

Medicare Supplement Fundamentals



Course Manual



Important Information

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The information in this course was obtained from the following government resources:

- <http://www.medicare.gov>
- **2005 Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare**
<http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>

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1—Medicare Supplement Features

Medicare Supplement Basics

A Medicare Supplement (Medigap) policy is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn’t cover. If someone is in the Original Medicare Plan and has a Medigap policy, then Medicare and the Medigap policy will each pay its share of covered health care costs.

Insurance companies can only sell a “standardized” Medigap policy. These Medigap policies are standardized so they can be compared easily. Since 1992, there have been 10 standardized Medigap policies called Plans “A” through “J.” In 2005, there are two new standardized Medigap policies available, called Plans “K” and “L.”

(There are different types of standardized Medigap policies for residents of Massachusetts, Minnesota, and Wisconsin.)

A person with Medicare is able to choose from up to 12 different standardized Medigap policies (Plans A through L). Medigap policies must follow Federal and state laws. The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each Plan, A through L, has a different set of basic and extra benefits. The standardized Medigap policies that insurance companies offer must provide the same benefits. Generally, 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 every Medigap plan (A through L). Each insurance company decides which Medigap policies they want to sell.

To be eligible to purchase a Medigap policy, a person must have Medicare Part A and Part B and pay the Medicare Part B monthly premium (\$78.20 in 2005). In addition, the person must pay a premium to the Medigap insurance company for the Medigap policy. Generally, a Medigap policy is guaranteed renewable year after year for as long as the premium is paid. If a husband and wife want Medigap coverage, they each need to purchase separate Medigap policies.

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.

It is illegal for anyone to sell a Medigap policy to someone who:

- Is enrolled in a Medicare Advantage Plan (like an HMO, PPO, or PFFS).
- Has Medicaid (there are some exceptions).
- Already has a Medigap policy (unless the old policy is being replaced).

A Medigap policy is intended specifically for individuals who are in the Original Medicare Plan and want:

- Lower out-of-pocket costs, and
- More health insurance coverage.

Gaps in the Original Medicare Plan

A Medigap policy will cover some, but not all of the gaps in the Original Medicare Plan. Below are some examples of gaps in the Original Medicare Plan that a Medigap policy may help pay for in 2005.

Part A—Hospital Stays	For each benefit period, the patient pays: <ul style="list-style-type: none"> • \$912 for the first 60 days • \$228 per day for days 61–90 • \$456 per day for days 91–150
Part A—Skilled Nursing Facility Stays	For each benefit period, the patient pays: <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$114 per day for days 21–100
Blood	The patient pays for the first three pints.
Medicare Part B Yearly Deductible	The patient pays the \$110 per year deductible.
Medicare Part B Covered Services	The patient pays: <ul style="list-style-type: none"> • 20% of the Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment • Copayment for outpatient hospital services

A person in the Original Medicare Plan, who has a Medigap policy, can go to any doctor, hospital, or other health care provider who accepts Medicare. However, if they have the type of Medigap policy called Medicare SELECT, he/she must use specific hospitals and, in some cases, specific doctors to get their full insurance benefits.

Examples of things NOT covered by Medigap policies include:

- Long-term care
- Vision or dental care

- Hearing aids
- Private-duty nursing

Comparison of Medigap Plans

Medigap Plans A through J cost more than Medigap Plans K and L. Plans A through J provide more benefits and have lower out-of-pocket costs.

Each standardized Medigap policy must cover **basic** benefits. Medigap Plans A through J have one set of basic benefits, and Plans K and L have a different set of basic benefits. (See the Basic Benefits charts below.)

Most Medigap policies pay some, 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. Medigap Plans F and J have a high-deductible option. If this option is chosen, the deductible must be paid first before the Medigap policy pays anything.

