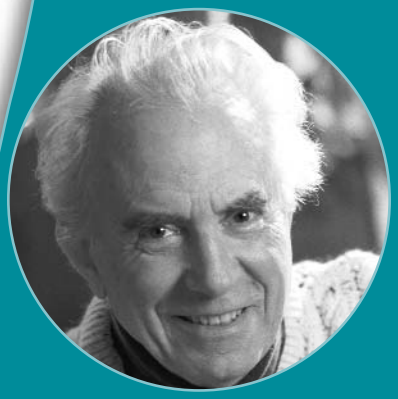
2005

Choosing A Medigap Policy:

A Guide to Health Insurance for People With Medicare



This official government guide can help you

- Learn what a Medigap (Medicare Supplement Insurance) policy is.
- Decide if you want to buy a Medigap policy.
- Understand when you can buy a Medigap policy.
- Choose the Medigap policy that best meets your needs.
- Understand how Medigap policies will change when Medicare prescription drug plans start in 2006.
- Know where to go if you have questions.

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

How to use this Guide

There are two ways to find the information you need:

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

2. The "List of Topics" on pages 94–97 lists every topic in this Guide and the page number to find it on.

Who should read this Guide

This guide was written to help people with the Original Medicare Plan understand Medigap (Medicare Supplement Insurance) policies.

A Medigap policy is private insurance that helps you pay for some of the costs that Medicare doesn't pay for. This guide explains in detail how Medigap policies work. It also includes information about new Medicare prescription drug plans (starting in 2006) and how these plans will change Medigap policies.

If you have a Medigap policy with prescription drug coverage, you should read pages 39–40.

The "2005 Choosing A Medigap Policy: A Guide to Health Insurance for People With Medicare" isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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Table of Contents

section 1

How Medicare and Medigap Policies are Changing

Use this section to find out about the changes in 2006.

If you already have a Medigap policy or you are thinking about buying a Medigap policy, there are a few things you should know about what's new in Medicare and how Medigap policies are changing. Below is a quick look at these changes.

What's NEW in Medicare

A new Federal law has brought many new changes to the Medicare Program. The following changes give you even more choices in how you get your health care benefits, including coverage for prescription drugs.

Medicare prescription drug coverage—Starting in 2006

- Enrollment in Medicare prescription drug plans starts in 2005. Medicare prescription drug plans will begin coverage on January 1, 2006.

New Medicare-covered preventive services—Starts in 2005

- Cardiovascular screening blood tests
- Diabetes screening tests
- "Welcome to Medicare" physical exam

To learn more about Medicare choices or changes, you can get a free copy of the "Medicare & You" handbook (CMS Pub. No. 10050) by visiting www.medicare.gov on the web. Select "Search Tools" at the top of the page. This website also includes information on what Medicare health plans and Medigap policies are available in your area. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What's NEW in Medigap (Medicare Supplement Insurance) policies

New Medigap policies

The new Federal law gives you more choices in Medigap policies. In addition to Medigap Plans A through J, two new Medigap policies will be offered in 2005 (Medigap Plans K and L). Below is a quick look at the two new Medigap policies.

Medigap Plans K and L will offer

- different benefits than Medigap Plans A through J.
- lower premiums than Medigap Plans A through J.

If you use the benefits in Medigap Plans K and L, you will have to pay higher out-of-pocket costs than Medigap Plans A through J. Otherwise, Medigap Plans A through J may be cheaper.

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 80–82.

To learn about the types of benefits that Medigap Plans K and L offer, see pages 19 and 21.

For more information about how Medigap Plans A through J are different from Medigap Plans K and L, see page 17.

Note: If you bought your Medigap policy before 1992 **or** live in Massachusetts, Minnesota, or Wisconsin, your Medigap policy may be called something different.

Changes to Medigap policies with prescription drug coverage

Medicare will start to offer prescription drug coverage starting January 1, 2006. Some Medigap policies offer prescription drug coverage, and the new Medicare prescription drug coverage will affect those policies.

Note: Medigap Plans H, I, and J **are different from** Medicare prescription drug plans.

- Beginning January 1, 2006, when Medicare prescription drug plans start, you won't be able to buy a new Medigap policy covering prescription drugs. These same policies may still be sold, but without prescription drug coverage.
- If the Medigap policy that you have now covers prescription drugs, you will get detailed information in the mail from your Medigap insurance company about your drug options (see page 39 and **Situation #8** on page 62). You will need to decide which drug option best meets your needs. Help will be available.

Where can I get more information about what's new in Medicare and Medigap policies?

If you have questions about Medicare, Medicare prescription drug plans, Medigap policies, or other Medicare-related questions, you can visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call your State Health Insurance Assistance Program (see pages 85–86).

Words in green are defined on pages 88–91.

section **2**

Medicare Overview

Use this section to learn the basics of Medicare.

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

If you already know the basics about Medicare and Medicare health plans, turn to Section 3 "What You Need to Know About Medigap Policies," which starts on page 11.

If you want to learn more about the new Medicare prescription drug plans and how they affect Medigap policies, read Section 4 "Prescription Drug Coverage Overview," which starts on page 37.

Words in green are defined on pages 88–91.

What is Medicare?

Medicare is a health insurance program for

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

Medicare has

- Medicare Part A (Hospital Insurance),
- Medicare Part B (Medical Insurance), and
- Medicare prescription drug coverage.

  Starting November 15, 2005, you can enroll in a Medicare prescription drug plan. Medicare prescription drug plans will begin coverage on January 1, 2006. For information about Medicare prescription drug plans, see page 37.

What is Medicare Part A?

Medicare Part A helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care) when they are medically necessary.

What is Medicare Part B?

Medicare Part B helps cover your doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover. These services are covered when they are medically necessary.

What are Medicare Health Plans?

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

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

Note: Medigap policies **aren't** Medicare Advantage Plans.

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

Original Medicare Plan and Medigap policies at a glance

If you get your health care from the Original Medicare Plan, you use your red, white, and blue Medicare card (see sample card on page 27) which tells you if you have Medicare Part A, Part B, or both. You don't need Medicare Part B to be in the Original Medicare Plan. However, you generally must have Medicare Part A **and** Part B to buy a Medigap policy.

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

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

You might want to consider buying a Medigap policy to cover these gaps in Medicare coverage. Some Medigap policies also cover benefits that Medicare doesn't cover, like Medicare Part B excess charges and emergency health care while traveling outside the U.S. A Medigap policy may help you save on out-of-pocket costs. If you buy a Medigap policy, you will also have to pay a monthly premium to the private insurance company that sells you the policy.

Medigap policies only help pay health care costs if you are in the Original Medicare Plan. To learn what Medigap policies cover, see pages 43–48.

Medicare Advantage Plans at a glance

If you decide to join a Medicare Advantage Plan, you will still have a Medicare card, but you need to use the membership card that you get from the plan for your health care. These plans often give you extra benefits, like coverage for extra days in the hospital, than the Original Medicare Plan.

Note: If you have End-Stage Renal Disease, you usually can't join a Medicare Advantage Plan.

If Medicare Advantage Plans are available in your area, and you have Medicare Part A and Part B, you can join one and get your Medicare-covered benefits through the plan. You will have to pay the monthly Medicare Part B premium ($78.20 in 2005). In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer. You should call the Medicare Advantage Plans for more information.

If you are in a Medicare Advantage Plan, you don't need a Medigap policy, because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover. Medigap policies won't work with Medicare Advantage Plans.

Note: If you have a Medigap policy and you join a Medicare Advantage Plan, you must drop your Medigap policy. If you drop your Medigap policy, you may not be able to get it back with the same benefits.

Where can I get more information?

Get a free copy of the "Medicare & You" handbook (CMS Pub. No. 10050) or "Your Medicare Benefits" (CMS Pub. No. 10116) at www.medicare.gov on the web. Select "Search Tools" at the top of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

section 3

What You Need to Know About Medigap Policies

This section includes information about what Medigap policies are, what they cover and don't cover, cost information, the best time to buy and more.

What is a Medigap policy?

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

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, different types of standardized Medigap policies are sold in your state (see pages 80–82).

Insurance companies can only sell you a "standardized" Medigap policy. These Medigap policies are standardized so you can compare them easily.

Since 1992, there have been 10 standardized Medigap policies called Plans "A" through "J." In 2005, there will be two new standardized Medigap policies available, called Plans "K" and "L." You may be able to choose from up to 12 different standardized Medigap policies (Plans A through L).

Medigap policies must follow Federal and state laws. These laws protect you. The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance." **Each Plan, A through L, has a different set of basic and extra benefits** (see pages 18–21).

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

What is a Medigap policy? (continued)

Words in green are defined on pages 88–91.

Generally, when you buy a Medigap policy you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium ($78.20 in 2005). In addition, you will have to pay a premium to the Medigap insurance company. As long as you pay your premium, your Medigap policy is guaranteed renewable. This means it is automatically renewed each year. Your coverage will continue year after year as long as you pay your premium.

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

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

It is illegal for anyone to sell you a Medigap policy if

- you are in a Medicare Advantage Plan (like an HMO, PPO, or PFFS).
- you have Medicaid. There are certain exceptions (see page 75).
- you already have a Medigap policy (unless you are cancelling your old Medigap policy).

What are some examples of coverage that are NOT a Medigap policy?

A Medigap policy is different from

- a Medicare Advantage Plan,
- Medicare Part B,
- a Medicare prescription drug plan,
- Medicaid,
- TRICARE, and
- Veterans' benefits.

Why would I want to buy a Medigap policy?

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

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

- lower your out-of-pocket costs, and
- get more health insurance coverage.

Some Examples of Gaps in Medicare-covered Services		
What YOU Pay in 2005 (These amounts can change each year.)		**A Medigap policy may help pay these costs**
Hospital Stays	**For each benefit period, YOU PAY** • $912 for the first 60 days • $228 per day for days 61–90 • $456 per day for days 91–150	✓
Skilled Nursing Facility Stays	**For each benefit period, YOU PAY** • Nothing for the first 20 days • Up to $114 per day for days 21–100	✓
Blood	**YOU PAY** the cost of the first three pints.	✓
Medicare Part B Yearly Deductible	**YOU PAY** the $110 per year deductible.	✓
Medicare Part B Covered Services	**YOU PAY** • 20% of the Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment* • Copayment for outpatient hospital services	✓

* Medigap Plans A through J must pay 50% coinsurance for outpatient mental health treatment services. This percentage is different for Medigap Plans K and L.

