2000 Guide

To Health Insurance for People with Medicare

A Guide For:

- Buying a Medigap Policy
- Using a Medigap Policy
- Other Kinds of Health Insurance

Get the basics on pages 3-21.

HEALTH CARE FINANCING ADMINISTRATION

The Federal Medicare Agency

TABLE OF CONTENTS

Introduction

How To Use This Guide 1

Part 1 - Medigap Basics

A Quick Look At Medicare 4

Buying a Medigap Policy.....9

Using a Medigap Policy.....18

Other Kinds of Health Insurance.....19

Summary of Medigap Basics.....21

Part 2 - Beyond the Basics

Buying a Medigap Policy.....23

Using a Medigap Policy.....62

Other Kinds of Health Insurance.....67

Watch Out for Illegal Insurance Practices.....83

Discrimination.....84

Who to Call for Medicare or Medigap Information 85

Charts of Standardized Medigap Plans in Massachusetts, Minnesota, and Wisconsin 94

Medicare Part A and Medicare Part B Coverage Charts 97

Definitions Of Important Words 100

Index (An alphabetical list of Medicare and Medigap topics) 104

What's new in 2000?

- Medicare Part A & Part B Rates, see pages 97 and 98.
- Medicare Part B Preventive Services, see page 99. New in 2000, Medicare covers Prostate Cancer Screening.
- Medigap Compare: A new way to compare Medigap policies on the Internet at www.medicare.gov, see page 13.
- Nursing Home Compare: A new way to get information on nursing homes in your area on the Internet at www.medicare.gov, see page 82.

Tell us what you think! We welcome your comments on the *2000 Guide To Health Insurance for People with Medicare* although we may not be able to respond to you directly.

Send your comments to:
Health Care Financing Administration
Guide To Health Insurance Comments
7500 Security Boulevard
Baltimore, MD 21244-1850

How To Use This Guide ▸

Why do I need this guide?

Medicare is a federal health insurance program for people 65 years of age or older, and certain younger people with disabilities or End-Stage Renal Disease (permanent kidney failure). It pays for much of your health care, but not all of it. You have to pay some costs yourself, unless you buy more insurance. There are three ways you can get more insurance:

- Medigap policies (from a private company or group)
- Employer or union coverage
- Other kinds of insurance

This booklet was written to explain Medigap and other insurance policies.

What is the purpose of this Guide?

The purpose of this Guide is to give you basic and detailed information about Medigap policies. You will not find information about the cost of any Medigap policy in this Guide because costs will be different depending on where you live and which insurance company you buy the policy from. You may want to talk to family and friends, and insurance counselors about the information in this Guide and other insurance matters. Whether you need a Medigap policy is a decision only you can make. If you want information on the cost of a Medigap policy, call an insurance company that sells Medigap policies in your state. You can find out which companies sell Medigap policies in your state by calling your State Insurance Department (see pages 86-87). Or, you can use a computer to look on the Internet at www.medicare.gov and click on “Medigap Compare.”

How To Use This Guide (continued)

* At the time this Guide was printed, no private insurance companies were offering these types of plans. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to get the most current information about these types of plans.

Do I need a Medigap policy?

Medigap policies only help pay health care costs if you have the Original Medicare Plan.

You do not need to buy a Medigap policy if you are in a:

- Medicare managed care plan
- Private Fee-for-Service plan
- Medicare Medical Savings Account Plan*
- Religious Fraternal Benefit Plan*

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

If you have Medicaid, it is illegal for an insurance company to sell you a Medigap policy (except in certain situations), see page 79.

How should I use this Guide?

Read over "A Quick Look At Medicare" in Part 1. This will help you understand what Medicare does and does not cover.

Use the chart on page 10 to help get an idea of the benefits that Medigap policies cover. These benefits are described in more detail on pages 24-27 in Part 2.

Use Part 2 to get more information about Medigap insurance and other kinds of insurance.

How To Use This Guide (continued)

Do I have to buy more insurance?

The choice to buy more insurance is yours. If you have the Original Medicare Plan, you don't have to buy any additional insurance. But remember, even with a Medigap policy there are still costs that the Original Medicare Plan doesn't cover. More insurance is the best way to be sure that you can cover your other medical costs.

Part 1 - Medigap Basics ▸

A Quick Look At Medicare .....Pages 4-8

Buying a Medigap Policy .....Pages 9-17

Using a Medigap Policy .....Page 18

Other Kinds of Health Insurance .....Pages 19-20

Summary of Medigap Basics ..... Page 21

Remember, Part 2 has more details on each of these topics.

A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some disabled people under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

There are two parts of Medicare:

Part A - Hospital Insurance

Helps Pay For: Care in hospitals, some skilled nursing facilities, hospice, and some home health care (see chart on page 97).

Cost: For most people, Part A is premium-free. This means most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

Part B - Medical Insurance

Helps Pay For: Doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health services (see charts on pages 98-99).

Cost: You pay the Medicare Part B premium of $45.50 per month in 2000. Premiums can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible for Medicare.

Terms in red are defined on pages 100-103.

How do I get Part B?

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older.

A Quick Look At Medicare (continued)

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

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

General Enrollment Period

The General Enrollment Period is from January 1 through March 31 of each year. You can sign up for Part A or Part B at your local Social Security Administration office. Your Part B coverage will start on July 1 of that year.

Special Enrollment Period

If you didn't take Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union, you can sign up for Part B during a Special Enrollment Period.

You can sign up:

1. Anytime you are still covered by the employer or union group health plan through your or your spouse's **current or active** employment, or

2. Within 8 months of the date when the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the

A Quick Look At Medicare (continued)

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

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

What are my Medicare health plan choices?

Depending on where you live, you may have three choices: the Original Medicare Plan, a Medicare managed care plan, or a Private Fee-for-Service plan.

The Original Medicare Plan (also known as fee-for-service)

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Medicare Part B health care. You may go to any doctor, specialist, or hospital that accepts Medicare. You pay your share on a pay-per-visit basis, and Medicare pays its share. Some things are not covered, like most prescription drugs, cosmetic surgery, and routine physical exams.

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

Medicare Managed Care Plans (like an HMO)

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

Note: Medigap policies **don't help** pay health care costs if you are in a Medicare managed care plan.

A Quick Look At Medicare (continued)

Private Fee-for-Service Plans

This is a new health care choice that will become available in some areas of the country in 2000.

A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan which is offered by the federal government. In a Private Fee-for-Service plan, Medicare pays a set amount of money every month to the private company to provide health care coverage to people with Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Note: Medigap policies **don't help** pay health care costs if you are in a Private Fee-for-Service plan.

For more information about this type of plan, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Your Guide to Private Fee-for-Service Plans* or use a computer to look on the Internet at www.medicare.gov.

If I am in the Original Medicare Plan, why would I buy a Medigap policy?

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

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

You may want to buy a Medigap policy because Medicare does not pay for all of your health care. There are "gaps" or costs that you must pay in Original Medicare Plan coverage. The chart on page 8 explains these gaps and gives examples.

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

Gaps in the Original Medicare Plan

	Why there's a Gap	Examples of Gaps
1. What you pay for Medicare covered services	The law requires you to pay for part of some Medicare coverage	■ Part A deductible for each benefit period ■ Part B deductible of $100 per year ■ 20% coinsurance for most Part B covered services
2. What is covered in part by Medicare	Medicare only pays for part of some services	■ Home health care that does not meet certain required conditions ■ Costs for skilled nursing facility care for days 21-100 in the benefit period (see page 97). ■ First three pints of blood each year
3. What is not covered by Medicare	Medicare doesn't cover some medical costs	■ Outpatient prescription drugs ■ Eyeglasses ■ Hearing aids ■ Routine physical exams ■ Emergency care outside the U.S. ■ Custodial care ■ Orthopedic shoes ■ Cosmetic surgery ■ Dental care ■ Dentures ■ Routine foot care

What you have to pay to cover the gaps shown on the chart will depend on:

- Whether your doctor or supplier accepts "assignment" or takes Medicare's approved amount as payment in full (see page 100).
- How often you need health care.
- What type of health care you need.
- Whether you buy a Medigap policy.
- What Medigap policy you buy.
- Whether you have other health insurance coverage.

Buying a Medigap Policy

"The thing about Medigap is you can take as much or as little coverage as you want. When I had knee surgery, my Medigap policy paid much of the costs that Medicare did not pay."

Mark
Providence, Rhode Island

The chart on page 10 lists the benefits in the 10 standardized Medigap plans.

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

Remember, terms in red are defined on pages 100-103.

What is a Medigap policy and how does it work?

A Medigap policy is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." In all but three states (Minnesota, Massachusetts, and Wisconsin), there are 10 standardized Medigap plans called "A" through "J." Each plan has a different set of standard benefits.

Medicare SELECT is a type of Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J (see page 23).

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

What do Medigap policies cover?

Each standardized Medigap policy must cover basic (core) benefits (see the chart on page 10). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts. These policies may also cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to fill more of the gaps in your coverage, like prescription drugs. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

Chart of Ten Standardized Medigap Plans A through J

Medigap policies (including Medicare SELECT) can only be sold in 10 standardized plans. This chart gives you a quick and easy look at all the Medigap plans and what benefits are in each plan. For more details about Medigap plan benefits, see pages 24-27.

Basic Benefits: Included in All Plans.

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

A	B	C	D	E	F*	G	H	I	J*
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			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 11). Call your State Insurance Department for more information (see pages 86-87). Note: This chart does not apply if you live in Massachusetts, Minnesota, or Wisconsin (see pages 94-96).

Buying a Medigap Policy (continued)

Do any Medigap policies cover prescription drugs?

Yes. Plans H and I offer the "basic" prescription drug benefit. Plan J offers the "extended" prescription drug benefit (see chart below).

	After you pay...	The plan pays...
Plans H and I ▸ Basic Prescription Drug Benefit	$250 per year deductible	50% of prescription drug costs up to a maximum of $1,250 per year. (For more information, see page 26.)
Plan J ▸ Extended Prescription Drug Benefit	$250 per year deductible	50% of prescription drug costs up to a maximum of $3,000 per year. (For more information, see pages 26 and 27.)

What is a "high deductible option" and how does it affect my costs?

Insurance companies may offer a "high deductible option" on Plans F and J. If you choose this option, you must pay a $1,530 deductible for the year 2000 before the plan pays anything. This is an increase for all high deductible plans that were bought before 2000. This amount can go up each year.

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

In addition to the $1,530 deductible that you must pay for the high deductible option on plans F and J, you must also pay deductibles for prescription drugs ($250 per year for Plan J) and foreign travel emergency ($250 per year for Plans F and J).

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

What is not covered by Medigap policies?

Medigap policies do not cover:

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

What should I think about before buying a Medigap policy?

