

GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE

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GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE

- * WHAT MEDICARE PAYS AND DOESN'T PAY
- * 10 STANDARD MEDIGAP INSURANCE PLANS
- * YOUR RIGHT TO MEDIGAP INSURANCE
- * TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE

Developed jointly by the National Association of Insurance
Commissioners and the Health Care Financing
Administration of the U.S. Department
of Health and Human Services.

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-NOTICE -

Listed in the back of this booklet are the addresses and telephone numbers of each of the state agencies on aging and the state insurance departments. They are available to assist you with any questions you may have about private insurance to supplement Medicare.

Suspected violations of the laws governing the marketing of insurance policies should generally be reported to your state insurance department since states are responsible for the regulation of insurance within their boundaries.

There are, however, federal penalties for certain violations concerning Medicare supplement insurance ("Medigap") policies. It is, for example, a federal offense for an insurance agent to indicate that he or she represents the Medicare program or any other federal agency in order to sell a policy. It is also illegal for an insurance company or agent to sell you a policy that duplicates coverage you already have.

The federal toll-free telephone number for filing complaints is:

1-800-638-6833

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DEFINITIONS OF SOME MEDICARE TERMS

Actual Charge: The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge. For physician services the approved amount is taken from a national fee schedule that assigns a dollar value to all physician services covered by Medicare.

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as the total charge for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the provider after the beneficiary meets the annual Part B deductible of \$100. The beneficiary pays the other 20%.

Benefit Period: A benefit period is a way of measuring a beneficiary's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the beneficiary is hospitalized and ends after the beneficiary has been out of the hospital or skilled nursing facility for 60 days in a row. If the beneficiary is hospitalized after 60 days, a new benefit period begins and most Medicare Part A benefits are renewed. There is no limit as to the number of benefit periods a beneficiary can have.

Coinsurance: The portion or percentage of Medicare's approved amounts for covered services that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must first incur before Medicare begins payment for covered service's.

Excess Charge: The difference between the Medicare-approved amount for a service or supply and the actual charge, if the actual charge is more than the approved amount.

Limiting Charge: The maximum amount a physician may charge a Medicare beneficiary for a covered physician service if the physician does not accept assignment of the Medicare claim. The limit is 15% more than the fee schedule amount for nonparticipating physicians. Limiting charge information appears on Medicare's Explanation of Medicare Benefits (EOMB) form.

Medicare Carrier: An insurance organization under contract to the federal government to process Medicare Part B claims from physicians and other health care providers. The names and

addresses of the carriers and areas they serve are listed in the back of The Medicare Handbook, available from any Social Security Administration office.

Medicare Hospital Insurance: This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance: This is Part B of Medicare. This part helps pay for medically necessary physician services and many other medical services and supplies not covered by Part A.

Participating Physician and Supplier: A physician or supplier who agrees to accept assignment on all Medicare claims.

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most older Americans covered by Medicare, there are aspects of the federal health insurance program that you find complex and confusing. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This booklet will give you a better understanding of your Medicare benefits, identify the gaps in your Medicare coverage, and provide tips on shopping for private health insurance to fill those gaps. As a Medicare beneficiary, you probably are already aware that Medicare does not cover all of your potential health care costs. For example, you are responsible for Medicare's deductibles and coinsurance and for charges for services not covered by Medicare.

Few people can afford to pay all of those expenses out of their own funds, so many rely on supplemental insurance to cover some of the costs. As you seek to limit your out-of-pocket costs for health care services, you will find that there are three basic ways of doing so:

1. Through the purchase of Medicare supplement insurance, which is also called "Medigap" or "MedSup" insurance;
2. By enrolling in a managed care plan, such as a health

maintenance organization (HMO) that has a contract to serve Medicare beneficiaries; and,

3. By continuing coverage under an employer-provided health insurance policy, if you are eligible for such protection.

In addition, for beneficiaries who qualify, some costs may be covered by state Medicaid programs (see page 17).

Each of these ways will be discussed in subsequent sections. Special attention will be devoted to employer plans and Medigap insurance, which most Medicare beneficiaries purchase.

Insurance Counseling

Although the information in this booklet will help you to be a better informed and more careful purchaser, you may wish to obtain additional information before buying health insurance. Information about insurance to supplement Medicare is available from various senior citizen advocacy organizations and governmental agencies.

You first may want to turn to your state government for help, as all states now offer insurance counseling in one-on-one confidential sessions with trained counselors. In these sessions, you will be able to clarify insurance issues that you find confusing and receive assistance in evaluating your insurance needs. These services are provided at no charge to you.

The telephone number for your state insurance counseling office is listed in the directory of state insurance departments and agencies on aging beginning on page 27.

WHAT IS MEDICARE

Before discussing Medigap and the other types of private insurance available to supplement Medicare, it will be helpful to review your Medicare benefits and identify the payment gaps.

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S.

Department of Health and Human Services (HHS). The Social Security Administration, also a part of HHS, provides information about the program and handles enrollment.

Two Parts of Medicare

Medicare has two parts--Hospital Insurance (Part A) and Medical Insurance (Part B). Part A is financed through part of the Social Security (FICA) tax paid by workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse is entitled to benefits under either the Social Security or Railroad Retirement systems or worked a sufficient period of time in federal, state, or local government employment to be insured.