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

- routine yearly check-ups (Beginning in 2005, Medicare covers a one-time "Welcome to Medicare" physical exam within the first six months of having Medicare Part B.),
- Medicare Part B excess charges (the difference between your doctor's charge and the Medicare-approved amount) that only apply if your doctor doesn't accept assignment,
- And more (see pages 20–21).

Who can buy a Medigap policy?

To buy a Medigap policy, you generally must have Medicare Part A and Part B. You are guaranteed the right to buy a Medigap policy if you are

- in your Medigap open enrollment period (see page 26), or
- covered under a Medigap protection (see pages 54–63).

You might not be able to buy a Medigap policy if you

- are in a Medicare Advantage Plan (like an HMO, PPO, or PFFS).
- have Medicaid.
- already have a Medigap policy (unless you are cancelling your old Medigap policy).
- are under age 65 and you are disabled or have End-Stage Renal Disease (ESRD).

If you are under age 65, you might not be able to buy a Medigap policy until you turn age 65. More information about Medigap policies for people under age 65 starts on page 65.

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

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

What is Medicare SELECT?

Medicare SELECT is a type of Medigap policy sold in some states. If you buy a Medicare SELECT policy, you are buying one of the 12 standardized Medigap Plans A through L. With a Medicare SELECT policy, you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits (except in an emergency). For this reason, **Medicare SELECT policies generally cost less than other Medigap policies.**

What are some examples of things that are NOT covered by Medigap policies?

- Long-term care,
- Vision or dental care,
- Hearing aids, or
- Private-duty nursing.

How do Medigap Plans A through J differ from Medigap Plans K and L?

Medigap Plans A through J offer different benefits than Medigap Plans K and L and cost more because they provide more benefits and have lower out-of-pocket costs. Listed below is a quick look at how Medigap Plans A through J differ from Plans K and L.

Comparing Medigap Policies

	Medigap Plans A through J	Medigap Plans K and L
Premiums	Higher premiums	Lower premiums
Out-of-pocket costs	Lower (or no) out-of-pocket costs	Higher out-of-pocket costs, but subject to out-of-pocket annual limits (see page 19)
Basic Benefits	Includes • Medicare Part A coinsurance and hospital benefits • Medicare Part B coinsurance or copayment • Blood See page 18 for details about these basic benefits.	Includes • Medicare Part A coinsurance and hospital benefits • Medicare Part B coinsurance or copayment • Blood • Hospice care See page 19 for details about these basic benefits.
Extra Benefits	May include • Skilled Nursing Facility Coinsurance • Medicare Part A and B deductibles • Part B Excess Charges • Foreign Travel Emergency • At-Home Recovery • Drug Coverage (until January 1, 2006) • Preventive Care See page 20 for details about these extra benefits.	May include • Skilled Nursing Facility Coinsurance • Medicare Part A Deductible See page 21 for details about these extra benefits.

On the next four pages, you will see four different charts. These charts are side-by-side to help you compare the different types of benefits that each Medigap policy offers. The charts on pages 18–19 will help you compare the different **basic** benefits for Medigap Plans A through J with Medigap Plans K and L. See pages 20–21 to compare the different **extra** benefits for Medigap Plans A through J with Medigap Plans K and L.

What do Medigap policies cover?

If you live in Massachusetts, Minnesota, or Wisconsin, see pages 80–82.

Each standardized Medigap policy **must** cover basic benefits. Medigap Plans A through J have one set of basic benefits, and Plans K and L have a different set of basic benefits (see the basic benefits charts below for Plans A through J and page 19 for Plans K and L). Most Medigap policies pay some, if not all, of the Original Medicare Plan coinsurance and outpatient copayment amounts. These policies may also cover Original Medicare Plan deductibles. Some Medigap policies cover extra benefits to help pay for things Medicare doesn't cover (see the extra benefits charts on page 20 for Plans B through J and page 21 for Plans K and L).

Note: Medigap Plans F and J have a high-deductible option (see page 24). If you choose this option, you must pay the deductible first before the Medigap policy pays anything.

A Quick Look at the Basic Benefits for Medigap Plans A through J

Basic benefit	What Medigap Plans A through J pay in 2005 (These amounts can change each year.)
Medicare Part A coinsurance and hospital benefits	**Plans A through J pay** • $228 per day for days 61–90 of a hospital stay • $456 per day for days 91–150 of a hospital stay • Up to 365 more days for hospital stays during your lifetime after you use all Medicare hospital benefits
Medicare Part B coinsurance or copayment	**Plans A through J pay** all coinsurance and copayment amounts after you meet the Part B $110 yearly deductible.
Blood	**Plans A through J pay** for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.

See pages 20, 43, and 46–47 for more information about Medigap Plans A through J.

A Quick Look at the Basic Benefits for Medigap Plans K and L	
Basic benefit	**What Medigap Plans K and L pay in 2005 (These amounts can change each year.)**
Medicare Part A coinsurance and hospital benefits	**Plan K and Plan L pay** • $228 per day for days 61–90 of a hospital stay • $456 per day for days 91–150 of a hospital stay • Up to 365 more days of a hospital stay during your lifetime after you use all Medicare hospital benefits
Medicare Part B coinsurance or copayment	**Plan K pays** 50% Part B coinsurance after you meet the Part B $110 yearly deductible. It pays 100% coinsurance for Part B preventive services. **Plan L pays** 75% Part B coinsurance after you meet the Part B $110 yearly deductible. It pays 100% coinsurance for Part B preventive services.
Blood	**Plan K pays** 50% of the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use. **Plan L pays** 75% of the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.
Hospice care	**Plan K pays** 50% hospice cost-sharing for all Part A Medicare covered expenses and respite care. **Plan L pays** 75% hospice cost-sharing for all Part A Medicare covered expenses and respite care.

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

See pages 21, 44–45, and 48 for more information about Medigap Plans K and L.

Overview of Medigap Plans A through J

Medigap policies (including Medicare SELECT) can only be sold as standardized plans. This chart gives you a quick look at the Medigap Plans A through J and their benefits. Medigap Plans A through J must cover the basic benefits listed on **page 18.** Read down to find out what benefits are in each plan. This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin; **see pages 80–82**. If you need more information, call your State Insurance Department or State Health Insurance Assistance Program **(see pages 85–86)**.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible
		Medicare Part B Deductible			Medicare Part B Deductible				Medicare Part B Deductible
					Medicare Part B Excess Charges (100%)	Medicare Part B Excess Charges (80%)		Medicare Part B Excess Charges (100%)	Medicare Part B Excess Charges (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 ***

Important Notes

- For details about the Medigap policy extra benefits listed in the chart (Skilled Nursing Facility Coinsurance, Medicare Part A and Part B Deductible, Medicare Part B Excess Charges, Foreign Travel Emergency, At-Home Recovery, Prescription Drug Benefits, and Preventive Care), **see pages 46–47**.

* Medigap Plans F and J also have a high-deductible option, **see page 24**.

** Starting January 1, 2006, you won't be able to buy Medigap policies covering prescription drugs. However, if you buy a policy with prescription drug coverage before January 1, 2006, you will have to decide if you want to keep this coverage. For more information about prescription drug coverage, **see pages 37–40**.

*** Medigap policies cover some preventive care that isn't covered by Medicare, **see page 47**.

Overview of Medigap Plans K and L

In 2005, you might be able to buy Medigap Plans K and L (also can be sold as Medicare SELECT) from a Medigap insurance company. These new Medigap policies can be sold only as standardized plans. This chart gives you a quick look at the Medigap Plans K and L and their benefits. Medigap Plans K and L must cover the basic benefits listed on **page 19**. The basic benefits for Medigap Plans K and L are different from the basic benefits offered in Medigap Plans A through J. Read down to find out what benefits are in each plan. This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin; **see pages 80–82**. If you need more information, call your State Insurance Department or State Health Insurance Assistance Program **(see pages 85–86)**.

Plan K	Plan L
Basic Benefits (see page 19)	Basic Benefits (see page 19)
Skilled Nursing Facility Coinsurance (50%)	Skilled Nursing Facility Coinsurance (75%)
Medicare Part A Deductible (50%)	Medicare Part A Deductible (75%)

Important Notes

- You will have to pay part of the cost-sharing of some covered services until you meet the annual out-of-pocket limit. Plan K has a $4,000 out-of-pocket limit. Plan L has a $2,000 out-of-pocket limit. Once you meet the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. These amounts can change each year.
- For details about the Medigap policy extra benefits listed in the chart (Skilled Nursing Facility Coinsurance and Medicare Part A Deductible), **see page 48**.

How much do Medigap policies cost?

The cost of Medigap policies can vary widely. **There can be big differences in the premiums that insurance companies charge for exactly the same coverage**. As you shop for a Medigap policy, be sure you are comparing the same Medigap policy (for example, compare a Plan A from one company with Plan A from another company). Although this Guide **can't** give actual costs of Medigap policies, you can get this information by calling insurance companies, or by visiting www.medicare.gov on the web. Select "Search Tools" at the top of the page. See page 49 for more details. Or, you can call your State Health Insurance Assistance Program (see pages 85–86).

How do insurance companies set the price of Medigap policies?

Each insurance company sets its own premiums. It is important to ask how an insurance company prices Medigap policies. How they set the price affects how much you pay now and in the future. Medigap policies can be priced or "rated" in three ways:

1. Community-rated (or "no-age-rated")
2. Issue-age-rated
3. Attained-age-rated

Each of these ways of pricing policies is described in the chart on the next page. Monthly premiums may vary by insurance company and by Medigap policy. The amounts in the examples **aren't** actual costs. Only you can choose the insurance company that best meets your needs. Remember, you should look at how much the policy will cost you now and in the future.

