Wisconsin Guide to Health Insurance for People with Medicare

2012

For more information on health insurance call:
MEDIGAP HELPLINE
1-800-242-1060

This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

For information on how to file insurance complaints call:

INSURANCE COMPLAINT HOTLINE

(608) 266-0103 (Madison)
or
1-800-236-8517 (Statewide)

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

OCI's Web Page:
oci.wi.gov

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the Commissioner of Insurance . . .

Leading the way in

informing and protecting

the public

and

responding to their

insurance needs.

This guide is not a legal analysis of your rights under any insurance policy or government program. Your insurance policy, program rules, Wisconsin law, federal law, and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

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Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently than the hard copy versions to reflect any necessary changes. Visit OCI's Web site at **oci.wi.gov**.

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Introduction

This booklet briefly describes the Medicare program. It also describes the health insurance available to those on Medicare. A booklet entitled Medicare Supplement Insurance Approved Polices, which describes individual and group Medigap insurance policies currently sold in Wisconsin, may be obtained from:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Both booklets are available on our Web site at oci.wi.gov/pub_list.htm. Our Web site also includes information and booklets regarding other types of consumer insurance policies, including long term care insurance, life insurance, automobile, and homeowner's insurance. A list of consumer publications is also included at the back of this booklet.

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers, please contact:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103

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IMPORTANT NOTICE

The state of Wisconsin has received a waiver from the federal A-N standardization regulations on Medicare supplement insurance. This means that policies sold in Wisconsin are somewhat different from those available in other states. This booklet describes only those policies that are available in Wisconsin.

What is Medicare?

Remember, words in *italics* in the text are defined on pages 47 - 50.

Medicare is the health insurance program administered by the federal *Centers for Medicare & Medicaid Services (CMS)* for people 65 years of age or older, people of any age with permanent kidney failure, and some disabled individuals under age 65. Although Medicare may pay a large part of your health care expenses, it does not pay for them all. Some services and medical supplies are not fully covered. A handbook titled Medicare & You 2012 is available free from any Social Security office. The handbook provides a detailed explanation of Medicare.

Medicare is divided into four types of coverage, Part A, Part B, Part C, and Part D.

Medicare Part A

Medicare Part A is commonly known as hospitalization insurance. For most people, Part A is premium-free, meaning that you do not have a monthly payment for the coverage. It pays your hospital bills and certain skilled nursing facility expenses. It also provides very limited coverage for skilled nursing care after hospitalization, rehabilitative services, home health care, and hospice care for the terminally ill. It does not pay for personal (*custodial*) care, such as help with eating, dressing, or moving around. Under Medicare Part A, a period of hospitalization is called a *benefit period*. A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a nursing facility for 60 consecutive days. If you are re-admitted within that 60 days, you are still in the same benefit period and would not pay another *deductible*. If you are admitted to a hospital after that benefit period ends, an entirely new benefit period begins and a new deductible must be paid.

If you do not automatically get premium-free Medicare Part A, you may be able to buy it. For more information, visit www.ssa.gov or call Social Security at 1-800-772-1213.

Medicare Part B

Medicare Part B is commonly known as medical insurance. It helps pay your doctors' bills and certain other charges, such as surgical care, diagnostic tests and procedures, some hospital outpatient services, laboratory services, physical and occupational therapy, and *durable medical equipment*. It does not cover prescription drugs, dental care, physicals, or other services not related to treatment of illness or injury. The premium is automatically taken out of your Social Security check each month.

Medicare Part C

Medicare Part C is the Medicare program commonly known as Medicare Advantage that provides Medicare coverage through private insurance plans. Medicare Advantage plans provide the same coverage as Medicare and also provide supplemental health insurance coverage. You do not need to purchase a Medicare supplement policy if you enroll in a Medicare Advantage plan. However, Medicare Advantage plans may include deductibles and copayment and/or coinsurance amounts (out-of-pocket expenses) that do not apply to Wisconsin standardized Medicare supplement policies. You may also have to see doctors that belong to the plan or go to certain hospitals to get services. Additional information regarding these plans is available in our booklet, *Medicare Advantage in Wisconsin*.

Medicare Part D

Medicare Part D is the Medicare program created by the federal government to provide some assistance for Medicare beneficiaries to pay for outpatient prescription drug costs. It is an optional program available to Medicare beneficiaries eligible for Medicare Part A and/or enrolled in Medicare Part B.

Medicare Part D coverage is offered by approved Prescription Drug Plans (PDPs). Private companies that contract with Medicare, some of which may be insurance companies, will administer the PDP benefits. The cost of your Medicare Part D coverage will vary based on the PDP that you choose. PDP plans may have deductible, coinsurance and copayment amounts (out-of-pocket expenses) that must be met before the PDP pays for your outpatient prescription drug costs.

This booklet briefly describes the federal Medicare program and private Medicare supplement insurance as of January 1, 2012. The deductible amounts listed in the charts are for 2012 only.

What Are Specific Limitations Under Medicare?

Medicare was not designed to pay all your health care expenses. It does not cover long-term care expenses. Medicare provides limited coverage for skilled nursing care and for home health care. Medicare does not pay for personal care, such as eating, bathing, dressing, or getting into or out of bed. Most nursing home care is not covered by Medicare.

Skilled Nursing Care Limitations

Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as defined by Medicare. For more information, contact the Office of the Commissioner of Insurance and ask for the Guide to Long-Term Care.

Home Health Limitations

Medicare pays limited benefits for home health care services that are considered "*medically necessary*" by Medicare. For more information, contact the Office of the Commissioner of Insurance and ask for the Guide to Long-Term Care.

What Preventive Care Is Covered Under Medicare?

Medicare helps cover some preventive care services to help maintain your health and to keep certain illnesses from getting worse. **You may be required to pay a portion of the costs for these services.** Your Medicare handbook provides more details regarding these costs. Information regarding Medicare preventive services is available in your Medicare & You 2012 booklet.

What Does Accepting Assignment Mean?

Sometimes a doctor or other provider accepts "*assignment*." This means that the doctor or provider is paid directly by Medicare and accepts the "Medicare-*approved" amount*. The list of doctors accepting assignment may be reviewed at your local Social Security office.

A doctor or other provider who does not accept assignment can charge 15% over Medicare's approved amount. In this case, you are responsible not only for the usual 20% of the approved charge for the service, but also for 100% of the *excess charges*, which is the portion of the fee that exceeds the approved amount.

What Is Meant by Out-of-Pocket Expenses?

Out-of-pocket refers to costs, bills, fees, or expenses you will have to pay yourself. Out-of-pocket expenses occur when you receive a service not covered by Medicare, when you receive a service only partially covered by Medicare, or when you choose a provider whose fees exceed Medicare's approved amount. You will also have to pay out-of-pocket expenses to cover the Medicare *deductibles* and *copayments*. The amount of these expenses you pay out of pocket depends on whether you have insurance that supplements your Medicare coverage.

Your Part B Premium is Based on Your Income

As required in the federal Medicare Modernization Act of 2003 (MMA), single Medicare beneficiaries with annual incomes over $85,000 and married couples with incomes over $170,000 will pay a higher percentage of the cost of Medicare Part B coverage, reducing Medicare's share. These higher-income beneficiaries will pay a monthly premium equal to 35, 50, 65, or 80 percent of the average Part B costs, depending on their income level.