If you do not qualify for premium-free Part A benefits, you may purchase the coverage if you are at least age 65 and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and you still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. If you do not qualify for premium-free Part A but had at least 30 quarters of covered employment, the Part A monthly premium in 1994 is \$184. If you had fewer than 30 quarters or no quarters of covered employment the premium is \$245 per month in 1994.

Part B is optional and is offered to all beneficiaries when they become entitled to Part A. It also may be purchased by most persons age 65 or over who do not qualify for premium-free Part A coverage. The Part B premium, which most Medicare beneficiaries have deducted from their monthly Social Security check, is \$41.10 per month in 1994.

You are automatically enrolled in Part B when you become entitled to Part A unless you state that you don't want it. Although you do not have to purchase Part B, it is a good buy because the federal government pays about 75 percent of the program costs.

Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your coverage started. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health care benefit.

Benefit Periods

Medicare Part A hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a qualified hospital. It ends when you have been out of a hospital or skilled nursing or rehabilitation facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, all Part A hospital and skilled nursing facility benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits that were used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges for covered hospital services during the first 60 days of a benefit period except for the deductible. The Part A deductible in 1994 is \$696 per benefit period. You are responsible for the deductible. In addition to the deductible, you are responsible for a share of the daily costs if your hospital stay lasts more than 60 days. For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of \$174 a day in 1994. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be

used whenever you are in the hospital for more than 90 consecutive days. When a reserve day is used, Part A pays for all covered services except for coinsurance of \$348 a day in 1994. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps in Medicare Inpatient Hospital Coverage:

- * You pay \$696 deductible on first admission to hospital in each benefit period.
- * You pay \$174 daily coinsurance for days 61 through 90.
- * No coverage beyond 90 days in any benefit period unless you have "lifetime reserve" days available and use them.
- * You pay \$348 daily coinsurance for each lifetime reserve day used.
- * No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part B, it does not have to be met under Part A.
- * No coverage for a private hospital room, unless medically necessary, or for a private duty nurse.
- * No coverage for personal convenience items, such as a telephone or television in a hospital room.
- * No coverage for care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.
- * No coverage for care received outside the U. S. and its territories, except under limited circumstances in Canada and Mexico.

Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. Medicare

benefits are payable only if you require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis, and the care is provided in a facility certified by Medicare. Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

To qualify for Medicare coverage for skilled nursing facility care, you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility. You must be admitted to the facility for the same condition for which you were treated in the hospital and the admission generally must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and receive, skilled nursing or skilled rehabilitation services on a daily basis.

Medicare can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance in 1994 is \$87. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Gaps in Medicare Skilled Nursing Facility, Coverage:

- * You pay \$87 daily coinsurance for days 21 through 100 in each benefit period.
- * No coverage beyond 100 days in a benefit period.
- * No coverage for care in a nursing home, or in a SNF not certified by Medicare, or for just custodial care in a Medicare-certified SNF.
- * No coverage for 3-pint blood deductible (see list of gaps under inpatient hospital care).

Home Health Care

Medicare fully covers medically necessary home health visits if you are homebound, including parttime or intermittent skilled nursing services. A Medicare-certified home health agency can also furnish the services of physical and speech therapists. Should you require speech-language pathology, physical therapy, continuing occupational therapy or intermittent skilled nursing services, are confined to your home, and are under the care of a physician, Medicare can also pay for medical supplies, necessary part-time or intermittent home health aide services, occupational therapy, and medical social services. Coverage is also provided for a portion of the cost of wheelchairs, hospital beds and other durable medical equipment (DME) provided under a plan-of-care set up and periodically reviewed by a physician.

Gaps in Medicare Home Health Coverage

- * No coverage for full-time nursing care.
- * No coverage for drugs or for meals delivered to your home
- * You pay 20% of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.
- * No coverage for homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare beneficiaries certified as terminally ill may choose to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. If you enroll in a Medicare-certified hospice program, you will receive medical and support services necessary for symptom management and pain relief. When these services which are most often provided in your home-are furnished by a Medicare-certified hospice program, the coverage includes: physician services, nursing care, medical appliances and supplies (including drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, home health aide and homemaker services.

You do not have to pay Medicare's deductibles and coinsurance for services and supplies furnished under the hospice benefit. You must pay only limited charges for outpatient drugs and inpatient respite care. In the event you require medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps in Medicare Hospice Coverage:

- * You pay limited charges for inpatient respite care and outpatient drugs.
- * You pay deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Psychiatric Hospital Care

Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days (or have used fewer than 190 days but have exhausted your inpatient hospital coverage), Part A doesn't pay for any more inpatient care in a psychiatric hospital. However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Gaps in Medicare Inpatient Psychiatric Hospital Care:

- * No coverage for care after you have received 190 days of such specialized treatment in your lifetime (even if you have not yet exhausted your inpatient hospital coverage).

MEDICARE MEDICAL INSURANCE (PART B) BENEFITS

Part B helps pay for medically necessary physician services no matter where you receive them--at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the use at home of durable medical equipment, such as wheelchairs and hospital beds.

Additionally, Part B covers medically necessary physical therapy, occupational therapy, and speech-language pathology services in a doctor's office, as an outpatient, or in your home. Mental health services are covered as are mammograms and Pap smears. And if you qualify for home health care but do not have Part A, then Part B pays for all covered home health visits.

Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished to hospice enrollees, non-self administrable drugs provided as part of a physician's services, and special drugs, such as drugs furnished during the first year after an organ transplantation, erythropoetin for home dialysis patients, and certain oral cancer drugs.