How Insurance Companies set prices for Medigap Policies

Type of pricing	How it's priced	What pricing may mean for you	Examples
Community-rated (also called no-age-rated)	The same monthly premium is charged to everyone who has the Medigap policy, regardless of age.	Premiums are the same no matter how old you are, and won't change except for inflation.	Mr. Smith is 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because with this type of policy, everyone pays the same price, regardless of age.
Issue-age-rated	The premium is based on the age you are when you buy (are "issued") the Medigap policy.	Premiums are lower for younger buyers, and won't change except for inflation.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is 72. She buys the same Medigap policy as Mr. Han. Since she is older at the time she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you have "attained") so your premium goes up each year.	Premiums for these Medigap policies are low for younger buyers, but go up every year and can eventually become the most expensive. They may also go up because of inflation.	Mrs. Anderson buys a Medigap policy at age 65. She pays a $165 monthly premium. Her premium will go up every year. • At age 66, her premium goes up to $171 • At age 67, her premium goes up to $177 • At age 72, her premium goes up to $189 Mr. Dodd buys his Medigap policy at age 72. He pays a $175 monthly premium. His premium is higher than Mrs. Anderson's because it is based on his current age. Mr. Dodd's premium will go up every year. • At age 73, his premium goes up to $185 • At age 74, his premium goes up to $190

Note: Look at page 32 if you are thinking about switching Medigap policies to save money.

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

Yes. The cost of your Medigap policy may be affected

- **By Discounts:** Insurance companies may offer discounts to females, non-smokers, and/or married people.
- **By Medical Underwriting:** Some insurance companies may use medical underwriting. This means that you must answer medical questions on an application. Fill the application out carefully and completely. The insurance company uses this information to decide whether to sell you a Medigap policy, how much they will charge you, and whether you will have to wait for coverage to start. Some companies may add a waiting period for pre-existing conditions if your state law allows (see page 29).

  Insurance companies can't use medical underwriting if you are in your Medigap open enrollment period (see pages 26–28) or if you have special rights (called Medigap protections) to buy a Medigap policy (see pages 54–63).
- **If you buy a high-deductible option:** Insurance companies may offer a "high-deductible option" on Medigap Plans F and J (see chart on page 20). If you choose this option, you must pay the first $1,730 (the deductible in 2005) in Medigap-covered costs before the Medigap policy pays anything. This amount can change each year.

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

  In addition to the $1,730 (in 2005) deductible that you must pay for the high-deductible option for Plans F and J, you must **also** pay deductibles for

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

Words in green are defined on pages 88–91.

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

- **If you buy a Medicare SELECT policy:** Medicare SELECT is a type of Medigap policy sold by some insurance companies in some states. If you buy a Medicare SELECT policy, you are buying one of the 12 standardized Medigap Plans A through L. Medicare SELECT policies require you to use specific hospitals and, in some cases, specific doctors to get full insurance benefits (except in an emergency). Generally, Medicare SELECT policies cost less than other Medigap policies.

  If you have a Medicare SELECT policy and you don't use a Medicare SELECT hospital or doctor for non-emergency services, your costs will be higher. You will have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

Words in green are defined on pages 88–91.

When is the best time to buy a Medigap policy?

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

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

- age 65 or older, **and**
- enrolled in Medicare Part B.

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

During this period, an insurance company can't

- deny you any Medigap policy it sells,
- make you wait for coverage to start, or
- charge you more for a policy because of your health problems.

If you buy a Medigap policy during your Medigap open enrollment period, in many cases the insurance company must shorten the waiting period for pre-existing conditions (see page 29) if you had recent health coverage. This is called "creditable coverage" (see page 30).

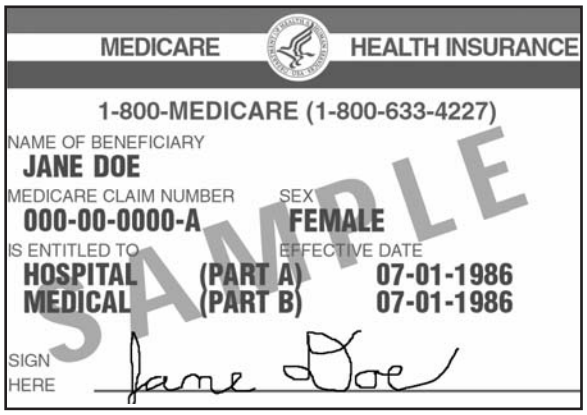
If you are eligible for Medicare because you're disabled or have End-Stage Renal Disease (ESRD), see pages 65–68.

Note: You may want to apply for a Medigap policy before your Medigap open enrollment period starts if you are losing coverage because you are eligible for Medicare. This will allow you to have continuous coverage.

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

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

Words in green are defined on pages 88–91.



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

Example: Medigap Open Enrollment Period

It is October 1, 2005, and Mr. Rodriguez (age 65) wants to buy a Medigap policy. He needs to know if he is in his Medigap open enrollment period. He looks at his Medicare card. His Medicare Part B coverage started August 1, 2005. To figure out if he is in his open enrollment period, he must add six months to his Medicare Part B start date and see if it is before or after the current date.

August 1, 2005 + six months = February 1, 2006

Since it is October 1, 2005, he is still in his open enrollment period. Mr. Rodriguez has until January 31, 2006, to buy a Medigap policy during his Medigap open enrollment period.

Although Mr. Rodriquez has until January 31, 2006 to buy a Medigap policy, he won't be able to buy a Medigap policy with prescription drug coverage after December 31, 2005.

What if I missed my Medigap open enrollment period?

If you apply for a Medigap policy after your open enrollment period has ended, the Medigap insurance company is allowed to use medical underwriting (see page 24) to decide whether to accept your application, and how much to charge you for the policy. If you are in good health, the insurance company is likely to sell you the policy, but there is no guarantee that they will (unless you become eligible for one of the Medigap protections listed on page 55). Remember, not all insurance companies use medical underwriting.

I am over age 65 and still working (or covered under my spouse's health plan). Should I enroll in Medicare Part B and start my Medigap open enrollment period?

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

However, if your employer group health plan only pays after Medicare pays, your plan can require you to enroll in Medicare Part B in order to get benefits under that plan.

Important information about enrolling in Medicare Part B

If you don't enroll in Medicare Part B when you are first eligible or after you drop employer coverage, you may have to pay a higher monthly premium. You will have to pay this extra amount as long as you have Medicare Part B.

There are three times when you can enroll in Medicare Part B. These are called:

1. Initial Enrollment Period
2. General Enrollment Period
3. Special Enrollment Period

It's very important to learn about these enrollment periods.

For more information about these enrollment periods, get a free copy of "Enrolling in Medicare" (CMS Pub. No. 11036) at www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Pre-existing conditions

What is a pre-existing condition?

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

Words in green are defined on pages 88–91.

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

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

- **During your Medigap open enrollment period**

  If you buy a Medigap policy during your Medigap open enrollment period, and you had at least six months of previous health coverage that qualifies as "creditable coverage" (see page 30), the company can't apply a pre-existing condition waiting period to you. If you had less than six months of creditable coverage, this waiting period will be reduced by the number of months of creditable coverage you had.

- **When you have special Medigap protections (Guaranteed Issue Rights)**

  If you buy a Medigap policy when you have special Medigap protections (also called guaranteed issue rights), the insurance company can't use a pre-existing condition waiting period. For more information about Medigap protections, see pages 54–63.

  If you want to know if you will have a pre-existing condition waiting period if you switch Medigap policies, see page 32.

Creditable coverage

What is creditable coverage?

Creditable coverage (for Medigap policies) is generally any other health coverage you had before you apply for a Medigap policy.

These types of health care coverage may count as creditable coverage for Medigap policies:

- A group health plan (like an employer or union plan)
- A health insurance policy
- Medicare Part A or Medicare Part B
- Medicaid (see pages 74–75)
- A medical program of the Indian Health Service or tribal organization
- A state health benefits risk pool (sometimes called a state high risk pool)
- TRICARE (the health care program for military dependents and retirees, see page 76)
- A Federal Employees Health Benefit plan
- A public health plan
- A health plan under the Peace Corps Act
- COBRA (see pages 71–72)

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

The following doesn't count as creditable coverage:

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

What is creditable coverage? (continued)

Example: Creditable Coverage

Mr. Smith is 65 and is being treated for heart disease. His Medicare Part A and Part B started November 1, 2004. Before this date, he had no health insurance coverage.

On March 1, 2005, Mr. Smith buys a Medigap policy. His Medigap insurance company refuses to cover his heart disease condition for six months (the pre-existing condition waiting period). However, since Mr. Smith had Medicare Part A and Part B from November 1 to March 1, the insurance company must use his four months of Medicare coverage as creditable coverage to shorten this six-month waiting period.

Now his waiting period will only be two months instead of six months. During these two months, after Medicare pays its share, Mr. Smith will have to pay the rest of the costs for the care of his heart disease. He will also have to pay his Medigap premiums. The Medigap policy will pay for other covered care.

Switching Medigap policies

What if I have an old Medigap policy and I want to switch to a different Medigap policy?

Words in green are defined on pages 88–91.

You may not have a guaranteed right to switch Medigap policies. But, if you are given the opportunity, make sure you compare benefits and premiums before switching policies. If you bought your Medigap policy before 1992, it may offer better coverage than a newer policy. On the other hand, older Medigap policies may have bigger premium increases than newer standardized Medigap policies currently being sold.

If you decide to switch, don't cancel your first Medigap policy until you have decided to keep the second Medigap policy. You have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look" period. The 30-day free look period starts when your Medigap policy is issued to you.

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

No. If you have an older Medigap policy that you bought before 1992, you can **generally** keep it. You don't have to switch to one of the standardized Medigap policies. But, if you decide to buy a newer Medigap policy, you won't be able to go back to your old Medigap policy.

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

No, but your new Medigap policy might not cover all your pre-existing conditions if you've had your current Medigap policy for less than six months. However, the amount of time you've had your current Medigap policy must count towards the amount of time you must wait before your new policy covers your pre-existing condition.

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

Losing Medigap coverage

Can my Medigap insurance company drop me?

In most cases, no. If you bought your Medigap policy **after 1990**, the policy is guaranteed renewable. This means your insurance company can drop you only if

- you stop paying your premium,
- you aren't truthful about something under the policy, or
- the insurance company goes bankrupt.

Words in green are defined on pages 88–91.

For more information, see Medigap Protections, **Situation #6** on page 60.

