn about Medigap policies."

section 2

Steps to Buying a Medigap Policy

This section provides useful steps to help you choose the best Medigap policy for you.

Steps to buying a Medigap policy

Buying a Medigap policy is an important decision. Only you can decide if a Medigap policy is the right kind of Medicare supplement health insurance coverage for you. If you decide to buy a Medigap policy, shop carefully. Look for a Medigap policy that you can afford and that gives you the coverage you need most. As you shop for a Medigap policy, keep in mind that different insurance companies may charge different amounts for the same type of Medigap policy, and not all insurance companies offer all of the Medigap policies.

The steps to buying a Medigap policy include the following:

STEP 1: Look at which benefits best meet your needs (see below and pages 33–35).

STEP 2: Find out which insurance companies sell Medigap policies in your State (see page 36).

STEP 3: Call the insurance companies and compare costs (see page 37).

STEP 4: Choose the best Medigap policy for you (see page 38).

STEP 5: Buy the Medigap policy (see page 39).

STEP 1. Look at which benefits best meet your needs.

Use the chart on pages 33–35 to help you decide which Medigap policy benefits you need. It will also help you when you begin to shop for the Medigap policy that is right for you.

Important: You should think about your current and future health care needs, and place a checkmark next to those benefits you think you may need or want. As you get older, your health care needs might increase.

After you have checked off all of the benefits you need or want on pages 33–35, you should find out which insurance companies sell Medigap policies in your State that cover those benefits (see page 36).

Medigap Basic (Core) Benefits

Remember, Medigap Plan A covers only the basic (core) benefits listed below. Medigap Plans B through J include the basic (core) benefits and some extra benefits. See the next page for the extra benefits.

Note: This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin, see pages 74–76. The amounts shown in this chart are for 2004. These amounts can change each year.

✔ Check the box next to the benefits you feel you may need or want. Use this information when talking to insurance companies to help choose the Medigap policy you want. Insurance companies usually offer some, but not all, of the Medigap plans.

✔	Benefit	What *Medicare* pays in 2004…	What *you* pay in 2004 if you *don't* have a Medigap Policy…	What *you* pay in 2004 if you *have* a Medigap Policy that covers this benefit…	Medigap policies that cover this benefit
	Medicare Part A hospital benefits	Medicare pays its share of a covered hospital stay.	You pay… • $219 per day for days 61–90 of the hospital stay. • $438 per day for days 91–150 of the hospital stay. • All costs for each additional day after the 150th day of the hospital stay after you have used all your lifetime reserve days.	You pay… • Nothing for days 61–90 of the hospital stay. • Nothing for days 91–150 of the hospital stay. • No costs that Medicare would have paid for up to 365 more days of hospital stays during your lifetime after you use all Medicare hospital benefits. • All costs after you have used all Medicare hospital benefits and the 365 days of additional Medigap hospital stay coverage.	A B C D E F G H I J
	Medicare Part B coinsurance or copayment	Medicare pays nothing for your first $100* (yearly deductible) of Part B covered services. Then it generally pays 80% of the Medicare-approved amount for Medicare Part B covered services and supplies.	After you pay for the first $100* (yearly deductible) of Part B covered services (like doctor services and outpatient hospital care), you generally pay 20% of the Medicare-approved amount for Medicare Part B covered services and supplies.	After you pay for the first $100* (yearly deductible) of Part B covered services (like doctor services and outpatient hospital care), you generally pay nothing for any Medicare-approved amount for Medicare Part B covered services and supplies.	A B C D E F G H I J
	Blood	Medicare pays nothing for the first 3 pints of blood or equal amounts of packed red blood cells per calendar year.	You pay the total cost for the first 3 pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.	You pay nothing for the first 3 pints of blood or equal amounts of packed red blood cells per calendar year.	A B C D E F G H I J

* The Medicare Part B deductible will go up to $110 in 2005.

Medigap Extra Benefits

Extra Medigap benefits, and the Medigap policies that cover them, are shown below. Look to see which Medigap policies cover the benefits you are most interested in (see the last column). Keep in mind, extra benefits will increase your monthly premium, but may save you out-of-pocket costs if you use the benefits. Choose the Medigap policy that best meets your needs, and fits your budget. Remember, all Medigap policies must include the basic (core) benefits listed on page 33.

✔ Check the box next to the benefits you feel you may need or want. Use this information when talking to insurance companies to help choose the Medigap policy you want. Insurance companies usually offer some, but not all, of the Medigap plans. For more detailed information about what Medicare covers, see pages 57–60.

Note: In the last column, if the box is blank this means the Medigap policy doesn't offer that benefit. The amounts shown in this chart are for 2004.

✔	Benefit	What *Medicare* pays in 2004…	What *you* pay in 2004 if you *don't* have a Medigap Policy…	What *you* pay in 2004 if you *have* a Medigap Policy that covers this benefit…	Medigap policies that cover this benefit
	Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related 3-day hospital stay.)	Medicare pays all covered costs for the first 20 days of SNF care. After day 20, Medicare pays all but up to $109.50 for the 21st –100th day of SNF care.	You pay… • Nothing for the first 20 days. • Up to $109.50 per day for days 21–100. • All costs after day 100.	You pay… • Nothing for the first 20 days. • Nothing for days 21–100. • All costs after day 100.	C D E F G H I J
	Medicare Part A Deductible	Medicare pays all but a total of $876 for a hospital stay of 1–60 days.	For each benefit period, you pay a total of $876 for a hospital stay of 1–60 days.	You pay nothing for days 1–60 of a hospital stay.	B C D E F G H I J
	Medicare Part B Deductible	Medicare pays nothing for your first $100* (yearly deductible) of Part B covered services (like doctor services and outpatient hospital care).	You pay for the first $100* (yearly deductible) of Part B covered services and supplies (listed on pages 58–60).	You pay nothing for the first $100* (yearly deductible) of Part B covered services and supplies.	C F J
	Medicare Part B Excess Charge (difference between a doctor or other health care provider's actual charge and Medicare's approved payment amount).	If your doctor doesn't accept assignment, and charges more than the Medicare-approved amount, Medicare won't pay the difference.	You pay the total difference between what Medicare pays and the doctor who doesn't accept assignment charges. This is called the excess charges.	If you have Plans F, I, or J you pay none of the excess charges. If you have Plan G, you pay 20% of the excess charges.	F G I J
	Foreign Travel Emergency	Generally, Medicare pays nothing for emergency health care outside the U.S.	You pay 100% for emergency health care outside the U.S. There are some exceptions for some care in Canada and Mexico.	You pay the first $250, and then 20% of the remaining costs of emergency health care during the first 60 days of each trip. There is a $50,000 lifetime maximum.	C D E F G H I J

