

2010

Iowa's
Guide to
Medicare
Supplement
Insurance

For policies effective
June 1, 2010 and later



<http://www.therightcalliowa.gov>

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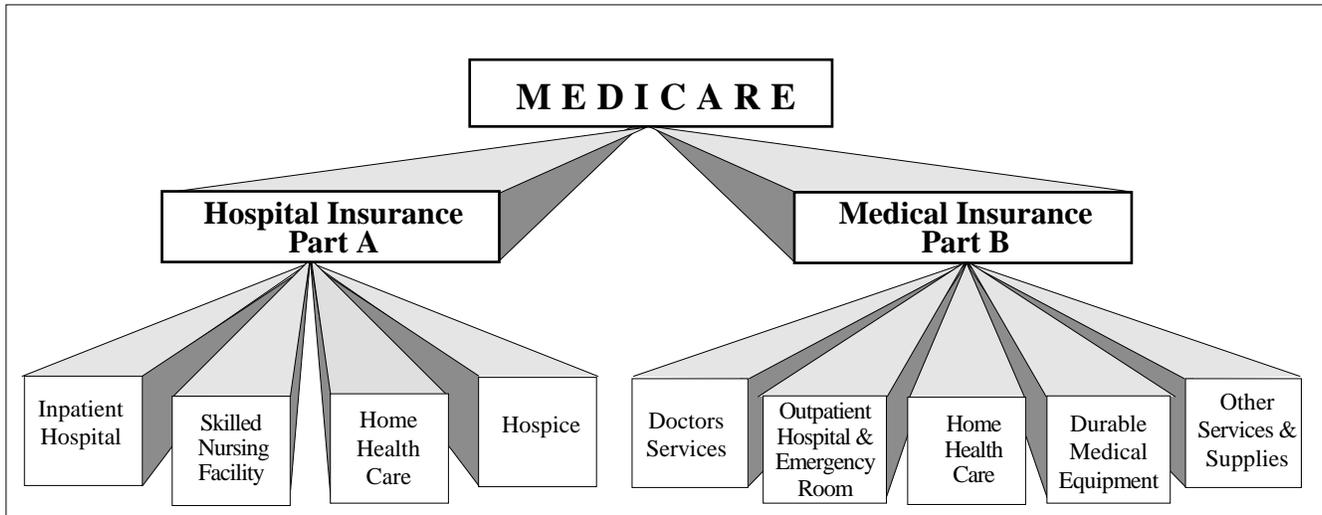


Medicare Basics

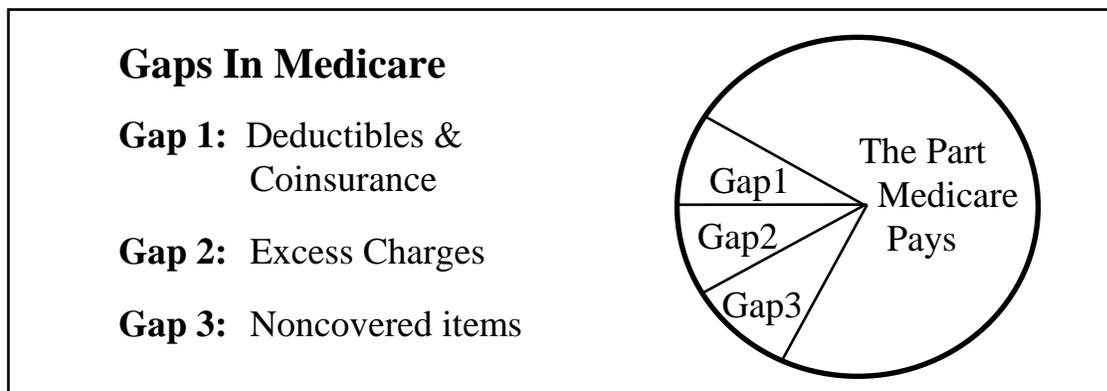
Medicare is the federal health insurance program available to specific groups:

- ◆ People age 65 and older
- ◆ Those under age 65 who have been on Social Security disability for 24 months (No wait is required if diagnosed with ALS or Lou Gehrig's disease.)
- ◆ Those who have end-stage renal disease (permanent kidney failure).

As shown below, Medicare is made up of Part A and Part B. Most get Medicare Part A free. Everyone pays a monthly premium for Medicare Part B (see page 4).



Approval of covered services for Medicare benefits is usually based on what is **medically necessary**. The amounts approved are based on payment schedules set by Medicare. Under Part A, the health care providers are not allowed to charge more than what Medicare approves. Part B does allow "excess charges" for some services. The maximum excess charge allowed for most services is 15% more than Medicare's approved amount.