Insurance companies in some states may be able to drop you if you bought your policy **before 1990**. For an insurance company to refuse to renew one of these older Medigap policies, the company must get the state's approval. If this happens, you have the right to buy another Medigap policy (see Medigap Protections, **Situation #6** on page 60).

How your bills get paid

Does the Medigap insurance company pay my doctor directly?

Most Medigap insurance companies get information about your bills directly from Medicare.

Words in green are defined on pages 88–91.

However, if your Medigap insurance company doesn't have this service, ask your doctors if they accept "assignment" for their Medicare patients. If your doctor does accept assignment, then ask their staff to put on the Medicare claim form that you want Medigap insurance benefits paid to the doctor. You will need to sign the claim form or have your doctor keep your signature on record. Make sure this information is correct.

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

If the Medigap insurance company doesn't pay your doctor directly, you should report this to your State Insurance Department (see pages 85–86). For more information on Medigap claim filing by Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Watch out for illegal insurance practices

It is illegal for anyone to

- pressure you into buying a Medigap policy, or lie or mislead you to switch from one company or policy to another.
- sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- sell you a Medigap policy if they know you have Medicaid, except in certain situations (see page 75).
- sell you a Medigap policy if they know you are in a Medicare Advantage Plan.
- claim that a Medigap policy is part of the Medicare Program or any other Federal program. Remember, Medigap is private health insurance.
- sell you a Medigap policy that can't legally be sold in your state. Check with your State Insurance Department (see pages 85–86) to make sure that the Medigap plan you are interested in can be sold in your state.
- sell you a Medigap policy with prescription drug coverage after December 31, 2005.
- misuse the names, letters, or symbols of the U. S. Department of Health and Human Services (HHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare. (For example, suggesting the Medigap policy has been approved or recommended by the Federal government.)
- claim to be a Medicare representative.

If you believe that a Federal law has been broken, call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). In most cases, however, your State Insurance Department can help you with insurance-related problems (see pages 85–86).

Ways to check if an insurance company is reliable

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

- Call the State Insurance Department in your state (see pages 85–86). Ask if they keep a record of complaints against insurance companies and ask whether these can be shared with you.
- Call the State Health Insurance Assistance Program in your state (see pages 85–86). These programs can give you free help with choosing a Medigap policy.
- Go to your local public library. Your local public library can help you
    - get information on an insurance company's financial strength by independent rating services such as, Weiss Rating, Inc., A.M. Best, and Standard & Poors, and
    - look at information on the web.
- Talk to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy.

Words in green are defined on pages 88–91.

section 4

Prescription Drug Coverage Overview

This section explains new Medicare prescription drug plans and changes to Medigap policies with prescription drug coverage.

If you have a Medigap policy with prescription drug coverage, you should read this section carefully.

Medicare prescription drug plans

Words in green are defined on pages 88–91.

Beginning January 1, 2006, new Medicare prescription drug plans will be available to people with Medicare. Insurance companies and other private companies are working with Medicare to offer these Medicare prescription drug plans.

When the new Medicare prescription drug plans become available, the rules about prescription drug coverage under Medigap policies will change.

Note: If your prescription drug coverage is through a Medigap policy, see **"Medigap policies and Medicare prescription drug plans"** on pages 39–40 and **Situation #8** on page 62.

The new Medicare prescription drug plans might be a good choice for you. For information about Medicare prescription drug plans, you can

- look in the "Medicare & You 2006" handbook (CMS Pub. No. 10050). This handbook is mailed to people with Medicare every fall.
- visit www.medicare.gov on the web. **Note:** In late fall 2005, you will be able to get personalized Medicare prescription drug plan information for your area from this website.
- call 1-800-MEDICARE (1-800-633-4227). A customer service representative can answer your Medicare questions and help compare Medicare prescription drug plans, when they become available. TTY users should call 1-877-486-2048.
- call your State Health Insurance Assistance Program (SHIP) (see pages 85–86). Your SHIP can provide one-on-one help comparing your health insurance options.

Medigap policies and Medicare prescription drug plans

I have a Medigap policy with prescription drug coverage. How does the new Medicare prescription drug coverage affect my Medigap policy?

If your Medigap policy covers prescription drugs, sometime between September 15, 2005 and November 15, 2005, your Medigap insurance company will mail you information describing how the new Medicare prescription drug coverage will affect your Medigap policy. When you get this notice, make sure you read it carefully before making any decisions. Here is a summary of what the notice will tell you.

Option	Situation	What You Need to Do or Know
1	You can enroll in a Medicare prescription drug plan and keep your Medigap policy with the prescription drug coverage removed.	• Enroll in a Medicare prescription drug plan that meets your needs. • Tell your Medigap insurance company when your Medicare prescription drug plan starts. • You will no longer get prescription drug coverage under your Medigap policy and your premium will be adjusted based on this change.
2	You can enroll in a Medicare prescription drug plan by May 15, 2006 and buy a different Medigap policy without prescription drug coverage.	• Enroll in a Medicare prescription drug plan that meets your needs. • Contact your Medigap insurance company and find out which other Medigap policy you can buy. See **Situation #8** on page 62 for information about your right to buy the Medigap policy.
3	You can enroll by May 15, 2006 in a Medicare Advantage Plan that includes prescription drug coverage.	• Enroll in a Medicare Advantage Plan that meets your needs. • Tell your Medigap insurance company if you enrolled in a Medicare Advantage Plan. You won't need your Medigap policy. Remember, Medigap policies won't work with Medicare Advantage Plans.
4	You can keep your Medigap policy without any changes.	• You don't need to do anything. • Your Medigap premium could increase more quickly than in the past. • Keep in mind, if you change your mind and enroll in a Medicare prescription drug plan after May 15, 2006, you may have to permanently pay more for your Medicare prescription drug plan or Medicare Advantage prescription drug premium and you will lose your right to switch to another policy.

To learn more about your options, look for more information in the mail from your Medigap insurance company or call your State Health Insurance Assistance Program (see pages 85–86).

Medigap policies and Medicare prescription drug plans (continued)

How does my Medigap prescription drug coverage compare to a Medicare prescription drug plan?

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

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

You will get a notice from your Medigap insurance company that tells you how your Medigap policy's prescription drug coverage compares to a Medicare prescription drug plan's coverage. If you have questions, you can call your Medigap insurance company or your State Health Insurance Assistance Program (see pages 85–86).

section **5**

Steps to Buying a Medigap Policy

This section provides steps to help you choose a Medigap policy that's right for you.

Steps to buying a Medigap policy

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

The steps to buying a Medigap policy include the following:

STEP 1: Decide which benefits you want, then decide which of the Plans A through L best meet your needs (see below and pages 43–48).

STEP 2: Find out which insurance companies sell Medigap policies in your state (see page 49).

STEP 3: Call the insurance companies that sell the Medigap policies that you are interested in and compare costs (see page 50).

STEP 4: Choose the right Medigap policy for you (see page 51).

STEP 5: Buy the Medigap policy (see page 52).

Words in green are defined on pages 88–91.

STEP 1. Decide which benefits you want, then decide which of the Plans A through L best meet your needs.

The charts on the following pages will help you compare the different types of benefits that each Medigap policy offers. The charts on pages 43–45 will help you compare the **basic benefits**. See pages 46–48 to compare the **extra benefits**.

Important: You should think about your current and future health care needs because you might not be able to switch Medigap policies later. As you get older, your health care needs might increase. You may also want to think about prescription drug coverage. Starting January 1, 2006, Medicare will offer prescription drug coverage for all people with Medicare. If you think you will need prescription drug coverage, you may want to enroll in a Medicare prescription drug plan. You can enroll in a Medicare prescription drug plan starting November 15, 2005. For more information about Medicare prescription drug coverage, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Basic Benefits for Medigap Plans A through J

Note: This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin; **see pages 80–82**. The amounts shown in this chart are for 2005. These amounts can change each year.

Remember, Medigap Plan A covers only the basic benefits listed below. Medigap Plans B through J include the basic benefits and some extra benefits. See pages 46–47 for extra benefits that are offered for Medigap Plans B through J.

Use this information when talking to insurance companies to help choose the Medigap policy you want. Some insurance companies offer all Medigap policies, but many offer only some of them.

Benefit	What *Medicare* pays in 2005...	What *you* pay in 2005 if you *don't* have a Medigap Policy...	What *you* pay in 2005 if you *have* a Medigap Plan A through J...
Medicare Part A coinsurance and hospital benefits	Medicare pays its share of a covered hospital stay.	You pay... • For days 1–60, see page 46. • $228 per day for days 61–90 of a hospital stay. • $456 per day for days 91–150 of a hospital stay. • All costs for each additional day after the 150th day of the hospital stay after you have used all your lifetime reserve days.	You pay... • For days 1–60, see page 46. • Nothing for days 61–90 of a hospital stay. • Nothing for days 91–150 of a hospital stay. • No costs above what Medicare would have paid for up to 365 more days of hospital stays during your lifetime after you use all Medicare hospital benefits. • All costs after you have used all Medicare hospital benefits and the 365 days of additional Medigap hospital stay coverage.
Medicare Part B coinsurance or copayment	Medicare pays nothing for your first $110 (yearly deductible) of Part B-covered services. Then it generally pays 80% of the Medicare-approved amount for Medicare Part B-covered services and supplies.	After you pay for the first $110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care), you generally pay 20% of the Medicare-approved amount for Medicare Part B-covered services and supplies.	After you pay for the first $110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care), you generally pay nothing for any Medicare-approved amount for Medicare Part B-covered services and supplies.
Blood	Medicare pays nothing for the first three pints of blood or equal amounts of packed red blood cells per calendar year.	You pay the total cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.	You pay nothing for the first three pints of blood or equal amounts of packed red blood cells per calendar year.

See pages 46–47 for extra benefits that are offered by Medigap Plans B through J.

Basic Benefits for Medigap Plans K and L

Note: This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin; **see pages 80–82**. The amounts shown in this chart are for 2005. These amounts can change each year.

Medigap Plans K and L are new in 2005. They will have different basic benefits than Medigap Plans A through J, as shown below.