	At-Home Recovery **(Home Health Care See page 58)**	Medicare pays the full Medicare-approved amount of all Medicare-approved home health services.	You pay nothing for Medicare-approved home health services. You pay 100% for non-Medicare covered services	• You pay nothing for Medicare-approved home health services. • You pay nothing for up to 8 additional weeks of at-home help after skilled care is no longer needed. • Medigap policies will pay up to $40 each visit and $1,600 each year.	D G I J
	Prescription Drugs Starting January 1, 2006, you won't be able to buy Medigap policies covering prescription drugs. For more information, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227).	Medicare doesn't cover most outpatient prescription drugs. In 2004, Medicare-approved prescription drug discount cards will be available.	You pay 100% for most outpatient prescription drugs.	You pay for the first $250 of outpatient prescription drugs each year. Then you pay 50% for all prescription drugs not covered by Medicare. Plans H and I have a $1,250 per year limit. For Plans H and I to be of full value, you should have at least $2,750 in drug costs per year (you pay $1,250 plus $250; plan pays $1,250). Plan J has a $3,000 per year limit. For Plan J to be full value, you should have at least $6,250 in drug costs per year (you pay $3,000 plus $250; plan pays $3,000). Purchase of these plans is only guaranteed during your open enrollment period.	H I J
	Medicare-covered Preventive Services Note: Some Medicare-covered preventive services waive the Part B deductible.	After you pay the $100* yearly deductible for Part B, Medicare will pay 75–100% of some preventive services under Part B. For a full list of preventive services, see pages 59–60.	You pay a $100* yearly deductible for Part B. You pay 20–25% for most Medicare-covered preventive services. You pay nothing for some shots. You pay 100% for routine yearly check-ups and tests like serum cholesterol screening, hearing testing, and diabetes screening.	After you pay the $100* yearly deductible for Part B, you pay nothing for most Medicare-covered preventive services.	E J
	Non-Medicare covered Preventive Services	Medicare pays nothing.	You pay 100% for non-Medicare covered preventive services.	You may pay nothing for routine yearly check-ups and any non-Medicare covered preventive services your doctor recommends. This benefit has a $120 per year limit. You pay 100% after you have met your yearly limit.	

Note: Plans F and J have a high-deductible option, which means your monthly premium would cost less, but you would have to pay the first $1,690 (in 2004) of your Medigap-covered costs before the Medigap policy would begin to pay its share. For more information about high-deductible, see page 16.

* The Medicare Part B deductible will go up to $110 in 2005.

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, you can do any of the following:

- Call your State Health Insurance Assistance Program (see pages 79–80). Ask if they have a Medigap rate comparison shopping guide for your State. These types of guides usually list the insurance companies that sell Medigap policies in your State and compare the costs of policies from each insurance company.

- Call your State Insurance Department (see pages 79–80).
- Look at www.medicare.gov on the web. Select "**Medicare Personal Plan Finder**."

  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 the following:

  - ✓ Some insurance companies that sell Medigap policies in your State,
  - ✓ How to contact these insurance companies,
  - ✓ What the policies must cover, and
  - ✓ 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.

- 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. You will get your Medicare Personal Plan Finder results in the mail within three weeks. TTY users should call 1-877-486-2048.

You should plan to call more than one insurance company that sells Medigap policies in your State since costs can vary between companies. Check the companies you call to be sure they are honest and reliable (see page 29).

STEP 3. Call the insurance companies and compare costs.

Call different insurance companies and ask the questions listed below. Friends and relatives can tell you about their Medigap policies and the quality of service, but their Medigap policies might not fit your needs. Shop around for the best Medigap policy for you at a price you can afford.

You should ask each insurance company the questions listed below. If you aren't in your Medigap open enrollment period or in another situation where you have a guaranteed issue right to buy a Medigap policy (see pages 41–50), ask questions about how your costs could be affected. Remember, there are different ways insurance companies can price a Medigap policy (see pages 14–15).

Medigap Policy Comparison Worksheet

Use this worksheet to compare costs and benefits you are considering. **Make sure you get the agents' and the insurance companies' names, addresses, and telephone numbers.**

Ask each insurance company…	Company 1	Company 2
Is this insurance company licensed in this State? (The answer should be yes.)		
Which Medigap policies do you sell? (Insurance companies usually offer some, but not all, of the plans. Make sure they sell the plan you want.)		
What is the cost, this year, of the Medigap policy I am interested in?		
What has the cost of this Medigap policy been for the past few years?		
How is the price decided? • What type of pricing does this insurance company use? • Is there a discount if I am a female, a non-smoker, or married?		
Are there any additional ("innovative") benefits or discounts included in this policy?		
If you aren't in your Medigap open enrollment period or in another situation where you have a guaranteed issue right, ask: • Will you accept my application? • Do you review my health records or application (medical underwriting) to decide how much to charge me for a Medigap policy? • If you have a pre-existing condition ask, "Will my pre-existing condition mean a delay in the start of my benefits?"		

STEP 4. Choose the best Medigap policy for you.

After you call the insurance companies, compare their costs, and check to see if the companies are reliable. Then choose the Medigap policy that is best for you.

To make your final choice, make sure:

- You carefully review the Medigap policy benefits.
- You can afford the cost of the Medigap policy.
- The Medigap policy covers the benefits you need and want.
- You feel good about and trust the insurance company and/or the insurance agent.
- You talk with someone you trust, like a family member, friend, doctor, insurance agent, or your State Health Insurance Assistance Program (see pages 79–80) about your choice.

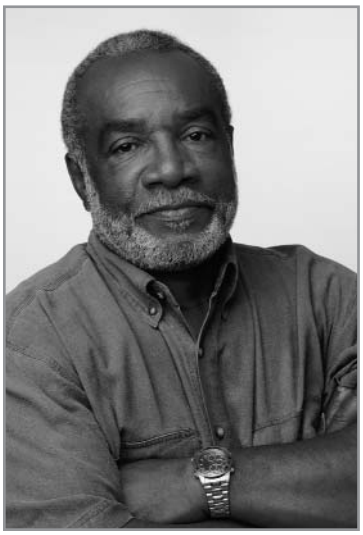
Once you have checked the items above, you are now ready to move on to Step 5 (see page 39).

STEP 5. Buy the Medigap policy.

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

- Fill out your application carefully and completely. Answer all of the medical questions. If the insurance agent fills out the application, review it to make sure it's correct. However, if you buy your Medigap policy during your open enrollment or guaranteed issue period, you can't be asked these medical questions.
- Don't buy more than one Medigap policy. If you already have a Medigap policy, it is illegal for an insurance company to sell you a second policy unless you put in writing that you are going to cancel the first Medigap policy. However, don't cancel your first Medigap policy until the second one is in place, and you have decided to keep the second Medigap policy. Once you have received the second 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 your Medigap policy is issued to you.
- It is best to pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. Get a receipt with the insurance company's name, address, and telephone number for your records.
- Ask for your Medigap policy to become effective when you want coverage to start, or when your previous Medigap policy coverage ends. If, for any reason, the insurance company won't give you the start date you want, call your State Insurance Department (see pages 79–80).
- Make sure you get a copy of your policy within 30 days. If you don't get your policy in 30 days, call your insurance company. If you don't get your policy in 60 days, call your State Insurance Department (see pages 79–80).