Plan K has a \$4,000 out-of-pocket annual limit. Plan L has a \$2,000 out-of-pocket annual limit. Once a patient meets the annual limit, the plan pays 100% of the Medicare Part A and Part B copayments and coinsurance for the rest of the calendar year. Charges from the doctor that exceed Medicare-approved amounts, called "excess charges" aren't covered and don't count toward the out-of-pocket limit. The patient will have to pay these excess charges. The out-of-pocket annual limit can increase each year because of inflation.

Comparison of Basic Benefits for Medigap Plans (2005)

(This chart does not apply to residents of Massachusetts, Minnesota, and Wisconsin.)

<p>Medicare Part A Coinsurance and Hospital Benefits</p>	<p>All Plans (A through L) pay</p> <ul style="list-style-type: none"> • \$228 per day for days 61–90 of a hospital stay • \$456 per day for days 91–150 of a hospital stay • Up to 365 more days for hospital stays during a person’s lifetime after they use all Medicare hospital benefits
<p>Medicare Part B Coinsurance or Copayment</p>	<p>Plans A through J pay all coinsurance and copayment amounts after the patient meets the Part B \$110 yearly deductible.</p> <p>Plan K pays 50% Part B coinsurance after the Part B \$110 yearly deductible. It pays 100% coinsurance for Part B preventive services.</p> <p>Plan L pays 75% Part B coinsurance after the Part B \$110 yearly deductible. It pays 100% coinsurance for Part B preventive services.</p>
<p>Blood</p>	<p>Plans A through J pay for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless the patient or someone else donates blood to replace what is used.</p> <p>Plan K pays 50% of the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless the patient or someone else donates blood to replace what is used.</p> <p>Plan L pays 75% of the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless the patient or someone else donates blood to replace what is used.</p>
<p>Hospice Care</p>	<p>Plan K pays 50% hospice cost-sharing for all Part A Medicare covered expenses and respite care.</p> <p>Plan L pays 75% hospice cost-sharing for all Part A Medicare covered expenses and respite care.</p>

Comparison of Medigap Plans A through J

(This chart does not apply to residents of Massachusetts, Minnesota, and Wisconsin.)

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

* Medigap Plans F and J also have a high-deductible option.

** Basic Benefits vary by plan.

*** Starting January 1, 2006, Medigap policies covering prescription drugs will no longer be available for purchase. However, if someone purchases a policy with prescription drug coverage before January 1, 2006, that person will have to decide if they want to keep this coverage.

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

Comparison of Medigap Plans K and L

(This chart does not apply to residents of Massachusetts, Minnesota, and Wisconsin.)

	K	L
Basic Benefits	Yes	Yes
Skilled Nursing Facility Coinsurance	Yes 50%	Yes 75%
Medicare Part A Deductible	Yes 50%	Yes 75%

In 2005, Medigap Plans K and L (also can be sold as Medicare SELECT) can be purchased from a Medigap insurance company. These new Medigap policies can be sold only as standardized plans. The above chart gives a quick look at the Medigap Plans K and L and their benefits. Medigap Plans K and L must cover basic benefits, but these benefits are different from the basic benefits offered in Medigap Plans A through J.

People with Medigap Plans K and L have to pay part of the cost-sharing of some covered services until they meet the annual out-of-pocket limit. Plan K has a \$4,000 out-of-pocket limit. Plan L has a \$2,000 out-of-pocket limit. Once the annual limit is met, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. These amounts can change each year.

Medigap Policy Pricing

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.

Each insurance company sets its own premiums for Medigap policies. Insurance companies use one of three methods to rate a Medigap policy:

1. **Community-rated.** This method is also called no-age-rated. The same monthly premium is charged to everyone who has the Medigap policy, regardless of age. Premiums are the same no matter how old a person is and won't change except for inflation.
2. **Issue-age-rated.** The premium is based on the person's age when they buy (are "issued") the Medigap policy. Premiums are lower for younger buyers, and won't change except for inflation.
3. **Attained-age-rated.** The premium is based on the person's current age (the age "attained") so the premium goes up each year. Premiums for these Medigap policies are low for younger buyers, but go up every year and can eventually become the most expensive. They may also go up because of inflation.