Benefit	What *Medicare* pays in 2005...	What *you* pay in 2005 if you *don't* have a Medigap Policy...	What *you* pay in 2005 if you *have* Plan K...	What *you* pay in 2005 if you *have* Plan L...
Medicare Part A coinsurance and hospital benefits	Medicare pays its share of a covered hospital stay.	You pay... • For days 1–60, see page 48. • $228 per day for days 61–90 of a hospital stay. • $456 per day for days 91–150 of a hospital stay (60 days maximum in your lifetime). • All costs for each additional day after the 150th day of the hospital stay after you have used all your lifetime reserve days.	You pay... • For days 1–60, see page 48. • Nothing for days 61–90 of a hospital stay. • Nothing for days 91–150 of a hospital stay (60 days maximum in your lifetime). • No costs above what Medicare would have paid, for up to 365 more days during your lifetime after you use all Medicare hospital benefits. • All costs after you have used all Medicare hospital benefits and the 365 days of additional Medigap hospital stay coverage.	You pay... • For days 1–60, see page 48. • Nothing for days 61–90 of a hospital stay. • Nothing for days 91–150 of a hospital stay (60 days maximum in your lifetime). • No costs above what Medicare would have paid, for up to 365 more days during your lifetime after you use all Medicare hospital benefits. • All costs after you have used all Medicare hospital benefits and the 365 days of additional Medigap hospital stay coverage.
Medicare Part B coinsurance or copayment	Medicare pays nothing for your first $110 (yearly deductible) of Part B-covered services. Then it generally pays 80% of the Medicare-approved amount for Medicare Part B-covered services and supplies.	After you pay for the first $110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care), you generally pay 20% of the Medicare-approved amount for Medicare Part B-covered services and supplies.	• After you pay for the first $110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care), you generally pay 10% of any Medicare-approved amount for Medicare Part B-covered services and supplies. • You pay no coinsurance or copayment for Part B preventive services.	• After you pay for the first $110 (yearly deductible) of Part B covered services (like doctor services and outpatient hospital care), you generally pay 5% of any Medicare-approved amount for Medicare Part B-covered services and supplies. • You pay no coinsurance or copayment for Part B preventive services.

Basic Benefits for Medigap Plans K and L (continued)

Benefit	What *Medicare* pays in 2005...	What *you* pay in 2005 if you *don't* have a Medigap Policy...	What *you* pay in 2005 if you *have* Plan K...	What *you* pay in 2005 if you *have* Plan L...
Blood	Medicare pays nothing for the first three pints of blood or equal amounts of packed red blood cells per calendar year.	You pay the total cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless you or someone else donates blood to replace what you use.	You pay 50% of the cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year.	You pay 25% of the cost for the first three pints of blood or equal amounts of packed red blood cells per calendar year.
Hospice Care	Medicare pays most of the costs for hospice services.	A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care (which changes each year). Medicare generally doesn't pay for room and board except in certain cases.	You pay 50% of your share (5% of the Medicare-approved amount) for outpatient prescription drugs and inpatient respite care.	You pay 25% of your share (5% of the Medicare-approved amount) for outpatient prescription drugs and inpatient respite care.

See page 48 for extra benefits that are offered by Medigap Plans K and L.

Extra Benefits for Medigap Plans B through J

Extra Medigap benefits, and the Medigap policies that cover them, are shown below. Look to see which Medigap policies cover the benefits you are most interested in (see the last column). Keep in mind, extra benefits will increase your monthly premium, but may save you out-of-pocket costs if you use the benefits. Choose the Medigap policy that meets your needs, and fits your budget. Remember, all Medigap Plans A through J must include the basic benefits listed on page 43.

Use this information when talking to insurance companies to help choose the Medigap policy you want. Some insurance companies offer all Medigap policies, but many offer only some of them. **Note:** The amounts shown in this chart are for 2005.

Benefit	What *Medicare* pays in 2005…	What *you* pay in 2005 if you *don't* have a Medigap Policy…	What *you* pay in 2005 if you *have* a Medigap Policy…
Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related 3-day hospital stay.)	Medicare pays all covered costs for the first 20 days of SNF care.	You pay… • Nothing for the first 20 days. • Up to $114 per day for days 21–100. • All costs after day 100.	If you have **Medigap Plan C, D, E, F, G, H, I, or J** you pay… • Nothing for the first 20 days. • Nothing for days 21–100. • All costs after day 100.
Medicare Part A Deductible	Medicare pays all but a total of $912 for a hospital stay of 1–60 days.	For each benefit period, you pay a total of $912 for a hospital stay of 1–60 days.	If you have **Medigap Plan B, C, D, E, F, G, H, I, or J** you pay nothing for days 1–60 of a hospital stay.
Medicare Part B Deductible	Medicare pays nothing for your first $110 (yearly deductible) of Part B-covered services (like doctor services and outpatient hospital care).	You pay for the first $110 (yearly deductible) of Part B-covered services and supplies.	If you have **Medigap Plan C, F, or J** you pay nothing for the first $110 (yearly deductible) of Part B-covered services and supplies.
Medicare Part B Excess Charges (difference between a doctor or other health care provider's actual charge and Medicare's approved payment amount).	If your doctor doesn't accept assignment, and charges more than the Medicare-approved amount, Medicare won't pay the difference.	You pay the total difference between what Medicare pays and what the doctor charges who doesn't accept assignment charges. This is called the excess charges.	If you have **Medigap Plans F, I, or J** you pay none of the excess charges. If you have Plan G, you pay 20% of the excess charges.
Foreign Travel Emergency	Generally, Medicare pays nothing for emergency health care outside the U.S.	You pay 100% for emergency health care outside the U.S. There are some exceptions for some care in Canada and Mexico.	If you have **Medigap Plan C, D, E, F, G, H, I, or J** you pay the first $250, and then 20% of the remaining costs of emergency health care during the first 60 days of each trip. There is a $50,000 lifetime maximum.

Extra Benefits for Medigap Plans B through J (continued)

At-Home Recovery	Medicare pays the full Medicare-approved amount of all Medicare-approved home health services.	You pay… • Nothing for Medicare-approved home health services. • 100% for non-Medicare-covered services.	If you have **Medigap Plan D, G, I, or J** • You pay nothing for Medicare-approved home health services. • You pay nothing for up to eight additional weeks of at-home help after skilled care is no longer needed. • Medigap policies will pay up to $40 each visit and $1,600 each year.
Prescription Drugs Starting January 1, 2006, you won't be able to buy Medigap policies covering prescription drugs. See pages 37–40 for more information about Medigap prescription drug coverage.	In 2005, Medicare doesn't cover most outpatient prescription drugs. Medicare-approved prescription drug discount cards are available to help with prescription drug costs in 2005 (see page 75).	You pay 100% for most outpatient prescription drugs.	If you have **Medigap Plan H, I, or J** you pay for the first $250 of outpatient prescription drugs each year. Then you pay 50% for all prescription drugs not covered by Medicare. Plans H and I have a $1,250 per year limit. For Plans H and I to be of full value, you should have at least $2,750 in drug costs per year (you pay $1,250 plus $250; plan pays $1,250). Plan J has a $3,000 per year limit. For Plan J to be of full value, you should have at least $6,250 in drug costs per year (you pay $3,000 plus $250; plan pays $3,000).
Medicare-covered Preventive Services Note: You don't have to pay the Part B deductible for some Medicare-covered preventive services.	After you pay the $110 yearly deductible for Part B, Medicare will pay 75–100% of some preventive services under Part B.	You pay... • $110 yearly deductible for Part B. • 20–25% for most Medicare-covered preventive services. • Nothing for some shots. • 100% for routine yearly check-ups* and tests like serum cholesterol screening, hearing testing, and diabetes screening.	If you have **Medigap Plan E or J** you pay... • A $110 yearly deductible for Part B. • Nothing for Medicare-covered preventive services.
Non-Medicare-covered Preventive Services	Medicare pays nothing.	You pay 100% for non-Medicare-covered preventive services.	You may pay nothing for routine yearly check-ups* and any non-Medicare-covered preventive services your doctor recommends. This benefit has a $120 per year limit. You pay 100% after you have met your yearly limit.

* Medicare Part B covers a one-time "Welcome to Medicare" physical exam within the first six months of having Part B.

Note: Plans F and J have a high-deductible option, which means your monthly premium would cost less, but you would have to pay the first $1,730 (in 2005) of your Medigap-covered costs before the Medigap policy would begin to pay its share. For more information about high-deductible options, see page 24.

Extra Benefits for Medigap Plans K and L

Note: This chart doesn't apply if you live in Massachusetts, Minnesota, or Wisconsin; **see pages 80–82**. The amounts shown in this chart are for 2005. These amounts can change each year.

Medigap Plans K and L are new in 2005. They will have different extra benefits than Medigap Plans A through J, as shown below. You will pay part of the cost-sharing of some covered services until you meet the annual out-of-pocket limit of $4,000 for Plan K, or $2,000 for Plan L.

Benefit	What *Medicare* pays in 2005	What *you* pay in 2005 if you *don't* have a Medigap Policy…	What *you* pay in 2005 if you *have* Plan K…	What *you* pay in 2005 if you *have* Plan L…
Skilled Nursing Facility (SNF) Care Coinsurance (Skilled nursing and rehabilitative services in a skilled nursing facility after a related three-day hospital stay). (See benefit period on page 88).	Medicare pays all covered costs for the first 20 days of SNF care.	You pay... • Nothing for the first 20 days. • Up to $114 per day for days 21–100. • All costs after day 100.	You pay… • Nothing for the first 20 days. • Up to $57 per day for days 21–100. * • All costs after day 100.	You pay… • Nothing for the first 20 days. • Up to $28.50 per day for days 21–100. * • All costs after day 100.
Medicare Part A Deductible	Medicare pays all but a total of $912 for a hospital stay of 1–60 days.	For each benefit period you pay a total of $912 for a hospital stay of 1–60 days.	You pay $456 for days 1–60 of a hospital stay.	You pay $228 for days 1–60 of a hospital stay.

*These amounts count toward your annual limit.

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

To find out which insurance companies sell Medigap policies in your state, you can do any of the following:

- Call your State Health Insurance Assistance Program (see pages 85–86). Ask if they have a "Medigap rate comparison shopping guide" for your state. These types of guides usually list the insurance companies that sell Medigap policies in your state and compare the costs of policies from each insurance company.

