NAVIGATION GUIDE TO MEDICARE PARTS A & B

A Quick Reference Guide for
SHIP Counseling

The Navigation Guide for Medicare Parts A & B is designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of she/he, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 6 option 1.

COUNSELING GUIDELINES

INTRODUCTION

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)
CODE OF CONDUCT FOR VOLUNTEERS

As a SHIP Volunteer Counselor:

- I will not use the title of SHIP volunteer to promote personal opinions or causes
- I will keep personal opinions and actions separate from those made as a representative of this organization
- I will remain impartial in discussions and writing to people with Medicare, general public, and the media
- I must not misrepresent SHIP for the financial gain of myself, friends, or family members
- I may not accept payment or in-kind contributions for my services
- I have committed to upholding of the Conflict of Interest policy and agree to discuss any potential appearance of a conflict with an Area Manager and will be truthful in all matters to do with my volunteer relationship with SHIP
- I will treat all others with dignity, care and respect and will be sensitive to and educate myself about individual and group differences, will respect all clients' rights to self-determination, and agree to support people in making their own personal choices
- I agree to maintain respectful and professional relationships and appropriate boundaries with others during the course of my volunteer work
- I will uphold the standards of the State Health Insurance Assistance Program and keep updated with new information and training
- I understand that the lack of training and education may limit ability to serve clients and recognize the need to ask for assistance or refer when appropriate
- I agree to complete the necessary training before, during and in the course of volunteering and do this by keeping updated on new information, attending scheduled counselor meetings and Fall and Spring trainings, and by taking advantage of opportunities such as seminars and workshops offered both within and outside of SHIP
- I agree to participate in supervision that is acceptable, reasonable, regular and visible according to the guidelines of SHIP
- I shall hold STRICTLY CONFIDENTIAL all privileged information concerning clients
- I agree to report on duty free from the influences of illegal drugs and alcohol
- I will avoid conduct that would jeopardize program effectiveness

I understand that failure to adhere to any and all parts of this code may result in suspension from my volunteer duties and/or termination of my volunteer relationship with SHIP

Social Security Number Protection and Compliance Q&A

Question: **Why should we be concerned about Social Security Protection?**

Answer: Identity theft is the fastest growing crime in America. It occurs every 79 seconds, and if it hasn't already affected you or someone you know, it likely soon will. It is estimated that almost 11 million people have been affected by this crime at this point. (http://idtheft.about.com/od/dataandstat1/a/ID_Theft_Stats.htm)

Question: **Why should we as SHIP Volunteers be concerned about the protection of other people's Social Security Numbers or Medicare Numbers?**

Answer: The Indiana legislature and the Office of the Attorney General have recently responded to this growing problem with new laws and regulations. These laws directly affect the Indiana Department of Insurance/SHIP and you, as even a negligent disclosure can be a criminal infraction.

Question: **What is the general law regarding the disclosure of Social Security Numbers?**

Answer: SHIP may not disclose an individual's Social Security Number or Medicare Number. However, disclosing the last 4 digits of a Social Security Number is NOT considered a disclosure.

Question: **How does SHIP comply with this general law?**

Answer: SHIP will be in compliance by removing or completely and permanently obscuring a Social Security Number or Medicare Number on Client Contact forms or other printed materials after use. SHIP Counselors will need to permanently black out Medicare Numbers before submitting Client Contact forms. It is okay to have the SSN or Medicare Number available on an open case. However if you don't need it, don't get it, and don't keep it.

Question: **Are there circumstances when SHIP may disclose an individual's Social Security Number or Medicare Number?**

Answer: Yes. SHIP may disclose an individual's Social Security Number or Medicare Number in the following circumstances:

- To a state, local, or federal agency (unless prohibited by state law, federal law, or court order)
- If the disclosure of the SSN or Medicare Number is expressly required by state law, federal law, or court order
- If the individual <u>expressly</u> consents to the disclosure in a signed writing that is dated in a legible form

Social Security Number Protection and Compliance Q&A

Question: **What happens if a SHIP Counselor wrongfully discloses a Social Security Number or Medicare Number?**

Answer: This depends on the circumstances surrounding the disclosure and how the counselor responds to the situation.

Criminal Disclosures—SHIP Counselors who knowingly, intentionally, or recklessly disclose a SSN or Medicare Number in violation of the above laws commit a Class D felony.

The AG's office may investigate any allegation that a SSN or Medicare Number has been disclosed in violation of the above laws. If there is evidence of a criminal act, the AG must report the findings to the prosecutor's office and the state police department.

Negligent Disclosures—For SHIP Counselors who negligently disclose a SSN or Medicare Number, the AG's Office has the discretion to determine that a release was negligent and not criminal, if one or more of the following have been met:

1. The release of the SSN or Medicare Number is immediately stopped.
2. Affected individuals are notified in a timely manner.
3. The release was unintended, de minimis, and nonsystematic.
4. If the release involves a SHIP sponsoring agency, the sponsoring agency's contract contained a clause that requires the agency to comply with the above laws.
5. The agency has reasonable policies and procedures in place to prevent unauthorized disclosures.
6. The agency has taken steps to prevent further disclosures under similar circumstances.
7. Other relevant circumstances.

Question: **What steps must SHIP Counselors take if a SSN or Medicare Number is wrongfully disclosed?**

Answer: Within two (2) days of the disclosure, the SHIP Counselor must notify the SHIP Program Director of the following:

1. The nature of the release
2. The steps taken by the Counselor to
   A. Stop the current release
   B. Notify the individuals affected
   C. Prevent future releases

LIABILITY ISSUES

The Governor's Office has advised that "so long as a counselor is acting in good faith in performing the counselor's functions within the scope of the counselor's service to SHIP, the State would indemnify the counselor for any judgment taken against the counselor" (after a review of Indiana Code 34-3-16.5-5{b}). This means the State would pay any loss incurred from a lawsuit, **AS LONG AS** the counselor acted in good faith, while performing services **WITHIN** the guidelines of SHIP. The Attorney General's office would defend the counselor under these same stated conditions.

Should a lawsuit be brought against a counselor and (upon review by the State) it is determined the counselor acted with malicious intent or acted outside the guidelines of SHIP, the counselor would then be responsible for obtaining and paying for their own defense, plus any loss incurred from the lawsuit.

Generally, a volunteer will not be held personally liable by a client for any of his actions, if such actions are performed within the scope of his duties and in good faith, without any malicious intent.

For these reasons, it is extremely important that you always use the written disclosure statement and the Client Agreement form. You must also follow your training instructions and not advise clients to enter into or to terminate specific transactions. **Your role is to educate the client** in an unbiased manner on elements of health insurance which they may wish to consider; **or to refer** the client to seek the assistance of an attorney of their choice or a public agency with relevant resources and jurisdiction.

To the extent that you act in other ways, you run the risk of incurring liability for yourself.

COUNSELING GUIDELINES

Introduction

As a SHIP counselor, you are providing a unique service to the residents of our state: providing guidance and information to your clients in order to help them make well-informed decisions about their health insurance. You will need to draw upon your SHIP training, past experiences, and communication skills to be an effective counselor.

Communication Skills

Communication is defined as the transfer of ideas and information. This is a two-way process. You cannot properly serve your clients unless you understand their needs, and the client will not give you the necessary information unless they understand that you are there to help.

There are three types of communication: **verbal, non-verbal (body language), and written correspondence (including e-mail).** Always remember to be cordial yet professional.

Verbal Communication

- Speak clearly, loudly, and slowly. Many of your clients may have hearing impairments, or English may not be their first language. Hearing impaired clients may be better served in a face-to-face meeting.

- Be careful to not use slang or jargon. Your client may not understand terms, acronyms and phrases that you find familiar.

- If you know that the client has difficulty hearing or with comprehending, it may be best to ask that a relative or representative to be present.

- Ask yes-or-no **and** open-ended questions. Asking only yes or no questions will not give the client an opportunity to give you the whole picture.

Listening Skills (Verbal Communication continued)

Practice good listening skills to improve your communication:

- **Be open** to differences in values, attitudes, cultures, and beliefs.

- **Paraphrasing** is a good way to show your client that you've really listened to him/her and understand their situation. When there is a natural pause in the conversation, restate briefly what you heard your client say by rephrasing in your own words. Then ask if this is correct.

- **Clarification –** Ask questions and clarify anything your client said that you don't quite understand. Make sure you understand your client's situation before you react to what has been said. Don't provide information that is not pertinent or helpful.

- **Feedback –** Provide feedback by sharing, with your client, your understanding of what they have told you.

Non-verbal (Body language)

- Let your facial expressions show your understanding and interest. Gently nodding lets them know that they are getting the information across to you.

- Sit or stand in an attentive posture. Let the client know that you are interested in the conversation.

- Avoid habits such as using excessive hand gestures, clicking of pens, drumming on the table, and other body language that can be very distracting. These habits may prevent you from effectively communicating with your client. Out of politeness, clients will not usually tell you about these personal habits.

Written Communication

- **Keep it professional and non-biased** when you are responding to a client's request, or when you are providing information to media sources. Be sure to take advantage of the many brochures and booklets that we have available to share with your clients.

- Always end your letter or e-mail with an invitation to contact you again.

Not everyone gets along with everyone; however, you should feel comfortable and at ease in discussions with clients. If a client makes you feel uncomfortable (for example uses in-appropriate language, or is over-bearing), don't let this get in the way of getting them help. Discuss the problem with your Local Coordinator or Area Manager.

Telephone Conversations

A simple, direct, and effective way to answer the telephone is: **"State Health Insurance Assistance Program, how may I help you?"** At once you have told the client that they may or may not have called the correct number, and that you are willing to help them.

Be Prepared, the caller/client will:

- **Start out fast and get faster!** After multiple tries, they may have finally reached a real person, and they don't want to miss the chance to tell all.

- Mistake you for their insurance company representative and start logging their complaint or start asking one question right after the other.

- Have no clue why they called **you** except that they need help and someone gave them SHIP's number.

- Be an insurance agent or provider simply seeking information.

- Be responding to information that they got through the media, from a friend, Medicare, Medicaid, their doctor's office, Social Security, their insurance company, or through the mail.

As a counselor you need an abundance of patience. Let the caller have their say. Wait for an opening, (**taking notes as they speak**), and then simply ask:

- "Are you familiar with SHIP and our services?" (It is probably their first contact with a SHIP counselor) If they are not aware of SHIP, reply with:

  "We are a federally funded agency, in Indiana we are under the Indiana State Department of Insurance." All of our counseling and information is free to you. So that I can determine how we may best help you, may I ask you some questions?"

Then begin with leading questions like:

- "Are you currently covered by an insurance plan?"
- "Are you retired? From where did you retire?"
- "What is your age please?" If they are under age 65, ask if they are receiving Social Security Disability benefits.
- "Do you have Medicare Part A & Part B?"
- "Are you on a limited income?"
- "Are you a veteran?"

By this time, you have now established a mutual trust and a cross-flow of information. The conversation will progress from there. To better help your client, you may need to make an appointment with them for further discussions. The following guidelines will help.

COUNSELING PROCESS

Session Location

Counseling sessions may be held at the local SHIP site, over the phone, at the client's home, or other suitable locations.

- **SHIP site** Contact the client and make an appointment. Complete your Client Contact form, explain your role as a SHIP counselor, and tell them what information they are to bring to your meeting. Close the call and remind them of the appointment time/date and what to bring.

- **Telephone** State that you are calling (or returning their call) to discuss their health insurance situation. If further discussions are needed, set another appointment. Begin the call with using a Contact Form. If you are taking 800 calls, see Navigational Guide 4 section R - Forms.

- **Client's home (for homebound clients)** Take your SHIP I.D. card with you to show the client. Take another counselor with you to act as a witness to the information you have shared. Ask to sit at a table where both of you can be comfortable and can write or display information. Start the session with the Contact Form.

Session Guidelines

- **Introduce Yourself** Put the client at ease with brief general conversation. Explain your role as a SHIP Counselor and the time limit you want for the session.

- **Client Contact Form** Complete this form as you work with the client.

- **Client Agreement Form** This form should be signed by the client, and kept in a secure place by either you or your local coordinator. Do not send this form to the SHIP state office.

- **Client questions or concerns** - ask the client if they have questions or concerns that you can review and use as a basis for developing a strategy to help them. Provide information, analyze policies, organize claims records, and/or make referrals.

- **Decide on the next step** Schedule another appointment if necessary, and if necessary refer the client to an appropriate source. Advise the client to review all materials discussed, and tell the client how you will help them.

- **Close the Session** After closing the session, complete the Contact form and forward it to your Local Coordinator on the schedule that has been arranged.

SHIP 800 Telephone Counselor Guidelines

In 2007, SHIP received over 25,000 Client contacts. That's an average of 2,083 contacts per month or 69 calls per day, but that's not how it works in the real world. Many of these contacts come through our 1-800 line. We really can't predict what our peak times will be, but volunteers are needed daily.

You can't count on one particular day or week of the month being the busiest. Below is an example of a seven month period:

MONTH	BUSIEST DAY OF THE MONTH	BUSIEST WEEK OF THE MONTH
Jan	Tuesday	Week 4
Feb	Thursday	Week 1
Mar	Monday	Week 3
Apr	Tuesday	Week 4
May	Wednesday	Week 2
Jun	Tuesday	Week 1
Jul	Wednesday	Week 4

If you choose to volunteer to help with the 800 line, sometimes you will be swamped and sometimes you'll only receive a few calls. In either situation, your assistance is always greatly appreciated by the staff.

Notify your Area Manager and the operators at 1-800-452-4800 that you are volunteering and what hours each week you are willing to take calls. Try to pick a time that is slow at your site, and no appointments have been scheduled.

At the time that you are scheduled to take calls, call 1-800-452-4800, Ext. 6 then option 3 at the next prompt and let the operator know if you are ready to receive calls. If not, an operator will attempt to call you at the times you are scheduled. If you need to change your schedule, just let us know. Especially if you are leaving early, call the SHIP operator so that she doesn't continue to transfer calls.

Most 800 counselors take calls to keep fresh and to be exposed to a variety of counseling questions. Taking 800 calls keeps counselors sharp and on top of the most important issues for people with Medicare.

If the operator asks you to take "call backs", you do not have to accept them. These are calls that need to be returned because the caller left a message. If you are too busy, just say so or tell the operator how many call backs you can take. **If you end up with call backs that you are not able to reach or get to by the end of your scheduled time, call the 800 operator and let her know that you were not able to complete the call.** Counselors often take these calls to arrange meetings with the caller at their local site. Some sites will take as many as are offered even in different areas just so they keep busy.

Remember that there is no reason for your site to incur the cost of any long distance calls. All you need to do is call the 800 number, and the operator will transfer your call.

Sometimes, you may receive only a few calls during your time so be prepared to take on other responsibilities at your local site. The Medicare Prescriptions Drug Plans have made many consumers aware of their local sites. So be available for local calls coming into your agency. Also, check with your Local Coordinator to see if there's office work that needs to be done. Arrange presentations or deliver brochures to other agencies if this is a slow call period. And all of us can use the time to review our Navigational Guides or catch up on the latest Medicare rules and regulations.

Be sure to fill out a client contact form for each call even if the call lasted a few minutes. You want credit for all the work you do.

If you have trouble answering a question, be assured that we are here to help. **Nelle Worthington, Counselor Assistance Coordinator, is available Monday through Thursdays mornings 8:30-12:00**. The SHIP staff is available in the main office to assist you during normal business hours.

Remember that you are serving an important role for hundreds of Hoosiers across the state who call in for help at 1-800-452-4800.

KEEPING UP-TO-DATE

Change - Change - Change! The insurance business and government programs are constantly changing. To add to the complexity, many companies are either going out of business or reforming, leaving thousands of individuals and families with no health insurance coverage. To keep you informed, we will send you updated information in monthly SHIP Updates.

Please verify information through your Area Manager
any information that you see or hear through media sources.

When you receive new information, immediately insert or write it in your manual. New information could be a new list, chart, a new telephone number, new figures, or a new page to be inserted into your manual.

Cross out or throw away old outdated information. Updating materials is extremely important in providing the correct information.

Keep learning Read the Medicare and You Handbook and the Guide to Health Insurance for People with Medicare as well as the various brochures that SHIP has available. Try completing the Long Term Care Insurance Self-Assessment Guide **for yourself.** It's good practice, and you may be surprised at what you find out about your own insurance needs.

THANK YOU! Your willingness to help others is truly appreciated.

SHIP has invested time in training you to be a SHIP Volunteer Counselor, and your local SHIP site has agreed to have you be one of their volunteers. It is now your turn to use your experience, training, and most of all, your **good judgment** to help those in need.

Remember to look for opportunities to provide SHIP counseling and be of service to your community.

COUNSELING OBLIGATIONS

Never make decisions for your client. **Do NOT** tell them: to buy, not to buy, which company to use, or where to go for medical services. Give them information, review with them the viable options, and then let them make the decisions. When asked for an opinion, be careful with your answer. Simply state, "**Only you and/or your caregivers can decide what is best for you**."

Before giving the client an answer or presenting options to them, be sure that **you** understand their situation, and that you have all of the facts.

WHEN IN DOUBT CHECK IT OUT! It is always safe to say up-front, "I don't know." Of course you should add that you will get the correct answer for them. You can't be expected to know everything, and information changes very quickly.

You have many sources to help you including your **Navigational Guides**, other SHIP counselors, professionals at your counseling site, the SHIP state staff, toll-free telephone numbers, and the Internet**.** Many questions can be best answered by the agencies which are going to provide services to your client. **Use their information hotlines**.

Never tell clients that their claims will definitely be resolved. **Nothing is ever definite!** Even after a client has been qualified and is receiving services, there may be changes to their status and benefits.

Before you finish the contact with your client, discuss whether a follow-up is needed. Summarize what you have both accomplished and what steps are next for the client. Be sure to **follow through.**

ALL CLIENT INFORMATION IS CONFIDENTIAL. Everything a client tells you is to be used and shared only with their permission. When you need to contact an agency on the client's behalf, ask the client for permission to discuss their personal information.

If you need to write down the client's Social Security Number or Medicare Claim Number, **ALWAYS use a black marker to mark out the numbers.** We must be very careful not to let our client's personal information fall into the hands of others.

When giving public presentation, speaking with the media, with care-givers or with the client, **speak objectively-never give an opinion**.

When discussing a client's health insurance policy, have the policy in you hands, and use the policy checklist.

REPORTING REQUIREMENTS

SHIP receives a grant from The Centers for Medicare & Medicaid Services (CMS) To justify this funding, we must report to these sources our activities, progress, and accomplishments. The form that you will use to help with our reporting requirements is called the "State Health Insurance Assistance Program (SHIP) Client Contact Form." We commonly call this form the:

Client Contact Form

The Client Contact Form should be used whenever possible with **every type of contact** that you have with a client including:

At SHIP sites	At work	Talking with relatives
Over the telephone	Visiting homebound clients	Visiting clients in facilities
Counseling at presentations	Counseling on the Internet	Counseling caregivers

It is important that you complete the Client Contact Form accurately and completely even if it was just a quick telephone call. The form is divided into sections including your information, contact information, client information, client's demographics, topics discussed during counseling sessions, and informational materials needed and/or given. **Please print whenever possible-cursive handwriting can be difficult to read.** A separate Publicity and Media Form is used for presentations, health fairs, etc.

Please use the latest edition of the Client Contact Form. If you are not sure that you have a current form, ask your Local Coordinator, your Area Manager, or call the SHIP toll free number and request that you be sent a supply of forms.

The completed contact forms are to be given/sent to your Area Manager, who reviews them and forwards them to our SHIP state office for data entry. Talk with your Area Manager to determine the schedule for submitting your completed forms.

SHIP VISION

To be the premier health benefit education, counseling, and assistance network in the nation.

SHIP MISSION

To ensure that healthcare consumers have a competent, committed, and compassionate, consumer-focused network of staff and volunteers who provide accurate and objective information through innovative community programs at the state and local levels. We promote fairness and quality, and empower consumers by facilitating solutions to individual and systemic health benefits problems.

SHIP STRUCTURE

State staff consists of State Program Director, Training Director, Clerical Staff, and Counselor Assistance Consultant. State staff is responsible for development, implementation, administration, supervision, and evaluation of the program. Their duties include, but are not limited to:

State Program Director: supervises all functions of the SHIP program to ensure effective implementation.

Training Director: creates a standardized curriculum for volunteer and staff training, conducts new counselor trainings, semi-annual update trainings and specialized training sessions as needed, and publishes monthly updates.

Clerical Staff: operates 800 helpline, gathers statewide data, submits reports to CMS, and mails materials and supplies.

Counselor Assistance Consultant: assists volunteer counselors with understanding and resolving insurance problems facing their clients.

AREA MANAGERS – are responsible for the local administration of SHIP. Their duties include, but are not limited to:

- **Volunteer Coordination** – recruit and retain volunteers, provide orientations, facilitate teambuilding, provide volunteer recognition, and conduct conflict resolution.

- **Counselor Support** – setup initial & update training, provide technical support & mentoring, review client assessment forms, assist with counselor updates, report changes in counselor status, and utilize volunteers' abilities.

- **Sponsoring Agency Support** – discuss and address organization's needs and/or concerns, assess organization's compliance with its agreement with the state, recommend plans for program development, act as a resource, coordinate site's educational & promotional materials.

- **Public Education** – educate the community about SHIP's services, conduct presentations, cover local health fairs or senior expos, and educate the public about senior health insurance options and rights.

SPONSORING ORGANIZATIONS – agree to sponsor the SHIP program within their agencies. They have agreed to:

- Provide suitable space for training and counseling services, and adopt the official title of "State Health Insurance Assistance Program."

- Assist with appointing a properly qualified individual, who may be a volunteer, as a Local Coordinator of counselor activities.

- Ensure that the Local Coordinator has submitted Client Assessment Forms filled out by the volunteers on a monthly basis.

- Provide telephone, copying, supplies, postage, and a place to keep records in confidence.

- Monitor the Local Coordinator's activities and have him/her report to the Area Manager on a regular basis to ensure program integrity.

- Assist in local publicity of SHIP Services.

LOCAL COORDINATORS – are responsible for the administrative aspects of their local SHIP site. Their duties include, but are not limited to:

- Assist the Area Manager with volunteer counselor recruitment, advertising, interviewing, scheduling, etc.

- Receive consumer contact during normal working hours and refer the calls to a counselor.

- Investigate opportunities and assist with the distribution of counseling and informational materials on the local level.

VOLUNTEER COUNSELORS – provide objective, confidential counseling to people with Medicare. Their duties include, but are not limited to:

- Answer questions related to Medicare, Medicare Supplemental Insurance, Medicare Prescription Drug Plans, Medicare Managed Care Plans, Long Term Care Insurance, help with prescription costs, and low-income assistance.

- Make client contacts through face-to-face appointments, local telephone calls, 800 telephone calls, presentations, and other local activities.

- Complete a Client Contact Form on each contact.

- Attend semi-annual training events and keep current on update information provided by the State Office.

SOCIAL SECURITY and MEDICARE BASICS

SECTION A

Social Security Overview

Social Security was established when President Franklin D. Roosevelt signed the Social Security Act into law August 14, 1935. The Act created a program to pay retired workers 65 and older a continuing income after retirement. Other provisions included unemployment insurance, old age assistance, aid to dependent children, and grants to states to provide various medical assistance. Over time Social Security has evolved to include benefits to aged spouses, dependents, and the disabled.

The **Social Security Administration** (SSA) handles the eligibility and enrollment functions of Medicare. The local office of the Social Security Administration must be notified of any change in address or other information. The SSA is divided into 10 regional offices. Indiana's regional office in located in Chicago. Contact information for field offices located in Indiana can be found in the SHIP Telephone Directory.

For specific Social Security questions or applications, contact the local Social Security office, or call **toll-free 1-800-772-1213**. SSA's toll free number is in operation from 7:00 a.m. to 7:00 p.m. Monday through Friday. There is a touch tone automated system available on the 1-800 number after hours and on weekends. More information can be found at **www.ssa.gov**. Most Social Security issues can be handled by phone and/or by mail.

Social Security Retirement Benefits

Most people need **40 credits** (10 work years) to qualify for **full** Social Security retirement benefits. Work credits are earned based on a set income requirement per calendar quarter. This income requirement is subject to change annually. In 2008, you will have to earn $1,050 per calendar quarter to earn one work credit. You can earn up to 4 credits each year.

When you were born will determine when you can expect to retire and receive **full** Social Security benefits. Those born **after** 1937 must be older than 65 to be eligible for **full** retirement benefits.

Full Retirement

How old do you have to be to retire? It depends upon the year of your birth.

Year of Birth	Full Retirement Age
1937 or earlier	65 years
1938	65 years & 2 months
1939	65 years & 4 months
1940	65 years & 6 months
1941	65 years & 8 months
1942	65 years & 10 months
1943-1954	66 years
1955	66 years & 2 months
1956	66 years & 4 months
1957	66 years &6 months
1958	66 years & 8 months
1959	66 years & 10 months
1960 or later	67 years

The above chart refers to eligibility for **full** Social Security retirement income benefits. Currently, **Medicare still begins at age 65** (unless you are disabled).

Your retirement benefits are basis on the earned average over your lifetime. SSA will use the adjusted earns for the 35 years you earned the most to calculate your retirement benefit.

Once you reach your full retirement age you may sign up to receive your full Social Security retirement benefits. You are not required to retire once you reach your full retirement age. You may choose to delay your retirement. By continuing to work you may increase your Social Security benefits. Each year you work will add an additional year of earning to your work record. Higher lifetime earns may lead to higher retirement benefits. In addition, by delaying retirement your retirement will be increased by a certain percentage. These increases, called **delayed retirement credits**, will be added automatically until you retire or reach the age of 70.

Early Retirement

At age 62, you are able to begin collecting Social Security retirement benefits. With **early retirement**, benefits are reduced from 1%-20% of the full benefits that you are able to get at full retirement age. Benefits for early retirees are reduced in order to stretch the benefits out over a longer period of time. Your benefit will not change once you reach full retirement age. You will continue to receive the reduced benefit for the remainder of your lifetime.

Spousal Benefits

If your spouse has never worked, your spouse is entitled to retirement benefits based on your work record. At full retirement age your spouse will be eligible for up to one half of your full retirement amount. Your spouse may chose early retirement as early as 62. If this is the case their benefit will be permanently reduced based on their age.

Divorced Persons

If you are divorced, you can get benefits on a former husband's or wife's Social Security record:

- If the marriage lasted **at least 10 years**.
- **Both you and your divorced spouse must be 62 or older**.
- If the spouse has been divorced at least two years, he or she can get benefits, even if the worker is not retired. However, the worker must have enough credits to qualify for benefits, and be age 62 or older.
- The amount of benefits a divorced spouse receives has no effect on the benefits of a current spouse.

Widow or Widower's Benefits

In order to receive Social Security benefits you would have had to be married to the deceased at least 9 months prior to death. There are a few exceptions if you meet certain criteria. You can choose to receive widow/ widower benefits at your full retirement age or choose a reduced amount at age 60. If you are a **disabled widow/widower, you** may receive benefits at age 50.

Generally you cannot get widow/widower's benefits if you remarry prior to the age of 60, but marriage after 60 (or 50 if disabled widow/widower) will have no effect on your eligibility.

Supplemental Security Income (SSI)

You may recieve SSI benefits if you are either age 65 or older, blind, or disabled, and have limited income and assets. Effective January 1, 2008, the SSI payment to a single individual is $637 and $956 for eligible married couple.

SSI funds come out of the government's general revenues, not from Social Security Income taxes. Support received from children or other sources **will count** toward income and could affect the amount of SSI payment. (See *Navigation Guide for Low Income Assistance and Prescription Assistance*.)

Social Security Disability Benefits

To qualify, you **must have worked 5 of the last 10 years** before becoming disabled (criteria changes if under age 31). In Indiana, eligibility decisions are made by the Disability Determination Section of Vocational Rehabilitation.

Disability

The Social Security Administration defines a disability as:

The inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or to last for a continuous period of not less than 12 months.

For a blind worker aged 55 or older, disability is defined as:

The inability due to blindness to engage in any substantial gainful activity requiring skills comparable with those in any gainful activity in which they were previously engaged with some regularity, and over a substantial period of time. Blindness is defined as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or tunnel vision of 20 degrees or less.

Medicare as Secondary Payer for Under 65 and Disabled Beneficiaries - Medicare will be the secondary payer for a **disabled employee** under age 65 who is **actively working** and covered under both Medicare and an employer group health plan. Medicare will also be the secondary payer when a **disabled spouse** with Medicare under age 65 is covered under an **actively working spouse's** employer health plan. These rules apply when the employer has 100 or more employees. If fewer than 100, Medicare stays primary.

Checklist for Medicare Beneficiaries Under 65 and Disabled - If a beneficiary is under 65 and disabled, the following options for insurance and assistance **may** be available:

- Medicare
- Medicaid
- Medicare Supplement - there is no open enrollment period for under 65 and disabled. Normal rules will apply at 65.
- Medicare Managed Care Plan
- COBRA
- ICHIA
- Veteran's Administration
- Pharmaceutical Manufacturer's Drug Assistance Program

Under 65 and Disabled

Generally, for individuals under age 65, disability Medicare automatically begins (Part A is free) after a person has been entitled to disability benefits for 24 consecutive months, (the qualifying period), and begins the 1st day of the 25th month of entitlement to disability benefits. **To qualify for disability benefits an individual must have worked (5) five of the last (10) ten years before becoming disabled.** The process is:

1. Medicare determines the disability start date.
2. From the start date, there is **a 5 full month waiting period,** beginning with the **first full month of disability.**

   For example:

   If the disability date (called the **onset date)** is 6/1, the waiting period starts 6/1, ends 10/31, and disability starts 11/1.

   If the disability date (**onset**) is 6/15, the waiting period starts 7/1, ends 11/30, and disability starts 12/1 (the person must have **5 full months** waiting time).

Note - Individuals under age 31 have different guidelines.

AMYOTROPHIC LATERAL SCLEROSIS (ALS) Lou Gehrig's Disease

Individuals medically determined to have ALS **will not** have to serve the 24 month qualifying period.

END STAGE RENAL DISEASE (ESRD) Permanent Kidney Failure

Different rules apply - see ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*** for more information.

DISABILITY REENTITLEMENT

In Disability Reentitlement cases, months from the previous entitlement disability may be counted in determining when the 24-month qualifying period is met. Examples of other specific cases include:

- Disabled Adult Child (DAC)
- Disabled workers, or disabled widows(ers) who had a previous entitlement to disability that ended within a certain time period before the current disability started.

Medicare Basics

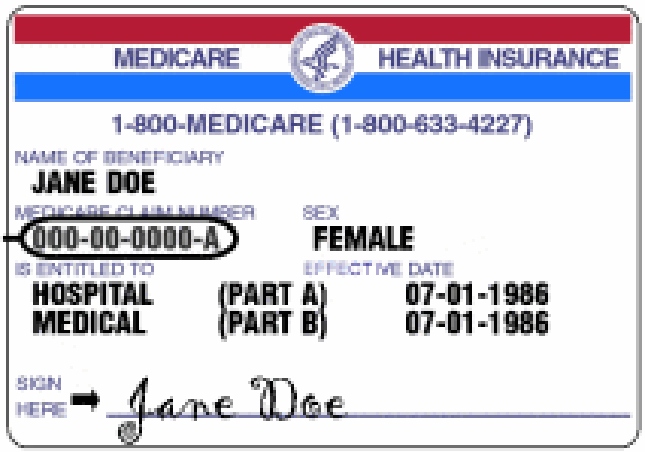
Medicare is the federal health insurance program for people *65 and older,* and for those *under 65 and disabled.* Medicare is administered by the **Centers for Medicare & Medicaid Services, (CMS),** formerly the Health Care Financing Administration (HCFA). For Medicare claims questions contact Medicare at 1-800-633-4227. Medicare and Medicaid programs were signed into law by President Lyndon Johnson, July 30, 1965 in a ceremony held in Independence, Missouri. President Harry S. Truman was the first beneficiary to enroll in Medicare. The Part B premium was $3 a month.

Medicare Part A - Hospital Insurance
Helps pay for: inpatient hospital care, limited coverage in a skilled nursing facility, and full coverage for eligible home health care and hospice care.

Medicare Part B - Medical Insurance
Helps pay for: physician's services, outpatient hospital services, durable medical equipment, some home health care, and other services.

The Medicare Card
The Medicare Card shows the following information:

- **Beneficiary's name** In order to avoid delays in having your Medicare claims paid, always provide your doctor or service provider with your name as it appears on your Medicare card.
- **Medicare Claim Number** (usually the Social Security number with 1 or 2 letters). The letters indicate how you qualify for Medicare - on your work record, your spouse's work record, under 65 and disabled, etc. Note: A **Railroad Retiree's Medicare Card** has a prefix instead of a suffix.



See chart on following page for more information on the beneficiary identification codes.

Beneficiary Identification Codes used in Medicare Claim Numbers.

Beneficiary Identification Codes	
A	Primary claimant
B	Aged wife, age 62 or older
B1	Aged husband, age 62 or older
B6	Divorced wife, age 62 or older
BR	Divorced husband, age 62 or older
D	Aged widow, age 60 or older
D1	Aged widower, age 60 or older
D9	Remarried widow
DP	Remarried widower
T	End-stage Renal Disease Beneficiary
TA	Medicare qualified government employee
W	Disabled widow, age 50 or over
W1	Disabled widower, age 50 or over

Medicare Card (cont'd)

- **Medicare coverage** - Part A, Part B or both.
- **Date Medicare coverage became effective**. Effective dates of coverage may not be the same for Parts A and B.

For replacement cards or questions regarding Medicare eligibility or enrollment, contact your local Social Security office, call toll-free 1-800-772-1213, visit Social Security's website at www.ssa.gov or Medicare's website www.medicare.gov.

Medicare Eligibility

You are eligible for Medicare Part A & B benefits if you meet residency requirements and are either age **65+**, or are **under age 65** with a disability.

Part A is usually free if you or your spouse have earned enough work credits. **Part B does have a monthly premium** which is normally deducted from Social Security checks. For details, contact your local Social Security Office.

Government Employees
If you are a government employee, you may have different eligibility criteria to receive Social Security benefits, and should contact your local Social Security Administration with questions.

Social Security Disability
You are eligible for **premium-free** Medicare Part A, if you have been a disabled beneficiary under Social Security Disability or Railroad Retirement Disability for **24 months** or more. You may work and still be disabled. In this case, Medicare could continue for up to 48 months after you begin working and are still considered disabled by Social Security. After the 48 months, you can buy Medicare Parts A and B (not B only). Medicare coverage will end if you recover from the disability unless you are 65+.

Lou Gehrig's Disease: Amyotrophic Lateral Sclerosis (ALS) Disease
As of July 1, 2001, there is no longer a 24-month waiting period for Medicare entitlement for individuals whose disability is ALS. Entitlement began either July 1, 2001, or the first month of entitlement to disability benefits, whichever was later. For specific information about ALS, call **1-800-782-4747**, the Amyotrophic Lateral Sclerosis Association Patient Services Hotline.

Kidney Failure (End Stage Renal Disease - ESRD)
You will get Medicare Part A **free** if you are receiving regular kidney dialysis, or have received a kidney transplant due to permanent kidney failure. Medicare ends 12 months after dialysis treatment stops, or 36 months after a kidney transplant. (For more information see ***Medicare***

What should happen when Social Security denies eligibility for Medicare?
The Social Security Administration will write you a letter informing you that you are **not** eligible to receive Medicare benefits.

