1997

GUIDE

To Health Insurance for People with Medicare

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

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

1997 Guide to Health Insurance for People with Medicare

Resource ID#: 4058

– NOTICE –

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

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

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

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

1-800-638-6833

TABLE OF CONTENTS

DEFINITIONS OF SOME MEDICARE TERMS

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

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

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

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

Coinsurance: The portion or percentage of the Medicare-approved amount that a beneficiary is responsible for paying.

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

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

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

Medicare Carrier: An insurance organization under contract to the federal government to process Medicare Part B claims from physicians and other suppliers. The names and addresses of the carriers and areas they serve are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

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

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

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

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most people covered by Medicare, there are things about the federal health insurance program that you find hard to understand. You may be uncertain about what Medicare covers and does not cover and how much it pays toward your medical bills. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

The National Association of Insurance Commissioners (NAIC) and the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services have written this guide to give you information that should help you make health insurance choices. This guide does not recommend insurance companies or policies. The purpose of the guide is to:

- Explain your Medicare benefits;
- Identify what Medicare does not pay in full or at all (the gaps in your coverage);
- Describe the different types of insurance available to fill the gaps in your Medicare coverage;
- Provide tips on shopping for private health insurance, and
- List the names and telephone numbers of state agencies that can answer your questions about health insurance.

Covering Medicare's Gaps

You probably know that there are health care costs that Medicare either does not pay in full or does not pay at all. For example, when you go to the doctor or hospital for services covered by Medicare, you must pay part of the cost. If you get services not covered by Medicare, you must pay all of the bill. Other than paying what you owe out of your own pocket, which few people can afford to do, there are four basic ways to help fill the payment gaps in your Medicare coverage:

1. By buying Medicare supplement insurance, which is also called "Medigap" insurance.
2. By joining a managed care plan, such as a health maintenance organization (HMO) that has a Medicare contract.
3. By keeping coverage under an employer-provided health insurance policy, if you are eligible for such a policy.
4. By qualifying for state assistance in paying some of your Medicare costs, or for full benefits under the Medicaid program.

What To Do First

Before buying additional insurance, you should:

- ☑ Review any insurance you already have, such as employer-paid coverage, to see whether you need and can afford more insurance.
- ☑ If you have a low income and limited resources, check with your state to see whether you qualify for Medicaid or for other state help in paying for your health care costs (see page 23). A few states have programs that help pay for prescription drugs and other medical services. You can find out if yours does by contacting the state office that provides insurance counseling.

Insurance Counseling

Each state offers insurance counseling by trained counselors. The counselors will generally be able to answer your questions about Medicare and private insurance to supplement your Medicare benefits. These services are free. The telephone number for your state insurance counseling office is listed in the directory of state insurance departments and agencies on aging beginning on page 27.

The following section briefly explains the Medicare program. The discussion about Medigap, Medicare-contracting managed care plans, and other types of private insurance begins on page 11.

WHAT IS MEDICARE?

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with permanent kidney failure. Medicare is run by the Health Care Financing Administration. The Social Security Administration helps HCFA by enrolling people in Medicare and by collecting Medicare premiums.

Two Parts of Medicare

Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital and a skilled nursing facility, and for home health and hospice care. Part B helps pay doctor bills, and for outpatient hospital care and other medical services not covered by Part A. Your Medicare card shows the Medicare coverage you have—Hospital Insurance (Part A), Medical Insurance (Part B), or both—and the date your coverage started.

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers, and by part of the Self-Employment Tax paid by self-employed persons. You do not have to pay a monthly premium for Part A if you or your spouse worked for at least 10 years in Medicare-covered employment, and you are 65 years old and a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients also qualify for premium-free Part A.

If you do not qualify for premium-free Part A, you may buy it if you are at least 65 years old and meet certain other requirements. You also may buy Part A if you are under age 65, were once entitled to Medicare under the disability provisions and still have the same disability but your benefits were ended because of your work and earnings. The monthly premium in 1997 is $187 if you had at least 30 quarters of Medicare-covered employment but fewer than 40 quarters. It is $311 if you had fewer than 30 quarters or no quarters of covered employment.

Everyone who enrolls in Medicare Part B must pay a premium. The monthly premium in 1997 is $43.80 and most enrollees have it deducted from their monthly Social Security check. You are automatically enrolled in Part B when you become entitled to premium-free Part A unless you state that you don't want it. Even if you do not qualify for premium-free Part A, you generally can buy Part B if you are 65 or older.

Enrollment

Enrollment in Medicare is handled in two ways: either you are automatically enrolled or you must apply. If you are getting Social Security or Railroad Retirement Board benefits before you turn 65, you are automatically enrolled and your Medicare card will be mailed to you about three months before your 65th birthday. If you are not receiving retirement benefits, you must apply by contacting a Social Security Administration office or, if appropriate, the Railroad Retirement Board. You should apply three months before your 65th birthday to avoid a possible delay in the start of your coverage. If you are disabled, you will automatically get a Medicare card in the mail when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months.

The initial enrollment period for Part B and Part A, if you have to buy Part A, runs for seven months beginning three months before the month in which you turn 65. If you do not enroll during your initial 7-month enrollment period, you will have to wait until the next "general enrollment period." These enrollment periods are held each year, from January 1 through March 31. Your Medicare coverage begins the following July 1.

Premiums for both Part A and Part B generally will be higher if you wait to enroll during a general enrollment period. The Part B premium goes up 10 percent for each 12 months after you were first eligible to buy it. So, if you wait 24 months to enroll in Part B, your premium will always be 20 percent higher. The increase in the Part A premium (if you have to pay a premium) is limited to 10 percent no matter how late you enroll for the coverage.

In some cases you can delay enrolling in Part B without having to pay higher premiums. Specifically, if you are 65 or over and have group health insurance based on your or your spouse's current employment, you have a choice as to when to enroll. You may enroll while you are covered by the group plan or you may wait and enroll during a special 8-month enrollment period. It begins the month you or your spouse stops working or when you are no longer covered under the employer plan, whichever comes first. If you do not enroll during this period, you will have to wait until Medicare's next general enrollment period.

Even if you continue to work after you turn 65, you should at least sign up for Part A. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be a good idea to sign up for Part B at the same time. You would have to pay the monthly Part B premium and the Part B benefits would be of limited value to you as long as the employer plan is the primary payer of your medical bills. Moreover, you would start your Medigap open enrollment period. This is a period of time during which you can buy the Medigap policy of your choice (see page 16).

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital and in a skilled nursing facility after a hospital stay. Part A also pays for home health and Hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health care benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Benefit Periods

Medicare hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service as an inpatient in a qualified hospital and ends when you have been out of a hospital or other facility that mainly provides skilled nursing or rehabilitation services for 60 days in a row. It also ends if you remain in a facility (other than a hospital) that mainly provides skilled nursing or rehabilitation services but do not get any skilled care there for 60 days in a row.

If you go back to the hospital after 60 days, a new benefit period begins, your hospital and skilled nursing facility benefits are renewed, and you must pay another hospital deductible. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

Medicare Part A helps pay for up to 90 days of medically necessary care in a Medicare-certified hospital in a benefit period. During the first 60 days Medicare pays all covered costs except for the first $760. That's the hospital deductible for 1997. You only pay it once no matter how many times you go to the hospital during the benefit period.

For the 61st through the 90th day in a benefit period, Medicare pays all covered hospital costs except for coinsurance of $190 per day in 1997. You are responsible for paying the coinsurance. In the unlikely event that you are in the hospital for more than 90 days in a benefit period, you can use your "reserve days" to help pay the bill. When a reserve day is used, Medicare pays all covered cost except for daily coinsurance of $380 in 1997. You have a supply of 60 reserve days to use during your lifetime.

Gaps In Inpatient Hospital Coverage

You Pay:

- $760 deductible on first admission to hospital in each benefit period.
- $190 daily coinsurance for days 61 through 90.
- All charges for coverage after 90 days in any benefit period unless you have "lifetime reserve" days available and use them.