- How much am I spending on health care?
- What are my health care dollars spent on?
- Which Medigap benefits do I need?
- How much can I afford to spend on premiums?
- What will my future health care costs be? Remember, you may need more health care as you get older.

"Before I bought my first policy, I looked at different insurance companies and compared what they pay for and how much it was going to cost me to join. That way, I was able to see the difference between what I pay now for certain medical costs and what I would pay with a Medigap policy."

Abigail
Wilmington, North Carolina

Buying a Medigap Policy (continued)

How can I get information on Medigap policies in my state?

You can get information about Medigap policies in your state by calling:

- Your State Insurance Department to find out what Medigap polices are available in your state and which companies sell them (see pages 86-87); or
- Your State Health Insurance Assistance Program to get free counseling to help you decide which policy is best for you (see pages 88-89).

New in 2000! ▶

You can also use a computer to find information on and compare Medigap policies offered in your state. Look on the Internet at www.medicare.gov and click on "Medigap Compare." This website has information on:

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

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

Buying a Medigap Policy (continued)

When is the best time to buy a Medigap policy?

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

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

- Age 65 or over; **and**
- Enrolled in Medicare Part B.

During this period, an insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems (see the "open enrollment" Example on page 36).

If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage (creditable coverage) you have (see page 38).

If you are disabled or have End-Stage Renal Disease, see page 39.

Should I start my Medigap open enrollment period if I am age 65 or over and still working?

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

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

"I checked all the insurance companies in my state...that paid the deductible and also had prescription drug coverage, because I take a lot of prescriptions."

Kristina
Richmond, Virginia

How do I shop for a Medigap policy?

Quick Shopping Tips

- First, review the 10 standardized Medigap plans and choose the type of plan that has the benefits you want.
- Shop carefully. Call different insurance companies about the plan you want and compare cost and service before you buy.
- **Do not** buy more than one Medigap policy at a time.
- **Do not** let a salesperson rush you into buying a policy.
- **Do not** pay cash. Pay by check, money order, or bank draft made payable to the insurance company, not to the agent or anyone else.

Caution: Before you shop for a Medigap policy, look at more detailed shopping information on pages 27-35.

What are Medigap protections?

Medigap protections are special rights you have to buy a Medigap policy in addition to your Medigap open enrollment period. You have these rights only in certain situations (see pages 16-17). Medigap protections are important because **if you do not buy a Medigap policy during your open enrollment period, and you don't have these protections**, an insurance company may be able to refuse to sell you a policy, or may charge you more for a policy. Also, if you drop your Medigap policy, you may not be able to get it back unless you have these protections.

Buying a Medigap Policy (continued)

What situations give me the right to buy a Medigap policy after my Medigap open enrollment period ends?

There are certain situations involving health coverage changes where you may have the right to buy a Medigap policy after your Medigap open enrollment period ends. These are also called "guaranteed issue" rights because insurance companies are required by law to issue you a policy. For example:

- Your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or stops giving care in your area (see Situation #1 on pages 43-47); or
- You move outside your Medicare health plan's service area (see Situation #2 on pages 47-50); or
- You leave the Medicare health plan because it failed to meet its contract obligations to you (see Situation #2 on pages 47-50); or
- You are in an employer group health plan that supplemented or paid some of the costs not paid for by Medicare, and the plan ends your coverage (see Situation #2 on pages 47-50); or
- Your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, Medicare SELECT policy, Programs of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own. For example, the company goes bankrupt (see Situation #2 on pages 47-50); or
- You dropped your Medigap policy to join a Medicare managed care plan, or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave that plan or policy

For more information on PACE, see pages 19 and 76.

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

within one year after joining (see Situation #3 on pages 51-54); or

- You joined a Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year of joining, you decided to leave the Medicare health plan (see Situation #4 on pages 55-57).

In these situations, the Medigap insurance company can't deny you insurance, place conditions on a policy, or charge you more for a policy because of past or current health problems. If you think any of these situations applies to you, call your State Health Insurance Assistance Program (see pages 88-89) to make sure that you qualify. If you are denied Medigap coverage, you should call your State Insurance Department (see pages 86-87).

If you live in Massachusetts, Minnesota, or Wisconsin, you have the right to buy a Medigap policy that is similar to the standardized policies you can buy in other states. For more information, call your State Insurance Department (see pages 86-87).

Note: If you are under age 65 and disabled or have End-Stage Renal Disease, you may have the right to buy certain Medigap policies that are sold to people under age 65 (see pages 39-40). For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Using a Medigap Policy

How do my bills get paid if I have a Medigap policy?

Information on how your bills are paid should come with your Medigap policy. Your insurance company can also tell you how your claims are filed.

Generally, when you get health care covered by both Medicare and your Medigap policy, you will not have to file a separate claim to the Medigap insurance company. The Medicare Carrier that handles Medicare claims for your area will send your claims to the Medigap insurance company. To find out more about Medigap claims, see page 62.

Will Medicare and Medigap pay if I sign a private contract with my doctor?

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. By signing a private contract, you agree to pay whatever the doctor charges you and there is no limit on what can be charged. Medicare and Medigap will **not** pay for any health care service you get from that doctor. (For more detailed information about private contracts, see page 63.) You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract with your doctor (see pages 88-89).

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance

What other kinds of health insurance or programs, besides Medigap, will pay for some of my health care costs not covered by Medicare?

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

- Employee or retiree coverage from an employer or union: Call your benefit administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment. Since this kind of health insurance coverage is not a Medigap policy, the rules that apply to Medigap policies do not apply.

- COBRA Coverage (Consolidated Omnibus Budget Reconciliation Act of 1985): This law requires an employer to let you and your dependents stay covered under the employer's group health plan for a certain length of time after losing your job, having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium. For more information on COBRA, see pages 70-72.

- The PACE Program (Programs of All-Inclusive Care for the Elderly): This program combines both inpatient and outpatient medical and long-term care services for eligible persons. To be eligible, you must be at least 55 years old, live in the service area of a PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent, and living in your community as long as possible, and to provide quality care at low cost. For more information on PACE, see page 76.

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

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

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance (continued)

- Federally Qualified Health Centers (FQHCs): These are special health centers, like a community health center, tribal health clinic, migrant health service, and health center for the homeless, that can give you routine health care at a lower cost. For more information on FQHCs, see page 77.

- Medicaid: This is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. If you cannot afford to pay your Medicare premiums and other health care costs, you may be able to get help from your state. For more information on Medicaid, see pages 78-79.

- Hospital Indemnity Insurance: This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. **It is not designed to fill gaps in your Medicare coverage**. For more information on hospital indemnity insurance, see page 80.

- Specified Disease Insurance: This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. **It is not designed to fill gaps in your Medicare coverage**. For more information on specified disease insurance, see page 80.

- Long-Term Care Insurance: This kind of insurance policy may cover medical and non-medical care like care to help you with your daily needs, such as bathing, dressing, using the bathroom, and eating. Generally, Medicare does not pay for long-term care. This type of insurance may help fill some gaps in the coverage that you and/or your spouse may need in the future. For more information on long-term care insurance, see pages 80-82.

Remember, terms in red are defined on pages 100-103.

Summary of Medigap Basics

Medicare

Depending on where you live, you may have choices in how you get your health care:

- The Original Medicare Plan
- Medicare managed care plans
- Private Fee-for-Service plans - New in 2000

Medicare does not pay for all your health care. Medigap policies are designed to fill gaps in the Original Medicare Plan coverage.

Medigap Policies

- Up to 10 standardized Medigap plans may be available in your state (except in Massachusetts, Minnesota, and Wisconsin, see pages 94-96).
- Medigap policies only help pay health care costs if you have the Original Medicare Plan.
- Medigap policies (including Medicare SELECT) are sold by private insurance companies to help fill the gaps in the Original Medicare Plan.
- You choose the policy you want and pay a premium to the insurance company.

Using a Medigap Policy

- In most cases, your Medicare Carrier sends your claims to the Medigap insurance company.

Other Kinds of Health Insurance

There are other kinds of health care programs or insurance to help pay health care costs, like:

- Employer or Retiree Health Coverage
- COBRA
- PACE
- FQHC
- Medicaid
- Hospital Indemnity Insurance
- Specified Disease Insurance
- Long-Term Care Insurance

Note: These are not Medigap policies.

Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a Medicare managed care plan, or a Private Fee-for-Service plan (available in 2000 in some areas). You may also want to think about your long-term care needs (see pages 80-82).

Part 2 - Beyond the Basics ▸

Part 2 goes beyond the basics. It gives more detailed information about what you learned in Part 1.

Buying a Medigap Policy .....Pages 23-61

Your Medigap Policy Choices .....Pages 23-24
What Medigap Policies Cover .....Pages 24-27
Shopping for a Medigap Policy .....Pages 27-35
Medigap Policies for People Age 65 and Older .....Pages 36-39
Medigap Policies for People Under Age 65 .....Pages 39-40
Medigap Protections .....Pages 41-61

Using a Medigap Policy .....Pages 62-66

How Your Bills Get Paid.....Page 62
Private Contracts.....Page 63-64
Switching Medigap Policies.....Pages 64-66

Other Kinds of Health Insurance .....Pages 67-82

Group Health Coverage .....Pages 67-69
More on Employee Coverage .....Pages 69-72
Who Pays First .....Pages 72-75
Other Health Insurance Options .....Pages 76-79
Other Private Health Insurance Options.....Page 80
Long-Term Care Insurance.....Pages 80-82

Watch Out for Illegal Insurance Practices.....Page 83

Discrimination.....Page 84

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy

Your Medigap Policy Choices

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 94-96.

What are my Medigap policy choices?

In all but three states (Massachusetts, Minnesota, and Wisconsin), you can buy any one of up to 10 standardized Medigap policies that are sold in your state. Plan A is the "basic" benefit package and is included in all the other plans. Insurance companies must give you the benefits offered under each policy.

Federal law lets states allow an insurer to add "new and innovative benefits" to the benefits in a standardized policy. Check with your insurance company to find out if these benefits are available.

What is Medicare SELECT?

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

If you do not use a Medicare SELECT provider for non-emergency services, you will have to pay what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what provider you choose. Medicare SELECT might not be offered in your state.

For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Is there any other important information I need to know?

There are many situations when your health coverage changes (like losing your Medicare managed care plan or employer coverage) that can affect what

Remember, terms in red are defined on pages 100-103.

Buying a Medigap Policy (continued)

Medigap policies you can buy and when. For more information on your rights to buy a Medigap policy in these situations, see pages 42-61.

What Medigap Policies Cover

What are the basic (core) benefits in all standardized Medigap plans?