- You should **appeal** at the local Social Security office, and find out what information you will need to proceed with the appeal process.
- You will need to **provide evidence** proving that you meet the Medicare Eligibility requirements.

Buying Medicare

At age 65 (and meeting all requirements),you can enroll in Parts A & B unless you notify Medicare that you want to delay enrollment. If you are 65+ and have not earned 40 work credits, you are not eligible to receive Part A **premium-free**. However, you may **buy** Medicare Part A and Part B. You must be a United State citizen, or an alien lawfully admitted for permanent residence, and have lived in the U.S. for **five consecutive years** before applying for Medicare.

- **Buying Part A.** You **must also buy Part B** (persons 65+ may not buy Medicare Part A only). If you decide to cancel Part B, Part A will be lost. You may have just Part B.

- **Buying Part B.** If you **delay enrollment** in Part B the monthly **premium may increase by 10% for each 12-month period** that you could have had Part B. With few exceptions, (an example is if you continue working and are covered by a company plan) this extra amount will continue for as long as you have Part B.

For more information about buying Medicare, call the Social Security Administration at, **1-800-772-1213**.

MEDICARE ENROLLMENT
4 Types of Enrollment

1. **AUTOMATIC**
2. **INITIAL**
3. **GENERAL**
4. **SPECIAL**

Automatic Enrollment

If you are already receiving Social Security benefits and meet one of the following criteria, you are **automatically** enrolled in Medicare Parts A & B (Part B can be refused by contacting a Social Security Office).

- **Age 65** and already receiving Social Security **Retirement** benefits. A Medicare card will be sent approximately 3 months prior to your 65th birthday.

- **Under age 65** and receiving Social Security **Disability** benefits. A Medicare card will be sent approximately 24 months from the determined disability date, which may include an additional 5 month waiting period.

- **A Widow or Widower** receiving Social Security Widow or Widower's benefits prior to age 65. A Medicare card will be sent approximately 3 months prior to your 65th birthday.

If you are automatically enrolled in Medicare, you will receive a Medicare card approximately 3 months prior to the date Medicare is scheduled to begin. You will be enrolled in both Medicare Parts A and B. You can refuse Part B by contacting your local Social Security Office.

Initial Enrollment

An **individual must initiate** this process, and has a **7 month enrollment period** to sign up for Medicare. This enrollment period begins 3 months **before** the 65th birthday month, and ends 3 months **after** the 65th birthday month.

If the birthday is on the 1st of the month, the previous month is considered to be the birthday month.

The date of a person's initial enrollment determines the effective date of Medicare Coverage.

If the Beneficiary Enrolls:	Then Medicare coverage begins:
During the 3 months prior to the birthday	The 1st day of the month of the 65th birthday
The month of the 65th birthday	The 1st day of the month following the month of the birthday
The month after the month of the birthday	Up to 2 months after the month of enrollment
During the 2 to 3 months after the month of the 65th birthday	Up to 3 months after the month of enrollment

General Enrollment

If you **fail to enroll** in Medicare Part B during the time of the initial enrollment period, you must wait for a **General Enrollment Period** to sign up. Reinstating a cancelled Part B must be done during a General Enrollment Period.

A Medicare General Enrollment Period is held each year from:
January 1 - March 31

When you enroll during the General Enrollment Period, Medicare **coverage begins July 1** of that year. You **may be charged a premium penalty for late enrollment,** unless you qualify for a special enrollment period. (See #4, Special Enrollment Period)

It is a good idea to get Part A at age 65. It is usually free.

You may decline Part B without penalty if you are **actively working** and covered under an employer group health plan, or covered under the **current** employment of a spouse or other family member. This also applies if you must buy Part A.

If you **enroll late for Medicare Part B** (again, you must enroll during a General Enrollment Period - unless you qualify for a Special Enrollment Period), a 10% **surcharge may be charged** on the Part B premium for **each year** after you were first eligible to sign up during the Initial Enrollment Period. The Part B 10% penalty surcharge will be the same every year, so the dollar amount increases when Medicare Part B premiums increase. This penalty will continue as long as you have Part B.

If you are **under 65, disabled,** and **do not take Medicare**, you will **not** lose the Social Security Disability benefit.

Special Enrollment

The Special Enrollment Period for Medicare lasts 8 months.
This includes the month in which you retire.

You may enroll in Part B anytime while still working, or just prior to retiring. (This also applies to Part A, if you must buy A.) A Medicare **Special Enrollment Period** begins the month the group health insurance ends. If you take Medicare Part A and have group health insurance, Medicare will be the **secondary payer** until the group insurance ends **unless you are disabled**.

Disabled Special Enrollment Period

If you are disabled, you also have a Medicare Special Enrollment Period due to discontinuation of health insurance through your own or a spouse's employer, or due to retirement. You would also have a **Special Enrollment Period** if your group health plan is no longer classified as a large group health plan of 100+ employees.

Options If You Are Not Eligible for Medicare

If you **retire before age 65,** and **do not qualify** for Medicare, you may have difficulty finding individual medical insurance coverage.

Options may include:

- Medicaid
- A parent who is a legal dependent of an employed person may be eligible through an employee health plan
- Hospital or specific disease indemnity insurance plans
- Veteran's benefits for services related to a disability or condition
- Group travel insurance.
- Memberships in organizations that sponsor group health insurance plans
- Enrollment in a college or school that provides group health insurance
- Conversion of prior group coverage to individual coverage
- Retiree insurance plans
- Special Clinics
- Enrollment in a state high risk pool, such as the Indiana Comprehensive Health Insurance Association, (ICHIA) (See: *Navigation Guide Section on Supplemental and Other Insurance*.)

For More Information on Medicare eligibility and enrollment, see *The Medicare and You Handbook*. Consumers may obtain this by calling either:

State Health Insurance Assistance Program at 1-800-452-4800
Social Security Administration at 1-800-772-1213.

MEDICARE PART A

SECTION B

2009 MEDICARE PART A
COVERED SERVICES AND COPAYMENTS

Services	Benefit	Medicare Pays	You Pay
Hospitalization Semi-private room and board, general nursing and other hospital	First 60 days	All but $1,068 Per Benefit Period	$1,068 Per Benefit Period
services, and supplies.	Days 61-90	All but $267/Day	$276/per day
Medicare payments are based	Days 91-150	All but $512/Day	$512/per day
on benefit periods.	Days 150+	Nothing	All Costs

Services	Benefit	Medicare Pays	You Pay
Skilled Nursing Facility Care	First 20 days	100% aprvd.amt.	Nothing
Semi-private room and board,			
general nursing, skilled nursing rehabilitative services, other	Additional 80 days	All but $133.50 per day.	Up to $133.50 per day
services and supplies.			
(Medicare payments are based on benefit periods)	Beyond 100 days	Nothing	All costs

Services	Benefit	Medicare Pays	You Pay
Home Health Care Part-time or intermittent skilled	Unlimited as long as you meet Medicare	100% aprvd.amt.	Nothing
care, home health aide services, durable medical equipment and supplies, and other services.	conditions	80% for Durable Medical Equip. Approved amt.	20% Durable Medical Equip. Approved amt.

Services	Benefit	Medicare pays	You Pay
Hospice Care Pain relief, symptom management support services for the terminally ill.	Unlimited as long as doctor certifies the need	All but limited co-pay for outpatient drugs and inpatient respite care	Limited co-pay for out-patient drugs and inpatient respite care

Services	Benefit	Medicare Pays	You Pay
Blood	Unlimited if medically necessary	All but first three (3) pints per calendar year	For first (3) three pints if not replaced

2009 MEDICARE PART A COVERAGE AND PREMIUMS

2009 PREMIUM

Worked 40 quarters or more • Free
Worked 30-39 quarters • $233 per month
Worked up to 30 quarters • $423 per month

DEDUCTIBLES and CO-PAYMENT

Hospital

2009 - Deductible per benefit period • $1,068
Co-Pay for days 61-90 • $267 per day
Co-Pay for days 91-150 • $534 per day

Skilled Nursing Facility

Medicare pays in full for days 1-20
2009 Co-Pay for days 21-100 • $133.50 per day

Blood

First 3 Pints Under Part A or B

Medicare Part A

Medicare Part A is often referred to as hospital insurance. When all requirements are met Part A helps pay for:

- **inpatient hospital** care (including critical access hospitals)
- limited coverage in a **skilled nursing** facility (but not custodial or long term care)
- full coverage for eligible **home health care**
- full coverage for eligible **hospice care**

Part A is usually free if you or your spouse have earned enough work credits (40 credits). About 99% of Medicare beneficiaries do not pay a premium for Part A.

If you are 65+ and have not earned 40 work credits, you are not eligible to receive Part A **premium-free**; however, you may **buy** Medicare Part A. In order to do so, you must be:

- a United States citizen or
- an alien lawfully admitted for permanent residence, and have lived in the U.S. for **five consecutive years** before applying for Medicare.

When buying Part A, you **must** also buy Part B (persons 65+ may not buy Medicare Part A only). If you decide to cancel Part B, your Part A will be lost.

If you are not sure if you have Part A, check your Medicare card. If you have Part A, you will find “HOSPITAL (PART A)” along with the effective date printed on your card.

INPATIENT HOSPITAL COVERAGE

Medicare Part A helps pay for Inpatient Hospital Care when **all** of the following conditions are met:

- A physician prescribes inpatient treatment of the illness or injury.
- The kind of care required can be provided only in a hospital.
- The hospital participates in Medicare.
- The hospital's Utilization Review Committee, the *Peer Review Organization,* (PRO) or the Medicare intermediary does not disapprove the stay.

Hospital Benefit Period
Medicare coverage of hospital care is measured in **BENEFIT PERIODS**, not based on a calendar year. A **hospital benefit period** begins the first day that you receive Medicare covered inpatient hospital services, and continues until you have been out of the hospital or skilled nursing facility for **60 consecutive days**.

The benefit period could continue if you are transferred from the hospital to another facility that provides **skilled nursing or rehabilitation services**. The benefit period ends when you have been out of the facility, or have not received skilled care in the facility, for 60 consecutive days.

A **new hospital benefit period** starts when inpatient hospital services are again required **after 60 consecutive days have passed** since you left the hospital or skilled care facility. You can experience more than one hospitalization during a benefit period for a different condition without a new deductible.

You can have more than one benefit period during a year*,* if the hospitalizations in a skilled facility are more than 60 days apart from discharge to admittance. **You must pay the Part A deductible each time** a new benefit period starts. The Part A deductible is the full amount you will pay for the first 60 days of inpatient hospital care. It is technically possible, (but unlikely) to have six (6) benefit periods in one year. You may have an unlimited total number of inpatient hospital care benefit periods during your lifetime, as **benefit periods are renewable.**

Hospital Deductible for Medicare Part A

You must pay the Part A deductible for each hospital benefit period. Only one (1) deductible per benefit period may be charged by the hospital.

Services Covered by Medicare Part A During a Hospital Stay

- Semi-private room and board, including meals for special diets. A private room will be paid for only if medically necessary. Normally, telephones and television services are not covered if listed separately from the room charge.
- Special care units, such as intensive care or coronary care units.
- Regular nursing services, **not private duty nursing**.
- Drugs furnished by the hospital during the inpatient stay.
- Lab tests included in the hospital bill, which may include diagnostic tests provided up to 72 hours prior to admission, if the tests are related to the reason for admission.
- Radiology services included in the hospital bill, such as x-rays or radiation therapy.
- Medical supplies such as casts, splints and surgical dressings.
- Operating and recovery room costs.
- Use of medical appliances such as wheelchairs.
- Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services.
- Blood transfusions during a hospital stay, after the first three pints per calendar year. You must either pay for the first three pints of blood, have a donor replace them, or build a reserve prior to the need.

Doctor services received in a hospital are covered under Part B.

Medicare Part A payment for days 61 - 150 in a hospital

During the 61st-150th days of hospitalization, Medicare pays all covered hospital costs except for a daily charge, called **co-payment**. The hospital will bill the co-payment to you, or to your other insurance. Your daily co-payment for days 91-150 is higher then it is for days 61-90.

Lifetime Reserve Days

If hospitalization extends beyond **150 days,** you will be charged for the stay. You may pay the charges, or elect to use your **Lifetime Reserve Days** to have Medicare assist with payment.

With Medicare you have **60 extra days**, called **Lifetime Reserve Days**. These can be used only once in a lifetime, and only after you have used 90 inpatient hospital days. The hospital stay must still be Medicare approved, and Lifetime Reserve Days include a coinsurance for each day. For 2008, this co-payment is the same as the co-payment for days 91-150.

- Lifetime Reserve Days are **not renewable**. The use of these days can be spread out over several benefit periods, but can only be used once.

- You decide when to use the reserve days and how many to use within a given benefit period.

- Unless the hospital is **notified in writing** either upon admission, or up to 90 days after discharge, the hospital will assume that you want to use reserve days. You can have this decision reversed by contacting the hospital.

Care in a Psychiatric Hospital

Psychiatric care in a general hospital is treated the same as any other Medicare inpatient hospital care. **Psychiatric care in a freestanding psychiatric hospital is subject to a lifetime limit.**

Medicare Part A pays no more than 190 days of inpatient care in a freestanding Medicare participating hospital in a lifetime. Lifetime Reserve Days can be used for care received in a freestanding psychiatric hospital after Medicare has paid for 190 days of care.

Foreign Travel and Medicare

Outside the United States, Medicare will not pay for **any** services, except for services in certain emergency or distance related conditions. U.S. territories Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered a part of the United States.

Care in a Christian Science Sanitarium

Medicare pays for inpatient care received in a participating Christian Science sanitarium **if** it is operated or listed and certified by the First Church of Christ Scientist, in Boston. **Part B will not pay for the practitioner.**

For more information about Part A coverage in nonparticipating hospitals, or in hospitals outside the U.S., contact Medicare at 1-800-Medicare (1-800-633-4227).

How Medicare Pays Hospitals

Medicare reimbursement to hospitals is determined through the **Prospective Payment System** (**PPS**). Hospitals are paid by the **diagnosis,** not by the length of the hospital stay, and payments are based on the average costs for treating a particular illness or injury. The various illness categories are called **Diagnosis Related Groups** (**DRGs**).

In special cases where costs for necessary care are unusually high, or the length of stay is unusually long, Medicare **may** make extra payments to the hospital. **You are only responsible for the Part A deductible, the coinsurance, and the cost of any non-covered services.**

Discharge from a hospital occurs when the Diagnosis Related Group payment is exhausted, or when your condition stabilizes and other means of treatment are available.

You have the right to appeal a hospital's and/or Medicare's decision to deny coverage for inpatient hospital stays.

SKILLED NURSING FACILITY CARE

Medicare may help pay for **Skilled Nursing Facility (SNF) Care**. **Skilled Nursing Care** must be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services include physical therapy performed by, or under the supervision of, a professional therapist.

Custodial Care is help with **Activities of Daily Living** (**ADLs**), or meeting personal needs, and can be provided safely and reasonably by people without professional skills or training. ADLs assistance may include help with walking, getting in and out of bed, bathing, dressing, and eating. **Medicare does not pay for custodial care when it is the primary kind of care needed.**

Medicare Requirements for Skilled Nursing Facility Care

To qualify for SNF coverage under Medicare Part A:

- You must be admitted to a **Medicare participating SNF** Medicare designated bed.
- Medicare Intermediary does not disapprove of the stay.
- Your condition requires **skilled nursing or skilled rehabilitation** services on a daily basis in a SNF, and a medical professional has certified that you need to receive this care.
- You must have spent **at least three (3) days in the hospital**, (not counting the day of discharge), before going to the SNF.
- Admission to an SNF **within 30 days** after leaving the hospital.
- Care in a SNF for a **condition that was treated in the hospital** or for a condition that arose while receiving care in the SNF.

Skilled Nursing Facility Benefit Period

Medicare Part A helps pay for a **maximum of 100 days** in a Skilled Nursing Facility in each benefit period. A benefit period begins the first day that you are transferred from a hospital to the SNF. If you are discharged from a SNF before using the 100 SNF days and are readmitted within 60 days, the same benefit period will continue. **A new benefit period will start only after you have been out of a skilled facility (SNF or hospital) for over 60 days.**

A new 3-day prior hospitalizaton would **only be required** when you have not recieved skilled care in a hospital or Skilled Nursing Facility for 31 days or more (even if still within the same benefit period) or when Medicare has paid for 100 days in a benefit period.

You will not normally need 100+ days of Skilled Nursing Care. Skilled Nursing Facility coverage is not meant for long term care.

Major Services Covered by Medicare Part A During a Skilled Nursing Facility Stay

- Semi-private room and board, including special diets. **Private room if medically necessary.**
- Regular nursing services. **Not private duty nurses.**
- Doctor ordered physical, occupational, and speech therapy.
- Drugs furnished by the SNF during the stay including blood transfusions **after** the first three (3) pints per year.
- Use of medical equipment and supplies furnished by the Skilled Nursing Facility including wheel chairs, splints, casts, etc.

Doctor services received in a SNF are covered under Medicare Part B.

HOME HEALTH COVERAGE

If you need **skilled health care** at home for treatment of an illness or injury, **Medicare pays 100% for all covered Home Health Care (HHC) services.**

Medicare Part A and Part B each pay for some parts of HHC. **If you have only Part B**, then Part B would pay for the HHC services; the Part B deductible would not apply.

In order for Medicare to cover HHC services, the agency must be Medicare participating, and provide skilled nursing care.

Home Health Care agencies should do a **free evaluation** to see if you qualify for Medicare HHC coverage. **Your physician** should refer you to a Medicare participating HHC agency.

Medicare Requirements for HHC

In order to receive Medicare Part A coverage of HHC benefits, you must meet the following qualifications:

- A physician determines the need and sets up a plan for HHC.
- You must be **confined to the home** (homebound), but not necessarily bed ridden. Ask the HHC agency where you can go.
- The care must be part-time or **intermittent skilled** care, and/or physical therapy or speech therapy. This benefit will cover eight (8) hours per day of reasonable and necessary care up to 21 consecutive days, or longer in certain cases (therapy up to 35 hours per week).
- The agency providing the services is a Medicare participating HHC agency. The **HHC agency submits all the claims for payment** and is paid directly by Medicare.
- **No prior hospitalization is required to receive covered HHC services.**

Services Covered During HHC Visits Include:

- Part-time or intermittent **skilled nursing care**.
- Physical and speech therapy.
- If receiving physical or speech therapy, Medicare will also pay for:
  - Occupational therapy.
  - Part-time or intermittent assistance with ADLs (bathing or changing of dressings) by home health aides.
- Medical social services.
- Medical supplies.
- Durable medical equipment (**subject to a 20% coinsurance**).

Services Not Covered During HHC Visits

The following services are **not** covered by Medicare in HHC:

- Drugs and biologicals that can be self-administered.
- Homemaker services such as laundry, meal preparation, shopping, or other chores.
- Meals delivered to the home.
- Blood transfusions.
- 24 hour/day nursing care at home. **Services provided by your relative or a member of the household.**

HOSPICE CARE COVERAGE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill patients. It can include both home and inpatient care, as well as a variety of services not normally covered under Medicare.

Medicare Requirements for Hospice Care

In order to receive Medicare Hospice benefits, you must meet the following conditions:

- A doctor must certify that you are **terminally ill** (diagnosed as having six (6) months or less to live if the illness runs its normal course).
- You choose to receive care from hospice **instead** of regular Medicare benefits for the terminal illness.
- The care must be through a Medicare participating hospice program.

Medicare will pay 100% for most covered hospice services. You may have to pay a **small coinsurance fee** for:

- Outpatient prescription drugs.
- Inpatient respite care (to provide some time off for the person who regularly provides care in the home), not to exceed five (5) days per stay.

Hospice programs can provide a few days of relief for family members who are caring for a terminally ill relative.

Special Benefit Period for Hospice Care

You may elect to receive hospice care for two 90 day benefit periods followed by an unlimited number of 60 day periods. The benefit periods may be used consecutively or at intervals. You must be certified as **terminally ill** at the **beginning** of each period.

You have the right to cancel hospice care at any time, and return to standard Medicare coverage, then later re-elect the hospice benefit. If you cancel hospice care during one of the benefit periods, any days left in that period are lost.

Services Covered Under Hospice

The following services under hospice are covered by Medicare:

- Doctor and nursing services.
- Home health aide and homemaker services.
- Short term inpatient care.
- Medical supplies and appliances.
- Physical, occupational and speech therapy.
- Drugs including outpatient medications for pain relief and symptom management, with a possible co-payment required.
- Counseling including bereavement counseling.
- Medical social services.

Other Illnesses and Hospice

If a patient requires treatment for a condition **not related to the terminal illness**, Medicare will help pay for all necessary covered services under the standard Medicare benefit program.

MEDICARE PART B

SECTION C

2009 MEDICARE PART B
MEDICARE SERVICES, BENEFITS, PAYMENT

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
Medical Expenses Doctor's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, DME, and other services	Unlimited if medically necessary	80% of approved amt. after deductible, 50% of approved amt. for most outpatient mental health services.	**$135** deductible plus 20% of approved amt, and Limiting Charges above that amount
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Clinical Laboratory Services Blood tests, urinalysis, and more.	Unlimited if medically necessary	Generally 100 % of approved amount	Nothing
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
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 conditions.	100% of approved. Amt. 80% for DME approved amount.	Nothing for services, 20% for DME.
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Outpatient Hospital Treatment Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost.	20% of billed amount per procedure code after the deductible. (There may be multiple codes charges during one outpatient visit)
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Blood	Unlimited if medically necessary	80% of approved amt. after the deductible, starting with the 4th pint.	First three (3) pints plus 20% of approved amt. after deductible. (If blood is not replaced by Part A or Part B)

2009 MEDICARE PART B FIGURES

2009 PREMIUM

Yearly Income Filed Individual Tax Return	Yearly Income Filed Joint Tax Return	Monthly Premium
$85,000 or less	$170,000 or less	$96.40
$85,001-$107,000	$170,001-$214,000	$134.20
$107,001-$160,000	$214,001-$320,000	$192.70
$160,001-$213,000	$320,001-$426,000	$250.50
$213,00 or more	$426,000 or more	$308.30

2009 DEDUCTIBLE

$135 per year

LIMITING CHARGE

115% Of Medicare's Approved Amount
This applies when using nonparticipating physicians and some supplies.

MEDICARE PART B

Medicare Part B helps pay for medical services such as doctors' services, outpatient hospital care, and preventive care. Part B is sometimes referred to as medical insurance. Coverage for eligible beneficiaries is **optional**. To decline Part B, contact a Social Security Office for the required forms.

There is a premium for each beneficiary who is receiving Medicare Part B. The Part B premium is normally deducted from your monthly Social Security check, or if you do not receive a monthly check, you will be billed every three months.

Your monthly premium will be based on your annual income. According to CMS, most Medicare beneficiaries will pay the standard premium of $96.40. If your annual income is more than $85,000 and you filed an individual tax return, you will pay a higher premium ($170,000 for a joint tax return). Social Security (SSA) will use the income you reported two years ago to determine your premium. If your income has decreased since 2006, you can request that SSA use a more recent tax year, but you must meet certain criteria. Contact SSA for information on the criteria that must be met to use a more recent year.
[Counselors Note: See chart on page C-2 for details on the premium amounts]

The Part B Deductible & Coinsurance

You are responsible for the Part B deductible, (2009 $135) in each calendar year. Services not covered by Medicare and charges in excess of the Medicare approved charges do not apply toward the deductible. The deductible must be met **only once per calendar year**.

Medicare Part B pays 80% of approved charges for coverage unless otherwise specified. You are responsible for your share **(coinsurance)** of the Medicare approved amount, **which is usually 20% of the approved charges.**

PART B PAYMENT SYSTEM

How Medicare Pays Providers

Part B approved amounts are based on the Medicare **fee schedule amounts.** The fee schedule applies to physicians and certain suppliers nationwide, and lists payments for each Part B service. Geographic variations in the cost of practice is taken into consideration in setting the fee schedule. The fee schedule amount is often **less** than the actual charges billed by physicians and suppliers.

When a Part B claim is submitted, the Medicare carrier **compares** the actual charge shown on the claim with the fee schedule amount for that service. **The Medicare approved amount is the lower of the actual charge, or the fee schedule amount.** Medicare Part B will then usually pay 80% of this approved amount.

Participating in Medicare

Participating in Medicare means that the provider is set up to file a claim with Medicare for services provided. This can also be referred to as being Medicare Approved or Medicare Certified. Not all providers or suppliers are participating. They elect whether or not to participate in Medicare each calendar year.

Finding a Participating Provider/Supplier

A list of local participating providers/suppliers is available by contacting Medicare. To get a copy of this list call **1-800-Medicare (1-800-633-4227).**

This information is also available on the Medicare website:
www.medicare.gov.

Accepting Assignment

Participating providers/suppliers can choose whether or not to accept Medicare Assignment. By accepting Medicare Assignment they are agreeing to accept the Medicare Approved Amount as total payment for the service provided. This is sometimes shown on the physician's bill as an **adjustment**, or a **Medicare allowance amount**.

- Those participating physicians and suppliers agree to take assignment in **all** Medicare cases for the full year.

- After the deductible has been met, Part B pays 80% of the remaining Medicare approved charge, and the beneficiary pays the remaining 20%.

Medicare pays the participating provider or supplier directly.

You are responsible for paying the:

- **Part B Deductible**
- **20% Coinsurance**

Not Accepting Assignment

Not accepting assignment means that a provider or supplier does **not agree to accept** Medicare's approved charge as total payment for services. You must pay these doctors or suppliers directly. **However, the provider must still file the claim with Medicare.** Medicare pays 80% of the approved amount **directly to you.** You are responsible for the remaining charges (the 20% coinsurance and the excess amount over the Medicare approved amount - Limiting Charge).

You may ask a nonparticipating doctor if they would accept assignment on a claim-by-claim basis. If they agree to accept assignment, then you will only be responsible for the 20% coinsurance.

You are responsible for paying the:

- **Part B Deductible**
- **20% coinsurance**
- **any excess amount over the Medicare approved charge**

LIMITING CHARGE

The Limiting Charge is 115% of what Medicare approves.
This may also appear as 15% over the Medicare approved amount,
or may be called the excess charge.

Physicians and certain suppliers not accepting assignments **may be fined by Medicare** for charging amounts over the Limiting Charge for such services as:

- Portable x-ray suppliers
- Independent labs
- Independent physiological labs
- Independent physical and occupational therapists
- Physician's services which they actually perform themselves

Not every service in a physician's office has a Limiting Charge. Limited Charges apply to a physician's personal services. If you have paid more than the Limiting Charge, ask the physician for a reduction in the charge, or a refund. Credits to an existing account may be given only for services already performed. If you have a **Limiting Charge Problem,** contact **National Government Services (formally AdminaStar Federal)** for assistance**.**

When a physician/supplier **does not accept assignment**, you are responsible for any charges above the Medicare approved amount up to the Limiting Charge, the 20% coinsurance, and the Part B deductible.

Special Rule for Non-Participating Doctors and Elective Surgery

If elective surgery is to cost **over $500,** the nonparticipating doctor **must** give the patient a written estimate of Medicare approved charges including the excess costs the physician is charging for the service. If no written estimate is given, the nonparticipating doctor must refund any payments that you have made that were over the approved amount. You are not responsible for anything over the Medicare approved amount. If you are unsure of charges, or whether you have been charged the correct amount, first contact your service provider. If still not satisfied, contact **National Government Services at 1-800-622-4792.**

PART B BENEFITS

Medicare Coverage for Physician Services

Medicare Part B helps pay for covered services received from a **physician** in their office, hospital, skilled nursing facility, patient's home, or any other location in the U.S. These include Doctors of Medicine (MD) or Doctors of Osteopathy (DO).

Doctor's Services Covered

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures
- Radiology and pathology services (inpatient or outpatient)
- Drugs and biologicals (injectables) that cannot be self administered, except for certain oral cancer drugs
- Transfusions of blood and blood components **after** the third pint
- Services of the doctor's nurse
- Medical supplies and x-rays
- Physical/occupational therapy, and speech pathology services

Limited Coverage for Doctors' Services Include:

Chiropractor: Part B only pays for manual manipulation of the spine to correct a subluxation. National Government Services determines how many visits are medically necessary to treat subluxation. Medicare **will not** pay for x-rays furnished by a chiropractor, or any other diagnostic or therapeutic services the chiropractor provides.

Podiatrist: Part B will **help pay** for covered services provided by a licensed podiatrist to treat injuries and diseases of the foot, such as heel spurs, hammer toe deformities, ingrown toenails, and bunion deformities. **Medicare will not pay for routine foot care**, such as trimming nails, cutting or removal of corns, calluses and most warts. **Note:** There may be exceptions if you are under the active care of a medical doctor for certain medical conditions, such as diabetes or peripheral vascular disease, which require routine care to be performed by a podiatrist, physician or doctor of osteopathy.

Optometrist: Medicare will **not** pay for routine eye exams or eyeglasses. Part B will pay for a licensed optometrist's services that are involved in the treatment and diagnosis of eye disease, cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses, or conventional contact lenses if necessary after cataract surgery with insertion of an intraocular lens.

Doctors' Services Not Covered

- Experimental medical procedures and services that Medicare does not consider medically reasonable or necessary.
- Routine physical examinations and tests related to such examinations, with the exceptions of **mammograms and pap tests.**
- Routine foot care.
- Exams for prescribing or fitting of **hearing aids** or **eyeglasses**, with the exception of **one pair** of eyeglasses after cataract surgery.
- Most immunizations, **except** Hepatitis B vaccine for high risk persons, a Pneumococcal Pneumonia vaccine, the Influenza (flu) vaccine **one time** during the flu season, and immunizations required because of an injury or immediate risk of infection.
- Routine dental care or dentures **with the exception** of surgery of the jaw or related structures.
- Acupuncture.
- Cosmetic surgery, unless needed to improve the function of a malformation of the body or from damage from an accident.
- Services rendered by Christian Science practitioners.
- Most prescription drugs.
- Services rendered outside the US-limited coverage in Mexico and Canada.

Second Opinion Before Surgery

A doctor may determine that you need surgery for a non-emergency health problem. Medicare recommends, (and will help pay for) a second doctor's opinion about surgery. Medicare will also help pay for a third opinion if the first and second opinions contradict each other. Your own doctor, or another doctor they trust are good sources for referrals for additional opinions.

Do not wait for a second opinion for emergency surgery. To avoid duplicate testing when seeking a second opinion **for non-emergency surgery**, ask the first doctor's office to send all medical records to the doctor who will be giving the second opinion. ***See Medicare and You handout Getting a Second Opinion Before Surgery.***

Services of Special Practitioners

Medicare may help pay for services received from specially qualified practitioners approved by Medicare, and who accept assignment for most of their services. Some of these practitioners are approved by Medicare to practice only in certain facilities or in certain locations, and may include the following:

- Certified registered nurse anesthetist
- Certified nurse midwife
- Clinical psychologist
- Clinical social worker
- Physician assistant
- Nurse practitioner and clinical nurse specialist supervised by a doctor

Coverage of Outpatient Hospital Services

Outpatient services in a participating hospital for diagnosis and treatment of an illness or injury. With each procedure, you are responsible for 20% of the hospital charge up to a maximum limit set by law. This maximum amount equals the Part A hospital deductible. If you have outpatient surgery, the actual surgery could be considered **one procedure** and the **anesthesia another procedure**. Deductibles do apply. Services covered include:

- Emergency room or outpatient clinic, including same day surgery.
- X-rays and other radiology services billed by the hospital.
- Medical supplies such as splints and casts.
- Laboratory tests billed by the hospital.
- Drugs and biologicals which cannot be self administered.
- Blood transfusions furnished to an outpatient after the third pint.
- Mental health care in a partial hospitalization psychiatric program as long as a doctor certifies that inpatient treatment would be required without it.

Outpatient Surgery at an Ambulatory Surgical Center
An ambulatory surgical center can be hospital-affiliated, or independent, but must provide **only** outpatient surgery services. Medicare Part B pays 80% of the approved amount for certain **approved** procedures, physicians, and anesthesia provided in connection with the procedure. The center must be participating in Medicare.

Home Health Care Services
Medicare Part A will usually pay for HHC benefits up to 100 visits **after a three (3) day hospital stay**. Part B pays for HHC benefits when you do not have Medicare Part A. Part B also pays for HHC visits after Part A has paid for 100 visits, and if you have had no hospital stay. The deductible **does not apply** in these cases.

Outpatient Rehabilitation Therapy
Part B helps pay for **medically necessary** outpatient physical therapy, occupational therapy, and speech pathology services. A doctor must prescribe the service and periodically review the plan. Either a doctor or a therapist may set up the plan of treatment.

Two options for service are:

- If you are an outpatient at a Medicare participating hospital, there is no annual limit, and no excess charge for covered services. Medicare pays 80% of the approved charge.

- For services provided at a SNF, home health agency, clinic, rehabilitation agency, public health agency, or comprehensive outpatient rehabilitation facility, there is no annual limit, and no excess charge for covered services. Medicare pays 80% of the approved charge.

Therapy sessions can be delivered by an independently practicing Medicare approved physical or occupational therapist in their office, or in your home if the treatment is prescribed by a doctor.

Comprehensive Outpatient Rehabilitation Facility
Comprehensive Outpatient Rehabilitation Facilities (CORFs) provide skilled rehabilitation services. You **must** be referred by a doctor before Medicare may help pay. A Medicare participating CORF provides physician's services, physical, speech, occupational, and respiratory therapies, and other related services. **The annual Part B deductible and 20% coinsurance apply.**

Federally Qualified Health Center Services
Federally Qualified Health Centers (FQHCs) are Medicare participating clinics, and are located in both rural and urban areas. FQHC benefit services are delivered by physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, clinical psychologists, or clinical social workers. The FQHCs can explain which services are provided and which are covered. **No Part B deductible is charged** when services are received at a FQHC.

You are **responsible** for the 20% coinsurance for Medicare approved charges unless they are waived. If you are under the FQHC benefit plan, the clinic provides additional services, **you must pay** the Part B deductible and the 20% coinsurance for Medicare approved charges. (Additional services might be x-rays, crutches, etc.)

Rural Health Clinic Services
Medicare will help pay for services at Rural Health Clinics of physicians, nurse practioners, physicians assistants, nurse midwives, visiting nurses, clinical psychologists, or clinical social workers. **At rural health clinics only the 20% coinsurance and the Part B deductible may be charged (no excess charges).**

Outpatient Mental Health Treatment
Services provided by psychiatrists, clinical psychologists, clinical social workers, and other special practitioners can be provided in hospitals, Comprehensive Outpatient Rehabilitation Facilities, community mental health centers, and/or Skilled Nursing Facilities. Medicare pays **approximately 50% (not 80%)** of approved charges.

Outpatient Mental Health Treatment (con't)
On assigned cases, you have coinsurance of 50%. When **not assigned,** you pay the coinsurance, plus any excess charges. Exceptions to the 50% payment limit are partial hospitalization services, and brief office visits for monitoring or changing prescriptions.

Ambulance Coverage
Transportation by ambulance must be **medically necessary**. Ambulance, equipment, and personnel must meet Medicare requirements. When transportation in another vehicle would endanger your health.