(over)

- $380 daily coinsurance for each lifetime reserve day used.
- For the first three pints of whole blood or units of packed cells used in each year in connection with covered services unless the blood is replaced. To the extent the blood deductible is met under one part of Medicare, it does not have to be met under the other part.
- For a private hospital room, unless medically necessary, and for a private nurse.
- For personal convenience items such as a telephone or television in a hospital room.
- For non-emergency care in a hospital that does not participate in Medicare.
- For care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

Psychiatric Hospital Care

Medicare Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for. Inpatient care in a psychiatric hospital is subject to the same terms and conditions as inpatient care in a general hospital. If you receive psychiatric care in a general hospital, there is not a limit on the number of days of care that you can receive during you lifetime.

Gaps In Inpatient Psychiatric Hospital Coverage

You Pay:

- For all care after you have received 190 days of such specialized treatment in a psychiatric hospital in your lifetime (even if you have not yet exhausted your coverage for inpatient care in a general hospital).
- The gaps in general hospital coverage also apply to psychiatric hospital coverage.

Skilled Nursing Facility Care

Medicare Part A can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare, except for a daily coinsurance amount. The daily coinsurance in 1997 is $95. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the101st day.

A skilled nursing facility is different from a nursing home. It is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility such as a hospital.

Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine. Medicare does not pay for custodial care if that is the only kind of care you require.

To qualify for Medicare-covered skilled nursing facility (SNF) benefits, you must:

- ☑ Require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.
- ☑ Be in the hospital for at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility that is certified by Medicare.
- ☑ Be admitted to the skilled nursing facility for the same condition for which you were treated in the hospital.
- ☑ Generally be admitted to the facility within 30 days of your discharge from the hospital.
- ☑ Be certified by a medical professional as needing skilled nursing or skilled rehabilitation services on a daily basis.

Gaps In Skilled Nursing Facility Coverage

You Pay:

- $95 daily coinsurance for days 21 through 100 in each benefit period.
- All costs after 100 days in a benefit period.
- All costs for care that is less than the level of care Medicare covers in a skilled nursing facility.
- All costs if you were not transferred to the skilled nursing facility in a timely manner after a qualifying hospital stay.
- For care in a general nursing home, or in a skilled nursing facility not approved by Medicare, or for just custodial care in a Medicare-approved skilled nursing facility.
- The 3-pint blood deductible (see list of gaps under inpatient hospital care on page 4).

Home Health Care

Medicare pays the full cost of medically necessary home health visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services. Services are provided on an intermittent or part-time basis, not full-time, by a visiting nurse and/or home health aide.

To qualify for coverage, you must:

- ☑ Need intermittent skilled nursing care, physical therapy, or speech therapy.
- ☑ Be confined to your home,
- ☑ Be under a doctor's care.

A stay in the hospital is not needed to qualify for the home health benefit, and you do not have to pay a deductible or coinsurance for services. You do have to pay 20 percent of the approved amount for durable medical equipment such as wheelchairs and hospital beds provided under a plan-of-care set up and reviewed periodically by a doctor.

Gaps in Home Health Coverage

You Pay:

- For full-time nursing care and drugs.
- For meals delivered to your home.
- Twenty percent of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.
- For homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare pays for hospice care for terminally ill beneficiaries who choose to receive hospice care rather than regular Medicare benefits for management of their illness. Under Medicare, hospice is primarily a program of care provided in the patient's home by a Medicare-approved hospice. The focus is on care, not cure. Hospice services covered under Medicare Part A include:

- ☑ Physician services
- ☑ Nursing care
- ☑ Medical appliances and supplies
- ☑ Drugs (for pain and symptom relief)
- ☑ Short-term inpatient care
- ☑ Medical social services
- ☑ Physical therapy, occupational therapy and speech/language pathology services
- ☑ Dietary and other counseling

There is no deductible for these hospice care benefits. Copayments are, however, required for the following two benefits:

1. Prescription drugs for pain relief and symptom management, for which patients can be charged 5% of the reasonable cost, but no more than $5 for each prescription.

(over)

2. Respite care, for which the patient can be charged about $5 per day, depending on the area of the country. The patient can receive inpatient care for up to 5 days per stay to provide some time off for the person who regularly provides care in the home.

If you need medical services for a health problem unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for any Medicare deductible and coinsurance amounts that must be paid.

Gaps In Hospice Coverage

You Pay:

- Limited charges for inpatient respite care and outpatient drugs.
- Deductibles and coinsurance when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

Medicare Part B pays for many medical services and supplies, but the most important coverage is for your doctor's bills. Medically necessary services of a doctor are covered no matter where you receive them—at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also covers:

- ☑ Outpatient hospital services
- ☑ X-rays and laboratory tests
- ☑ Certain ambulance services
- ☑ Durable medical equipment, such as wheelchairs and hospital beds, used at home
- ☑ Services of certain specially qualified practitioners who are not physicians
- ☑ Physical and occupational therapy
- ☑ Speech/language pathology services
- ☑ Partial hospitalization for mental health care
- ☑ Mammograms and Pap smears
- ☑ Home health care if you do not have Part A

While Part B generally does not cover outpatient prescription drugs, it does cover some oral anticancer drugs, certain drugs for hospice enrollees, and drugs that you cannot administer yourself but that are provided as part of a doctor's services. Certain drugs furnished during the first year after an organ transplantation and epoetin for home dialysis patients are also covered, as well as antigens, and flu, pneumococcal, and hepatitis B vaccines. Blood is also covered after you meet the 3-pint annual deductible.

Part B Deductible And Coinsurance

When you use Part B benefits, you must pay the first $100 each year of the charges approved by Medicare. This is called the deductible. After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for all covered services you receive during the rest of the year. You are responsible for the other 20 percent, which is called coinsurance.

Sometimes, however, your share of the bill is more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you pay 20 percent of whatever the hospital charges, not 20 percent of an amount approved by Medicare. If you receive oupatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides the deductible and coinsurance, you may also have other out-of-pocket costs if your doctor or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge."

Medicare-Approved Amount

The amount Medicare approves for a covered service provided by a doctor is the *lesser* of the Medicare fee schedule amount for a particular service or the amount charged by the doctor. The fee schedule lists the dollar amount that Medicare considers to be the reasonable charge for each of the services provided by a doctor that Medicare will help pay for.

What is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment of Medicare claims. If they do, they will accept the amount Medicare approves for a particular service or supply. That could mean savings for you.

For example, let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare-approved amount for the service you receive is $100. Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115. which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge. Medicare would pay 80 percent of $100, or $80, and you would be responsible for the remaining $35. But because Medicare pays its share of the bill to you and not the doctor when a claim is unassigned, the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

In certain situations all doctors and medical suppliers are required to accept assignment For instance, all doctors and qualified laboratories must accept assignment for clinical diagnostic laboratory tests covered by Medicare. Doctors also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 23).

The names, addresses and telephone numbers of doctors and medical suppliers who accept assignment on all Medicare claims are listed in *The Medicare Participating Physician/Supplier Directory*. The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging. It also is available free by writing or calling the insurance company that processes Medicare Part B claims for your area. The names, addresses and telephone numbers of the companies, which are called Medicare "carriers," are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Doctor Charge Limits

Doctors who do not accept assignment of a Medicare claim can charge up to 15 percent more than the Medicare-approved amount, and you are responsible for paying it. This is called the "limiting charge."

To determine the limiting charge for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form usually sent to you by the carrier after you receive a Medicare-covered service. If the EOMB shows that your doctor exceeded the charge limit, contact the doctor and ask for a reduction in the charge, or a refund if you have paid the bill. If you cannot resolve the issue with the doctor, call your Medicare carrier.

Medicare carriers also are required to screen doctor bills for overcharges and notify the doctor and the patient within 30 days of any overcharge. The doctor is then required to refund the overcharge within 30 days or credit your account for it. Doctors who knowingly, willfully and repeatedly charge more than the legal limit are subject to sanctions.

Some states have also enacted charge limit laws. Currently, Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island and Vermont have such laws. If you live in one of these states, or if you want to find out whether your state has a law limiting physician charges, contact your state insurance department counseling program or office on aging (see listings beginning on page 27).