There are factors other than age that may affect the cost of a Medigap policy. The cost

of a Medigap policy may also be affected by:

- **Discounts.** Insurance companies may offer discounts to females, non-smokers, and/or married people.
- **Medical Underwriting.** Some insurance companies may use medical underwriting. This means that a person must answer medical questions on an application. The insurance company uses this information to decide whether to issue the person a Medigap policy, how much they will charge, and whether there will be a waiting period for coverage to start. Some companies may add a waiting period for pre-existing conditions if state law allows. Insurance companies can't use medical underwriting if the person is in the Medigap open enrollment period or if that person has special rights (called Medigap protections) to buy a Medigap policy.
- **High-Deductible Option.** Some insurance companies may offer a "high-deductible option" on Medigap Plans F and J. If this option is chosen, the person must pay the first \$1,730 (the deductible in 2005) in Medigap-covered costs before the Medigap policy pays anything. This amount can change each year. High-deductible policies often have lower premiums, but if a lot of Medicare-covered health care services, supplies, and equipment is needed, the out-of-pocket costs will be higher, and the person may not be able to change to another Medigap policy. In addition to the \$1,730 (in 2005) deductible that must be paid for the high-deductible option for Plans F and J, the person must also pay deductibles for (a) Prescription drugs (\$250 per year for Plan J only, because Plan F doesn't cover prescription drugs), and (b) Foreign travel emergency (\$250 per year for Plans F and J).
- **Medicare SELECT.** Medicare SELECT is a type of Medigap policy sold by some insurance companies in some states. If someone buys a Medicare SELECT policy, they are buying one of the 12 standardized Medigap Plans A through L. With a Medicare SELECT policy, a person 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. If someone with a Medicare SELECT policy doesn't use a Medicare SELECT hospital or doctor for non-emergency services, their costs will be higher. He/she 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 is visited.

Purchasing a Medigap Policy

The best time for someone to buy a Medigap policy is during their Medigap open enrollment period. The Medigap open enrollment period lasts for six months. It starts on the first day of the month in which a person is both (a) age 65 or older, and (b) enrolled in Medicare Part B.

Once someone's six-month Medigap open enrollment period starts, it can't be changed. During this period, an insurance company can't

- Deny someone any Medigap policy it sells,
- Make someone wait for coverage to start, or
- Charge someone more for a policy because of their health problems.

If someone buys a Medigap policy during their Medigap open enrollment period, in many cases the insurance company must shorten the waiting period for pre-existing conditions if he/she had recent health coverage. This is called "creditable coverage."

A person may want to apply for a Medigap policy before their Medigap open enrollment period starts if they are losing coverage because they are eligible for Medicare. This will allow them to have continuous coverage.

If someone applies for a Medigap policy after their open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting to decide whether to accept the application, and how much to charge for the policy. If the person is in good health, the insurance company is likely to sell them the policy, but there is no guarantee that they will (unless the person is eligible for one of the Medigap protections listed). Not all insurance companies use medical underwriting.

If someone (or their spouse) is working and have group health coverage through an employer or union, their Medigap open enrollment period won't start until they sign up for Medicare Part B. In that situation, the person may want to wait to enroll in Medicare Part B. Once someone is age 65 or older and enrolled in Medicare Part B, their Medigap open enrollment period starts and can't be changed. However, if the employer group health plan only pays after Medicare pays, the plan can require the person to enroll in Medicare Part B in order to get benefits under that plan.

If someone doesn't enroll in Medicare Part B when he/she is first eligible or after they drop employer coverage, they may have to pay a higher monthly premium. They will have to pay this extra amount as long as they have Medicare Part B.