Medicare may help pay for transportation from home or the scene of an accident to the local hospital or SNF, or from the hospital or SNF to home. Medicare will **not** pay for ambulance use as routine transportation.

Air ambulance coverage is **limited**, and Medicare may pay when:

- the medical condition is life threatening;
- immediate treatment is required for survival or to avoid severe health damage;
- land transportation is not available;
- in limited cases so time consuming as to endanger life.

When air transportation is **not medically necessary**, Medicare may help pay for the air ambulance, **but at the land ambulance rate**. You pay the difference.

Durable Medical Equipment

Durable Medical Equipment (DME) and supplies are generally paid at 80% of the approved charge. Medicare does **not** cover items that may be necessary but not medical in nature, such as humidifiers, adhesive tape, etc. A physician must order or prescribe the equipment prior to purchasing or renting it, must be medically necessary and be appropriate for use in your home. The supplier must be Medicare certified.

Special Claims Information for Durable Medical Equipment

- Medicare Limiting Charge does not apply to DME claims.
- Nonparticipating suppliers may accept assignment on a case by case basis. With few exceptions, DME suppliers must now file claims with Medicare.
- Medicare usually determines whether an item is to be purchased or rented.

Claims are filed based on your state of permanent residency. When renting or buying medical equipment, you should inform the supplier of your state of residence.

Medicare Covered Durable Medical Equipment and Supplies May Include:

- Oxygen equipment, wheelchairs, power operated vehicles, walking aids, hospital beds, and certain other medical equipment.

- Prosthetic devices that are used to replace or assist body parts, such as: pacemakers, corrective lenses after cataract surgery, ostomy bags and related supplies, breast prostheses and surgical brassieres.

- Artificial limbs and eyes, arm, neck, back and leg braces.

- Orthopedic shoes, (if part of leg braces), and therapeutic shoes for diabetics, (one pair per year of shoes and inserts to avoid amputation).

- Supplies ordered by a physician such as surgical dressings, splints, and casts.

- Some oral cancer and immuno-suppressive drugs.

- Outpatient radiation therapy given under medical supervision.

- Diabetic supplies including: glucose monitors, blood testing strips, and lancets. Before paying for testing strips, Medicare must either purchase a monitor, or a doctor's order must state that you already have a monitor.

- Coverage of infusional insulin and infusion pumps. To qualify, you must test your blood glucose at least 4 times a day, and take at least 3 shots of insulin daily. Type I diabetics must keep a log if testing more than 3 times a day. Type II diabetics must keep a log if testing more than once a day.

Durable Medical Equipment and the Excess Charge
It is important that you find a supplier that accepts Medicare Assignment. Suppliers that do not accept Medicare Assignment are not subjected to a cap on the Limiting Charge. You will pay more out of pocket by using a supplier that does not accept assignment. **This information is not usually posted - you need to ask about assignment.**

If the supplier accepts assignment, you will be responsible for the Part B Deductible, and the 20% coinsurance. **If the supplier does not accept assignment, you will be responsible for the Part B Deductible, and the difference between the Medicare approved amount and the amount charged by the supplier.**

For Example: You need to purchase a cane and have satisfied your Part B deductible. The **Medicare approved amount is $20**. Your supplier bills Medicare for $100.

If the supplier **accepts Medicare assignment**, Medicare will pay $16 (80% of the approves amount) and **you will pay $4** (the 20% coinsurance).

If the supplier **does not accept** assignment, Medicare will pay $16 and **you will be responsible for the remainder of the charges - $84**.

Laboratory Services

Medicare Part B will cover 100% of the approved amount for diagnostic tests, if the following criteria is met:

- The lab must accept Medicare Assignment;
- The lab must bill Medicare, not you; and
- The tests must be coded as diagnostic, not screening.

The lab may be independent, part of a hospital's outpatient department, or in a doctor's office. In laboratories **not participating** in Medicare, Medicare pays 80% of the approved charge. When the lab is independent and nonparticipating, the 15% Limiting Charge applies.

Portable Diagnostic X-Rays
Part B helps pay for these services when physicians order them. Services can be performed in your home, or at other locations. The supplier providing the equipment must be **Medicare approved**. When services are provided by **nonparticipating** portable x-ray suppliers, the 15% Limiting Charge applies.

Independent Physiological Labs
These labs determine the functions and vital processes of the body such as long term EKG and EEG diagnostic services. When services are provided by **nonparticipating independent physiological labs, the 15% Limiting Charge applies**.

Diabetic Supplies

Medicare Part B will cover certain supplies if you have diabetes. These supplies include:

- Blood Sugar Monitors
- Therapeutic Shoes
- Insulin Pumps

Blood Sugar Monitors

Medicare will cover the blood sugar testing monitor as well as the test strips, lancet devices and lancets. You are covered whether or not you are insulin dependent. A prescription from your doctor is required. You must get your supplies from a Medicare participating supplier. You may pay more for your supplies if you use a supplier that does not accept assignment.

If your supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges. **Claims to Medicare must be submitted by the supplier.** Beneficiaries can no longer submit claims for diabetic supplies to Medicare.

Therapeutic Shoes

If you have diabetes and meet certain conditions Medicare will cover therapeutic shoes if you need them. The types of shoes covered each year are one pair of depth-inlay shoes and three pair of inserts, or one pair of custom-molded shoes and two additional inserts. In order for Medicare to cover these shoes **you must meet all** of the following conditions:

- You must have diabetes.
- Have **at least one** of the following conditions in one or both feet:
  - Partial or complete foot amputation
  - Past foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses

    - Poor circulation
    - Deformed foot
- Are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes

Medicare also requires that a podiatrist or other qualified doctor prescribes the shoes. Also that the shoes are fitted and provided by a doctor or other qualified provider like a pedorthist, orthotist, or prosthetist.

If your provider or supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your provider or supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges.

Insulin Pumps

If you need to use an insulin pump worn outside of the body, Medicare may cover the pump as well as the insulin to be used with the pump. You must meet certain conditions and have the doctor prescribe the pump. Work with your doctor to see if you meet the requirements for Medicare to cover the pump.

If your supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges.

Medicare Preventive Services

Preventive Service	Frequency	What You Pay
Abdominal Aortic Aneurysms Screening	Once in a lifetime	20% coinsurance; Part B deductible is waived
Bone Mass Measurement	Once every 24 months	20% Coinsurance after deductible
Cardiovascular Screenings	Once every 5 years	Nothing
Colorectal Cancer Screening Fecal Occult Blood Test Flexible Sigmoidoscopy Screening Colonoscopy Barium Enema	Fecal Occult Blood - 12 months Sigmoidoscopy - 24 months Colonoscopy - 48 months; 24 months if high risk Barium Enema - 48 months; 24 if high risk	Fecal Occult Blood Test - Nothing All others 20% coinsurance (if Sigmoidoscopy or Colonoscopy is performed as a hospital outpatient 25%) Part B deductible is waived.
Diabetes Screening	Two per year	Nothing
Flu Shots	One per flu season	Nothing
Glaucoma Tests	Once every 12 months	20% Coinsurance after deductible
Hepatitis B Shots	Three shot series	20% Coinsurance after deductible
Pap Test, Pelvic Exam & Clinical Breast Exam	Once every 24 months; 12 months if high risk	Pap Test - Nothing Pelvic & Breast Exam - 20% Coinsurance; not subject to deductible
Pneumococcal Shot	Talk to your doctor	Nothing
Prostate Cancer Screening (PSA) & Digital Rectal Exam	Once every 12 months	PSA – Nothing Digital Rectal Exam - 20% Coinsurance after deductible
Screening Mammograms	Once every 12 months	20% Coinsurance not subject to deductible
Welcome to Medicare Physical Exam	Once - but must be within the first 6 months of having Part B	20% Coinsurance after deductible

Preventive Services

Bone Mass Measurement

Bone mass measurements help determine if you are at risk for broken bones. The density of your bone is measured. The lower your bone density, the higher your risk is for a fracture. Medicare covers these measurements **once every 24 months** (more often if medically necessary). **You will pay 20% of the Medicare approved amount after the yearly Part B deductible.**

Cardiovascular Screenings

Beginning January 1, 2005, Medicare covers tests for cholesterol, lipids, and triglyceride levels to determine your risk for cardiovascular disease. These tests include the following screenings:

- Total Cholesterol Test
- Cholesterol Test for High Density Lipoproteins (Lipids)
- Triglyceride Test

Medicare covers these tests **once every 5 years**. **You will pay nothing** for these tests - there is no coinsurance and the Part B deductible is waived.

Colorectal Cancer Screening

Medicare covers colorectal screening tests to help find pre-cancerous polyps, so that they can be removed before turning cancerous. These tests are available to all people with Medicare age 50 and older - except for the screening colonoscopy, there is no minimum. These tests include the following:

- **Fecal Occult Blood Test**
  - **Once every 12 months**.
  - **You will pay nothing** - there is no coinsurance and the Part B deductible is waived.
- **Flexible Sigmoidoscopy**
  - **Once every 48 months**.
  - You will pay **20% of Medicare approved amount, the Part B deductible is waived**.

Colorectal Cancer Screening (continued)

- Screening Colonoscopy
  - **Once every 48 months**; once every 24 months if at high risk.
  - If you are not at high risk, payment could not be made for such procedures if performed within ten (10) years of a previous Screening Colonoscopy or 48 months of a Flexible Signoidoscopy screening.
  - **There is no age restriction**.
  - You will pay **20% of the Medicare approved amount, the Part B deductible is waived**..
- Barium Enema
  - **Once every 48 months**; once every 24 months if at high risk.
  - Your doctor can decide to use this test instead of the Flexible Sigmoidoscopy or the Screening Colonoscopy.
  - You will pay **20% of the Medicare approved amount, the Part B deductible is waived**..

Diabetes Screening and Self-Management Training

Beginning January 1, 2005, Medicare covers tests to check for diabetes. These tests are available if you have any of the following risk factors:

- High blood pressure
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- History of high blood sugar
- Or two or more of the following characteristics -
  - Age 65 or older
  - Overweight
  - Family history of diabetes
  - History of gestational diabetes (diabetes during pregnancy) , or delivered a baby weighing more than 9 pounds.

Medicare will pay for two diabetes screenings a year. Diabetes screenings that are covered include **fasting plasma glucose tests** and other tests approved by Medicare as appropriate. **You will pay nothing** for these tests - there is no coinsurance and the Part B deductible is waived.

Flu Shots, Hepatitis B Shots and Pneumonia Vaccine

Flu Shot

Influenza or the "flu" is a highly contagious respiratory infection. Symptoms include fever, chills, headache, dry cough, runny or stuffy nose, sore throat, and muscle aches. Unlike other respiratory infections such as a cold, the flu can cause extreme fatigue and last for a week or longer.

According to the Centers for Disease Control every year 5% - 20% of the population get the flu, more than 200,000 people are hospitalized for flu complications, and 36,000 people will die from the flu. Older people, young children and people with certain health conditions are at high risk for serious flu complications.

Complications of the flu can include:

- bacterial pneumonia,
- ear infections,
- sinus infections,
- dehydration, and
- worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Flu Shots are available to anyone with Medicare. Medicare will pay for **one flu shot per flu season**. Medicare determines when the flu seasons are each year. Usually there is one season per year, but there can be more.

If you use a **participating provider, you will pay nothing** for this shot - there is no coinsurance and the Part B deductible is waived. If administered by **a nonparticipating provider, you are responsible for all excess charges. There is no limiting charge.** The provider must file the claim with Medicare - **Medicare will no longer reimburse you** for the cost of the shot.

Hepatitis B Shot

Hepatitis B is caused by a virus that attacks the liver. This virus can cause chronic infection, cirrhosis of the liver, liver cancer, liver failure and death. The Hepatitis B shot is administered in three injections. Hepatitis B Shots are available to Medicare beneficiaries who are medium to high risk for Hepatitis B.

Hepatitis B Shot (cont'd)

Common factors that put you at medium to high risk include:

- Hemophilia,
- ESRD (end-stage renal disease),
- And conditions that lower your resistance to inflection.

You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Pneumococcal Vaccine

Pneumococcal Pneumonia is a serious bacterial infection. It kills more people in the United States each year than all other vaccine preventable diseases combined. **You are at risk if . . .**

- **You are 65 and older**,
- You have serious long-term health problems or
- You have increased susceptibility to infection.

Pneumococcal pneumonia is often characterized by sudden onset of illness with symptoms including shaking, chills, fever, shortness of breath or rapid breathing, pain in the chest that is worsened by breathing deeply, and a productive cough. **Pneumococcal Vaccine** is available to all Medicare beneficiaries. **Most people only need this vaccine once in their lifetime.** If you use a participating provider, **you will pay nothing** for this shot - there is no coinsurance and the Part B deductible is waived. If you use a nonparticipating provider, you are responsible for all excess charges. **There is no limiting charge.**

Glaucoma Tests

Glaucoma is an eye disease caused by high pressure in the eye. It can cause you to gradually lose your eyesight without warning and often without symptoms. The best way to protect your eyesight is to have regular eye exams. Your risk for glaucoma increases if you . . .

- Have diabetes
- Have a family history of glaucoma,
- Are African-American age 50 and older, or
- Are Hispanic age 65 and older.

Medicare covers glaucoma tests for beneficiaries who are at high risk for glaucoma. Medicare will help pay for glaucoma tests **once every 12 months.** You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Pap Test/Pelvic Exam/Clinical Breast Exam

As part of your Medicare benefits, Medicare covers Pap test and a pelvic exam to check for cervical and vaginal cancers. The pelvic exam also includes a clinical breast exam to check for breast cancer. According to the American Cancer Society (ACS) **Cervical Cancer was once the number one cause of cancer death in women**, but since the use of Pap tests to detect cancer the number of deaths has declined.

This preventive service is **available to all women** who have Medicare. Medicare will cover the Pap test and pelvic exam **once every 24 months.** However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at **high risk** for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic **exam every 12 months**.

You do not pay anything for the Pap test lab work. You will pay a 20% coinsurance of the Medicare approved amount for the Pap collection, pelvic and breast exams. **The Part B deductible is waived.**

Prostate Cancer Screening

Prostate cancer can often be found early by testing the Prostate Specific Antigen (PSA) levels in your blood. Another method of early detection is a digital rectal exam. While all men are at risk for prostate cancer your risk increases . . .

- If you have a father, brother or son who has had prostate cancer - especially if they were young when diagnosed
- If you are African-American
- As you get older - 2 out of every 3 cases of prostate cancer are found in men over 65.

Medicare covers both PSA blood tests and digital rectal exams. This preventive service is available to men on Medicare age 50 and older. Coverage begins the day after your 50th birthday. Medicare will cover these tests once every 12 months

- **PSA** blood test - No coinsurance, and the Part B deductible is waived.
- Digital rectal examination - You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Screening Mammogram

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer deaths in American women. **Every woman is at risk, and this risk increases with age.** With early detection, breast cancer can usually be successfully treated. While all women are at risk for breast cancer, your risks increase if you . . .

- Had breast cancer in the past
- Have a family history of breast cancer
- Had your first baby after 30
- Have never had a baby
- Used hormone replacement therapy for a long time after menopause
- Have 2 or more alcoholic drinks every day
- Are overweight
- Do not exercise

Medicare will help cover mammograms performed in an FDA certified facility, and will accept FDA certification as evidence that the facility is qualified. **All women 40 and older can get a screening every 12 months**. Exams should be scheduled so that they are after the 11th month (i.e. if your last mammogram was February 15, 2006 - you can schedule your next screening February 1, 2007 or later). Medicare will pay for **one baseline mammogram for women between 35 and 39 years old.**

The Part B deductible is waived, but you will need to pay the 20% coinsurance of Medicare approved amount.

Note: Diagnostic mammograms are covered when there are signs or symptoms **present,** at 80% of the Medicare Fee Schedule Amount, and the **Part B deductible is charged.** The Medicare Fee Schedule Amount varies nationwide based on geographic location, and whether or not the physician is a Medicare participating physician. Medicare will cover a diagnostic mammogram when the doctor has specific reasons for ordering the test, regardless of your age.

Welcome to Medicare Physical Exam

Beginning January 1, 2005, anyone whose Medicare Part B began on or after January 1, 2005, is eligible for a one time preventive physical exam. **This exam must be done within the first 6 months you have Medicare Part B.** The exam will include a thorough review of your health, education and counseling about the preventive services you need like certain screenings, shots and referrals for other care if you need it.

During the exam your doctor will record your medical history and check your blood pressure, height, and weight. Your doctor may also give you a vision and electrocardiogram (EKG). Depending on your general health and medical history, further tests may be ordered if necessary.

Your doctor will also give you advice to help you prevent disease, improve your health or stay well. You will also get a written plan (such as a check-list) when you leave letting you know which screenings and other preventive services you should get.

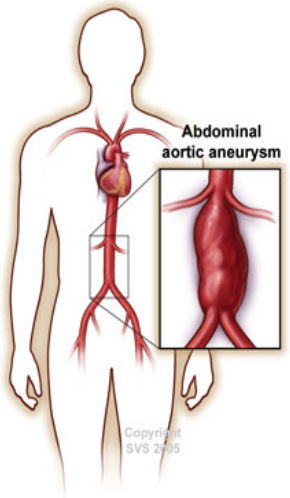
You should bring the following things with you when you go to your "Welcome to Medicare" physical exam:

- Medical records, including immunization records (if you are seeing a new doctor for the first time)
- Family health history - try to learn as much as you can about your family's health history before your appointment. Any information you can give your doctor can help determine if you are at risk for certain diseases.
- A list of prescription drugs that you currently take, how often you take them, and why

You pay 20% of the Medicare approved amount after you meet the yearly Part B deductible. Since this may be your first Medicare covered service, you may meet your entire Part B deductible at this visit.

Remember this exam is only covered during the first 6 months you have Medicare Part B.

Abdominal Aortic Aneurysms Screening



Starting January 1, 2007 Medicare will cover one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B. Payment may be made for a one-time ultrasound screening for AAA for people with Medicare who meet the following criteria:

- receives a referral for an ultrasound screening as a result of an initial preventive physical examination;
- receives ultrasound screening from a provider or supplier who is authorized to provide the service under Medicare;
- has not been previously furnished an ultrasound screening under the Medicare Program; and
- is included in at least one of the following risk categories:
    - has a family history of abdominal aortic aneurysm; or
    - is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime
    - is a beneficiary who has other risk factors.

Medicare will pay for this screening **once in a lifetime**. **The Part B deductible is waived, but you will need to pay the 20% coinsurance of Medicare approved amount**.

Smoking Cessation Counseling

Quitting smoking has significant health benefits, even in older adults who have smoked for years. This preventive service is covered if you have an illness caused or complicated by tobacco use, or if you take medication affected by tobacco use.

Medicare will **cover 8 cessation counseling sessions per year.** These can be received as an inpatient or outpatient. You will pay the annual **Part B deductible, and 20% of the Medicare approved amount**.

Medicare drug coverage can help pay for drug therapy such as nicotine patches.

Kidney Dialysis and Transplants

Medicare Part B helps pay for:

- Maintenance Dialysis
- Kidney Transplant Surgery
- Epoetin Alfa (EPO)
- Home Dialysis Equipment
- Support and Supplies
- Self-Dialysis Training
- Nutrition Therapy Services
- Drugs used in immunosuppressive therapy to prevent rejection of transplanted organs

For more detailed information see the ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services Handbook.***

Heart and Liver Transplants

Medicare Part B may help pay for:

Under certain conditions, heart and liver transplants in a Medicare approved facility.

Drugs used in immunosuppressive therapy to prevent rejection of transplanted organs. Coverage begins with the date of discharge from a hospital stay as an inpatient receiving an approved organ transplant.

MEDICARE CLAIMS PROCESSING

SECTION D

Medicare Claims Processing

All providers, participating and nonparticipating, are required by law to file Medicare claims for covered services, and to each provider you must supply correct information including:

- Your Medicare claim number.
- All health coverages, including Medicare A & B (to determine primary or secondary payer).
- Your name exactly as it apears on your Medicare card (no nicknames).
- Notify Social Security of any changes in address, phone number, and ask that changes be made in the Master File (which will also change the information in your Medicare file).
- Update providers' files with changes in address, phone number, etc.

Medicare is authorized to ask service providers for important medical or personal information about you, **but only with your permission.** This information is given to Medicare intermediaries, carriers, the medical review board, and providers in order to administer Medicare claims.

You **may refuse** to give permission to **release** the requested information, but-**you must give information about . . .**

- work injuries
- auto injuries
- other liability related insurance claims

Keep in mind, withholding information may result in slow or no payment. You have the right to obtain information about their claims.

Medicare Part A Claims

How are Part A claims Processed?
Medicare participating facilities submit the claim to Medicare. Since the facility accepts assignment, Medicare pays the facility directly.

When Should You Pay the Facility?
You should wait until you know that Medicare and any other insurance has paid before you pay anything. **You must inform the facility of your intention to wait.**

Usually, facilities file all private insurance claims as well as Medicare claims and receive reimbursement directly from the insurer. You may request an itemized bill from the facility, but this will not reflect Medicare's payment, only what was paid.

You will receive a **Medicare Summary Notice (MSN)** from Medicare. This form describes days used, and the deductible, and/or the co-payments that you owe. The MSN is usually received within 60-90 days after hospitalization. Wait on **both** the Medicare Summary Notice, **and** the hospital bill before paying.

Can the Service Provider Bill You for More Money?
For Medicare covered services, the facility **cannot** bill you for the difference between Medicare's payment and the facility's actual costs. The facility may bill you only for Medicare covered services that are counted toward the deductible, any co-payment, and any Medicare non-covered services provided.

Who is the Intermediary?
The intermediary is the organization that processes Part A claims. Hospital and skilled nursing facility claims are processed in Indiana by **National Government Services** (formally AdminaStar Federal)**.** Home health care and hospice claims are processed by regional intermediaries. Indiana's regional intermediary is **Palmetto Government Services**.

Medicare Part B Claims

When Are Part B Claims Processed by the Part A Intermediary?
This occurs when the individual receives Part B services in a Part A facility. In these instances, services are reimbursed according to Part B coverage through the Part A intermediary. This usually means that you must meet the Part B deductible, and coinsurance.

Railroad Retirees and Medicare
For Part B claims, **Railroad Retirees** should deal with **United Health Care**. Regional carriers are listed in the *Railroad Medicare Handbook*. The phone number will also be listed on the beneficiary's Medicare Summary Notice.

When Services Occur Outside Indiana
Medicare claims must be submitted to the Medicare carrier or intermediary **in the state where the individual received the service**. If you have residences in more than one state, take special note of where the service was performed, because there is an **exception** to this rule. Durable Medical Equipment claims are filed by the supplier with regional carriers in the state of your permanent residence (the address where you spend six {6} months of the year). The Social Security Administration can supply the name of each state's Medicare carrier. Carriers are listed in the back of the *Medicare and You Handbook*.

Medicare Summary Notice

The **Medicare Summary Notice (MSN)** is an easy to read statement that clearly details your insurance claim information. You will normally receive your MSN from the carrier. **These notices are sent on a quarterly basis (every three months),** unless you are due a payment check from Medicare. In that case the MSN will be sent as your claims are processed.

The MSN lists the details of services you received and the amount you may be billed. It is important to compare the MSN to bills received from providers to determine which have been processed and paid, and which have not.

- When it is determined that some medical bills have not been processed, request that the service provider **resubmit** the bills to Medicare.
- **Denied** payments may indicate that the service provider may have used an incorrect code. You should call the provider and ask them to double check the coding and **resubmit** the claim.
- If the deductible has not been met, it is subtracted from the Medicare approved amount. Medicare's 80% payment is then calculated.

Non-Participating Providers

When a provider does not accept assignment, you will be sent a check from Medicare to pay the provider. The **check will be attached to the bottom of the MSN**. These MSN are sent out as the claims are processed. Be careful to not file MSN attachments without understanding their purpose. Many beneficiaries do not notice the check and file it away without cashing it.

- **Deposit** the check, then **write a personal check** to the provider. This creates a way to track payments.
- Keep a copy of the MSN until the bill is completely settled.
- Send only **copies** of the MSN or other papers.

Submitting Claims

Assigned and non-assigned providers must submit claims within **12 months** of providing the service to you. Non-assigned providers may request a three (3) month extension. Medicare will usually deny payments on late claims. In these cases you are not responsible for paying the amount Medicare would have paid if the claim was filed on time, nor for paying any coinsurance.

If you have already paid money on these claims, Medicare will instruct the provider to **refund** the money. **Nonparticipating** providers on unassigned claims will be asked by Medicare to refund money paid by you, **but they are not required** to offer a refund. If a provider refused to submit a claim, or if you have a problem with delayed payments, contact:

1-800-Medicare (1-800-633-4227).
If you must submit a claim yourself, send all information to:
Medicare Part B Claims, P.O. Box 6160, Indianapolis, IN 46204-6160

Important Points of the MSN

- There are separate MSNs for Medicare Part A and Medicare Part B. (See copies of MSN brochures.)

- A claim is paid unless there is a message in the **Notes** section that says it was not or if the **Non-Covered Charges** column contains amounts other than zero (0).

- The Notes section contains valuable information that will explain how the claim was processed.

- The MSN provides the right to appeal the payment or claim denial. A beneficiary simply circles the item on the MSN he/she disagrees with, signs the form, and returns it to National Government Services for review. It is only necessary to return the form if the beneficiary disputes a denied claim or other problem.

- Deductible and coinsurance amounts are not shown separately. The two (2) amounts are added together and shown in the deductible and coinsurance column. The Notes section identifies the amount of the deductible met and still to be met.

- The dates of service do not appear at the top of the claim information. These dates are shown several lines down below the words “referred by.” They refer to the date the service was received, not the date the patient was referred for service.

- The logo in the upper left hand corner of the MSN refers to the Centers for Medicare and Medicaid Services (CMS). CMS is the government agency responsible for the Medicare and Medicaid programs. The logo shows both Medicare and Medicaid, but that does **not** mean that a beneficiary has both.

Below is a sample of an MSN for Part A and information on how to read it.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice (1)

June 16, 2006

(2) CUSTOMER SERVICE INFORMATION

(4) Name
Street Address
City, State ZIP Code

Your Medicare Number: 111-11-1111-A (3)

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

(5) **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Hospital Services
TTY users should call: 1-877-486-2048.

This is a summary of claims processed from 5/15/06 through 8/15/06.

(6) **PART A HOSPITAL INSURANCE - INPATIENT CLAIMS**

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
(7) Claim number 12345-84956-84556 (8) Hospital Name, Street Address, City, State ZIP Code Referred by: Paul Jones, M.D. (9) 04/07/06–05/09/06	(10) 14 days used	(11) $0.00	(12) $876.00	(13) $876.00	(14) a, b

THIS IS NOT A BILL – Keep this notice for your records.

1. **Date:** Date MSN was sent.
2. **Customer Service Information:** Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).

3. **Medicare Number:** The number on your Medicare card.

4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.

5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.

6. **Part A Hospital Insurance - Inpatient Claims:** Type of service. See the back of MSN for additional information. (**Please Note:** For outpatient services, this section is called "**Part B Medical Insurance - Outpatient Facility Claims.**")

7. **Dates of Service:** Dates service were provided. You may use these dates to compare with the dates shown on your hospital bill.

8. **Claim Number:** Number that identifies this specific claim.

9. **Benefit Days Used:** Shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods. (**Please Note:** For outpatient services, this column is called "**Amount Charged.**")

10. **Non-Covered Charges:** Shows the charges for services denied or excluded by the Medicare program for which you may be billed.

11. **Deductible and Coinsurance:** The amount applied to your deductible and coinsurance.

12. **You May Be Billed:** The total amount the provider may bill you, including deductibles, coinsurance, and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.

13. **See Notes Section:** If letter appears, refer to (15) for explanation.

14. **Provider's Name and Address:** Facility's name and billing address. The referring doctor's name will also be shown. The address shown is the billing address, which may be different from where you receive the service(s).

15 **Notes Section:**

a You have 46 full days remaining in this benefit period.

b $876.00 was applied to your inpatient deductible.

16 **Deductible Information:**

You have met the Part A deductible for this benefit period.

17 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

18 **Appeals Information - Part A (Inpatient)**

If you disagree with any claims decisions on Part A of this notice, your appeal must be received by **November 1, 2006**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here_____Phone Number (___)_____

15. Notes Section: Explains letters in (13) for more detailed information about your claim.

16. Deductible Information: How much of your deductible you have met for the benefit period.

17. General Information: Important Medicare news and information.

18. Appeals Information: How and when to request an appeal.

Below is a sample of an MSN for Part B and information on how to read it.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice (1)

June 16, 2006

(2) CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111-A (3)

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Doctor Services
TTY users should call: 1-877-486-2048.

(4) Name
Street Address
City, State ZIP Code

(5) **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

This is a summary of claims processed from 5/15/06 through 8/15/06.

(6) **PART B MEDICAL INSURANCE - ASSIGNED CLAIMS**

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
(7) Claim number 12345-84956-84556		(10)	(11)	(12)	(13)	(14)
(8) Doctor name, Street Address, City, State ZIP Code		$55.00	$44.35	$0.00	$44.35	a
(9) 04/07/06	1 Office/Outpatient Visit, ES (99214)					b

(15) **THIS IS NOT A BILL** – Keep this notice for your records.

1. **Date:** Date MSN was sent.
2. **Customer Service Information:** Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. **Medicare Number:** The number on your Medicare card.

4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.

5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.

6. **Part B Medical Insurance - Assigned Claims:** Type of service. See the back of MSN for information about assignment. (**Please Note:** For unassigned services, this section is called "**Part B Medical Insurance - Unassigned Claims.**")

7. **Dates of Service:** Date service or supply was received. You may use these dates to compare with the dates shown on the bill you receive from your doctor.

8. **Claim Number:** Number that identifies this specific claim.

9. **Services Provided:** Brief description of the service or supply received.

10. **Amount Charged:** Amount the provider billed Medicare.

11. **Medicare Approved:** Amount Medicare approves for this service or supply.

12. **Medicare Paid Provider:** Amount Medicare paid to the provider. (**Please Note:** For unassigned services, this column is called "**Medicare Paid You.**")

13. **You May Be Billed:** The total amount the provider may bill you, including deductibles, coinsurance, and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.

14. **See Notes Section:** If letter appears, refer to (16) for explanation.

15. **Provider's Name and Address:** Doctor (may show clinic, group, and/or referring doctor) or provider's name and billing address. The referring doctor's name may also be shown if the service was ordered or referred by another doctor. The address shown is the billing address, which may be different from where you received the services.

16 **Notes Section:**

a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

b This approved amount has been applied toward your deductible.

17 **Deductible Information:**

You have now met $44.35 of your $100 Part B deductible for 2006.

18 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

19 **Appeals Information - Part B**

If you disagree with any claims decisions on this notice, your appeal must be received by **November 1, 2006**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here_____Phone Number (___)_____

16. Notes Section: Explains letters in (14) for more detailed information about your claim.

17. Deductible Information: How much of your yearly deductible you have met.

18. General Information: Important Medicare news and information.

19. Appeals Information: How and when to request an appeal.

Assigned Claims

Providers **take assignment** and **accept Medicare's approved amount** as total payment for the service. You may be billed for:

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service

Non-Assigned Claims

Providers **do not** take assignment, and **do not accept Medicare's approved amount** as total payment for the service. You may be billed for:

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service
- Charges in excess of the Medicare approved amount, (not in excess of the 115% Limiting Charge.

If a provider will not refund charges in excess of the Limiting Charge or continues to attempt to collect the excess charges, the beneficiary should report this to the **Medicare Fraud and Abuse Division at: 1-800-Medicare (1-800-633-4227).**

Medicare Billing

Billing for Medicare Part A, Part B, and Managed Care Plans is all processed differently. Questions about bills and claims should be directed to Medicare, the Medicare carrier, Managed Care Plan, and/or the provider, depending on the services, claims and bills in question.

Part A Claims

When the beneficiary goes into the hospital:

1. The hospital bills Medicare for all covered charges.
2. The Medicare Intermediary sends payment directly to the hospital and sends a Medicare Summary Notice to the patient.
3. The hospital bills the patient for the Part A deductible and applicable co-payments if in over 60 days, and for any other services not covered by Medicare.

Part B Claims

When the beneficiary goes to a physician or other service provider that **accepts Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. The Medicare carrier pays 80% of the approved charge directly to the provider minus the Part B deductible and sends the beneficiary a Medicare Summary Notice.
3. The patient is then responsible for paying the 20% coinsurance to the provider and any amount applied towards the Part B deductible.

When the beneficiary goes to a physician or other service provider that **does not accept Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. Medicare sends a check for 80% of the approved charge with the MSN directly to the patient.
3. The patient should deposit the Medicare check and then must pay the provider Medicare's portion of the bill, the 20% coinsurance, any amounts to be applied toward the annual deductible, and any excess charges up to the Limiting Charge.

Medicare Supplement Policies

Federal and state law mandates that companies selling Medigap policies must participate in **Medigap Cross Over**. Many Medigap companies have a contract with the Medicare carrier and arrange to have Medicare send all claims directly to the Medigap company. This is called **All Claims Cross Over**.

Medigap Cross Over	All Claims Cross Over
Initiated by the beneficiary.	Initiated by the Medigap company.
Service covers all participating and nonparticipating providers.	Service is only for Medicare participating providers.
Payment is sent directly to the participating physician or supplier.	Payment may be to the beneficiary or to the provider.
Federal and state law mandates that companies selling Medigap must participate in Medigap Cross Over.	Companies do not have to offer this service, nor do beneficiaries have to take and buy this service.

How Does Someone Initiate Medigap Cross Over?

A beneficiary should:

- Ask the Medicare participating physician or supplier to submit a completed claim form to Medicare; sign the completed form in two (2) places, giving both Medicare and the insurance company his/her permission to send payment directly to the provider.
- Provide necessary Medigap policy information to the provider to be included on the HCFA claim form #1500 in box 9.

Medicare will:

- Process Medicare's part of the claim and forward the claim information to the Medigap company. The Medigap company is required by law to accept the claims information from Medicare. Medigap companies pay a user fee to receive these claims.

The Medigap company will:

- Pay its portion of the claim directly to the participating physician or supplier.

Managed Care Plans

Managed Care Plans provide covered services for Parts A and B. The beneficiary may have co-payments, as specified in the Managed Care agreement. There is no bill processing as is described above. Beneficiaries should contact their plan for more information on that company's billing process.

Beneficiaries should never send original copies of bills in question

When Medicare Is Not The Primary Payer

Medicare is the secondary payer after claims have been processed through the primary insurance company for the following:

Employer Group Insurance

Medicare is secondary for persons that are 65 years old or older who have an employer group health plan through **current employment** or the **current employment of a spouse**. This law applies when the employer has 20 employees or more.

- For Medicare covered services not included under the employer's plan, Medicare would be a primary payer.
- When the employer group plan is an HMO, and the person goes to a provider outside the HMO network, Medicare will pay as the primary payer for the first few claims. Medicare will send a letter stating that Medicare will no longer pay for out-of-network providers.
- For people who are disabled, Medicare is the secondary payer if he/she accepts a group health plan and:
  1. Is under 65 years old and has Medicare due to a disability
  2. Is covered under a group health plan because of current employment or the current employment of a family member of any age.
  3. The employer has 100 or more employees.