- Call your State Insurance Department (see pages 85–86).
- Visit www.medicare.gov on the web. Select "**Search Tools**" at the top of the page.

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

  - ✓ Insurance companies that sell Medigap policies in your state,
  - ✓ How to contact these insurance companies,
  - ✓ What the policies must cover, and
  - ✓ How insurance companies decide what to charge you for a Medigap policy premium.

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

You should plan to call more than one insurance company that sells Medigap policies in your state, since costs can vary between companies. Check the companies you call to be sure they are honest and reliable (see page 36).

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

Call more than one insurance company and ask the questions listed below. Friends and relatives can tell you about their Medigap policies and the quality of service, but their Medigap policies might not fit your needs.

Medigap Policy Comparison Worksheet

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

Ask each insurance company…	Company 1	Company 2
Are you licensed in this state? (The answer should be yes.)		
Which Medigap policies do you sell? (Insurance companies usually offer some, but not all, of the Medigap plans. Make sure they sell the plan you want.)		
What is the cost of this policy?		
What has the cost of this Medigap policy been for the past few years?		
How is the price decided? • What type of pricing does this insurance company use? (Community-rated, issue-age-rated, or attained-age-rated, see pages 22–23) • Is there a discount if I am a female, a non-smoker, or married?		
Are there any additional (“innovative”) benefits or discounts included in this policy?		
If you aren’t in your Medigap open enrollment period or in another situation where you have a guaranteed issue right, ask: • Will you accept my application? • Do you review my health records or application (medical underwriting) to decide how much to charge me for a Medigap policy? • If you have a pre-existing condition ask, “Will my pre-existing condition mean a delay in the start of my benefits?”		

STEP 4. Choose the right Medigap policy for you.

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

To make your final choice, you should do the following:

- Carefully review the Medigap policy benefits to make sure it covers the benefits you need and want.
- Decide if you can afford the cost of the Medigap policy.
- Make sure you feel good about and trust the insurance company and/or the insurance agent.
- If possible, talk with someone you trust, like a family member, friend, doctor, insurance agent, or your State Health Insurance Assistance Program (see pages 85–86) about your choice.

Once you have done the items above, you are ready to move on to Step 5 (see page 52).

STEP 5. Buy the Medigap policy.

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

- Fill out your application carefully and completely. If the insurance agent fills out the application, review it to make sure it's correct. Otherwise, answer all of the medical questions carefully. If you buy your Medigap policy during your open enrollment or guaranteed issue period, the insurance company can't use any medical answers you give them to deny you coverage or price the policy.
- Remember, you don't need more than one Medigap policy. If you already have a Medigap policy, it is illegal for an insurance company to sell you a second policy unless you tell them in writing that you are going to cancel the first Medigap policy. However, don't cancel your old Medigap policy until the new one is in place, and you have decided to keep the new Medigap policy. Once you have received the new Medigap policy, you have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look" period. The 30-day free look period starts when your Medigap policy is issued to you.
- It is best to pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. Get a receipt with the insurance company's name, address, and telephone number for your records.
- Ask for your Medigap policy to become effective when you want coverage to start, or when your old Medigap policy coverage ends. If, for any reason, the insurance company won't give you the start date you want, call your State Insurance Department (see pages 85–86).
- Your insurance company is required to send you a copy of your policy within 30 days after you are approved. If you don't get your policy in 30 days, call your insurance company. If you don't get your policy in 60 days, call your State Insurance Department (see pages 85–86).

section 6

Medigap Rights and Protections

Use this section to find out about your Medigap rights and protections.

Medigap rights and protections (guaranteed issue rights)

Your rights to buy a Medigap policy

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

In these situations, an insurance company

- must sell you a Medigap policy,
- must cover all your pre-existing conditions (see page 29), and
- can't charge you more for a Medigap policy because of past or present health problems.

In many cases, you get these protections when you have other health coverage that changes in some way.

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

Important: In some situations, you have a guaranteed issue right to buy a Medigap policy if you lose certain kinds of health coverage. You should keep a copy of any letters, notices, and claim denials that show you have lost your other coverage. Be sure to keep anything that has your name on it. Also, keep the postmarked envelope these papers come in as proof of when it was mailed. You may need to send a copy of some or all of these papers with your application for a Medigap policy to prove you lost coverage and have the right to these Medigap protections.

Remember, it is best to apply for a Medigap policy **before** your current health coverage has ended. You can apply for a Medigap policy while you are still in your health plan and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent breaks in your health coverage.

The Medigap protections in this section are from Federal law. Many states provide more Medigap protections than Federal law. Your state might let you choose from more Medigap policies or give you a longer time to apply for a Medigap policy when you lose your coverage. Call your State Health Insurance Assistance Program or State Insurance Department for more information (see pages 85–86).

If you live in **Massachusetts**, **Minnesota**, or **Wisconsin**, you have the same guaranteed issue rights to buy a Medigap policy, but the policies are different. If you have questions, call your State Insurance Department (see pages 85–86).

Words in green are defined on pages 88–91.

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

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

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

Important: Programs of All-inclusive Care for the Elderly (PACE) is available only in states that choose to offer it under Medicaid. If you have Medicaid, an insurance company can sell you a Medigap policy only in certain situations (see page 75).

Situation	Protects you if...	See page
1	You are in a Medicare health plan other than the Original Medicare Plan and the plan is going to leave the Medicare Program or stop giving care in your area.	56
2	You have employer group health plan or union coverage that is ending.	57
3	Your coverage ends because you move out of the plan's service area.	58
4	You joined a Medicare Advantage Plan or PACE when you were first eligible for Medicare at age 65 and within the first year of joining, you decide you want to switch to the Original Medicare Plan.	59
5	You dropped a Medigap policy to join a Medicare Advantage Plan or PACE, or to switch to a Medicare SELECT policy, for the first time, you have been in the plan less than a year, and you want to switch back.	60
6	Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	60
7	You leave a Medicare Advantage Plan, or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	61
8	You have a Medigap policy that covers prescription drugs. You want to enroll in a new Medicare prescription drug plan and switch to another Medigap policy that doesn't have prescription drug coverage.	62

Medigap protections

SITUATION #1: You are in a Medicare health plan other than the Original Medicare Plan and the plan is going to leave the Medicare Program or stop giving care in your area.

Programs of All-inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail people. PACE is available only in states that choose to offer it under Medicaid. For more information about PACE, see page 76.

In this situation, your Medicare health plan or PACE provider sends you a letter telling you when your coverage will be ending. The letter will tell you if there are any other Medicare health plans or PACE providers in your area. If you switch to one of those you won't need a Medigap policy.

However, if you decide to switch to the Original Medicare Plan you will have a right to buy a Medigap Plan A, B, C, or F that is sold in your state by any insurance company.

You have two choices when to get your Medigap policy

1. Leave (disenroll from) your Medicare health plan or PACE any time after the day you get your letter, but before your coverage would have ended. You will automatically return to the Original Medicare Plan. You will have **63 calendar days from the day you leave the plan** to apply for a Medigap policy.
2. Stay in your Medicare health plan or PACE until the date your coverage ends. You will automatically return to the Original Medicare Plan when your coverage ends. You will have **63 calendar days after your health coverage ends** to apply for a Medigap policy.

Important: You will have additional rights under **Situation #4** (see page 59) or **Situation #5** (see page 60) if

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

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

Medigap protections (continued)

SITUATION #2: You have employer group health plan or union coverage that is ending.

In this situation, you are in the Original Medicare Plan and you also have coverage from an employer group health plan or union. If your coverage is from your (or spouse's) current employment, the plan probably pays first, and Medicare pays second. If your coverage is retiree coverage, Medicare probably pays first, and your plan pays second. Here are your rights under Federal law if you are in a plan that pays second, and

- the employer goes out of business,
- the employer stops offering the health plan, or
- you are no longer eligible for the health plan (for example, if the coverage is from your spouse, and you get divorced or your spouse dies).

There are two ways you might find out that your employer group health or union coverage is ending

- the employer or union, the health plan, or the insurance company will send you a notice telling you the coverage is ending, or
- no one will send a notice in advance, but you will get a claim denial notice letting you know that a claim has been denied.

  Important: Keep the notice or claim denial that has your name on it. This will help prove that you lost coverage.

In this situation, you have the right to buy a Medigap Plan A, B, C, or F that is sold in your state by any insurance company.

You must apply for the Medigap policy within 63 calendar days after the date the coverage ends, or the date on your notice, or the date on your claim denial—whichever is later.

Note: In this situation, state laws may vary. If you lose coverage under an employer group health plan that pays before Medicare, state law might give you a right to buy a Medigap policy. If the employer offers you "COBRA" coverage (see pages 71–72) you can either buy a Medigap policy now, or you can wait until the COBRA coverage ends and then you will have another right to buy a Medigap policy. For more information, call your State Health Insurance Assistance Program (see page 85–86).

Medigap protections (continued)

SITUATION #3: Your coverage ends because you move out of the plan's service area.

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

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

You have the right to buy a Medigap Plan A, B, C, or F that is sold by any insurance company in your state (if you move within the same state but outside of the plan's service area), or the state you are moving to (if you move out of state).

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

Words in green are defined on pages 88–91.

Medigap protections (continued)

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

You have the right to buy any Medigap policy that is sold in your state by any insurance company. You must tell the health plan that you want to leave (disenroll) and give them a date to end your coverage. This date must be before you have been in the plan for a year. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

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

Medigap protections (continued)

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

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

If your former Medigap policy isn't available, you have the right to buy a Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company. You will have from 60 calendar days before your coverage ends until 63 calendar days after your coverage ends to apply for a new Medigap policy.

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

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

You have the right to buy a Medigap Plan A, B, C, or F that is sold in your state by any insurance company. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy. Because Medigap policies are guaranteed renewable, the only way you would lose coverage under a Medigap policy would generally be if the insurance company goes bankrupt.

Medigap protections (continued)

SITUATION #7: You leave a Medicare Advantage Plan, or drop a Medigap policy because the company hasn't followed the rules, or it misled you.