Notes



"Be sure to compare Medigap policies. It could save you money."

section 3

Medigap Rights and Protections

This section has detailed information about your Medigap rights and protections.

Medigap rights and protections (guaranteed issue rights)

Your rights to buy a Medigap policy

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the same guaranteed issue rights to buy a Medigap policy. If you have questions, call your State Insurance Department (see pages 79–80).

In some situations, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called "Medigap protections." They are also called guaranteed issue rights because the law says that insurance companies must sell ("issue") you a Medigap policy.

In these situations, an insurance company:

- Can't deny you Medigap coverage or place conditions on a policy (like making you wait for coverage to start),
- Must cover you for all pre-existing conditions (see page 21), and
- Can't charge you more for a Medigap policy because of past or present health problems.

In many cases, the guaranteed issue rights apply when your health coverage changes. Remember, it is best to apply for a Medigap policy **before** your current health coverage has ended. You can apply for a Medigap policy while you are still in your health plan and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage.

Note: If you drop your Medigap policy, you may not be able to get it back except in very limited cases.

Important: In some situations, you have a guaranteed issue right to buy a Medigap policy because you lost certain kinds of health coverage. You should keep a copy of any letters, notices, and claim denials you get. Be sure to keep anything that has your name on it. Also, keep 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 application for a Medigap policy to prove you lost coverage and have the right to these Medigap protections. The Medigap protections in this section are from Federal law. Many States provide more Medigap protections than Federal law. Call your State Health Insurance Assistance Program or State Insurance Department for more information (see pages 79–80).

Medigap protections if you lose or drop your health care coverage (guaranteed issue rights)

In order to get these Medigap protections, you must meet certain conditions listed below. These rights include both Medigap and Medicare SELECT policies.

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

Situation	Protects you if...	See page (s)
SITUATION #1	Your Medicare Advantage or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area.	44–45
SITUATION #2	Your employer group health plan coverage ends.	45–46
SITUATION #3	You have to end your health coverage because you move out of the plan's service area.	47
SITUATION #4	You joined a Medicare Advantage Plan or PACE program when you were first eligible for Medicare at age 65 and within the first year of joining, you decide you want to leave.	47
SITUATION #5	You dropped a Medigap policy to join a Medicare Advantage Plan, Medicare SELECT policy, or PACE program for the first time and now you want to leave and you have been in the plan less than a year.	48
SITUATION #6	Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	48
SITUATION #7	You leave your plan because your Medicare Advantage Plan, Medicare SELECT policy, or Medigap insurance company hasn't followed the rules or misled you. For example, the marketing materials were not true, or quality standards were not met.	49

Medigap protections

SITUATION #1: Your Medicare Advantage Plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

In this situation, your Medicare Advantage (formerly Medicare + Choice) Plan or PACE program sends you a letter telling you that you will no longer be covered by the plan. You have the right to buy a Medigap Plan A, B, C, or F that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available (based on health status), with no review of your medical records even if you have health problems.

You can apply for a Medigap policy as soon as you get the final notification letter from your plan. When you get this letter telling you that your plan is leaving the Medicare program or will no longer give care in your area, you may:

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

The Programs of All-inclusive Care for the Elderly (PACE) combines medical, social, and long-term care services for frail people. PACE is available only in States that choose to offer it under Medicaid. For more information about PACE, see page 72.

Medigap protections (continued)

SITUATION #1: Your Medicare Advantage Plan or PACE program coverage ends because the plan is leaving the Medicare program or stops giving care in your area. (continued)

Important: You will have additional rights under Situation #4 (see page 47) or Situation #5 (see page 48) if:

- This was the first time you were in a Medicare Advantage Plan,
- You were in the plan less than one year before the plan left the Medicare program or stopped giving care in your area, and
- You choose to return to the Original Medicare Plan and apply for a Medigap policy.

If, instead, you immediately join another Medicare Advantage Plan, you can stay in that plan for up to one year and still have the rights described in Situations #4 and #5.

SITUATION #2: Your employer group health plan coverage ends.

You have the right to buy a Medigap policy if you are in an employer group health plan that pays after (or "secondary to") Medicare, but your plan coverage ends because of the following:

- The employer goes out of business,
- The employer stops offering a plan, or
- You are no longer eligible for coverage under the plan.

For example, you may lose eligibility for coverage in the plan when you retire (or your spouse retires, if your coverage is through his or her plan) because the plan only covers current employees (and their dependents) and doesn't provide retiree coverage.

Medigap protections (continued)

SITUATION #2: Your employer group health plan coverage ends. (continued)

In this situation, you have the right to buy a Medigap Plan A, B, C, or F that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available (based on health status) with no review of your medical records even if you have health problems.

You may get a letter or a notice from your employer, the health plan, or the insurance company telling you that your coverage is or will be cancelled. You have 63 calendar days from the date your coverage ends or from the date on the letter or notice (whichever is later) to apply for a Medigap policy. In some cases, you won't get a notice, but you may get a claim denial. If this happens, this claim denial is the same as a letter telling you that your coverage has ended. Remember, keep a copy of the letter, notice, or claim denial, and the postmarked envelope. You may need these papers to prove you lost coverage. You will need to send a copy of the letter, notice, or claim denial with your application to prove that you have a right to this Medigap protection.

COBRA is a law that lets some people keep their group health plan coverage for a limited period of time after they leave their employment (see page 67).

State law may also give you the right to buy a Medigap policy when you lose coverage under an employer plan that paid before (or "primary to") Medicare. If you are offered COBRA when your employer plan ends, and decide to take it instead of getting a Medigap policy, you will again have guaranteed issue rights when your COBRA coverage ends. For more information about COBRA, see page 67.

Medigap protections (continued)

SITUATION #3: You have to end your health coverage because you move out of the plan's service area.

If you have health coverage from a Medicare Advantage (formerly Medicare + Choice) Plan or you are in a PACE program, and you move out of the plan's service area, you will have to end your coverage.

Words in green are defined on pages 82–85.

If you have a Medicare SELECT policy, you can keep your policy because it is guaranteed renewable. However, because you have moved, you can't use hospitals or other health care providers that are on the policy's list of approved providers. This is called the policy's "network." You might want to switch to another Medigap policy that is sold in your State.

You have the right to buy a Medigap Plan A, B, C, or F that is sold by any insurance company in your State (if you move within the same State but outside of the plan's service area), or the State you are moving to (if you move out of State). You can buy the Medigap policy at the best premium price available, with no review of your medical records even if you have health problems.

You must tell your current plan that you are moving and give them a date when you will end your coverage. You can apply for a Medigap policy as early as 60 calendar days before the date your health coverage ends. You must apply for a Medigap policy no later than 63 calendar days after your health coverage ends to get this protection.