End Stage Renal Disease Patients

Medicare is secondary for persons with ESRD that have an active employer group health plan or are on COBRA.

Veterans Administration

See the *Navigation Guide for Supplemental and Other Insurance*.

Federal Black Lung Program

See the *Medicare and Other Health Benefits* booklet.

Liability Settlements

Medicare will be the secondary payer whenever an injury has occurred which is covered and paid by a liability or no-fault insurance. This will occur in the following cases:

- **Automobile Insurance** Submit automobile accident related claims to the insurance company before submitting them to Medicare.
- **Liability Insurance** (homeowner, malpractice, etc.) These claims may be submitted to Medicare for a conditional payment (after three {3} months). After a liability settlement is reached, Medicare will recover the conditional payment from the settlement amount.
- **Worker's Compensation** Medicare will be billed first if the claim is contested and the person is waiting for the Worker's Compensation Board decision. The bill should include a statement that the claim is being contested.

Patients must inform the provider when the injury or illness for which he/she is seeking medical attention is the result of a **work related incident**, an **auto accident**, or an injury involving **liability** or **homeowner insurance**. This type of insurance would then be the primary payer.

Medicare beneficiaries and their providers must accurately complete the section of the Medicare claim form that deals with other health insurance.

Medicare has the right to be a secondary insurance payer due to **subrogation laws**. Subrogation prevents people from receiving double insurance payments and making a profit on an injury. A beneficiary that receives a monetary settlement could receive demands from Medicare to return payments that Medicare had previously made. To prevent this, Medicare beneficiaries should inform Medicare whenever there is any kind of liability insurance involved.

What Medicare Pays When Medicare Is the Secondary Payer?

Medicare does **not act like a supplement** to the primary insurance. This means **Medicare will not always pay the remaining amount after the primary insurance has paid**. If the primary insurance payment is less than Medicare's approved amount, Medicare may pay the difference. If the primary payment is equal to or more than the Medicare approved amount, Medicare will pay nothing.

Medicare does not act like a supplement to the primary insurance. Medicare deductibles must be met before Medicare will pay. This is true whether Medicare is the primary or secondary payer. AdminaStar Federal has a special department called the Medicare Secondary Payer Unit. Questions should be addressed there by calling 1-800-633-4227.

Who Files the Claim When Medicare is the Secondary Payer?
Facilities that provide the services will usually file with the primary insurance and also with Medicare when Medicare is the secondary payer. Doctors or suppliers have a choice of whether or not to file the claim with the primary insurance company when Medicare is a secondary payer.

When the doctor files a claim with the primary insurance and receives payment from them, then the doctor must also file the claim with Medicare.

When you file the claim with the primary insurance company and receives the payment from the company, then you can do either of these:

1. Take all paperwork to the doctor including the insurance company's payment information and request the doctor file the claim with Medicare.

2. File your own claim with Medicare, using form #1490-F. This form can be obtained from the Social Security Administration, or Medicare, (**1-800-633-4227)**

When filing claims with Medicare when Medicare is secondary, you must include a copy of the primary insurance company's benefit statement, whether it is the provider or the beneficiary filing the form.

Private Insurance Claims

Medigap policies **coordinate** benefits with Medicare. Some Medicare supplement policies pay for excess charges above the Medicare approved amount, usually up to the Limiting Charge. They may also pay for specific Medicare non-covered services.

Check the policy to know what it will pay.

Most private insurance companies want a copy of the Part B Medicare MSN before it will reimburse for the claim. Some also require a bill from the provider and its own insurance claim form. Some may have cross over service with Medicare. Check with the company for information about its services and requirements regarding claims. The typical filing process is as follows:

- The provider files the claim with Medicare. The beneficiary should wait to receive the MSN.
- The beneficiary attaches a copy of the MSN to the insurance company's claim form. He/she should also attach the actual bill if the insurance company requires it.
- The beneficiary mails all items in the envelope supplied by the insurance company (if there are any) to insure prompt processing.
- A beneficiary should **never** send his/her only copy of the MSN or other forms.

See *SHIP's Claims Record Form* in the *Navigation Guide 4 Section R Forms*.

Medicare: Fraud and Abuse

Most Medicare payment errors are due to simple mistakes, and not the providers trying to take advantage of system. Unfortunately there are those who do try to abuse or defraud Medicare. National Government Services (formally AdminaStar Federal) has fraud and abuse divisions where beneficiaries can report the following:

- Providers performing unnecessary or inappropriate services.
- Providers billing Medicare for services the person did not receive.
- Providers who refuse to file claims to Medicare.
- The use of someone else's Medicare claim number to receive services or supplies.

To contact National Government Services use the contact information on your MSN.

Detection Tips

You should be suspicious if the provider tells you that:

- The equipment or service is free; he only needs your Medicare number for his records. NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is no cost to the person with Medicare.
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for it.
- The more tests they provide the cheaper they are.

Be suspicious of providers that:

- Charge co-payments on clinical laboratory tests, and on Medicare covered Preventive Services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.
- Routinely waive co-payments on any services, other than those previously mentioned, without checking your ability to pay.
- Advertise "free" consultations to people with Medicare.
- Claim they represent Medicare.
- Use pressure or scare tactics to sell you high priced medical services or diagnostic tests.

- Bill Medicare for services you did not receive.
- Use telemarketing and door-to-door selling as marketing tools.

Prevention Tips

To help prevent Medicare fraud, you should report suspected instances of fraud. Whenever you receive a payment notice from Medicare, review it for errors. The payment notice shows what Medicare was billed for, what Medicare paid and what you owe. Make sure Medicare was not billed for health care services or medical supplies and equipment you did not receive.

The following is a list of tips to prevent fraud:

- Don't ever give out your Medicare Health Insurance Claim Number (on your Medicare card) except to your physician or other Medicare provider.
- Don't allow anyone, except appropriate medical professionals, to review your medical records or recommend services.
- Don't contact your physician to request a service that you do not need.
- Do be careful in accepting Medicare services that are represented as being free.
- Do be cautious when you are offered free testing or screening in exchange for your Medicare card number.
- Do be cautious of any provider who maintains they have been endorsed by the Federal government or by Medicare.
- Do avoid a provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid.

The carrier or intermediary need to be notified of the possible fraud or abuse, the date it occurred, and the names and addresses of the provider and beneficiary involved.

Always report suspected Medicare Fraud and Abuse.

Privacy and Medicare

The purpose of the Privacy Act of 1974 is to provide safeguards for you against an invasion of privacy by Federal agencies. Guidelines for releasing Medicare information have been established for you living or deceased. There are **two (2) ways** to release Medicare information that include the following:

Direct Consent (or Verbal Permission) to Release Information
Direct consent from you will enable the Customer Service Representative (CSR) at National Government Services (formally AdminaStar Federal) to release your information including payment if the CSR receives verbal consent over the phone from you.

Written Consent (or Authorized Permission) to Release Information
Written consent from you will enable the CSR to release information including payment if the caller can verify certain information asked by the CSR and has a consent form on file at the Medicare office. Also, if the caller is a Representative Payee for you or if the caller has Power of Attorney on file at the Medicare office they can receive information about you.

Without Verbal or Written Consent to Release Information
No consent from you will limit the amount of information a CSR can give to a third party caller. Only the following four (4) types for information can be offered:

- If and when Medicare received a claim.
- When the claim was processed (not how).
- When you will receive your MSN.
- General Medicare and coverage questions.

Medicare can send the third party a consent form. There are separate consent forms for Part A, Part B and Durable Medical Equipment. Once the form is filled out, signed, and returned to the Medicare office, Medicare can release information for the Medicare beneficiary on the form only or Medicare can send a copy of the MSN directly to you. Most of the information will be on the notice.

For questions or to have a consent form mailed out, call 1-800-633-4227.

APPEALS

SECTION E

MEDICARE APPEAL PROCESS

Traditional Medicare Part A Appeals

A Traditional Medicare Part A appeal starts with a notice from the provider to the Medicare beneficiary that the provider does not believe Medicare coverage can continue past a specified date. The notice contains a form that the beneficiary may complete and return to the provider. By completing and returning the form, the beneficiary can indicate that she wants to continue the services (and will find a way to pay for them) and that she believes Medicare should continue to cover the service.

There are three levels of administrative appeal that an aggrieved Medicare beneficiary may pursue, followed by the option of filing a case in federal court. There are slight differences in the structure of the appeal process for hospital, skilled nursing facility and home health cases. The rules must be closely followed. All original documentation and copies of written appeals should stay in your possession.

Hospital Appeals

Important Message to Medicare Beneficiaries is given to the patient upon admission. The text of the Important Message may be found on Pages 7-8 of the Medicare Hospital Manual, Transmittal 801. This Transmittal can be viewed at http://www.cms.hhs.gov/medicare/bni/R193FormInstruction.pdf

The Medicare beneficiary/patient is informed that Medicare coverage for the hospital stay will cease.

I. Immediate Review

The patient may appeal by requesting an Immediate Review.

- To request an Immediate Review, the patient is informed by the Important Message to call 1-800-Medicare for referral to Quality Improvement Organization, (QIO). **In Indiana it is Health Care Excel.**

- The patient must call the QIO to ask for Immediate Review.
- The call to the QIO must be made by noon of the day after hospital notification that Medicare coverage will cease.
- The QIO obtains the pertinent hospital records, reviews them and makes a decision on Medicare coverage by the following day.
- The QIO decision is delivered in writing. If mailed, there is a presumption that it is received no later than 5 days after it was mailed.
- If the QIO affirms the Medicare coverage termination, the patient becomes liable for the cost of the care if she does not leave the hospital by noon of the day following receipt of the QIO's adverse Immediate Review decision.

II. Reconsideration

The beneficiary may appeal the QIO's adverse Immediate Review decision by requesting Reconsideration.

- Reconsideration must be requested in writing and request forms are available on http://www.medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration, or with the QIO.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $200 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There must be $200 at issue to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $200 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Skilled Nursing Facility (SNF) Appeal

The SNF Notice: The SNF provides a written notice, called a Sarassat Notice. The Sarassat Notice informs the Medicare beneficiary that if she disagrees with the SNF's determination that Medicare coverage will cease, she must complete and return to the SNF the form included with the notice (usually found on the back of the notice,) indicating that she wants the SNF to submit a claim to the Medicare fiscal intermediary for services provided after the date the Sarassat notice indicates that Medicare coverage will cease.

The Demand Bill

The claim submission is called a demand bill. Unless she remains in the SNF receiving daily skilled services, and has the SNF submit a demand bill, no Medicare appeal may be brought.

I. The Medicare Initial Determination

The Medicare fiscal intermediary reaches a decision on Medicare coverage and notifies the beneficiary by sending a Medicare Summary Notice, (MSN). To view Medicare Summary Notices and to obtain more information about these notices, you may go to http://www.medicare.gov/Basics/SummaryNotice.asp.

II. Reconsideration

The beneficiary must request Reconsideration in writing no later than 120 days after receipt of the adverse MSN. Reconsideration must be requested in writing and request forms are available on http://www.medicare.gov/Basics/forms/default.asp.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.

- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.

There must be at least $100 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There must be $ 100 at issue to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,000 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Home Health Care

The Home Health Agency Notice

At least one day or one visit prior to the discontinuance of Medicare coverage, the home health agency gives the patient a **Home Health Advance Beneficiary Notice, (called a HHABN)** . The HHABN contains a form that must be complete returned to the home health agency, to request submission of a demand bill.

Requirements to Maintain a Home Health Appeal

In order to maintain a Medicare appeal, services must be continued after the date on which the agency has notified the beneficiary that Medicare coverage will cease. And a demand bill must be submitted to the Medicare fiscal intermediary or carrier (depending upon which Part of Medicare was covering the services prior to the issuance of the HHABN).

I. The Medicare Initial Determination

The Medicare carrier or fiscal intermediary makes a decision and transmits it to the beneficiary by issuing an MSN. Medicare decisions based on demand and bills are usually adverse to the beneficiary, ratifying the provider's view that Medicare coverage should cease.

II. The Reconsideration

The beneficiary must request Reconsideration in writing no later than 120 days after receipt of the adverse MSN.

- Reconsideration must be requested in writing and the request forms are available on http://www.medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration, or with the fiscal intermediary.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing. The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision. The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp. There must be at least $100 at issue in order to appeal a Medicare denial of home health coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There must be $ 100 at issue to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,000 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision. While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Traditional Medicare Part B Appeals

In Medicare Part B, the provider always submits the Medicare claim to the Medicare carrier. The Medicare Carrier issues its initial determination in a notice to the beneficiary, after which, an aggrieved beneficiary may pursue three levels of administrative review, followed by the possibility of filing a federal court case. The rules governing the time lines for submission of appeals and the amount of money that must be at issue must be closely followed.

I. The Medicare Claim

The Medicare Part B provider submits the Medicare claim to the carrier.

II. The Initial Determination

The carrier makes a decision on Medicare coverage, called an initial determination. The Medicare carrier sends the Initial Determination to the beneficiary by issuing an MSN or an Explanation of Medicare Benefits, (EOMB.) To view Medicare Summary Notices and to obtain more information about these notices, you may go to http://www.medicare.gov/Basics/SummaryNotice.asp.

III. The Review

An adverse initial determination is appealed by requesting a review by the carrier. A request for review must be made in writing and forms for this purpose may be found on http://www.medicare.gov/Basics/forms/default.asp.

The review request must be filed with the carrier by 120 days after receipt of the MSN or EOMB. There is a 5 day presumption for receipt after the date on which the carrier mailed the MSN or EOMB to the beneficiary.

IV. The Carrier Hearing

If the review decision is adverse, the beneficiary may appeal by requesting a Carrier Hearing.

- The Carrier Hearing must be requested within 180 days of receipt of the adverse review decision.
- There must be $100 at issue to take an appeal to a Carrier Hearing.
- The Carrier Hearing must be requested in writing and forms for requesting a Carrier Hearing may be found on http://www.medicare.gov/Basics/forms/default.asp.

V. The Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $100 at issue in order to appeal a Medicare Part B overage denial to an Administrative Law Judge.

VI. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal.

- DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at www.medicare.gov.
- There must be $100 at issue to appeal a case to the DAB.

VII. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,000 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

NAVIGATION GUIDE TO MEDICARE SUPPLEMENTAL INSURANCE

A Quick Reference Guide for
SHIP Counseling

The Navigation Guide for Medicare Supplemental Insurance is designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of she/he, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 6 option 1.

MEDICARE SUPPLEMENT INSURANCE

(MEDIGAP POLICIES)

SECTION G

MEDICARE SUPPLEMENT INSURANCE

Introduction

A Medicare Supplement Insurance policy, also known as a Medigap policy, is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare coverage. These gaps in coverage include deductibles, co-insurance, and co-payments. When you purchase a Medigap policy you will pay a monthly premium in addition to your Medicare Part B premium. Medigap policies can be either a group policy or an individual policy. Medigap policies must follow federal and state laws. These laws are for your protection. The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

Group Policies

Group Medigap policies can be offered by an employer as part of a retirement package, or obtained through an organization that offers this type of insurance to its members (i.e. The American Legion). The employer or organization is the group policyholder. As the group policyholder the employer or organization will determine how and when the policy will pay. Benefits covered by these group policies will vary based on how the policy is structured.

Not all retirement plans are Medigap policies. Many insurance policies offered by employers, labor organizations, or trustees of a fund established by an employer or labor organization are not Medicare Supplement Policies.

Individual Policies

Individual Medigap policies are available for purchase from private insurance companies. Originally these policies covered a variety of benefits. Medigap policies changed with the Omnibus Budget Reconciliation Act (OBRA) of 1990. Beginning January 1, 1992, insurance companies can only sell you a “standardized” Medigap policy. These policies must all have specific benefits so that you can easily compare.

Currently there are 12 standardized Medigap policies available (Medigap Plans A through L). See pages G7-G11 for more information on specific benefits for each plan.

Medigap Policy Requirements

As a Medicare beneficiary you have protections based on federal and state laws. Insurance companies must meet certain requirements in offering Medigap policies. These requirements include:

- **Outline of Coverage**: Insurance agents must give each applicant an outline of coverage, summarizing the policy's benefits and features.

- **30 Day Free Look**: Once you receive the certificate or policy you have 30 days to review the policy and return it for a full refund of premiums paid. This is called a "free look period." If the certificate or policy is mailed to you, the 30 day free look begins the date of the postmark on the envelope.

- **Pre-existing Condition**: While the insurance company can't make you wait for all your coverage to start, it may be able to make you wait for coverage for a pre-existing condition. A pre-existing condition is a health problem you have received treatment before the date a new insurance policy begins.
    - If you have a health problem before your Medigap policy starts, the insurance company can refuse to cover that health problem for **up to 6 months**. This is called a **pre-existing condition waiting period**.

    - The insurance company can only use this waiting period **if your health problem was diagnosed or treated during the 6 months before the Medigap policy starts.**

    - If you buy a Medigap policy during your Medigap Open Enrollment and you had at least 6 months of health coverage that qualifies as "creditable coverage," the company cannot apply a pre-existing waiting period.

- If you had less than 6 months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had 4 months of creditable coverage, the waiting period would be reduced to 2 months.

- Creditable coverage for Medigap policies is defined as any other health coverage you had prior to applying for a Medigap policy, without a break in coverage longer than 63 days. These types of health coverage may be considered creditable coverage:
    - A group health plan (i.e. employer or union plan)
    - A health insurance policy
    - Medicare Part A or Part B
    - Medicaid
    - A medical program of the Indian Health Service or tribal organization
    - ICHIA (state health benefits risk pool)
    - TRICARE (military retirees and dependents)
    - A Federal Employees Health Benefit plan
    - A public health plan
    - COBRA
    - SCHIP (State Children's Health Insurance Program)
  - The following are **not considered** creditable coverage:
    - Hospital indemnity insurance
    - Specified disease insurance (i.e. cancer insurance)
    - Vision or dental plans
    - Long-term care policies

- If you buy a Medigap policy when you have special Medigap protections (also called guaranteed issue rights), the insurance company cannot use a pre-existing condition waiting period.

- If you are replacing a Medigap policy, the new company will waive any waiting periods that apply if you were covered under the old policy.

- **Guaranteed Renewable**: If you purchased your Medigap policy after 1990, the Medigap policy is required to be guaranteed renewable. **This means the insurance company can only drop you if you stop paying your premium, you aren't truthful about something under the policy, or the company goes bankrupt.**

- **Coordination of Benefits**: Medigap policies may not contain benefits that duplicate benefits provided by Medicare. This means the policies will not duplicate any payments Medicare has made. It also means policies will not usually cover services that Medicare would not approve. Exception - some policies will pay for additional benefits not covered by Medicare (such as foreign travel, preventive care, and Part B excess charges).

- **Canceling A Group Master Policy**: When a group policyholder cancels their Medigap group master policy, the insurance company must offer each insured beneficiary the opportunity to convert their group coverage to an individual Medigap policy.

- **Medigap Standardization**: There are **12 standardized plans** that can be sold in any state. These plans were developed by the National Association of Insurance Commissioners (NAIC). They are labeled **Plans A though L**.
    - Each standardized plan will be **identical in benefits** from company to company; however, premiums for each plan may vary from company to company.

    - A state may limit the number of plans sold in that state to less than 12, but **Plan A must be included as one of the plans for sale**.

    - In Indiana, all Medigap insurance companies must offer Plan A, but can choose to sale any of the other 11 plans. Other than Plan A, the insurance companies, in Indiana, are not required to sale any other plan.

    - Not all standardized plans are offered in every state.

- Some states are exempted from federal standardization due to programs in place prior to the law being enacted (Minnesota, Massachusetts, and Wisconsin).

- Some states allow additional benefits to be offered by the insurance company.

- The only US areas where standardization is not in effect are Guam, American Samoa, and the Northern Mariana Islands.

- **Pre-standardized Policies**: If you have a Medigap policy purchased before 1992, then it is most likely a pre-standardized policy.
  - **In Indiana, the standardization law does not effect the pre-standardized policies**. Medicare beneficiaries were not required to purchase a standardized policy.

  - While these policies can no longer be sold, as long as the policies are in effect the benefits will still be covered.

  - Basic benefits for pre-standardized policies included co-payment coverage for Parts A and B, the first 3 pints of blood, and coverage for an additional 365 days of hospitalization (paid at 90%).

  - Insurance companies added various other benefits to these policies and combined then in a number of ways. Many of these policies offered excellent prescription drug coverage.

  - These policies must be reviewed in order to determine what benefits are covered by the policy.

- **Duplication of Coverage**: It is illegal for an agent to knowingly sell you a second Medigap policy, if you already have a Medigap policy, or are in a Medicare Advantage Plan. When you buy a Medigap policy to replace a current policy, you must state in writing that you intend to cancel the first policy after the new policy becomes effective.

- **You should never cancel a Medigap policy until the new one is in your hands and you have decided to keep it.** Just because you want to switch plans does not mean the insurance company has to sell you the plan. If you are not in your Medigap Open Enrollment Period or have a Guaranteed Issue, it is up to the company to choose whether or not to sell you a plan.

- **Medicaid and Medigap**: There are some special situations when it comes to Medicaid and Medigap policies.
    - If you have a Medigap policy and then become a Medicaid member, you can suspend your Medigap policy within 90 days of receiving Medicaid coverage. This suspension can be for up to two years. During this time you will not be required to pay your premiums, but your policy will not pay for benefits. At the end of the suspension, you can restart your policy without new medical underwriting or pre-existing condition waiting periods. As of January 1, 2006, if you suspend your policy and it included drug coverage, you can still get your policy back but without the drug coverage benefit.

    - If you already have Medicaid, an insurance company can sell you a Medigap policy only if:
        - Medicaid pays your Medigap policy premium, or
        - Medicaid pays your Part B premium as part of the Medicare Savings Program.

- **Medicare SELECT**: Medicare SELECT policies are standardized Medigap policies that are offered through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization). **As a Medicare SELECT policyholder, you agree to use designated providers and in turn you may pay lower premiums.** You may **choose at anytime to switch** to a traditional standardized Medigap policy sold by the company, or a policy containing lower benefit levels. Should the Medicare SELECT program be discontinued, continuation of coverage will be offered to you in the form of a traditional Medigap policy.

Medigap Coverage

Basic Benefits

Each standardized Medigap policy must cover basic benefits. Plans A though J have one set of standardized benefits, and Plans K and L have another set. Most policies pay some if not all of the Medicare coinsurance and co-payments. In addition, Medigap policies can offer "Extra Benefits." These benefits can cover such things as Part A and/or Part B Deductibles, Skilled Nursing co-payments, Foreign Travel, Preventive Care, and the Part B Excess Charge. The following charts list the basic benefits and how they are covered by each Medigap Plan.

Basic Benefits	What Medigap Plans A through J will pay in 2008
Medicare Part A co-payment and hospital benefits	**Medigap Plans A through J pay**: $267 per day for days 61-90 of a hospital stay $534 per day for days 91-150 of a hospital stay (while using your 60 lifetime reserve days) Up to 365 more days for hospital stays during your lifetime after you use all of your Medicare hospital benefits.
Medicare Part B co-payments or coinsurance	**Medigap Plans A through J pay:** all coinsurance and co-payment amounts after you meet your $135 annual deductible for Medicare Part B.
Blood	**Medigap Plans A through J pay:** for the first three pints of blood per year.

Basic Benefits	What Medigap Plans K and L will pay in 2008
Medicare Part A co-payment and hospital benefits	**Medigap Plans K and L pay**: $267 per day for days 61-90 of a hospital stay $534 per day for days 91-150 of a hospital stay (while using your 60 lifetime reserve days) Up to 365 more days for hospital stays during your lifetime after you use all of your Medicare hospital benefits
Medicare Part B co-payments or coinsurance	**Medigap Plan K pays** 50% of the Medicare Part B coinsurance and co-payment amounts after you meet your $135 annual deductible. It pays 100% of the coinsurance for preventive services. **Medigap Plan L pays** 75% of the Medicare Part B coinsurance and co-payment amounts after you meet your $135 annual deductible. It pays 100% of the coinsurance for preventive services
Blood	**Medigap Plan K pays** 50% of the first three pints of blood per year. **Medigap Plan L pays** 75% of the first three pints of blood per year.
Hospice Care	**Medigap Plan K pays** 50% of the cost-sharing for all Part A expenses and respite care. **Medigap Plan L pays** 75% of the cost-sharing for all Part A expenses and respite care.

Overview of Medigap Plans A through L

A	B	C	D	E	F*	G	H	I	J*	K	L
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits (Includes Hospice Coinsur-ance)	Basic Benefits (Includes Hospice Coinsur-ance)
		Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility (50%)	Skilled Nursing Facility (75%)
	Part A Deductible	Part A Deductible	Part A Deducti-ble	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible (50%)	Part A Deductible (75%)
		Part B Deductible			Part B Deductible				Part B Deductible		
					Part B Excess Charge (100%)	Part B Excess Charge (80%)		Part B Excess Charge (100%)	Part B Excess Charge (100%)		
		Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel		
			At Home Recovery			At Home Recovery		At Home Recovery	At Home Recovery		
				Preven-tive Care					Preven-tive Care		

* denotes that plans F and J offer high deductible options. The plans pay the same benefits as Plans F and J after you have paid an annual deductible ($1,790).

Extra Benefits

Skilled Nursing Facility Care Co-payment
The amount you must pay for days 21-100 in a skilled nursing facility. In Plans C through J will pay 100% of the co-payment; Plan K pays at 50%, and Plan L pays at 75%.

Part A Deductible
The amount you are responsible for before Medicare will begin to pay for an inpatient hospital stay in each benefit period. Plans B through J will pay 100% of the deductible; Plan K pays at 50% and Plan L pays at 75%.

Part B Deductible
The initial amount that you must pay each year before Medicare will begin to pay Part B services. Plans C, F and J will pay 100% of the deductible.

Part B Excess Charge
The difference between Medicare's approved payment amount and the doctor's or health care provider's actual charge subject to any limiting charge. Plans F, I and J pay 100% of the excess charge; Plan G pays 80% of the excess charge.

Foreign Travel Emergency
Generally, Medicare pays nothing for health care outside of the United States. Plans C through J will pay 80% of health expenses for emergency care after you pay a $250 deductible. This care must be received within the first 60 days of each trip. There is a $50,000 lifetime maximum.

At-Home Recovery
If you have Plans D, G, I or J and you receive Medicare-covered home health benefits, the Medigap policy may pay up to $40 per visit for additional, non-Medicare covered visits to assist you with Activities of Daily Living (ADLs) during recovery from an illness, injury, or surgery. Certain limits apply such as:

- Total number of at-home recovery visits cannot exceed the total number of Medicare covered visits.
- After the date of the last home visit covered by Medicare, the policy will only pay for benefits for up to 8 additional weeks.
- The policy pays maximum of $1,600 per year.

- The visits are limited to 4 hours in duration, $40 per visit, and 7 visits per week.

Preventive Care
If you have Plan E or J you may pay nothing for routine yearly checkups and any non-Medicare covered preventive services your doctor recommends. This benefit has a $120 per year limit.

Note: Plans H through J purchased prior to January 1, 2006, included prescription drug benefits.

Plans H and I offered a Basic Drug Benefit - You pay an annual $250 deductible, and the Medigap plan pays 50% of your prescription drug costs up to a maximum of $1,250 per year.

After January 1, 2006, Medigap policies could no longer be sold with the drug benefits as they did not provide coverage as good as the Medicare Prescription Drug Plans (PDP). Beneficiaries who had plans that offered drug coverage could choose to do one of the following:

- Keep their Medigap policy and its drug coverage,
- Purchase a Medicare PDP and drop their Medigap policy's drug benefit, or
- If they purchased a Medicare PDP before May 15, 2006, they had a guaranteed issue to switched to another Medigap policy.
- If they waited until after May 15, 2006, to purchase a Medicare PDP, they will likely pay a higher premium for their PDP and lose their right to switch to another Medigap policy.

You can drop the Medigap policy's drug coverage only if you purchase a Medicare PDP. If you have drug coverage that is considered creditable coverage for a PDP (such as VA, retirement benefits, etc), you cannot drop your Medigap policy's drug benefit. Creditable coverage is not the same as a Medicare PDP.

Medigap Open Enrollment

The best time to buy a Medigap policy is during your Medigap open enrollment period. **Your open enrollment period lasts for 6 months. It starts on the first day of the month in which you are both age 65 or older, *and* enrolled in Medicare Part B.** Once your open enrollment period starts, it cannot be changed.

During this time, the insurance company:

- **cannot deny you any Medigap policy it sells**
- **make you wait for all your coverage to start**
- **charge you more than the standard rate for any Medigap policy because of your health problems** (medically underwrite your policy).

While the insurance company cannot make you wait for all your coverage to start, it may be able to make you wait for coverage of any pre-existing conditions - this is called a pre-existing condition waiting period. **This waiting period cannot not be longer then 6 months.** Prior health insurance coverage (creditable coverage) reduces or eliminates this waiting period. The insurance company can only use this waiting period **if your health problem was diagnosed or treated during the 6 months before the Medigap policy starts.**

If you buy a Medigap policy during your Medigap open enrollment and you had at least 6 months of health coverage that qualifies as "creditable coverage" the company cannot apply a pre-existing waiting period. If you had less than 6 months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had 4 months of creditable coverage, the waiting period would be reduced to 2 months. (Note: a list of types of creditable coverage is included on page G-3).

Whether you had creditable coverage depends on whether you had any **"breaks in coverage" - when you were without any type of health coverage for more than 63 days in a row**. If you have had one or more breaks in coverage, but each break was shorter than 63 days, then you can add the periods of coverage together.

You can send in your application for a Medigap policy before your open enrollment period begins. This may be important if you currently have coverage that will end when you turn 65. This will allow you to have continuous coverage, without any break.

Federal law allows individuals **under 65 and on Medicare due to disability** to receive a Medigap open enrollment period once they turn 65 years old.

If you are **over 65** and have delayed enrolling in Medicare Part B for any reason, you will have a Medigap open enrollment period once you enroll in Medicare Part B and coverage goes into effect.

If you are unsure if your Medicare open enrollment has passed and you are 65 or older, check your Medicare card. Look at the effective date for your Part B coverage and add 6 months. If that date is in the future you are in your open enrollment. If that date is in the past your open enrollment is over.

If your open enrollment period is over, the insurance company is allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the policy. There is no guarantee that the company will sell you a policy, unless you fall under a “Guarantee Issue Protection.” Under guarantee issue, if you meet certain conditions you may have the right to purchase a Medigap policy without underwriting, and the company cannot deny your application.

Medigap Policy Pricing

Each insurance company sets its own premiums. It is important that you ask how the insurance company sets the prices for their Medigap policies. The method used will effect how much you will pay now and in the future. Medigap policies can be priced in three ways:

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

Type of Pricing	How it's Priced	What Pricing May Mean for You	Examples
Community-rated (also called no-age-rated)	The same monthly premium is charged to every-one who has the Medigap policy, regardless of age.	Premiums are the same no matter how old you are. Inflation will affect the premium.	Mr. Smith is age 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is age 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because with this type of policy, everyone pays the same price regardless of age.
Issue-age-rated	The premium is based on the age you are when you buy (are issued) the Medigap policy.	Premiums are lower for younger buyers. Inflation will affect the premium.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is age 72. She buys the same Medigap policy as Mr. Han. Since she is older at the time she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you have "attained") so your premium goes up each year.	Premiums are low for younger buyers, but go up every year and can eventually become the most expensive. Inflation will affect the premium.	Mrs. Anderson is age 65. She pays a $165 monthly premium. Her premium will go up every year. • At age 66, her premium goes up to $171 • At age 67, her premium goes up to $177 • At age 72, her premium goes up to $189

Medigap Plans and Disability or ESRD

In Indiana, insurance companies can choose to sell Medigap Plans A, B, C or F to individuals under 65 and have Medicare due to disability or ESRD (End Stage Renal Disease). **You must be allowed to purchase Medigap Plans A, B, C or F, if the company chooses to sell to those Medicare beneficiaries under 65.** The monthly premium for these plans may cost you more than policies sold to those over the age 65.

If you are already enrolled in Part B, when you turn 65 years old you will have a 6 month Medigap open enrollment period. This open enrollment period will begin the first day of the month you turn 65 years of age. It does not matter that you have had Part B before you turned 65. During this time:

- you can **purchase any Medigap policy** from any company;
- insurance **companies cannot refuse to sell** you a Medigap policy due to disability or other health problems;
- insurance **companies cannot charge you a higher premium** based on health status than they charge other people who are 65 years old.

When you buy a Medigap policy during your open enrollment period, the insurance company must shorten the waiting period for any pre-existing conditions by the amount of creditable coverage you have. If you had Medicare Part A and/or B for more than 6 months before you turned 65 years old, and you didn't have a break in coverage of 63 or more days, you will not have a pre-existing waiting period.

If you are under 65, have a Medigap policy and have employer group health coverage, you have the right to put your Medigap on hold (suspend your coverage). If you want to suspend your Medigap coverage, you will need to contact your insurance company. Your Medigap coverage will stop, and you will not have to pay your monthly premium while you are enrolled in your or your spouse’s employer group health plan.

When you want to reinstate your Medigap policy, you will not have to pay more for your monthly premium than you would otherwise have to pay if you had not suspended your policy.

Medicare Rights and Protections

In some situations you have the right to buy a Medigap policy outside of your open enrollment period. These rights are called “Medicare protections.” They are also known as “guaranteed issue rights” because the law stated that insurance companies must sell (or issue) you a Medigap policy even if you have health problems. These rights are for both Medigap and Medicare SELECT policies. During this time the insurance company. . .

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

In some situations you have a guaranteed issue right to buy a Medigap policy if you lose certain types of health coverage. You should keep a copy of any letters, notices and claim denials that show you have lost your coverage. Keep anything that has your name on it and any postmarked envelopes to prove when it was received by mail.

It is best to apply for a Medigap policy before your current health coverage ends. This will prevent any breaks in coverage. There may be times when more than one situation applies to you. If that is the case, you may choose the Medigap company that gives you the best choice for policies.

Situations in which you may qualify for a "Guarantee Issue."

There are 7 situations in which you may qualify for a guarantee issue right. These situation include:

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

Your Medicare Health Plan will send you a letter letting you know when your coverage will end. This letter will also include information on any other Medicare Health Plans in your area. You have the option to switch to one of the Medicare Health Plans in your area (in this case you will not need a Medigap policy) or switch to Original Medicare and purchase a Medigap policy.

If you decide to switch to Original Medicare:

- You have the right to buy a **Medigap Plan A, B, C or F**.
- You may leave you Medicare Health Plan any time after the day you receive your letter, but before your coverage ends.
- You may choose to remain in your Medicare Health Plan until your coverage ends.
- You will have **63 days from the day your coverage ends** to apply for a Medigap policy.

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

In this situation, you are in the Original Medicare Plan and you also have coverage from an employer group health plan or union, including COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage.

- If you lose coverage for one of the following reasons:
  - The employer goes out of business
  - The employer stops offering the health plan
  - Your are no longer eligible for the health plan (i.e. if your coverage is from your spouse and you divorce, or your spouse dies)
  - You have COBRA coverage that is ending

- You have the right to buy a Medigap Plan A, B, C or F.

- You must apply or the policy within 63 days after the latest of these dates:
  - The date your coverage ends,
  - The date on your notice that coverage is ending, or
  - The date on your claim denial, if this is the only way you know that your coverage has ended.