Other Charge Limits

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

Gaps In Doctor and Medical Supplier Coverage

You Pay:

- $100 annual deductible.
- Generally, 20% coinsurance and permissible charges in excess of Medicare-approved amount.
- 50% of the Medicare-approved amounts for most outpatient mental health treatment.
- All charges in excess of Medicare's maximum yearly payment of $720 each for an independent physical therapist and an independent occupational therapist.
- All charges for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- All charges for most self-administerable prescription drugs and immunizations, except for pneumococcal, influenza and hepatitis B vaccinations, and certain oral cancer drugs.
- All charges for routine physicals and other screening services, except for periodic mammograms and Pap smears.
- All charges for most dental care and dentures.
- All charges for acupuncture treatment.
- All charges for routine eye examinations or eyeglasses, except prosthetic lenses after cataract surgery.
- All charges for hearing aids or routine hearing loss examinations.
- All charges for care outside the United States and its territories, except in certain instances in Canada and Mexico.
- All charges for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.
- All charges for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- Unless replaced, all charges for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

Medicare Benefit Charts

The charts on pages 9 and 10 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

MEDICARE HOSPITAL INSURANCE (PART A) COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies. (Medicare payments based on benefit periods; see pg.3.)	First 60 days	All but $760	$760
	61st to 90th day	All but $190 a day	$190 a day
	91st to 150th day*	All but $380 a day	$380 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. ** (Medicare coverage based on benefit periods; see pg. 3.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $95 a day	Up to $95 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements for home health care benefits.	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.
** Neither Medicare nor Medigap insurance will pay for most nursing home care.
*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

MEDICARE MEDICAL INSURANCE (PART B) COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Physician's services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment.	Unlimited services if medically necessary, except for the services of independent physical and occupational therapists.	80% of approved amount (after $100 deductible); 50% of approved amount for most outpatient mental health services; up to $720 a year each for independent physical and occupational therapy.	$100 deductible;* 20% of approved amount after deductible; charges above approved amount;** 50% for most outpatient mental health services; 20% of first $900 for each independent physical and occupational therapy and all charges thereafter each year.
CLINICAL LABORATORY SERVICES Blood tests, urinalysis, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE*** Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements.	100% of approved amount for services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of amount Medicare approves for durable medical equipment.
OUTPATIENT HOSPITAL SERVICES Services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of whatever the hospital charges (after $100 deductible).*
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible). ****

* You pay the $100 Part B deductible only once each year.
** Federal law limits charges for physician services (see page 7).
*** Part B pays for home health care only if you do not have Part A of Medicare.
**** To the extent any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year they do not have to be paid for or replaced under the other part.

TYPES OF PRIVATE HEALTH INSURANCE

If you decide that you need more insurance, there is a variety of private insurance policies available to help pay health care expenses that Medicare covers only partially or not at all. The basic types of coverage include:

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

Each of these options will be discussed in turn, but let's start with Medigap insurance.

Medigap

Medigap insurance is specifically designed to supplement Medicare's benefits and is regulated by federal and state law. It must be clearly identified as Medicare supplement insurance and it must provide specific benefits that help fill the gaps in your Medicare coverage. Other kinds of insurance may help you with out-of-pocket health care costs but they do not qualify as Medigap plans.

Standard Medigap Plans: To make it easier for consumers to comparison shop for Medigap insurance, all states (except Minnesota, Massachusetts and Wisconsin), U.S. territories and the District of Columbia limit the number of different Medigap policies that can be sold in any of those jurisdictions to no more than 10 standard Medigap plans.

The plans, which are detailed beginning on page 13, were developed by the National Association of Insurance Commissioners and incorporated into state and federal law. They have letter designations ranging from"A" through "J," with Plan A being the "basic" benefit package. Each of the other 9 plans includes the basic package plus a different combination of additional benefits. Plan J provides the most coverage of all the plans. The plans cover specific expenses either not covered or not fully covered by Medicare. Insurance companies are not permitted to change the combination of benefits or the letter designations of any of the plans.

States must allow the sale of Plan A and all Medigap insurers must make Plan A available if they are going to sell any Medigap plans in a state. While not required to offer any of the other 9 plans, most insurers offer several plans to pick from, and some offer all 10. Insurers can decide which of the 9 optional plans they will sell as long as the plans they select have been approved for sale in the state in which they are to be sold. Only two states—Delaware and Vermont—do no allow for the sale of all 10 standard plans. Delaware does not permit the sale of Plans C, F, G and H and Vermont prohibits the sale of Plans F, G and I.

The 10 standard plans do not apply to residents of **Minnesota, Massachusetts** and **Wisconsin** because these states had alternative Medigap standardization programs in effect before the federal legislation standardizing Medigap was enacted. Therefore, these states were not required to change their Medigap plans. If you live in Minnesota, Massachusetts or Wisconsin, contact your state insurance department to find out what Medigap coverage is available.

What Medigap Plans Cover: Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide coverage for Medicare's deductibles. Some of the 10 standard plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States. Coverage is also provided in some plans for health care provider charges in excess of Medicare's approved amount and for some care in your home.

Some of the benefits have dollar limits. For example, the at home recovery benefit available in some plans pays up to $40 per visit for up to seven visits a week by a health care professional. It will pay for up to 8 weeks of care after your Medicare-covered home health care visits stop. The maximum benefit is $1,600 per calendar year. To qualify for the at home recovery benefit, you must receive Medicare-covered home health care services after an illness, injury or surgery and the services covered by the Medigap policy must be ordered by your doctor.

Both the basic and the extended outpatient prescription drug benefits also have pay-out limits. Under basic coverage, you are responsible for a $250 deductible each calendar year. After you pay the first $250, the policy covers 50 percent of outpatient prescription drug charges up to a maximum of $1,250 for the balance of the calendar year. The extended prescription drug benefit also pays 50 percent of your drug bills up to a maximum of $3,000 per year after you pay the first $250.

The preventive screening benefit pays a maximum of $120 per year for doctor-ordered health care screenings. The foreign travel emergency benefit covers 80 percent of the costs of emergency medical care begun during the first 2 months of each trip outside the United States after you pay the $250 annual deductible. There is a lifetime maximum benefit of $50,000.

When describing the benefits of each of the Medigap plans, insurance companies must use the same format, language and definitions. They also are required to use a uniform chart and outline of coverage to summarize the benefits. These requirements are intended to make it easier for consumers to compare policies. As you shop for a Medigap policy, keep in mind that each company's products are alike, so they are competing on service, reliability and price. Compare benefits and premiums and be satisfied that the insurer is reputable before buying.

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

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

Medigap Premiums: Although the benefits are identical for all Medigap plans of the same type, the premiums may vary greatly from one company to another and from area to area. Insurance companies use three different methods to calculate premiums: issue age, attained age and no age rating.

If your company uses the issue age method, and you were 65 when you bought the policy, you will always pay the same premium the company charges people who are 65 regardless of your age. If it uses the attained age method, the premium is based on your current age and will increase as your grow older. Under the no age rating, everyone pays the same premium regardless of age. Your state insurance department must approve the rates charged for all Medigap policies. The insurance company can raise your premiums only when it has approval to raise the premiums for everyone else with the same policy.

Continued on page 16

Standard Medigap Plans

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

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

- Coverage for the Part A coinsurance amount ($190 per day in 1997) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($380 per day in 1997) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health services) after $100 annual deductible is met.

PLAN B includes the basic benefit plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($760 per benefit period in 1997).

PLAN C includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount ($95 per day for days 21 through 100 per benefit period in 1997).
- Coverage for the Medicare Part B deductible ($100 per calendar year in 1997).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

PLAN D includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at home recovery. The at home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations (see page15).

PLAN E includes the basic benefit plus:

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

PLAN F **includes the basic benefit plus:**

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

PLAN G **includes the basic benefit plus:**

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

PLAN H **includes the basic benefit plus:**

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

PLAN I **includes the basic benefit plus:**

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

PLAN J **includes the basic benefit plus:**

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges.*
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care (see Plan E).
- Coverage for at home recovery (see Plan D).
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible (this is called the "extended" drug benefit).

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

Chart of the Ten Standard Medicare Supplement Plans

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First 3 pints of blood each year.

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

Continued from page 12

Medicare SELECT: Another Medicare supplement health insurance product, called "Medicare SELECT," is permitted to be sold by insurance companies and HMOs throughout the country. Medicare SELECT is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the standard Medigap plans. The only difference between Medicare SELECT and standard Medigap insurance is that each insurer has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, in order to be eligible for full benefits. Medicare SELECT policies generally have lower premiums because of this requirement.