SITUATION #4: You joined a Medicare Advantage Plan or PACE program when you were first eligible for Medicare at age 65 and within the first year of joining, you decide you want to leave.

You have the right to buy any Medigap policy that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available, with no review of your medical records even if you have health problems. You must tell the plan that you want to leave (disenroll) and give them a date to end your coverage. This date must be before you have been in the plan for a year. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

Your rights under this situation may last for an extra 12 months if the plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the plan for one year, AND you immediately join another Medicare Advantage Plan or PACE program.

Medigap protections (continued)

SITUATION #5: You dropped a Medigap policy to join a Medicare Advantage Plan, Medicare SELECT policy, or PACE program for the first time and now you want to leave and you have been in the plan less than a year.

You have the right to go back to the Medigap policy you had, if the same insurance company still sells it. You need to tell the Medicare Advantage (formerly Medicare + Choice) Plan, Medicare SELECT, or PACE program or policy that you want to leave (disenroll) and give them a date to end your coverage. This date must be before you have been in the plan for a year.

If your former Medigap policy isn't available, you have the right to buy a Medigap Plan A, B, C, or F that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available, with no review of your medical records even if you have health problems. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

Your rights under this situation may last for an extra 12 months if the plan you first joined leaves the Medicare program or stops giving care in your area before you have been in the plan for one year, AND you immediately join another Medicare Advantage Plan or PACE program.

SITUATION #6: Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.

You have the right to buy a Medigap Plan A, B, C, or F that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available, with no review of your medical records even if you have health problems. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy. Because Medigap policies are guaranteed renewable, the only way you would lose coverage under a Medigap policy would generally be if the insurance company goes bankrupt.

Medigap protections (continued)

SITUATION #7: You leave your plan because your Medicare Advantage Plan, Medicare SELECT, or Medigap insurance company hasn't followed the rules, or misled you.

In this situation, you leave the health plan because it failed to meet its contract obligations to you. This could include things such as quality standards weren't met, the company misled you, or it used untrue statements in its marketing materials. Generally, to have this right, you must have filed a grievance with the health plan, Medicare, or the State Insurance Department and received a decision that the plan was at fault.

You have the right to buy a Medigap Plan A, B, C, or F that is sold in your State by any insurance company. You can buy the Medigap policy at the best premium price available, with no review of your medical records even if you have health problems. You must tell the plan that you want to leave (disenroll) and give them a date to end your coverage. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy.

Remember, some States provide more Medigap protections. Your State might let you choose from more Medigap policies or give you a longer time to apply for a Medigap policy when you lose your coverage. Call your State Health Insurance Assistance Program for more information (see pages 79–80).

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the same guaranteed issue rights (see page 42) to buy a Medigap policy. If you have questions, call your State Insurance Department (see pages 79–80).

Medigap protections (continued)

Special note for people with Medicare under age 65

If you are in a situation that gives you the right to:

- Return to a Medigap policy you previously had but dropped, or
- Buy Medigap Plans A, B, C, or F,

you must be allowed to return to the same Medigap policy you dropped, if it is still available from your old insurance company, or to buy a Medigap Plan A, B, C, or F that is sold by any insurance company in your State to people under age 65. You can buy the Medigap policy at the best premium price available, with no review of your medical records. However, there is no Federal law that says insurance companies must sell Medigap policies to people under age 65. If an insurance company does sell these Medigap policies to anyone under age 65, they must sell one to you if you are in one of these situations (listed on pages 44–49).

Special note for people with End-Stage Renal Disease (ESRD)

If you have ESRD and are in a Medicare Advantage (formerly Medicare + Choice) Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan. You don't have to use your one-time right to join a new Medicare Advantage Plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan at a later date during a time that people can enroll in a Medicare health plan.

Where to get more information about Medigap protections

- Call your State Health Insurance Assistance Program (see pages 79–80) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.
- Call your State Insurance Department (see pages 79–80) if you are denied Medigap coverage in any of these situations.

section **4**

Medigap and Disability or ESRD

This section has information about how Medigap policies work if you are disabled or have ESRD.

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

You may have Medicare before age 65 due to:

- A disability, or
- ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

If you are a person with Medicare under age 65 and are disabled or have ESRD, you might not be able to buy the Medigap policy you want until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under age 65. However, some States require Medigap insurance companies to sell you a Medigap policy, at certain times (during a limited Medigap open enrollment period), even if you are under age 65. These States are listed below. If you have questions, you should call your State Health Insurance Assistance Program (see pages 79–80).

At the time of this printing, the following States require insurance companies to offer at least one kind of Medigap policy to people with Medicare under age 65.

- California
- Colorado
- Connecticut
- Kansas
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Mississippi
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Texas
- Vermont
- Washington
- Wisconsin

Even if your State doesn't require insurance companies to sell Medigap policies to people with Medicare under age 65, some insurance companies may voluntarily sell Medigap policies to some people under age 65. Whether or not your State requires insurance companies to sell to you, Medigap policies sold to people under age 65 may cost you more.

Remember, if you live in a State that has a Medigap open enrollment period for people under age 65, you will still get another Medigap open enrollment period when you turn age 65. You may have other choices of Medigap policies or be able to get a better rate on your Medigap policy at that time.

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

Also, if you join a Medicare Advantage (formerly Medicare + Choice) Plan and your coverage ends, you may have the right to buy a Medigap policy (see "Special note for people with Medicare under age 65" on page 50). If you have questions, you should call your State Health Insurance Assistance Program (see pages 79–80).

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

The first six months after you turn age 65 **and** are enrolled in Medicare Part B is your Medigap open enrollment period. It doesn't matter that you have had Medicare Part B before you turned age 65. During this time:

- You can buy any Medigap policy (including those Medigap policies that currently help pay the cost of prescription drugs*), and
- Insurance companies can't refuse to sell you a Medigap policy due to a disability or other health problem, or charge you a higher premium than they charge other people who are 65 years old.

When you buy a Medigap policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage you have. If you had Medicare for more than six months before you turned 65 years old, you won't have a pre-existing condition waiting period because Medicare counts as creditable coverage. (See page 22 for more information about creditable coverage.)

* Starting January 1, 2006, Medigap policies will no longer be sold with outpatient prescription drug coverage. See page 20 for more information.

Right to suspend a Medigap policy for disabled people with Medicare

If you are under 65, have Medicare, have a Medigap policy, and have employer group health plan coverage, you have a right to suspend (put on hold) your Medigap policy. Your Medigap coverage will stop, and you don't have to pay the monthly premium while you are enrolled in your or your spouse's employer group health plan. You won't have to pay more when you start your Medigap policy again than you would otherwise have to pay if you had not suspended your policy.

If, for any reason, you lose your employer group health plan coverage, you can get your Medigap policy back. Within 90 days of losing your employer group health plan coverage, you must notify your Medigap insurance company that you want your Medigap policy back.

"I wasn't sure if I could buy a Medigap policy, so I called my State Health Insurance Assistance Program. They were very helpful and answered all of my questions."