- If the employer offers you COBRA coverage you can either buy a Medigap policy right away or you can wait until the COBRA coverage ends then you will have another right to buy a Medigap policy.

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

If you receive your health coverage from a Medicare Advantage Plan or are in PACE (Program of All-inclusive Care for the Elderly), and you move out of the plan's service area, you will have to end your coverage.

- If you have a Medicare SELECT policy, you can keep your policy because it is guaranteed renewable. However, because you have moved, you may not be able to use a hospital or other providers that are not in the policy's network. If this is the case you may want to consider switching to another Medigap Plan.
- You have the right to buy **Medigap Plans A, B, C or F**.
- You must tell your current pan that you are moving and give them a date when your coverage will end.
- You may apply for a Medigap policy **as early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

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

Medicare Advantage Plans are managed care plans. These plans can be HMO (health maintenance organization), PPO (preferred provider organization) or PFFS (private-fee-for-service) plans. In this situation. . .

- You have the right to purchase **any Medigap Plan** A through L.
- You must tell the health plan that you want to leave (disenroll) and give them date to end your coverage.
- This date must be **before you have been in the plan for a year (twelve months)**.
- You can apply for a policy as **early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends

Situation #5: You dropped a Medigap policy to join a Medicare Advantage Plan or other Medicare Health Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year; and you want to switch back.

If the same insurance company still sells it, you have the right to go back to the Medigap policy you had.

- You must tell the health plan that you want to leave (disenroll) and give them the date to end your coverage.
- This date must be **before you have been in the plan for a year (twelve months)**.
- If your former Medigap policy is not available, you have the right to buy a Medigap Plan A, B, C or F.
- If your former policy included prescription drug coverage, you have the right to go back to the plan if the same insurance company still sells it, but you will not be able to get the drug coverage back.
- If your former policy included drug coverage, even if the same company still sells the plan, you have the right to purchase a Medigap Plan A, B, C, F, K or L. You will have to purchase a separate drug plan for your prescription coverage.
- You can apply for a policy as **early as 60 days before your coverage ends**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends

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

Because Medigap policies are guaranteed renewable, the only way you would lose coverage under a Medigap policy would be if the company goes bankrupt or the coverage ends through no fault of your own.

- You have the right to purchase **a Medigap Plan A, B, C or F**.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

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

In this situation you leave the Medicare Advantage Plan because it failed to meet its contract obligation to you. For example, the company isn't paying your claims, or it made untrue statements to convince you to buy the policy.

- You have the right to purchase **a Medigap Plan A, B, C or F**.
- Generally to have this right you must have filed a grievance with the Medicare Advantage Plan, Medicare, or the Indiana Department of Insurance and received a decision that the Medicare Advantage plan was at fault.
- You must tell the Advantage Plan that you want to leave (disenroll) and give them a date to end coverage.
- You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Laws for Insurance Companies and Agents

Advertising

- An advertisement which contains information concerning Medigap cannot refer to Medicare on the envelope, the reply envelope, or the address side of the reply postcard.
- Also prohibited is any language to imply that failure to respond would jeopardize Medicare benefits.
- The company's complete address and name must appear on all documents and advertisements.
- Advertisements must prominently disclose that they are advertisements for insurance or that they are intended to obtain insurance prospects.

An agent must:

- Identify themselves as insurance agents (with name, address and telephone number) and identify the company for which they work.

- Give the consumer a receipt for materials (documents, cash, checks, etc.) given to them by the customer.

- Completely disclose the purchaser's medical history on the application (when medical history is required).

- Give the purchaser an Outline of Coverage at the time of application. This is an overview of what the policy covers.

- If an existing Medigap policy is to be replaced, give the applicant a Notice Regarding Replacement of Medicare Supplement Insurance.

- Not use any false, deceptive, or misleading representation to induce a sale; nor use any methods of marketing having an effect of or tending to induce the purchase of insurance through force, fright or threat; whether explicit or implicit.

Please report any violations by agents to:
Indiana Department of Insurance's Consumer Services
1-800-622-4461

Illegal Insurance Practices

It is illegal for any company or individual to:

- Pressure you into buying a Medigap policy, lie or mislead you to get you to switch from one company to another.
- Sell you a second Medigap policy.
- Sell you a Medigap policy, if they know you have Medicaid, unless they understand that exceptions can be made if Medicaid pays your Medigap premiums, or Medicaid pays only your Part B premium.
- Sell you a Medigap policy if they know you are enrolled in a Medicare Advantage Plan.
- Claim that a Medigap policy is part of the Medicare program or any federal program.
- Sell you a Medigap policy that cannot be sold in Indiana.
- Misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Centers for Medicare and Medicaid Services (CMS) or any other programs like Medicare.

Discrimination

It is illegal to discriminate (treat a person differently from everyone else) based on Race, Color, Sex, Disability, Age or National Origin. Report violations to the department of Health and Human Services, Civil Rights Division.

Financial Stability

Several private rating agencies conduct financial analyses of insurance companies. Their ratings on the financial health of those companies analyzed are published along with useful information about each company. Different rating scales are used by each rating service, and the rating scales may change without notice. To get a clear picture of a company's status, check what each service uses as a top rating. The published ratings may be found in the reference section of local public libraries or by contacting the rating agencies as listed below

Remember there may be a charge to your telephone bill for "900" number calls. Some of these agencies may also charge you for verbal and/or written financial reports. Be sure to ask about charges at the beginning of your call.

A.M. Best Company

Three options to access this service:

1. Website: www.ambest.com Ratings are free after you register.
2. Call 1-908-439-2200 You may charge materials to your phone bill.
3. Call 1-808-424-BEST to use your VISA or MasterCard.

Duff & Phelps (Fitch Investors Service, Inc.)

For a free rating of a single company call 1-800-853-4824, ext 199

Fitch Investors Service, Inc.

Up to 5 verbal rating, no charge 1-800-892-4824, ext 199

Moody's Investor Service

1-212-553-0377 No charge for up to three ratings
www.moodys.com

Standard & Poor's Services

1-212-438-2400 No charge for up to ten ratings
www.standardpoor.com Ten free ratings on email

Weiss Research, Inc.

1-800-289-9222 Charge for rating reports, ask for fee schedule.

MEDICARE ADVANTAGE PLANS

(MANAGED CARE PLANS)

SECTION H

MEDICARE ADVANTAGE PLANS

Introduction

Medicare Advantage Plans (MA) are health plan options that are approved by Medicare and run by private companies. These plans are also known as Medicare Part C, Medicare+Choice, and Medicare Managed Care Plans. They are another way of getting your Medicare benefits. There are five types of plans available; however, not every type of plan is available throughout the state. These types are:

- Medicare Health Maintenance Organization (HMO)
- Medicare Preferred Provider Organization (PPO)
- Medicare Private-Fee-for-Service (PFFS)
- Medicare Special Needs Plans (SNP)
- Medicare Medical Savings Account Plans (MSA)

Medicare HMO's have been an option for Medicare beneficiaries since the 1970's. The Balanced Budget Act of 1997 authorized new plans such as PPO, PFFS and MSA plans. Regional PPO plans and SNP were created with the Medicare Modernization Act of 2003. Of the almost 43 million Medicare beneficiaries 19% (8.3 million) receive their Medicare benefits through MA plans.

How do these plans work?

If you join one of these plans, you will generally receive all your Medicare covered health care through that plan. MA plans provide your Part A and Part B coverage and must cover medically-necessary services. They may offer additional benefits such as prescription drug, vision and dental coverage. Medicare pays a set amount of money for your care every month, whether or not you use the covered services. These plans often have networks, which means that you may have to see doctors who belong to the plan or go to certain hospitals to get covered services.

MA plan benefits and out-of-pocket costs may differ from Original Medicare. Since each plan can vary, it is important that you review plan materials carefully for details about copayments and covered services.

Who Can Join?

MA plans are available to most people with Medicare. To be eligible to join a MA plan you must:

- Live in the plan's service area.
- Be enrolled in Medicare Part A and Part B (if you are already in a MA plan and only have Part B, you may stay in the plan).
- Not have End-Stage Renal Disease (ESRD - permanent kidney failure requiring dialysis or a kidney transplant). There are a few exceptions:
    - If you are already in an MA plan when diagnosed, you may either stay in your current plan, or join another plan offered by the same company
    - If you have ESRD and are in an MA plan that leaves Medicare or no longer provides coverage in your area, you have a one time right to join another MA plan. You do not have to use your one time immediately, you can choose to join at a later date in the plan is still accepting new members.
    - You may join a Special Needs Plan (SNP) for people with ESRD in one is available in your area. (Currently there are no SNP plans for ESRD in Indiana)

In addition, you must:

- Agree to provide necessary information to the plan,
- Agree to follow the plan's rules, and
- Belong to only one MA plan at a time.

When Can I Join?

There are different times when you can join or switch a MA plan. These time periods are as follows:

- Initial Coverage Election Period
- Annual Election Period (AEP)
- MA Open Enrollment Period (OEP)
- Limited Open Enrollment Period (L-OEP)
- Special Enrollment Periods (SEP)

Initial Coverage Election Period
During your Initial Coverage Election Period when you first become eligible for Medicare you will have a 7 month enrollment period.

- If you are eligible for Medicare **due to age** (turning age 65), your initial enrollment will begin 3 months before the month you turn age 65 and will end 3 months after the month you turn age 65.
- If you are eligible for Medicare **due to disability**, your initial enrollment will begin 3 months before to 3 months after your 25th month of Social Security Disability eligibility.

Annual Election Period (AEP)
Each year from November 15 to December 31, you can make changes in your plan enrollment. You may choose to join an MA plan with or without drug coverage or return to Original Medicare with or without a Medicare prescription drug plan. Changes will be effective the following January 1. Unless the plan has a capacity limit waiver, MA plans must accept eligible new members during the AEP. A capacity limit waiver means the plan has been authorized to close enrollment because it already has reached a certain number of enrollees.

MA Open Enrollment Period (OEP)
In addition to the Annual Election Period, you have an opportunity to change during the OEP. The OEP is January 1 through March 31 each year. During this time you will be able to switch to a different type of MA plan, but you cannot change your drug coverage (nor can you enroll or disenroll in a Medicare Medical Savings Account, if offered in your area). The chart below shows your options during the OEP.

If you have . . .	You can join . . .	You CANNOT join . . .
MA plan with prescription drug coverage (MAPD)	Another MAPD or switch to Original Medicare & PDP or an PFFS & an PDP	An MA-only or switch to Original Medicare only
MA plan with no drug coverage (MA-only)	Another MA-only or switch to Original Medicare only	An MAPD or switch to Original Medicare & PDP
Original Medicare & a Medicare Prescription Drug plan (PDP)	An MAPD or an PFFS and the same PDP	An MA-only or switch to another PDP
Original Medicare	An MA-only	An MAPD or join a PDP

Limited Open Enrollment Period (L-OEP)
The *Tax Relief and Health Care Act of 2006* allowed people with Original Medicare to join an MA plan that **does not include** Medicare prescription drug coverage. **On July 18, 2007, Public Law 110-48 ended the L-OEP as of July 31, 2007.**

Special Enrollment Periods (SEP)
You can switch to another MA plan under special circumstances. These include the following:

- If you move out of your plan's service area
- If your plan decides to leave the Medicare program
- If your plan reduces its service area and your area is no longer covered by the plan
- Special trial rights available if you have joined a MA plan for the first time, you may switch back to Original Medicare anytime within the first 12 months of your plan coverage.
- Two SEP for new MA enrollees:
    - If the beneficiary enrolled in an MA plan when they were first aged-in to Medicare (age 65), they can disenroll anytime during the first 12 months after their coverage started. They would then have the right to purchase any Medigap plan A through L.
    - If the beneficiary dropped a Medigap plan to enroll in an MA plan for the first time, they can disenroll anytime during the first 12 months and return to their original Medigap (if still available) or choose A, B, C, or F.

Types of MA Plans

Medicare HMO's

In a Medicare HMO, the co-payments and coinsurance you pay is set by the plan. There are doctors and hospitals that contract with the plan (join the plan's network). **Generally you must get your care and services from the plan's network.** If you get your health care outside of the network, you may have to pay for these services yourself. In most cases, neither the plan or Original Medicare will pay for these services.

When you join a Medicare HMO plan, **you may be asked to choose a primary care doctor**. Your primary care doctor is the doctor you will see first for most health problems. In many HMO's you must see your primary care doctor before you can see any other health care provider. **You will usually need to get a referral from your primary care doctor to see a specialist** (i.e. cardiologist). If the type of specialist you need is not available in the plan's network, the plan will arrange for care outside the network.

If you are considering joining a Medicare HMO and want to keep seeing your current doctor, you should call and ask your doctor (usually the doctor's billing department) to see if he is in the network. Contact the plan for information on providers and facilities in their network. Keep in mind doctors can join or leave a network. If your primary care doctor leaves the HMO plan, the plan will notify you in advance and provide an opportunity to pick a new doctor.

There are **special rules for certain services**. Women can go once a year without referral for a screening mammogram. They can go every other year to a specialist in the network for Medicare covered routine and preventive women's care services.

If a Medicare HMO includes prescription drug coverage, you will pay a co-payment or coinsurance for each covered prescription. In most, cases if you are in a MA plan, you may not join a separate Medicare prescription drug plan to get drug coverage.

Medicare PPO's

Medicare PPO's use many of the same rules as Medicare HMO's. However, in a PPO generally you can see any doctor or provider that accepts Medicare. You do not need a referral to see a specialist. If you go to doctors, hospitals or other providers that are not in the network (out of network, or non-preferred), you do not need a referral, but you will usually pay more. Every PPO plan must pay for all covered services received out-of-network, but every plan is different in what your cost share (co-payment/coinsurance) will be. PPO plans can be either local (cover individual counties) or regional (regions can cover an entire state or multiple states). Beginning in 2006, regional PPO's were available in most areas of the country.

In a regional PPO you will have an added protection for Medicare Parts A and B benefits because regional PPO's limit out-of-pocket costs. The annual out-of-pocket limit varies by plan. Regional PPO's may have a higher yearly deductible and/or premium than other PPO's.

As a PPO member you may also be able to get your Medicare prescription drug coverage from the PPO plan.

Medicare PFFS Plans

In a PFFS plan, you can choose which provider you will see. You do not need a referral to see a specialist, and can get service outside of your service area. While you can go to any Medicare approved doctor or hospital, that provider must accept the terms and conditions of your plan's payment schedule.

You may get extra benefits not covered under Medicare, such as extra days in the hospital. The plan, rather than Medicare, decides what you pay for the services you receive. You can get your Medicare prescription drug coverage from a PFFS if offered, or you can join a stand-alone Medicare prescription drug plan if drug coverage is not offered by your PFFS.

Medicare Special Needs Plans (SNP)

Special Needs Plans are MA plans specially designed for people with certain chronic diseases and other specialized health needs. There are three types of SNP:

- Plans designed to meet the needs of people **who live in certain institutions** (like a nursing home).
- Plans designed to meet the needs of **specific chronic or disabling conditions** (like ESRD, Diabetes, Cancer).
- Plans designed to meet the needs of people who are eligible for both **Medicare and Medicaid** (dual-eligibles).

SNP's are designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.

For Example:

An SNP for people with diabetes might have:

- additional providers with experience caring for people with diabetes,
- have focused special education or counseling
- and have nutrition and exercise programs designed to help control the condition

An SNP for people with both Medicare and Medicaid might help members:

- access community resources
- coordinate many of their Medicare and Medicaid services

SNP must include Medicare prescription drug coverage.

SNP in Indiana

Currently in Indiana there is only one company offering Special Needs Plan. These plans are available as follows:

- **SNP Low Income:** Adams, Allen, Boone, Fulton, Hamilton, Hancock, Hendricks, Johnson, Kosciusko, Madison, Marion, St. Joseph, Wells
- **SNP Chronic Disease:** Adams, Allen, Fulton, Kosciusko, St. Joseph, Wells
- **SNP Institutional:** Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion

Medicare MSA Plans

Medicare Medical Savings Account Plans became available in 2007. These plans are similar to Health Savings Accounts available outside of Medicare, and they have two parts.

The first part is **an MA plan with a high deductible**. The plan will begin to cover your costs once you meet a high yearly deductible, which varies by plan. During the time you are paying for services before the deductible is met, providers cannot charge you more than the Medicare approved amount for services received. This part is also referred to as your Health Plan.

The second part is a special type of **savings account**. The Medicare deposits money into your account. You can choose to use money from this account to pay your health costs, even before you meet the deductible. Money left in your account at the end of the year stays in the account.

For more information contact 1-800-Medicare to ask for a copy of *Your Guide to Medicare Medical Savings Account Plans*, or visit http://www.medicare.gov/Publications/Pubs/pdf/11206.pdf.

Medicare Savings Plans Fact Sheet—by Health Assistance Partnership

Medical Savings Accounts are the result of the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. MSAs are known as "Medicare Savings Accounts." They can exist through employers, state benefits, and through the federal government. This information refers only to the federally qualified Medicare Savings Accounts (MSAs) that are offered under the Centers for Medicare & Medicaid Services as approved Medicare Advantage plans for 2007. The Medicare Advantage **MSA plan enrollments for 2007 coincide with the Part D Annual Enrollment Period, but they are not synonymous and differ greatly in structure and benefit. Applications are in paper form through the plan, one cannot enroll on-line.**

Theoretically, MSAs had the potential to exist since 1997; it was not until very recently that any plans were offered. For 2007 they are offered in both demonstration projects that are statewide, and "regular" plans that are locally offered. In general, one who signs up for an MSA is insuring themselves for catastrophic coverage. They are designed for someone who can afford to spend at least $2,500 per year out of their own pocket for routine or preventive care, in addition to and apart from, any Part D related expenses. **In general, MSAs allow you to choose a Medicare Advantage Health Plan that is linked to a newly developed personal savings account used to pay for medical expenses.** By using this account to pay for medical expenses you are meeting your health plan's high deductible. First you choose a health plan and then they supply you with any and all banking information. You cannot choose your own bank or use an existing account. Banking arrangements are set up by the plan.

The following chart illustrates the most important aspects of MSAs:

BANK	DEDUCTIBLE/Premiums	HEALTH INSURANCE	Prescription Drugs
Medicare Advantage Health Plan	**Medicare Advantage Health Plan**	**Medicare Advantage Health Plan**	**Stand-Alone PDP - Part D Prescription Drug Coverage**
Medicare deposits a lump sum anywhere from $1,000 up to $2,000 at the beginning of the year into an interest bearing savings account.	High deductible must be met before benefits of Medicare Advantage Plan takes effect.	Local (Regular) or statewide (Demonstration) plan.	MSA Medicare Advantage Plans do not carry drug coverage.
Lump sum is used to meet medical expenses that go towards your deductible.	Still paying Part B premium in addition to any deductibles, premiums or copays under the MA MSA plan	Access to any Medicare provider within the geographic area ("network") set forth by the plan	Have option to sign up for a stand alone Medicare Part D benefit.
Deductible is met through medical spending and cannot be more than $9,500 per year.	Medicare pays premium on behalf of beneficiary directly to the MA plan.	Benefits are similar to Original Medicare.	No coordination of coverage occurs between the MSA MA plan and a PDP Part D plan.
You can use an electronic debit card to pay for your medical expenses linked to this account.	Can charge a separate premium for additional coverage such as dental, vision, hearing, etc. up to yearly cap.	Non-Medicare participating providers can "balance bill" up to 15%.	You can use the funds in your MSA account to cover Part D costs and they do count towards TrOOP, however, using the funds in this way is not tax exempt.
You cannot deposit funds in to this account.	Out of pocket expenses capped yearly at $9,500 - including yearly deductible.	Those with Medicaid, supplemental "Medigap," retiree, union, VA, TFL or FEHBP or other health insurance cannot enroll in an MSA plan	
Money that goes unused after a year of being in the plan rolls over into next year.	Demonstration MSA plans allow for copayments or coinsurances after meeting the deductible up to yearly cap. Regular plans cover 100% of any Medicare covered cost once deductible has been met.	Plans cannot offer supplemental benefits to cover the cost of the deductible. Access to your health plan's coverage under Medicare only occurs after you have met your yearly deductible.	When utilizing a Special Enrollment Period to disenroll or change your MSA MA at any time, you can keep your stand -alone Part D PDP benefit.
Income tax is paid on any money used towards non-medical expenses.			

Medicare Cost Plans

Medicare Cost Plans are available in limited areas of the country. These plans have many of the same rules as Medicare HMO plans; however:

- If you go to a non-network provider, the services are covered under Original Medicare.
- You can join a Medicare Cost Plan any time it is accepting new members, and can leave anytime to return to Original Medicare.
- You can get Medicare prescription drug coverage from your plan if it is offered, or you can buy a separate Medicare drug plan to add prescription coverage.

These are general rules for Medicare Cost Plans. Rules may differ for some plans, be sure to read plan materials carefully.

Comparing Plans

Since each plan can vary, it is important that you read the plan materials carefully. There are several questions you can use when consider enrolling into a Medicare Advantage Plan. These questions include:

- Are prescription drugs covered?
- Do I need to chose a primary care doctor?
- Is my current doctor or preferred hospital part of the network?
- Am I willing to switch doctors?
- Can I get my health care from any doctor or hospital?
- Do I have to see a primary care doctor to get a referral to see a specialist?
- What else do I need to know about this type of plan?

See pages H-11 and H-12 for a Medicare Advantage Plan Compare.

Medicare Advantage Plan Compare

Plan Name:_____

Is this a local or regional plan? _____
Is Medicare approved prescription drug coverage available?_____
If prescription coverage is available, is there an additional premium? _____
Are my current doctors members of the network? _____
Is the hospital I normally go to in the network? _____

Benefit	*What I pay with Original Medicare*	*What I pay in network*	*What I pay out of network*
Plan Premium	$0.00	_____	_____
Part A			
Hospital Inpatient			
1-60 days	$1068	_____	
61-90 days	$267 per day	_____	_____
91-150 days	$534 per day	_____	_____
> 150 days	Full amount	_____	_____
Skilled Nursing			
1-20 days	$0.00	_____	_____
21-100 days	$133.50 per day	_____	_____
> 100 days	Full amount	_____	_____
Home Health	$0.00	_____	_____
Hospice - Durable Medical Equipment	20% approved amt	_____	_____
Blood			
First 3 pints	Full Amount	_____	_____
Additional pints	20%	_____	_____
Part B			
Premium	$96.40*	$96.40*	$96.40*
Medical and other Services			
Deductible	$135	_____	_____
Coinsurance	20% approved amt	_____	_____

* if your annual income is greater than $80,000 ($160,000 - married) your premium may be higher

Benefit	*What I pay with Original Medicare*	*What I pay in network*	*What I pay out of network*
Part B con't			
Outpatient Therapies	20% approved amt	_____	_____
Outpatient Mental Health	50% approved amt	_____	_____
Outpatient Hospital	Coinsurance based on type of service	_____	_____
Preventative Services			
Bone Mass Measurement	20% approved amt	_____	_____
Colorectal Cancer Screening	20% approved amt	_____	_____
Diabetes Services and Supplies	20% approved amt	_____	_____
Glaucoma Screening	20% approved amt	_____	_____
Mammogram	20% approved amt	_____	_____
Pap test, Pelvic & Breast exams	$0.00 pap test 20% pap collection and exams	_____	_____
Prostrate Cancer Screening	$0.00 PSA 20% for digit rectal Exam	_____	_____
Flu & Pneumococcal Vaccines	$0.00	_____	_____
Welcome to Medicare Physical	20% approved amt	_____	_____
Additional Benefits Not covered by Medicare			
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

Your Rights in an MA Plan

All people with Medicare have certain guaranteed rights and protections. You have them whether you are in Original Medicare, a MA plan or have a Medigap policy. Your rights include:

- The right to get the health care services you need.
- The right to receive easy-to-understand information.
- The right to have your personal medical information kept private.

When you enroll in a MA plan, you are guaranteed additional rights.

- If you have a complex or serious medical condition, you have the right to get a treatment plan that lets you see a specialist within the plan as many times as you and your doctor think you need.

- Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.

- When you ask your plan how it pays its doctors, the plan must tell you. Medicare does not allow MA plans to pay doctors in a way that would not let you get the care your need.

- You have the right to file a complaint or appeal, and to a fair, efficient and timely process to resolve differences with your health plan. This includes the initial decision made by your plan, an internal review, and an independent external review.

- You have the right to a fast appeals process whenever you are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

Appeal in Medicare Advantage Plans

If your plan will not pay for, does not allow, or stops or reduces a course of treatment that you think should be covered or provided, you have the right to appeal. If you think your health could be seriously harmed by waiting for a decision, you can ask the plan for an expedited appeal decision.

Your plan must provide, to you in writing, information on the process of filing an appeal. The plan must also provide notices after every adverse coverage determination (plan's initial decision) or appeal. In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain:

- the decision, including detailed explanation of why services were denied,
- information on the next appeal level, and
- specific instructions about how to file the appeal.

Appeal Levels

Following an adverse decision by the plan, you have the following levels of appeals:

- **Plan Reconsideration** - This must be filed within 60 days of the date of the determination notice; no minimum amount in controversy needed; health plan has jurisdiction.
- **Independent Review Entity (IRE)** - This is automatic if the Plan Reconsideration does not change the initial determination; no minimum amount in controversy needed; IRE has jurisdiction.
- **Administrative Law Judge (ALJ) Hearing** - This appeal must be filed within 60 days of the date of IRE decision; minimum amount $110 (adjusted annually).
- **Medicare Appeals Council (MAC) Review** - This appeal must be filed within 60 days of receipt of ALJ hearing decision/dismissal; minimum amount $110 (adjusted annually); Jurisdiction Department of Health and Human Services Departmental Appeals Board (DAB).
- **Judicial Review** - This is the final step of appeal. The appeal must be filed within 60 days of receipt of DAB decision/ declination; minimum amount $1,130 (adjusted Annually); jurisdiction U.S. District Court.

Fast-Track Appeals
This process is available when you believe your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. Your provider must give you a *Notice of Medicare Non-coverage* (NOMNC) at least 2 days before your services are expected to end. These fast-track appeals are not automatic, but if your do appeal, the plan must provide a *Detailed Explanation of Non-coverage*. You will get a decision within 2 days from the Quality Improvement Organization (QIO) that will decide if services need to continue.

Inpatient Hospital Appeals
The provider or plan must provide a *Notice of Discharge and Medicare Appeal Rights* (NODMAR) at least the day before services end if:

- you disagree with the discharge decision, or
- your provider/plan is lowering the level of your care within the same facility.

You can appeal by sending a request to the QIO by noon of the day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. You will remain in the hospital pending the QIO's decision, and generally will incur no financial liability during the appeal, even if the decision is not in your favor.

MA Plan Marketing Guidelines

MA plans may send information to or call Medicare beneficiaries about Medicare prescription drug coverage they are offering. They may use the Medicare Rx seal on marketing material if they offer a MAPD.

Plans must:

- Use marketing materials that have been submitted to CMS (Centers for Medicare and Medicaid Services) and reviewed according to the marketing guidelines and other applicable guidance.
- Comply with the “Do not call registry.”
- Provide beneficiaries with information in a professional manner.
- Use a state-licensed, certified, or registered individual to perform marketing, if the state has such a marketing requirement.

Plans may NOT:

- Solicit Medicare beneficiaries door-to-door prior to receiving an invitation.
- Send unsolicited email to a beneficiary.
- Enroll people by phone, unless the person calls them.
- Offer beneficiaries cash payment as an induction to enroll.
- Misrepresent or use high pressure sales tactics to enroll a beneficiary.

Important MA Points to Remember

If you join a MA plan:

- You are still in the Medicare program.
- You still have Medicare rights and protections.
- You still get complete Medicare Part A and Part B coverage.
- You may be able to get your Medicare prescription drug coverage from your MA plan.
- You may be able to get extra benefits offered by the plan, such as coverage for vision, dental, hearing, and/or health and wellness programs.
- You still pay your Part B premium along with your MA plan premium.
- You usually will have to pay some other costs (co-pays and coinsurance).
- You do not need to buy a Medigap policy. If you have a Medigap plan and decide to join an MA plan, you can keep your Medigap policy but there is little reason to do so - your Medigap plan will not pay any deductible, co-pays or insurance while you are in an MA plan.
- In some cases your costs could be higher than in Original Medicare: for example you see a doctor outside of the network.
- Every Fall the plan will send you information about any changes in benefits, costs or service areas.

MEDICARE PRESCRIPTION DRUG PLANS

SECTION I

MEDICARE PRESCRIPTION DRUG PLANS

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2004 (MMA) established a voluntary outpatient prescription drug benefit for Medicare beneficiaries, known as Part D. All 43 million Medicare beneficiaries are eligible to enroll in these drug plans. Drug coverage is offered through private plans approved by Centers for Medicare and Medicaid Services (CMS). Medicare prescription drug coverage helps you pay for both brand name and generic drugs. To get a Medicare prescription drug coverage you must choose and join a Medicare drug plan.

This drug benefit is offered through 2 types of private plans: stand-alone prescription drug plans (PDP) and Medicare Advantage Plans (MAPD).

- Medicare PDP adds coverage to Original Medicare, some Medicare Private-Fee-for-Service (PFFS) plans that don't offer Medicare drug coverage, some Medicare Cost Plans, and Medicare Medical Savings Account Plans.

- Many Medicare Advantage plans, such as HMO's and PPO's include coverage for prescription drugs. You will generally receive all your health care and drug coverage through your plan.

After you join the Medicare PDP of your choice, the plan will mail you membership materials including a member's card. You will use this card when you get your prescriptions filled.

Are All Drug Plans the Same?

Medicare drug plans vary based on which drugs are covered, what your out-of-pocket costs will be and which pharmacies you can use. When considering a Part D plan keep four points in mind: Coverage, Cost, Convenience, and Peace of Mind.

Coverage
Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose what specific drugs are covered in each drug category.

Cost
Monthly Premiums and your share of the cost of your prescriptions vary depending on which plan you choose. If you have limited income and resources, you may qualify for Extra Help in paying your drug costs, through the Social Security Administration (SSA).

Convenience
Drug plans must contract with pharmacies in your area. Check with the plan to make sure the pharmacies in the plan are convenient to you. Some plans allow you to get your drugs through mail order.

Peace of Mind
Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan. As we age, most people need prescription drugs to stay healthy.

How Do I Find the Drug Plans in My Area?
Information about specific drug plan is included in the *Medicare & You* handbook. You can also get this information online at www.medicare.gov or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

How Much Will My Drug Coverage Costs?
Your cost will depend greatly on your prescription drug and the drug plan your choose. Costs you will incur with a drug plan include:

- **Monthly Premium** - Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. It is possible that some plans charge no premium.

- **Yearly Deductible** - This is the amount you pay for your prescription before your plan begins to pay. Some plans charge no deductible, this may affect the monthly premium.

- **Co-payments or Coinsurance** - Amounts you pay for your prescription after you meet your deductible. Co-payments refer to specific dollar amount; coinsurance is the percentage of the drug cost.

- **Coverage Gap (the Donut Hole)** - Some plan have a coverage gap. This means that after you have spent a certain amount of money for you covered drugs. You will have to pay 100% of the drug costs. This includes your deductible, co-payments and coinsurance. This amount does not include your monthly premium. The most you will have to pay out-of-pocket in the coverage gap is $3,051.25. There are plans available that offer some coverage during the donut hole. Coverage during the gap will also affect the premium.

- **Catastrophic Coverage** - Once you have reached your plan's out-of-pocket limit, you will have "catastrophic coverage." This means that you will only pay a coinsurance amount (5% of the drug cost) or co-payment ($2.15 generic; $5.35 brand-name) for the rest of the calendar year.

How Do I Pay My Monthly Premiums?

In general, there are three ways to pay your premiums:

- You can have the premium deducted every month from your Social Security benefits.

- You can have the plan send you a bill each month. Many times the plans will bill quarterly.

- You can give permission to the plan to have your premiums automatically deducted from a savings or checking account, or charged to a credit or debit card.

If your drug coverage is through a Medicare Advantage Plan, the monthly premium you pay to the plan may include an amount for drug coverage.

What if I Cannot Afford a Drug Plan?

There is help available for those beneficiaries who need it most. If you have limited income and resources, you may qualify for Extra Help to pay for your Medicare prescription drug costs. If you qualify, you will receive help in paying your monthly premiums, and possibly your deductible, co-pays, coinsurance and coverage during the donut hole (coverage gap).

Ways You May Qualify for Extra Help

You may automatically qualify for Extra Help and do not need to apply.

- You have Medicare, full Medicaid coverage and live in a nursing home.
- You have Medicare and full Medicaid.
- You get help paying your Medicare premiums from the Medicare Saving Program (QMB, SLMB, QI).
- You have Medicare and receive Supplemental Security Income (SSI), but not Medicaid.

Each month, Medicaid will send verification of the previously mentioned categories.

If your annual income is $15,510 or less ($21,240 if married and living with your spouse) and your resources are $12,510 or less ($25,041 if married and living with your spouse), you may still qualify for Extra Help. You will need to apply. You can do this by calling the Social Security Administration (1-800-772-1213), visit www.ssa.gov on the web or apply at your local Medicaid office.

See chart of following pages for detail on Extra Help.

2009 Medicare Prescription Drug Benefit (Part D)
Eligibility & Enrollment Chart for Indiana

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
No Medicare Coverage	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Call SHIIP 1-800-452-4800	N/A
Medicaid Only	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Medi*caid* will continue to cover your prescriptions	N/A
Medicaid & Medicare (Dual-Eligible) **AND:** Yearly Income below $10,640 (single) or $14,240 (married) **OR:** Yearly Income above $10,640 (single) or $14,240 (married)	You are eligible for Extra Help No premium No deductible No gap in coverage $1.10 - $3.20 co-pay for prescriptions $2.40 - $6.00 co-pay for prescriptions	**New to Medicare** You will be auto-enrolled in a plan for coverage first day of Medicare entitlement unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Medicaid** You will be auto-enrolled into a plan if you are not already in a drug plan. Coverage will be retroactive to the month your Medicaid coverage began.	CMS will notify you by mail if you are to be auto-enrolled. (CMS—Centers for Medicare & Medicaid Services)	You do not need to apply for Extra Help. You are already eligible.	**New to Medicare** - You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Medicaid** - If you are auto-enrolled into a plan that does not cover your medication you may switch plans.