When you go to the insurer's "preferred providers," Medicare pays its share of the approved charges and the insurer is responsible for the full supplemental benefits provided for in the policy. In general, Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges regardless of the provider you choose.

Congress designed Medicare SELECT as an experimental program and initially approved its availability in 15 states. It was later expanded to include all states and extended until at least 1998. Even if Congress decides not to continue Medicare SELECT, insurers will be required to honor all existing Medicare SELECT policies. If you have a Medicare SELECT policy and the program is terminated in 1998, you will be able either to keep the SELECT policy with no changes in benefits or, regardless of the status of your health, purchase another Medigap policy offered by the insurer, if the insurer issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similiar benefits.

While authorized for sale in every state, Medicare SELECT may not yet have been approved for sale in your state. You can find out whether it is available to you by calling your state insurance department or state insurance counseling office.

Open Enrollment Guarantees Your Right To Medigap Coverage: State and federal laws guarantee that for a period of 6 months from the date you are both enrolled in Medicare Part B and age 65 or older, you have a right to buy the Medigap policy of your choice regardless of any health problems you may have. If, however, your birthday falls on the first day of the month, your Part B coverage (if you buy it) begins on the first day of the previous month,while you are still 64. Your Medigap open enrollment period would also begin at that time.

During this 6-month open enrollment period, you can buy any Medigap policy sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy because of your medical history, health status or claims experience. The company can, however, impose the same preexisting condition restrictions (see pages 17 and 25) that apply to Medigap policies sold outside the open enrollment period.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are generally not eligible. (If you were entitled to Medicare before age 65, see the following section on open enrollment and the disabled.)

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

If you are covered under an employer plan that is primary to Medicare in paying your medical bills, you will not need a Medigap plan until you are no longer covered under the employer plan. If you begin buying Part B as a supplement to your employer plan while it is the primary payer, you will start your Medigap open enrollment period when it is of little use to you.

You may, therefore, want to wait to buy Part B until you are ready to make optimum use of your Medigap open enrollment period. Also keep in mind that if you have already triggered your Medigap open enrollment period at age 65, you cannot get another one by dropping Part B and re-enrolling during a special enrollment period after you are no longer covered under the employer plan.

Medigap Open Enrollment and the Disabled: If you become eligible for Part B benefits before age 65 because of a disability or permanent kidney failure, federal law guarantees you access to the Medigap policy of your choice when you reach age 65. During the first 6 months you are age 65 and enrolled in Part B, you can buy the policy of your choice regardless of whether you had enrolled in Part B before you were 65.

During these 6 months, you cannot be refused a policy because of your disability or for other health reasons. Moreover, you cannot be charged more than other applicants, which can greatly reduce the amount you are paying. This includes Medigap policies that cover outpatient drugs, if they are available in your state. A waiting period of up to 6 months, however, may be imposed for coverage of a pre-existing condition.

Several states go beyond federal law and require at least a limited open enrollment for Part B beneficiaries under 65. Check to see whether your state does. In addition to any state requirement, federal law requires that you be given an open enrollment opportunity when you turn 65, even if you were previously entitled to open enrollment under state law.

Guaranteed Renewable: All standard Medigap policies are guaranteed renewable. This means that the insurance company cannot refuse to renew your policy unless you do not pay the premiums or you made material misrepresentations on the application. Older policies may allow the company to refuse to renew on an individual basis. These older policies provide the least permanent coverage.

Older Medigap Policies: Many federal requirements do not apply to Medigap policies sold before 1992, when Medigap was standardized. There is generally no requirement that you switch to one of the standard plans if you have an older policy. However, you may be required to switch if your older plan was not guaranteed renewable and the company discontinues the type of policy you have. Check with your state insurance department to find out what state-specific requirements are in force.

Switching Medigap Policies: Even if you are not required to convert an older policy, you may want to consider switching to one of the standardized Medigap plans if it is to your advantage and an insurer is willing to sell you one. If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide better coverage, especially for prescription drugs and extended skilled nursing care. On the other hand, older Medigap polices, which cannot be sold to new applicants, may experience greater premium increases than newer standardized policies which can enroll new applicants (younger, healthier policyholders whose better claims experience will help to moderate premiums).

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

You do not need more than one Medigap policy. If you already have a Medigap policy, you must sign a statement when you buy another indicating that you intend to replace your current policy and will not keep both policies. However, do not cancel the old policy until the new one is in force and you have decided to keep it.

Use the "Free-Look" Provision: Insurance companies must give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company

within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

Non-Standard Plans: It is illegal for anyone to sell you a Medigap plan that does not conform to Medigap standardization requirements. This may include a "retainer agreement" that your doctor may offer you under which he or she will provide certain non-Medicare-covered services and waive the Medicare coinsurance and deductible amounts. This arrangement may violate federal laws governing Medigap policies. If a doctor refuses to see you as a Medicare patient unless you pay him or her an annual fee and sign one of these retainer agreements, you should register a complaint with federal authorities by calling **1-800-638-6833**.

Carrier Filing of Medigap Claims: Under certain circumstances, when you receive medical services covered by both Medicare and your Medigap insurance, you may **not** have to file a separate claim with your Medigap insurer in order to have payment made directly to your doctor or medical supplier.

By law, the Medicare carrier that processes Medicare claims for your area must send your claim to the Medigap insurer for payment when the following three conditions are met for a Medicare Part B claim:

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

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medigap insurer and generally send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your doctor or medical supplier and send you a notice that it has done so.

If the insurer refuses to pay the doctor directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact the Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the carrier for your area.

Under another arrangement, some Medigap insurers have "crossover" contracts with Medicare. If your company has a crossover contract, Medicare will automatically send all of your claims directly to the insurer, even if the doctor has not signed a participation agreement with Medicare.

Medicare and Managed Care Plans

Managed care plans are sometimes called coordinated care or prepaid plans or HMOs. They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they provide health care services.

Each plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. Depending on how the plan is organized, services are usually provided either at one or more centrally located health care facilities or in the private practice offices of the doctors and other health care professionals that are part of the plan.

Most managed care plans allow you to select a primary care doctor from those that are part of the plan. If you do not make a selection, one will be assigned to you. Your primary care doctor is responsible for managing your medical care, admitting you to a hospital and referring you to specialists.

You may have to pay a fixed monthly premium to the plan and small copayments each time you go to the doctor or use other services. The premiums and copayments vary from plan to plan and can be changed each year. You also must continue to pay the Part B premium to Medicare. You do not pay Medicare's deductibles and coinsurance.

Usually there are no additional charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. You will get all of the Medicare hospital and medical benefits to which you are entitled through the plan, and, as a plan member, you would retain all of your Medicare protections and appeal rights.

Before joining a plan, ask whether the plan has a "risk" or a "cost" contract with Medicare. Plans with risk contracts have "lock-in" requirements. This means that you generally are locked into receiving all covered care from the doctors, hospitals and other health care providers who are affiliated with the plan. In most cases, if you go outside the plan for services, neither the plan nor Medicare will pay. You will be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which you may receive anywhere in the United States, and for urgently needed care, which you may receive while temporarily away from the plan's service area.

There is a third exception offered by a few risk plans. It is called the "point-of-service" (POS) option. Under the POS option, the plan permits you to receive certain services outside the plan's established provider network and the plan will pay a percentage of the charges. In return for this flexibility, you must pay a portion of the cost. Expect to pay at least 20 percent of the bill.

Unlike risk plans, cost plans do not have lock-in requirements. If you enroll in a cost plan, you can either go to health care providers affiliated with the plan or go outside the plan. If you go outside the plan, the plan probably will not pay but Medicare will. Medicare will pay its share of charges it approves. You will be responsible for Medicare's coinsurance, deductibles and other charges, just as if you were receiving care under the fee-for-service system. Because of this flexibility, a cost plan may be a good choice for you if you travel frequently, live in another state part of the year, or want to continue to use a doctor who is not affiliated with a plan.