- Coverage for the Part A coinsurance amount ($194 per day in 2000) for days 61-90 of a hospital stay in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($388 per day in 2000) for days 91-150 of a hospital stay while using Medicare's 60 lifetime reserve days (which you may only use once).
- After you use up all Medicare hospital benefits, coverage for 100% of the Medicare Part A eligible hospital expenses. You have this coverage for up to 365 more days of inpatient hospital care during your lifetime. After you use up your Medigap hospital benefits, you may have to pay the full cost of hospital expenses.
- Coverage under Medicare Part A and Part B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless this blood is replaced.
- Coverage for the coinsurance amount for Part B services (generally 20% of Medicare-approved amount) after you meet the $100 annual deductible.

For a higher Medigap premium, you can buy extra benefits (see pages 25-27).

Remember, terms in red are defined on pages 100-103.

Medigap Extra Benefits

Before you make any decisions about your health care coverage, think about your personal needs. Then, decide if the extra benefits offered are worth the extra premium costs.

Medicare Hospital Deductible

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

Medigap Plans B through J cover the Medicare hospital deductible, which is $776 in 2000. Keep in mind that the additional cost that you pay in premiums for this benefit is generally less than the cost of paying the hospital deductible. Each time you have to stay in the hospital you will have to pay the deductible if it's the beginning of a new benefit period.

Skilled Nursing Facility Coinsurance

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

Plans C through J cover the skilled nursing facility coinsurance, which is $97 a day in 2000. Medicare pays all of the covered costs for the first 20 days of care in a skilled nursing facility. If you are in a nursing facility for more than 20 days, Plans C through J will pay the $97 a day coinsurance for days 21 through 100.

Medicare Part B Annual Deductible

Plans C, F, and J

Plans C, F, and J cover the Medicare Part B deductible, which is $100 per year in 2000.

Foreign Travel Emergency

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

Plans C through J cover foreign travel emergencies. This benefit pays for emergency care outside the United States beginning the first 60 days of each trip. After you meet the $250 deductible, this benefit pays 80% of the cost of your care for up to $50,000 in your lifetime. If you travel, this benefit could save you money for emergency care.

Medigap Extra Benefits (continued)

At-Home Recovery
Plans D, G, I, and J

Plans D, G, I, and J cover the cost of at-home help with activities of daily living (like bathing and dressing) in addition to Medicare-covered home health visits. You can get this benefit if you are already getting Medicare-covered home health care services. It also covers home health care for up to 8 weeks after skilled care is no longer needed. However, it will not pay more than $40 each visit and $1,600 each year.

Medicare Part B Excess Charge
Plans F, G, I, and J

Plans F, G, I, and J cover Medicare Part B excess charges when your doctor charges more than Medicare will pay. These policies pay the difference between your doctor's charge and Medicare's approved amount. Plans F, I, and J pay all of the excess charges. Plan G pays 80% of the excess charges. Under federal law, doctors who don't accept "assignment" (take Medicare's approved amount as payment in full) may charge up to 15% more than the Medicare-approved amount (some states have even stricter limits). For example, if Medicare approves $100, your doctor can charge as much as $115. Plan F, I, or J would cover the $15 difference. Plan G would pay you $12 (80% of $15).

Assignment can save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free brochure.

Preventive Care
Plans E and J

Plans E and J cover preventive care, which is limited to $120 each year. The preventive care benefit helps pay for routine yearly check-ups, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

Prescription Drugs
Plans H, I, and J

Plans H, I, and J offer some prescription drug coverage. This benefit has a $250 yearly deductible and pays 50% of drug costs that Medicare doesn't cover. It will only pay up to $1,250 a year under Plans H and I, and up to $3,000 a year under Plan J. You may think about this benefit if you have high prescription drug costs. Because it covers half your drug costs after the yearly deductible, to get the full benefit under Plans H and I, you should have at least $2,750 in drug costs in a year (you pay $1,250 plus $250; plan pays $1,250). To get the full benefit under Plan J, you should have at least

Remember, terms in red are defined on pages 100-103.

Medigap Extra Benefits (continued)

$6,250 in drug costs in a year (you pay $3000 plus $250; plan pays $3,000). Note: In some states, you may not be able to get policies with a prescription drug benefit unless you enroll during your open enrollment period.

Insurance companies may offer a high deductible option on Plans F and J. For more information on this option, see page 11.

More Information

For more information on Medigap policies, see the chart on page 10 or use a computer to look on the Internet at www.medicare.gov. Click on "Medigap Compare."

Shopping for a Medigap Policy

"When I was looking for my Medigap policy, I looked at what different policies cover, their prices, whether they covered prescription drugs...Once I found the company I wanted, I called the State Insurance Department to make sure it was a reliable company."

Janice, Washington, D.C.

Remember, terms in red are defined on pages 100-103.

What should I keep in mind as I shop for a Medigap policy?

As you shop for a Medigap policy, keep in mind that each company's benefits are alike, so they are competing on service, reliability, and price. Compare premiums and make sure that the insurance company is honest and reliable before buying. Insurer rating services look at the financial health of insurance companies. Different rating services use different rating scales. Be sure to find out how the rating service labels its highest ratings and the meaning of the ratings for the companies you are considering. You can get ratings from some insurer rating services for free at most public libraries.Your State Insurance Department can also give you information about the insurance companies (see pages 86-87). You can also use a computer to look on the Internet at www.medicare.gov. Click on "Medigap Compare."

Federal law lets states allow an insurer to add "new and innovative benefits" to the benefits in a standardized policy. Check with your insurance company to find out if these benefits are available.

Shopping for a Medigap Policy (continued)

What do I need to know about Medigap policy premiums?

There can be big differences in the premiums that insurance companies charge for exactly the same coverage. When you compare premiums, be sure you are comparing the same Medigap policies.

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

- **No-age-rated (also called community-rated) policies**

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

Example:
Sally pays the same premium at each age.

Premium at Age 65	$60
Premium at Age 75	$60
Premium at Age 85	$60

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

- **Issue-age-rated policies**

  The premium for these policies is based on your age when you first buy the policy, and the cost does not go up automatically as you get older.

Example:
Sally pays the same premium depending on how old she is when she buys the policy.

Buy Policy at Age 65

Premium at Age 65	$70
Premium at Age 75	$70
Premium at Age 85	$70

Shopping for a Medigap Policy (continued)

Buy Policy at Age 75

Premium at Age 65	--
Premium at Age 75	$95
Premium at Age 85	$95

Buy Policy at Age 85

Premium at Age 65	--
Premium at Age 75	--
Premium at Age 85	$130

- **Attained-age-rated policies**

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

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

Example:
Sally pays higher premiums as she gets older.

Premium at Age 65	$50
Premium at Age 75	$85
Premium at Age 85	$120

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

Shopping for a Medigap Policy (continued)

What other factors may affect my premium when I buy a Medigap policy?

Other factors that may affect your premium when you buy a Medigap policy are:

- Whether you are male or female. Some companies offer discounts for females.
- Whether you smoke or not. Some companies offer discounts for non-smokers.
- Whether you are married or not. Some companies offer discounts for married couples.

What is underwriting? Can it affect the cost of my Medigap policy?

Medical underwriting is the process that a company uses to review your health and decide whether to accept your application for insurance. You usually must answer medical questions on an application. You need to fill out this application carefully (see page 34). Some companies may want to review your medical records before they sell you a policy. The company may use this information to add a waiting period for pre-existing conditions if your state law allows. The company may also use this information to decide how much to charge you for a Medigap policy.

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

Insurance companies may "medically underwrite" any Medigap policy at times other than open enrollment or when you have a right to buy a Medigap policy (see pages 41-61).

Remember, terms in red are defined on pages 100-103.

Shopping for a Medigap Policy (continued)

Whether you need a Medigap policy is a decision that only you can make. Depending on your health care needs and finances, you may want to continue your employee or retiree health coverage, or join a Medicare managed care plan or a Private Fee-for-Service plan (available in 2000 in some areas). You may also want to think about your long-term care needs (see page 80).

Shopping Tips

If you decide to buy a Medigap policy, shop carefully. Look for a policy that you can afford and that gives you the coverage you need most. Read the following tips to help you shop for a Medigap policy.

☑ Review the plans

The benefits in each of the standardized Medigap policies are the same no matter which insurance company sells it. Review the plans and choose the benefits that you need most.

☑ Shop carefully before you buy

Although each of the standardized Medigap policies is the same no matter which insurance company sells it, the costs may be very different. Companies use different ways to price Medigap policies. Companies also differ in customer service. Call different insurance companies and compare cost and service before you buy.

☑ Don't buy more than one Medigap policy at a time

It is illegal for an insurance company to sell you a second Medigap policy unless you tell them in writing that you are going to cancel the first Medigap policy when the second Medigap policy goes into effect. Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) to report anyone who tries to sell you a Medigap policy when you already have one.

Shopping for a Medigap Policy (continued)

☑ Check for pre-existing condition exclusions

Before you buy a Medigap policy, you should find out whether it has a waiting period before it fully covers your pre-existing conditions. If you have a health problem that was diagnosed or treated during the 6 months immediately before the Medigap policy starts, the policy might not cover your costs right away for care related to that health problem. Medigap policies must cover pre-existing conditions after the policy has been in effect for 6 months. Some insurance companies may have shorter waiting periods before covering a pre-existing condition. Other insurance companies may not have any waiting period. If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have. This is called creditable coverage (see page 38).

☑ Be careful of switching from one Medigap policy to another

You should only switch policies to get different benefits, better service, or a better price. However, do not keep a policy that does not meet your needs because you have had it for a long time. If you decide to buy a new Medigap policy, the company must count the time you had the same benefits under the first policy towards the pre-existing condition waiting period. However, you may have a waiting period for pre-existing conditions for new benefits that you did not have under your first policy. You must also sign a statement that you plan to cancel the first policy. Do not cancel the first policy until you are sure that you want to keep the new policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.

☑ Make sure you get your policy within 30 days

You should get your policy within 30 days. If you do not, call the company and ask them to put in writing why the policy was delayed. If 60 days go by without an answer, call your State Insurance Department (see pages 86-87).

Shopping for a Medigap Policy (continued)

☑ Watch out for illegal marketing practices

It is illegal for an insurance company or agent to pressure you into buying a Medigap policy, or lie to you or mislead you to get you to switch from one company or policy to another. False advertising is also illegal. Another type of illegal advertising involves mailing cards to people who may want to buy insurance. If you fill out and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

☑ Neither the state nor federal government sells or services Medigap policies

State Insurance Departments approve Medigap policies sold by private insurance companies. This means that the company and Medigap policy meet requirements of state law. Do not believe statements that Medigap insurance is a government-sponsored program (like the Original Medicare Plan). It is illegal for anyone to tell you that they are from the government and try to sell you a Medigap policy. If this happens to you, report that person to your State Insurance Department (see pages 86-87). It is also illegal for a company or agent to claim that a Medigap policy has been approved for sale in any state in which it has not been.