In this situation, you leave the health plan because it failed to meet its contract obligations to you. For example, the company isn't paying your claims, or it used untrue statements to convince you to buy the policy. Generally, to have this right, you must have filed a grievance with the health plan, Medicare, or the State Insurance Department (see pages 85–86) and received a decision that the plan was at fault.

You have the right to buy a Medigap Plan A, B, C, or F that is sold in your state by any insurance company. You must tell the plan that you want to leave (disenroll) and give them a date to end your coverage. You will have 63 calendar days from the date your coverage ends to apply for a new Medigap policy.

Medigap protections (continued)

SITUATION #8: You have a Medigap policy that covers prescription drugs. You want to enroll in a new Medicare prescription drug plan and switch to another Medigap policy that doesn't have prescription drug coverage.

If you enroll in a Medicare prescription drug plan between November 15, 2005 and May 15, 2006, you will be able to keep your Medigap policy, but the prescription drug coverage will be removed as of January 1, 2006. You also have the right to switch from the Medigap policy you have now and buy a Medigap Plan A, B, C, F (including the high-deductible Plan F), K, or L that is sold by your current Medigap insurance company. However, you are only guaranteed this right from the same insurance company. If you apply to a different insurance company they may be able to use medical underwriting.

You must apply for your new Medigap policy within 63 calendar days after your Medicare prescription drug coverage starts.

If you sign up for a Medicare prescription drug plan after May 15, 2006, you will no longer have the right to buy another Medigap policy from the same insurance company, unless your state has a law that requires it.

Important: Starting January 1, 2006, no new Medigap policies with prescription drug coverage can be sold.

If you have a Medigap policy that covers prescription drugs you will get a notice from your Medigap insurance company sometime between September 15, 2005 and November 15, 2005. This notice will describe your options for getting prescription drug coverage. Read the entire notice carefully and review your options before making any decisions.

More information about Medicare prescription drug plans starts on page 38.

Medigap protections (continued)

Special note for people with Medicare under age 65

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

- return to a Medigap policy you used to have, or
- buy Medigap Plans A, B, C, or F,

you must be allowed to return to the same type of Medigap policy you used to have, if it is still available from your old insurance company, or buy a Medigap Plan A, B, C, or F that is sold by any insurance company in your state to people under age 65.

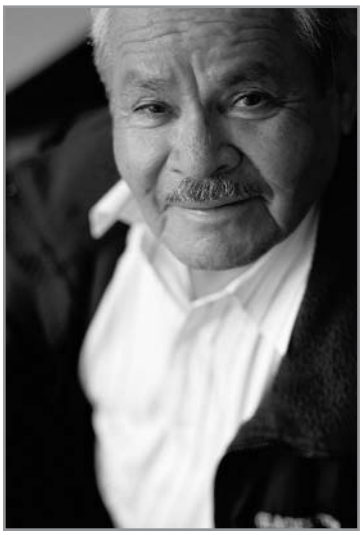
There is no Federal law that says insurance companies must sell Medigap policies to people under age 65. However, if an insurance company does sell these Medigap policies to anyone under age 65, they must sell one to you if you are in one of these situations (listed on pages 56–62).

Note: If the Medigap policy you used to have included prescription drug coverage, you won't be able to get this coverage back.

Where to get more information about Medigap protections

- Call your State Health Insurance Assistance Program (see pages 85–86) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.
- Call your State Insurance Department (see pages 85–86) if you are denied Medigap coverage in any of these situations.

Notes



"I used this section to learn about my Medigap rights and protections."

section 7

Medigap Policies and Disability or ESRD

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

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

Words in green are defined on pages 88–91.

You may have Medicare before age 65 due to

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

If you are a person with Medicare under age 65 and are disabled or have ESRD, you might not be able to buy the Medigap policy you want until you turn age 65. Federal law doesn't require insurance companies to sell Medigap policies to people under age 65. However, some states require Medigap insurance companies to sell you a Medigap policy, at certain times (during a limited Medigap open enrollment period), even if you are under age 65 (see pages 56–62). These states are listed below. If you have questions, you should call your State Health Insurance Assistance Program (see pages 85–86).

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

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

Even if your state isn't on this list, some insurance companies may voluntarily sell Medigap policies to some people under age 65 (see pages 56–62). Whether or not your state requires insurance companies to sell to you, Medigap policies sold to people under age 65 may cost you more than policies sold to people over age 65.

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

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

Also, if you join a Medicare Advantage Plan and your coverage ends, you may have the right to buy a Medigap policy. If you have questions, you should call your State Health Insurance Assistance Program (see pages 85–86).

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

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

- you can buy any Medigap policy from any insurance company, and
- insurance companies can't refuse to sell you a Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65 years old.

When you buy a Medigap policy during your Medigap open enrollment period, the insurance company must shorten the waiting period for pre-existing conditions by the amount of creditable coverage you have. If you had Medicare for more than six months before you turned 65 years old, you won't have a pre-existing condition waiting period because Medicare counts as creditable coverage. (See page 30 for more information about creditable coverage.)

Right to suspend a Medigap policy for people with Medicare who have a disability

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

If, for any reason, you lose your employer group health plan coverage, you can get your Medigap policy back. Within 90 days of losing your employer group health plan coverage, you must notify your Medigap insurance company that you want your Medigap policy back. If your Medigap policy included prescription drug coverage, you can still get your Medigap policy back but without the prescription drug coverage (after January 1, 2006).

Your Medigap benefits and premiums will start again on the day your employer group health plan coverage stops. The Medigap policy must have the same benefits and premiums it would have had if you had never suspended your coverage. Your Medigap insurance company can't refuse to cover care for any pre-existing conditions (health problems) you have (see page 29). So, if you are disabled and working, you can enjoy the benefits of your employer's insurance while knowing that you will be able to get your Medigap policy back when you need it.

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

section 8

Other Ways to Pay Health Care Costs

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

Other kinds of insurance and ways to pay health care costs

There are other kinds of health care coverage, besides a Medigap policy, that may pay some of your health care costs not covered by Medicare. The chart on pages 71–77 describes some of the following types of insurance and other ways to pay health care costs:

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
COBRA ("Continuation Coverage" under the Consolidated Omnibus Budget Reconciliation Act) may give you and your dependents the right to keep your health care coverage temporarily if • you lose your job, • your working hours are reduced, • you leave your job voluntarily, or • your employer goes bankrupt. COBRA may also help your spouse temporarily keep health care coverage if you die, or you get divorced.	If you are covered under an employer or retiree health plan, and you lose your coverage for one of the reasons listed in the left-hand column, COBRA allows you to keep your coverage for a while longer. However, if you also have Medicare you need to know about how COBRA may affect some of your choices under Medicare and Medigap. **When you have COBRA coverage before Medicare starts** If you already have COBRA when you enroll in Medicare, your employer may stop your COBRA coverage entirely, or change the length of time your spouse can have coverage under COBRA. However, if you have the opportunity to keep your COBRA for a while, you might think it's better to keep the COBRA and not start paying premiums under Medicare Part B. Here's what you need to consider: • When you become eligible for Medicare at age 65 you have an "Initial Enrollment Period" for Part B. Some people who are still working can wait and have a "Special Enrollment Period" after they stop working. However, if you or your spouse aren't working, you will have to pay more for Part B if you join after your Initial Enrollment Period. Therefore, you need to think about how long you will be able to keep your COBRA, and whether you would be better off if you sign up for Part B. • Enrolling in Part B, regardless of when you enroll after you are age 65, starts your six-month Medigap open enrollment period. Once this period starts, it can't be changed. If you stay on COBRA, and enroll in Part B, but decide to wait until after your open enrollment period to buy a Medigap policy, you may have trouble buying a Medigap policy if you have health problems. • Once your open enrollment period ends, the only way you have guaranteed rights to buy a Medigap policy is if you have "Medigap protections." (See Medigap protections, **Situation #2** on page 57.) Whatever you decide to do, you need to keep in mind the timeframes for getting each type of coverage: • For **COBRA** you have 60 days to sign up for the coverage, beginning either the day you lose your employer coverage, or the day you get a notice that you have COBRA rights, whichever comes later.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
COBRA (continued)	Whatever you decide to do, you need to keep in mind the timeframes for getting each type of coverage: (continued) • Your **Initial Enrollment Period** for Part B starts three months before you turn age 65. • Your **Medigap open enrollment period** is the six-month period that starts on the first day of the month in which you are both age 65 or older **and** enrolled in Medicare Part B. During this period you have the right to buy **any** Medigap policy. • For **Medigap protections** you have 63 days to sign up after you find out that your employer coverage has ended. • If you decide you want to join a **Medicare health plan** instead of the Original Medicare Plan, there may be limits on the times you can enroll.
Employee or retiree coverage from an employer or union may help employees or spouses who had health care coverage from a current or previous employer or union.	In some cases, you or your spouse might be able to get your health care coverage from an employer or union based on your or your spouse's current employment. This is called "employee coverage." Some employers or unions might let you or your spouse continue your health care coverage after the employment ends. This is called "retiree coverage." If you have this type of coverage from an employer or union, they may change the benefits or premiums, and may also be able to cancel the coverage if they choose. If you or your spouse are working and have group health coverage based on current or active employment there are special things to think about with Part B and Medigap policies. See the information about Medigap open enrollment period on pages 26–28. **Employee and retiree coverage and Medigap** If you have employee or retiree coverage and it ends, you may have the right to buy a Medigap policy. You may get a notice or claim denial letting you know that your health care coverage is ending. You have 63 calendar days from the date your coverage ends or from the notice or claim denial to apply for a Medigap policy (see Medigap protections, **Situation #2** on page 57).
Federally Qualified Health Centers (FQHCs) may help people who live near a FQHC.	FQHCs are special health centers, usually located in urban or rural areas, that can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Home and Community-Based Service/Waiver programs (HCBS) may help certain elderly and disabled individuals.	HCBS programs are available to some people with Medicaid. They offer services and programs that help you get care in your home and community. Some examples of this care include homemaker services, personal care, adult day care, meals, and transportation. This program allows you to stay more independent.
Hospital indemnity insurance may help pay for hospital stays up to a certain number of days.	This kind of insurance pays a set amount of money for each day of a hospital stay. You won't need this insurance if your health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn't fill gaps in your Medicare coverage. It usually pays in addition to your health insurance.
Long-term care insurance may help pay for your health or personal care needs and activities of daily living, such as bathing, dressing, using the bathroom, and eating.	Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care. Make sure you choose the long-term care insurance policy that best meets your needs. For 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 85–86) or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Or, call your State Health Insurance Assistance Program (see pages 85–86).