While benefits vary from plan to plan, all plans that have either a risk or cost contract must provide all of the Medicare benefits generally available in the plan's service area. Whether you are entitled to Parts A and B, or Part B only, you can get all of your Medicare benefits through the plan. In addition to offering you all your Medicare benefits, many plans promote preventive health care by providing extra benefits such as eye examinations, hearing aids, check-ups, scheduled inoculations and prescription drugs for little or no extra fee.

Managed Care Plan Enrollment: Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll:

1. You must have Medicare Part B and continue paying Part B premiums.

2. You must live in the plan's service area.

3. You cannot be receiving care in a Medicare-certified hospice.

4. You cannot have permanent kidney failure at the time of enrollment.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Plans that contract with Medicare must have at least one 30-day open enrollment period each year.

The names of the plans in your area are available by calling your state insurance counseling office (see state-by-state listing beginning on page 27).

Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the type and extent of your coverage. If your area is served by more than one plan, compare the doctors' qualifications, facilities, premiums, and copayments to determine which plan best suits your needs at a price you can afford. Determine whether the plan's providers are in a location convenient to you and whether transportaion is available at all hours to get you to them. Also, carefully consider the advantages and disadvantages of enrolling in a plan if you travel a lot or live part of the year in another state.

Disenrollment: You can stay in a managed care plan as long as it has a Medicare contract or you can leave at any time to join another plan or return to fee-for-service Medicare. To end your enrollment, send a signed request to the plan or to your local Social Security Administration office or, if appropriate, the Railroad Retirement Board. You return to fee-for-service Medicare the first day of the next month. To change from one managed care plan to another, simply enroll in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

Should you enroll in a plan and later move out of the plan's service area, you will have to disenroll and either return to regular fee-for-service Medicare or enroll in a plan that serves your new location. Because each plan is different, your benefits and premiums probably will not be exactly the same if you enroll in another plan.

Managed Care Plans and Medigap: If you have a Medigap policy and decide to enroll in a managed care plan, you may either keep the policy or, if after deciding you like the plan, you may cancel it. You will generally not need a Medigap policy if you enroll in a Medicare managed care plan. Keeping it after you enroll means that you may be paying twice for the same coverage.

In fact, until recently, insurers would have been prohibited from selling you a policy because it would duplicate benefits you were getting through the plan. However, this is no longer true. Therefore, before you give up your Medigap policy or let a Medigap open enrollment period expire, you should take the following factors into account and also consider discussing your particular circumstances with your state insurance counseling office.

If you enroll in a plan with a risk contract, a Medigap policy will likely be of little or no value to you during the time you are enrolled. For example, a Medigap policy will not pay any copayments or premiums charged by the plan. If you go outside the plan for Medicare-covered services, neither Medicare nor the Medigap policy will pay for those services because you are enrolled in a Medicare risk plan. For services not covered by Medicare such as prescription drugs, many of the same benefits that would be covered under a Medigap policy will likely be available through the plan. A Medigap policy might be of value to you only if you left the plan for fee-for service Medicare. In returning to fee-for-service the Medigap policy of your choice may not be available to you if you have health problems.

If you enroll in a cost plan, it is advisable to get all services through the plan, since you may already be paying a premium and would probably incur only minimal copayments each time you used a service. However, if you expect to go outside the plan for services, a Medigap policy might cover the Medicare deductibles and coinsurance you will incur.

Group Insurance

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

Employer Group Insurance for Retirees. When they reach 65 many people still have private insurance through their or their spouse's current employer or union membership. If you have such coverage, find out if it can be continued after retirement. Check the price and the benefits, including benefits for your spouse.

Group health insurance that is continued after retirement usually has the advantage of having no

waiting periods or exclusions for pre-existing conditions, and the coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance protection.

Retirement plans provided by employers or unions are not subject to the rules that apply to Medigap policies. These plans have their own rules and might not fill the gaps in Medicare. Furthermore, they might not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. If you are uncertain how your plan works in conjunction with Medicare, get a copy of the benefits booklet or call the plan's benefit office and ask for an explanation of how the plan pays when you have Medicare. While the policy may not provide the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care.

Retiree Health Benefits and Medigap. Until recently, it was illegal for an insurer to sell you a Medigap policy if it would duplicate other benefits you had under another policy such as a retiree health plan. This is no longer true. You may now be sold a Medigap plan even if it duplicates your retiree health plan benefits, and the Medigap plan must pay full benefits even if the retiree plan also pays for the same service. Your retiree health plan may, however, contain a coordination of benefits clause. If it does, it will not pay duplicate benefits. You may want to consult your state insurance counseling program before purchasing a Medigap policy that would duplicate any of your retiree plan benefits.

Special Rules for Beneficiaries Aged 65 or Over Who Are Employed or the Spouse of an Employed Individual. If you are age 65 or over and you or your spouse works, Medicare may be the secondary payer to any group health plan (GHP) you have through an employer, if the employer has 20 or more employees. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses or denies a service entirely, Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer plan. This requirement applies to those who have employer group health plan coverage as an employee, employer, self-employed person, or a business associate of the employer. Employers with 20 or more employees must also offer the same health benefits, under the same conditions, to employees age 65 or over and to their spouses who are 65 or over, that they offer to younger employees and spouses.

You may accept or reject coverage under the employer group health plan. If you accept the employer plan, it will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, an employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care and physical check-ups. Bear in mind that if you elect to have Medicare as your primary payer and you enroll in Medicare Part B, your 6-month Medigap open enrollment period will be triggered.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary to large group health plan (LGHP) coverage for certain people under age 65 who are entitled to Medicare based on disability. In this instance an LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. The secondary payer requirement applies to employers, employees, and members of their families covered by a group health plan. It also applies to those who have GHP coverage as a self-employed person, business associate of an employer, or as a family member of one of these people. An LGHP must not treat any of these beneficiaries differently because they are disabled and have Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is the secondary payer to GHPs for 18 months for beneficiaries

who have Medicare because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under a GHP or are covered under a GHP as dependents. GHPs are primary payers during this period without regard to the size of the GHP, the number of employees, or whether the individual works.

The 18-month period begins with the earlier of:

- The first month in which the person becomes entitled to Medicare Part A based on permanent kidney failure; or
- The first month in which the person would have been entitled to Part A if he or she had filed an application for Medicare benefits.

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

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

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

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

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing home. Some of these policies also cover at home care, and others are available to pay for care in a skilled nursing facility (SNF) even if Medicare benefits are unavailable. Beginning in 1997 some types of long-term care insurance policies, referred to as " qualified long-term care insurance contracts," will provide federal income tax advantages. Contact your state insurance counseling office for details.

If you are shopping for nursing home or long-term care insurance, find out which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it either does not duplicate skilled nursing facility coverage provided by any Medigap policy, managed care plan, or other coverage you have, or pays benefits without respect to that other coverage.

It is important to remember that purely custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only nursing home care that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility (see page 4 for an explanation of the Medicare benefit for skilled nursing facility care).

For more information about long-term care insurance, request a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also obtain a copy of the *Guide to Choosing a Nursing Home* by writing to Medicare Publications, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed cash amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs associated with any of these specified diseases you may contract.

DO YOU NEED MORE INSURANCE?

Whether you need health insurance in addition to Medicare is a decision that only you can make. As you saw from the review of Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance can fill many of the gaps. But before buying insurance to supplement your Medicare benefits, make sure you need it. Not everyone does.

Medicaid Recipients

If you are eligible for full Medicaid benefits, you may not need more insurance. Medicaid is a joint federal and state program that provides medical assistance for certain individuals with low incomes and limited assets. While coverage and eligibility vary from state to state, most of your health care costs would be covered if you qualified for both Medicare and Medicaid. In addition to standard hospital and medical coverage, states provide Medicaid recipients with benefits such as nursing home care and outpatient prescription drugs.

Besides the standard Medicaid program, there are two other programs that help certain low-income Medicare beneficiaries pay their health care costs. One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program. While they do not necessarily eliminate the need for private insurance to supplement your Medicare benefits, they could save you hundreds of dollars each year if you qualify for assistance.

QMB: The QMB program pays all of Medicare's premiums, deductibles and coinsurance amounts for certain elderly and disabled persons who are entitled to Medicare Part A, whose annual income is at or below the national poverty level, and whose savings and other resources are very limited.