☑ Find out if the insurance company is licensed

An insurance company must meet certain standards in order to sell policies in your state. You should check with your State Insurance Department to make sure that the insurance company you are doing business with is licensed in your state. This is for your protection. Insurance agents must also be licensed by your state and the state may require them to carry proof that they are licensed. The proof will show their name and the name of the companies they represent. Do not buy a policy from any insurance agent that cannot prove that he or she is licensed. **A business card is not a license**.

Shopping for a Medigap Policy (continued)

☑ Start looking early so you won't be rushed

Do not be pressured into buying a Medigap policy. Good sales people will not rush you. Keep in mind, that if you are within your 6-month Medigap open enrollment period (see page 36) or in a situation where you have a guaranteed right to buy a Medigap policy, there are time limits you must follow (see pages 41-61). Buying the Medigap policy of your choice may be harder after the Medigap open enrollment or special protection period ends. This will be especially true if you have a pre-existing health condition. If you are not sure whether a Medigap policy is what you need, ask the salesperson to explain it to you with a friend or family member present.

☑ Keep agents' and/or companies' names, addresses, and telephone numbers

Write down the agents' and/or companies' names, addresses, and telephone numbers or ask for a business card with this information.

☑ If you decide to buy, fill out the application carefully

Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. You must answer the medical questions even if you are applying during your Medigap open enrollment period (see page 36) or you are in a situation where you have the right to buy a Medigap policy (see pages 41-61). During these two times, the company cannot use your answers to turn you down or use this information to decide how much to charge you for a Medigap policy. However, if you leave out any of the medical information they ask for, the company could refuse to cover you for a period of time for any medical condition you did not report. The company also could deny a claim or cancel your Medigap policy if you send in a bill for care of a health problem you did not report.

Shopping for a Medigap Policy (continued)

☑ Beware of non-standardized plans

It is illegal for anyone to sell you a policy and call it a Medigap policy if it does not match the standardized Medigap policies sold in your state. A doctor may offer you a "retainer agreement" that says he/she can provide certain non-Medicare-covered services and not charge you the Medicare coinsurance and deductible amounts. This type of agreement may be illegal. If a doctor refuses to see you as a Medicare patient unless you pay him or her a yearly fee and sign a "retainer agreement," you should call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

☑ Look for an outline of coverage

You must be given a clearly worded summary of a Medigap policy. **Read it carefully**.

☑ Do not pay cash

Pay by check, money order, or bank draft payable to the insurance company, not the agent or anyone else. Get a receipt with the insurance company's name, address, and telephone number for your records.

Medigap Policies for People Age 65 and Older

When do most people buy a Medigap policy?

Most people buy a Medigap policy during their Medigap open enrollment period. Your Medigap open enrollment period lasts for six months after the first day of the month in which you are both age 65 or older **and** enrolled in Medicare Part B. Once the six month Medigap open enrollment period starts, it cannot be changed. During this time, you have the right to buy the Medigap policy of your choice and the insurance company cannot deny you insurance coverage, place conditions on a policy (like making you wait for coverage to start), or change the price of a policy because of past or present health problems. If you buy a policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of previous health coverage you have. This is called creditable coverage (see page 38).

Example (Open Enrollment) ▸

Mr. Smith is 68 and has heart disease. He has just enrolled in Medicare Part B and his coverage starts on March 1, 2000. Mr. Smith has until September 1, 2000 to buy his Medigap policy without his heart disease affecting the cost or type of policy he can choose. After September 1, 2000, Mr. Smith will not have this guarantee.

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

Your Medicare card shows the dates that your Part A and/or Part B coverage started. If you are age 65 or older, you can figure out whether you are in your Medigap open enrollment period by adding 6 months to the date that your 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.

Remember, terms in red are defined on pages 100-103.

Medigap Policies for People Age 65 and Older (continued)

"My wife had an insurance policy through her employer and I was on her policy. When she retired, she changed to my policy. Then, when I retired, we decided to get Medicare Part B and buy a Medigap policy."

Larry,
Boston, Massachusetts

Example ▸

Remember, terms in red are defined on pages 100-103.

Should I enroll in Medicare Part B and start my Medigap open enrollment period if I am age 65 or over and still working?

If you enroll in Medicare Part B to supplement your employer or union coverage, you will start your Medigap open enrollment period when it may be of little use to you. You may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your or your spouse's **current or active** employment (see page 5 "Special Enrollment Period"). Carefully consider your options. **Once you are age 65 or older and enrolled in Part B, the 6-month Medigap open enrollment period starts and cannot be changed.**

Mrs. Poole just turned 65. She is still working and has health coverage through her employer. She decides to enroll in Medicare Part B. Her coverage will begin on May 1, 2000. Mrs. Poole decides she doesn't need to buy a Medigap policy because her employer group health plan covers the same benefits as a Medigap policy. However, once she is enrolled in Part B, her Medigap 6-month open enrollment period will start. Therefore, Mrs. Poole will have until November 1, 2000 to buy the Medigap policy of her choice without conditions or price changes even though she doesn't need it.

Should I wait to get Medicare Part B and start my Medigap open enrollment period if I am in good health?

If you are over age 65 and still working, you may want to wait to take Part B until you can make the best use of your Medigap insurance open enrollment period. However, the cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see page 5, "Special Enrollment Period"). An insurance

Medigap Policies for People Age 65 and Older (continued)

company would probably accept your application, use medical underwriting to decide if they will sell you a policy, and charge you a reasonable premium. However, this is not guaranteed. Remember, your health could change at any time!

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

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

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

What is creditable coverage?

Creditable coverage is any previous health coverage you had under:

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

Remember, terms in red are defined on pages 100-103.

Medigap Policies for People Age 65 and Older (continued)

Example (Creditable Coverage) ▶

Mrs. Johnson is 68 and has heart disease. She has had Medicare Part B since November 1, 2000. Before this date, she had no health insurance. On March 1, 2001, Mrs. Johnson buys a Medigap policy. Her insurance company may refuse to cover her pre-existing heart disease condition for 6 months (the pre-existing condition waiting period). However, Mrs. Johnson can use her 4 months of Medicare Part B coverage to shorten this 6 month pre-existing condition waiting period. This waiting period will now be 2 months instead of 6 months. During these 2 months, after Medicare pays its share, Mrs. Johnson will have to pay the rest of the costs for the care of her heart disease.

Medigap Policies for People Under Age 65

Is there a Medigap open enrollment period for people under age 65 who first get Medicare because of a disability or End-Stage Renal Disease (ESRD)?

Yes, but only when you turn age 65.

You may have Medicare Part B benefits before age 65 due to a disability or ESRD (permanent kidney failure treated with dialysis or a kidney transplant). In this case, you may not be able to buy a Medigap policy right away, but you will have the right to choose and buy any Medigap policy when you turn age 65. It does not matter that you had Medicare Part B before you turned age 65.

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

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

Medigap Policies for People Under Age 65 (continued)

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

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

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

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

Also, if you join a Medicare health plan and your coverage ends, you may have the right to buy a Medigap policy (see Situations #1 and #2 on page 42).

If you have questions, you should call your State Health Insurance Assistance Program (see pages 88-89).

Remember, terms in red are defined on pages 100-103.

Introduction to Medigap Protections

What are Medigap protections?

Medigap protections are special rights you have to buy a Medigap policy in addition to your Medigap open enrollment period. These are also called "guaranteed issue" rights because insurance companies are required by law to issue you a policy. These protections are important because if you do not buy a Medigap policy during your Medigap open enrollment period, an insurance company might be able to refuse to sell you a policy, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back unless you have this protection.

The Medigap protections in this section are from federal law. Some states provide more Medigap protections than federal law. At the time this Guide was printed, these states reported that they offer more Medigap protections than federal law requires:

- Arkansas
- Delaware
- Florida
- Iowa
- Illinois
- Indiana
- Kansas
- Maine
- Massachusetts
- North Carolina
- New Hampshire
- New Mexico
- Nevada
- New York
- South Dakota
- Texas
- Virginia
- Vermont
- Wisconsin
- West Virginia
- Wyoming

Call your State Insurance Department (see pages 86-87) or State Health Insurance Assistance Program (see pages 88-89) to find out if your state offers more Medigap protections than federal law.

Medigap Protections

When do I have a right to Medigap protections?

There are a few types of situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy even when you are not in your Medigap open enrollment period. For example:

1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see Situation #1 on pages 43-47), or

2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy or Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own including your moving outside of the plan's service area (see Situation #2 on pages 47-50), or

3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave the plan or policy within one year after joining (see Situation #3 on pages 51-54), or

4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65 and within one year of joining, you decided to leave the health plan (see Situation #4 on pages 55-57).

Each situation will be discussed in detail on the following pages.

If you live in Massachusetts, Minnesota, or Wisconsin, you have the right to buy a Medigap policy that is similar to the standardized policies you have a right to buy in the other states. Call your State Insurance Department (see pages 86-87).

Medigap Protections (continued)

Situation #1

Can I buy a Medigap policy if my Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or stops giving care in my area?

If your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or stops giving care in your area, you have the right to buy Medigap plans A, B, C, or F that are sold in your state.

In some cases, you have the right to return to your old Medigap policy (see Situation #3 on pages 51-54) or to buy any of the 10 standardized Medigap policies sold in your state (see Situation #4 on pages 55-57).

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

1. **Stay in your plan until the date your coverage ends.** You have 63 calendar days after your health coverage ends to apply for a Medigap policy.

2. **Switch to another Medicare managed care plan in your area.** In some cases, you may have to wait until the new plan is accepting new members to join.

3. **Leave your plan (disenroll) as soon as you get your letter.** You have 63 calendar days from the date on the letter from your Medicare managed care plan or Private Fee-for-Service plan telling you that the plan will no longer be giving care in your area, to apply for a Medigap policy.

Choice #3 only applies to Private Fee-for-Service plans or Medicare managed care plans with a "Medicare + Choice" contract (not a "cost contract").

Medigap Protections (continued)

Situation #1 (continued) ▸

Call your managed care plan to find out what kind of contract they have so you will know if you can leave the plan as soon as you get your letter without losing your Medigap protections.

You have the right to buy Medigap plans A, B, C, or F that are sold in your state. If you decide to leave your plan before your coverage ends, you must turn in a **written** request to your plan telling them you want to leave (disenroll).Your coverage will end on the last day of the month in which your plan gets your written request to leave (see Example #1a).