Medicare pays most of the health care costs for those eligible, but significant gaps can leave large bills to pay. The Medicare Benefit Chart on the next page shows Medicare's benefits and the amounts for which you are responsible.

Medicare Benefit Chart 2010

Part A Hospital Insurance - Covered Services (Hospital deductibles and coinsurance amounts change each year. The numbers shown in this chart are effective for 2010.)

Services	Benefit	Medicare Pays	You Pay (Other insurance may pay all or part)
Hospitalization Semiprivate room, general nursing, misc. services	First 60 days	All but \$1,100	\$1,100
	61st to 90th day	All but \$275 per day	\$275 per day
	91st to 150th day	All but \$550 per day	\$550 per day
	Beyond 150 days	Nothing	All charges
Skilled Nursing Facility Care	First 20 days	100% of approved	Nothing if approved
	21st to 100th day	All but \$137.50 per day	\$137.50 per day
	Beyond 100 days	Nothing	All costs
Home Health Care Medically necessary skilled care, therapy	Part-time care	100% of approved	Nothing if approved
Hospice Care for the terminally ill	As long as doctor certifies need	All but limited costs for drugs & respite care	Limited costs for drugs & respite care
Blood	Blood	All but first 3 pints	First 3 pints

Part B - Medical Insurance - Covered Services

Services	Benefit	Medicare Pays	You Pay (Other insurance may pay all or part)
Medical Expense Physician services & medical supplies	Medical services in and out of the hospital	80% of approved (after \$155 deductible*)	20% of approved (after \$155 deductible*) plus excess charges
Outpatient Hospital Treatment	Unlimited if medically necessary	Amount based on a fee schedule (after \$155 deductible*)	Coinsurance or copayment amount which varies according to the service (after \$155 deductible*)
Clinical Laboratory	Diagnostic tests	100% of approved	Nothing if approved
Home Health Care Medically necessary skilled care, therapy	Part-time care	100% of approved	Nothing if approved
Durable Medical Equipment (DME)	Prescribed by Dr. for use in home	80% of approved (after \$155 deductible*)	20% of approved (after \$155 deductible*) plus excess charges
Blood	Blood	All but first 3 pints	First 3 pints

*A single \$155 deductible per year covers all Part B services.

Your 2010 Part B Monthly Premium

If Your Yearly Adjusted Gross Income is		Premium You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	\$110.50*
\$85,001 - \$107,000	\$170,001-\$214,000	\$154.70
\$107,001 - \$160,000	\$214,001 - \$320,000	\$221.00
\$160,001 - \$214,000	\$320,001 - \$428,000	\$287.30
Greater than \$214,000	Greater than \$428,000	\$353.60

*Beneficiaries who had the Part B premium withheld from their Social Security check in 2009 will pay \$96.50 in 2010.

Supplementing Medicare

Medicare supplement insurance is also called "Medigap" or "MedSup." It is private insurance designed to fill gaps in Medicare coverage and is sold by many companies. It is not sold by the government. Those eligible for employer-provided insurance or Medicaid assisted programs usually do not need Medicare supplement insurance. If you are enrolled in a Medicare Advantage plan such as an HMO, Medicare supplement policies don't pay benefits and aren't needed

Only ONE Medicare supplement policy is needed!

Since January 1, 1992 insurance companies selling Medicare supplement policies in Iowa are limited to selling "**Standardized Policies.**" Beginning June 1, 2010 companies can only sell 10 plans identified by the letters A, B, C, D, F, G, K, L, M and N. A company does not have to sell all 10 plans, but every Medicare supplement company must sell Plan A (Basic Benefits only) along with Plan C or F. **An insurance company cannot add to or modify the benefits in any way.**

Companies must continue to honor policies purchased prior to June 1, 2010. You **DO NOT** have to drop a policy purchased before that date.

The Balanced Budget Act of 1997 introduced a **high-deductible version of Plan F.** The benefit package is the same as in the no-deductible F. However, you pay annual expenses out-of-pocket for covered services up to a deductible amount. The deductible is **\$2,000** for 2010 and will increase each year based on the Consumer Price Index.

Ten Standard Medicare Supplement Plans

Basic Benefits	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Part A Hospital	X	X	X	X	X	X	X	X	X	X
Day 61-90 Coinsurance	X	X	X	X	X	X	X	X	X	X
Day 91-150 Coinsurance	X	X	X	X	X	X	X	X	X	X
365 more days – 100%	X	X	X	X	X	X	X	X	X	X
Part A Hospice coinsurance	X	X	X	X	X	X	50%	75%	X	X
Part B Coinsurance or Copay	X	X	X	X	X	X	50% **	75% **	X	X ****
Parts A & B Blood	X	X	X	X	X	X	50%	75%	X	X
Additional Benefits	A	B	C	D	F	G	K	L	M	N
Skilled Nursing Facility Coinsurance Day 21-100			X	X	X	X	50%	75%	X	X
Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Part B Deductible			X		X					
Part B Excess					X	X				
Foreign Travel Emergency			X	X	X	X			X	X
Out-of-pocket annual limit							\$4,620 ***	\$2,310 ***		

X = Supplement pays 100% 50% and 75% = the amount the supplement pays

*Plan F has an option called high deductible Plan F.