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Medicaid may help people with limited incomes and resources.	Medicaid helps pay your medical costs. Since Medicaid is a joint Federal and state program, coverage varies from state to state. People with Medicaid may get coverage for things like nursing home care and home care that aren't covered by Medicare. Starting in 2006, Medicare will cover outpatient prescription drugs instead of Medicaid. Medicare will send you information about these changes in 2005. **Medicaid and Medigap** If you have a Medigap policy and then get Medicaid, there are a few things you should know: • You can put your Medigap policy on hold ("suspend") within 90 days of getting Medicaid. • You won't have to pay your Medigap policy premiums while it is suspended. • Your Medigap policy won't pay benefits while the Medigap policy is suspended. • You can suspend a Medigap policy for up to two years. • At the end of the suspension, you can restart the Medigap policy without new medical underwriting or pre-existing condition waiting periods. • Starting January 1, 2006, if you suspend your Medigap policy and it includes prescription drug coverage, you can still get the Medigap policy back but without the prescription drug coverage. To help you with making a decision about suspending a Medigap policy, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). For questions about suspending a Medigap policy, call your insurance company.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Medicaid (continued)	If you already have health insurance coverage through your state Medicaid Program, an insurance company can sell you a Medigap policy only in certain situations: • The insurance company can legally sell you any Medigap policy if Medicaid pays your Medigap policy premium or if Medicaid only pays your Medicare Part B premium. • The insurance company can legally sell you Medigap Plans H, I, or J if Medicaid only pays your Medicare premiums, deductibles, or coinsurance. (This only applies to Medigap policies sold **between now and January 1, 2006**.) In any other situation, it is illegal for an insurance company to sell you a Medigap policy if you are getting any Medicaid benefits.
Medicare-approved drug discount cards may help people save money on prescription drugs.	Medicare contracts with private companies to offer drug discount cards. This is a temporary program to help with your prescription costs until Medicare prescription drug plans start in 2006. You can enroll in this program through November 30, 2005. Medicare-approved drug discount cards are good until May 15, 2006, or until you enroll in a Medicare prescription drug plan, whichever is first. You might be able to save on prescription drugs with a Medicare-approved drug discount card. For more information about Medicare-approved drug discount cards, visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. **Drug discount cards and Medigap Policies** You might already have a drug discount card with your Medigap policy. If the drug discount card you have with your Medigap policy isn't a Medicare-approved drug discount card, you can also get a Medicare-approved drug discount card.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Medicare Savings Programs (help from your state as part of the State Medical Assistance Program) may help people with limited income and resources.	These programs can help pay your Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance. To be eligible for this program, you must meet certain requirements. These programs may not be available in Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa. To find out if these programs are available in your area or for more information, call your State Medical Assistance Office. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227). Since the names of these programs may vary by state, ask for information on Medicare Savings Programs.
Military retiree benefits (TRICARE) may help active duty and retired uniformed services members and their families.	TRICARE is a health care program that offers medical coverage to eligible members. The TRICARE Program includes TRICARE Prime, TRICARE Extra, TRICARE Standard, and TRICARE for Life (TFL). If eligible, you get all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. For more information about the TRICARE Programs, call 1-800-538-9552 or visit www.tricare.osd.mil on the web.
PACE (Programs of All-inclusive Care for the Elderly) may help frail people who live in the service area of PACE.	PACE combines medical, social, and long-term care services for frail people. PACE might be a better choice for you than getting your care through a nursing home. PACE is available only in states that have chosen to offer it under Medicaid. If you live in a state that offers PACE, and you have Medicare and are eligible for PACE, you can choose to get your Medicare benefits through this program. To find out if you are eligible and if there is a PACE site near you, or for more information, call your State Medical Assistance Office. To get their telephone number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit www.medicare.gov on the web.

Types of insurance or other ways to pay health care costs…	A quick look at how it works…
Prescription drug and other assistance programs may help people get discounted or free prescription drugs.	Some states offer programs that either offer lower cost or free prescription drugs. They may also offer other assistance programs to help pay for your other health care costs. To be eligible for these programs, you must meet certain requirements. For more information, visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. **Prescription drugs and Medigap** If you are thinking about signing up for your state's prescription drug assistance program and you haven't yet bought a Medigap policy, get your Medigap policy **before** you apply for prescription drug assistance. After you get the prescription drug assistance you might not be able to buy a Medigap policy.
Specified disease insurance may help people with a certain type of disease.	Specified disease insurance pays benefits for a single disease, such as cancer, or for a group of diseases. You usually have to buy this insurance before you are diagnosed or treated for the specified disease. You won't need this insurance if your health insurance coverage or Medigap policy already pays for this type of care. This insurance doesn't fill gaps in your Medicare coverage. It usually pays in addition to your health insurance.
State Children's Health Insurance Program (SCHIP) may help uninsured children under age 19.	Some states offer free or low-cost health insurance to uninsured children whose families don't qualify for Medicaid. For more information about your state's program, visit www.cms.hhs.gov/schip/ on the web.
Veterans' benefits may help people who have had any military service or are veterans.	The U.S. Department of Veterans Affairs offers health care benefits and other types of benefits and services to eligible members. For more information about VA benefits and services, call the U.S. Department of Veterans Affairs at 1-800-827-1000.

Notes

"Be sure to compare Medigap policies and your other Medicare health care options. It could save you money."

section 9

Massachusetts, Minnesota, and Wisconsin Medigap Plans

Different types of standardized Medigap plans are sold in these three states. For standardized Medigap plans sold in other states, see pages 19 and 21.

Massachusetts – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

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

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

* This plan, offered by Blue Cross and Blue Shield of Massachusetts, also provides coverage for the following services: routine vision services, routine dental services, routine hearing services, fitness programs, and weight loss programs. Contact plan for details. For more information on these policies, call your State Insurance Department (see pages 85–86) or visit www.medicare.gov on the web. Select "Search Tools" at the top of the page.

** Prescription drug coverage may not be sold after January 1, 2006.

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

Minnesota – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

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

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

Optional Riders

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

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

** Prescription drug coverage may not be sold after January 1, 2006.

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

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

Wisconsin – Chart Of Standardized Medigap Plans

Basic benefits included in all plans:

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

Medigap Benefits	Basic Plan
Basic Benefits	✓
Medicare Part A: Skilled-Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	40 visits in addition to those paid by Medicare
Medicare Part B: Coinsurance	✓
Outpatient Mental Health	✓
Prescription Drugs * (after a deductible of $6,250, pays 80%)	✓

Optional Riders

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

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

* Prescription drug coverage may not be sold after January 1, 2006.

For more information on these policies, call your State Insurance Department (see pages 85–86) or visit www.medicare.gov on the web. Select "Search Tools" at the top of the page.

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

section **10**

For More Information

Use this section to learn where to get more information.

On pages 85–86, you will find telephone numbers for your State Health Insurance Assistance Program and State Insurance Department. These telephone numbers were correct at the time of printing. Telephone numbers sometimes change. You can find the most up-to-date telephone numbers by visiting www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in green are defined on pages 88–91.

Where to get more information

- Call your State Health Insurance Assistance Program (see pages 85–86) for help with
  - buying a Medigap policy or long-term care insurance,
  - choosing a Medicare prescription drug plan,
  - dealing with payment denials or appeals,
  - Medicare rights and protections,
  - choosing a Medicare health plan,
  - deciding whether to suspend your Medigap policy, or
  - questions about Medicare bills.
- Call your State Insurance Department (see pages 85–86) if you have questions about the Medigap policies sold in your area or any insurance-related problems.

Where to call with Medicare questions

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227). Customer service representatives are available 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

section 11

Words to Know

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

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

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

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

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

Creditable Coverage (Medigap)—Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period. (See pre-existing conditions.)

Deductible—The amount you must pay for health care or prescriptions, before Medicare or your prescription drug plan begins to pay. For example, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

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

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

Guaranteed Issue Rights (also called "Medigap Protections")—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

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

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

Lifetime Reserve Days—In the Original Medicare Plan, there are 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($456 in 2005).

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

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

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

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

Medically Necessary—Services or supplies that

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

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

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

Medicare Prescription Drug Plan—Beginning January 1, 2006, Medicare will provide prescription drug coverage through insurance companies and private companies. These companies will offer different Medicare prescription drug plans with different covered prescriptions and costs. Like other insurance, if you join a Medicare prescription drug plan you will pay a monthly premium, a yearly deductible, and a share of the cost of your prescriptions. You can sign up for one of these plans starting November 15, 2005. **Note:** These plans are different than Medigap policies that offer prescription drug coverage (see "Medigap prescription drug coverage").

Medicare SELECT—A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medigap Policy—A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. There are 12 standardized plans labeled Plan A through Plan L, except in Massachusetts, Minnesota, and Wisconsin. These states have different standardized plans. Medigap policies only work with the Original Medicare Plan.

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

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

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

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

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

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

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

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

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

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

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

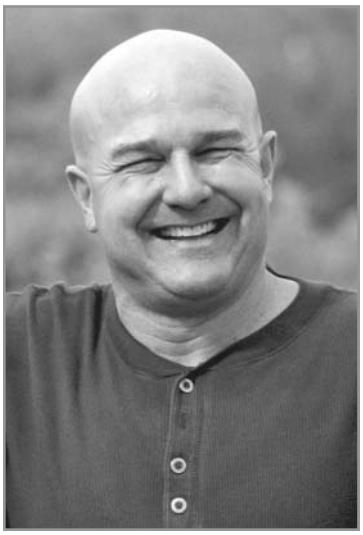
Special Needs Plan—A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

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

State Insurance Department—A state agency that regulates insurance and can provide information about Medigap policies and any insurance-related problems.

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

Notes



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

section 12

List of Topics

This section is an alphabetical list of specific topics discussed in this Guide, with page numbers.

TIP: Use the "Table of Contents" on pages 1–2 to help you find the sections you want to read.

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**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

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Official Business
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CMS Pub. No. 02110
Revised April 2005

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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