When you use your Part B benefits, you will be required to pay the first \$100 (the annual deductible) each calendar year. The deductible must represent charges for services and supplies covered by Medicare. It also must be based on the Medicare approved amounts, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for covered services you receive the rest of the year. You are responsible for the other 20 percent. If you require home health services, you do not have to pay a deductible or coinsurance. You do, however, have to pay 20 percent of the Medicare-approved amount for any durable medical equipment! supplied under the Medicare home health benefit.

You may also have other out-of-pocket costs under Part B if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge" or "balance billing." You should be aware, however, that there are certain charge limitations mandated by federal law (discussed below) and that some states also limit

physician charges.

Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on a national fee schedule. The schedule assigns a dollar value to each physician service based on work, practice costs and malpractice insurance costs. Under this payment system, each time you go to a physician for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians and medical suppliers whether they accept assignment of Medicare claims.

Accepting Assignment

Those who take assignment on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by Medicare, except for the deductible and coinsurance amounts that you must pay.

For example, for your first annual visit, if you go to a participating physician, or if you go to a nonparticipating physician who accepts assignment, and the Medicare-approved amount for the service you receive is \$200, you will be billed \$120: \$100 for the annual deductible plus 20 percent of the remaining \$100, or \$20. Medicare would pay the other \$80. Having met the deductible for the year, the next time you used Part B services furnished by a physician or medical supplier who accepts assignment, you would be responsible for only 20 percent of the Medicare-approved amount.

Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in The Medicare Participating Physician/Supplier Directory, which is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging.

It also is available free by writing or calling the

insurance company that processes Medicare Part B claims for your area. Called a Medicare "carrier," the company's name, address and telephone number are listed in the back of The Medicare Handbook, available from any Social Security office.

Even if your physician or supplier does not participate in Medicare, ask before receiving any services or supplies whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. If your physician or supplier will not accept assignment, you are responsible for paying all permissible charges.

Medicare will then reimburse you its share of the approved amount for the services or supplies you received. Regardless of whether your physician or supplier accepts assignment, they are required to file your Medicare claim for you.

In certain situations nonparticipating providers of services are required by law to accept assignment. For instance, all physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 18).

Physician Charge Limits

While physicians who do not accept assignment of a Medicare claim can charge more than physicians who do, there is a limit as to the amount they can charge you for services covered by Medicare. Under the law, they are not permitted to charge more than 115 percent of the Medicare-approved amount for the service. Physicians who knowingly, willfully, and repeatedly charge more than the legal limit are subject to sanctions. If you think you have been overcharged, or you want to know what the limiting charge is for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form that you generally receive from the Medicare carrier when you go to a physician for a Medicare-covered service. You do not have to pay charges that exceed the legal limit.

If you think your physician has exceeded the charge limit, you should contact the physician and ask for a reduction in the

charge, or a refund, if you have paid more than the charge limit. If you cannot resolve the issue with the physician, you can call your Medicare carrier and ask for assistance.

More Charge Limits

Another federal law requires physicians who do not accept assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be \$500 or more. If the physician did not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount. Any nonparticipating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary and thus will not pay for, is required to so notify you in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps in Medicare Coverage for Doctors and Medical Suppliers

- * You pay \$100 annual deductible.
- * Generally, you pay 20% coinsurance.
- * You pay legally permissible charges in excess of the Medicare-approved amount for unassigned claims (see page 6).
- * You pay 50% of approved charges for most outpatient mental health treatment.
- * You pay all charges in excess of Medicare's maximum yearly limit of \$900 for independent physical or occupational therapists.
- * No coverage for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- * No coverage for most self-administerable prescription drugs or immunizations, except for pneumococcal, influenza and hepatitis B vaccinations.

- * No coverage for routine physicals and other screening services, except for mammograms and Pap smears.
- * Generally, no coverage for dental care or dentures.
- * No coverage for acupuncture treatment.
- * No coverage for hearing aids or routine hearing loss examinations.
- * No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.
- * No coverage for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.
- * No coverage for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- * No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.
- * No coverage for routine eye examinations or eyeglasses, except prosthetic lenses, if needed, after cataract surgery.

Medicare Benefit Charts

The charts on pages 8 and 9 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

[Graphic Omitted]

[Graphic Omitted]

TYPES OF PRIVATE HEALTH INSURANCE

Whether you need health insurance in addition to Medicare is a decision that only you can make. As you saw from the review of your Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance can help fill many of the gaps. But before buying insurance to supplement your Medicare benefits, make sure you need it. Not everyone does (see page 17). In general it is advisable to buy the additional protection that private health insurance can provide. If you decide to buy supplemental insurance, shop carefully and buy a policy that offers the kind of additional help you think you need most.

A variety of private insurance policies is available to help pay for medical expenses, services and supplies that Medicare covers only partly or not at all. The basic types of policies include:

1. Medigap, which pays some of the amounts that Medicare does not pay for covered services and may pay for certain services not covered by Medicare.
2. Managed care plans [these include health maintenance organizations (HMOs) and competitive medical plans (CMPs)], from which you purchase health care services directly for a fixed monthly premium;
3. Continuation or conversion of an employer-provided or other policy you have when you reach 65;
4. Nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home or at-home care;
5. Hospital indemnity policies, which pay only when you need treatment for the insured disease.
6. Specified disease policies, which pay only when you need treatment for the insured disease.