** Plans K and L pay 100% of the Part B coinsurance for preventive services.

***Plans K and L pay 100% of your cost for Part A and B after the annual out-of pocket limit is reached.

****Exceptions: You pay up to \$20 for an office visit and up to \$50 for an emergency room visit before the plan pays. The emergency room copay will be waived if you are admitted to the hospital.

Open Enrollment

Every new Medicare recipient who is age 65 or older has a **guaranteed right to buy** a Medicare supplement policy during a **six-month "open enrollment."** A company **cannot reject you** for any policy it sells, and it cannot charge you more than anyone else your age.

Your open enrollment period **starts** when you are age 65 or older and enroll in Medicare Part B for the first time. It **ends** 6 months later. If you apply for a policy after the open enrollment period, some companies may refuse coverage because of health reasons.

If you have Medicare Part B coverage because of **Medicare disability or end-stage renal disease**, you do not get open enrollment before age 65. However, you will be eligible for an open enrollment period **when you become 65**.

Pre-Existing Conditions

A **waiting period** can apply before benefits are paid for pre-existing conditions even when you buy a policy during open enrollment. The maximum waiting period a company can require is **six months**.

You may **avoid a waiting period** for pre-existing conditions in these situations:

1. You are in your open enrollment period, and you apply for your Medicare supplement within **63 days** of the end of previous health insurance coverage.
2. You **lose health care benefits** in certain situations described on pages 7 and 8, and you apply for the Medicare supplement policy within 63 days of the end of your previous coverage.
3. You apply for a Medicare supplement policy to **replace** one you have had for at least six months, and no gap occurs between the end of the old policy and the beginning of the new policy.

If previous health care coverage was for less than six months, you are given credit for the amount of time covered under the previous health benefit plan. If the new Medicare supplement insurance has benefits not included in the previous coverage, a six-month waiting period may apply for the added benefits.

Guarantee Issue Without Open Enrollment

Guarantee issue means an insurance company does not consider existing health conditions when issuing insurance coverage. An insurance company may offer a guarantee issue plan at any time. However, the policy may have a much higher premium and require a waiting period for pre-existing health conditions.

Certain events trigger **special rules** for some guarantee issue plans. The events and rules are described in the chart below. You must apply for your new Medicare supplement within **63 days** of the end of previous coverage. You have these special protections regardless of existing health conditions:

- ◆ Companies **cannot turn you down**
- ◆ Companies **cannot charge higher premiums**
- ◆ You **will not have a waiting period** before benefits are paid

	Events Which Trigger A Guarantee Issue Opportunity	Enrollment Options Available For 63 Days Only
1.	You are covered by an employer group health benefit plan that pays benefits after Medicare, and the plan stops providing some or all health benefits to you.	<ul style="list-style-type: none"> ◆ You must be allowed to enroll in any Medicare supplement Plan A, B, C, F (including a high deductible Plan F), K or L from ANY COMPANY selling those plans. ◆ If Medicare Select plans are available in your area, you may choose the Select Plan A, B, C, F (including a high deductible Select Plan F), K or L from ANY COMPANY selling those plans. ◆ If you are on Medicare under age 65, you can buy only from companies selling to those under age 65.
2.	You are enrolled in a Medicare Advantage, Medicare Cost or Medicare Select Plan and you disenroll because <ul style="list-style-type: none"> ◆ You move from the service area or ◆ The plan stops providing Medicare services or ◆ The plan seriously violates the contract or misrepresents the plan during marketing. 	
3.	You are enrolled under a Medicare Supplement policy and it ends because <ul style="list-style-type: none"> ◆ The insurance company is insolvent or bankrupt or ◆ Coverage is involuntarily ended or ◆ The plan seriously violates the contract or misrepresents the plan during marketing. 	