Example #1a ▸

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan (with a Medicare + Choice contract) telling her that the plan will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to get health care coverage from the Original Medicare Plan. She turns in her written request to leave her plan on October 12, 2000. Her coverage will end October 31, 2000. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by December 2, 2000 (63 calendar days from the date on the plan's letter to her).

Medigap Protections (continued)

Situation #1 (continued) ▸

As long as you apply for your new Medigap policy no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends (see Example #1b), the insurance company:

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

Example #1b ▸

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan telling her that it will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to stay in her plan until her coverage ends on December 31, 2000. She will automatically be enrolled in the Original Medicare Plan starting January 1, 2001. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by March 4, 2001 (63 calendar days after her health coverage ends).

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

Medigap Protections (continued)

Situation #1 (continued) ▸

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65. However, if any insurance company in your state sells Medigap plans A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situation #1, #2, or #3 listed on page 42. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Summary of your Medigap Protections if your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program or will no longer be giving care in your area:

- You may have three choices about what to do, and when to do it (see page 43);
- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (such as making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation #1 (continued) ▸

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

Remember, if you wish to leave the plan as soon as you get your letter without losing your Medigap protections, you should first call your managed care plan to make sure it has a "Medicare + Choice" contract rather than a "cost contract."

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Situation # 2 ▸

Can I buy a Medigap policy if my health coverage ends other than in the case where my Medicare managed care plan leaves the Medicare program?

For more information on PACE, see page 76.

If your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, or Programs of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends, in certain situations you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You must apply no later than 63 calendar days after your health coverage ends.

The insurance company must sell you one of these Medigap plans if:

- You move outside of the plan's service area (the

Medigap Protections (continued)

Situation # 2 ▸ (continued)

area where the plan accepts members and where you get services from the plan); or

- You leave the health plan because it failed to meet its contract obligations to you (for example, the marketing material was misleading or quality standards were not met); or
- You were in an employer group health plan that supplemented or paid some of the costs not paid for by Medicare, and the plan ends your coverage; or
- Your insurance company ends your Medicare SELECT policy and you're not at fault (for example, the company goes bankrupt); or
- Your PACE program stops participating in Medicare or stops giving care in your area.

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

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

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage (see Example #2 on page 49).

Caution: In most cases in Situation #2, you must stay in your health plan until the date your coverage ends. If you leave the plan before that date, you may lose your right to buy Medigap plans A, B, C, or F that are sold in your state.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 2 (continued) ▸

Example #2 ▸

Mrs. Jones was covered under an employer group health plan that paid some of the costs not paid for by Medicare. She got a letter in the mail telling her that her health plan coverage was ending on April 5, 2000. Mrs. Jones wanted to buy a Medigap policy that would help pay her health care costs not covered by Medicare. Because her health care coverage was ending, Mrs. Jones had the right to buy Medigap plans A, B, C, or F that were sold in her state as long as she applied by June 7, 2000 (63 calendar days after her health coverage ended). She had to stay in her employer group health plan until the date her coverage ended, or she would lose her right to buy one of these Medigap plans. Mrs. Jones applied for a Medigap policy on March 16, 2000 and chose to start her Medigap coverage on April 6, 2000, the day after her health coverage ended. This prevented gaps in her health coverage.

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

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65. However, if any insurance company in your state sells Medigap plans

Medigap Protections (continued)

Situation # 2 (continued) ▶

A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situations #1, #2, or #3 listed on page 42. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Summary of your Medigap Protections if your health coverage ends (except in the case where your Medicare managed care plan or Private Fee-for-Service plan leaves the Medicare program, see page 43):

- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;
- If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are otherwise sold in your state to people under age 65 with Medicare.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may

Medigap Protections (continued)

still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Situation # 3 ▸

If I drop my Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy, and then leave the plan or policy, will I be able to get my Medigap policy back?

Maybe. If you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or a Private Fee-for-Service plan) or buy a Medicare SELECT policy, and then leave the plan or policy, under certain conditions, you may be able to return to the Medigap policy you had before (if it is still available).

You have this protection, if:

- This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and
- You leave the Medicare health plan or Medicare SELECT policy within one year after joining.

You must apply for your former Medigap policy no later than 63 calendar days after your Medicare health plan coverage ends (see Example #3 on page 53). If your former Medigap policy is no longer available, see “What can I do if the Medigap policy I had is no longer available?” on page 52.

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

Medigap Protections (continued)

Situation # 3 (continued) ▶

coverage ends. This will prevent gaps in your health coverage (see Example #3 on page 53.)

Important: If you bought a Medigap policy before 1990, your policy is not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.

What can I do if the Medigap policy I had is no longer available?

If your former Medigap policy is no longer available, you have the right to buy Medigap plans A, B, C, or F from any insurance company which sells these plans in your state. You must apply no later than 63 calendar days after your Medicare health plan coverage ends. As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

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

Important information about Medicare SELECT policies.

You may also have this same protection if you dropped a Medicare SELECT policy to join a Medicare health plan (like a Medicare managed care plan). This is because a Medicare SELECT policy is a type of Medigap policy.

Medigap Protections (continued)

Situation # 3 (continued) ▶

If you currently have a Medicare SELECT policy, you also have the right to switch, at any time, to a regular Medigap policy that is sold by the same company (if any are available). The Medigap policy you switch to must have equal or less coverage than the Medicare SELECT policy you currently have.

Example #3 ▶

Mr. Perkins joined a Medicare managed care plan on December 1, 2000. He had never been in a Medicare managed care plan before. Before that, Mr. Perkins was in the Original Medicare Plan and had a Plan J Medigap policy. Six months later, Mr. Perkins decided to leave the managed care plan and return to the Original Medicare Plan. He put in his request in writing to leave his managed care plan on June 5, 2001. His managed care plan coverage ended on June 30, 2001. Because this was the first time he had ever been in a Medicare managed care plan, he had the option of returning to his Plan J Medigap policy as long as he applied for it by September 1, 2001 (63 calendar days after his health coverage ended). Mr. Perkins found out that his Medigap insurance company still sold Medigap policy Plan J. He applied for it on June 10, 2001, and chose to start his Medigap coverage on July 1, 2001, the day after his Medicare health plan coverage ended. This prevented gaps in his health coverage.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 3 (continued) ▶

Summary of your Medigap protections if you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan), or buy a Medicare SELECT policy for the first time, then leave the plan or policy within one year after joining:

- You have the right to return to your former Medigap policy (if it is still available from the same insurance company). You must apply no later than 63 calendar days after your Medicare health plan coverage ends;
- If your former policy is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Medigap Protections (continued)

Situation # 4 ▸

Is there any other time when I have the right to buy any of the 10 standardized Medigap policies, other than during my Medigap open enrollment period?

Yes. You have the right to buy **any** Medigap policy sold in your state if:

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

This only applies to Private Fee-for-Service plans or Medicare managed care plans with a Medicare + Choice contract. Call your managed care plan to find out if they have a Medicare + Choice contract.

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

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

You should not wait until your Medicare health plan coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your Medicare health plan) and choose to start your Medigap coverage the day after your Medicare health plan coverage ends. This will prevent gaps in your health coverage (see Example #4 on page 56).

*You are eligible for Medicare on the first day of the month in which you turn age 65. If your birthday is on the first day of the month, your Medicare coverage starts on the first day of the month before your birthday.

Medigap Protections (continued)

Situation # 4 (continued) ▶

Note: If you are still in your 6-month Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

Example #4 ▶

Mrs. Miner joined a Medicare managed care plan on February 1, 2000, the first day of the month in which she turned 65. Six months later, she decided to leave her plan. She turned in her written request to leave her plan on August 3, 2000. Her managed care plan coverage ended on August 30, 2000. Since she did not choose to join another managed care plan, she was automatically enrolled in the Original Medicare Plan. Mrs. Miner had the right to buy any Medigap policy, as long as she applied by November 2, 2000 (63 calendar days after her health coverage ended). Mrs. Miner applied for her Medigap policy on August 25, 2000, and chose to start her Medigap coverage on September 1, 2000, the day after her Medicare health plan coverage ended. This prevented gaps in her health coverage.

Remember, terms in red are defined on pages 100-103.

Medigap Protections (continued)

Situation # 4 (continued) ▸

Summary of Medigap protections when you joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and you leave the plan within one year after joining:

- You have the right to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet these conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 88-89).

General Medigap Protection Information

If you think any of the previous situations apply to you, you may have the right to buy a Medigap policy. Call your State Health Insurance Assistance Program (see pages 88-89) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.

Important: When your health coverage ends (see Situation #1 on page 43 and Situation #2 on page 47), your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you to prove that you have been denied your Medigap rights if this happens.

If you are denied Medigap coverage, call your State Insurance Department (see pages 86-87).

Remember, to get these protections, you must apply no later than 63 calendar days after your health coverage ends.

Summary of Medigap Protections Chart

The following chart is a summary of the situations, explained on the previous pages, that may give you the right to buy a Medigap policy when your health coverage changes, and the protections that apply for each situation. In order to get these Medigap protections, you must meet certain conditions. See the following chart for more details. If you live in Massachusetts, Minnesota, or Wisconsin see page 42 for your protections.

Note: There may be times when more than one of these situations apply to you. When this happens, you may want to choose the protection that gives you the best choice of policies. For example, if both situations #1 and #4 apply to you, you may have the right to buy any Medigap policy. This is because situation #4 offers you the best choice by allowing you to buy any Medigap policy that is sold in your state. Situation #1 limits your choices to only Medigap plans A, B, C, or F that are sold in your state.

Your Health Coverage Situation	Medigap Protections
1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or will no longer give care in your area.	You may have three choices. (For more information on these three choices, see page 43.) You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days from the date on the letter from your plan (for Medicare health plans with a Medicare + Choice contract) or no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or **ESRD**, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. Remember, there is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65.

Your Health Coverage Situation	Medigap Protections
2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or a Medicare managed care demonstration project) ends through no fault of your own.	You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or **ESRD**, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. **Caution:** In most cases, you must stay in your health plan until the date your coverage ends. If you leave the plan before this date, you may lose your right to buy Medigap plans A, B, C, or F.

Your Health Coverage Situation	Medigap Protections
3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy, then leave the plan or policy, and: ■ This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and ■ You leave the Medicare health plan or Medicare SELECT policy within one year after joining.	You must be allowed to return to your former Medigap policy if it is still available from the same insurance company. You must apply no later than 63 calendar days after your health coverage ends. If it is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. **Caution:** If you bought a Medigap policy before 1990, your policy is probably not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.
4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract, or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and you leave the plan within one year after joining.	You must be allowed to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. Note: If you are still in your Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy.

All rights to buy Medigap policies under these protections include Medicare SELECT policies since they are a type of Medigap policy.

Using a Medigap Policy

How Your Bills Get Paid

Does the Medigap insurance company pay my doctor directly?