The 2012 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return [including those who are single, head of household, qualifying widow(er) with dependent child] or married filing separately who lived apart from their spouse for the entire taxable year, or married filing a joint tax return are:

Part B Income-Related Premium*

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly monthly amount
$85,000 or less	$170,000 or less	$0.00	$99.90
$85,001 to $107,000	$170,001 to $214,000	$40.00	$139.90
$107,001 to $160,000	$214,001 to $320,000	$99.90	$199.80
$160,001 to $214,000	$320,001 to $428,000	$159.80	$259.70
$214,001 or more	$428,001 or more	$219.80	$319.70

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are:

Beneficiaries who are married but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly monthly amount
$85,000 or less	$0	$99.90
$85,001 to $129,000	$159.80	$259.70
$129,001 or more	$219.80	$319.70

* Centers for Medicare and Medicaid Services.

Most people will continue to pay the same Part B premium they paid last year.

Medicare Hospital Insurance (Part A)

Covered services per calendar year for 2012

Service	Benefit	Medicare Pays	You Pay
Hospitalization Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	All but $1,156 per *benefit period*	$1,156 per benefit period
	Days 61 to 90	All but $289 a day	$289 a day
	Days 91 to 150	All but $578 a day	$578 a day
	Beyond 150 days	Nothing	All costs
Skilled nursing facility care* After a 3-day hospitalization in a facility approved by Medicare within 30 days of discharge	Days 1 to 20	100% of approved amount	Nothing
	Days 21 to 100	All but $144.50 a day	Up to $144.50 a day
	Beyond 100 days	Nothing	All costs
Home health care Medically necessary skilled care	Visits limited to part-time or intermittent nursing care	100% of approved amount for services; 80% of *approved amount* for durable medical equipment	Nothing for services; 20% of approved amount or durable medical equipment
Hospice care Available only to terminally ill	As long as doctor certifies medical need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost-sharing for outpatient drugs and inpatient respite care
Blood	Blood	All but first 3 pints per calendar year	First 3 pints

*Medicare does not pay for most nursing home care. You must pay for custodial care.

Source: Centers for Medicare & Medicaid Services

Medicare Medical Insurance (Part B)

Covered services per calendar year for 2012

Service	Benefit	Medicare Pays	You Pay
Medical expense Physicians' services, physical and speech therapy, durable medical equipment, ambulance, etc.	Reasonable and necessary services	80% of *approved amount* (after $140 *deductible*)	$140 deductible plus 20% of balance of approved amount (plus some excess charges above approved amount)
Clinical laboratory services	Blood tests, biopsies, urinalysis, etc.	100% of approved amount	Nothing
Some outpatient hospital services and community mental health center partial hospitalization	Unlimited if medically necessary. Emergency room visits, x-rays, stitches for cuts, getting a cast, etc.	A set amount based on prospective payment system (after $140 deductible)	$140 deductible plus a *coinsurance* or fixed *copayment* amount for each service based on prospective payment system
Blood	Blood	80% of approved amount (after $140 deductible, starting with the fourth pint)	First 3 pints plus 20% of approved amount (after $140 deductible)

*Medicare does not pay for most nursing home care. You must pay for *custodial care*.

Source: Centers for Medicare & Medicaid Services

What is Medicare Part D?

Medicare Part D is the program created by the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to provide some assistance for Medicare beneficiaries to pay for outpatient prescription drug costs. It is an optional program available to Medicare beneficiaries eligible for Medicare Part A and/or enrolled in Part B.

Medicare Part D

Medicare Part D includes an annual *open-enrollment period* of October 15 through December 7, during which you can enroll or choose to change to another Prescription Drug Plan (PDP). Your coverage will begin on January 1 of the following year. Individuals not yet on Medicare will be able to join a PDP whenever they become eligible for Medicare.

Enrollment in Medicare Part D is voluntary, and you are not required to participate. However, you may have to pay a penalty if you decide to sign up after your eligible enrollment period ends. Currently, the late enrollment penalty is equal to one percent of the base premium for every month that you waited to join. This penalty amount changes every year and you will have to pay it as long as you have Medicare prescription drug coverage.

Medicare Part D coverage will be offered by approved PDPs. The PDP benefits will be administered by private companies, some of which may be insurance companies. There are two types of Medicare prescription drug plans. One is a stand-alone prescription drug plan (PDP) which offers only prescription drug coverage. The other is a Medicare Advantage plan with prescription drugs (MA-PD) which provides all your Medicare-covered services and includes prescription drug coverage.

You should review your drug coverage during every annual *open-enrollment period* to make sure you still have the best plan for your prescription drug needs.

Premiums

The cost of your Medicare Part D coverage will vary based on the PDP that you choose. If you are not eligible for low-income assistance (referred to as Limited Income Subsidy), you will pay a monthly premium, an annual *deductible*, and a percentage of your drug costs. Your PDP will pay for your outpatient prescription drug expenses after you have met deductible and *coinsurance* amounts. Deductible

and coinsurance amounts are those expenses you must pay out of pocket before Medicare Part D will pay any money for your outpatient prescription drugs.

Coverage

The prescription drugs covered by your PDP will vary based on the plan that you choose. If you enroll in a Medicare Part D prescription drug plan, it is important that you understand that your PDP will pay for only those prescriptions in the PDP's *formulary*. A formulary is list of specific drugs a Medicare PDP will cover. Only the cost of drugs covered by your PDP will count toward the *deductible* and *out-of-pocket limits*. Outpatient prescription drug expenses not covered by the PDP or drugs covered by a drug discount card that you have will not count toward the out-of-pocket expense requirement of your PDP.

The Donut Hole

Medicare Part D PDPs have a coverage gap or "donut hole." A coverage gap means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay out-of-pocket all costs for your drugs while you are in the gap.

Beginning in 2011, if you reach the "donut hole" gap you may get a 50% discount on brand name prescription drugs when you buy them. There will be additional savings in the "donut hole" gap each year through 2020 when the "donut hole" is closed completely.

Out-of-Pocket Limit

Once you have reached your plan's out-of-pocket limit, you will have catastrophic coverage. Catastrophic coverage assures that once you have spent up your plan's out-of-pocket limit for covered drugs, you only pay a small *coinsurance* amount or *copayment* for the drug for the rest of the year.

Extra Help for People with Limited Income and Resources

If your income is low, you may qualify for Extra Help, also called Low Income Subsidy or LIS. This is a federal program that helps you pay for most of the costs of Medicare prescription drug coverage. If your income is below $16,425 ($21,855 for couples) and your resources are less than $13,070 ($26,100 for couples), you may qualify for Extra Help. The amount of assistance you qualify for will depend on your income.

You can apply for Extra Help to assist in paying for your Medicare prescription drug coverage through the Social Security Administration (SSA) by means of paper or online application. You can contact the SSA at www.ssa.gov or by phone at 1-800-772-1213. You also can apply for Extra Help at your local Medicaid office.

Tips to Remember

- Participation in the Medicare Part D program is voluntary.
- You do not have to pay an enrollment fee or pay for assistance to enroll in Medicare Part D.
- You will have to pay for Medicare Part D coverage, which may include monthly premiums and annual *deductibles*, *coinsurance* and *copayments*.
- You may be eligible for help to pay for your Medicare Part D prescription drug coverage based on your income.
- You do not have to enroll in Medicare Part D in order to keep your Medicare Part A and Part B coverage.
- You do not have to buy any additional insurance products to be eligible to enroll in Medicare Part D and should be wary of any individual who uses a Part D sales pitch to sell other insurance products.