Your Medigap benefits and premiums will start again on the day your employer group health plan coverage stops. The Medigap policy must have the same benefits and premiums it would have had if you had never suspended your coverage. Your Medigap insurance company can't refuse to cover care for any pre-existing conditions (health problems) you have (see page 21). So, if you are disabled and working, you can enjoy the benefits of your employer's insurance while knowing that you will be able to get your Medigap policy back when you need it.

section 5

Original Medicare Plan

This section provides information about the Original Medicare Plan, Medicare Part A and Part B, and how much you pay for each service.

The Original Medicare Plan has two parts:

Medicare Part A (Hospital Insurance)

- **What it covers.** Medicare Part A helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not unskilled or long-term care). It also covers hospice care and some home health care. You must meet certain conditions to get these benefits.

- **What you pay.** Most people don't have to pay a monthly payment, called a premium, for Medicare Part A. This is because they or a spouse paid Medicare taxes while they were working.

See the next page for more Medicare Part A coverage information.

Medicare Part B (Medical Insurance)

- **What it covers.** Medicare Part B helps cover your doctors' services, outpatient hospital care, and some other medical services that Medicare Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part B helps pay for these covered services and supplies when they are medically necessary. It also covers some preventive services.

- **What you pay.** Most people pay the monthly premium of $66.60 (in 2004) for Medicare Part B. However, the cost will **go up 10% for each full 12-month period** that you could have had Part B but didn't sign up for it, except in special cases (see page 62). You might have to pay this extra amount as long as you have Part B.

  You also pay a $100 Part B deductible each year before Medicare starts to pay its share. The Part B deductible will go up to $110 in 2005.

See pages 58–60 for more Medicare Part B coverage information.

Look at www.medicare.gov on the web for more details about what services or supplies are covered by Medicare. Select "Your Medicare Coverage."

Note: Medigap policies work with the Original Medicare Plan. To see what Medigap policies pay for, see pages 33–35.

COVERED SERVICES IN THE ORIGINAL MEDICARE PLAN - PART A

Medicare Part A (Hospital Insurance) helps cover your medically necessary:	What YOU Pay in 2004* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in your room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period:** • A total of $876 for a hospital stay of 1–60 days. • $219 per day for days 61–90 of a hospital stay. • $438 per day for days 91–150 of a hospital stay. (See Lifetime Reserve Days on page 83.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related 3-day hospital stay).	**For each benefit period:** • Nothing for the first 20 days. • Up to $109.50 per day for days 21–100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.**
Home Health Care: Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	• Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.**
Hospice Care: For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in your home (which may include a nursing home if it's your home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).	• A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount you pay for respite care can change each year. Medicare generally doesn't pay for room and board except in certain cases. For example, room and board aren't covered if you get general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.**
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	• For the first three pints of blood, unless you or someone else donates blood to replace what you use.

* New Medicare Part A and Part B amounts will be available by January 1, 2005.

** If you have general questions about Medicare Part A, call your Fiscal Intermediary. To get the telephone numbers for Fiscal Intermediaries or Regional Home Health Intermediaries, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

COVERED SERVICES IN THE ORIGINAL MEDICARE PLAN - PART B

Medicare Part B (Medical Insurance) helps cover your medically necessary:	What YOU pay in 2004* in the Original Medicare Plan
Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers a second and third surgical opinion for surgery that isn't an emergency, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy. (These services are also covered for long-term nursing home residents.)	• $100 deductible (once per calendar year). • 20% of the Medicare-approved amount after the deductible (if the doctor or provider accepts "assignment"). • 20% for all outpatient physical, occupational, and speech-language therapy services. • 50% for most outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, some screening tests, and more.	• Nothing for Medicare-approved services.
Home Health Care: Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	• Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage call your Regional Home Health Intermediary.**
Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.	• A coinsurance or copayment amount, which may vary according to the service.
Blood: Pints of blood you get as an outpatient or as part of a Part B covered service.	• For the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.

* New Medicare Part A and Part B amounts will be available by January 1, 2005.

** **Note:** Actual amounts you must pay may be higher if the doctor or supplier doesn't accept assignment **and you may have to pay the entire charge at the time of service**. Medicare will then send you its share of the charge. If you have general questions about Medicare Part B, call your Medicare carrier. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

COVERED PREVENTIVE SERVICES IN THE ORIGINAL MEDICARE PLAN - PART B

Medicare Part B covered preventive services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Discuss with your doctor to see if you qualify.	20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test (FOBT) - Once every 12 months. • Flexible Sigmoidoscopy - Once every 48 months. • Colonoscopy - Once every 24 months if you are at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, once every ten years, but not within 48 months of a screening flexible sigmoidoscopy. • Barium Enema - Doctor can use this instead of flexible sigmoidoscopy or colonoscopy. It's covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	All people with Medicare age 50 and older. Note: There is no minimum age for having a colonoscopy.	Nothing for the fecal occult blood test (FOBT). For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Diabetes Services: • Diabetes self-management training.	Certain people with Medicare who are at risk for complications from diabetes. Your doctor or other health care provider must request these services.	20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Testing: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your State.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African Americans age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible.

Note: To find out what services and supplies are covered by Medicare, look at www.medicare.gov on the web. Select "Your Medicare Coverage." Or, you can get a free copy of *Your Medicare Benefits* (CMS Pub. No. 10116) by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

COVERED PREVENTIVE SERVICES IN THE ORIGINAL MEDICARE PLAN - PART B

Medicare Part B covered preventive services	Who is covered...	What YOU pay in the Original Medicare Plan...
Pap Test and Pelvic Examination (includes a clinical breast exam): Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.	Nothing for the Pap lab test. For Pap test collection, and pelvic and breast exams, 20% of the Medicare-approved amount (or a copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after your 50th birthday).	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the Prostate Specific Antigen (PSA) Test.
Screening Mammograms: • Once every 12 months (11 full months must have elapsed from the last screening). • Medicare also covers new digital technologies for screening mammograms.	All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
Shots (vaccinations): • Flu Shot* - Once a flu season in the fall or winter. • Pneumococcal Pneumonia Shot - One shot may be all you will ever need. Ask your doctor. • Hepatitis B Shot	All people with Medicare. All people with Medicare. Certain people with Medicare at medium to high risk for Hepatitis B.	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or a copayment amount) after the yearly Part B deductible.

* The flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 65 and older. and people of any age with certain chronic medical conditions. You need a flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only helps protect you from the flu for about one year. There is a chance that you may still get the flu, but your symptoms will be less severe.

How do I enroll in Medicare Part A?

Most people are enrolled automatically, without taking any action. For more information about enrolling in Medicare Part A, call the Social Security Administration at 1-800-772-1213. Or, look at www.medicare.gov on the web. Select "Medicare Eligibility Tool."

Note: Even if your full retirement age for Social Security or Railroad Retirement benefits is older than 65, you are still eligible for Medicare at age 65.

How do I enroll in Medicare Part B?