There are three times when someone can enroll in Medicare Part B:

- Initial Enrollment Period
- General Enrollment Period
- Special Enrollment Period

Coverage for Pre-Existing Conditions

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

In some cases, if a person had a health problem before their 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 the health problem was diagnosed or treated during the six months before the Medigap policy started. This means that the insurance company can't make the person wait for coverage of the condition just because the company thinks the patient should have known to see a doctor.

If someone buys a Medigap policy during their Medigap open enrollment period, and they had at least six months of previous health coverage that qualifies as "creditable coverage," the company can't apply a pre-existing condition waiting period. If they had less than six months of creditable coverage, this waiting period will be reduced by the number of months of creditable coverage they had.

If someone buys a Medigap policy when they have special Medigap protections (also called guaranteed issue rights), the insurance company can't use a pre-existing condition waiting period.

Creditable Coverage

Creditable coverage (for Medigap policies) is generally any other health coverage a patient had before applying for a Medigap policy. These types of health care coverage may count as creditable coverage for Medigap policies:

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

Whether someone had creditable coverage depends on whether they had any "breaks in coverage"—when they were without any of these kinds of health coverage for more than 63 days in a row. A person can only count creditable coverage that they had after that break in coverage. If they have had one or more breaks in coverage, but each break was shorter than 63 days, then he/she can add the periods of coverage together. This will count towards creditable coverage.

The following doesn't count as creditable coverage:

- Hospital indemnity insurance
- Specified disease insurance (like cancer insurance)
- Vision or dental policies
- Long-term care policies

Switching Medigap Policies

If someone already has a Medigap policy, he/she may not have a guaranteed right to switch Medigap policies. But, if they are given the opportunity, they should make sure they compare benefits and premiums before switching policies. If they bought their Medigap policy before 1992, it may offer better coverage than a newer policy. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies currently being sold.

If someone decides to switch, they should not cancel the first Medigap policy until they have decided to keep the second Medigap policy. A person has 30 days to decide if he/she wants to keep the new Medigap policy. This is called a “free look” period. The 30-day free look period starts when the Medigap policy is issued.

If someone has an “old” Medigap policy (bought before 1992), they don’t have to switch to one of the standardized Medigap policies. But, if they decide to buy a newer Medigap policy, they won’t be able to go back to their old Medigap policy.

A person does not have to wait a certain length of time before they can switch to a different Medigap policy. However, their new Medigap policy might not cover all the pre-existing conditions if they have had their current Medigap policy for less than six months. However, the amount of time they’ve had their current Medigap policy must count towards the amount of time they must wait before their new policy covers their pre-existing conditions.

If the new Medigap policy has a benefit that wasn’t in an old policy, the company can make a person wait up to six months before covering them for that benefit.

Losing Medigap Coverage

Generally, an insurance company cannot cancel a Medigap policy. If a Medigap policy was purchased after 1990, the policy is guaranteed renewable. This means the insurance company can only drop a person if:

- He/she stops paying the premium,
- He/she isn’t truthful about something under the policy, or
- The insurance company goes bankrupt.

Insurance companies in some states may be able to drop someone if they bought a

Medigap policy before 1990. For an insurance company to refuse to renew one of these older Medigap policies, the company must get the state's approval. If this happens, the person has the right to buy another Medigap policy.

Getting Bills Paid

Most Medigap insurance companies get information about a patient's bills directly from Medicare. However, if the Medigap insurance company doesn't have this service, the doctor should be asked if they accept "assignment" for their Medicare patients. If the doctor does accept assignment, then the doctor should be asked to indicate on the Medicare claim form that Medigap insurance benefits should be paid to the doctor. The patient will need to sign the claim form or have the doctor keep the patient's signature on record.

Once these conditions are met, Medicare will process the claim and send it to the Medigap insurance company. The Medigap insurance company will pay the doctor directly and then send the patient a notice. If the patient doesn't get this notice, he/she may ask the Medigap insurance company for the notice.

If the Medigap insurance company doesn't pay the doctor directly, the patient should report this to the State Insurance Department.