	Events Which Trigger A Guarantee Issue Opportunity	Enrollment Options Available For <u>63 Days Only</u>
4.	<p>You are enrolled in a Medicare supplement policy</p> <ul style="list-style-type: none"> ◆ And you stop the Medicare supplement and enroll in a Medicare Advantage, Medicare Cost, or Medicare Select plan for the first time, ◆ Then you disenroll from the new plan in the first 12 months. 	<p>You must be allowed to</p> <ul style="list-style-type: none"> ◆ Re-enroll in the Medicare supplement you were most recently enrolled in if it is available from the same company,* or <u>if not available</u>, ◆ Enroll in any Medicare supplement plan A, B, C, F, K, L (including Medicare Select or high deductible choices) from ANY COMPANY selling those plans in Iowa. <p>If you are under age 65, you can buy only from companies selling to those under 65.</p>
5.	<p>You enroll for the first time in Medicare Part B at age 65 or older, and you enroll in a Medicare Advantage plan for the first time. Then you disenroll within 12 months.</p>	<p>You must be allowed to enroll in ANY standardized Medicare supplement plan, A through L, offered by ANY COMPANY selling those plans in Iowa. (Includes Medicare Select and high deductible choices.)</p>

* This option does NOT apply to employer retiree health plans. If you give up your retiree plan to try a Medicare Advantage plan, you may not get your retiree plan back.

* If you bought your Medicare supplement plan before June 1, 2010, it is no longer being sold. You can buy only a 2010 standardized plan.

You Must Be Notified

When you lose coverage under any of the situations described in the above chart, you should receive a notice from the insurance company or organization that issued the health coverage. The notice must explain your right to purchase other coverage and your protection against waiting periods for pre-existing conditions.

Standard Plan Benefits

BASIC BENEFITS (All Plans)

Part A: Hospitalization (Per Benefit Period)

Benefit Period

A Benefit Period begins the first day of inpatient hospital care. It ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. **It is possible to have more than one benefit period per year.**

- ◆ **Days 1-60:** Medicare pays the hospital for all covered services except for the Part A Deductible. Basic Benefits **do not pay** the Part A Deductible.
- ◆ **Days 61-90: Basic Benefits** in all 10 plans pay the daily coinsurance (see page 3 for the current amount). After 60 days of hospitalization in a "benefit period" (defined above), the policy pays the coinsurance and Medicare pays the rest. The first 90 days of Medicare coverage are available each time you begin a new benefit period.
- ◆ **Days 91-150 (Lifetime Reserve Days): Basic Benefits** in all 10 plans pay the daily coinsurance (see page 3 for the current amount). "Lifetime Reserve Days" are available when a hospital stay extends beyond the first 90 days of a benefit period. The policy pays the coinsurance and Medicare pays the rest. Each lifetime reserve day is available only once in your lifetime.
- ◆ **Beyond 150 days: Basic Benefits** in all 10 plans provide for 365 additional lifetime days. Each of these days is available only once in your lifetime. After Medicare's benefits are exhausted for one benefit period, the policy will pay 100% of billed charges for Medicare approved type services.

- ◆ **Blood: Basic Benefits** in Plans A, B, C, D, F, M and N combine with Medicare to cover blood expenses (except the \$155 Part B deductible) both in and out of the hospital. Plan K pays 50% and Plan L pays 75% of the Medicare eligible expenses for the first three pints of blood.
- ◆ **Hospice Care:** Plans sold after June 1, 2010 now include coverage of coinsurance for all Part A eligible Hospice and respite care expenses. Plans A, B, C, D, F, G, M and N pay 100% of these costs; Plan K pays 50% and Plan L pays 75% of the coinsurance.

Part B: Medical Expenses (Per Calendar Year)

- ◆ **Part B coinsurance or copayment: Basic Benefits** in all of the plans, except high deductible F, pay after the \$155 annual deductible has been met. For most Medicare Part B services, payments are based on the amount approved by Medicare. (If charges exceed the approved amount, Basic Benefits will not cover them. See "Part B Excess Charges" on page 13.)

Payments under this benefit:

- ✓ Most services: Medicare pays 80% of the approved amount and Plans A-D, F, G, M pay the 20% coinsurance; Plan K pays 50% of the 20% and Plan L pays 75% of the 20% coinsurance. Plans K and L pay the full coinsurance for preventive services. For Plan N you pay the lesser of \$20 or the Medicare Part B coinsurance for each office visit (including visits to specialists); and the lesser of \$50 or the Medicare Part B coinsurance for each emergency room visit. The emergency room copayment will be waived if you are admitted to the hospital.
- ✓ Mental health outpatient treatment: In 2010 Medicare pays 55% of the approved amount and Plans A-D, F, G, M, N pay 45%; Plan K pays half of the 45% and Plan L pays 75% of the 45% coinsurance.
- ✓ Hospital Outpatient: Plan A-D, F, G, M, N pays the Medicare determined copayment; Plan K pays 50% and Plan L pays 75% of the copayment.

**PART A
DEDUCTIBLE
(Plans B, C, D, F,
G, K, L and N)**

Medicare requires that you pay a **deductible** when hospitalized (see page 3 for the current amount). The deductible amount can change each year. It is charged whenever you begin a new benefit period, which may occur more than once a year. Plans B, C, D, F, G and N include the **Part A Deductible Benefit** that pays the **full deductible amount** each time it is charged. Plans K and M pay 50% of the hospital deductible and Plan L pays 75% of the Part A deductible per benefit period.