Contacts

Information regarding Medicare Part D can be obtained from the Wisconsin Prescription Drug Helpline for Medicare Beneficiaries at 1-800-242-1060 (toll-free). Contact information is also included on pages 44-46 of this booklet. (Updated 05/2012)

Coverage Options Available When You Are Eligible for Medicare

Finding the right coverage at an affordable price may be difficult as no one policy is right for everyone. Coverage options include:

- Group insurance, including
  - Employer group plans
  - Association group plans
- Individual Medicare supplement policies
- Individual Medicare cost-sharing policies
- Individual *managed care* Medicare supplement policies, including
  - Medicare select policies
  - Medicare cost policies
- Medicare Advantage (formerly called Medicare+Choice plans), including
  - Medicare *managed care* plans
  - Medicare preferred provider organization plans (PPO)
  - Medicare private fee-for-service plans (PFFS)

There are many options available under employer groups, retirement groups, and voluntary association plans. This booklet focuses on the coverage options available under individual Medicare supplement insurance policies, Medicare select insurance policies, Medicare cost insurance policies, Medicare cost-sharing policies, and Medicare Advantage plans.

Before you decide to purchase a policy to help fill Medicare gaps, you need to familiarize yourself with Medicare options, benefits, and rules.

The *Centers for Medicare and Medicaid Services (CMS)*, which administers the Medicare Program, produces several guides, all of which are free and can be obtained by writing to CMS or contacting 1-800-MEDICARE (1-800-633-4227) or www.medicare.gov.

Group Insurance Options

If you are covered under an employer group plan, you may still be eligible for coverage after you reach age 65 either as an active employee or as a retiree. You may also be eligible to purchase coverage through a voluntary association.

Employer Group Plans

If you are currently covered under an employer's group insurance plan, you should determine whether you have the option of continuing coverage or converting to suitable coverage to supplement Medicare before you decide to retire, become eligible for Medicare, or reach age 65. State and federal laws require many employers to offer continued health insurance benefits for a limited period of time if your group coverage ends because of divorce, death of a spouse, or termination of employment for reasons other than discharge for misconduct. You should check with your employer for more information.

If either you or your spouse plan to continue working after age 65, you need to take extra care in making insurance decisions. Your group insurance plan may not provide the same coverage you received prior to your 65th birthday.

Federal law determines when Medicare is *primary payer* and when it is *secondary payer*. This determination is based on whether you are defined as the employee or dependent under the group insurance policy, and on whether the group insurance policy is offered by an employer with 20 or more employees. You should submit a written request to your insurance company regarding the benefits you will have under the group insurance policy after you or your spouse become eligible for Medicare.

If you continue to work past age 65 and your employer has at least 20 employees, your group plan will be primary payer over Medicare. If you are 65, retired, covered under your employed spouse's group plan, and your spouses's employer has at least 20 employees, the group plan will be primary payer.

If you continue to work past age 65 but your employer has fewer than 20 employees, Medicare is primary and your group policy is secondary payer. If you don't enroll in Medicare Part B, your group policy may pay only the 20% and you will be responsible for paying the 80%. This is because your group policy may calculate its benefit payment as if you were covered by Medicare regardless of whether you sign up for Medicare part B. If your spouse is covered under your employer plan

and becomes eligible for Medicare because of disability or retirement, your group policy may change to paying only 20% because Medicare is primary as soon as your spouse becomes eligible for Medicare.

You should contact your local Social Security office for information on Medicare and Other Health Benefits: Your Guide to Who Pays First. You may view this publication on-line at www.medicare.gov and click on Resource Locator and then Publications; enter the CMS publication number 02179.

Your employer may offer a supplement to Medicare through a group retiree plan.

Remember: Employer group coverage is often available regardless of your health and usually does not include any *waiting periods* for *preexisting conditions*.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is the law that allows some people to keep their group health coverage for a limited period of time after they leave their employment. However, there are important time frames that affect COBRA coverage when you are eligible for Medicare and Medicare supplement policies.

Special Enrollment

If you elect to get COBRA coverage when your employer coverage ends, you should enroll in Medicare Part B at the same time because you will not get another special *enrollment period*. The special enrollment period means you have to sign up for Medicare Part B within eight months after your group health plan coverage ends.

If you are age 65 or older and are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. The best time to sign up for Medicare Part B is before your employment ends or you lose your employer's coverage. If you wait to sign up for Medicare Part B during the eight months after your employment or coverage ends, your employer may make you pay for services that Medicare would have paid for if you had signed up earlier.

If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if your first Medicare enrollment is after the date you elected COBRA coverage.

Additional information regarding COBRA coverage and Medicare Part B is available in the booklet Medicare & You, available at your Social Security office or go to the Medicare Web site www.medicare.gov and click on Medicare & You 2012 Handbook.

Voluntary Associations Plans

If you do not have adequate group insurance, you may want to apply for a voluntary association plan. Many associations offer group health insurance coverage to their members. Association plans are not necessarily less expensive than comparable coverage under an individual policy. Be sure you understand the benefits included and then compare prices. Association groups that offer Medicare supplement insurance must comply with the same rules that apply to other Medicare supplement policies.

Individual Policy Options

Many insurance companies offer to individuals eligible for Medicare individual policies that supplement the benefits available under Medicare. These policies are referred to as Medicare supplement or Medigap policies.

The federal government has expanded the options available to include *managed care* plans that require that you see only *network* providers to receive optimum benefits, and plans whereby the insurance company agrees to provide all Medicare benefits.

What are Medicare Supplement Policies?

Medicare supplement policies provide coverage for some of the costs not covered by Medicare Part A and Medicare Part B.

Medicare was never intended to pay 100% of your medical bills, but instead was created to offset your most pressing medical expenses by providing a basic foundation of benefits. Thus, while it will pay a significant portion of your medical bills, Medicare does not cover all services that you might need. Even those services that are covered are not covered in full. Medicare requires that you pay *deductibles*, and pays many Part B expenses at 80% of the Medicare *approved amount*. Insurance companies sell policies that pay some of these expenses if you are enrolled in both Part A and Part B of Medicare. These policies are referred to as "Medicare supplement" or "*Medigap*" policies and provide a way to fill the coverage gaps left by Medicare. You are automatically eligible for individual Medigap coverage for six months starting with the first day you are enrolled in Medicare Part B, regardless of your health history.

Outline of Coverage

The Outline of Coverage is a summary of benefits for Medicare Parts A and B and the benefits provided by the Medigap policy. The outline includes a chart showing the expenses that are both covered and not covered by either Medicare or the Medigap policy. An agent or insurance company must give you an Outline of Coverage when selling you a new policy or replacing one you already own.

Medicare Supplement Policies

Individual Medicare supplement policies are designed to supplement the benefits available under the original Medicare program. Medicare supplement policies pay the 20% of Medicare-*approved charges* that Medicare does not pay. These Medicare

supplement policies do not restrict your ability to receive services from the doctor of your choice. However, these policies may require that you submit your claim to the insurance company for payment.

Individual Medicare supplement policies include a basic core of benefits. In addition to the basic benefits, Medicare supplement insurance companies offer specified optional benefits. Each of the options that an insurance company offers must be priced and sold separately from the basic policy.

Some insurance companies offer Medicare supplement or Medicare select cost-sharing policies. These plans require that you pay a portion of the costs for Medicare-covered services until you reach an out-of-pocket limit. For 2012, the out-of-pocket limit for 25% cost-sharing plans is $2,330, and the out-of-pocket limit for 50% cost-sharing plans is $4,660. The out-of-pocket limits for Medicare suppplement or Medicare select cost-sharing policies are updated each year and are based on estimates of the United States Per Capital Costs (USPCC) of the Medicare program published by CMS. The cost-sharing and out-of-pocket expenses would ordinarily be paid by the policy.

Medicare Select Policies

Medicare select policies are supplemental policies that pay benefits only if covered services are obtained through network medical providers selected by the insurance company or HMO. Each insurance company that offers a Medicare select policy contracts with its own *network* of doctors or other providers to provide services. Each of these insurance companies has a provider directory that lists the doctors and other providers with whom they have contracts.