Illegal Insurance Practices

It is illegal for anyone to:

- Pressure someone into buying a Medigap policy, or lie or mislead someone into switching from one company or policy to another.
- Sell someone a second Medigap policy when they know that person already has one—unless that person tells the insurance company in writing that they plan to cancel the existing Medigap policy.
- Sell someone a Medigap policy if they know they have Medicaid—except in certain situations.
- Sell someone a Medigap policy if they know that person is in a Medicare Advantage Plan.
- Claim that a Medigap policy is part of the Medicare Program or any other Federal program. (Medigap is private health insurance.)
- Sell someone a Medigap policy that can't legally be sold in that state.
- Sell someone a Medigap policy with prescription drug coverage after December 31, 2005.
- Misuse the names, letters, or symbols of the U. S. Department of Health and Human Services (HHS), Social Security Administration (SSA), Centers for

Medicare & Medicaid Services (CMS), or any of their various programs like Medicare. (For example, suggesting a Medigap policy has been approved or recommended by the Federal government.)

- Falsely claim to be a Medicare representative.

Medigap Prescription Drug Coverage

If someone has a Medigap policy that covers prescription drugs, sometime between September 15, 2005 and November 15, 2005, the Medigap insurance company will mail them a notice describing how the new Medicare prescription drug coverage will affect their Medigap policy. The notice will inform the person they have four options:

- Enroll in a Medicare prescription drug plan and keep their Medigap policy with the prescription drug coverage removed.
- Enroll in a Medicare prescription drug plan by May 15, 2006 and buy a different Medigap policy without prescription drug coverage.
- Enroll by May 15, 2006 in a Medicare Advantage Plan that includes prescription drug coverage.
- Keep their Medigap policy without any changes.

On average, most Medigap prescription drug coverage won't cover as much as a new Medicare prescription drug plan. Unless the Medigap policy is one of a few that are found to be "at least as good as" Medicare coverage and if the person doesn't join a Medicare prescription drug plan when first eligible (November 15, 2005 through May 15, 2006), that person may have to pay more to join later. Prescription drug plan premium cost will go up at least 1% per month for every month the person waited to enroll and doesn't have coverage at least as good as standard Medicare prescription drug coverage. This extra amount will have to be paid for as long as the person has Medicare prescription drug coverage. The person may also have to wait until November 15–December 31 to enroll in a Medicare prescription drug plan and may not be able to switch to another Medigap policy.

A person will get a notice from their Medigap insurance company telling them how the Medigap policy's prescription drug coverage compares to a Medicare prescription drug plan's coverage.

A Medigap policy with prescription drug coverage bought before mid-1992 may cover as much as or more than a Medicare prescription drug plan. (Medigap policies sold in Massachusetts, Minnesota, and Wisconsin with prescription coverage may also cover as much as or more than a Medicare prescription drug plan.)

2—Medicare Basic Benefits

Basic Benefits: Medigap Plans A through J—2005

These amounts can change each year. Medigap Plan A covers only the basic benefits listed below. Medigap Plans B through J include the basic benefits and some extra benefits. Some insurance companies do not offer all Medigap plans. This chart doesn't apply to residents of Massachusetts, Minnesota, and Wisconsin.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't have</u> a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Plan A through J</i>
Medicare Part A coinsurance and hospital benefits	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1–60, see Extra Benefits: Medigap Plans B through J—2005 • \$228 per day for days 61–90 of a hospital stay • \$456 per day for days 91–150 of a hospital stay • All costs for each additional day after the 150th day of the hospital stay after lifetime reserve days have been used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1–60, see Extra Benefits: Medigap Plans B through J—2005 • Nothing for days 61–90 of a hospital stay • Nothing for days 91–150 of a hospital stay • No costs above what Medicare would have paid for up to 365 more days of hospital stays during a lifetime after all Medicare hospital benefits have been used • All costs after all Medicare hospital benefits have been used and all the 365 days of additional Medigap hospital stay coverage have been used
Medicare Part B coinsurance or copayment	<p>Patient pays...</p> <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care) • Then after the first \$110, 20% of the Medicare-approved amount for Medicare Part B-covered services and supplies 	<p>Patient pays...</p> <ul style="list-style-type: none"> • Only the first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care)
Blood	<p>Patient pays...</p> <ul style="list-style-type: none"> • The total cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year—unless the patient or someone else donates blood to replace the blood used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • Nothing for the first three pints of blood or equal amounts of packed red blood cells per calendar year