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

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

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

In most cases, Medicare claims are sent directly to the insurance company, even if the doctor does not accept assignment (also called a participation agreement).

What happens if the Medigap insurance company does not pay my doctor directly?

If the Medigap insurance company does not pay your doctor directly (when the above three conditions are met), you should report this to your State Insurance Department (see pages 86-87). For more information on Medigap claim filing by the carrier, call your Medicare Carrier (see pages 92-93).

Remember, terms in red are defined on pages 100-103.

Private Contracts

If I sign a private contract with my doctor, will Medicare and Medigap pay?

No. A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to the services given by the doctor who asked you to sign it. This means that Medicare and Medigap will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. **Note:** You still have the right to see other Medicare doctors for services.

What happens if I sign a private contract with my doctor?

If you sign a private contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
- You will have to pay whatever this doctor or provider charges you (the limiting charge will not apply).
- Medicare managed care plans or Private Fee-for-Service plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- Many other insurance plans will not pay for the service either.

Can I pay on my own for services that are not covered by Medicare?

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

Remember, terms in red are defined on pages 100-103.

Private Contracts (continued)

always free to get non-Medicare-covered services on your own if you choose to pay for the service yourself.

A Medigap policy will not pay any coinsurance or deductible amounts on the cost of services that would generally be covered by Medicare, but are denied by a Medicare Carrier or Fiscal Intermediary because they are not medically necessary for a particular patient. However, some of the 10 standardized Medigap policies contain certain benefits that provide payment for limited categories of services that are never covered by Medicare. For example, the foreign travel emergency benefit in plans C through J; the outpatient prescription drug benefit in Medigap plans H, I, and J; the at-home recovery benefit in plans D, G, I, and J; and the preventive care benefit in plans E and J all pay for limited categories of non-Medicare-covered services.

Switching Medigap Policies

Can my Medigap insurance company drop me?

In most cases, no. Medigap policies sold after 1990 are required to be guaranteed renewable. This means that your insurance company must let you renew your Medigap policy unless you do not pay the premiums, you lie, or commit fraud under the policy. There is only one situation where you may lose a Medigap guaranteed renewable policy: if the insurance company goes bankrupt. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state.

Insurance companies may refuse to renew older Medigap policies that were not sold as guaranteed renewable. To do this, an insurance company must decide to cancel all policies of this type sold in your state. If this happens, you have the right to buy Medigap plans A, B, C, or F that are sold in your state (see Example on page 65).

Remember, terms in red are defined on pages 100-103.

Switching Medigap Policies (continued)

Example ▸

In 1987, Mr. Jones bought a Medigap policy from Company A. The Medigap policy Mr. Jones bought was not guaranteed renewable. Company A is no longer offering this type of Medigap policy and wants to cancel all policy contracts of this type. Therefore, Mr. Jones may switch to another Medigap policy. His choices include Medigap policies A, B, C, or F that are sold in his state.

Do I have to switch my older Medigap policy for one of the newer standardized Medigap plans?

No, you do not have to switch your policy.

What should I do before switching my Medigap policy?

Before switching policies, compare benefits and premiums. Some of the older Medigap policies may offer better coverage, especially for prescription drugs and long-term care. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies. Older Medigap policies cannot be sold to people who are now buying Medigap insurance.

If I decide to switch my Medigap policy, and then I change my mind, can I go back to my older Medigap policy?

No. If you do switch Medigap policies, you will not be able to go back to your Medigap policy if it was sold to you before 1990.

Remember, terms in red are defined on pages 100-103.

Switching Medigap Policies (continued)

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

No. However, if you had a Medigap policy for at least 6 months and you decide to switch, your second Medigap policy generally must cover you for all pre-existing conditions. If you had a Medigap policy for less than 6 months, the new policy must give you credit for the time you were covered under the older policy. If there is a benefit in the second Medigap policy that was not in your first policy, the company can make you wait up to 6 months before covering that benefit.

Do I need more than one Medigap policy?

No. It is illegal for insurance companies to sell you a second policy. If you already have a Medigap policy and you want to buy another one, you must sign a statement saying that you plan to cancel your first Medigap policy. Do not cancel your first Medigap policy until the second one is in place, the pre-existing condition waiting period is over, and you decide to keep the second Medigap policy. You have 30 days to decide if you want to keep the new policy. This is called your free look period.

Remember, terms in red are defined on pages 100-103.

Other Kinds of Health Insurance

Group Health Coverage

What kinds of group health coverage are there?

There are several kinds of coverage that might be called "group" health coverage, such as coverage offered under:

- Employers or unions: This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than you can get if you buy a policy yourself, and employers may pay part of the cost.

- Organizations or associations: This type of group health coverage is for members of an organization or association. Just because you are buying through a group does not always mean that you are getting a lower rate. This type of coverage can cost as much as, or more than, the same coverage you get with a policy you buy yourself. Be sure you understand the benefits included and how the premiums are decided, then compare prices.

What happens if I have employer or union coverage when I turn age 65?

When you reach age 65 you will need to make a decision about Part B (see page 37). You may still have health coverage through your or your spouse's current or active employer or union membership. If you do, be sure to read the information in the sections "Special Enrollment Period" (see page 5), "More on Employee Coverage" (see pages 69-72), and "Who Pays First" (see pages 72-75). Also, find out if your employer coverage can be continued after you retire. Check the price and benefits, including benefits for your spouse. Make sure you know what effect your continued coverage as a retiree will have on his or her insurance protections.

Group Health Coverage (continued)

How does retiree coverage work?

Retiree coverage that is not a Medigap policy does not have to follow the rules for Medigap policies. However, under some circumstances, retiree coverage must follow the rules of the Department of Labor. These plans might not fill the gaps in Medicare. They might not pay your medical costs during any period in which you were eligible for Medicare but did not sign up for it.

While retiree coverage may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retiree coverage provided by your employer or union may have limits on how much it will pay. It may also provide "stop loss" coverage, or a limit on your out-of-pocket spending after you have already paid a certain amount of out-of-pocket costs.

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

If you are not sure how your plan works with Medicare, get a copy of your plan's benefits booklet, or look at the summary plan description provided by your employer or union. You can also call your benefit administrator and ask how the plan pays when you have Medicare.

What happens if I drop employer-based coverage?

If you drop your employer-based group health coverage, you probably won't be able to get it back. For more information, call your benefit administrator.

Remember, terms in red are defined on pages 100-103.

Group Health Coverage (continued)

What if I buy a Medigap policy while I have retiree coverage?

Although it is generally unwise to buy more insurance than you need, you may buy a Medigap policy even if it has some of the same benefits as your retiree coverage under a group health plan. Your retiree coverage may have a coordination of benefits clause, sometimes called a "carve out." If it does, it will not pay benefits the Medigap policy pays. The Medigap policy must pay full benefits even if the retiree coverage also pays for the same service. You may want to call your benefit administrator or your State Health Insurance Assistance Program (see pages 88-89) before buying a Medigap policy that has the same benefits as your retiree coverage.

More on Employee Coverage

What health benefits must my employer provide if I am age 65 or older and still working?

Employers with 20 or more employees must offer the same benefits, including health benefits under the same conditions, to current or active employees age 65 and over as they offer to younger employees. If they offer coverage to spouses, they must offer the same coverage to spouses age 65 and over that they offer to spouses under age 65. If your employer and/or employer group health coverage does not follow this rule, you should call the Health Care Financing Administration (see page 90).

Note: Sometimes, employee health coverage ends automatically at the end of a calendar year even before you get a notice from your employer that your coverage has ended. This could start the 63 calendar day period for Medigap protections before you even find out you are entitled to them (see pages 47-50). Check with your employer to make sure you understand how your coverage works and how you can protect yourself.

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

What happens if I or my spouse stop working, stop group health coverage, and already have Medicare?

You should:

- Call your Medicare Carrier (see pages 92-93) or write a letter telling them that your or your spouse's employment situation has changed.
- Give the carrier the name and address of the employer plan, your policy number with the group health plan, the date coverage stopped, and why.
- When you get health care services, tell the doctor or hospital that Medicare now pays first and should be billed first. Give the date your group health plan coverage stopped.

Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires your employer to send you a Certificate of Creditable Coverage when your group health coverage ends. All the information you need to give to the Medicare Carrier will be on this certificate. If for some reason your employer does not send you a Certificate of Creditable Coverage, you should ask for one. These certificates are free.

What is COBRA?

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions. This is called "continuation coverage." You may have this right if you lose your job or have your working hours reduced, or if you are covered under your spouse's

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

plan and your spouse dies or you get divorced. COBRA generally lets you and your dependents keep the group coverage for 18 months (or up to 29 or 36 months in some cases), but you may have to pay both your share and the employer's share of the premium. Some state's laws require employers with less than 20 employees to let you keep your group health coverage for a time, but you should check with your State Insurance Department to make sure (see pages 86-87). In most situations that give you COBRA rights, other than a divorce, you should get a notice from your benefit administrator. If you don't get a notice, or if you get divorced, you should call your benefit administrator as soon as possible.

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare. For more information about group health coverage under COBRA, call your State Insurance Department (see pages 86-87).

However, if you elect COBRA coverage after you enroll in Medicare, you can keep your continuation coverage. When your group health coverage ends, you and your dependents can get coverage under COBRA. If you only have Medicare Part A when your group health plan coverage ends (based on **current or active** employment), you can enroll in Medicare Part B during a special enrollment period without having to pay a Part B premium penalty. You need to enroll in Part B **either** at the same time you enroll in Part A **or** during a special enrollment period after your group health plan coverage, based on **current or active** employment, ends. Remember, this will also start your Medigap open enrollment period

Remember, terms in red are defined on pages 100-103.

More on Employee Coverage (continued)

(see page 37). However, if you only have Medicare Part A, sign-up for COBRA coverage and wait until the COBRA coverage ends to enroll in Medicare Part B, **you will have to pay a Part B premium penalty. You do not get a Part B special enrollment period when COBRA coverage ends**. State law may give you the right to continue your coverage under COBRA beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law.

Who Pays First

Does Medicare or my group health plan pay first?

If you are age 65 or over and covered by a group health plan because of **current or active** employment or the **current or active** employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees and covers any of the same services as Medicare. This means that the group health plan is the primary payer. It pays first on your hospital and medical bills. Medicare will review what your group health plan paid for Medicare-covered health care services, and pay any additional costs up to the Medicare-approved amount. You will have to pay the costs of services that Medicare or the group health plan does not cover.

If you do not take the group health plan coverage, Medicare will be the primary payer. Medicare will pay its share for any Medicare-covered health care service you get (see pages 97-99 for a list of Medicare-covered services). Your employer can offer you a plan that will pay for services not covered by Medicare such as hearing aids, routine dental care, prescription drugs, and routine physical check-ups. However, the employer cannot offer you a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in any other way.