If you buy a Medicare select policy, each time you receive covered services from a plan provider, Medicare pays its share of the *approved charges* and the insurance company pays the full supplemental benefits provided for in the policy. Medicare select insurers must pay supplemental benefits for emergency health care furnished by providers outside the plan provider network.

In general, Medicare select policies deny payment or pay less than the full benefit if you go outside the network for nonemergency services. However, Medicare still pays its share of approved charges if the services you receive outside the network are services covered by Medicare.

Medicare Cost Policies

Medicare cost policies are offered by certain HMOs that have entered into a special arrangement with the federal *Centers for Medicare & Medicaid (CMS)*. You must live in the plan's geographic *service area* to apply for Medicare cost insurance. The HMO plan doctors or other providers are selected by the HMO. The HMOs agree to provide Medicare benefits and may provide additional benefits at additional cost. Medicare cost insurance will only pay full supplemental benefits if covered services are obtained through HMO plan doctors or other providers, called the plan's "network."

If you purchase a Medicare cost policy, Medicare pays its share of approved charges if you receive services from outside the plan's network area. **However, if you go to a doctor or other provider who does not belong to your HMO without a referral from your HMO doctor, you will pay for all Medicare deductibles and copayments. The HMO will not provide supplemental benefits.**

Insurers that market Medicare cost policies offer both basic Medicare cost policies and enhanced Medicare cost policies. The basic Medicare cost policies supplement only those benefits covered by Medicare and do not provide the benefits mandated under Wisconsin insurance law.

Medicare Advantage Plans (Medicare Part C)

Medicare Advantage plans (formerly known as Medicare+Choice plans) are offered by certain HMOs and insurance companies that have entered into special arrangements with the federal *Centers for Medicare & Medicaid Services (CMS)*. Under these arrangements the federal government pays the HMO or insurance company a set amount for each Medicare enrollee. The HMO or insurance company agrees to provide Medicare benefits and may provide some additional benefits, which may be at an additional cost.

Your Medicare Advantage plan can terminate at the end of the contract year if either the plan or CMS decides to terminate their agreement.

Medicare Advantage plans may include *deductibles* and *copayment*/*coinsurance* amounts (out-of-pocket expenses) that do not apply to Wisconsin standardized Medicare supplement policies.

Medicare Advantage plans are not regulated by the state of Wisconsin Office of the Commissioner of Insurance. Therefore, these plans are **NOT** required to cover Wisconsin mandated benefits, nor are the plans *guaranteed renewable* for life like

Medicare supplement policies. Information regarding benefits mandated by Wisconsin insurance laws is available on pages 25-26 of this booklet or by contacting OCI at oci.wi.gov or the phone numbers listed on page 44 of this booklet.

You can obtain more information by requesting a copy of OCI's booklet, Medicare Advantage in Wisconsin. You may also call CMS at 1-800-MEDICARE (1-800-633-4227) or (312) 353-7180 for information.

Medicare Advantage Health Maintenance Organization Plans

If you enroll in a Medicare Advantage plan through a health maintenance organization (HMO) that has contracted with CMS, you are required to seek care from plan providers. This means that, except for emergency or urgent care situations away from home, you must receive all services from HMO-contracted medical providers. If you go to a doctor or other provider who does not have a contract with your HMO without a *referral* from your doctor, you will be responsible for the entire cost of the services you receive, **including Medicare costs.** To be eligible for a Medicare Advantage plan through an HMO, you must live in the HMO's geographic *service area*.

Medicare Advantage Preferred Provider Organization Plans

You may also enroll in a Medicare Advantage plan through an insurance company with a preferred provider organization plan (PPO) that has entered into a contract with CMS. **In order to receive full coverage under the PPO option, you must receive all services, except for emergency or urgent care situations away from home, from plan providers.** However, you may receive services from providers outside the plan at an additional cost.

Medicare Advantage Private Fee-For-Service Plans

Medicare Advantage private fee-for-service (PFFS) plans differ from Medicare Advantage HMO and PPO plans because they allow you to go to any doctor, hospital, or health care provider that agrees to accept the PFFS plan's terms of payment. PFFS plans do not have contracts with doctors, hospitals, or health care providers. You do not have to obtain a referral from the plan to go to a doctor, hospital, or specialist of your choice. **However, it is your responsibility to verify that the doctor or other provider is willing to accept the PFFS plan's payment terms.** Doctors and other providers can stop accepting the Medicare Advantage PFFS plan's terms and reimbursement rates at any time they choose.

Basic Benefits Included in Medicare Supplement Policies

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

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

Optional Riders
Insurance companies are allowed to offer these seven riders to a Medicare supplement policy. • Medicare Part A *Deductible* • Medicare 50% Part A Deductible (effective June 1, 2010) • Additional Home Health Care (365 visits including those paid by Medicare) • Medicare Part B Deductible • Medicare Part B *Copayment* or Coinsurance (effective June 1, 2010) • Medicare Part B *Excess Charges* • Foreign Travel Emergency

Basic Benefits Included in Medicare Select Policies

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

Medigap Benefits	Basic Plan
Basic Benefits	√
Medicare Part A Deductible	√
Medicare Part A: Skilled Nursing Facility Coinsurance	√
Inpatient Mental Health Coverage	175 days per lifetime in addition to Medicare
Home Health Care	365 visits in including those paid by Medicare
Medicare Part B: Deductible	√
Medicare Part B: Coinsurance	√
Other Wisconsin Mandated Benefits	√
Outpatient Mental Health	√
Foreign Travel Emergency	√

What Are Wisconsin Mandated Benefits?

Wisconsin insurance law requires that individual Medicare supplement policies, Medicare select policies, and some Medicare cost policies contain the following "mandated" benefits. These benefits are available even when Medicare does not cover these expenses. **Medicare Advantage plans are NOT required to provide these benefits.**

Skilled Nursing Facilities—Medicare supplement and Medicare select policies cover 30 days of skilled nursing care in a skilled nursing facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care. No prior hospitalization may be required. The facility must be a licensed skilled care nursing facility. The care also must meet the insurance company's standards as *medically necessary*.

Home Health Care—Medicare supplement and Medicare select policies cover up to 40 home care visits per year in addition to those provided by Medicare, **if you qualify.** Your doctor must certify that you would need to be in the hospital or a skilled nursing home if the home care was not available to you. Home nursing and medically necessary home health aide services are covered on a part-time or intermittent basis, along with physical, respiratory, occupational, or speech therapy.

Medicare supplement insurance companies are required to offer coverage for 365 home health care visits in a policy year. Insurance companies may charge an additional premium for the additional coverage. Medicare provides coverage for all medically necessary home health visits. However, "medically necessary" is defined quite narrowly, and you must meet certain other criteria.

Kidney Disease—Medicare supplement and Medicare select policies cover inpatient and outpatient expense for dialysis, transplantation, or donor-related services of kidney disease up to $30,000 in any calendar year. Policies are not required to duplicate Medicare payments for kidney disease treatment.

Diabetes Treatment—Medicare supplement and Medicare select policies cover the *usual and customary expenses* incurred for the installation and use of an insulin infusion pump or other equipment or non-prescription supplies for the treatment of diabetes. Self-management services are also considered a covered expense. This benefit is available even if Medicare does not cover the claim.

Medicare supplement and Medicare select policies issued prior to January 1, 2006, for individuals who do not enroll in Medicare Part D cover prescription medication,

insulin, and supplies associated with the injection of insulin. Prescription drug expenses are subject to the $6,250 *deductible* for drug charges. This deductible does not apply to insulin.