Medigap

Medigap insurance is regulated by federal and state law and must be clearly identified as Medicare supplement insurance. Unlike other types of health insurance, it is designed specifically to supplement Medicare's benefits by

filling in some of the gaps in Medicare coverage.

To make it easier for consumers to comparison shop for Medigap insurance, nearly all states, U.S. territories, and the District of Columbia have adopted regulations that limit the number of different Medigap policies that can be sold in any of those jurisdictions to no more than 10 standard benefit plans. The plans, which have letter designations ranging from "A" through "J", were developed by the National Association of Insurance Commissioners and incorporated into state and federal laws. See pages 22-24 for descriptions and comparisons of the 10 plans.

Plan A of the 10 standard Medigap plans is the "basic" benefit package. Each of the other nine plans includes the basic package plus a different combination of benefits. The plans cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. Insurers are not permitted to change the combination of benefits in any of the plans or to change the letter designations.

Each state must allow the sale of Plan A, and all Medigap insurers must make Plan A available. Insurers are not required to offer any of the other nine plans, but most offer several plans, and some offer all 10. Insurers can independently decide which of the nine optional plans they will sell as long as the plans they select have been approved for sale in the state in which they are to be offered.

Some states have limited the number of plans available in the state. Delaware does not permit Plans C, F, G and H to be sold in the state. Pennsylvania and Vermont do not permit the sale of Plans F, G and I. (As this guide was being prepared for printing, however, Pennsylvania was considering a proposal that would permit the sale of all 10 plans.)

Residents of Minnesota, Massachusetts and Wisconsin will find that their Medigap plans are different than those sold in other states. This is because those states had alternative Medigap standardization programs in effect before the federal legislation standardizing Medigap was enacted. Therefore, they were not required to change their benefit plans. If you live in Minnesota, Massachusetts or Wisconsin, you should contact the state insurance department to find out what Medigap coverage is available to you.

The only areas where standardization is not in effect are Guam, American Samoa, and the Commonwealth of the Northern

Mariana Islands.

Comparing Medigap Plans: To make it easier for consumers to compare plans and premiums, the same format, language, and definitions must be used in describing the benefits of each of the plans. A uniform chart and outline of coverage also must be used by the insurer to summarize those benefits for you.

As you shop for a Medigap policy, keep in mind that each company's products are alike, so they are competing on service, reliability and price. Compare benefits and premiums and be satisfied that the insurer is reputable before buying. And in selecting the benefits that meet your needs, remember that Medicare pays only for services it determines to be medically necessary and only the amount it determines to be reasonable.

Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide coverage for Medicare's deductibles. Some of the 10 standard plans pay for services not covered by Medicare and some pay for charges in excess of Medicare's approved amount. Look for the plan that best meets your needs.

All standard Medigap plans must have a loss ratio of at least 65 percent for individual policies and 75 percent for group policies. This means that on average either 65 cents or 75 cents of each premium dollar goes for benefits.

Unlike some types of health coverage that restrict where and from whom you can receive care, Medigap policies generally pay the same supplemental benefits regardless of your choice of health care provider. If Medicare pays for a service, wherever provided, the standard Medigap policy must pay its regular share of benefits. The only exception is Medicare SELECT insurance, discussed on page 13.

Besides the standardized benefit plans, federal law permits states to allow an insurer to add "new and innovative benefits" to a standardized plan that otherwise complies with applicable standards. Any such new or innovative benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplification. Check with your state insurance department to find out whether such benefits are available in your state.

Your Right To Medigap Coverage: If you are 65 or older, state and federal laws guarantee that for a period of 6 months from the date you first enroll in Medicare Part B, you have a right to buy the Medigap policy of your choice regardless of

your health conditions.

During this 6-month open enrollment period, you have the choice of any of the different Medigap policies sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of your medical history, health status, or claims experience. The company can, however, impose the same preexisting condition restrictions (see page 19) that it applies to Medigap policies sold outside the open enrollment period.

Many individuals are enrolled automatically in Part B as soon as they turn 65, or they sign up during an initial 7-month enrollment period that begins 3 months before they turn 65. If you are in this group, your Part B coverage generally starts in the month you turn 65 or shortly thereafter, depending on when you applied for Part B. Your Medigap open enrollment period starts as soon as your Part B coverage starts.

Others may delay their enrollment in Part B. For example, if after turning 65, you continue to work and choose to be continuously covered by an employer insurance plan, or if you are continuously covered under a spouse's employment related insurance instead of Medicare Part B, you will have a special 7-month enrollment period for Part B. It begins with the month your or your spouse's work ends or when you are no longer covered under the employer plan, whichever comes first. Your 6-month Medigap open enrollment period starts when your Part B coverage begins.

If you are covered under an employer group health plan when you become eligible for Part B at age 65, carefully consider your options. Once you enroll in Part B the 6-month Medigap open enrollment period starts and cannot be extended or repeated.

If you cannot defer Part B enrollment as described above, but are 65 or older and are eligible for Part B but never signed up for it, you may buy Part B during Medicare's annual general enrollment period. It runs from January 1 through March 31. If you sign-up during an open enrollment period, both your Part B coverage and Medigap open enrollment period begin the following July 1.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective

date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are not eligible.