The 2009 Medicare Prescription Drug Benefit Enrollment & Eligibility Chart for Indiana is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare Savings Program **QMB, SLMB, or QI** (Medicaid helps pay for your Medicare) **AND**… Yearly income below $10,640 (single) or $14,240 (married) Yearly income above $10,640 (single) or $14,240 (married)	You are eligible for Extra Help No premium No deductible No gap in coverage $1.10 - $3.20 co-pay $2.40 - $6.00 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	You do not need to apply for Extra Help. You are already eligible.	**New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** If you are facilitated into a plan that does not cover your medication you may switch plans.
Medicare with no prescription coverage Yearly income below: $14,280 (single) or $19,140 (married) **AND** Resources less than $8,100 (single) or $12,910 (married)	You are eligible for Extra Help, but you must apply. No premium No deductible No gap in coverage $2.40 or $6.00 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan. You may want to also apply for the Medi*care* Savings Program if your resources are below $4,000 or $6,000 if married.	Any time **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

IF YOU HAVE...	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare with no prescription coverage Yearly income below $15,840 (single) or $21,240 (married) **AND** Resources less than $12,510 (single) or $25,041 (married)	You are eligible for Extra Help, but you must apply. $60 deductible 15% co-pay No gap in coverage Sliding Scale Premium * (see chart below)	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan	Any time. **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

If your income is:	Single Income	Married Income	What you will pay in monthly premium
135% FPL or lower	Below $14,280	Below $19,140	0% of the premium
135% - 140% FPL	$14,280 - $14,800	$19,140 – $19,840	25% of the premium
140% - 145% FPL	$14,800 - $15,320	$19,840 - $20,540	50% of the premium
145% - 150% FPL	$15,320 - $15,840	$20,540 - $21,240	75% of the premium

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare but your income and/or resources are above the Medicare Prescription Drug Benefit limits for Extra Help…	You are not eligible for Extra Help. • Est. $35/mo premium • $295 deductible • gap in coverage from $2,700 to $6,153.75 in drug expenses • After gap, you pay greater of 5% or $2/40 $6.00 co-pay	You will need to enroll in a Drug Plan	**N/A**	Consider selecting and enrolling in a Drug Plan	November 15 through December 31
Medicare with other prescription coverage	Your current prescription drug coverage may or may not change.		N/A	**Consider whether you should keep current coverage or enroll in the Medi*care* Prescription Drug Benefit	See chart below

****Medigap Policy** (Medi*care* Supplement Policy)	If you have a Medigap policy with prescription drug coverage, it may or may not continue in 2006. **Contact your insurance company for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****Retirement Insurance Plan**	Your retirement insurance plan may or may not change in 2006. **Contact your plan for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****HoosierRx** (IN State Pharmaceutical Assistance Program)	HoosierRx members will receive a letter about changes to the HoosierRx program in October 2005. Call Indiana's Pharmaceutical Assistance Program toll-free at 1-866-267-4679 for more information.
****VA Prescription Benefits** (Veteran's Administration)	If you receive VA Prescription Drug Benefits, you do not need to enroll in a Medicare Prescription Drug Plan. You will not have a late penalty if you decide to enroll later.

Whose Income and Resources Count?

Your income and resources are counted. If you are married and live with your spouse, both of your incomes and resources are counted even if only one of you is applying for Extra Help. If you are married but do not live with your spouse when you apply, only your income and resources are counted.

What Counts as Income?

Income is any cash or service that can be used to meet your needs.

Countable income includes, but is not limited to the following:

- Wages
- Earnings from self-employment
- Social Security or Railroad Retirement Benefits
- Veterans Benefits
- Pensions
- Annuities
- Alimony
- Rental Income
- Worker's Compensation

Income not counted:

- Income tax refunds
- Assistance based on need funded by a state or local government
- Foster care payments
- The value of expenses which a blind or disabled person needs to work

What Resources Are Counted?

The resources counted in deciding if you qualify for Extra Help include cash and others things that can be converted into cash within 20 days.

Types of resources counted include, but are not limited to:

- Savings, checking, and money market accounts
- Certificates of Deposit (CD's)
- Retirement accounts, such as IRA or 401K accounts
- Stocks, Bonds, Savings Bonds
- Mutual Fund Shares
- The equity value of property that is not connected to your home

Resources Not Counted:

- Life insurance policies you own with a combined face value of $1,500 or less ($3,000 or less if married).
- The home you live in and the land it is on.
- Resources such as family heirlooms, wedding/engagement rings.
- Property of a trade or business which is essential to your means of self-support.
- Non-business property which is essential to your means of self-support.
- Funds received and saved to pay for medical and/or social services.

How Long Will I Receive Extra Help?

If you qualify for Extra Help, the decision remains in effect for the calendar year as long as you are enrolled in a PDP and you do not have a change in your marital status. Changes in marital status include:

- Marriage
- Divorce
- Annulment
- Separation (not temporary)
- You and your spouse resume living together
- Death of a spouse

Any of the changes to your marital status mentioned could cause the amount of your Extra Help to increase, decrease or end. You should notify SSA of any changes in your status.

What if My Application Is Denied?

You have the right to appeal the decision. To request an appeal, call SSA toll free at 1-800-772-1213. You can also get a copy of the form SSA-1021, "*Appeal of Determination for Help with Medicare Prescription Drug Costs*" from www.ssa.gov on the web.

If you want to file an appeal remember the following:

- You have 60 days to ask for an appeal.
- The 60 days start the day after you receive your letter from SSA denying your application. SSA will assume you received the letter 5 days after the date on the letter.
- You can have a lawyer, friend or someone else help you.

Choosing a Drug Plan

Everyone on Medicare has a decision to make about prescription drug coverage. If you are new to Medicare and have prescription drug coverage, you have new choices to consider. If you are not new to Medicare you have the opportunity to review your drug coverage and join or switch plans during Open Enrollment - November 15 through December 31 every year.

What Do I Need to Think About Before I Decide if I Need a Drug Plan?
Before you make a decision, you need to answer the following questions:

- If you have drug coverage now, is it creditable coverage (is it as good as Medicare PDP)? Your current plan can tell you.
- If you have drug coverage now, should you keep it?
- How would a PDP affect your out-of-pocket costs?
- Are your drugs covered by plans in your area?
- Is there a particular pharmacy you want to use?
- Do you spend part of each year in another state?
- Does the plan you're interested in offer national coverage?

When Can I Enroll in a Plan?

If you are new to Medicare you have a **7 month Initial Enrollment Period**. This period begins 3 months prior to the month your Medicare coverage begins, the month your Medicare coverage begins, and ends 3 months after the month your Medicare coverage begins. This is the case if you are eligible for Medicare due to age or disability.

Every November 15 through December 31, you will have an Annual Open Enrollment. You may join or switch to any PDP or MAPD you choose. There are situations that will allow you to have a **Special Enrollment Period (SEP)**. These include:

- Extra Help (low income subsidy - LIS) redetermination beneficiaries - Those who have lost their Extra Help as a result of the redetermination process. They will have one SEP through March.

- Change in residence - Those who move out of their service area will have a SEP of 63 days.

- Contract Violations - If the PDP violates or drastically alters their plans, you have one SEP to select a new PDP.

- Non-renewals or terminations - Individuals affected by PDP leaving the area or leaving Medicare will have an SEP.

- Involuntary loss of coverage - Individuals who lose creditable coverage, including a reduction in the level of coverage so that it is no longer creditable. This is a one time SEP to join a Part D plan.

- Not adequately informed about creditable coverage - Individuals who were not adequately informed of creditable coverage by their current plan (i.e. retirement drug coverage) will have a one time SEP granted on a case-by-case basis.

- Enroll in or maintain other creditable coverage - Individuals may disenroll from a PDP or MAPD to enroll or maintain other creditable coverage (i.e. TRICARE or VA coverage).

- Error by Federal Employee - Enrollment or disenrollment due to an action, inaction or error by a federal employee. This one time SEP is granted on a case-by-case basis and permits one enrollment or disenrollment.

- Employer Group Health Plan - Those enrolling in an employer group/union sponsored Part D plan, disenrolling from a Part D plan to take employer coverage of any kind, or disenrolling from Employer/union sponsored coverage to enroll in a Part D plan.

- CMS Sanction - Those who want to disenroll from a PDP as a result of a CMA sanction against the company they currently have a plan. This SEP is granted on a case-by-case basis.

- Cost Plan - Enrollees of a HMO or CMP plan that is not renewing their cost contracts.

- PACE (Programs of All-inclusive Care for the Elderly) - Individuals enrolling in PACE. This is a one time SEP. Currently there are no PACE plans in Indiana, but surrounding states offer PACE plans.

- Institutional Individuals - Those who move into or out of an institution such as skilled nursing facility, long term care hospital, etc.

- Medicare Entitlement Determination is made retroactively - Individuals whose Medicare entitlement is determined retroactively and who should have been provided an opportunity to enroll in a PDP during their initial enrollment period.

- Individuals who enroll in Part B during General Enrollment Period - Those who are not entitled to Part A premium free and who enroll in Part B during General Enrollment (January 1 through March 31 each year).

- New LIS Eligibles - Those who are not currently in a Part D plan and who have newly qualified for Extra Help.

- SPAP (State Pharmacy Assistance Programs) - In Indiana The SPAP is HoosierRx. Those who belong to a qualified SPAP may make one enrollment choice at any time through the end of the year.

- Full benefit dual eligibles with retroactive uncovered months - full benefit dual eligibles who enroll in a Part D plan in the months before they would be auto-enrolled.

Late Enrollment Penalty

If you do not enroll in a Part D plan when you are first eligible you may have to pay more for your monthly premiums if you enroll at a later date. The penalty is calculated at 1% for every month you did not have a Part D plan, but were eligible. The percentage is based on the national average benchmark premium. For 2008 this benchmark is $30.36 The 1% equals $0.31.

What Do Plans Look Like?

Plans vary based on formularies, cost share structure, and price. All plans must meet the standard benefits.

Standard Benefits for 2009 are as follows:

- **Deductible** - You pay 100% of the first $295.
- **Partial Coverage** - You pay 25% of the next $2,700in total drug costs.
- **Coverage Gap (Donut Hole)** - You pay 100% of the next $3,453.75 in drug costs. At the end of the donut hole you will have paid a total out-of-pocket costs (not including monthly premiums) of $6,153.75.
- **Catastrophic Coverage** - Once you have spent $6,153.75 you will pay 5%. You will pay this for the reminder of the calendar year.

Plans can and do vary coverage they offer. Some offer coverage during the first $295. A few offer a little coverage during the donut hole. To compare plans visit www.medicare.gov and use the Plan Compare, or call 1-800 Medicare (1-800-633-4227).

See example on the next page of plans that could be offered.

Introducing No Brand Insurance Company's Medicare Prescription Drug Plans

What You Would Pay. . .	*The Red Plan*	*The White Plan*	*The Blue Plan*
For the first $295	Deductible: $295	Co-pay: Generics...$10 Brand Name Drugs.....$30	Co-pay: Generics....$0 Brand Name Drugs.....$25
For the next $2,700	Coinsurance: 25%	Co-pay: Tier 1.....$0 (Generics) Tier 2.....$15 Tier 3.....$30 Tier 4.....15% Coinsurance	Co-pay: Tier 1.....$0 (Generics) Tier 2.....$10 Tier 3.....$20 Tier 4.....10% Coinsurance
For the next $3,453.75 (Benefit Gap)	100% of the total drug cost	Co-pay: Generics...$25 100% of total drug costs for brand name drugs	Co-pay: Tier 1.....$10 (Generics) Tier 2.....$25 Tier 3.....$60 Tier 4.....50% Coinsurance
For the remainder of the year (Catastrophic Coverage)	$2.25 for generic drugs: $5.60 for brand name drugs; or 5% of total drug cost	$2 for generic drugs; $5 for brand name drugs; or 5% of total drug cost	$2 for generic drugs; $5 for brand name drugs

NOTE: This plan information is fictitious and is not intended to represent any actual Medicare Prescription Drug Plan available. It is for SHIP training purposes only.

What Types of Drugs Are Covered?

All Part D plans must make sure that you can receive medically-necessary drugs. Plans can use Formularies, Prior Authorization and Quantity Limits to design their drug plans.

Formularies

Drugs that are covered are included on the plans formulary or list of approved drugs. Drug plans may cover both generic and brand-name drugs. Drug lists must include a range of drugs in the prescribed categories and classes. To lower costs, many plans place drugs into different tiers, which cost different amounts. (See chart on previous page for examples). If a plan changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will notify you at least 60 days before the change is effective.

Prior Authorization

Plans may have rules that require prior authorization before it will cover a drug. Your doctor will first have to contact the plan and show that there is a medically-necessary reason you must have this drug. Plans can have their own forms that need to be filled out to request a prior authorization.

Step Therapy is a type of prior authorization. With step therapy, in most cases you must first try certain less expensive drugs. However, if you have already tried the drugs and they did not work, or your doctor believes that because of your medical condition it is medically-necessary for you to be on a step therapy drug, he can contact the plan to request an exception.

Quantity Limits

For safety and cost reasons, plans may limit the quantity of drug that they cover over a certain period of time. For example, people prescribed Nexium should take one tablet a day. Therefore, a plan may only cover 30 tablets for a 30 day supply. If your doctor believes that because of your medical condition a quantity limit isn't medically appropriate for you, you or your doctor can contact the plan for an exception.

Your Medicare Drug Plan Rights and Appeals

What if My Plan Won't Cover a Drug I Need?

You have the right to ask for a decision called a Coverage Determination. You, your doctor or someone else you choose as your representive can call your plan or write them a letter to request that the plan cover the prescription you need. You may file a standard request or an expedited request. Your request will be expedited if your plan determines, or your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard request. If the plan decides against you, you can appeal the decision. There are 5 levels of appeals:

- **Redetermination** - appeal through your plan; must be requested within 60 days from the date of the adverse decision; can be made in writing or over the phone; plans has 7 days for a standard request, 72 hours for an expedited request. For some types of redeterminations called exceptions, you will need a supporting statement from your doctor explaining why you need the drug your are requesting.

- **Independent Review Organization (IRO)** - must be submitted within 60 days of the adverse redetermination decision; must be in writing; once request has been filed the IRO has 7 days for a standard request, 72 hours for a expedited request.

- **Administrative Law Judge Hearing (ALJ)** - Must be requested in writing with 60 days of the adverse IRO decision; there is a minimum dollar amount.

- **Medicare Appeals Council (MAC)** - if you receive an adverse ALJ decision you will be advised on the process to request a review by the MAC.

- **Federal Court** - if you receive an adverse MAC decision you will be advised on the process to request a review by the a federal court.

When you join a plan you will receive information about the plan's appeal process.

How Do I File a Complaint?

You have the right to file a complaint with a plan. You should file your complaint within 60 days of the event that led to your complaint. Examples of why you might file a complaint:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The pharmacy charges you more than it is supposed to. If you think you have been charged too much, call your plan for the up-to-date price.
- The plan does not make a determination about a coverage determination or appeal within the required time frame.
- You disagree with the plan's decision not to expedite your request for a coverage determination or first-level appeal.

You should first contact your plan with your complaint. If the plan does not take care of your complaint call 1-800 Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

NAVIGATION GUIDE TO LONG TERM CARE INSURANCE

A Quick Reference Guide for
SHIP Counseling

The Navigation Guide for Long term Care Insurance is designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of she/he, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 6 option 1.

REFERENCE MATERIALS

SECTION L1

Reference Materials

- **Shopping Tips When Buying Long Term Care Insurance**
- **Traditional and Indiana Long Term Care Partnership Program Policies**
- **Long Term Care Insurance In Indiana - Company Listing**
- **Partnership Policies in Indiana - Company Listing**
- **Consumer Information Bulletin (LTC Policy Tax Information)**

Shopping Tips When Buying Long Term Care Insurance

- **Contact SHIP, the State Health Insurance Assistance Program**

  They can provide you with guidelines and a Long Term Care Self Assessment Guide. A list of insurance departments and counseling programs in the U.S. begins on page 20 of your "Shoppers Guide."

- **Check with several companies and agents**

  It is wise to contact several companies and agents before you buy a policy. Be sure to compare benefits, the types of facilities you have to be in to receive coverage, the limitations of coverage, the exclusions, and, of course, the premiums. (Policies that provide identical coverage and benefits may not necessarily cost the same.)

- **Take your time and compare Outlines of Coverage**

  Never let anyone pressure or scare you into making a quick decision. Don't buy a policy the first time an agent comes calling. Ask the agent to give you an "Outline of Coverage". The Outline of Coverage summarizes the policy's benefits and highlights important features. Compare Outlines of Coverage for several policies.

- **Understand the policies**

  Make sure you know and understand what is covered by a policy. If you have any questions, ask the agent, or call the insurance company's home office, before you buy. If an agent gives you answers that are vague or differ from information in the company literature, or if you have doubts about the policy, tell the agent you will get back them later.

  Don't hesitate to call or write to a company and ask your questions. **Beware of an agent who claims the policy can be offered only once.**

  Some companies may sell their policies through the mail, bypassing agents entirely. If you decide to buy a policy through the mail, and you don't understand how the policy works, call or write to the company.

- **Discuss the policy with a friend or relative.**
- **Don't be misled by advertising.**

  Most celebrity endorsers are professional actors paid to advertise. They are not insurance experts.

  Neither Medicare nor any other federal agency endorses or sells long-term care insurance policies. Be wary of any advertising that suggests the federal government is involved.

  Don't trust cards you get in the mail that look as if the federal government sent them. Insurance companies or agents trying to find buyers may have sent them. Be careful if anyone asks you questions over the telephone about Medicare or your insurance. They may sell any information you give to long term care insurance marketers, who might call you, come to your home, or try to sell you insurance by mail.
- **Don't buy more than one long-term care insurance policy.**

  You don't have to buy more than one policy to get enough coverage. One good policy is enough.
- **Don't be misled by long-term care insurance marketers who say your medical history isn't important.**

  Information about your medical history is very important. Be sure you fill out all of the application. Give correct information. If an agent fills out the application for you, don't sign it until you have read it. Make sure that all of the medical information is right. If it isn't and the company used that information to decide whether to insure you, it can refuse to pay your claims and can even cancel your policy.
- **Never pay in cash.**

  Use a check or money order made payable to the insurance company
- **Automatic Premium Withdrawal**

  Think about having the premium automatically taken out of your bank account. Automatic withdrawal may mean that you won't lose your coverage if an illness makes you forget to pay your premium. **If you decide not to renew your policy, be sure you tell the bank to stop the automatic withdrawals.**

- **Be sure to get the name, address, and telephone number of the agent and the company.**
  Get a local or toll-free number for both the agent and the company.
- **Check on the financial stability of the company you are considering**
  Several private companies rate insurance companies based upon their own research and from published data. These ratings offer an idea of the financial health of a rated company, however; there are no guarantees of accuracy attached to these ratings. Different agencies use different rating scales, so it is important to know what each agency's scale means.

  Ratings and rating agency information is available from most public and university libraries, or you can contact the agencies directly by telephone or by website. (Note, there is an extra charge for calls to a "900" number.)

Some widely used companies that offer ratings include:

- **A. M. Best Co.** (900) 555-BEST-to charge to phone bill
  (800) 555-BEST -to use credit card
  (a charge per call,
  & per each rating)
- **Duff U Phelps, Inc.** (312) 368-3157 One free rating
- **Fitch Investors Service, Inc.** (212) 908-0500
- **Moody's Investor Service** (212) 553-0377 Up to 3 free ratings
- **Standard & Poor's** (212) 208-1527 Up to 5 free ratings
- **Weiss research, Inc.** (800) 289-9222 Charge for Verbal ratings.
- **Telephone the Indiana Department of Insurance (IDOI) Consumer Service Division**
  For information on a company's licensing, or if you have question about the agent, the insurance company, or the

- **If you don't get your policy within 60 days, contact the company or agent.**

  You have a right to expect prompt delivery of your policy. When you do receive your policy, check to see if you need to sign and return any forms. **Be sure to keep the envelope** the policy was mailed in, or if the agent delivers it personally ask the agent for a signed delivery receipt as proof of the date you received the policy. Make and keep copies of any forms that you are asked to complete and return.

  Keep your policy in a convenient place where you can easily find it. Tell a trusted friend or relative where it is located.

- **Be sure you look at your policy during the 30 day free-look period.**

  Read the policy again. Make sure it gives you the coverage you want, and that the benefits are what you expected. If you have any questions, call the agent or company right away. Also, re-read the application that you signed. It is part of the policy. If it's not filled out correctly, contact the agent or insurance company right away.

  You have 30 days, starting from the day that you receive the policy, to return it for any reason for a full refund (**you do not have to give a reason**, but be prepared for the company to ask).

- If you want to cancel your policy, do the following:
  - Make a copy of the original envelope in which the policy was mailed, or if it was delivered, make a copy of the hand-delivered receipt.
  - Send the policy to the insurance company along with a **short letter asking for a refund**, a copy of the original mailing envelope or the hand delivered receipt, and copies of any forms that you completed.
  - Send your request certified mail. **Keep the mailing receipt.**
  - Keep a copy of all letters from the company to you, and from you to the company. **It usually takes four to six weeks to get your refund.**

FEATURES	TRADITIONAL LONG TERM CARE INSURANCE POLICIES (LTC)	INDIANA LONG TERM CARE PARTNERSHIP PROGRAM POLICIES (ILTCIP)
Agent Training	Agents must have (a) a health insurance license; (b) 8 hours of continuing education (C.E.) in LTC to begin selling LTC insurance; (c) 5 additional hours of C.E. in LTC every 2 years.	Agents must meet all of the requirements for selling traditional LTC policies **PLUS** must complete a one time only 7-hour course on the ILTCIP before ever selling or talking about these policies.
Asset Protection	These policies do *not* provide permanent asset protection.	Policies provide permanent asset protection through the *State-added* benefit known as "Medicaid Asset Protection."
Benefit Triggers	The *company* decides which benefit triggers (what has to occur before the policy starts paying benefits) to use and how to define the terms within the triggers.	The *State* determines which benefit triggers that all participating companies must use and how to define the terms within the triggers.
Daily Benefits	Can buy any amount of daily benefit the insurance company chooses to offer.	Can buy any amount of daily benefit the insurance company offers. A company must offer a minimum daily benefit of $110/day (*state-determined for 2006).*
Inflation Protection	**Inflation protection must be OFERED**.	**Inflation protection must be INCLUDED.** (Companies are using 5% compounded interest annually.)
Maximum Benefits	*Company* decides how the maximum benefit will be offered - in days, in dollars, one pool of money for all benefits, or separate maximum benefits for nursing home and home health care. Can buy any amount of maximum benefits the company offers.	*State* decided that maximum benefit would be one pool of money for all benefits available in the policy. Can buy any amount of maximum benefits the company offers. However, the company must offer the option of purchasing a maximum benefit equal to one year of nursing home coverage.

Portability	The policy will pay benefits in any state.	The policy will pay insurance benefits in any state. However, the State-added benefit of Medicaid Asset Protection can only be honored by Indiana's Medicaid program*. This means the person must be in Indiana when applying for and while receiving Indiana Medicaid assistance. (*Due to a reciprocal agreement between IN and CT, Connecticut's Medicaid program can also honor the asset protection earned in a Partnership policy. Asset protection honored under a reciprocal agreement is on a dollar-for-dollar basis only.)
Tax Deductions for Premiums	*Tax-Qualified policies are available for federal tax deduction. There is NO state tax deduction for traditional LTC policies.	*Tax-Qualified policies are available for federal tax deduction. Premiums paid for an ILTCIP policy qualify for an Indiana state tax deduction beginning with tax year 2000.
Types of Policies	Can buy policies covering: nursing home care only nursing home & home health care home health care only life insurance that will pay a portion of the death benefit early for LTC.	Can buy policies covering: nursing home care only nursing home and home health care All participating companies must offer policy type (b).

***Tax-Qualified LTC Policies:** Premiums (up to certain limits) may be deducted on a federal tax return AS PART OF the standard medical expense deduction. The benefits received from (federally) Tax-Qualified LTC policies will *not* be considered taxable income. Federal law requires Tax-Qualified policies to offer the option of purchasing a non-forfeiture benefit (a guarantee of some amount of benefit should the policyholder cancel the policy after owning it for a minimum number of years). This law also provides some guidance to the companies in determining the benefit triggers to use in their policies. "Medical Necessity" cannot be used as a benefit trigger in Tax-Qualified policies.

Note: Indiana Law and Insurance Regulation require ALL types of long term care insurance policies in Indiana to offer a 30-day free look, prohibit the requirement of prior hospitalization in order to receive benefits in policies sold after July 1991, prohibit waiting periods of longer than 6 months for pre-existing conditions, and require policies to be either guaranteed renewable or noncancellable.

Long Term Care Insurance In Indiana

The following companies have been approved by the Department of Insurance to sell individual Long Term Care insurance

Company Name	LTC #	LTC Claim #
Aetna Life	(800) 537-8521	(800) 248-0591
Aid Association (Lutherans only)	(800) 225-5225	(800) 225-5225
AIG Life	(800) 710-9876	(800) 710-9876
Allianz Life	(800) 814-8841	(800) 814-8841
American Family Life (AFLAC)	(800) 992-3522	(800) 992-3522
American Family Mutual	(800) 333-6886	(800) 333-6886
American Fidelity	(888) 412-2121	(800) 780-3724
American United Life	(800) 863-9354	(800) 863-9354
Bankers Life & Casualty	(888) 282-8252	(800) 621-3724
Bankers United Life	(800) 842-7799	(800) 432-0059
Catholic Order of Foresters	(800) 552-0145	(800) 552-0145
Central States Health & Life	(800) 541-2363	(800) 643-5264
Combined Insurance	(800) 999-2170	(800) 999-2170
Continental Life	(800) 264-4000	(800) 264-4000
CUNA Mutual Life	(800) 356-6006	(800) 643-5264
Farmers New World Life	(206) 232-8400	(800) 262-6995
First Penn-Pacific Life	(800) 323-1746	(800) 323-1746
Fortis Long Term Care	(800) 377-7311	(800) 377-7311
General Electric Capital	(800) 456-7766	(800) 876-4582
Genesis	(800) 838-0080 Ext 224	(800) 838-0080 Ext 224

Company Name	LTC #	LTC Claim #
Golden Rule	(800) 265-7791 Ext 2008	(800) 265-7791 Ext 2008
Great American Life	(800) 771-2142	(800) 921-9338
Hartford Life	(800) 921-9345	(800) 921-9345
IDS Life	(800) 862-7919	(800) 862-7919
John Alden Life	(888) 503-8104	(888) 503-8104
John Hancock Mutual Life	(800) 543-6415	(800) 543-6415
Kanawaha	(800) 635-4252	(800) 635-4252
Knights of Columbus	(800) 380-9995	(800) 214-9825
Life & Health	(800) 458-7493	(800) 458-7493
LifeUSA	(800) 814-8841	(800) 814-8841
Lincoln Benefit Life	(877) 525-4582	(888) 503-8110
Lutheran Brotherhood	(800) 990-6290	(800) 990-6290
MedAmerica	(800) 544-0327	(800) 544-0327
Medico Life	(800) 228-6080	(800) 228-6080
Metropolitan Life (AARP members only)	(800) 308-0179	(888) 687-0977
Mutual Protective	(800) 228-6080	(800) 228-6080
National States	(800) 868-6788	(800) 868-6788
New York Life	(800) 224-4582	(800) 224-4582
Northwestern LTC	(877)582-6582	(800) 890-6704
Penn Treaty	(800) 362-0700	(800) 222-3469
Pennsylvania Life	(800) 275-7366	(800) 636-4357
PFL Life	(800) 338-0257	(800) 432-0059

Company Name	LTC #	LTC Claim #
Physicians Mutual	(800) 228-9100	(800) 228-9100
Pyramid Life	(800) 777-1126 Ext 307	(800) 444-0321
Southwestern Life	(800) 792-4368 Ext 7443	(888) 304-9200
Standard Life	(888) 290-1085	(888) 350-1488
State Farm	(888) 827-2748	(888) 827-2748
State Life	(317)285-2326	(888) 505-8101
Teachers Insurance	(800) 223-1200	(800) 842-2733 . Ext 7307
Transamerica	(800) 690-2758	(800) 432-0059
Trustmark	(888) 249-6985	(800) 554-1640
United America	(972) 529-5085	(972) 529-5085
UNUM Life	(800) 543-7612	(800) 693-4988

Companies with Indiana Partnership Long Term Care Policies (07/2006)

INSURANCE COMPANY	*POLICY TYPES	AM BEST[1]	MOODY'S[1]	STANDARD & POOR'S[1]
Bankers Life and Casualty Company	3,4	B++	Baa3	BB+
Genworth Life Insurance Company	3,4		Aa3	AA-
John Hancock Life Insurance Company	3	A++	Aa2	AA+
Metropolitan Life Insurance Company	3,4	A+	Aa2	AA
Penn Treaty Network America Insurance Company	1,2	B	Not Rated	B
The prudential Insurance Company of America	3	A+		AA-
State Farm Mutual Automobile Insurance Company	3	A++	Aa1	AA
United Teachers Associates Insurance Company (Group policies only)	3	A-	Not Rated	Not Rated

*(1) Comprehensive policy - covers both nursing home and home care. (2) LTC Facility policy - covers care only in a facility such as a nursing home.
(3) Tax-Qualified Comprehensive policy - eligible for federal tax deduction. (4) Tax-qualified LTC Facility policy - eligible for federal tax deduction.

[1]Financial Stability Ratings – Explanation of ratings on reverse side. Experience shows the best resource for specific policy information is your local certified Indiana Partnership agent.

To obtain a free copy of the *Indiana Partnership Select Agent Directory*, call 317-233-1470.

Rating Scales And Definitions

A.M. Best Company

A++	Superior
A+	
A	Excellent
A-	
B++	Very Good
B+	
B	Fair
B-	
C++	Marginal
C+	
C	Weak
C-	
D	Poor
E	Under State Supervision
F	In Liquidation
S	Rating Suspended

Rating Modifiers

g	Group
p	Pooled
v	Reinsurance
u	Under Review

Moody's Investment Service

Aaa	Exceptional
Aa	Excellent
A	Good
Baa	Adequate
Ba	Questionable
B	Poor
Caa	Very Poor
Ca	Extremely Poor
C	Lowest

Modifiers:

1 = High end generic category
2 = Middle of generic category
3 = Low end generic category

Standard & Poor's

Secure Range:

AAA	Superior
AA	Excellent
A	Good
BBB	Adequate

Vulnerable Range:

BB	May be adequate, but vulnerable
B	Vulnerable
CCC	Extremely Vulnerable
R	Regulatory Action
pi	Rating based on public information only

Modifiers:

Plus (+) or Minus (-): Relative standing within major rating category.

Since company ratings can change, you are encouraged to check your local public libraries or the internet for the most current ratings. (Information 2004)

CONSUMER INFORMATION BULLETIN

Tax Breaks for Owners of Certain Long Term Care Insurance Policies

STATE Indiana residents who pay premiums for ***Indiana Partnership long term care insurance policies*** can receive a ***state tax deduction***, beginning with tax year 2000. A taxpayer may take this deduction only for premiums paid (during the tax year) for an Indiana Partnership policy for himself/herself, a spouse, or both taxpayer and spouse.

How do I know if I have an Indiana Partnership Policy?

To know if the policy you own is an Indiana Partnership policy, look for the following box of information on the outline of coverage, the application, or the front page of the policy:

> This policy qualifies under the Indiana Long Term Care Program for Medicaid Asset Protection. This policy may provide benefits in excess of the asset protection provided in the Indiana Long Term Care Program.

The Health Insurance Portability and Accountability Act of 1996 is a federal law providing limited federal tax breaks for owners of long term care (LTC) insurance policies that meet specific standards. Policies meeting these standards are called tax-qualified. The Act went into effect on January 1, 1997. It allows all LTC insurance policies bought before January 1, 1997, to qualify as tax-qualified.

What tax breaks does this federal tax law provide?

(1) **Premiums**: Premiums paid for federally tax-qualified LTC insurance policies are tax deductible as part of the standard deduction for medical expenses on a federal tax return. This deduction applies for each taxpayer who pays premiums, and began with the 1997 tax year. These deductions are limited according to the age of the taxpayer as indicated below (amounts listed are for tax year 2007 based on your age as of December 31, 2007, and change annually for inflation):

Age	Maximum Amount of Premium Deduction
40 or less	$ 290
41 to 50	$ 550
51 to 60	$ 1,110
61 to 70	$ 2,950
71 and over	$ 3,680

Premiums for self-employed: For self-employed persons, for tax year 2007, 100% of premiums paid for federally tax-qualified LTC insurance policies are tax deductible in a similar manner as other health insurance policy premiums. This deduction is limited according to the age table listed previously.

Benefits: Benefits received from a federally tax-qualified LTC insurance policy are not considered income for tax purposes. (The federal government has not yet determined whether benefits from a "non-tax-qualified" policy would count as taxable income.)

How do I know if a policy is a federally tax-qualified LTC insurance policy?

Look for language on the outline of coverage and on the policy that is similar to the following:
"This Policy is intended to be a Qualified Long Term Care Insurance Contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended."

What are some of the features included in federally tax-qualified LTC policies?

(1) Benefit Triggers: A benefit trigger is the event that must occur in order for the policy to begin paying out its benefits. The policyholder must meet the criteria of one of the benefit triggers. Federally tax-qualified policies will contain the following benefit triggers: (a) needing substantial assistance with at least 2 of 5 (or 6) activities of daily living, and (b) needing substantial supervision due to a severe cognitive impairment. A licensed health care practitioner must certify that the triggering condition exists and, to the best of their knowledge, will continue to exist for the next 90 days. (Activities of daily living may include bathing, continence, dressing, eating, toileting, and transferring.)

(2) Nonforfeiture Benefit: The applicant must be offered the chance to purchase a nonforfeiture benefit as part of their policy. A nonforfeiture benefit is a guarantee from the company that you will get some of the benefits in the policy you have bought, should you cancel the policy after a set period of time. This benefit increases the policy's price.

Required Consumer Protection Standards:

To get benefits from the policy, they cannot require you to be in the hospital first.

To keep up with rising costs in health care, an inflation protection benefit must be offered to you.

The policy must be guaranteed renewable. This means the policy will continue as long as you keep paying the premium. Your premium cannot be raised because you get older or have used some of the benefits in your policy.

For More Information

For a free packet of information on traditional LTC insurance policies and Indiana Partnership policies, call 1-800-452-4800.

For a free copy of the *Indiana Partnership Select Agent Directory*, call 317-233-1470; or, visit www.longtermcareinsurance.IN.gov.

LONG TERM CARE

SECTION L2

LONG TERM CARE (LTC)

A Brief Look at Long Term Care Insurance

LTC is the largest national catastrophic health expense. As more people live longer, the need for health care and long term care increases as is illustrated by the following information.

- Of those individuals who turned age 65 this year, 60% will need long term care as they grow older. Almost 43% will enter a nursing home at some point in their lives for varying lengths of stay. Women are at higher risk than men, with slightly more than half entering a nursing home at some point in their lives.
- Nearly 5% of the elderly are in a nursing home.
- Approximately 85% of nursing home residents are women.
- Over 40% of Americans receiving long term care are under age 65.
- Ten percent of nursing home patients are under age 65.
- Of those who enter a nursing home, 55% will need care for at least one year, and one in five will need care for five or more years.
- The average cost of nursing home care in Indiana is $126 per day, $46,892 per year. With an average length of stay of 2.5 year, the average cost for a nursing home stay is more than $110,000.
- Medicare pays less than 10% of nursing home costs.
- Over 2,100 employers offer group long term care insurance.
- Approximately one-half of all nursing home care is paid for by Medicaid, and another one-third is paid for by individuals directly out of pocket.
- The most frequently cited reason for purchasing long term care insurance is to maintain independence and choice.

Levels of Long Term Care

Should you need LTC due to a prolonged illness, disability, or frailty service may be provided in your home or in a nursing home (NH). Your physician and your physical condition will determine whether you need:

- **Skilled Nursing Care -** Skilled care is available 24 hours a day. Prescribed by a physician, it is for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists.

- **Intermediate Nursing Care -** Intermediate care is less specialized than skilled nursing care and often involves more personal service. It is for people in stable condition who require daily, but not 24-hour, nursing supervision. It is ordered by a physician and supervised by registered nurses.