The QMB monthly income limits in 1996* were:

All states except Alaska and Hawaii:
$665 (individual) $884 (couple)
Alaska: $825 (individual) $1,099 (couple)
Hawaii: $763 (individual) $1,014 (couple)

In addition to the income limit, financial resources such as bank accounts, stocks and bonds cannot exceed $4,000 for one person or $6,000 for a couple.

SLMB: The SLMB program is for persons entitled to Medicare Part A whose incomes are slightly higher than the national poverty level. Your income cannot exceed the national poverty level by more than 20 percent.

The SLMB monthly income limits in 1996* were:

All states except Alaska and Hawaii:
$794 (individual) $1,057 (couple)
Alaska: $986 (individual) $1,314 (couple)
Hawaii: $912 (individual) $1,213 (couple)

If you qualify for assistance under the SLMB program, the state will pay your Medicare Part B premium. You will be responsible for Medicare's deductibles, coinsurance and other related charges.

* 1997 amounts will be announced in March 1997.

Contact your state or local Medicaid or social service office if you think you qualify for full Medicaid benefits, or for either the QMB or SLMB program. If you cannot find the number in the telephone directory, call **1-800-638-6833** for assistance.

Medicaid And Medigap Plans: If you are entitled to both Medicare and regular Medicaid benefits, an insurance company cannot sell you a Medigap policy unless the state pays the premiums for you. If you qualify for QMB assistance, an insurer may not sell you a Medigap policy unless it includes coverage for prescription drugs. If you qualify for the SLMB program, there are no special restrictions on selling you a Medigap policy other than the restrictions that apply to all Medigap sales.

If you should become eligible for any Medicaid benefits and have a Medigap policy purchased after November 4, 1991, you can suspend the Medigap premiums and benefits for up to two years while you are covered by Medicaid. Here's what you do:

- ☑ Notify your Medigap insurer within 90 days of becoming eligible for Medicaid. Both premiums and benefits will be suspended as of the date of notification.
- ☑ To resume coverage, ask the insurance company to reinstate the policy within 90 days of losing your Medicaid eligibility and begin paying premiums again. The policy must be reinstated as of the date on which you lost Medicaid eligibility.

You do not have to suspend your policy if you become eligible for Medicaid. Before you do it, discuss your options with your state Medicaid office.

Medicaid and Other Private Health Insurance: Medicaid will not pay if you have other insurance that will pay for benefits Medicaid would otherwise cover for you. Therefore, if you are considering buying a health insurance policy, you should check with the state Medicaid agency about how it would affect your Medicaid benefits, and with the state insurance counseling office about whether you will really benefit from having the policy.

Federally Qualified Health Center: Another way to limit your health care costs is to go to a federally qualified health center (FQHC) for the type of care generally provided in a doctor's office. Medicare pays for some health services that are not otherwise Medicare-covered services, such as preventive care services, when they are provided by an FQHC. These facilities are typically community health centers, Indian health clinics, migrant health centers and health centers for the homeless. They are generally located in inner-city and rural areas. The services covered by Medicare include:

- ☑ Routine physical examinations.
- ☑ Screening and diagnostic tests for the detection of vision and hearing problems, as well as other medical condtion.
- ☑ Administration of certain vaccines for immunization against influenza and other diseases.

When these services are furnished at an FQHC, the $100 annual Part B deductible does not apply. However, if other services are provided, such as X-rays or screening mammograms, the FQHC may bill the Medicare carrier. In that case, you would be responsible for any unmet portion of the Part B annual deductible of $100.

While the Part B 20 percent coinsurance applies to all FQHC services, Public Health Service guidelines allow FQHCs to waive it in some instances. Any Medicare beneficiary may go to an FQHC for health care services. To find out whether one of these centers serves your area, call **1-800-638-6833.**

TIPS ON SHOPPING FOR HEALTH INSURANCE

Whether you need more health insurance is a decision that only you can make. If you decide to buy more insurance, shop carefully and buy a policy that you can afford and offers the benefits you think you need most. Here are some helpful tips for you to keep in mind when shopping for health insurance.

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

Don't Buy More Policies Than You Need. Duplicate coverage can be expensive and generally is unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. Federal law prohibits an insurer from selling you a second Medigap policy unless you state in writing that you intend to cancel the first policy after the replacement policy goes into effect. Recent changes in the law affect beneficiaries who get help from the state through its Medicaid program in paying their health care costs (see page 23 for details). Anyone who sells you a policy in violation of the various anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call 1-800-638-6833 to report suspected violations.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work, joining a managed care plan, buying a Medigap policy, or buying a long-term care insurance policy.

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

If you have had a health problem, the insurer might not cover you for expenses connected with that problem. Medigap policies, however, are required to cover pre-existing conditions after the policy has been in effect for 6 months. Some companies have shorter waiting periods before covering a pre-existing condition.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another—you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them for a long time. If you decide to replace your Medigap policy, you must be given credit for the time spent under the old policy in determining whether and to what extent any pre-existing conditions restrictions apply under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy. You have 30 days to decide.

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

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

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

Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by private insurance companies but approval only means the company and policy meets requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that they are from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities.

This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to claim that a policy has been approved for sale in any state in which it has not received state approval or to use fraudulent means to gain approval.

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

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy. Principled sales people will not rush you. If you are not certain whether a policy is what you need, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy the Medigap policy of their choice without special conditions being imposed (see page 16). Once this open enrollment period ends, you may be limited as to the Medigap policies available to you, especially if you have a pre-existing health condition.

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

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

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

For Your Protection

As previously noted, federal criminal and civil penalties can be imposed against anyone who sells a Medigap or other health insurance policy in violation of the anti-duplication and other insurance laws. Penalties may also be imposed for claiming that a Medigap policy meets legal standards for federal certification when it does not, or for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received approval.

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

This law is aimed primarily at mass marketers that use this information on mail solicitations to imply that the product is either endorsed or is being sold by the U.S. government. The advertising literature is often designed to look like it came from a government agency. If you believe that you have been the victim of any unlawful insurance sales practices, contact your state insurance department immediately.

If you believe that federal law has been violated, you may call **1-800-638-6833.** In most cases, however, your state insurance department can offer the most assistance in resolving insurance-related problems.

Directory of State Insurance Departments and Agencies on Aging

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

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department Consumer Service Division 135 South Union St. P.O. Box 303351 Montgomery, AL 36130-3351 (334) 269-3550	**Alabama** 1-800-243-5463	Commission on Aging 770 Washington Ave., Suite 470 P.O. Box 301851 Montgomery, AL 36130 1-800-243-5463 (334) 242-5594
Division of Insurance 3601 "C" St., Suite 1324 Anchorage, AK 99503 (907) 269-7900	**Alaska** (907) 562-7249	Division of Senior Services 3601 "C" St., Suite 310 Anchorage, AK 99503 (907) 563-5654
Insurance Department Office of the Governor Pago Pago, AS 96799 011-684/633-4116	**American Samoa**	Territorial Admin. on Aging Government of American Samoa Pago Pago, AS 96799 (684) 633-1252
Insurance Department Consumer Affairs Division 2910 N. 44th St. Phoenix, AZ 85018 (602) 912-8444	**Arizona** 1-800-432-4040 (501) 371-2640	Dept. of Economic Security Aging & Adult Administration 1789 W. Jefferson St. Phoenix, AZ 85007 (602) 542-4446
Insurance Department Seniors Insurance Network 1123 S. University Avenue Suite 400 Little Rock, AR 72204 1-800-852-5494	**Arkansas** 1-800-852-5494 (501) 371-2640	Division of Aging and Adult Services 1417 Donaghey Plaza South P.O. Box 1437/Slot 1412 Little Rock, AR 72203-1437 (501) 682-2441
Insurance Department Consumer Services Div. 300 Capitol Mall Sacramento, CA 95814 (916) 445-5544	**California** 1-800-434-0222 (916) 323-7315	Department of Aging Health Insurance Counseling and Advocacy Branch 1600 K Street Sacramento, CA 95814 (916) 322-3887