If you already get Social Security or Railroad Retirement benefits, you are automatically enrolled in Medicare Part B. If you aren't automatically enrolled in Medicare Part B, you will need to contact the Social Security Administration to get enrolled. You can enroll by:

- Calling or visiting your local Social Security office. The address and telephone number are in your local telephone book.
- Calling the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Looking at the Social Security Administration's website at www.socialsecurity.gov on the web. Some people who meet certain conditions are able to enroll by computer.

Note: If you get benefits from the Railroad Retirement Board (RRB), you will need to call your local RRB office or 1-800-808-0772 to apply.

When can I enroll in Medicare Part B?

Page 62 has a summary chart that explains when you can enroll in Medicare Part B. To learn more about how to enroll in Medicare, get a free copy of *Enrolling in Medicare* (CMS Pub. No. 11036). Look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You can also get information about Medicare eligibility and enrollment by looking at www.medicare.gov on the web. Select "Medicare Eligibility Tool."

For more information about enrolling in Medicare if you are disabled or have End-Stage Renal Disease, call the Social Security Administration at 1-800-772-1213. Different eligibility rules may apply. TTY users should call 1-800-325-0778.

Medicare Part B Enrollment Periods Summary Chart

Initial Enrollment Period

This is a seven-month period that begins three months before the month you are first eligible for Medicare Part B. (For most people, the Initial Enrollment Period **begins** three months *before* the month you turn 65. It **ends** three months *after* you turn 65.)

3 months before the month you turn 65	**2 months before** the month you turn 65	**1 month before** the month you turn 65	**The month you turn 65**	**1 month after** the month you turn 65	**2 months after** the month you turn 65	**3 months after** the month you turn 65

Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during these first three months.

If you wait until these last four months of your Initial Enrollment Period to sign up for Medicare Part B, your start date for your coverage will be delayed.

Note: If you wait until after the Initial Enrollment Period is *over*, you may have to **pay more** for your Medicare Part B premium (see example on the next page), except in special cases. See the special rules below under the Special Enrollment Period.

General Enrollment Period

This period runs from January 1 through March 31 of each year. If you didn't enroll in Medicare Part B when you first became eligible (during your Initial Enrollment Period), you can sign up during this enrollment period. Remember, the cost of Medicare Part B **will go up 10% for each full 12-month period** (see example on the next page) that you could have had Medicare Part B but didn't take it, except during special rules. See the special cases below under the Special Enrollment Period.

If you sign up during these months:			**Your coverage will begin on:**
January	February	March	July 1

Special Enrollment Period

This enrollment period may be used if you waited to enroll in Medicare Part B because you or your spouse (or family member if you are disabled) were still working and had group health plan coverage. If this applies to you, you can sign up for Medicare Part B:

Any time while you are still covered by the group health plan, through your or your spouse's (or family member if you are disabled) current employment status.

or

During the eight months following the month the group health plan coverage ends, or the employment ends **(whichever is first)**.

For more information about the Special Enrollment Period, see the next page.

How much will Medicare Part B cost if I didn't enroll when I first became eligible?

The cost of Medicare Part B **will go up 10% for each full 12-month period** that you could have had Medicare Part B but didn't take it, except in special cases (see page 62). You will have to pay this extra amount (called a premium surcharge) as long as you have Medicare Part B. Here is an example if you delayed enrolling for **24 months**.

Example: Premium Surcharge

If you delayed enrolling in Medicare Part B for **24 months**, you will have to pay a **20%** premium surcharge (10% for each full 12-month period that you could have been enrolled), plus your standard Medicare Part B monthly premium ($66.60 in 2004). These amounts might change each year.

$66.60	2004 Medicare Part B standard premium
+ $13.30	(20% of $66.60 is $13.32.
	In this example, this amount is rounded down.)
$79.90	**will be your Medicare Part B monthly premium for 2004.**

Note: The example above is if you delayed enrolling in Medicare Part B for **24 months**. You don't pay a premium surcharge if you enroll before a full 12-month period has passed.

Note about Special Enrollment Period

If you are still working and plan to keep your employer's group health coverage, you should talk to your benefits administrator or your State Health Insurance Assistance Program (see pages 79–80) to help you decide the best time to enroll in Medicare Part B. **When you sign up for Medicare Part B, you automatically begin your Medigap (Medicare Supplement Insurance) open enrollment period**. Once your Medigap open enrollment period begins, it can't be changed or restarted. See pages 18–20 to learn more about your Medigap open enrollment period.

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

Remember, most people who sign up for Medicare Part B during a Special Enrollment Period don't pay higher premiums. **However, if you are eligible but don't sign up for Medicare Part B during the Special Enrollment Period, you will only be able to sign up during the General Enrollment Period (see page 62), and the cost of Medicare Part B may go up.**

Special Enrollment Period for Medicare Part B and TRICARE for Life

If you are a military retiree, or the spouse or dependent child of either a military retiree or an active duty sponsor, and you have Medicare Part A but aren't enrolled in Medicare Part B, you may enroll in Medicare Part B without a premium surcharge during a Special Enrollment Period that will continue through **December 31, 2004**. Information about when the Special Enrollment Period will begin will be announced on www.tricare.osd.mil, the TRICARE website.

If you are a military retiree, or the spouse or dependent child of either a military retiree or an active duty sponsor and you are entitled to Medicare Part B between January 2001 and December 2004, and you are paying more than $66.60 a month for Medicare Part B, your Medicare Part B premium will be reduced to $66.60 beginning January 2004. You will get a refund for any excess premiums you have paid. You don't have to do anything. The premium reduction and refund will be done automatically.

section 6

Other Ways To Pay Health Care Costs

This section has helpful information about other ways to pay for your health care.

Other kinds of insurance and ways to pay health care costs

There are other kinds of health care coverage, besides a Medigap policy, that may pay for some of your health care costs not covered by Medicare. The chart on pages 67–72 gives you a brief description. If you think you may qualify and want more detailed information, you can get a free copy of the *Health Care Coverage Directory for People with Medicare* (CMS Pub. No. 02231) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Some of the types of insurance and other ways to pay health care costs are:

COBRA coverage 67

Employee or retiree coverage from an employer or union 68

Federally Qualified Health Centers (FQHCs) 68

Home and Community-Based Service/Waiver programs (HCBS) 68

Hospital indemnity insurance 68

Long-term care insurance 69

Medicaid 69–70

Medicare-approved drug discount cards 70

Medicare Savings Programs (help from your State) 71

Military retiree benefits (TRICARE) 71

Prescription drug and other assistance programs 71

Specified disease insurance 72

State Children's Health Insurance Program (SCHIP) 72

The PACE program (Programs of All-inclusive Care for the Elderly) 72

Veterans' benefits 72

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
COBRA ("Continuation Coverage" under the Consolidated Omnibus Budget Reconciliation Act) may provide you and your dependents with rights to keep your health care coverage temporarily if: • You lose your job, • Your working hours are reduced, • You leave your job voluntarily, • Your employer goes bankrupt. It may also help your spouse keep health care coverage if you die, or you get divorced.	COBRA allows you to keep your employer group health plan coverage for 18 months (or up to 36 months or sometimes even for a lifetime if you are a retiree and your former employer goes bankrupt) if you lose the coverage for one of the reasons listed in the left-hand column. There are important timeframes that you must know about COBRA and Medigap policies if you lose your employer coverage (see below). **COBRA and Medigap** If you lose your employer coverage, you might have to make a decision to either elect COBRA coverage or enroll in Medicare Part B. If you choose to enroll in Medicare Part B, your Medigap Open Enrollment Period will start. Once your Medigap Open Enrollment Period starts, it can't be changed (see pages 18–20). If your Open Enrollment Period has already passed, you might be protected by the Medigap protections listed on pages 45–46 (see Situation #2). Whether you choose to elect COBRA coverage, enroll in Medicare Part B, or have Medigap protections, you must follow the important timeframes below. In most cases these timeframes overlap. **COBRA** gives you a 60-day timeframe to elect COBRA coverage. This timeframe begins either the day you lose your employer coverage or the date when you get a notice from your employer letting you know you have COBRA rights, whichever occurs later. **Medigap Open Enrollment Period** is a six-month period that begins on the first day of the month in which you are both 65 or older **and** enrolled in Medicare Part B. During this period, you have the right to buy any Medigap policy. **Medigap Protections** are available only if you apply within 63 calendar days after you get a notice from your employer letting you know that your coverage is ending. In some cases, you won't get a notice, but you may get a claim denial. If this happens, you may have the right to buy a Medigap policy (see Medigap Protections, Situation #2 on pages 45–46) within 63 calendar days after you get a notice that a claim has been denied. Remember, this timeframe ends 63 calendar days after this notice or claim denial. The Medigap guaranteed issue timeframe might be different depending on the law in your State. In most cases, the COBRA timeframe and the Medigap guaranteed issue timeframe will overlap. To learn how these timeframes will affect you, call your State Health Insurance Assistance Program (see pages 79–80).

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Employee or retiree coverage from an employer or union may help: Employees or spouses who had health care coverage from a current or previous employer or union.	In some cases, you or your spouse might be able to get your health care coverage from an employer or union based on you or your spouse's current employment. This is called "employee coverage." Some employers or unions might let you or your spouse continue your health care coverage after the employment ends. This is called "retiree coverage." If you have this type of coverage from an employer or union, they may change the benefits or premiums, and may also cancel the coverage if they choose. There are some important timeframes that you must know about if you or your spouse are working and have group health coverage based on current or active employment, see "Medigap Open Enrollment Period" on pages 18–20. **Employee and retiree coverage and Medigap** If you have employee or retiree coverage and it ends, you may have the right to buy a Medigap policy. You may get a notice or claim denial letting you know that your health care coverage is ending. If this happens, you have the right to apply for a Medigap policy (see Medigap Protections, Situation #2 on pages 45–46) within 63 calendar days from the date your coverage ends or from the notice or claim denial.
Federally Qualified Health Centers (FQHCs) may help: People who live near a FQHC.	FQHCs are special health centers, usually located in urban or rural areas, that can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.
Home and Community-Based Service/Waiver programs (HCBS) may help: Certain elderly and disabled individuals.	HCBS programs are available to some people with Medicaid. They offer services and programs that help you get care in your home and community. This program allows you to stay more independent. Some examples are: homemaker services, personal care, adult day care, meals, and transportation.
Hospital indemnity insurance may help: Pay for hospital stays up to a certain number of days.	This kind of insurance pays a set amount of money for each day of a hospital stay. You won't need this insurance if your health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn't fill gaps in your Medicare coverage. It usually pays in addition to your health insurance.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Long-term care insurance may help: Pay for your health or personal care needs and activities of daily living, such as bathing, dressing, using the bathroom, and eating.	Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care. This insurance might help you stay independent. There are many types of long-term care choices for older people. Some long-term care examples are: assisted living facilities, community services (adult day care and meal programs), and nursing homes. Make sure you choose the long-term care policy that is best for you. To learn about your long-term care choices and long-term care insurance, get a free copy of *Choosing Long-term Care: A Guide for People with Medicare* (CMS Pub. No. 02223) at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227).
Medicaid may help: People with limited incomes and resources.	Medicaid helps pay your medical costs. Since this is a joint Federal and State program, coverage varies from State to State. People with Medicaid may get coverage for things like nursing home care, home care, and outpatient prescription drugs that aren't covered by Medicare. **Medicaid and Medigap** If you have a Medigap policy and then get Medicaid, there are a few things you should know: • You can suspend (put on hold) your Medigap policy within 90 days of getting Medicaid. • You won't have to pay your Medigap policy premiums while it is suspended. • Your Medigap policy won't pay benefits while the Medigap policy is suspended. • You can suspend a Medigap policy for up to two years. • At the end of the suspension, you can reinstate the Medigap policy without new medical underwriting or pre-existing condition waiting periods.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Medicaid (continued)	To help you with the suspension decision, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). For questions about suspending a Medigap policy, call your insurance company. If you already have health insurance coverage through your State Medicaid program, an insurance company can sell you a Medigap policy only in certain situations: • The insurance company can legally sell you any Medigap policy if Medicaid pays your Medigap policy premium or if Medicaid only pays your Medicare Part B premium. • The insurance company can legally sell you Medigap Plans H, I, or J if Medicaid only pays your Medicare premiums, deductibles, or coinsurance. (This only applies to Medigap policies sold between now and January 1, 2006.) In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you are getting any Medicaid benefits.
Medicare-approved drug discount cards may help: People save money on prescription drugs. NEW IN 2004	In 2004, Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. You might be able to save on prescription drugs with a Medicare-approved drug discount card. For more information about Medicare-approved drug discount cards, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. **Drug discount cards and Medigap Policies** You might already have a drug discount card with your Medigap policy. If the drug discount card you have with your Medigap policy isn't a Medicare-approved drug discount card, you can also get a Medicare-approved drug discount card.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Medicare Savings Programs (help from your State as part of the State Medical Assistance Program) may help: People with limited income and resources.	These programs can help pay your Medicare premiums and, in some cases may also pay Medicare deductibles and coinsurance. To be eligible for this program, you must meet certain requirements. These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa. To find out if these programs are available in your area or for more information, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). Since the names of these programs may vary by State, ask for information on Medicare Savings Programs.
Military retiree benefits (TRICARE) may help: Active duty and retired uniformed services members and their families.	TRICARE is a health care program that offers medical coverage to eligible members. The TRICARE program includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life (TFL). If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. For more information about the TRICARE programs, call 1-800-538-9552 or look at www.tricare.osd.mil on the web.
Prescription drug and other assistance programs may help: People get discounted or free prescription drugs that help pay for their health care.	Some States offer programs that either offer discounted or free prescription drugs. They also may offer other assistance programs to help pay for your other health care costs. To be eligible for these programs, you must meet certain requirements. For more information, look at www.medicare.gov on the web. Select "Prescription Drug and Other Assistance Programs." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. **Prescription drugs and Medigap** If you are thinking about signing up for your State's Prescription Drug Assistance Program and you haven't yet bought a Medigap policy, get your Medigap policy **before** you apply for prescription drug assistance. After you get the prescription drug assistance you might not be able to buy a Medigap policy.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Specified disease insurance may help: People with a certain type of disease.	This kind of insurance pays benefits for a single disease, such as cancer, or for a group of diseases. You usually have to buy this insurance before you are diagnosed or treated for the specified disease. You won't need this insurance if your health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn't fill gaps in your Medicare coverage. It usually pays in addition to your health insurance.
State Children's Health Insurance Program (SCHIP) may help: Uninsured children under age 19.	Some States offer free or low-cost health insurance to uninsured children whose families don't qualify for Medicaid. For more information about your State's program, look at www.cms.hhs.gov/schip/ on the web.
The PACE program (Programs of All-inclusive Care for the Elderly) may help: Frail people who live in the service area of a PACE program.	PACE combines medical, social, and long-term care services for frail people. PACE might be a better choice for you instead of getting your care through a nursing home. PACE is available only in States that have chosen to offer it under Medicaid. If you live in a State that offers PACE, and you have Medicare and are eligible for PACE, you can choose to get your Medicare benefits through this program. To find out if you are eligible and if there is a PACE site near you, or for more information, call your State Medical Assistance Office. To get their telephone number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at www.medicare.gov/Nursing/Alternatives/PACE.asp on the web.
Veterans' benefits may help: People who have had any military service or are a veteran.	The U.S. Department of Veterans Affairs offers health care benefits and other types of benefits and services to eligible members. For more information about VA benefits and services, call the U.S. Department of Veterans Affairs at 1-800-827-1000.