- **Custodial care** (also called personal care) - Custodial care is usually given by people without medical skills. It is less intensive than skilled or intermediate care. This type of care helps a person perform activities of daily living (such as bathing, eating, and dressing).

LTC services may be provided by one or a combination of the following:

- Family Members
- Home Health Care Agencies (HHC)
- Area Agencies on Aging (AAA)
- Adult Day Care
- Senior Centers
- Nursing Homes
- Assisted Living or Residential Care Facilities

Who Will Need LTC?

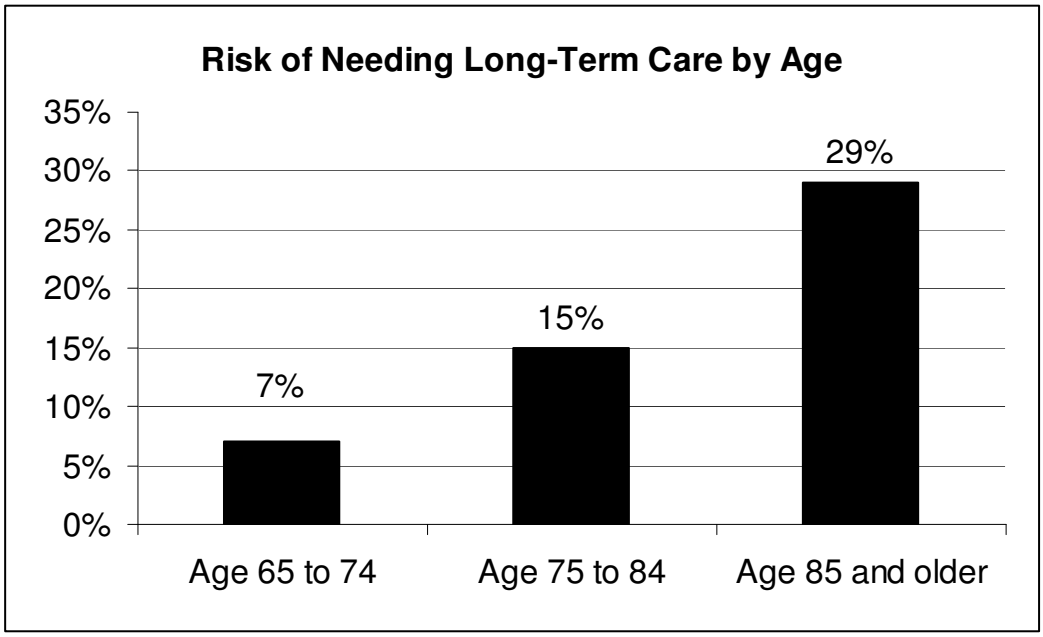
Most seniors will need **some** level of LTC at some point in their life (especially those living into their 80's).

Over 40% of Americans receiving LTC are ages 18-65

Most LTC is given informally by spouses and family members, with additional help given by friends, and/or neighbors. It is getting more difficult for family members to provide LTC because:

- More women, the typical caregivers, are working outside the home.
- Family size is smaller, and members do not always live nearby.
- A spouse is usually less able to provide care due to age and/or physical condition, and adult children have families and other obligations.

Hospital stays to recuperate from an illness or surgery are shorter due to the limits of Medicare and insurance policies that limit payments to hospitals to cover **only skilled care**. After short stays for treatment or surgery, patients are often moved to nursing homes to recuperate.



Common factors for predicting the need for Nursing Home Care are:

- **Age**

  The longer you live, the more likely you are to need nursing home care. Due to better health care and a more stable and healthy diet Americans are living longer.

  Life Expectancy in America between 1900 and 2000

  1900 the average life expectancy was 40.75 years
  1950 the average life expectancy was 65.45 years
  2000 the average life expectancy was 74.5 years
  An increase of 33.75 years from 1900 to 2000

- **Gender**

  Women are more likely to need nursing home care, since they usually live longer than men. Approximately 85% of nursing home residents are women.

  Average Life Expectancy in America by gender

	Men	Women
1900	40 years	41.5 years
1950	63 years	67.5 years
2000	71.5 years	77.5 years

- **Marital Status**

  Elderly widows and widowers are 5 times more likely to enter a nursing home than are elderly married individuals.

Marital Status for Americans 65 and older between 1900-1990

	Men	Women
1900	65% Married	34% Married
	29% Widowed	61% Widowed
1990	75% Married	39% Married
	14% Widowed	50% Widowed

- **Health**

  Family health history, individual health, and lifestyle factors influence the need for nursing home care.

PAYING FOR LONG TERM CARE

SECTION L3

How Much Does LTC Cost?

Long Term Care can be expensive. Costs depend on the amount and type of care needed and the facility. In 20 years, costs are expected to triple due to inflation. In Indiana, private pay rates in NHs have increased by 6.6% a year over the last 10 years. Costs vary by area and by provider (NH, HHC, etc.).

In 2001, the average national cost of . . .

- **Nursing Home** $56,000 per year, approximately $1,077 per week.

- **Home Health Care** Estimated Costs: HHC nurse - 3 visits/week for a year = $14,000+. Currently 50% of those receiving home health care require 2-3 visits/week; 20% receive more than 3 visits/week; 30% receive 1 visit/week. HHC aide - $15,000+ (8 hrs/day, five days a week, for one year)

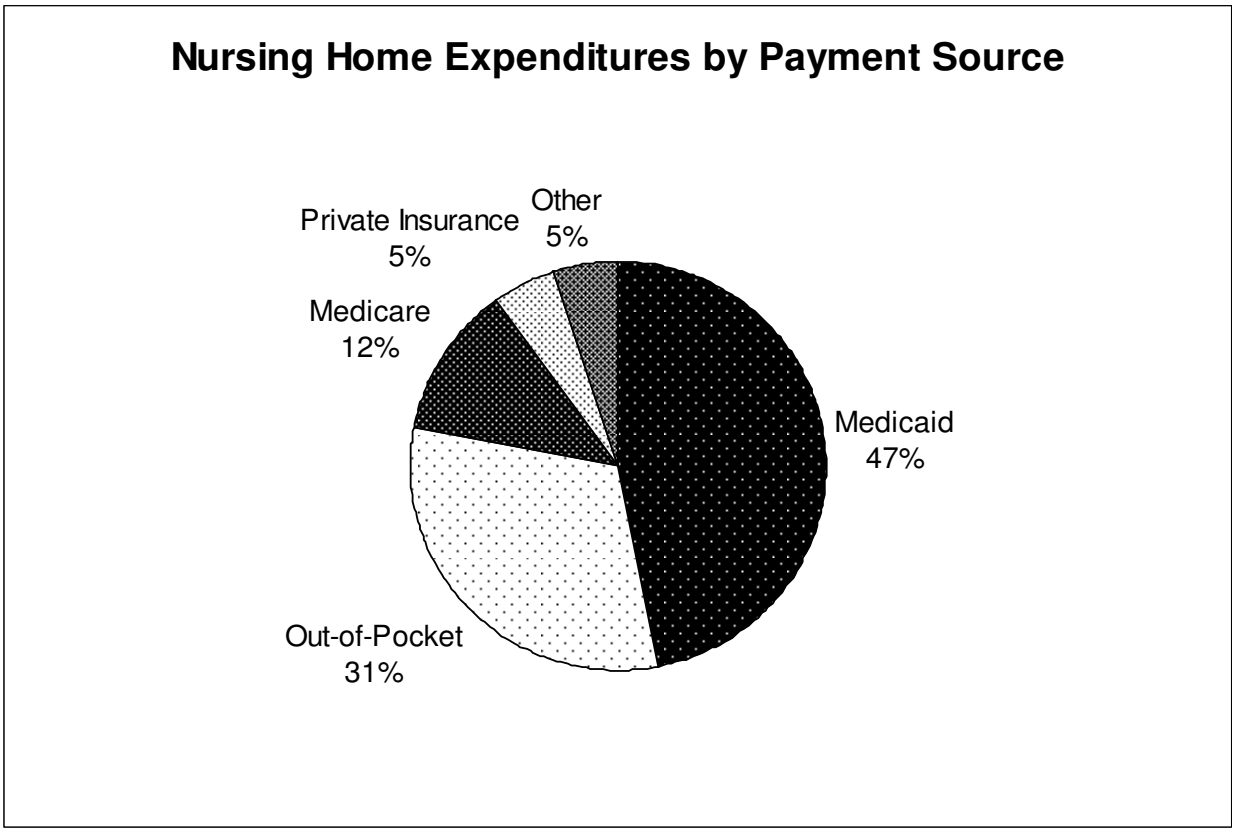
- **Adult Day Care Costs**: $160 - $240+/week

- **Assisted Living**: $22,500 per year

By comparison, in 2000, the median household income for persons age 65 and over was $23,048, which barely covers the cost of one year at an assisted living facility and covers **less than half the cost of one year in a nursing home.**

WHO PAYS FOR LTC?

Medicaid and Out-of-Pocket sources account for 78% of payments for nursing home expenses.



Out-of-pocket expenses may be paid from:

- Personal accounts
- Pensions
- Savings
- Investments
- Family assistance
- Contributions from children or relatives
- Associations, donors, other private funds
- Reverse Mortgages & Annuities

Who Pays for LTC - Your Family

Much LTC assistance is provided by informal, unpaid caregivers. In 1998, nearly one out of four American adults reported providing some form of informal LTC services. These caregivers are usually family members or friends who may provide a variety of services to assist their relatives or neighbors, from paying bills and preparing meals to helping them bathe or dress.

Caregivers provide assistance for a variety of reasons, including:

- The person being cared for does not require skilled professional services.
- The person being cared for cannot afford skilled professional services.
- The person being cared for does not want to be cared for by strangers.

Providing informal care, however, can take a significant toll on the caregiver. Many caregivers juggle their care giving responsibilities with other family or work responsibilities:

- over 60% informal caregivers are between the ages of 18 and 49
- more than two-thirds are married, indicating that many caregivers are probably raising their own children
- more than half are employed full-time
- another 12% are employed part-time.

These competing responsibilities can add to the emotional strain and financial burden of providing informal LTC services.

To ease the burdens of care giving, the federal government through the Older Americans Act and many states have created caregiver support programs. These programs typically provide counseling, information, and respite care to informal caregivers.

Fewer informal caregivers available

The responsibility of carrying for an elderly individual traditionally fell to the person's adult children (typically to heir adult daughters). Today, however, adult children often do not live near their parents, making such informal care giving arrangements difficult or impossible. In addition, women are increasingly working outside of the home, giving them little time to care for an elderly parent. Because fewer families can rely on informal caregivers, demand for home health aides and other professional care providers is increasing.

Services available to assist you and your family include

- Adult Day Care
- Case Management
- Chore Services
- Friendly Visitors and Senior Companions
- Home-delivered Meals (also called Meals-on-Wheels)
- Home Health and Personal Care Services
- Homemaker Services
- Hospice
- Personal Emergency Response Systems
- Respite Care
- Transportation Services

To find more information contact your local SHIP site, Area Agency on Aging, and/or Senior Services.

Who Pays for LTC - Self-Pay

If you have considerable investment assets and income, you may consider paying for your long term care needs as they arise or save for future long term care services. These assets should be invested to ensure growth that will keep up with the rising costs of long term care. As it is unknown when long term care is needed, it is difficult to determine when investing should begin.

Self-insuring is not the same as insurance. It does not provide the short-term protection that an insurance policy does. Insurance protects you from the possible risk of needing long term care before adequate funds are accrued.

Self-Pay Opportunities to Consider:

- You can retain full use of funds if not used for long term care.
- It works if you make the conscious choice years in advance of need.
- You have more choice and control over care.
- You don't have to worry about qualifying for LTC insurance.

Self-Pay Issues to Consider:

- It is unknown when/if the need for long term care will arise, and for how long.
- Amount saved may be insufficient to cover long term care costs.
- You need to be aware of rules of how and when funds can be accessed.
- You cannot control the rate of return.
- You need to start early to ensure enough time for funds to grow.
- You need to be disciplined and have discretionary income and assets to afford setting aside funds.
- Funds are tied up that you could use for other things.
- Self-insurance usually requires larger monthly amounts than traditional insurance.

Who Pays for LTC - Special Purpose Loans

There are many loans available known as deferred payment loans (DPL), property tax deferrals, or split loans. These low interest loans are available to those with low to moderate income.

Local agencies offer DPLs, which provide a one-time, lump-sum payment to be used for home repair or improvements. The types of improvements are usually specified and include improvements such as installation of ramps, grad bars and rails. These loans cannot be used to finance long term care, but they may allow you to remain independent and stay in your home longer. Interest is low and repayment does not occur until you not longer live in the home.

Contact your local SHIP site, Area Agency on Aging, or Senior Services for more information about Special Purpose Loans.

Special Purpose Loans Issues to Consider:

- The loan cannot be used to finance long term care needs.
- If you move into a nursing home, the loan payment comes due. This may negatively affect your long term care finances.

Who Pays for LTC - Medicare

Skilled Nursing Facility Care

Medicare provides some nursing home coverage, but this coverage is restricted to short-term nursing home stays after discharge from a hospital. Thus, this benefit is limited to post-acute care. The Skilled Nursing Facility (SNF) benefit was originally enacted to extend hospital care for patients recovering from an acute illness, but who could be more economically served in a skilled nursing facility.

For each benefit period, Medicare provides limited payment for skilled nursing home care as follows:

- Medicare pays for 100% of eligible charges for the first 20 days
- You make a daily co-payment for days 21-100. Medicare pays the balance of costs, if any.
- **Medicare payments end after 100 days**.

Most people do not require 100 days of skilled care in a nursing facility. Generally, after a couple of weeks of skilled care, they have stabilized and require only custodial care. In most cases, Medicare pays for less than three weeks of skilled care.

Medicare will only pay for daily skilled nursing care or rehabilitative services under very limited circumstances:

- Your physician has decided that you need daily skilled care.
- Your care begins within 30 days of a hospital stay of at least three (3) days for the same condition (about 50% of the people who need nursing home care do not first require care in a hospital).
- The beneficiary receives care only in a Medicare-certified skilled nursing facility and must be placed in a Medicare-certified bed.

Note: Not all nursing homes are Medicare-certified.

Home Health Care

The Medicare home health benefit covers the following services when certain circumstances are met:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and effectively by a licensed nurse.

  Intermittent or part-time means skilled nursing and home health aide services furnished any number of days per week, as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

- Home health aide services on a part-time or intermittent basis. Medicare does not cover home health aide services unless skilled care such as nursing care is also being provided.

- Physical therapy, speech-language therapy and occupational therapy as long as the service is certified by a physician.

- Medical social services to assist with social and emotional concerns related to illness.

- Certain medical supplies, such as wound dressings, but not prescription drugs or biologicals.

- Durable medical equipment, such as a wheelchair or walker.

The following services are <u>not</u> covered:

- 24-hour a day care at home
- Meals delivered to the home
- Homemaker services such as shopping, cleaning and laundry
- Personal care services, such as bathing, eating or dressing

If you meet all of the conditions described, then **Medicare pays the full cost of all covered home health visits**. For **durable medical equipment, Medicare pays 80 percent of the approved amount** for Medicare-covered medical equipment.

All of the following criteria must be met to receive the home health care benefit:

- Your physician determines that home care is needed and devises a plan for your care at home.
- You require at least one of the following medically-necessary types of care: intermittent skilled nursing care, physical therapy or speech -language therapy, or a continuing need for occupational therapy.
- You are homebound (unable to move outside the home without assistance). To be homebound means that leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or attend religious services.
- Home care is provided by a Medicare-certified home health care agency.

Medicare Supplemental Insurance

Medicare Supplemental Insurance policies (Medigap) are health insurance policies sold by private companies to fill in some of the gaps in Medicare coverage. Examples of some gaps in Medicare coverage include:

- **Deductibles** – The amount you pay for Medicare-approved expenses before Medicare starts to pay.
- **Coinsurance** – The part of each Medicare-approved amount that you must pay after you have paid the deductible.
- **Non-Covered Services** – Not all services are paid for by Medicare. You pay for these services.

Medicare supplemental insurance policies were **designed to cover certain gaps** in Medicare. If you have a Medicare supplemental policy or Medicare supplemental coverage through a Medicare Advantage Plan, you may not have to pay the Medicare co-payment for skilled nursing home care when you have an approved Medicare stay. However, these **supplemental policies do not provide payment for any of the custodial or personal care coverage that Medicare does <u>not</u> cover.**

Who Pays for LTC - Medicaid

Medicaid is the government program covering most Nursing Home costs. Medicaid is the largest payer for nursing home care. Medicaid spent $80 billion dollars on long term care in 2001, of which $43 billion was for nursing home care. Medicaid is intended for low-income persons who need financial assistance for their health care. Most persons entering a nursing home use their own money first to pay for their care. In fact, over 90% of the elderly, without LTC insurance, use up their resources within 1 year after entering a NH. After "spending down" their income and assets, they may qualify for Medicaid.

Medicaid pays less than the actual charges of nursing homes. This represents an operating loss to them and is an important factor in their withdrawal from the Medicaid program. The result is that many of those nursing homes that do accept Medicaid now have waiting lists.
(See Navigation Guide 4, Section O - Assistance for Low-income Persons, information on Medicaid eligibility, exempt vs. non-exempt assets, transferring of assets, and spousal impoverishment provisions.)

Spousal Impoverishment Protection Law

In the event that your spouse no longer lives at home due to poor health and **enters a nursing home,** (does not apply to home health care) the Spousal Impoverishment Protection Law protects you from losing all of your income and assets to pay for your spouse's care in the nursing home.

Income

- **Personal Income** - Income in the name of each spouse remains his or hers, including income from assets that are in each spouse's name only. The spouse at home may keep all of his/her income.
- **Jointly Owned Income** - Income from assets owned by both spouses is counted by Medicaid as jointly owned income. Jointly owned income is divided in half with each spouse getting a half. The spouse in the nursing home must use his/her income to pay for his/her care, but he/she may keep **$52** a month for personal needs.

After the income is split, if the income of the spouse at home is less than the maximum allowable per month, he/she may keep part of the nursing home spouse's income in order to bring the at-home spouse's income up to at least the maximum. If the spouse at home has very high living expenses, they may apply for an increase in their allowable income level.

Assets

Most assets are considered by Medicaid as **joint assets** between husband and wife, regardless of in whose name the assets are placed.

The spouse at home may keep **one-half** of all countable assets up to a total of **$101,640**, with a minimum of at least **$20,328**.

The home is not counted as an asset when the applicant, spouse, or dependent children live there. Countable assets include checking and savings accounts, CD's, stocks, bonds, mutual funds, revocable trusts, cash values of life insurance policies, and IRA's.

Caution: Transferring of assets to qualify for Medicaid may cause a delay in receiving Medicaid's help in paying for nursing home costs.

For more information call **SHIP** at 1-800-452-4800, your local Office of the Department of Family Resources (administers Medicaid), your attorney, or the Senior Law Project Office in your area. (Listed in your Telephone Reference Book).

Medicaid Estate Planning

In order to qualify for Medicaid, you must first spend down your assets and use the proceeds to pay for long term care before Medicaid begins to pay. Spend down means liquidating assets.

Some people reduce their assets by gifting them to family members or others, or set up irrevocable trusts instead of using the assets to pay for care. Medicaid planning is the legal practice of rearranging finances so that Medicaid pays for nursing home care, while preserving the assets through change of ownership. However, in most cases Medicaid does not pay for home care or assisted living, and once on Medicaid an individual does **not have control over assets or where care is received.**

Medicaid **"look-back" rules apply** when assets are transferred for less than fair market value. When an individual applies for Medicaid -

For transactions made **before February 8, 2006**:

- Medicaid looks back 3 years from the date of application (5 years for trusts), to see whether any assets were transferred **for less than fair market value**.

For transaction made **on or after February 8, 2006**:

- Medicaid looks back 5 years from the date of application **at all asset transfers**, to see whether any assets were transferred for less than fair market value.

If it is determined that a less than fair market value transfer has taken place, the applicant will not be eligible for Medicaid for a specific time period based upon the dollar amount of the transfer. After this penalty period, the applicant may re-apply for Medicaid. In circumstances where things may look suspicious, Medicaid may go back farther than normal look-back period.

For specific guidelines contact Medicaid through your local Department of Family Resources. Area phone numbers and/or internet addresses may be obtained by calling **SHIP at: 1-800-452-4800.** A qualified Elder Law attorney should be consulted when considering this option.

Medicaid Estate Planning Issues to Consider:

- This option is risky because of the look-back rules.
- You lose control of your assets.
- Transferring assets may affect your eligibility for Medicaid.
- Relying on Medicaid may limit access to care and choice of care.
- **Does not protect income**.

Who Pay for LTC - Veterans Benefits

The Veterans Administration (VA) provides an extensive array of long term care to veterans. Nearly 65,000 veterans will receive long term care this year through inpatient programs of VA or State Veterans Homes. More than 90% of VA's medical centers also provide outpatient long term care programs.

The VA provides institutional long term care to veterans through

- VA Nursing Homes,
- Community Nursing Homes,
- State Veteran Homes, and
- Domiciliary Care.

Services offered in both inpatient and outpatient settings include

- Hospice Care,
- Respite Care, and
- Geriatric Evaluation and Management (GEM).

Other outpatient long term care services provided by the VA include

- Home Based Primary Care,
- Community Home Health Care,
- Adult Day Health Care, and
- Homemaker/Home Health Aide Services.

VA also provides assistance to some veterans through the Community Residential Care Program.

Who is eligible for Nursing Home Care?

A veteran. . .

- who has a service-connected disability rating of 70% or more.

- who is rated 60% service-connected and is unemployable or has an official rating of “permanent and totally” disabled.
- with a combined disability rating of 70% or more.
- whose service-connected disability is clinically determined to require nursing home care.
- Non-service-connected veterans and those officially referred to as zero percent, non-compensable, service-connected veteran who require nursing home care for any non-service-connected disability and who meet income and asset criteria.
- If space and resources are available, other veterans on a case-by-case basis.

While many services are offered there are typically waiting lists for VA nursing homes, making access to veterans’ LTC services limited.

Service Centers in Indiana

The Indiana State Veterans Home is located in West Lafayette, Indiana. It provides nursing and domiciliary care for any Hoosier Veteran with at **least one day of wartime service**. To qualify you must have been a resident of Indiana for at least three years. The Home is open to **both wartime veterans and their spouses**. For more information write to the Home at: Indiana Veterans Home, 3851 N. River Road, West Lafayette, IN 47906. Or call (765) 463-1502.

The Richard L. Roudebush VA Medical Center located in Indianapolis offers LTC services, including Home Based Primary Care and Community Based Extended Care.

The VA Northern Indiana Health Care System, with locations in Fort Wayne and Marion, includes a 180 bed Nursing Home Care Unit. Services offered include a Dementia Unit, Home Based Primary Care, and Adult Day Health Care.

TRICARE For Life

TRICARE For Life (TFL) is a health insurance plan offered through the Department of Defense for active and retired military personnel and qualified family. TFL is for all TRICARE beneficiaries who are eligible for Medicare because of disability, ESRD or age. Like Medicare, TFL is designed to cover health care for injuries and illnesses. TFL will generally cover the same services that Medicare covers. Long term care is not a covered benefit through TFL.

TRICARE beneficiaries, upon attaining the age of 65 and becoming entitled to Medicare Part B, will transfer from TRICARE to TRICARE For Life. TFL will pay secondary to Medicare, beginning the first day of the first month you turn 65.

To be eligible for TFL you must be one of the following:

- Medicare eligible uniformed service retirees, including retired Guard and Reservists;
- Medicare eligible family members, including widows/widowers; or
- Medicare eligible unremarried former spouses, if they were eligible for TRICARE before age 65.

TFL pays in general like a Medigap policy -

- Medicare deductibles, coinsurance and co-payments
- First three pints of blood each year
- 80% of costs at TRICARE network
    - for inpatient hospital care from day 151
    - skilled nursing facilities (SNF) from day 101
- 75% of costs at non-TRICARE network from day 151 for hospital, or day 101 for SNF.

For more information about veterans benefits please contact your Indiana Veterans County Service Officer, or the Indiana Department of Veterans Affairs office by phone (317) 232-3910, toll free call 1-800-400-4520; or online at www.in.gov/veteran.

Federal Long Term Care Insurance Program

The Federal Long Term Care Insurance Program (FLTCIP) provides an alternative to traditional LTC insurance to approximately 20 million people. The program is administered by the Office of Personnel Management.

Who is eligible to apply for FLTCIP?

- Most Federal and US Postal Service employees
- Active members of the uniformed services
- Tennessee Valley Authority (TVA) employees
- Washington D. C. government employees who were employed by the D. C. government prior to October 1, 1987
- Employees of the D. C. Courts
- Most Federal and US Postal Service annuitants
- Retired members of the uniformed services
- Individuals receiving compensation from the Department of Labor who were separated from the Federal service
- Federal and US Postal Service deferred annuitants
- Retired military reservists, including grey reservists
- Retired employees of the TVA
- Retired D. C. government employees who were first employed before October 1, 1987
- Retired employees of the D. C. Courts
- Surviving Spouses, receiving Federal survivor annuity, of Federal & Postal employees or annuitants; D. C. government employees or annuitants who where first employed before October 1, 1987; or D. C. Courts employees or annuitants
- Qualified relatives:
  - Current spouses of the above listed employees and annuitants
  - Surviving spouses of members and retired members of the uniformed services
  - Adult children- including natural, adopted, and stepchildren of living employees
  - Parents, Parents-in-law, and stepparents of living employees

You must be **18 years old** in order to apply. You will also have to answer questions about your health, and you may have your medical records reviewed and have an interview with a nurse. **There is no guarantee of**

The FLTCIP offers four pre-packaged plans. You may chose one of these plans or customize you own plan by mixing and matching available benefits.

Pre-Packages Plans:

Facilities 100

- Covered Services: Nursing Homes, Assisted Living Facilities, Hospice Facilities, and Respite Service (in a facility).
- Daily Benefit Amount: $100
- Benefit Period: 3 years
- Maximum Lifetime Benefit: $109,500
- Waiting Period: 90 Days
- Inflation Protection: choice of automatic compound inflation protection, or option for future purchase.

Comprehensive 100

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount, Benefit Period, Maximum Lifetime Benefit, Waiting Period and Inflation Protection: same as Facilities 100.

Comprehensive 150:

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount: $150
- Benefit Period: 5 years
- Maximum Lifetime Benefit: $273,750
- Waiting Period: 90 days
- Inflation Protection: same as Facilities 100.

Comprehensive 150+

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount: $150
- Unlimited Benefit Period
- Maximum Lifetime Benefit: Unlimited
- Waiting Period and Inflation Protection: same as Facilities 100.

The FLTCIP does not cover the following:

- Illness, treatment or medical condition as a result of your participation in a felony, riot, or insurrection; your attempted suicide; or intentional self-inflicted injuries.
- Care or treatment of alcoholism or drug addiction.
- Care or treatment received in government facility, unless authorized by law.
- Care received while in a hospital.
- Any services covered by Medicare, except for deductible, coinsurance, or co-pay.
- Services or supplies you are not obligated to pay in the absence of insurance.
- Services provided by family members.

For more information you can go online at www.ltcfeds.com and order an Information Kit with application, or call 1-800-LTC-FEDS (1-800-582-3337).

Advantages of the FLTCIP:

- The Federal Program reimburses on the actual cost of care, not at "usual, customary, and reasonable" rates.
- No Mental/Nervous Exclusion.
- No War Exclusion.
- International Coverage.
- Generous Informal Care Benefit.

PRIVATE TRADITIONAL PLANS

SECTION L4

PRIVATE LONG TERM CARE INSURANCE

Long-term care insurance is a relatively new type of private insurance coverage designed to protect against the potentially catastrophic costs of LTC. It helps pay for LTC expenses up to a pre-set amount. You select this amount when purchasing a policy. Typically, LTC insurance pays for care in a wide variety of settings including facility care, home care, and community-based care, although some people purchase more limited coverage that focuses only on one type of care setting.

In some respects, LTC insurance is similar to automobile or homeowner's insurance – it is bought in advance and you hope it is never used. Long term care insurance is there to pay for the catastrophic expenses associated with an unanticipated need in case it should occur. It provides peace of mind and financial protection.

- LTC insurance policies usually cover nursing home care and may include coverage for other LTC services.
- Approximately 60 companies now offer LTC policies in Indiana.
- LTC insurance is **meant to provide coverage for the most catastrophic expense**. The main expense is room and board and custodial care in a nursing home. (LTC insurance may **NOT** cover all of an individual's LTC expenses.

Indiana's definition of LTC insurance:

"An insurance policy providing coverage for **at least 12 consecutive months** for each covered person on an expense incurred, indemnity, prepaid, or other basis for 1 or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care wing of a hospital.

WHO SHOULD BUY LTC INSURANCE?

Buying a LTC policy should not cause a financial hardship or greatly alter one's lifestyle. For some, a LTC policy is an affordable and attractive form of insurance. For others, the cost may outweigh the benefits. Emotional, financial, and physical needs as well as your lifestyle are factors that must be addressed when considering a LTC policy.

It is always a good idea to check your current health care coverage for LTC benefits. Check individual health care plans, retirement and/or group health plans, and veteran's benefits, etc. You may not need additional LTC insurance.

COUNSELORS NOTE:
Often clients ask about LTC price comparisons before they have determined a need for an LTC policy. No price is a good price for a policy that does not match their financial situation or their LTC needs.

SOME COMMON REASONS FOR BUYING LTC INSURANCE ARE:

- **Asset protection**. If your total assets, (generally excluding your home and one auto) are valued at more than $30,000.
- **To maintain your independence**. Depending upon the type of care that you may need, having an LTC policy may allow you to stay in your own home or move to a facility of your choice.
- **Family considerations**. Your spouse or other family members may not be able physically or financially to provide you with long term care. Even if they are able, you may not want them to face this responsibility.
- **Age at application**. Generally, the younger you are when purchasing an LTC policy, the less you will pay in monthly premiums.

To help you decide if buying an LTC policy would be right for you, use SHIP's **"Long Term Care Insurance Self-Assessment Guide**". (See Section L-5) This guide will help you evaluate your current situation (financial and factors such as age, gender, health, family participation) and determine what type of policy and options may best suit your needs.

Who Should Not Purchase LTC Insurance?

You should not purchase an LTC policy if you have or are:

- **Low Income:**

  If your only source of income is a minimum Social Security Benefit or Supplemental Security Income (SSI). You can barely buy food, medicine, or basic needs such as clothing and household items.

- **Few Assets:**

  You have no IRA's, cash value in life insurance, or others assets that can be converted to cash.

- **Poor Health:**

  If you have existing health problems, such as Alzheimer's or Parkinson's disease, or you require assistance to bathe, dress, eat, or perform other activities of daily living, you will not be able to purchase an LTC policy.

- **Age 84+**

  Very few companies sell LTC policies to those over age 84.

Who Sells Long Term Care Insurance?

- Private insurance companies sell individual coverage through company agents, independent agents, and direct mail.
- Some companies sell group coverage through senior citizen organizations, fraternal societies, business associations, and other groups.
- Some employers now offer LTC policies to their employees, their employee's parents, and to their retirees.
- You can also buy LTC benefits as part of an individual life insurance policy. Under this arrangement, a certain percentage of the policy's death benefit is paid when the policyholder requires LTC.

Indiana Standards for LTC Insurance

All LTC policies sold in Indiana after 1993 (Policies issued before January 1, 1993, operated under less strict standards) **must** meet the following standards:

- A policy cannot require a higher level of care to be paid by the policy before it would begin paying for a lower level of care.

  Ex: If in a policy it is stated that the policy pays for all levels of care, then it cannot require that skilled care to be given before it pays for intermediate care.

- Prior hospitalization cannot be required as a condition for the policy to pay benefits. For Home Health Care benefits, prior Nursing Home Care cannot be required as a condition for the policy to pay. (Over half of all persons admitted to nursing homes are **not** hospitalized first.)

- A pre-existing condition waiting period cannot be longer than **6 months**.

- LTC insurance policies must be either **guaranteed renewable** or **noncancellable** (this language is found on the front page of the policy).

- An **inflation protection** feature **must be offered** to each applicant at the time of purchasing a policy. The insurance company chooses the type of inflation protection offered; you either accept or reject this option.

- After a policy is purchased, **Alzheimer's disease may not be excluded**.

- An agent or company must give you an **Outline of Coverage** (a policy summary), and a **Shopper's Guide for LTC Insurance**.

- **"Free Look"** If you return an LTC policy **for any reason within 30 days** (beginning the day that you actually receive your policy), you must be given a full refund of your premium.

- When coverage under a **group LTC** policy is about to terminate, the insurance company **must** provide covered individuals (who have been insured under the group policy for a minimum of 6 months) with an option to continue or convert their coverage. You do not have to prove that you are insurable (healthy) for the new coverage.

- Agents who sell LTC insurance must complete 8 hours of initial training. Every 2 years, they must complete an additional 5 hours of continuing education in LTC insurance (effective 12/31/96).

Policy Features in LTC Insurance

There are **no standardized LTC** policies as there are for Medicare supplement insurance. Many combinations of benefits and coverage are available. You must first determine the types and amounts of benefits you want, consider any acceptable limitations, then shop around for a policy that matches these interests.

Read the policy carefully and **don't assume** all services are covered.

LTC Coverage may include:

- **Nursing Home Care**

  Unless otherwise stated in the policy, nursing home coverage usually means the policy will pay for all 3 levels of care; skilled, intermediate, and custodial.

- **Home Health Care**

  Home health care coverage varies on the types of care that are covered. Some policies cover only skilled nursing care, while others may cover services of home health aides and provide assistance with custodial care. Still other policies may cover home visit services such as cleaning, cooking, and running errands. The policy will state what services will be covered.

- **Combination Nursing Home and Home Health Care.**

  Some policies combine nursing home care and home health care. Policies of this type will state what services are covered and where these services are to be provided.

- **Community Care**

  These policies cover a variety of services. Policies that include home health and community care benefits must cover adult day care. **Adult Day Care** is a program for 6 or more persons providing social & health related services during the day in a community group setting.

- **Alternative Care**

  Alternative care policy options can cover care or services that are not specified in the policy, but are provided if agreed to by the insurance company, the insured person, and their physician. The care must be appropriate. Alternative care benefits are provided instead of normal policy benefits, are usually more desirable to the individual, and are less costly to the insurance company (ex: using an adult family home instead of a nursing home).

Policy Benefits and Limitations

Daily Benefit

The daily benefit is dollar amount the plan for care per day. It is usually paid out in **one of 3 ways:**

- **Indemnity**

  Many LTC policies are "indemnity" policies that pay a **fixed amount** or each day of received care.

  Ex: A policy that pays an $150/day benefit, means the policy pays $150 for each day of care, regardless of the actual cost of care. You are responsible for the remainder.

- **Percentage**

  Some policies pay a percentage of the actual cost of services.

  Ex: A 75% of the per diem (daily) charge benefit means that if the actual daily charge is $150, the policy pays 75%, or $112.50 per day. You are responsible for the remainder.

- **Up to Amount**

  Some policies pay **up to a specified dollar amount** to cover the **actual charges** for services received.

  Ex: An up to $150/day benefit means the policy pays the actual charge, up to a maximum of $150/day. If the actual charge is $145/day, the policy pays $145/day. If the actual charge is $170/day, the policy pays $150/day.