Basic Benefits: Medigap Plan K—2005

This chart doesn't apply to residents of Massachusetts, Minnesota, and Wisconsin.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't have</u> a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Plan K</i>
Medicare Part A coinsurance and hospital benefits	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1—60, see Extra Benefits: Medigap Plan K—2005 • \$228 per day for days 61—90 of a hospital stay • \$456 per day for days 91—150 of a hospital stay (60 days lifetime max.) • All costs for each additional day after the 150th day of the hospital stay after lifetime reserve days have been used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1—60, see Extra Benefits: Medigap Plan K—2005 • Nothing for days 61—90 of a hospital stay • Nothing for days 91—150 of a hospital stay (60 days lifetime max.) • No costs above what Medicare would have paid for up to 365 more days of hospital stays during a lifetime after all Medicare hospital benefits have been used • All costs after all Medicare hospital benefits have been used and all the 365 days of additional Medigap hospital stay coverage have been used
Medicare Part B coinsurance or copayment	<p>Patient pays...</p> <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care) • Then after the first \$110, 20% of the Medicare-approved amount for Medicare Part B-covered services and supplies 	<p>Patient pays...</p> <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care) • Then after the first \$110, 10% of the Medicare-approved amount for Medicare Part B-covered services and supplies • No coinsurance or copayment for Part B preventive services
Blood	<p>Patient pays...</p> <ul style="list-style-type: none"> • The total cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year—unless the patient or someone else donates blood to replace the blood used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • 50% of the cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year
Hospice Care	<p>Patient pays...</p> <ul style="list-style-type: none"> • A copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (which changes each year) 	<p>Patient pays...</p> <ul style="list-style-type: none"> • 50% of his/her share (5% of the Medicare-approved amount) for outpatient prescription drugs and inpatient respite care

Basic Benefits: Medigap Plan L—2005

This chart doesn't apply to residents of Massachusetts, Minnesota, and Wisconsin.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't have</u> a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Plan L</i>
Medicare Part A coinsurance and hospital benefits	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1—60, see Extra Benefits: Medigap Plan L—2005 • \$228 per day for days 61—90 of a hospital stay • \$456 per day for days 91—150 of a hospital stay (60 days lifetime max.) • All costs for each additional day after the 150th day of the hospital stay after lifetime reserve days have been used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • For days 1—60, see Extra Benefits: Medigap Plan L—2005 • Nothing for days 61—90 of a hospital stay • Nothing for days 91—150 of a hospital stay (60 days lifetime max.) • No costs above what Medicare would have paid for up to 365 more days of hospital stays during a lifetime after all Medicare hospital benefits have been used • All costs after all Medicare hospital benefits have been used and all the 365 days of additional Medigap hospital stay coverage have been used
Medicare Part B coinsurance or copayment	<p>Patient pays...</p> <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care) • Then after the first \$110, 20% of the Medicare-approved amount for Medicare Part B-covered services and supplies 	<p>Patient pays...</p> <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care) • Then after the first \$110, 5% of the Medicare-approved amount for Medicare Part B-covered services and supplies • No coinsurance or copayment for Part B preventive services
Blood	<p>Patient pays...</p> <ul style="list-style-type: none"> • The total cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year—unless the patient or someone else donates blood to replace the blood used 	<p>Patient pays...</p> <ul style="list-style-type: none"> • 25% of the cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year
Hospice Care	<p>Patient pays...</p> <ul style="list-style-type: none"> • A copayment of up to \$5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (which changes each year) 	<p>Patient pays...</p> <ul style="list-style-type: none"> • 25% of his/her share (5% of the Medicare-approved amount) for outpatient prescription drugs and inpatient respite care