This kind of benefit may be thought of as "first dollar coverage." First dollar coverage means the insurance pays from the first dollar of expense incurred. One way to save money on premiums is to pay for this deductible yourself.

**SKILLED
NURSING
FACILITY
COINSURANCE
(Plans C, D, F, G,
K, L, M and N)**

Medicare pays only when you are receiving **Medicare-approved skilled nursing care** in a **Medicare-approved facility**. The facility may be a nursing home, hospital area or hospital "swing bed". Standardized Plans C, D, F, G, M and N pay 100% of the Skilled Nursing Coinsurance Benefit. Plan K pays 50% and Plan L pays 75% of the skilled nursing facility coinsurance.

Qualifying Requirements:

- ◆ A three-day prior inpatient hospital stay.
- ◆ Care in a Medicare-certified skilled nursing facility
- ◆ Need for physician-certified **daily skilled care**, such as wound dressing, physical therapy or tube feeding.

Medicare pays all eligible costs for the first 20 days. For days 21 through 100 Medicare pays all but a daily coinsurance (see page 3 for the current amount). The **Skilled Nursing Coinsurance Benefit** pays some or all of the coinsurance amount.

Medicare doesn't provide coverage beyond 100 days. Standardized Plans don't pay benefits beyond 100 days. Medicare only pays as long as you need daily skilled services. The average stay in skilled care is less than 30 days. This

benefit pays only if you qualify for Medicare coverage. Most nursing home care in Iowa is intermediate or custodial, and neither Medicare nor standard Medicare supplement policies pay for these levels of care.

PART B DEDUCTIBLE (Plans C and F)

Medicare has a \$155 (per calendar year) deductible for Part B covered services. The first \$155 of Medicare **approved** Part B charges each year is your responsibility. The **Part B Deductible Benefit** pays the **\$155 deductible** under Plans C and F.

This benefit is another type of "first dollar coverage" and may cost as much in extra premium as the value of the benefit. To save premium dollars, you may consider paying this portion of your health care costs and choose a plan other than C or F.

FOREIGN TRAVEL EMERGENCY (Plans C, D, F, G, M and N)

Medicare does NOT cover care received outside the U. S. Standard Plans C, D, F, G, M and N include a **Foreign Travel Emergency Benefit** that pays as follows:

- ◆ Only for **emergency** care that begins within 60 days of leaving the U. S.
- ◆ \$250 calendar year **deductible**
- ◆ 80% of billed charges paid for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country
- ◆ \$50,000 **lifetime maximum**

An additional health insurance travel policy may be unnecessary when the "Foreign Travel Emergency" benefit is a part of their Medicare supplement policy.

**PART B
EXCESS
CHARGES
(Plans F and G)**

Plans F and G have an **Excess Charge Benefit**. Plans F and G pay 100% of allowed excess charges. Most doctors and other health care providers accept Medicare assignment. That means they accept Medicare's approved amount as full payment. Some providers charge more than Medicare approves.

Excess Charges Have Limits:

Excess charges are the difference between what Medicare approves and any limits under the law. The maximum limiting charge for most Medicare Part B services is **15%** over the Medicare-approved amount. A few charges such as for durable medical equipment are NOT limited to 15%.

EXAMPLE		
Limiting Charge	\$115*	<u>Plans F & G:</u>
Medicare Approved	<u>\$100</u>	100% x Excess = \$15
Excess Charges	\$ 15	
*15% over the approved amount		

One way to control medical costs is to use doctors who accept assignment. If most of your doctors accept assignment, you may prefer to pay for excess charges yourself instead of paying additional insurance premiums for this benefit.

**OUT-OF-
POCKET
ANNUAL LIMIT
(PLANS K and L)**

Plans K and L have an annual cap on out-of-pocket expenditures for Medicare Part A and B. Plan K and L will provide full coverage of all Medicare Parts A and B deductibles, co-payments and co-insurance amounts after the beneficiary has paid out-of-pocket expenses of \$4,620 (Plan K) or \$2,310 (Plan L). Out-of-pocket expenses include Medicare Part A and Part B deductibles, co-payment and coinsurance amounts.

Medicare Select - Another Option

Medicare supplement policies generally pay the same benefits regardless of your choice of health care provider. If Medicare pays for a service, the standard Medicare supplement policy must pay its regular share of benefits. One exception is Medicare SELECT.