Medicare supplement and Medicare select policies **issued beginning January 1, 2006,** do not cover prescription medication, insulin, and supplies associated with the injection of insulin as policies are prohibited from duplicating coverage available under the Medicare Part D**.**

Chiropractic Care—Medigap policies cover the *usual and customary expense* for services provided by a chiropractor under the scope of the chiropractor's license. This benefit is available even if Medicare does not cover the claim.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care—Medicare supplement and Medicare select policies cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care for an individual with a chronic disability or an individual with a medical condition that requires hospitalization or general anesthesia for dental care.

Breast Reconstruction—Medicare supplement and Medicare select policies cover breast reconstruction of the affected tissue incident to a mastectomy.

Colorectal Cancer Screening—Medicare supplement and Medicare select policies issued or renewed after December 1, 2010, cover colorectal cancer examinations and laboratory tests. Coverage is subject to any cost-sharing provisions, limitations, or exclusions that apply to other coverage under the policy.

Coverage of Certain Health Care Costs in Cancer Clinical Trials—Medicare supplement and Medicare select policies issued or renewed beginning November 1, 2006, cover certain services, items, or drugs administered in cancer clinical trials in certain situations. The coverage is subject to all terms, conditions, and restrictions that apply to other coverage under the policy, including the treatment under the policy of services performed by participating and nonparticipating providers.

Catastrophic Prescription Drugs—Medicare supplement and Medicare select policies issued prior to January 1, 2006, to Medicare beneficiaries who do not enroll in Medicare Part D cover at least 80% of the charges for outpatient prescription drugs after a drug *deductible* of no more than $6,250 per calendar year. Medigap policies issued beginning January 1, 2006, and after will not include catastrophic prescription drug coverage as these policies are not allowed to duplicate benefits available under Medicare Part D. This coverage does not qualify as Medicare Part D *creditable coverage*.

Basic Facts About Medicare Supplement Policies

Open Enrollment

Medicare supplement and Medicare select insurance companies must make coverage available to you, regardless of your age, for six months beginning with the date you enroll in Medicare Part B. This six-month period is called the ***open-enrollment period***. Insurance companies may not deny or condition the issuance of a policy on your health status, claims experience, receipt of health care, or medical condition. The policy may still have *waiting periods* before *preexisting health conditions* are covered. In addition, if you are under age 65 and enrolled in Medicare due to disability or end stage renal disease, you are entitled to another six-month open-enrollment period upon reaching age 65.

Medicare cost and Medicare Advantage insurance plans accept applicants who live in the plan's geographic *service area*, have Medicare Part A and Part B, and do not have permanent kidney failure.

Guaranteed Issue

In addition to the open-enrollment period, in some situations you have the right to enroll in a Medicare supplement or Medicare select policy regardless of your health status if your other health coverage terminates. The insurance company must offer you one of these Medigap policies if:

- Your Medicare Advantage or Medicare cost plan stops participating in Medicare or providing care in your service area; or
- You move outside the plan's geographic service area; or
- You leave the health plan because it failed to meet its contract obligations to you; or
- Your employer group health plan ends some or all of your coverage; or
- You terminate your employer group plan to join a Medicare Advantage plan but leave the Medicare Advantage plan within 12 months of enrollment.
- Your Medicare supplement insurance company ends your Medigap or Medicare select policy and you're not at fault (for example, the company goes bankrupt); or

- You drop your Medigap policy to join a Medicare Advantage plan, a Medicare cost plan, or buy a Medicare select policy for the first time, and then leave the plan or policy within one year after joining. However, you may only return to the policy under which you were originally covered, if available; or

- You join a Medicare Advantage plan or a Medicare cost plan when you first become eligible for Medicare Parts A and B at age 65 and within one year of joining, you decide to leave the health plan; or

- You have Medicare Parts A and B and are covered under Medical Assistance and lose eligibility in Medical Assistance.

- Your employer group plan increases your cost from one 12-month period to the next by more than 25% and the new payment for the employer-sponsored coverage is greater than the premium charged under the Medicare supplement plan the individual is applying for.

If you qualify for a guaranteed issue plan, you must apply for your new Medigap policy no later than 63 calendar days after your health plan or policy ends, the Medigap insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (such as a *waiting period*),

- Must cover you for all *preexisting conditions*, and

- Cannot charge you more for a policy because of past or present health problems.

If your policy was terminated, the insurance company must provide a notification that explains individual rights to guaranteed issue of Medigap policies. You must submit a copy of this notice (*creditable coverage*) or other evidence of termination with the application for the new policy.

Suspension of Medigap Policy

Medicare supplement and Medicare select policies must allow Medicare beneficiaries with coverage due to disability the right to suspend their Medigap coverage when they have employer group health plan coverage. This option was created by federal law and is referred to as a Ticket to Work provision. If you are an under age 65 Medicare beneficiary with Medigap coverage and you want to suspend your Medigap

policy, you can do so by calling your Medigap insurance company. If you later lose your employer group health plan coverage, you can contact the Medigap insurance company within 90 days of losing your employer coverage and get your Medigap policy back.

30-day Free Look

All Medicare supplement and Medicare select insurance policies sold in Wisconsin have a 30-day *free look period*. If you are dissatisfied with a policy, you may return it to the insurance company within 30 days and get a full refund if no claims have been made. You should use the time to make sure the policy offers the benefits you expected. Check your application for accuracy and check the policy for any limitations, exclusions, or waiting periods.

Renewability

All Medicare supplement and Medicare select policies sold today must be *guaranteed renewable* for life. This means that you can keep the policy as long as you pay the premium. **It does not mean that the insurance company cannot raise the premium.** Policies that are guaranteed renewable offer added protection. Be sure to ask the insurance agent or company about the renewability of the policy.

Medicare Advantage plans are not guaranteed renewable. Medicare Advantage plans are a special arrangement between federal CMS and certain HMOs or insurance companies. CMS, HMOs, or insurance companies may choose to terminate plans at the end of any calendar year.

Midterm Cancellation

All Medicare supplement and Medicare select policies include the right to a pro rata refund of premium if you want to cancel a policy before the end of a term. All you need to do is to send your Medicare supplement or Medicare select policy to the insurance company with a letter requesting cancellation. The right to midterm cancellation does not apply to Medicare cost or Medicare Advantage plans.

Waiting Periods, Limitations, and Exclusions

Many Medicare supplement insurance policies have *waiting periods* before coverage begins. If your policy excludes coverage for preexisting conditions for a limited time, it must provide this information on the first page of the policy. The waiting period

for *preexisting conditions* may not be longer than **six months**, and only conditions treated during the six months before the effective date of the policy may be excluded.

Insurance companies are required to waive any waiting periods for preexisting conditions if you buy a Medicare supplement policy during the *open-enrollment period* and have been continuously covered with *creditable coverage* for at least six months prior to applying for the Medicare supplement policy. Insurance companies are also required to waive any waiting periods for preexisting conditions when one Medicare supplement policy is replaced with another.

Creditable Coverage

Health Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health insurance issuers, group health plans and/or employers issue a HIPAA certificate of *creditable coverage* when your health coverage ends. The certificate indicates the date on which your coverage ends and how long you had the coverage. You should retain this document for your records because the certificate provides evidence of your prior coverage. If certain conditions are met, evidence of prior coverage may entitle you to a reduction or total elimination of a preexisting condition exclusion period under subsequent health benefits coverage you may obtain. CMS does not request or require a copy of this HIPAA certificate of creditable coverage. Therefore, you should not be instructed to send the certificate to CMS. For more information on HIPAA, go to www.cms.hhs.gov/HealthInsReformforConsume/.