3—Medicare Extra Benefits

Extra Benefits: Medigap Plans B through J—2005

These amounts can change each year. Medigap Plan A covers only the basic benefits. Medigap Plans B through J include the basic benefits and the extra benefits shown below. Some insurance companies do not offer all Medigap plans.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't have</u> a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Policy</i>
Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related 3-day hospital stay.)	Patient pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$114 per day for days 21–100 • All costs after day 100 	If patient has Medigap Plan C, D, E, F, G, H, I, or J—he/she pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Nothing for days 21–100 • All costs after day 100
Medicare Part A Deductible	Patient pays... <ul style="list-style-type: none"> • For each benefit period, a total of \$912 for a hospital stay of 1–60 days 	If patient has Medigap Plan B, C, D, E, F, G, H, I, or J—he/she pays... <ul style="list-style-type: none"> • Nothing for days 1–60 of a hospital stay
Medicare Part B Deductible	Patient pays... <ul style="list-style-type: none"> • The first \$110 (yearly deductible) of Part B-covered services and supplies (like doctor services and outpatient hospital care) 	If patient has Medigap Plan C, F, or J—he/she pays... <ul style="list-style-type: none"> • Nothing for the first \$110 (yearly deductible) of Part B-covered services and supplies
Medicare Part B Excess Charges (difference between a doctor or other health care provider's actual charge and Medicare's approved payment amount)	Patient pays... <ul style="list-style-type: none"> • The total difference between what Medicare pays and what the doctor charges who doesn't accept assignment charges; this is called the excess charges 	If patient has Medigap Plan F, I, or J—he/she pays... <ul style="list-style-type: none"> • None of the excess charges If patient has Medigap Plan G—he/she pays... <ul style="list-style-type: none"> • 20% of the excess charges
Foreign Travel Emergency	Patient pays... <p>100% for emergency health care outside the U.S.—there are some exceptions for some care in Canada and Mexico</p>	If patient has Medigap Plan C, D, E, F, G, H, I, or J—he/she pays... <p>The first \$250, and then 20% of the remaining costs of emergency health care during the first 60 days of each trip (\$50,000 lifetime maximum)</p>

Extra Benefits: Medigap Plans B through J—2005 (continued)

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't</u> have a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Policy</i>
At Home Recovery	<p>Patient pays...</p> <ul style="list-style-type: none"> • Nothing for Medicare-approved home health services • 100% for non-Medicare-covered services 	<p>If patient has Medigap Plan D, G, I, or J— he/she pays...</p> <ul style="list-style-type: none"> • Nothing for Medicare-approved home health services • Nothing for up to eight additional weeks of at-home help after skilled care is no longer needed <p>(Maximum of \$40 each visit and \$1,600 each year)</p>
<p>Prescription Drugs</p> <p>(Starting January 1, 2006 Medigap policies will not cover prescription drugs)</p>	<p>Patient pays...</p> <ul style="list-style-type: none"> • 100% for most outpatient prescription drugs 	<p>If patient has Medigap Plan H, I, or J— he/she pays...</p> <ul style="list-style-type: none"> • The first \$250 of outpatient prescription drugs each year, then 50% for all prescription drugs not covered by Medicare. <p>Plans H and I have a \$1,250 per year limit. (For Plans H and I to be of full value, patient should have at least \$2,750 in drug costs per year; patient pays \$1,250 plus \$250; plan pays \$1,250)</p> <p>Plan J has a \$3,000 per year limit. (For Plan J to be of full value, patient should have at least \$6,250 in drug costs per year; patient pays \$3,000 plus \$250; plan pays \$3,000)</p>
<p>Medicare-covered Preventive Services</p> <p>(Patient doesn't have to pay the Part B deductible for some Medicare-covered preventive services)</p>	<p>Patient pays...</p> <ul style="list-style-type: none"> • \$110 yearly deductible for Part B • 20–25% for most Medicare-covered preventive services • Nothing for some shots • 100% for most routine yearly check-ups and tests 	<p>If patient has Medigap Plan E or J he/she pays...</p> <ul style="list-style-type: none"> • A \$110 yearly deductible for Part B • Nothing for Medicare-covered preventive services
Non-Medicare-covered Preventive Services	<p>Patient pays...</p> <ul style="list-style-type: none"> • 100% for non-Medicare-covered preventive services 	<p>Patient pays...</p> <ul style="list-style-type: none"> • Nothing for routine yearly check-ups and any non-Medicare-covered preventive services the doctor recommends. (Benefit is limited to \$120 per year.)