If you are under age 65, disabled, and enrolled in Medicare Part B, you are not eligible for Medigap open enrollment unless your state requires open enrollment for persons under 65 who qualify for Medicare because of a disability. Moreover, unless your state requires otherwise, you will not be eligible for the Medigap open enrollment period when you turn 65 because you will not be enrolling in Part B for the first time.

Older Medigap Policies: Current federal requirements generally do not apply to Medigap policies in force in a state before the requirements which took effect in that state in 1992. Depending on which state you live in, you will not have to switch to one of the 10 standard plans if you have an older policy that is guaranteed renewable.

Some states, however, have specific requirements that affect existing non-standard policies. For example, some states require or permit insurers to convert older policies to the standardized plans. Check with your state insurance department to find out what state-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the standardized Medigap plans if it is to your advantage and an insurer is willing to sell you one.

If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide superior coverage, especially for prescription drugs and extended skilled nursing care.

If you had the old Medigap policy at least 6 months and you decide to switch, the new policy is not permitted to impose a waiting period for a preexisting condition if you satisfied a waiting period for a similar benefit under your old policy. If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to 6 months unless prohibited by your state may be applied to that particular benefit.

Because it is unlawful for anyone to sell you insurance that duplicates coverage you already have, and because you do not need more than one Medigap policy, you must sign a

statement that you intend to replace your current policy and will not keep both policies. Do not cancel the old policy until the new one is in force and you have decided to keep it (see "Free Look," page 20).

Medigap Insurance Defined: Under state and federal laws, Medigap policies are policies designed to supplement your Medicare benefits. They must provide specific benefits that pay, within limits, some or all of the costs of services either not covered or not fully covered by Medicare. The definition does not include all insurance products that may help you cover out-of-pocket costs. For example, neither a health plan offered by a company for current or former employees, nor by a labor organization for current or former members, is Medigap insurance. Nor are limited benefit plans such as hospital indemnity insurance. They do not qualify because they are not required to provide the same benefits that the 10 standard Medigap plans must provide.

Similarly, coverage provided to individuals enrolled in managed care plans, such as health maintenance organizations (HMOs) under contracts or agreements with the federal government, does not meet the definition of Medigap insurance even though some of the coverage may be similar. On the other hand, an HMO's supplemental insurance product sold to an individual Medicare beneficiary who is not enrolled under either an employer plan or a federal contract or agreement, does qualify as Medigap insurance.

Medicare SELECT. A Medicare supplement health insurance product called "Medicare SELECT" is permitted to be sold in Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. Medicare SELECT, which may be offered in the designated states by insurance companies and HMOs, is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard Medigap plans (see page 22).

The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT policies will only pay or provide full supplemental benefits if covered services are obtained through specified health care professionals and facilities. Medicare SELECT policies are expected to have lower premiums because of this limitation. The specified health care professionals and facilities, called "preferred providers," are selected by the insurance company or HMO. Each issuer of a Medicare SELECT policy makes arrangements with its own network of preferred providers.

If you have a Medicare SELECT policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay or provide the full supplemental benefits provided for in the policy. Medicare SELECT insurers must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network. In general, Medicare SELECT policies deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges if the services you receive outside the network are services covered by Medicare.

Medicare SELECT will be evaluated through 1994 to determine if it should be continued and made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the policies are discontinued. If the program is not extended, Medicare SELECT policyholders will have the option to purchase any standard Medigap policy that the insurance company or HMO offers, if in fact it issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similar benefits.

Carrier Filing of Medigap Claims. Under certain circumstances, when you receive medical services covered by both Medicare and your Medigap insurance, you may not have to file a separate claim with your Medigap insurer in order to have payment made directly to your physician or medical supplier. By law, the Medicare carrier that processes Medicare claims for your area must send your claim to the Medigap insurer for payment when the following three conditions are met for a Medicare Part B claim:

1. Your physician or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries:
2. Your policy must be a Medigap policy: and
3. You must instruct your physician to indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating physician or supplier. Your physician will put your Medigap policy number on the Medicare claim form.

When these conditions are met, the Medicare carrier will

process the Medicare claim, send the claim to the Medigap insurer and generally send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your physician or medical supplier and send you a notice that they have done so. If the insurer refuses to pay the physician directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact the Medicare carrier. Look in The Medicare Handbook for the name and telephone number of the carrier for your area.

Managed Care Plans That Contract With Medicare

Managed care plans, also called coordinated care and prepaid plans, include health maintenance organizations (HMOs) and competitive medical plans (CMPs). They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they arrange for health care.

As a Medicare beneficiary, you can choose how you will receive hospital, doctor, and other health care services covered by Medicare. You can receive them either through the traditional fee-for-service delivery system or through a managed care plan that has a contract with Medicare. If you choose fee-for-service care, you should consider purchasing Medigap insurance.

If you enroll in a Medicare-contracting HMO or CMP, you will not need a Medigap policy. In fact, insurers are prohibited from issuing you one because it would duplicate your HMO or CMP benefits. If you have a Medigap policy and decide to enroll in a plan, you will be asked to provide an assurance that you will give up the Medigap policy.

Should you enroll in a managed care plan and later disenroll and return to fee-for-service care, you likely will be able to buy a Medigap policy, but you may not get the policy; of your choice, especially if you have a health problem. On the other hand, both disabled and aged Medicare beneficiaries generally may enroll in a Medicare-contracting HMO or CMP without regard to any health problems they may have. For this and other reasons, managed care can be an attractive option for many beneficiaries.