Prescription Drug Creditable Coverage

The Medicare Modernization Act (MMA) imposes a late enrollment penalty if you do not maintain creditable drug coverage (coverage that is at least as good as Part D coverage) for a period of 63 days or longer following your initial enrollment period for the Medicare prescription drug benefit. MMA mandates that certain entities offering prescription drug coverage disclose to all Medicare eligible individuals with prescription drug coverage whether such coverage is creditable. You should retain this document for your records. *CMS* does not request or require a copy of this creditable coverage documentation. Therefore, you should not be instructed to send the certificate to CMS. For more information on creditable coverage as it relates to Part D, go to www.cms.hhs.gov/CreditableCoverage/01_Overview.asp.

Common Exclusions

No insurance policy will cover everything that is not covered by Medicare. Medicare excludes certain types of medical expenses. So do many Medicare supplement, Medicare select, Medicare cost policies, and Medicare Advantage plans.

Some services that are frequently excluded under these policies are:

- *custodial care* in nursing homes,
- private duty nursing,
- routine check-ups,
- eye glasses,
- hearing aids,
- dental work,
- cosmetic surgery, and
- prescription drugs.

Medigap policies include two other exclusions that are frequently misunderstood:

1. **Approved Charges—**Medicare pays only for charges that are considered reasonable and services that are considered necessary. Medicare's determination of a reasonable or "*approved" charge* may be much less than the *actual charge* for a covered service. For example:

Doctor's bill	$115
Medicare-approved	100
Medicare pays (80% coinsurance)	80

   In the example above, Medicare pays 80% of the approved charge ($80). Medicare supplement policies pay only the 20% difference between what Medicare approves and what Medicare pays ($20). If your doctor accepts *assignment*, you will not be charged the difference between what Medicare approves and the doctor's bill. Otherwise, you will be responsible for that portion of the bill. If you have the Medicare Part B *Excess Charges* Rider, the policy will pay the difference between what Medicare approves and the doctor's charge.

   Medicare select and Medicare cost policies cover the entire charge for covered services if you use doctors and hospitals connected to the plan. Medicare Advantage plans may charge a *copayment* for doctor office and emergency room visits.

2. **Custodial Care—**Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare **if your doctor certifies that it is necessary and you meet certain other criteria.** There are **no** benefits for *custodial care*. In general, Medicare supplement, Medicare select, Medicare cost, and Medicare Advantage plans cover only skilled care, and do not cover custodial or intermediate care. Skilled nursing care is quite narrowly defined.

Your Grievance and Appeal Rights

Grievance Procedure

If you have a complaint or question, you may wish to first contact your insurance company. Many complaints can be resolved quickly and require no further action. However, you do not have to file a complaint with your insurance company before you file a complaint with the appropriate state agency.

Medigap insurance companies are required to have an internal *grievance* procedure to resolve issues involving Wisconsin mandated benefits. If you are not satisfied with the service you receive, your insurance company must provide you with complete and understandable information about how to use the grievance procedure. You have the right to participate in the grievance committee's meeting and present additional information.

Insurance companies are required to have a separate expedited grievance procedure for situations where your medical condition might require immediate medical attention.

Medigap insurance companies are required to file a report with OCI listing the number of grievances they had in the previous year.

Benefit Appeal

If you are not satisfied with the denial of a benefit by your Medigap insurance company, you may appeal the decision. The insurance company must offer you the opportunity to submit a written request that the insurance company review the denial of benefits. Your policy or group insurance certificate and Outline of Coverage describe the benefit appeal procedure. If the insurance company denies any benefit under your Medigap policy, the insurance company must, at the time of denial, provide you with a written description of its appeal process.

Independent Review

For Wisconsin mandated benefits under Medicare supplement policies, if you are not satisfied with the outcome of a *grievance*, and the grievance involves a dispute regarding medical necessity or experimental treatment, you or your authorized representative may request that an independent review organization (IRO) review your insurance company's decision. The independent review process provides you with an opportunity to have medical professionals who have no connection to the

insurance company review the dispute. The IRO has the authority to determine whether the treatment should be covered by the insurance company.

Your insurance company will provide you with information on the availability of this process whenever it makes a determination that is eligible for the independent review process. Information regarding the IRO process is also available on OCI's Web site, oci.wi.gov/company/iro.htm.

Prescription Drug Discount Options

In Wisconsin, Medicare beneficiaries have access to discounted drugs through the SeniorCare program and can obtain discounted drugs through drug manufacturers, the Internet, and mail-order pharmacies.

SeniorCare Prescription Drug Assistance Program

The Wisconsin legislature created the SeniorCare prescription drug assistance program for residents age 65 years of age or older and who meet certain requirements. SeniorCare is designed to make prescription drugs more affordable and to make it easier to obtain needed prescription medications.

SeniorCare's eligibility requirements include:

1. Must be a Wisconsin resident.

2. Must be 65 years of age or older.

3. Must pay a $30 annual enrollment fee per person.

4. Only income is measured. Assets, such as bank accounts, insurance policies, home, property, etc., are not counted.

Under SeniorCare, you will need to pay *out-of-pocket* expenses depending on your annual income. There are different expense requirements and benefits based on your income and your spouse's income if your spouse lives with you.

If you think you might be eligible, contact your county or tribal aging office for more information, or call the SeniorCare Customer Service Hotline at 1-800-657-2038.

Consumer Buying Tips

Cost of Policies

When buying a Medigap policy, you should find out exactly what the premium will be. A few insurance companies charge everyone the same amount. Most companies charge different premiums based on your age at the time of application. Several companies also use other factors, such as different rates for men and women or different rates in different parts of the state.

You should also find out what happens to your premium as you get older. The premium for your policy will increase every year primarily due to inflation in medical costs and the increase in Medicare *deductibles* and *copayments*. The amount your premium increases may also depend on the way in which the company reflects the aging of its policyholders in the rates charged. Be sure to ask the agent for any Medigap policy you are considering to explain the approach the company uses. In general, insurance companies use one of the methods described below:

***Attained Age*.** In addition to medical inflation and increased Medicare deductibles and copayments, your premium will also increase as you age. This is due to the fact that you tend to use more medical services as you age. Premiums may be the least expensive at first but can eventually become the most expensive.

***Issue Age*.** Your premium will increase due to medical inflation and increased Medicare deductibles and copayments. It will not increase due to your age. Your initial premium will be higher than under the Attained Age approach because a portion of the initial premium is used to prefund the increased claims cost in later years.

No Age Rating. Your premium is the same as for all customers who buy this policy, regardless of age.

Under Age 65. Your premium is calculated for individuals who, due to a disability, are eligible to enroll in Medicare under age 65.

Policy Delivery and Refunds

Policy delivery or refunds on policies should be made promptly by insurance companies. If you do not receive your policy within a month, or if there is a delay in receiving a refund, call or write the insurance company.

If you buy from an agent, find a good local insurance agent who can help you buy the right policy and will also assist you with making claims.

Policy Storage

Keep the policy in a safe place. It is a good idea to choose someone ahead of time who can take over your affairs in case of a serious illness. This person should know where your records are kept.

Duplicate Coverage

Before buying additional, duplicate coverage, evaluate your current policy. Buying one comprehensive health insurance policy is much better than buying several limited policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

Health History

Do not be misled that your medical history on an application is not important. Omitting specific medical information on your application can be very costly. If your application for individual Medigap insurance includes questions about your health, be sure that you answer all medical questions completely and accurately. If an agent helps you fill out the application, do not sign the application until you read it. If you omit medical information and the insurance company finds out about it later, the company may deny your claim and/or terminate your policy.

Since the application is part of the insurance contract, you will receive a copy with the policy. Make sure that the application has not been changed and that all the medical information in the application is accurate.