Extra Benefits: Medigap Plan K—2005

These amounts can change each year. Patient will pay any part of the cost-sharing of some covered services until annual out-of-pocket limit of \$4,000 is met. This chart doesn't apply to residents of Massachusetts, Minnesota, and Wisconsin.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't</u> have a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Policy Plan K</i>
Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related 3-day hospital stay)	Patient pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$114 per day for days 21–100 • All costs after day 100 	Patient pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$57 per day for days 21–100 (counts towards the patient's annual limit) • All costs after day 100
Medicare Part A Deductible	Patient pays... <ul style="list-style-type: none"> • For each benefit period, a total of \$912 for a hospital stay of 1–60 days 	Patient pays... <ul style="list-style-type: none"> • \$456 for days 1–60 of a hospital stay

Extra Benefits: Medigap Plan L—2005

These amounts can change each year. Patient will pay any part of the cost-sharing of some covered services until annual out-of-pocket limit of \$2,000 is met. This chart doesn't apply to residents of Massachusetts, Minnesota, and Wisconsin.

<i>Benefit</i>	<i>What a Medicare patient pays in 2005 if he/she <u>doesn't</u> have a Medigap Policy</i>	<i>What a Medicare patient pays in 2005 if he/she has a Medigap Policy Plan L</i>
Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related 3-day hospital stay)	Patient pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$114 per day for days 21–100 • All costs after day 100 	Patient pays... <ul style="list-style-type: none"> • Nothing for the first 20 days • Up to \$28.50 per day for days 21–100 (counts towards the patient's annual limit) • All costs after day 100
Medicare Part A Deductible	Patient pays... <ul style="list-style-type: none"> • For each benefit period, a total of \$912 for a hospital stay of 1–60 days 	Patient pays... <ul style="list-style-type: none"> • \$228 for days 1–60 of a hospital stay

4—Medicare Supplement Terminology

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 (Medigap)

Certain kinds of 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 or prescriptions, before Medicare or your prescription drug plan begins to pay. For example, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

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.

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, there are 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 (\$456 in 2005).

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.

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.

Medicaid

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

Medical Underwriting

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

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 Prescription Drug Plan

Beginning January 1, 2006, Medicare will provide prescription drug coverage through insurance companies and private companies. These companies will offer different Medicare prescription drug plans with different covered prescriptions and costs. Like

other insurance, if you join a Medicare prescription drug plan you will pay a monthly premium, a yearly deductible, and a share of the cost of your prescriptions. You can sign up for one of these plans starting November 15, 2005. Note: These plans are different than Medigap policies that offer prescription drug coverage (see “Medigap prescription drug coverage”).

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.

Medigap Policy

A Medicare supplement insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. There are 12 standardized plans labeled Plan A through Plan L, except in Massachusetts, Minnesota, and Wisconsin. These states have different standardized plans. 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 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.

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.

Premium

The periodic payment to Medicare, an insurance company, or a health care plan for

health care coverage.

Private Fee-for-Service (PFFS) 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 pays and what you pay for the services you will get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

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 the 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. A need for 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.

Special Needs 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.

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 problems.

State Medical Assistance Office

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