A managed care plan generally arranges with a network of

health care providers (doctors, hospitals, skilled nursing facilities, etc.) to offer comprehensive, coordinated medical services to plan members on a prepaid basis. If you enroll in an HMO or CMP with a Medicare contract; services usually must be obtained from the professionals and facilities that are part of the plan, except in a medical emergency.

The plan must provide or arrange for all Part A and B services (if you are covered under both parts of Medicare). Some plans also provide benefits beyond what Medicare covers, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses.

Medicare makes a monthly payment to the plan to cover Medicare's share of the cost of the services you receive. Additionally, most plans charge enrollees a monthly premium and nominal copayments as services are used. Usually there are no other charges--no matter how many times you visit the doctor, are hospitalized, or use other covered services. Medicare's deductibles and coinsurance do not apply to beneficiaries enrolled in plans with Medicare contracts.

If you enroll in an HMO or a CMP that has a "risk" contract with Medicare, Medicare will not pay for non-emergency services you receive from providers outside of the HMO or CMP. That is, you must receive all your health care benefits (except in an emergency) from the HMO or CMP in order to be covered.

If you enroll in a plan that has a "cost" contract with Medicare, you can receive covered services either through the plan or outside the plan. If you go outside the plan for non-emergency services, Medicare will still pay but the plan will not. You would be responsible for the same charges that you would be liable for if you were only covered by Medicare, but you would no longer have a Medigap policy to cover those charges.

You are eligible to enroll in a managed care plan with a Medicare contract if you live in the plan's service area, are enrolled in Medicare Part B, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. The plan must enroll Medicare beneficiaries in the order of application, without health screening, during at least one open enrollment period each year.

Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. If you live in an area that is served by more than one managed care plan, compare benefits,

costs and other features to determine which plan meets your needs. Also, determine which type of contract the plan has with Medicare.

Group Insurance

There are two principal sources of group insurance: employers and voluntary associations.

Employer Group Insurance for Retirees. Many people have private insurance when they reach age 65 that often is purchased through their or their spouse's current employer or union membership. If you have such coverage, find out if it can be continued when you or your spouse retires. Check the price and the benefits, including benefits for your spouse.

Group health insurance that is continued after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions, and the coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance protection.

Furthermore, since employer group insurance policies do not have to comply with the federal minimum benefit standards for Medigap policies, it is important to determine what coverage your specific retirement policy provides. While the policy may not provide the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care.

Special Rules for Working People Age 65 or Over. If you are 65 or over and you or your spouse works, Medicare may be secondary payer to any employer group health plan (EGHP) coverage you have. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer plan.

Employers who have 20 or more employees are required to offer the same health benefits, under the same conditions, to employees age 65 or over and to employees' spouses who are 65 or over, that they offer to younger employees and spouses. EGHP

coverage of employers of 20 or more employees is primary to Medicare.

You may accept or reject coverage under the EGHP. If you accept the employer plan, it will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, you can buy supplemental insurance but an employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary for certain people under age 65 who are entitled to Medicare based on disability (other than those with permanent kidney failure) and who have large group health plan (LGHP) coverage. An LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees.

This requirement applies to those who have LGHP coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must not treat any of these people differently because they are disabled and have Medicare.

The term "employee" here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working, but whom the employer treats as employees. Medicare determines whether an individual is considered to be an employee.

Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is secondary payer to EGHPs for 18 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under an EGHP or are covered under an EGHP as dependents. EGHPs are primary payers during this period without

regard to the size of the EGHP or the number of employees. The 18-month period begins with the earlier of:

- * The first month in which the person becomes entitled to Medicare Part A or
- * The first month in which an individual would have been entitled to Part A if he had filed an application for Medicare benefits.

However, EGHPs may be primary for an additional 3 months, or a total of up to 21 months: the first three months of dialysis (a period during which an individual generally is not eligible for Medicare benefits) plus the first 18 months of Medicare eligibility or entitlement. After the period of up to 21 months expires, Medicare is primary payer for entitled individuals and the EGHP is secondary.

The Health Care Financing Administration pamphlet entitled Medicare Coverage of Kidney Dialysis and Kidney Transplant Services contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or the Consumer Information Center, Department 59, Pueblo, CO 81009.

Association Group Insurance. Many organizations, other than employers, offer group health insurance coverage to their members. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices. Association group Medigap insurance must comply with the same rules that apply to other Medigap policies.

The following types of coverage are generally limited in scope and are not substitutes for Medigap insurance or managed care plans.

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing home. Some of these policies also cover care in the home, and others are available to pay for care in a skilled nursing facility (SNF) after your Medicare benefits run out (see page 3 for an explanation of the Medicare benefit for skilled nursing facility care).

If you are in the market for nursing home or longterm care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any Medigap policy, managed care plan, or other coverage you have.

It is important to remember that custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only care of this nature that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility.

For more information about long-term care insurance, request a copy of A Shopper's Guide to Long-Term Care Insurance from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64 105-1925. You may also obtain a copy of the Guide to Choosing a Nursing Home by writing to Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, MD 21207.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed cash amount for each day you are hospitalized up to a designated number of days. Some coverage 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. Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have, but other group health insurance may coordinate benefits with hospital confinement indemnity insurance sold on a group basis.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits

are not designed to fill gaps in Medicare coverage.

DO YOU NEED MORE INSURANCE?