Payment

Make checks payable only to the insurance company—**do not pay cash or make a check out to the agent**. Be sure you have the agent's name, address, and Wisconsin agent's license number, and the name and address of the company from which you are buying the policy.

Replacing Existing Coverage

Make sure you have a good reason for switching from one policy to another. You should only replace existing coverage for different benefits, better service, or more affordable premiums. Do not terminate your existing policy until your new policy is in effect.

Insurance Agents and Companies

Insurance agents and companies must be licensed to sell Medicare supplement and other insurance. You can check with the Office of the Commissioner of Insurance to see if they are licensed. Keep the agent's business card and information regarding the insurance company's address and telephone number.

What If I Can't Afford a Medicare Supplement Policy?

You may find that you can no longer afford to pay insurance premiums, and if so, there may be other programs to assist you in paying for your medical care including Medicaid or other low-income programs. The Medicaid program provides health care coverage for individuals who meet the program's definition of low income. If you do not qualify for the Medicaid program, you may be eligible for either the Qualified Medicare Beneficiary (QMB) program or the Specified Low-Income Beneficiary (SLIB) program (see details below).

Medicaid Program

If you are eligible for Medicaid, you do not need to buy private health insurance. Medicaid pays almost all of the health care costs if you are eligible for the program. For more information, contact your county or tribal aging office. If you bought a Medicare supplement policy after November 5, 1991, and then become eligible for Medicaid, the law permits you to suspend your coverage for 24 months while you are enrolled in the Medicaid program.

If you lose your eligibility for Medicaid, you are allowed to reinstate your Medicare supplement or Medicare select insurance.

Qualified Medicare Beneficiary (QMB) and Specified Low-Income Beneficiary (SLMB) Programs

If you are a low-income Medicare beneficiary but don't qualify for the standard Medicaid program, you may be eligible for either the QMB or the SLMB program. While these programs do not necessarily eliminate your need for private insurance to supplement your Medicare benefits, they could save you hundreds of dollars each year in health care costs if you qualify for assistance.

The QMB program pays Medicare's premiums, *deductibles*, and *coinsurance* amounts if you are entitled to Medicare Part A, and your annual income is at or below the national poverty level, and your savings and other resources are very limited. The QMB program, therefore, functions like a Medigap policy and more because it also pays your Part B premium.

The SLMB program pays your Medicare Part B premium if you are entitled to Medicare Part A and your income does not exceed the national poverty level by

more than 20%. If you qualify for assistance under the SLMB program, you will be responsible for Medicare's *deductibles*, *coinsurance*, and other related charges.

In addition, you may be eligible for a Medicaid program that requires states to pay Medicare Part B premium assistance for low-income Medicare beneficiaries. Contact the state or local Medicaid or social services office or your benefit specialist to get more detailed eligibility information or to apply.

Limited Policies

The limited policies listed below should not be bought as substitutes for a comprehensive Medigap policy.

Long-Term Care Coverage - These policies cover long-term nursing home and/or home health care.

You may obtain a copy of the booklets Guide to Long-Term Care and Long-Term Care Insurance Approved Policies in Wisconsin from the Office of the Commissioner of Insurance.

Hospital Confinement Indemnity Insurance - These policies pay a fixed amount per day for a specific number of days during the time you are hospitalized. These policies are not related to Medicare and only pay a limited amount of any hospital bill. You should review these policies carefully to determine the number of days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage - These policies provide benefits for a single disease or group of specified diseases, such as cancer, and are not Medicare supplement or Medigap policies. These policies only provide coverage for the specified disease and therefore should not be bought as alternatives to more comprehensive coverage. A Shopper's Guide to Cancer Insurance prepared by the National Association of Insurance Commissioners is available from the Office of the Commissioner of Insurance.

ATTENTION

Federal law prohibits the sale of a health insurance policy that pays benefits in addition to Medicare unless it will pay benefits without regard to other health coverage and it includes a disclosure statement on or together with the application.

State Health Insurance Assistance Program (SHIP)

The *State Health Insurance Assistance Program (SHIP)* is a free counseling service for Medicare beneficiaries and their caregivers. SHIP's Medigap Helpline (1-800-242-1060) can help you with questions about health insurance, primarily Medicare supplements, Medicare savings programs, long-term care insurance, employer/retiree group insurance, the Medicaid program, and other health care plans available to Medicare beneficiaries, as well as prescription drug coverage.

The *Medigap* Helpline is provided by the State of Wisconsin Board on Aging and Long-Term Care at no cost to you. There is no connection with any insurance company. The program is funded by a grant from the federal government *Centers for Medicare & Medicaid Services* and the Wisconsin Office of the Commissioner of Insurance.

Filing a Claim

It is important to file claims properly. The following list will help:

- Keep an accurate record of all your health care expenses. Store this information with your Medigap insurance or other health insurance policies.
- Whenever you receive treatment, present your Medicare card and any other insurance card you have.
- File all claims promptly. With each claim payment from Medicare, you will receive a Medicare Summary Notice (MSN). If the insurance company requests a copy of the Medicare Summary Notice, make a copy of the MSN and record the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.
- You do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare provider must submit claims to Medicare for you.
- If you enroll in a health maintenance organization (HMO), you will not have to file claims for services covered by HMO providers. All claims for covered services will be handled by the HMO.
- Some Medicare supplement insurance companies have an automatic claims filing program. This means that the insurance company receives a copy of your claim as soon as it is processed by Medicare. There may be a charge for this service.
- For more information on filing claims, you may want to contact the benefit specialist at your county or tribal aging office.

NOTE

Under Wisconsin law, all Medicare supplement and Medicare select insurance policies must include a *benefit appeal* procedure for claim denials. This procedure will be explained in your policy and Outline of Coverage.

What if I Have Additional Questions or Complaints?

If you have questions or complaints about:

Health Insurance

- **Board on Aging and Long Term Care (BOALTC)**

  This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

  Address
  Board on Aging and Long Term Care
  1402 Pankratz Street, Suite111
  Madison, WI 53704-4001

  1-800-242-1060 - Medigap Helpline (toll-free)
  (608) 246-7001 Fax
  longtermcare.wi.gov

- **Office of the Commissioner of Insurance (OCI)**

  OCI publishes several consumer guides to assist seniors in shopping for insurance. The publications should be used only as a guide. These guides are not legal documents and do not represent your rights under any insurance policy or government program. Your policy, contract, or federal or state laws establish your rights. Consult an attorney for legal guidance about your specific rights. Legal assistance may also be available through your county or tribal aging office.

  If you are having a problem with your insurance, you should first check with your agent or with the insurance company that sold you the policy. If you do not get satisfactory answers, you may file a complaint with OCI.

  Mailing Address
  P.O. Box 7873
  Madison, WI 53703-7873

  Street Address
  125 South Webster Street
  Madison, WI 53702

  1-800-236-8517 (statewide) or (608) 266-0103 (Madison)
  711 TDD (ask for 608-266-3586)
  oci.wi.gov

- **Wisconsin County/Tribal Elder Benefit Specialists**
  (or call your county department on aging)

  Benefit specialists are trained to help anyone 60 years of age or older who is having a problem with private or government benefits.

  www.dhs.wisconsin.gov/aging/EBS/benspecs.htm

Medicare

- ***Centers for Medicare & Medicaid Services (CMS)***

  The Centers for Medicare & Medicaid Services is the federal agency that manages the Medicare and Medicaid programs.