- ◆ **Another type of Medicare supplement insurance.** Medicare SELECT is the same as standard Medicare supplement insurance in nearly all respects. If you buy a Medicare SELECT policy you are buying one of the standard plans identified by letters A, B, C, D, F, G, K, L, M and N.
- ◆ **Restricted provider network.** With Medicare SELECT you must use specific hospitals, and in some cases specific doctors, to receive full benefits. Hospitals or doctors specified by a Medicare SELECT policy are called “participating or preferred providers.” When you go to the preferred provider, Medicare pays its share of the approved charges. The Medicare SELECT policy then pays the supplemental benefits described in the policy.
- ◆ **Medicare is not restricted.** You can go to a provider outside the network for nonemergency care and Medicare still pays its share of approved charges. However, the Medicare SELECT policy will not pay under these circumstances.
- ◆ **Emergencies outside the network.** Generally Medicare SELECT policies are not required to pay any benefits when you don’t use a preferred provider. The only exception is in the case of an emergency.
- ◆ **Designated service area.** Medicare SELECT requires that you live in a designated service area to be eligible for enrollment. SELECT plans are available in some areas of Iowa. The *Iowa Medicare Supplement Premium Comparison Guide* from SHIP shows plans and the areas where they are sold.
- ◆ **Lower premiums.** Medicare SELECT policies generally have lower premiums because service areas and providers are limited. If you live in a designated area and agree to receive your care from the preferred providers for your plan, a Medicare SELECT plan may save you money.
- ◆ **Replacing a Medicare SELECT policy.** You can replace a Medicare SELECT policy with a regular Medicare supplement insurance policy if you move out of the service area. You also may choose to change after a Medicare SELECT policy has been in effect for six months. The insurance company that sold you the Select policy must allow you to purchase a regular Medicare supplement policy with equal or lesser benefits regardless of your health condition.

Shopping For Medicare Supplement Insurance

Assess your needs. Review your own health profile and decide what benefits and services you are most likely to need. Determine which standard plan is best for you. Then shop for the company from which to buy the plan. Make a careful comparison to avoid mistakes. If a poor decision is made, you may have more limited choices in the future.

The *Iowa Medicare Supplement Premium Comparison Guide* can be a big help. The guide shows premium information, how age affects premium and whether a company offers automatic claims filing. To obtain a copy, call SHIIP at 1-800-351-4664 (TTY 1-800-735-2942). The most current rates can be found on the SHIIP website at www.TheRightCallIowa.gov.

PRICE COMPARISON

- ◆ **What are the premium differences between plans?**
In deciding which standard plan to choose, you will find tradeoffs of different benefits for different premium. Which balance best suits **your** needs and **your** budget?
- ◆ **What are the premium differences for the same plan?**
Premium amounts for the same plan can vary significantly.
- ◆ **Does the premium increase because of your age?**
Normal increases occur because of claims paid and changes in Medicare deductibles and coinsurance. Some companies also base premiums on age. Check to see if the premium is based on your age at the time the policy is issued (issue age) or if it goes up as you get older (attained age). Compare premiums for your current age and for at least the next ten years. A bargain today may be a burden later.
- ◆ **Are discounts available?**
Some companies charge different rates based on several factors such as gender, nonsmoker status or your zip code. They may also give a discount if both you and your spouse buy a policy or if you pay through your bank automatically.

SERVICE

- ◆ **Does the company sell through an agent or by mail?**
An agent can help you when completing your application and with problems later. If you have a few companies with which you prefer to do business, check the yellow pages for local agents who represent those companies or call the company directly to ask about agents.

- ◆ **Is a service office located conveniently to your home?**
A local agent with a good reputation, preferable one you know and trust, is more likely to take a personal interest in providing you good service.
- ◆ **Is a toll-free telephone number available for questions?**
This is especially important if you don't have a local agent.
- ◆ **What kind of letter grade does the company have from a financial rating service?**
Several rating services such as A. M. Best, Moody, and Standard and Poor evaluate the financial stability of insurance companies. Ratings don't tell how good a policy is or what kind of service the company provides, they reflect only the financial stability of the company. The Internet is the best source for the most recent ratings information. SHIIP's fact sheet, "Understanding Insurance Company Financial Stability Ratings," links the SHIIP website (www.TheRightCallIowa.gov) to rating services' websites.
- ◆ **Is a waiting period required for pre-existing conditions?**
If you haven't had health insurance before buying Medicare supplement insurance, the policy may have a waiting period for pre-existing conditions. This means benefits may not be paid when health care services are received for a pre-existing conditions. (See page 6 for more on pre-existing conditions.)
- ◆ **Is crossover claims filing available?**
Some companies have "crossover" contracts with Medicare. After paying its share of the bill, Medicare will send claims **directly** to the insurance company for you.

If the company does not have a crossover contract, automatic filing is still available if:
 - Your **doctor always accepts Medicare assignment** and
 - You give the doctor information on your insurance card.