Remember, terms in red are defined on pages 100-103.

Who Pays First (continued)

Remember, when you enroll in Medicare Part B, you start your 6-month Medigap open enrollment period (see page 37). To help decide whether to keep your group health plan coverage, talk with your benefit administrator, your State Insurance Department (see pages 86-87), or your State Health Insurance Assistance Program (see pages 88-89).

Who pays first if I'm a disabled Medicare beneficiary under age 65?

Medicare pays first if you are under age 65, have Medicare because of a disability, and your group health plan coverage is through an employer with fewer than 100 employees. If the employer has 100 employees or more, the health plan is called a large group health plan (LGHP). If you are covered by a LGHP because of your current employment or the current employment of a family member, Medicare pays second. Sometimes employers with fewer than 100 employees join other employers in a LGHP. If at least one employer in the LGHP has 100 employees or more, then Medicare always pays second. Some LGHPs let others join the plan such as a self-employed person, a business associate of an employer, or a family member of one of these people. A LGHP cannot treat any of their plan members differently because they are disabled and have Medicare.

Who pays first if I have Medicare because of End-Stage Renal Disease (ESRD), and have group health coverage?

Remember, terms in red are defined on pages 100-103.

If you are eligible to enroll in Medicare because of ESRD (permanent kidney failure), your group health plan will pay first on your hospital and medical bills for 30 months whether or not you are enrolled in

Who Pays First (continued)

Medicare and have a Medicare card. During this time, Medicare is the secondary payer. The group health plan pays first during this period no matter how many employees work for the employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare becomes the primary payer. This only applies to those with ESRD, whether you have your own group health coverage or you are covered as a family member.

For more information on ESRD, you can get a free copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also see and print a copy of this booklet by using a computer to look on the Internet at www.medicare.gov.

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

Know Who Pays If You Have Other Health Insurance

If you...	Condition	Pays first	Pays second
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	■ The employer has fewer than 20 employees	■ Medicare	■ Group health plan
	■ The employer has 20 or more employees	■ Group health plan	■ Medicare
Are disabled and covered by a large group health plan (LGHP) because you are working or because of a family member who is working	■ The employer has fewer than 100 employees	■ Medicare	■ Group health plan
	■ At least one employer covered by the plan has 100 or more employees	■ Large group health plan	■ Medicare
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	■ First 30 months of eligibility or entitlement to Medicare	■ Group health plan	■ Medicare
	■ After 30 months	■ Medicare	■ Group health plan
Have an employer retiree plan and are age 65 or older or are disabled	■ Eligible for Medicare	■ Medicare	■ Retiree coverage

Chart modified and used with permission from the Medicare Rights Center, Inc.

If you have Medicare and group health plan coverage **be sure to tell your doctor and other providers so your bills can be sent to the appropriate payer to avoid delays.**

New in 2000:

If you are over age 65 and in a PACE program that leaves the Medicare program or stops giving care in your area, you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You must apply no later than 63 calendar days after your health coverage ends (see pages 47-50).

What is the PACE program?

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

Services include primary care, social work, therapy to help you get better, medical services for special problems, medical services that support routine treatment, and long-term care services (such as transportation, meals, and personal care). The services are given in the PACE center, at home, and in other inpatient settings such as a hospital.

A team of health care providers looks at your needs, makes a plan of care, and gives you services for the total care that you need. This health care team includes, but is not limited to, doctors, nurses, therapists, and social workers. If you need nursing home care, PACE will give you this service and check your health condition on a regular basis.

PACE sites get payments directly from Medicare and Medicaid for services that all eligible enrollees get. However, PACE sites are only in certain communities. To find a PACE site near you, or for more information, call your state, county, or local medical assistance office - not a federal office. You can also use a computer to look on the Internet under the Nursing Home section of www.medicare.gov for PACE locations and telephone numbers.

Remember, PACE does not work with Medigap policies.

Other Health Insurance Options (continued)

What is a Federally Qualified Health Center?

Another possible way to lower your health care costs is to go to a Federally Qualified Health Center (FQHC). At a FQHC, you can get routine care. When you use a FQHC, Medicare pays for some health services like preventive care that are not usually covered. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Anyone with Medicare may go to a FQHC for health care services. They are usually in inner-city and rural areas. FQHC services that are available to people with Medicare include:

- Routine physical exams.
- Screening and diagnostic tests for vision and hearing problems, and other health problems.
- Flu shots and other similar shots.

When you get these services at a FQHC, you do not have to pay the $100 yearly Part B deductible. If you get other services like X-rays, you will have to pay the usual Part B yearly deductible of $100. Sometimes you will not have to pay the 20 percent coinsurance for Part B services.

To find the FQHC nearest to you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired). Ask for the telephone number of the Primary Care Association in your state.

Can I get help paying health care costs for young children in my care who don't have insurance?

If you have young children under age 19 in your care who don't have insurance, you may be able to get help to pay for their health care costs under your State Children's Health Insurance Program.

Health Insurance For Children under Age 19

A new State Children's Health Insurance Program is now available. Call 1-877-KIDS-NOW (1-877-543-7669) or look on the Internet at www.insurekidsnow.gov for more details.

Other Health Insurance Options (continued)

How can Medicaid help Medicare beneficiaries?

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

Some of these programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

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

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than $1,238 for an individual or $1,661 for a couple. These income limits are slightly higher in Hawaii and Alaska. (These income limits will change slightly in 2001.)
- Have savings of $4,000 or less for an individual or $6,000 or less for a couple. Savings include money in a checking or savings account, stocks, or bonds.

Call your nearest medical assistance office if you think you qualify.

If you want more information on these programs, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information on "Savings for Medicare Beneficiaries."

Other Health Insurance Options (continued)

What should I do if I have a Medigap policy and then go on Medicaid?

If you have a Medigap policy and go on Medicaid, you have the right to suspend the Medigap policy rather than dropping it while you are on Medicaid. However, in some cases, it may not be a good idea to suspend your Medigap policy. Call your state medical assistance office to help you with this decision.

If you do suspend your policy, while it is suspended, you do not pay premiums and it will not pay benefits. You can only suspend a Medigap policy for up to 2 years. At the end of the suspension, you can start it up again without new medical underwriting or pre-existing condition waiting periods. Call your insurance company to find out how to suspend a policy.

Can an insurance company sell me a Medigap policy if I already have Medicaid?

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

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

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

Other Private Health Insurance Options

The following types of policies are generally limited in scope and are not substitutes for Medigap insurance or comprehensive health coverage. Benefits under these policies are not designed to fill gaps in your Medicare coverage.

What is hospital indemnity insurance?

- Hospital indemnity insurance pays a fixed cash amount for each day you are in the hospital up to a certain number of days. Some policies may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

What is specified disease insurance?

- Specified disease insurance, which is only available in some states, pays benefits for only one disease, such as cancer, or for a group of specified diseases. The value of this coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs from any specified diseases you may have.

Long-Term Care Insurance

Remember, terms in red are defined on pages 100-103.

What is long-term care?

Long-term care is different from traditional medical care. Someone with a long physical illness, or a disability, or a memory or thought problem (such as Alzheimer's disease) often needs long-term care. Long-term care is made up of many different services to help people with chronic conditions overcome limitations that keep them from being independent. Long-term care may include help with activities of daily living,

Long-Term Care Insurance (continued)

home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. Long-term care may also include case management services, which will evaluate your needs and coordinate and monitor the delivery of long-term care services.

Does Medicare cover long-term care?

No. Generally, Medicare only covers medically necessary care under Part A (Hospital Insurance) and Part B (Medical Insurance). You must meet certain conditions for Medicare to cover skilled nursing facility, home health, and hospice care (see pages 97-99).

What is long-term care insurance?

Long-term care insurance is one way you may pay for long-term care. This type of insurance will pay for some or all of your long-term care. Long-term care insurance is a relatively new type of insurance. It was introduced in the 1980s as nursing home insurance. It has changed a lot and now often covers much more than nursing home care.

If you are shopping for long-term care insurance, find out which types of long-term care services the different policies cover. For more information about long-term care insurance, get a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State Insurance Department (see pages 86-87) or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also get a copy of *Your Guide to Choosing a Nursing Home* from the Health Care Financing Administration by calling 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Remember, terms in red are defined on pages 100-103.

Long-Term Care Insurance (continued)

Who sells long-term care insurance?

Private insurance companies sell long-term care insurance policies. You can buy them from an insurance agent or through the mail. Or, you can buy a group policy through an employer or through membership in an association. You can also get long-term care benefits through a life insurance policy. Insurance companies must be licensed in your state to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your state. If you are not sure, call your State Insurance Department (see pages 86-87).

New in 2000! ▸

How can I find out about nursing homes in my area?

You can now get important information about the nursing homes in your area by using a computer to look on the Internet at www.medicare.gov. Click on "Nursing Home Compare" to see where nursing homes are located in your area, how big they are, what types of residents they have, and whether or not the nursing home accepts Medicare or Medicaid. With "Nursing Home Compare," you can also see nursing home inspection reports that can tell you if any problems were found during the inspection. If you don't have a computer, your local library or senior center may be able to help you look at this information.

Watch Out for Illegal Insurance Practices

It is illegal for anyone to:

- 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 79).
- Sell you a Medigap policy if they know you are enrolled in a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan.
- Claim that a Medigap policy is part of the Medicare program or any other federal program.
- Use the mail to advertise Medigap policies that are not approved for sale in your state.
- Misuse the names, letters, symbols, or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs like Medicare.

You should report any suspected violations of the laws on marketing insurance policies to your State Insurance Department (see pages 86-87).

If you believe that a federal law has been violated, you may call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). In most cases, however, your State Insurance Department can help you with insurance-related problems (see pages 86-87).

Discrimination

Every facility or agency that participates in the Medicare program must comply with the law. It's illegal to discriminate on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Department of Health and Human Services, Office of Civil Rights at 1-800-368-1019 (TTY/TDD: 1-800-537-7697 for the hearing and speech impaired).

Who to Call for Medicare or Medigap Information

For the most recent contact information,visit the Important Contacts section of this website.

If you are in a Medicare health plan like a managed care plan or a Private Fee-for-Service plan, you should call your plan with questions about bills, health services, and appeals.

CALL...	IF YOU HAVE QUESTIONS ABOUT...	
State Insurance Department	Medigap policies sold in your area and insurance-related problems.	
State Health Insurance Assistance Program	Buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, your care or treatment, choosing a Medicare health plan, or Medicare bills.	
Health Care Financing Administration Regional Offices	Local seminars and health fairs on Medicare health plan choices, or to report a complaint directly to the Health Care Financing Administration.	
State Agencies on Aging	Services for older persons.	
Medicare Carrier	Medicare Part B coverage, bills, and medical services, or how to recognize Medicare fraud and abuse.	