Before buying insurance to supplement Medicare, ask yourself whether you need private health insurance in addition to Medicare. Not everyone does.

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. They also qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you become eligible for Medicaid, and you have Medigap insurance purchased on or after November 5, 1991, you can request that the Medigap benefits and premiums be suspended for up to two years while you are covered by Medicaid. Should you become ineligible for Medicaid benefits during the two years, your Medigap policy will be reinstated if you give proper notice and begin paying premiums again. You do not, however, have to suspend your Medigap policy, and suspension is not always to a Medicaid recipient's advantage. You may want to discuss your options with your state Medicaid representatives.

Qualified Medicare Beneficiary Program: Assistance for

Low-Income Elderly

Limited financial assistance is available through Medicaid for paying Medicare premiums, deductibles, and coinsurance amounts for certain low-income elderly and disabled beneficiaries. If your annual income is at or below the national poverty level and your cash and savings are very limited, you may qualify for state assistance in paying Medicare's monthly premiums, deductibles and coinsurance. This is called the "Qualified Medicare Beneficiary" (QMB) program.

To have qualified in 1993, your income could not have been more than \$601 per month for one person or \$806 per month for a couple, except in Alaska and Hawaii. In Alaska the income limits were \$745 per month for one person and \$1,002 per month

for a couple. In Hawaii they were \$690 per month for one person and \$925 per month for a couple. The limits for 1994 will be announced in February 1994. Financial resources such as bank accounts, stocks, and bonds cannot exceed \$4,000 for one person or \$6,000 for a couple.

Financial assistance also is available for Medicare beneficiaries under the "Specified Low-Income Medicare Beneficiary" (SLMB) program. This program is for beneficiaries whose incomes exceed the poverty level by not more than 10 percent and who meet certain resource limitations. To have qualified for this program in 1993, your income could not have been more than \$659 a month for one person or \$884 a month for a couple, except in Alaska and Hawaii. In Alaska the income limits were \$818 per month for one person and \$1,100 per month for a couple. In Hawaii they were \$758 per month for one person and \$1,016 per month for a couple. Individuals in this category are eligible only for Medicaid payment of their Medicare Part B premium, which is \$41.10 per month in 1994. If you think you qualify for state assistance in paying your Medicare expenses under either of these two programs, contact your state or local social service agency. If you cannot find a telephone number for the state agency, call 1-800638-6833 for assistance.

Federally Qualified Health Center

Medicare pays for some health services, including preventive care, when provided by a federally qualified health center (FQHC). These facilities are typically community health centers, migrant health centers and health centers for the homeless. They are generally located in inner-city and rural areas. The services covered by Medicare at FQHCs include routine physical examinations, screenings, and diagnostic tests for the detection of vision and hearing problems and other medical conditions, and the administration of certain vaccines for immunization against influenza and other diseases.

When those services are furnished at a FQHC, the \$100 annual Part B deductible does not apply (see page 5). However, if other services are provided, such as X-rays or screening mammograms, the FQHC may bill the Medicare carrier. In that case, you would be responsible for any unmet portion of the Part B annual deductible of \$100. As for the 20 percent Part B coinsurance, it is applicable for all FQHC services but Public Health Service guidelines allow the FQHC to waive it in some instances. Any Medicare beneficiary may seek services at an FQHC.

To find out whether one of these centers serves your area, call 1-800-638-6833.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop Carefully Before You Buy. Policies differ as to coverage and cost, and companies differ as to service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage is expensive and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. Federal law prohibits issuing duplicative coverage to Medicare beneficiaries even if both policies would pay full benefits. The law generally prohibits the sale of a Medicare supplement policy to a person who has Medicaid or another health insurance policy that provides coverage for any of the same benefits.

Similarly, the sale of any other kind of health insurance policy is generally prohibited if it duplicates coverage you already have. When you buy a replacement Medigap policy, the insurer is required to obtain your written statement that you intend to cancel the first policy after the new policy becomes effective. If you are on Medicaid, insurers may not sell you a Medigap policy unless the state pays the premium. Anyone who sells you a policy in violation of these anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call 1-800-638-6833 to report suspected violations.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other managed care plan; buying a Medigap policy; or buying a longterm care insurance policy.

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the 6 months before the date the policy went into effect.

Don't be misled by the phrase "no medical examination

required." If you have had a health problem, the insurer might not cover you immediately for expenses connected with that problem. Medigap policies, however, are required to cover preexisting conditions after the policy has been in effect for 6 months.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another--you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them a long time. If you decide to replace your Medigap policy, you must be given credit for the time spent under the old policy in determining when any preexisting conditions restrictions apply under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy.

Prohibited Marketing Practices. It is unlawful for a company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make fraudulent or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising also is prohibited. This tactic involves mailings to identify individuals who might be interested in buying insurance. If you fill in 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.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies (but not Medigap policies) pay less than the Medicare-approved amounts for hospital outpatient medical services and for services provided in a doctor's office. Others do not pay anything toward the cost of those services.

Check Your Right to Renew. States now require that Medigap policies be guaranteed renewable. This means that the company can refuse to renew your policy only if you do not pay the premiums or you made material misrepresentations on the application. Beware of older policies that let the company refuse to renew on an individual basis. These policies provide the least permanent coverage.

Even though your policy may be guaranteed renewable, the company may adjust the premiums from time to time. Some

policies have premiums which increase as you grow older.