  Address
  7500 Security Boulevard
  Baltimore MD 21244-1850

  1-800-633-4227 (toll-free)
  www.cms.gov

- **Billing Medicare - Wisconsin Information**

  Medicare *Carrier*
  Part B bills and services

  Wisconsin Physician Services
  1-866-359-1599 (toll-free)

  Fiscal Intermediary
  Part A bills and services, hospital care, skilled nursing care, and fraud

  Blue Cross Blue Shield of Wisconsin
  (d.b.a. United Government Services, LLC)
  1-800-633-4227 (toll-free)

- **SeniorCare**

  SeniorCare is Wisconsin's prescription drug assistance program for Wisconsin residents who are 65 years of age or older and who meet eligibility requirements.

  1-800-657-2038 SeniorCare Customer Service Hotline (toll-free)
  TTY and translations services are available
  www.dhs.wisconsin.gov/seniorcare

  If you think you are eligible, contact your county or tribal aging office for more information .
  www.dhs.wisconsin.gov/seniorCare/HowWhere.htm

- **Wisconsin Prescription Drug Helpline for Medicare Beneficiaries**

  The Wisconsin Prescription Drug Helpline is a toll-free information line that provides free counseling to all Wisconsin Medicare beneficiaries (regardless of age or income) on prescription drug coverage options in Wisconsin, including Medicare Part D.

  (Updated 05/2012)
  Wisconsin Board on Aging and Long Term Care
  1402 Pankratz Street, Suite 111
  Madison, WI 53704-4001

  1-800-242-1060 (toll-free)
  BOALTC@wisconsin.gov

Glossary of Terms

Actual charge: The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Appeal: A special kind of complaint you make if you disagree with any decision about your health care services. This complaint is made to your Medicare health plan or to Medicare. There is usually a special process you must use to make your complaint.

Approved amount or charge: Also called the allowable, eligible, or accepted charge, this is the maximum fee set by Medicare that it will approve for a particular service or procedure, of which Medicare will reimburse 80%.

Assignment: This means that a doctor agrees to accept Medicare's fee as full payment. Accepting assignment means that the doctor agrees to bill no more than the approved charge for a service. In other words, a doctor will not charge more than Medicare will approve. Doctors not accepting assignment charge 15% more and you will be responsible for 100% of the excess charges.

Attained age: This means that as you age, your premiums will change to meet your age range and your premiums will become higher.

Beneficiary: A person who has health insurance through the Medicare program.

Benefit appeal: The opportunity for the Medicare beneficiary to submit a written request for review by the insurer of the denial of a claim for Wisconsin mandated benefits under the Medicare supplement policy.

Benefit period: A designated period of time during and after a hospitalization for which Medicare Part A will pay benefits.

Carrier: A private company that has a contract with Medicare to process your Medicare Part B bills.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program.

Coinsurance: The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. If you have supplemental coverage, this is the balance of a covered health expense that you are required to pay after insurance has covered the rest.

Copayment: A copayment is a set amount you pay for a service.

Creditable coverage: Previous health/drug coverage that reduces the time you have to wait before preexisting health conditions are

covered by a policy you buy during your Medigap open enrollment period or guarantee issue period.

***Custodial care*:** Personal care, such as help with activities of daily living, like bathing, dressing, eating, getting in and out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. Medicare does not pay for custodial care.

***Deductible*:** The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year.

***Drug formulary*:** A formulary is a list of generic and brand name prescription drugs that are covered by your insurance policy or health plan.

***Durable Medical Equipment (DME)*:** Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

***Excess charge*:** The difference between a doctor's or other health care provider's actual charge and the Medicare-approved payment amount.

***Enrollment period*:** The six-month period after you turn 65, during which you can enroll in any Medicare supplement insurance plan or policy if you have enrolled in Medicare Part B. During this period, you cannot be denied based on any preexisting medical condition.

***Free look period*:** The 30-day period of time when you can review a Medicare supplement policy. If you change your mind about keeping the policy during this 30-day period, you can cancel the policy and get your money back.

***Grievance*:** Your right under Wisconsin insurance law to file a written complaint regarding any dissatisfaction with your policy or plan regarding mandated benefits. Medicare also provides you the right to file a grievance if you have a problem calling the plan, staff behavior, or operating hours. Medicare has a separate appeal process for complaints about a treatment decision or a service that is not covered.

***Guaranteed issue rights*:** Rights you have in certain situations when insurance companies are required to accept your application for a Medicare supplement policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all preexisting conditions, and cannot charge you more for a policy because of past or present health problems.

***Guaranteed renewable*:** A right you have to automatically renew or continue your Medicare supplement policy, unless you commit fraud or do not pay your premiums.

***Issue age*:** Premiums are set at the age you are when you buy the policy and will not increase because you get older. Premiums may increase for other reasons.

***Limiting charge*:** The maximum a doctor or other provider who does not accept assignment may legally charge for a Medicare-covered service. This is 15% over Medicare's approved amount and you are responsible for 100% of the excess charges.

***Managed care*:** A health plan that has an established network of providers that you must use.

***Medically necessary*:** Services or supplies that are needed for the diagnosis or treatment of your medical condition; are provided for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of you or your doctor.

Medicare Part A (Hospital Insurance): Coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance): Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Part C (Medicare Advantage Plan): A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare services are covered through the plan and are not paid for under Original Medicare.

Medicare Part D (Prescription Drug Coverage): Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

***Medigap*:** A term used to refer to Medicare supplement and Medicare select policies designed to fill the "gaps" in Original Medicare plan benefits.

***Network*:** A group of doctors, hospitals, pharmacies, and other health care experts that have entered into an agreement with a health plan to provide health care services to its members.

***Open-enrollment period*:** A one-time only six-month period when you can buy any Medicare supplement policy you want that is sold in

Wisconsin. It starts when you sign up for Medicare Part B and you are age 65 or older. You cannot be denied coverage or charged more due to present or past health problems during this time period.

***Out-of-pocket costs*:** Medical costs that you must pay on your own because they are not covered by Medicare or other insurance.

***Preexisting condition*:** A medical condition diagnosed or treated up to six months prior to the purchase of an insurance policy. Medicare supplement policies may impose up to a 180-day waiting period before coverage for that condition begins.

***Primary payer*:** An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

***Referral*:** An approval from your primary care doctor and health plan for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

***Secondary payer*:** An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.

***Service area*:** The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

***State Health Insurance Assistance Program (SHIP)*:** A state program that gets money from the federal government to give free health insurance counseling and assistance to people with Medicare.

***Usual and customary charge*:** The fee most commonly charged by providers for a particular service, procedure, or treatment, for that specialty, in that geographic area.

***Waiting period*:** The time between when you sign up with a Medicare supplement insurance company or Medicare health plan and when the coverage starts.

Acronyms

We have tried to limit the use of acronyms and initials, but some terms are used so often, the acronyms are practical and of assistance to you. The term has been spelled when first used in the text with the acronym or initials following in parentheses. For your convenience, the following is a listing of acronyms and initials that appear in the Wisconsin Guide to Health Insurance for People with Medicare booklet:

BOALTC Board on Aging and Long Term Care

CMS Centers for Medicare & Medicaid Services

COB Coordination of Benefits

COBRA Consolidated Omnibus Budget Reconciliation Act

DME Durable Medical Equipment

EOB Explanation of Benefits

EOMB Explanation of Medicare Benefits

HMO Health Maintenance Organization

IRO Independent Review Organization

MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MSN Medicare Summary Notice

OCI Office of the Commissioner of Insurance

PDP Prescription Drug Plan

PFFS Private Fee for Service Plan

PPO Preferred Provider Organization Plan

QMB Qualified Medicare Beneficiary Program

SHIP State Health Insurance Assistance Program

SLMB Specified Low-Income Medicare Beneficiary Program

SNF Skilled Nursing Facility