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Division 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499, ext. 356	**Colorado** 1-800-544-9181 (303) 894-7499, ext. 356	Aging and Adult Services Dept. of Social Services 110 16th St., Suite 200 Denver, CO 80203-1714 (303) 620-4147
	Commonwealth of the Northern Mariana Islands	Department of Community and Cultural Affairs Civic Center Commonwealth of the Northern Mariana Islands Saipan, CM 96950 (607) 234-6011
Insurance Department P.O. Box 816 Hartford, CT 06142-0816 (203) 297-3800	**Connecticut** 1-800-994-9422	Commission on Aging 25 Sigourney Street Hartford, CT 06106-5033 (806) 424-5360
Insurance Department Rodney Building 841 Silver Lake Blvd. Dover, DE 19904 1-800-282-8611 (302) 739-4251	**Delaware** 1-800-336-9500	Services for Aging & Adults with Physical Disabilities Dept. of Health & Social Svcs. 1901 N. DuPont Highway 2nd Fl. Annex Admin. Bldg. New Castle, DE 19720 (302) 577-4791 1-800-223-9074
Insurance Department Consumer & Professional Services Bureau 441 4th Street, NW Suite 850 North Washington, D.C. 20001 (202) 727-8000	**District of Columbia** (202) 676-3900	Office on Aging 441 4th Street, NW 9th Floor Washington, D.C. 20001 (202) 724-5626 (202) 724-5622
	Federated States of Micronesia	State Agency on Aging Office of Health Services Federated States of Micronesia Ponape, E.C.I. 96941
Department of Insurance 200 E. Gaines Street Tallahassee, FL 32399-0300 (904) 922-3100	**Florida** 1-800-963-5337 (904) 414-2060	Department of Elder Affairs 4040 Esplanade Way Suite 260 Tallahassee, FL 32399-7000 (904) 414-2060

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 2 Martin L. King, Jr., Dr. 716 West Tower Atlanta, GA 30334 (404) 656-2056	**Georgia** 1-800-669-8387 (404) 657-5334	Division of Aging Services Dept. of Human Resources 2 Peachtree St., NW, Rm 18.403 Atlanta, GA 30303 (404) 657-5258
Insurance Division Department of Revenue & Taxation P.O. Box 23607 GMF Barrigada Guam 96921 011 (671) 475-5000	**Guam** (671) 475-0262/3	Division of Senior Citizens Dept. of Public Health and Social Services P.O. Box 2816 Agana, Guam 96910 011 (671) 475-0262/3
Dept. of Commerce and Consumer Affairs Insurance Division P.O. Box 3614 Honolulu, HI 96811 (808) 586-2790	**Hawaii** (808) 586-0100	Executive Office on Aging 250 S. Hotel St.. Suite 107 Honolulu, HI 96813 (808) 586-0100
Insurance Department SHIBA Program 700 W. State St., 3rd Fl. Boise, ID 83720-0043 (208) 334-4350	**Idaho** S.W. - 1-800-247-4422 N. - 1-800-488-5725 S.E. - 1-800-488-5764 C. - 1-800-488-5731	Office on Aging Statehouse, Room 108 Boise, ID 83720 (208) 334-3833
Insurance Department 320 W. Washington St. 4th Floor Springfield, IL 62767 (217) 782-4515	**Illinois** 1-800-548-9034 (217) 785-9021	Department on Aging 421 E. Capitol Ave., No. 100 Springfield, IL 62701-1789 1-800-252-8966
Insurance Department 311 W. Washington St. Suite 300 Indianapolis, IN 46204 1-800-622-4461 (317) 232-2395	**Indiana** 1-800-452-4800 (317) 233-3475 (317) 232-5299	Div. of Aging & Rehabililitative Services 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207-7083 1-800-545-7763 (317) 232-7020
Insurance Division Lucas State Office Bldg. E. 12th & Grand Sts. 6th Floor Des Moines, IA 50319 (515) 281-5705	**Iowa** 1-800-351-4664	Dept. of Elder Affairs 200 10th Street Third Floor Des Moines, IA 50309-3709 (515) 281-5187

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 420 S.W. 9th Street Topeka, KS 66612 1-800-432-2484 (913) 296-3071	**Kansas** 1-800-860-5260	Department on Aging 150-S. Docking State Office Building 915 S.W. Harrison Topeka, KS 66612-1500 (913) 296-4986
Insurance Department 215 W. Main Street P.O. Box 517 Frankfort, KY 40602 (502) 564-3630 1-800-595-6053	**Kentucky** 502-564-7372	Division of Aging Services Cabinet of Family & Children 275 E. Main St., Frankfort, KY 40621 (502) 564-7372
Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804-9214 1-800-259-5301 (504) 342-5301	**Louisiana** 1-800-259-5301 (504) 342-5301	Governor's Office of Elderly Affairs 4550 N. Boulevard P.O. Box 80374 Baton Rouge, LA 70806-0374 (504) 925-1700
Bureau of Insurance 34 State House Station Augusta, ME 04333 (207) 624-8475	**Maine** 1-800-750-5353 (207) 623-1797	Bureau of Elder and Adult Services State House, Station 11 Augusta, ME 04333 (207) 624-5335
Insurance Administration Complaints and Investigation Unit - Life & Health 501 St. Paul Place Baltimore, MD 21202-2272 (410) 333-2793 (410) 333-2770	**Maryland** 1-800-243-3425 (410) 767-1074	Office on Aging 301 W. Preston Street Room 1007 Baltimore, MD 21201 (410) 767-1074
Insurance Division Consumer Services Section 470 Atlantic Ave. Boston, MA 02210-2223 (617) 521-7777	**Massachusetts** 1-800-882-2003 (617) 727-7750	Executive Office of Elder Affairs 1 Ashburton Place, 5th Floor Boston, MA 02108 1-800-882-2003 (617) 727-7750
Insurance Bureau P.O. Box 30220 Lansing, MI 48909 (517) 373-0240 (General Assistance) (517) 335-1702 (Senior Issues)	**Michigan** 1-800-803-7174	Office of Services to the Aging 611 W. Ottawa Street P.O. Box 30026 Lansing, MI 48909 (517) 373-8230

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department Department of Commerce 133 E. 7th Street St. Paul, MN 55101-2362 (612) 296-4026	**Minnesota** 1-800-882-6262 (612) 296-2770	Board on Aging Human Services Building 4th Floor 444 Lafayette Road St. Paul, MN 55155-3843 (612) 296-2770
Insurance Department Consumer Assistance Division P.O. Box 79 Jackson, MS 39205 (601) 359-3569	**Mississippi** 1-800-948-3090	Div. of Aging & Adult Services 750 N. State Street Jackson, MS 39202 1-800-948-3090 (601) 359-4929
Department of Insurance Consumer Services Section P.O. Box 690 Jefferson City, MO 65102-0690 1-800-726-7390 (314) 751-2640	**Missouri** 1-800-390-3330 (573) 893-7900	Division of Aging Dept. of Social Services 615 Howerton Court Jefferson City, MO 65109-1337 1-800-285-5503 (573) 751-3082
Insurance Department 126 N. Sanders Mitchell Bldg., Rm. 270 P.O. Box 4009 Helena, MT 59601 (406) 444-2040	**Montana** 1-800-332-2272	Division.of Senior & Long-Term Care/DPHHS 48 N. Last Chance Gulch P.O. Box 4210 Helena, MT 59604-8005 1-800-332-2272 (406) 444-7781
Insurance Department Terminal Building 941 "O" St., Suite 400 Lincoln, NE 68508 (402) 471-2201	**Nebraska** (402) 471-2201	Department on Aging State Office Building 301 Centennial Mall South Lincoln, NE 68509-5044 1-800-942-7830 (402) 471-2306
Department of Business & Industry Division of Insurance 1665 Hot Springs Rd., Ste. 152 Carson City, NV 89710 1-800-992-0900 (702) 687-4270	**Nevada** 1-800-307-4444 (702) 486-4602	Dept. of Human Resources Division for Aging Services 340 N. 11th St., Suite 114 Las Vegas, NV 89101 1-800-243-3638 (702) 486-3545
Insurance Department Life and Health Division 169 Manchester St. Concord, NH 03301 1-800-852-3416 (603) 271-2261	**New Hampshire** 1-800-852-3388 (603) 225-9000	Dept. of Health & Human Services Div. of Elderly & Adult Services State Office Park South 115 Pleasant Street Annex Building No. 1 Concord, NH 03301 (603) 271-4680