Be A ware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program.

If anyone tells you that they are from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to claim that a policy has been approved for sale in any state in which it has not received state approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your state. You should check with your state insurance department to make sure that any company you are considering is licensed in your state. This is for your protection. Agents also must be licensed by your state and may be required by the state to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

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 that provides all that information.

Take Your Time. Do not be pressured into buying a policy. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy the Medigap policy of their choice without conditions being imposed (see page 11). Once this open enrollment period elapses, you may be limited as to the Medigap policies available to you, especially if you have a preexisting health condition.

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who tells you that your medical history on an application is not important. Some companies ask for detailed medical information. If you leave

out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

Look For an Outline of Coverage. You must be given a clearly worded summary of the policy... **READ IT CAREFULLY.**

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. Get a receipt with the insurance company's name, address and telephone number for your records.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without a response, contact your state insurance department.

Use the "Free-Look" Provision. Insurance companies must give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

For Your Protection

As noted above, federal criminal and civil penalties can be imposed against anyone who sells you a policy that duplicates coverage you already have unless you sign a statement declaring that the first policy will be cancelled, or unless you have Medicaid and the state Medicaid agency pays the premium for your Medigap policy. Penalties may also be imposed for claiming that a policy meets legal standards for federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received state approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, or the Health Care Financing Administration. It also is illegal to use the names, letters, symbols or emblems of their various programs.

This law is aimed primarily at mass marketers who use this information on mail solicitations to either imply or claim that the product they are selling whether it be insurance or something else--has either been endorsed or is being sold by the U.S. government. The advertising literature used by these organizations is often designed to look like it came from a government agency.

If you believe you have been the victim of any unlawful sales practices, contact your state insurance department immediately. If you believe that federal law has been violated, you may call 1-800-638-6833. In most cases, however, your state insurance department can offer the most assistance in resolving insurance related problems.

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these basic benefits:

- * Coverage for the Part A coinsurance amount (\$174 per day in 1994) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- * Coverage for the Part A coinsurance amount (\$348 per day in 1994) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- * After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.
- * Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- * Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges

for mental health services) after \$100 annual deductible is met.

PLAN B includes the basic benefits plus:

- * Coverage for the Medicare Part A inpatient hospital deductible (\$696 per benefit period in 1994).

PLAN C includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care coinsurance amount (\$87 per day for days 21 through 100 per benefit period in 1994).
- * Coverage for the Medicare Part B deductible (\$100 per calendar year in 1994).
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

PLAN D includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for at-home recovery. The at-home recovery benefit pays up to \$1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

PLAN F includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * Coverage for the Medicare Part B deductible.
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for 100% of Medicare Part B excess charges. *

PLAN G includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * Coverage for 80% of Medicare Plan B excess charges.*
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for at-home recovery (see Plan D).

PLAN H includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$1,250 after the policyholder meets a \$250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * Coverage for 100% of Medicare Part B excess charges. *
- * Basic prescription drug coverage (see Plan H for description).
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- * Coverage for at-home recovery (see Plan D).

PLAN J includes the basic benefits plus:

- * Coverage for the Medicare Part A deductible.
- * Coverage for the skilled nursing facility care daily coinsurance amount.
- * Coverage for the Medicare Part B deductible.
- * Coverage for 100% of Medicare Part B excess charges. *
- * 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

* Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of \$3,000 after the policyholder meets a \$250 per year deductible (this is called the "extended" drug benefit).

* Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

[Graphic Omitted]

Basic Benefits pay the patient's share of Medicare's approved amount for physician services (generally 20%) after \$100 annual deductible, the patient's cost of a long hospital stay (\$174/day for days 60-90, \$348/day for days 91-150, approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. a "basic" benefit with \$250 annual deductible, 50% coinsurance and a \$1,250 maximum annual benefit (Plans H and I above), and
2. an "extended" benefit (Plan J above) containing a \$250 annual deductible, 50% coinsurance and a \$3,000 maximum annual benefit.

Each of the 10 plans has a letter designation ranging from "A" through "J". Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans, they all must make Plan A available if they sell any of the other 9 in a state.

INSURANCE POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

POLICY I POLICY 2 POLICY 3

Does the policy cover: YES NO YES NO YES NO

Medicare Part A hospital deductible?

*Medicare Part A hospital daily coinsurance?

*Hospital care beyond Medicare's 150-day limit?

Skilled nursing facility (SNF) daily coinsurance?

SNF care beyond Medicare's limits?

Medicare Part B annual deductible?

*Medicare Part B coinsurance?

Physician and supplier charges in excess
of Medicare's approved amounts?

*Medicare blood deductibles?

Prescription drugs?

Other Policy Considerations

Can the company cancel or non-renew the policy?

What are the policy limits for covered services?

How much is the annual premium?

How often can the company raise the premium?

How long before existing health problems are covered?

Does the policy have a waiting period before any
benefits will be paid? How long?

* Most states now require that these benefits be included in
all newly issued Medigap policies.

NOTES

DIRECTORY OF STATE INSURANCE DEPARTMENTS AND AGENCIES ON AGING

Each state has its own laws and regulations governing all types of insurance. The insurance offices listed in the left column of this directory are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. The middle column of the directory lists the telephone number to call for insurance counseling services. Calls to an 800 number listed in this directory are free when made within the respective state.

[Table Omitted]

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

HCFA ICN 003622
SSA ICN 002795

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