AVAILABILITY

- ◆ **Does the company sell Medicare supplements to those on disability?**
A few companies sell Medicare supplement plans to disabled Medicare beneficiaries.
- ◆ **Does the company have guarantee issue policies?**
A guarantee issue policy means you will not be turned down for a policy because of existing health conditions.

Use SHIP's premium guide for much of the information needed.

Compare company prices.

COMPANY	A	B	C	D	F	G	K	L	M	N

Compare company service.

COMPANY NAME						
Sells through agent or mail	Agent	Mail	Agent	Mail	Agent	Mail
Service office convenient	Yes	No	Yes	No	Yes	No
Company has toll-free #	#_____		#_____		#_____	
Company's financial rating						
Offers automatic claims filing						
Waiting period for pre-existing conditions	Yes	No	Yes	No	Yes	No
	#months?_____		#months?_____		#months?_____	

Which companies and which plans are available?

COMPANY NAME			
Guaranteed Issue policies	Plans:	Plans:	Plans:
Medicare disability policies	Plans:	Plans:	Plans:

Shopping Tips

- ◆ **Buy just ONE.** You only need one good Medicare supplement policy. You are paying for unnecessary duplication if you own more than one.
- ◆ **Take your time. DON'T BE PRESSURED** into buying. If you have questions or concerns, ask the agent to explain the policy to a friend or relative whose judgment you trust, or **call a SHIP volunteer**. If you need more time, tell the agent to return later. Don't fall for the age-old excuse, "I'm only going to be in town today so you'd better buy now." Show the agent to the door!
- ◆ **Nothing pays 100%.** Ignore claims that a policy pays 100% of the difference between you medical bills and what Medicare pays. **No policy does that!**

- ◆ **Check the agent's insurance license.** An agent must have a license issued by the State of Iowa Insurance Division to be authorized to sell insurance in Iowa. Don't buy from a person who can't show proof of licensing. A business card isn't a license. Contact the Insurance Division to check on an agent's license (call 877-955-1212 or visit the website at www.iid.state.ia.us).
- ◆ **Medical questions may be important.** Don't be misled by the phrase "no medical examination required." You may not have to go to a physician for an exam, but medical statements you make on the application might prevent you from getting coverage after your open enrollment period. Also the policy may require a waiting period before benefits are paid for pre-existing conditions.
- ◆ **Complete the application carefully.** Before you sign an application, read the health information the agent recorded. Be sure **all** health information is complete and accurate. If you leave out requested information, the insurance company could deny coverage for that condition or cancel your policy.
- ◆ **DO NOT pay with cash.** Pay by check, money order, or bank draft. Make it payable to the insurance company only, not the agent. Completely fill in the check before presenting it to the agent.
- ◆ **It takes time to be approved.** You are NOT insured by a new Medicare supplement policy on the day you apply for it. Generally, it takes at least 30 days to be approved.
- ◆ **Do not cancel a current policy** until you have been accepted by the new insurer and have a policy in hand. Consider carefully whether you want to drop one policy and purchase another.
- ◆ **Expect to receive the policy within a reasonable time.** A policy should be delivered within a reasonable time after application (usually 30 days). If you haven't received the policy or had your check returned in that time, contact the company and obtain in writing a reason for delay. **If a problem continues, contact the Iowa Insurance Division (877-955-1212).**
- ◆ **Use your 30-day free-look period.** The 30 days start when you have a policy in your hand. Review it carefully. If you decide not to keep it, return it to the company and **request a premium refund in writing.** After the "free-look" period, insurance companies are not required to return unused premiums if you decide to drop the policy. If an agent tries to sell you a new policy saying you can get a premium refund for your current policy, report the agent to the Iowa Insurance Division.
- ◆ **Your policy is guaranteed renewable** if you bought it after December 1, 1990. That means the company can't drop you unless you fail to pay the premium.

Alternatives To Medicare Supplement Insurance

EMPLOYER HEALTH INSURANCE

The questions to ask and the answers differ depending on your situation, such as how old you are or if you continue to work. SHIIP has a fact sheet, “Getting Ready to Retire: Health Insurance Issues,” that identifies the questions you need to ask.

If you or your spouse **continue to work** after your 65th birthday, you may be able to continue under an employer group health insurance plan. In many situations your employer plan will be primary (it will pay first). In that case, you may not need to sign up for Medicare Part B or buy a Medicare supplement. Contact Social Security with any questions regarding enrollment in Medicare Part B.

When you **retire** at age 65 or later and are not covered by an employed spouse’s plan, Medicare will become your primary insurance plan. You **must** enroll in Medicare Part B to avoid a penalty for late enrollment. Your employer may offer a retiree health plan that will pay after Medicare.

Employer group insurance plans **don’t** have to comply with the regulations governing Medicare supplement policies. Carefully compare benefits and costs before deciding to keep employer insurance or replace it with a Medicare supplement.