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 20 West State Street Roebling Building CN 325 Trenton, NJ 08625 (609) 292-5363	**New Jersey** 1-800-792-8820	Health & Human Svcs. Div. Dept. of Senior Affairs 101 S. Broad Street CN 807 Trenton, NJ 08625-0807 1-800-792-8820 (609) 984-3951
Insurance Department P.O. Drawer 1269 Santa Fe, NM 87504-1269 (505) 827-4601	**New Mexico** 1-800-432-2080 (505) 827-7640	State Agency on Aging La Villa Rivera Bldg. 224 E. Palace Ave. Santa Fe, NM 87501 1-800-432-2080 (505) 827-7640
Insurance Department 160 West Broadway New York, NY 10013 (212) 602-0203 Outside of New York City 1-800-342-3736	**New York** 1-800-333-4114 (212) 869-3850 - NY City area	State Office for the Aging 2 Empire State Plaza Albany, NY 12223-0001 1-800-342-9871 (518) 474-9871
Insurance Department Seniors' Health Insurance Information Program (SHIIP) P.O. Box 26387 Raleigh, NC 27611 1-800-662-7777 (Consumer Services) (919) 733-0111 (SHIIP)	**North Carolina** 1-800-443-9354	Division of Aging 693 Palmer Drive Caller Box 29531 Raleigh, NC 27626-0531 (919) 733-3983
Insurance Department Senior Health Ins. Counseling 600 E. Boulevard Bismarck, ND 58505-0320 1-800-247-0560 (701) 328-2440	**North Dakota** 1-800-247-0560	Dept. of Human Services Aging Services Division P.O. Box 7070 Bismarck, ND 58507-7070 1-800-755-8521 (701) 328-8910
Insurance Department Consumer Services Division 2100 Stella Court Columbus, OH 43215-1067 1-800-686-1526 (614) 644-2673	**Ohio** 1-800-686-1578 (614) 644-3458	Department of Aging 50 W. Broad Street 9th Floor Columbus, OH 43215-5928 1-800-282-1206 (614) 466-1221

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department P.O. Box 53408 Oklahoma City, OK 73152 1-800-522-0071 (405) 521-2828	**Oklahoma** 1-800-763-2828 (405) 521-6628	Dept. of Human Services Aging Services Division 312 NE 28th Street Oklahoma City, OK 73125 (405) 521-2327
Dept. of Consumer & Business Services Senior Health Insurance Benefits Assistance 350 Winter St.,NE, Rm. 440 Salem, OR 97310 1-800-722-4134 (503) 378-4484	**Oregon** 1-800-722-4134 (503) 378-4636 ext. 600	Dept. of Human Resources Senior & Disabled Services Division 500 Summer St., NE, 2nd Floor Salem, OR 97310-1015 1-800-232-3020 (503) 945-5811
	Palau	State Agency on Aging Dept. of Social Services Republic of Palau Koror, Palau 96940
Insurance Department Consumer Services Bureau 1321 Strawberry Square Harrisburg, PA 17120 (717) 787-2317	**Pennsylvania** 1-800-783-7067	Department of Aging "Apprise" Health Insurance Counseling and Assistance 400 Market Street Rachel Carson State Ofc. Bldg. Harrisburg, PA 17101 1-800-783-7067
Office of the Commissioner of Insurance P.O. Box 8330 San Juan, PR 00910-8330 (809) 722-8686	**Puerto Rico** (809) 721-5710	Governor's Office of Elderly Affairs Gericulture Commission Box 11398 Santurce, PR 00910 (809) 722-2429
	Republic of the Marshall Islands	State Agency on Aging Dept. of Social Services Republic of the Marshall Islands Marjuro, Marshall Islands 96960
Insurance Division 233 Richmond St., Suite 233 Providence, RI 02903-4233 (401) 277-2223	**Rhode Island** 1-800-322-2880	Dept. of Elderly Affairs 160 Pine Street Providence, RI 02903 (401) 277-2880

Insurance Departments	Insurance Counseling	Agencies on Aging
Department of Insurance Consumer Services Section P.O. Box 100105 Columbia, SC 29202-3105 1-800-768-3467 (803) 737-6180	**South Carolina** 1-800-868-9095 (803) 737-7500	Division on Aging 202 Arbor Lake Drive Suite 301 Columbia, SC 29223-4554 (803) 737-7500
Insurance Department 500 E. Capitol Avenue Pierre, SD 57501-5070 (605) 773-3563	**South Dakota** 1-800-822-8804 (605) 773-3656	Office of Adult Services and Aging 700 Governors Drive Pierre, SD 57501-2291 (605) 773-3656
Dept. of Commerce & Insurance Insurance Assistance Office 4th Floor 500 James Robertson Pkwy. Nashville, TN 37243 1-800-525-2816 (615) 741-4955	**Tennessee** 1-800-525-2816	Commission on Aging Andrew Jackson Bldg., 9th Floor 500 Deaderick Street Nashville, TN 37243 (615) 741-2056
Department of Insurance Complaints Resolution, (MC 111-1A) 333 Guadalupe St. (78701) P.O. Box 149091 Austin, TX 78714-9091 1-800-252-3439 (512) 463-6515	**Texas** 1-800-252-3439	Department on Aging P.O. Box 12786 (78711) 1949 IH 35 South Austin, TX 78741 1-800-252-9240 (512) 424-6840
Insurance Department Consumer Services 3110 State Office Bldg. Salt Lake City, UT 84114-6901 1-800-439-3805 (801) 538-3805	**Utah** 1-800-439-3805 (801) 538-3910	Division of Aging and Adult Services 120 North 200 West Salt Lake City, UT 84103 (801) 538-3910
Dept. of Banking & Insurance Consumer Complaint Division 89 Main Street, Drawer 20 Montpelier, VT 05620-3101 (802) 828-3302	**Vermont** 1-800-642-5119 (802) 861-1577	Dept. of Aging & Disabilities Waterbury Complex 103 S. Main Street Waterbury, VT 05671-2301 (802) 241-2400

Insurance Departments	Insurance Counseling	Agencies on Aging
Bureau of Insurance 1300 E. Main Street Richmond, VA 23219 (804) 371-9691 1-800-552-7945	**Virginia** 1-800-552-3402	Dept. for the Aging 700 Centre, 10th Floor 700 E. Franklin Street Richmond, VA 23219-2327 1-800-552-3402 (804) 225-2271
Insurance Department Kongens Gade No. 18 St. Thomas, VI 00802 (809) 773-6449 ext. 248	**Virgin Islands** (809) 774-2991	Senior Citizen Affairs Div. Dept. of Human Services 19 Estate Diamond Fredericksted St. Croix, VI 00840 (809) 772-0930
Insurance Department 4224 6th Ave., SE, Bldg. 4 P.O. Box 40256 Lacey, WA 98504-0256 1-800-397-4422 (360) 407-0383	**Washington** 1-800-605-6299	Aging & Adult Services Admin. Dept. of Social & Health Services P.O. Box 45600 Olympia, WA 98504-5600 (360) 493-2500
Insurance Department Consumer Service 2019 Washington St., E P.O. Box 50540 Charleston, WV 25305-0540 (304) 558-3386 1-800-642-9004 1-800-435-7381 (hearing impaired)	**West Virginia** 1-800-642-9004 (304) 558-3317	Commission on Aging State Capitol Complex Holly Grove 1900 Kanawha Blvd., East Charleston, WV 25305-0160 (304) 558-3317
Insurance Department Complaints Department P.O. Box 7873 Madison, WI 53707 1-800-236-8517 (608) 266-0103	**Wisconsin** 1-800-242-1060	Board on Aging and Long-Term Care 214 N. Hamilton St. Madison, WI 53703 1-800-242-1060 (608) 266-8944
Insurance Department Herschler Building 122 W. 25th Street Cheyenne, WY 82002 1-800-438-5768 (307) 777-7401	**Wyoming** 1-800-856-4398 (307) 856-6880	Division on Aging Hathaway Building 2300 Capitol Ave., Room 139 Cheyenne, WY 82002 1-800-442-2766 (307) 777-7986

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Publication No. HCFA-02110
Revised December 1996