MASSACHUSETTS STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

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

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on “Medigap Compare.”

MINNESOTA STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

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

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on "Medigap Compare."

Optional Riders

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

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

WISCONSIN STANDARDIZED MEDIGAP PLANS

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance ✓
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) ✓
- Blood: First 3 pints of blood each year ✓

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

For more information on these policies, call your State Insurance Department (see pages 86-87) or look on the Internet at www.medicare.gov and click on "Medigap Compare."

Optional Riders

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

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

MEDICARE PART A COVERAGE CHART

Medicare Part A (Hospital Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period you pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. (See Lifetime Reserve Days on page 102) • 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 3-day hospital stay).	**For each benefit period you pay:** • Nothing for the first 20 days. • Up to $97 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 skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**You pay:** • Nothing for home health care services. • 20% of 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:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**You pay:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.***
Blood: Given at a hospital or skilled nursing facility during a covered stay.	**You pay:** • For the first 3 pints of blood if you do not replace it.

* New Part A and B amounts will be available by January 1, 2001.

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

*** Call 1-800-633-4227 to get the telephone number for the Fiscal Intermediary or Regional Home Health Intermediary in your state.

If you have general questions about Medicare Part A, call your Fiscal Intermediary.

MEDICARE PART B COVERAGE CHART

Medicare Part B (Medical Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers).	**You pay:** • $100 deductible (pay once per calendar year). • 20% of approved amount after the deductible, except in the outpatient setting.
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech therapy services.
Outpatient mental health services.	• 50% for most outpatient mental health. **See note below.**
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** • Nothing for Medicare-approved services.
Home Health Care****:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care, and other supplies and services.	**You pay:** • Nothing for services. • 20% of approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** • 20% of the charged amount (after the deductible). During the year 2000, this will change to a set copayment amount.
Blood: Pints of blood needed as an outpatient, or as part of a Part B covered service.	**You pay:** • For the first 3 pints of blood, then 20% of the approved amount for additional pints of blood (after the deductible) if you do not replace it.

* New Part A and B amounts will be available by January 1, 2001.

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

Note: Actual amounts you must pay are higher if the doctor does not accept assignment (see page 100). If you have general questions about your Medicare Part B coverage, call your Medicare Carrier (see pages 92-93).

MEDICARE PART B PREVENTIVE SERVICES CHART

Medicare Part B Covered Preventive Services	Who is covered...	What you pay...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy - Once every four years. • Colonoscopy - Once every two years if you are high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months.	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap Smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap Smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare-approved amount with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (Vaccinations): • Flu Shot - Once every 12 months. • Pneumonia Shot - One may be all you ever need, ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu and pneumonia shots if the doctor accepts assignment (see page 100). For Hepatitis B shots, 20% of the Medicare-approved amount after the Part B deductible.

* ACTIVITIES OF DAILY LIVING (ADL): Activities you usually do during a normal day. Although definitions differ, ADL's are usually viewed as everyday activities such as walking, getting in and out of bed, dressing, bathing, eating, and using the bathroom.

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

BASIC (CORE) BENEFITS: Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.

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

BENEFITS: The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

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%).

* CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985: COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health plan coverage for a period of time after they leave their group health plan under certain conditions. You may have to pay both your share and the employer's share of the premium.

COORDINATION OF BENEFITS CLAUSE: A written statement that tells which health plan or insurance policy pays first if two health plans or insurance policies cover the same benefits. If one of the plans is Medicare, federal law may decide who pays first.

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

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 2000.

CREDITABLE COVERAGE: Any previous health coverage that can be used to shorten the pre-existing condition waiting period. (See pre-existing conditions.)

CUSTODIAL CARE: Personal care, such as bathing, cooking, and shopping. This is usually not covered by Medicare.

DEDUCTIBLE (MEDICARE): The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year. (see Benefit Period; Part A; Part B)

DURABLE MEDICAL EQUIPMENT (DME): Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and you pay 20% coinsurance in the Original Medicare Plan.

* END-STAGE RENAL DISEASE (ESRD): Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Social Security payments if found to be disabled.

* EXCESS CHARGE (MEDIGAP): 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.

FISCAL INTERMEDIARY: A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

GAPS: The costs or services that are not covered under the Original Medicare Plan. Also called Medicare gaps.

GUARANTEED ISSUE SITUATIONS: Certain situations involving health coverage changes where you may have the right to buy a Medigap policy in addition to your Medigap open enrollment period.

GUARANTEED RENEWABLE: A Medigap policy that your insurance company must allow you to automatically renew or continue, unless you do not pay your premiums.

HEALTH CARE FINANCING ADMINISTRATION (HCFA): The federal agency that runs the Medicare program. In addition, HCFA works with the States to run the Medicaid and State Children's Health Insurance Program. HCFA works to make sure that the beneficiaries in these programs are able to get high quality health care.

HOME HEALTH CARE: Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury. (See Activities of Daily Living.)

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 2000.

LIFETIME RESERVE DAYS: Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($388 in 2000).

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

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

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 whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

MEDICARE: A federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes called ESRD).

MEDICARE CARRIER: A private company that contracts with Medicare to pay Part B bills. (Also called "Carrier.")

MEDICARE COVERAGE: Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

MEDICARE PART A (HOSPITAL INSURANCE): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

MEDICARE PART B (MEDICAL INSURANCE): Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

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

MEDIGAP: A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps.)

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

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

OUT-OF-POCKET COSTS: Health care costs that you must pay on your own, because they are not covered by Medicare or other insurance.

PRE-EXISTING CONDITION (MEDIGAP): A health problem for which you got medical treatment or advice within 6 months before the date that a new insurance policy starts.

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

PREVENTIVE CARE: Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

PRIMARY PAYER: The insurance company that pays first on a claim for medical care. This could be Medicare or another insurance company.

MEDIGAP PROTECTIONS: Your rights to buy a Medigap policy in certain situations after your Medigap open enrollment period.

PROVIDER: A hospital, health care professional, or health care facility.

SECONDARY PAYER: The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

SKILLED NURSING FACILITY (SNF): A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.

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

Activities of Daily Living (ADL) 26, 80, 100
Assignment.....8, 26, 62, 98, 100
At-home Recovery 10, 26
Attained-Age-Rated Policies 29
Basic Core Benefits 10, 23, 24, 100
Benefit Period.....8, 24, 97, 100
Blood 24, 97-98
Claims.....18, 62
Coinsurance 8, 9, 99, 100
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) 19, 70-72, 100
Coordination of Benefits Clause.....69, 100
Copayment 97, 100
Creditable Coverage....32, 38, 39, 101
Custodial Care 8, 101
Deductible 8, 10-11, 25, 101
Department of Labor 68
Durable Medical Equipment 97, 98, 101
Employee Coverage.....19, 69-72
Employer Group Health Plan 16, 67-70
End-Stage Renal Disease (ESRD) 4, 17, 39, 59, 101
Excess Charges.....10, 26, 101
Explanation Of Medicare Benefits.....62
Federally Qualified Health Center 20, 77
Fiscal Intermediary.....97, 101
Foreign Travel Emergency ..10, 11, 25
Free Look Period 32, 66
Gaps 7-9, 20, 101
General Enrollment Period (Part B) 5
Group Health Coverage.....67-69
Guaranteed Issue Rights.....16, 101
Guaranteed Renewable.....64, 101
Health Care Financing Administration (HCFA) 81, 90, 101
Home Health Care... 8, 26, 97-98, 101
Hospice Care 97
Hospital Indemnity Insurance.....20, 80
Issue-Age-Rated Policies 28-29
Large Group Health Plan 73
Lifetime Reserve Days 24, 97, 102
Limiting Charge 63, 102
Long-Term Care Insurance 20, 80-82
Medicaid 2, 20, 78-79
Medical Underwriting 30, 102
Medicare Carrier 18, 62, 98, 102
Medicare Managed Care Plan 6, 16, 17, 42
Medicare Medical Savings Account Plan 2
Medicare Part A (Hospital Insurance) 4-6, 97, 102
Medicare Part B (Medical Insurance).....4-6, 98-99, 102
Medicare SELECT.....9, 16, 23, 102
Medicare Summary Notice.....62
Medicare Supplemental Insurance 9
Medigap
- over age 65.....36-39
- under age 65.....39-40

Medigap Benefits Chart.....10
- For Massachusetts 94
- For Minnesota.....95
- For Wisconsin 96

Medigap Compare 1, 13, 27
Medigap Protections 15, 41-61, 69
Mental Health Care 97, 98
National Association of
Insurance Commissioners 81
No-Age-Rated Policies.....28
Nursing Home Compare 82
Occupational Therapy 4, 97, 98
Open Enrollment Period
(Medigap) 14-16, 36-41, 73, 103
Original Medicare Plan.....2-9, 21, 53
Out-of-Pocket Costs 11, 68, 103
PACE.....16, 19, 42, 47-48, 60, 76
Part A
(Hospital Insurance).....4, 6, 8, 10, 36
Part B
(Medical Insurance) 4-6, 8, 10, 14
Participation Agreement.....62
Physical Therapy 4, 95, 97, 98
Pre-Existing
Condition ..14, 30, 32, 38-40, 46, 103
Premium ..4-6, 25, 28-30, 65, 79, 103
Prescription Drugs 6, 9-12, 26, 72
Preventive Care 26, 77, 94-96, 99
Primary Payer 72-73, 103
Private Contract.....18, 63-64
Private Fee-for-Service Plan 2, 6-7
Provider 23, 62, 103
Railroad Retirement Board.....5
Regional Home Health
Intermediary 97
Religious Fraternal
Benefit Plan 2
Retainer Agreement 35
Retiree Coverage.....19, 31, 68-69, 75
Riders 94-96
Secondary Payer 72-75, 103
Skilled Nursing
Facility Care ..4, 8, 10, 25, 80-81, 103
Social Security Administration.....5, 6
Special Enrollment
Period (Part B) 5-6, 67, 71
Specified Disease Insurance.....20, 80
Standardized Medigap Plans..9-10, 23
For Massachusetts 94
For Minnesota.....95
For Wisconsin.....96
State Agencies on Aging 91
State Children's Health
Insurance Program 77
State Health Insurance
Assistance Program.....13, 17, 23, 40, 47
State Insurance
Department ..10, 13, 17, 27, 32, 41-42
State Medical
Assistance Office 79
TRICARE 38
Union Coverage 19, 37, 67, 68
Waiting Period 14, 32, 103
www.medicare.gov 1, 13, 27, 76

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