MEDICARE ADVANTAGE

Your Medicare Part A and Part B benefits can be provided through private plans that have a contract with Medicare. Some of these options include HMOs, PPOs, and Private Fee-For-Service plans.

Choices available depend on where you live. For information about plans serving your area, check with SHIIP at 1-800-351-4664 (TTY 1-800-735-2942) or www.TheRightCallIowa.gov.

A Medicare supplement is not needed when you are enrolled in a Medicare Advantage plan and will not pay benefits.

MEDICARE SAVINGS PROGRAM

The **Qualified Medicare Beneficiary (QMB)** program is a state assistance program that pays Medicare deductibles, Medicare coinsurance and Medicare's Part B monthly premium.

The **Special Low-income Medicare Beneficiary (SLMB)** and **Expanded SLMB** programs pay the Medicare Part B monthly premium.

These programs are designed for people with limited income and assets. Contact your county Department of Human Services (DHS) office or SHIIP for more information. SHIIP has a worksheet to help you see if you meet income guidelines.

MEDICAID

You may be eligible for Medicaid assistance if you have limited assets and low monthly income or you have high medical bills. Medicaid pays eligible expenses without deductibles or copays. It also pays for intermediate or custodial care in a nursing home, which is NOT covered by Medicare. For more information, contact your county Department of Human Services (DHS) office or Area Agency on Aging.

Generally, you don't need a Medicare supplement while receiving Medicaid assistance. However, if you have a Medicare supplement that was issued after November 5, 1991, and you become eligible for Medicaid, you can suspend your policy for up to 24 months. You must make this request within 90 days of Medicaid eligibility. Your policy can be reinstated any time during the 24 months if you no longer qualify for Medicaid.

A SHIIP volunteer insurance counselor can talk with you about Medicaid assistance programs and your health insurance needs. You also will be able to get the appropriate referral for further help. **To get the name and telephone number of the SHIIP location near you call 1-800-351-4664.**

Limited Benefit Policies Are Not A Substitute For A Medicare Supplement Policy

Limited benefit policies such as hospital indemnity, dread disease (cancer, stroke, heart disease, etc.) and accident plans **do not cover the gaps in Medicare benefits**. They provide benefits only in limited circumstances and duplicate coverage from Medicare and Medicare supplement insurance. These plans are **generally unnecessary and not an effective use of premium dollars**.

INSURANCE COMPLAINTS

Any Iowa citizen who feels he or she hasn't been treated properly in an insurance transaction may write to the Iowa Insurance Division. All complaints are investigated. A complaint can also be submitted through the Insurance Division website at www.TheRightCallIowa.gov.

Examples of complaints:

- An insurance agent misrepresents a product or company.
- You experience delays in claims handling.
- You disagree with the amount of an insurance settlement.
- An agent continues to persist after you have said you do not want further discussion or contact.
- An agent tells you your current company is unsound financially or otherwise not reputable.

<u>Address complaints to</u> Iowa Insurance Division 330 Maple Street Des Moines, IA 50319-0065	<u>Include the following information:</u> <ul style="list-style-type: none">• Your name and address• The insurance company name• Your policy number (if applicable)• The name and address of your insurance agent (if applicable)• A description of the problem• Supporting documentation
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PLEASE PRINT YOUR NAME, ADDRESS & PHONE NUMBER

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Daytime phone number: _____
(in case we have a question about your request)

Please send me one of each of the following publications: (CHECK all that apply)

<input type="checkbox"/> Iowa Guide To Medicare Supplement Insurance	<input type="checkbox"/> Medicare and Insurance Claims Organizer
<input type="checkbox"/> Iowa Medicare Supplement Premium Comparison Guide	<input type="checkbox"/> Part D: Medicare Drug Benefit
<input type="checkbox"/> Iowa Guide To Long Term Care Insurance	<input type="checkbox"/> SHIIP Brochure
<input type="checkbox"/> Medicare Advantage Plans in Iowa	

Please call SHIIP at 800-351-4664 (TTY 1-800-735-2942) to:

*Schedule a speaker for your group *Get information on being a SHIIP volunteer
*Get the phone # of the SHIIP volunteer nearest you

Use This Postcard For More Information From SHIIP

(March 2010)

Contacting SHIIP

- ✓ To request a speaker for your group
- ✓ To request confidential, objective assistance with senior health insurance questions
- ✓ To order publications

1-800-351-4664
(TTY 1-800-735-2942)

E-mail: shiip@iid.iowa.gov
For the latest information check
SHIIP's Website: www.TheRightCallIowa.gov

First Class
Postage
Required



TO: SHIIP
Iowa Insurance Division
330 Maple
Des Moines IA 50319-0065