section 7

Massachusetts, Minnesota, and Wisconsin Medigap Plans

Different types of standardized Medigap plans are sold in these three States. For standardized Medigap plans sold in other States, see page 13.

Massachusetts – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **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.

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

* This plan, offered by Blue Cross and Blue Shield of Massachusetts, also provides coverage for the following services: routine vision services, routine dental services, routine hearing services, fitness programs, and weight loss programs. Contact plan for details. For more information on these policies, call your State Insurance Department (see pages 79–80) or look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Note: The checkmarks in this chart mean the benefit is covered under that plan.

Minnesota – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

- **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.

Medigap Benefits	Basic Plan	Extended Basic Plan
Basic Benefits	✓	✓
Medicare Part A: Inpatient Hospital Deductible		✓
Medicare Part A: Skilled-Nursing Facility Coinsurance	✓	✓
Medicare Part B: Deductible		✓
Foreign Travel Emergency	80%	80%*
Outpatient Mental Health	50%	50%
Usual and Customary Fees		80%*
Preventive Care	✓	✓
Prescription Drugs		80%
At-home Recovery		✓
Physical Therapy	20%	20%
Coverage while in a Foreign Country		80%*
State-Mandated Benefits (Diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations.)	✓	✓

Optional Riders

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

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

* The policy pays 100% after you spend $1000 of out-of-pocket expenses for a calendar year.

Note: The checkmarks in this chart mean the benefit is covered under that plan.

Wisconsin – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

- **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.

Medigap 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	✓
Prescription Drugs (after a deductible of $6,250, pays 80%)	✓

Optional Riders

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

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

Wisconsin also has many other state-mandated benefits under the Medigap Basic Plan. For more information, call your State Insurance Department (see pages 79–80) or look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."

Note: The checkmarks in this chart mean the benefit is covered under that plan.

section 8

For More Information

Use this section to learn where to get more information.

On pages 79–80, you will find telephone numbers for your State Health Insurance Assistance Program and State Insurance Department. These telephone numbers were correct at the time of printing. Telephone numbers sometimes change. You can find the most up-to-date telephone numbers by looking at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Where to get more information

Words in green are defined on pages 82–85.

- Call your State Health Insurance Assistance Program (see pages 79–80) 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 health plan, or
  - Deciding whether to suspend your Medigap policy, or
  - Questions about Medicare bills.
- Call your State Insurance Department (see pages 79–80) if you have questions about the Medigap policies sold in your area and any insurance-related problems.

Who do I call with questions about Medicare?

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227). Customer Service Representatives are available 24 hours a day, everyday. TTY users should call 1-877-486-2048.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

section 9

Words To Know

Use this section to learn the definitions of words printed in green throughout this Guide.

Assignment: In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

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

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

Copayment: In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Creditable Coverage: Any previous health insurance coverage that can be used to shorten a pre-existing condition waiting period. (See pre-existing conditions.)

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.

Durable Medical Equipment (DME): Medical equipment that is ordered by a doctor for use in the home. These items must be durable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Regional Carrier: A private company that contracts with Medicare to pay bills for durable medical equipment.

End-Stage Renal Disease (ESRD): Permanent kidney failure that requires dialysis or a kidney transplant.

Excess Charges: If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Guaranteed Issue Rights (also called "Medigap Protections"): 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 insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

Guaranteed Renewable: A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don't pay your premiums.

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

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

Lifetime Reserve Days: In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($438 in 2004).

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

Long-term Care: A variety of services that help people with health or personal needs and activities of daily living over a long period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes and limited 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.

Medically Necessary: Services or supplies that:

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

Medicare Advantage Plan: A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medicare-approved Amount: In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Carrier: A private company that contracts with Medicare to pay Part B bills.

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

Medicare Preferred Provider Organization (PPO) Plan: A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan: A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

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.

Medicare Specialty Plan: A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

Medigap Policy: A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period: A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B **and** you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Original Medicare Plan: A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-existing Condition: A health problem you had before the date that a new insurance policy starts.

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

Programs of All-inclusive Care for the Elderly (PACE): PACE combines medical, social, and long-term care services for frail people. PACE is available only in States that have chosen to offer it under Medicaid. To be eligible, you must:

- be 55 years old or older,
- live in the service area of the PACE program,
- be certified as eligible for nursing home care by the appropriate state agency, and
- be able to live safely in the community.

The goal of PACE is to help people stay independent and living in their community as long as possible, while getting the high-quality care they need.

Skilled Nursing Facility Care: A level of care that requires daily involvement of skilled nursing or rehabilitation staff and can't be done on an outpatient basis. Examples of skilled nursing care include getting intravenous injections and physical therapy. Needing custodial care, such as help with bathing and dressing, can't, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for skilled nursing or rehabilitation care, Medicare covers all of your care needs in the facility.

Skilled Nursing Facility: A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

State Health Insurance Assistance Program: 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 any insurance-related problem.

State Medical Assistance Office: A State agency that is in charge of the State's Medicaid program and can give information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

Notes

"This section helped me understand words I didn't know."

section **10**

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