How the daily benefit is selected

- **For Nursing Home Care**: Insurance companies will offer a choice of daily benefits, usually from $50 to $250 a day for care. Before you select a daily benefit level, it is important that you know the cost of facilities in your area.
- **For Home Health Care:** The daily benefit for Home Health Care is usually **one-half** of that for nursing home care. Some policies pay the actual costs of care up to the daily benefit amount of your policy.
- **For Alternate Facility Care:** Policies may pay a lower daily benefit for residential care or assisted living services.

Insurance policies usually pay only after claims have been submitted. You will usually pay 1st, and then you will be reimbursed by the company.

Maximum Benefit

When buying a policy, you will be asked to choose a maximum benefit either **how long** you want the benefit to last, or **how much** you want the total dollar amount of benefits to be.

- **In time** - Benefits can last from one year to a lifetime in length. Policies pay until the specified amount of time has been reached.

- **In dollars** - You can choose policies with no maximum dollar amount, or for set amounts, for example; $30,000, $50,000, etc.

In some policies, the home health care benefit period coverage may be shorter than for nursing home coverage. **Read the policy for details!** Some policies limit the benefit period **by limiting the number of consecutive days they will pay**. This could result in your reaching the policy time limits before reaching the policy's maximum amount benefits.

Also, look at how the policy pays if you have a repeat stay in a nursing home. Some policies require you to be out of a facility for a certain period of time before you can receive benefits for a second stay. The longer or larger the maximum benefit, the more the premium will cost.

How Much Coverage Should I buy?

It's hard to predict future needs. You should choose a policy that has the **highest maximum benefits** that you can **comfortably afford**. Keep in mind, that one-half of all nursing home stays are **6 months or less** in length, because most people receive short term rehabilitation services. The other half of stays are for an **average** length of **2.8** years.

Inflation Protection

Inflation protection provides a way to cushion you from the full effects of future increases in long term care costs (i.e. NH, HHC). This can be important, because nursing home costs are predicted to rise a minimum of 5% each year due to inflation.

For example, a nursing home cost of $150/day:

2003	2008	2013	2018
$150/day	**$191/day**	**$244/day**	**$312/day**

Inflation protection can be one of the most important additions you can make to a LTC policy, but depending upon whether you select simple or compound interest, an inflation protection feature may **significantly increase the policy's premium.**

In Indiana, insurance companies **must offer** the option of inflation protection. If you decline this option, you **must sign** a statement saying that you do not want the inflation protection provision.

A company may offer 3 kinds of inflation protection

- **Additional Coverage -** Every few years you could increase your daily benefit (at the price for your current age). Buying additional coverage this way **can raise the policy premium rapidly**, with the result being that you may find the additional protection unaffordable. If the additional coverage is **declined** when it is first offered, some companies may not allow future purchases of additional coverage.

- **Automatic Benefit Increases -** Under this option, you will have automatic benefit increases on the daily benefit by a **fixed percentage of not less than 5%.** Increases may be by either simple or compound interest, and must continue throughout the life of the policy. (Some older policies may stop the automatic benefit increase when you reach age 80 or 85.)

- **A Percentage of the Actual Or Reasonable Charges -** This inflation protection pays a percentage of whatever the actual or reasonable daily charges. For example: If today's actual cost of care is $100/day, a 75% policy would pay $75/day.

Waiver of Premium

A waiver of premium **usually only occurs when you are in a nursing home** and are receiving benefits from a LTC policy. Under this benefit, **during** your stay you are not required to pay the premiums for the policy. It **does not usually apply** when you are receiving home health care benefits.

Some policies:

- Waive the premium as soon as the first benefit payment is made. (You do not pay policy premiums or for benefits)
- Require a 60 or 90 day wait for the waiver. (Policy pays for benefits, you pay policy premiums)
- Require a 60 or 90 day wait before the policy begins to pay for benefits, **and** before the waiver of premium. (You pay the premiums and for any benefit) This is known as meeting the elimination period). (See p. 20 in the LTC Shopper's Guide)

If you pay LTC premiums advance, (3-month, 6-month, etc.) and your policy starts paying premiums under the waiver of premiums provision, the insuring company is not required to repay your advance premiums. When you return home your premiums will be taken from your advance payment balance, then you resume paying the policy premiums.

Nonforfeiture Benefit

If you cancel your LTC policy, the **nonforfeiture benefit** returns to you what you have invested in the policy. Without this provision, your loss could be substantial, especially if you drop the policy after 10 or 20 years, and never used any of the policy's benefits. A nonforfeiture benefit significantly increases the cost of the policy.

Non-forfeiture benefits may be offered in the form of a **reduced paid-up** policy, in which part of the benefits of the policy are still payable, even after you drop the policy.

A few companies offers a **return of premium** option in which they return all or part of the total premiums paid if a person drops a policy after a certain number of years.

Restoration of Benefits

The restoration of benefits provision in a LTC policy means that if the policyholder remains "off-claim" for a specific period of time (often 6 months) after a covered illness or confinement, the full amount of the policy benefits is once again available to be used by the person.

> **Ex**: You own a LTC policy with maximum benefits of $50,000. You are admitted to a nursing home for 3 months during which time you receive $6,000 in benefits from the policy. Your total remaining benefit is now $44,000.
>
> You return home and remain there for 1 year (off-claim). Upon returning to the nursing home, **a policy with restoration of benefits** renews the policy benefits, and you again have $50,000 available in benefits.

Due to the risk the company takes when including the restoration of benefits provision, premiums are usually higher with this option in a policy.

Policy Limitations: Gatekeepers

All LTC policies use "**gatekeeper**" provisions, that define what conditions must be met before you receive policy benefits. Gatekeepers **limit** the number of eligible claims which helps companies control their losses.

Gatekeepers are often subtle and hard to identify because, unlike policy exclusions, gatekeepers are not listed or labeled separately nor clearly. In the policy, look for “if” and “when” statements.

Questions to Ask about Gatekeepers

- Where, or from whom, must the person receive care?
- What level of care is eligible for benefits to be paid?
- Who must authorize the care?
- What must occur for care to begin?
- Must the person be disabled for benefits to be paid?
- How many days or visits must be satisfied before benefits begin?

Pre-Existing Conditions

Are you eligible to buy a policy? Remember, insurance companies **“underwrite**” their coverage. This means they will look at your health before they will issue you a policy. Companies prefer to sell to persons who are healthy.

Many companies will sell a policy to people who have relatively minor health problems, but will not cover them for those conditions for a set period of time. This is known as a **pre-existing condition waiting period**.

Indiana residents who purchase new LTC policies to replace an original LTC policy, will have the pre-existing condition waiting period in the **new** policy **waived** for any similar benefits (as long as a similar waiting period was satisfied under the original policy).

Elimination Period

When do benefits begin? With most policies, benefits will not begin the first day that you enter a NH or use home health care. LTC policies come with an **elimination period** (also called a deductible or waiting period). The elimination period is the amount of time you must be receiving care, and paying for that care, before the policy will begin to pay benefits. Elimination periods vary from company to company. Usually, **the shorter waiting time** for benefits to begin, **the higher you pay** in premiums. The Elimination Period can be no longer than 180 days.

Definitions and Exclusions

What services are covered, and **where** the services are to be provided will be stated in the policy. Does the policy cover **"assisted living",** which is a residential living arrangement that provides **individualized personal care and health services** for people who require assistance with activities of daily living.

Activities of daily living (ADLs). Policies with this benefit trigger require that you are unable to perform a certain number of ADLs, before the policy begins to pay.

The main activities of daily living may include:

Bathing	**Dressing**
Mobility	**Using the toilet**
Maintaining Continence	**Eating**

Bathing and dressing are usually the first 2 ADL skills an elderly person is unable to perform. Read the definitions section of the policy to see which ADLs are used as benefit triggers

Who authorizes the care?

In the past, most insurance companies required authorization from a doctor for care to be given. Now a **"case manager"**, hired by the insurance company, usually makes the decision. These individuals take into account your medical history, social situation, and your family history, and normally work with a physician to develop a treatment plan.

The least restrictive policies allow care that is provided by state licensed NHs and HHC agencies. Check the policy carefully for restrictions on choosing providers.

Be sure to see whether the policy states what it means by the **"inability to perform"** a particular activity. Some policies clearly state they mean failure to feed or to bathe yourself, others leave it up to interpretation. Some terms to look for and understand in a policy include "hands-on", "continual one-to-one", "supervisory", or "directional" assistance.

Cognitive impairment. With this benefit trigger, you may qualify for benefits if you are unable to pass certain tests assessing your mental function, and if you have a condition such as Alzheimer's disease.

You must follow the procedures outlined in the policy for obtaining case manager approval, or obtaining benefits or claims for services may be denied.

What is not covered?

All LTC policies include a section that lists conditions under which the policy will not pay. **Typical exclusions** in a policy are:

- Mental or nervous disorders, other than Alzheimer's.
- Alcoholism and drug addiction.
- Treatment needed due to acts of war or attempted suicide.
- Treatment already paid for by the government (Medicare, Medicaid, or VA).
- Services provided by a family member.

Benefit Triggers

"Benefit triggers" are another type of gatekeeper requirement that answers the question, "What has to happen before the policy will begin to pay benefits?" In a policy, these requirements are usually discussed in sections called **"eligibility for benefits", "qualifying for benefits", or "benefit conditions."**

There is a wide variation among policies regarding benefit triggers. Some policies may have more than one. Some policies may have different benefit triggers for Home Health Care than they do for Nursing Home care. Pay careful attention to the benefit triggers when reading a policy.

Typical benefit trigger terms to look for:

- **Medically necessary**. Some policies require a doctor's statement that a procedure is medically necessary.

- **Injury or sickness**. This benefit trigger usually applies when the insurance company determines that you are sick or injured enough to receive benefits.

What Do LTC Policies Cost?

A LTC policy can be expensive. Paying premiums should not cause you economic hardships now or in the future.

The Main Factors that Affect Price Are:

- **Age** - The younger you are when you purchase a LTC policy ("issue age") the lower the premiums. Your premiums may increase over time due to loss-ratios of the insuring company, but premiums will not go up due to "attained age".
- **Amount of daily & maximum benefits purchased** - The larger the daily benefit amount and the longer the benefit period, the higher your premiums.

Other options that generally raise the cost of an LTC policy include **inflation protection, nonforfeiture of benefits, and home health care.**

A portion of the cost of long term care premiums may be off-set by **tax deductions**. See the Consumer Information Bulletin (LTC Policy Tax Information, in the Section L1, Reference Materials for details on how you may qualify for State and Federal tax breaks. Please read the information carefully as not all policies qualify for these programs.

Can Rates Be Raised in the Future?

This answer depends on the **type of renewability** in the policy. LTC policies sold in Indiana must be either Guaranteed Renewable or Noncancellable. Most policies are Guaranteed Renewable. (See Navigation Guide 4, Section N - General Insurance for more information)

Buy a New Plan or Upgrade Existing Coverage?

Before you buy a new policy, make sure it's better than the one you already have. Your agent may have switched companies and now wants you to buy a new policy, or you may have heard about a new policy offering.

Some important points to consider:

- Carefully consider any changes and the reasons why you want to change.

- Make sure your new application is accepted before you cancel the old policy.

- If you cancel your policy in the middle of its term, most companies will not return any premiums unless you have a “return of premiums” option that **includes** cancellation of a policy.

- Switching may be appropriate if you have an older policy which requires a prior hospital stay or requires you to receive skilled care before it will pay for custodial care.

- If you bought a policy and now want to add options or change parts of the policy, ask your insurance company about adding enhancements to the policy in the form of **policy riders**, such as inflation protection, etc. It might be cheaper to keep the policy that you have and improve it rather than to buy a new one.

INDIANA LONG TERM CARE INSURANCE PARTNERSHIP PROGRAM (ILTCIP)

SECTION L5

The Indiana Long Term Care Insurance Partnership Program

These policies are commonly referred to as **Indiana Partnership LTC Policies.** All LTC insurance provides some level of asset protection in that the policy pays for LTC instead of you paying out of your assets. Once the benefits of a **traditional LTC insurance** policy are used up and you apply for Medicaid, you must meet the Medicaid requirements for assets and income to be eligible for Medicaid benefits unless you have purchased a policy with unlimited benefits.

If you had purchased an **ILTCIP policy**, you would only need to spend-down those assets which are above the amount of insurance benefits used (unless you had a **total asset** protection policy) and meet the income provisions to qualify for Medicaid.

Origin, Structure, and Objectives

- The Indiana Partnership Long Term Care Insurance Program (ILTCIP) **provides an incentive and a means to protect assets** for Hoosiers who are considering their potential LTC needs.
- The ILTCIP is a **Partnership between Indiana's Medicaid program and private insurance companies**.
- In 1993 ILTCIP policies became available to Indiana Residents, and may be purchased from private companies that are approved to sell ILTCIP policies in Indiana.
- **On the front of the policy it must be stated that it is a ILTCIP policy.**
- A primary goal of the Program is to prevent Hoosier seniors from becoming impoverished due to catastrophic costs of LTC.
- The Indiana Long Term Care Insurance Program is administered by the **Indiana Family and Social Services Administration**, in conjunction with the Indiana Department of Insurance.

Components of the ILTCIP

Quality Assurance

ILTCIP insurance policies participating in the Program must meet special requirements established in regulation, containing important consumer protection features. These features are in addition to the standards adopted by the Department of Insurance for all LTC insurance.

Asset Protection

By purchasing a qualifying policy or certificate, you will be able to protect all (total asset protection) or part, (dollar for dollar) of your assets in the event that you apply for Medicaid to pay for your long term care. Protected assets will be considered exempt by Medicaid in determining your eligibility for Medicaid benefits. **Your income is not protected**.

- If you have **a dollar for dollar policy,** you will be able to protect assets equal to the amount of benefits paid for the actual cost of your long term care (up to the limits of your policy).
- To have **total asset protection**, you must purchase a policy at the **state required minimum level** for the year in which you purchase the policy. The minimum levels are listed below.

The original effective date of your policy	The State Set minimum dollar amount for total asset protection
2006	$206,844
2007	$217,186
2008	$228,045
2009	$239,447
2010	$251,419

What Assets are Protected?

The ILTCIP policy allows you to protect all assets that Medicaid would normally consider should you apply for Medicaid, including such assets as **stocks, cash, bonds, other real property, and the fair market value of your primary home (if you have no spouse).** These assets are **not usually exempt,** and must normally be expended before the person would be eligible for Medicaid.

Remember, under the "Spousal Impoverishment" provision, the community spouse is allowed to keep a portion of the couple's non-exempt assets, while qualifying the NH spouse for Medicaid. Under this provision, the protection of assets no longer applies once the NH spouse dies or if the community spouse enters a nursing home.

Features and Benefits of ILTCIP Policies

Policies must cover room & board and nursing care in licensed Nursing Homes.

Companies **must offer** you the option of purchasing an **Integrated Policy**. If you choose to purchase only an **LTC Facility Policy**, **you must sign a statement of rejection** of the integrated policy.

- **Integrated Policies must include home and community care benefits.** Maximum benefits must be available for either NH care or home and community care (comprehensive coverage). Home and community care coverage **must include** home health nursing, home health aide, attendant care, respite care, and adult day care. These benefits must be provided through **a case management system**. This system will develop a plan of care and then link you with the appropriate provider agencies.

- **LTC Facility Policies** cover only care received in a LTC facility. **Coverage does not include home and community care benefits** (after one year, a comprehensive rider may be added).

Indiana Long Term Care Insurance Partnership Policies **must include Inflation Protection**.

You are guaranteed the right to reinstate a lapsed ILTCIP policy within a specific time period, (as stated in your policy) from the date of lapsing the policy, if the lapse was due to a cognitive impairment. This time period should be stated in the policy.

If your coverage is about to lapse, you must be offered (at least once) the option of a policy with a lesser maximum benefit at a reduced premium.

Maximum Benefits must be available in **Dollars**.

Benefits must be coordinated with other public and private insurance benefits, extending the length of time benefits are available. This means ILTCIP policies pay last, except with Medicaid (the payer of last resort).

Benefit triggers are **standardized** for all participating policies. Insurers are required to use **Activities of Daily Living and Cognitive Impairment as criteria** for when the policy would start paying benefits.

Agents selling participating policies must complete an **additional 7 hours of training on ILTCIP** before marketing any ILTCIP policies (a total of 15 hours of training WITH 8 hrs in LTC insurance and 7 hrs on ILTCIP.)

A one year policy must be offered by all insurers in the Program.

Companies **must offer a minimum daily benefit**, which is 75% of the average daily private pay rate in Indiana (State determines this figure). The minimum daily benefit for policies sold in 2006 is **$110/day**. Many companies are selling their one year ILTCIP policy with a maximum benefit of $36,000.

Examples of How the Asset Protection Benefit Works

The amount of maximum benefits that are purchased in a policy is based on the amount of assets to protect. The protected amount should be at least equal to the cost of 1 year of coverage in a nursing home, or approximately $36,500.

Example # 1

Mr. M purchases a Partnership policy with **maximum benefits of $60,000** (about **2 years** of care in a NH).

Mr. M enters a NH and stays for 2 years, and his policy pays the full $60,000 in benefits, **protecting $60,000 of Mr. M's assets**, but he must stay longer in the NH.

He may now apply for Medicaid coverage, since $61,500 of his assets are now protected from Medicaid in determining his eligibility ($60,000 from ILTCIP policy + $1,500 allowed by Medicaid). His income will pay for the cost of his care and Medicaid will pay his remaining medical expenses.

$60,000 - Policy paid out = the amount of assets protected.
$61,500 = Mr. M's assets + Medicaid $1,500 asset allowance.

Mr. M has no remaining assets he must expend before being eligible for Medicaid.

Example # 2

Mr. T has $100,000 in assets. He is only interested in protecting $60,000, so he purchases a Partnership policy with maximum benefits of $60,000.

Mr. T. enters a NH and stays for 2 years. The **policy has paid the full $60,000 in benefits**. Assume, however that Mr. T remains in the NH. If he applied for Medicaid at this point, he would be denied eligibility.

$100,000 - total amount of Mr. T's assets.
$60,000 - Policy paid out = the amount of assets protected.

Mr. T has $40,000 in assets remaining. He must expend $38,500 towards his medical expenses ($40,000 - $1,500 = $38,500) to meet the Medicaid asset requirement. His income would also continue to pay for the cost of his care. Medicaid would pay the rest of his medical expenses.

What if you have a ILTCIP Policy and Move Out of State?

If you move from Indiana to another state, the insurance **benefits** of ILTCIP policy **would be paid** regardless of where you are living (some policies may have exclusions for care outside the United States).

The **Medicaid Asset Protection** offered in Indiana Partnership policies applies only to Indiana's Medicaid program.

For example: You are receiving LTC benefits from your ILTCIP policy while living in another state, your policy has paid the maximum allowable benefits, and you apply for Medicaid in that state.

Your **assets will not be protected*** unless you must move back to Indiana and make application to Indiana's Medicaid program.

The only exception would be if you are living in a state having a reciprocal agreement with Indiana Medicaid. As of March, 2004, **only Connecticut** has a reciprocal agreement with Indiana. Asset protection honored under this reciprocal agreement is only on a dollar-for-dollar basis.

The Future of the ILTCIP Program

The Program has been established in State statute and **cannot be discontinued without legislative action**. Should the Program be discontinued in the future, for whatever reason, **the state will stand behind the asset protection benefit** of all qualifying policies sold to that point, for the remainder of the lives of those who purchased these policies.

For further information or if you have questions, contact SHIP 1-800-452-4800 or **The ILTCIP Program at:**

1-866-234-4582

or

www.in.gov/fssa/iltcp

PRIVATE PAY OPTIONS

SECTION L6

Private Options Available to Pay for Long Term Care

There are other options, besides Long Term Care insurance, government programs, and family that you can chose from to finance your long term care expenses. However, not everyone will qualify or have the means for all options. It will be important to assess your physical and economic circumstances in choosing the options that best suit your long term care needs.

Private Long Term Care Financing Options

Life Insurance	Long Term Care Annuities	Trusts	Home Equity	Assisted Living
Accelerated Death Benefits	Deferred	Medicaid Disability Trusts	Reverse Mortgage	Continuing Care Retirement Community
Life Settlements	Immediate	Charitable Trusts	Reverse Annuity Mortgage	
Viatical Settlements			Sell Back	
Single Premium Life/LTC			Leaseback	

Life Insurance Policy Accelerated Death Benefits

Life insurance policies sold in Indiana after 1987 may have an **accelerated death benefits provision**. An accelerated death benefit (ADB) allows cash advances against your death benefit while you are still alive. You may obtain a portion of the **"face value",** (the amount that the policy pays at the death of the insured) plus accumulated earnings, (if applicable) **prior to your death.** Accelerated death benefits are usually offered in the form of **policy riders** and can may be added to existing policies at little or no cost.

ADB policies will specify what conditions must occur in order to activate the accelerated benefits. Typical triggers are:

- **Terminal Illness** - You are diagnosed by one or more doctors that death is expected within a specified period. This is the **most common** type sold. Most of these policies pay out in a lump sum payment.
- **Dread Disease** - You become ill from a specific condition or disease named in the policy (ex: stroke, life threatening cancer) which, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span. Some policies cover major organ transplants. Most of these policies pay out in a lump sum payment.
- **Confinement to a nursing home** - You are **permanently** confined to a nursing home with permanent function loss - incapable of performing certain activities of daily living (ADLs). The life expectancy is usually less than 6 months; although, some companies use less than 12 months to live. Currently only about 3% of products include this provision.
- **Long Term Care** - You may be covered under the policy for Home Health Care expenses as well as for confinement in a LTC facility. LTC is the second most common type of accelerated death benefit. Most of these policies pay out periodically (usually monthly).

The use of funds, received from the ADB, is restricted to covering the expenses resulting from the benefit trigger.

Normally you do not have to pay an additional premium for the accelerated death benefit product (in Indiana). Most companies in Indiana use a **"discounted method"**. When benefits are paid out, you receive the percentage of benefits stated in the policy; however, the company keeps the amount of interest they would have earned had the acceleration of benefits not occurred. So, you pay for the accelerated benefit either way.

The amount of your ADB is based on the provisions of your insurance policy and the conditions triggering the benefit. Usually the ADB payment is **capped at 50% of the death benefit** - there are some policies that will allow the full amount to be used. For ADB policies that cover long term care the monthly benefit is typically equal to 2% of the face value for nursing home care and 1% for home care.

> For example, if the face value is $50,000, the monthly benefits would be $1,000 for nursing home care and $500 for home care.

The amount of the ADB is subtracted from the amount payable to beneficiaries upon your death. The more ADB used for your care the smaller death benefit will be left for your heirs.

ADB's paid to **terminally or chronically ill people are not subject to federal income tax.** Check with your tax advisor to verify the status of state income tax on ADB's. There is the possibility that an ADB would affect your eligibility for Medicaid. Check with your lawyer or case worker for verification of your situation.

ADB Opportunities To Consider:

- An ADB included at the time you purchase a life insurance policy may help you later because you might not qualify for a long term care policy at an older age.

- You can add an ADB rider to an existing policy at little or no cost.

- From one insurance policy you can benefit two ways - paying for your long term needs, and leaving a death benefit to your heirs.

ADB Issues To Consider:

- ADB policy benefits are usually more limited than typical long term care insurance. These policies can only be used if you have a terminal illness, dreaded disease, need nursing home care permanently, or cannot perform ADL's.

- The face value amount may not be large enough. In this case the ADB payment will not be enough to pay for your long term care needs.

- You must continue to own your policy and pay the premiums. An ADB policy can lapse if premiums are not paid.

- Inflation protection is not usually offered.

- If you need a lot of health care and use the ADB, there may be little if any death benefit for your heirs.

- If you are on Medicaid or plan to apply in the near future, this option may affect your Medicaid eligibility.

Life Settlements

Life Settlements (also know as Senior Settlements, Elder Settlements, or High Net Worth Settlements) give you the option to adjust to changes in your health goals or life circumstances by selling your life insurance policy, for the present value of the policy. This is usually done when the original reason why you bought the policy no longer exists (i.e. a divorce, or your heirs do not need the funds) or the insurance premium may not be affordable after retirement. The money from the sale of your policy can be used to pay for your long term care.

To be eligible for this you must meet an **age requirement**: 74 years of age for women and 70 years for men. Some companies will make an exception and may purchase a life insurance policy from a 65 year old, if the life expectancy is determined to be 12 years or less. **You do not have to be in poor health or terminally ill to take advantage of a Life Settlement.**

What types of policies can be sold?

- Term Life Insurance
- Whole Life Insurance
- Universal Life Insurance
- Individual Policies
- Group Policies
- Policies held in an irrevocable life insurance trust
- Buy-sell agreements
- “Key-Man” Policies - policies taken out on individual whose death would have a significant financial impact on the company or organization.

The use of the proceeds is unrestricted and can be used for a variety of expenses. You can purchase a long term care insurance policy, or you can use the funds to cover long term care expenses, if you are denied for a long term care insurance policy.

There are tax consequences for this option

- The difference between the settlement payment and the cash surrender value of the policy is taxed as capital gains.

- The difference between the total premiums paid and the cash surrender value is taxed as ordinary income.

If you are considering this option, you should discuss your situation with a tax professional before selling your policy.

Life Settlement Opportunities to Consider:

- You can use the money from the sale of your life insurance policy to pay for your long term care needs.

- You do not have to be in poor health to take advantage of this option. You may qualify for long term care insurance and use the proceeds from the sale to pay for the insurance.

- If you do not need long term care, you can leave something to your heirs.

Life Settlement Issues to Consider:

- The money you get from selling your life insurance policy is taxable. Check with a tax professional before selling your policy.

- Depending on the amount you receive, you may not have enough money to pay for all of your long term care needs.

Viatical Settlements

If you have a terminal illness, you may consider selling your life insurance policy to viatical settlement company in exchange for a percentage of the policy's face vale. The viatical company will become the sole beneficiary of the policy and responsible for paying the premiums.

The difference between a Life Settlement and a Viatical Settlement is a matter of time and health. In general a Viatical Settlement is the sale of a policy by someone who has a life expectancy of two years or less (exception: some companies will purchase a policy if the life expectancy is four years), whereas a Life Settlement is an option for someone with a life expectancy of more than two years, but less than thirteen years. There are different tax consequences as well. Viatical Settlements are usually federal income tax free, but Life settlements are subject to tax.

Each company sets its own rules for determining which life insurance policies it will buy. For example, most viatical companies will require that:

- You have owned your policy for at least two years.
- Your policy has a large value, most companies have a minimum policy size such as $100,000 or $250,000.
- Your current beneficiary sign a release or waiver.
- Your policy be issued from a well-known insurance company.
- You sign a release allowing the company access to your medical records.

The National Association of Insurance Commissioners (NAIC) has developed the Viatical Settlements Model act governing the licensing and regulation of viatical companies. After December 1998, in order to act as a viatical settlement provider in Indiana, an individual must be licensed by the Indiana Department of Insurance.

NAIC Suggested Guidelines for Viatical Payments

Life Expectancy	% of Death Benefit Paid
1-6 months	80%
6-12 months	70%
12-18 months	65%
18-24 months	60%
Over 24 months	50%

Other factor influencing the amount of the payments are:

- Insurer's rating—a lower rating may lower the viatical payment.
- Waiver of premium - if the company does not have to pay a premium on the policy, than the payment may be higher.
- Case Diversification of Viatical Company - you may get a better offer from a company with a diversified consumer base.

Because the decision to sell your life insurance policy is a very complex matter, you should **consult your tax advisor**. Generally speaking, if you sell your policy to a viatical settlement company, the proceeds are federal tax free when you have a life expectancy of less than two years and you live in a state that requires licensing. However, you may still owe state tax on the proceeds.

If you are considering a Viatical Settlement on your life insurance policy, take care not to make hasty decisions. These consumer guidelines should be considered before any action is taken:

- **Avoid companies that use a hard seller high pressure approach**. You have the right for unconditional rescission of the contract 5 days after receiving payment, or 30 days after the contract is executed, which ever is longer.
- **Shop around.** Review offers from several companies to make sure offers are competitive, and be aware of the prevailing discount rates.

- **Ask about privacy policy**. During the negotiations the broker should respect your privacy. Companies unrelated to the negotiations should not be contacting you.
- **Insure the funds are available**. Insist that the company set up an escrow account with a reputable independent institution before the company sends the offer papers for your signature. An escrow account will ensure that the funds are available to cover the offer.
- **Check with the Indiana Department of Insurance** to verify the company is licensed in the State of Indiana, and check on any complaints against the company.

Viatical Settlement Issues to Consider:

- If you live longer than expected, your funds may be exhausted.
- The settlement may be insufficient for the type and amount of long term care needed. This type of care is for those who are terminally ill, not just in need of long term care.
- Your survivors will not receive any proceeds from the policy. If leaving an inheritance is important to you, this may not be a good option.
- You may not qualify for this option as more than 50% of applicants are declined.
- The settlement may affect your eligibility for Medicaid.

You also may want to contact the following organizations for more information:

- **Affording Care** - 429 E 52nd St, Unit 4-GNew York City, NY 10022-6431
- **American Council of Life Insurance** - 1001 Pennsylvania Ave.,N.W.Washington, DC 20004-2599
- **National Association of Insurance Commissioners** - 444 North Capitol St., N.W.Washington, DC 20001
- **National Association of People With AIDS** - 1413 K Street, N.W.Washington, DC 20005
- **National Viatical Association** - 7910 Woodmont Ave., Suite 1430, Bethesda, MD 20814
- **North American Securities Administrators Assoc.** - 555 New Jersey Ave., N.W.Washington, DC 20001
- **Viatical Association of America** - 1200 19th St., N.W. Suite 300Washington, DC 20036

Single Premium Life/LTC Policies

Unlike traditional Long Term Care (LTC) policies that require premiums to be paid for life or until the care is needed, Single Premium Life/LTC Policies are funded through a **lump sum payment**. You may receive at least double the amount of your deposit for long term care expenses.

You can use the following sources of funds for you lump sum payment:

- Cash
- Certificates of deposit (CD's)
- Non-qualified and qualified annuities
- Cash value from a life insurance policy
- Money market accounts
- IRAs and Keogh plans

The source of the premium payment will affect the issue age. If the premium is paid from qualified annuities, IRAs or Keogh plans, an issue age of 59.5 or higher may be required. The usual maximum issue age is usually 80 years. **A joint policy can be issued if both spouses fall within certain age parameters**.

Minimum deposits can be in the $10,000-$20,000 range, but for a meaningful benefit the deposit should be around the $100,000 range, for a couple at 60 years of age. If you are willing to self-insure a portion of long term care expenses, or have other ways of financing your long term care, a smaller deposit can be made.

The lump sum deposit purchases a death benefit and depending on the amount used for long term care your heirs may receive a death benefit. The longer you have the policy and do not file a claim, the more money you will have for your future long term care. If long term care is needed immediately, the policy could pay as much as four years of benefits at 2% per month.

Single Premium Life/LTC Opportunities to Consider:

- You may have access to twice the amount of your deposit for long term care needs.
- This type of insurance policy pays a death benefit to your heirs.
- No monthly premiums.
- You may be able to move money from your life insurance policy without paying tax penalties. For more information about tax issues, check with tax professional.

Single Premium Life/LTC Issues to Consider:

- To keep pace with rising long term cost, you may needs to purchase additional coverage, or buy a rider for inflation protection and make additional payments.
- You would need to make a substantial lump sum payment for the long term care benefit to be meaningful.
- Your policy may not cover your long term care needs as you get older. Make sure the policy will cover your current and future needs.

Long Term Care Annuities

An annuity is a series of regular payments over a specified and defined period of time. Annuities can help you pay for your long term care if you do not qualify for Long Term Care insurance due to age or health problems. There are two types of Long Term Care Annuities: deferred and immediate.

Deferred Annuity with long term care benefits:

This annuity is available for persons **up to age 85** and has seven broad health questions that most people can satisfy.

One example of this type of annuity consists of two funds. The first fund is for long term care expenses and grows at a high interest rate with a five year guarantee. It then grows at the current interest rate thereafter. The second fund grows at three percent guaranteed and is a regular cash fund.

The purpose of the separate long term care fund is to allow immediate use of funds for licensed long term care services. Otherwise, early withdrawals from a regular deferred annuity are limited and can be penalized. The amount of the monthly benefit is determined by dividing the long term care fund balance by 34.5. A lifetime rider may be available for an additional premium.

You may make annual withdrawals of 10% from the cash fund to pay for additional expenses under the long term care fund. **Withdrawals greater than 10% from the cash fund may be penalized**. If the long term care fund is not exhausted at the time of death, any remaining money in the cash fund will be passed on to the beneficiary.

Tax Rules

- Earnings on the money are tax deferred, however you may be taxed on the gain as withdrawals are made.
- These deferred annuities are non-tax qualified long term care policies. There may be a risk of being taxed on the money from the fund that is used to reimburse long term care expenses.
- A tax professional should be consulted.

Another type of annuity/long term care product would act as a standard deferred annuity with a long term care rider attached. This rider could be accessed after a six year waiting period through traditional activities of daily living (ADLs), and cognitive impairment benefit triggers. It would pay a monthly benefit based on a percentage of the amount that had accrued in the annuity portion but would not reduce the annuity portion of the contract.

The money from the long term care rider is considered taxable. As there is no medical underwriting required, this might be an option for someone who is uninsurable with traditional long term care insurance with a condition that might not require care for six or more years (early stages of Parkinson's for example).

Deferred Annuity Issues to Consider:

- The benefit may not adequately cover all long term care expenses. This may happen if long term care is needed before the annuity fund has grown or the long term care rider is available for access.
- Inflation protection is not included. You would need to put in enough money to accommodate inflation.
- You should consult a tax professional.

Immediate Annuity

Immediate annuities are available to people with **uninsurable health conditions or who may already be receiving long term care**, as well as those in good health. A single premium payment is converted to a monthly income stream guaranteed for a specified period of time. Most common time periods are:

- The life of the policyholder
- A minimum guaranteed period
- Life plus a minimum guarantee period
- A joint and survivor annuity option.

The annuity **pay out is based on age and gender**. With an annuity that is not medically underwritten and all things being equal (age, amount of annuity, etc.), as women tend to live longer than men, a man would receive a higher monthly payment than a woman. If the annuity is medically underwritten, a person with impaired health would receive a larger payout, due to a shortened life span. Medically underwritten annuities are not available in all states.

Immediate Annuity Issues to Consider:

- You must carefully plan for inflation in order to ensure that enough funds are available for your long term care needs.

- Income may be insufficient as the type and amount of long term care may be unknown.

- If your health condition does not reduce life expectancy, the annuity payments may not be any better for a medically underwritten annuity than for a regular annuity.

- The annuity can continue to pay to your beneficiaries after your death if an annuity with a minimum guarantee period is chosen, not a life only option.

- Tax treatment of immediate annuities is complicated. **A tax professional should be consulted**.

Trusts

A Trust is a legal arraignment by which one person (the grantor) transfers assets to another (the trustee) for the benefit of one or more third parties. The trustee holds the title to assets and manages them, acting in the best interest of the beneficiary or beneficiaries. Trusts may provide some options to fund long term care. Primary examples are Medicaid Disability Trusts and Charitable Remainder Trusts.

Medicaid Disability Trusts

This trust is the only type exempt from rules regarding trusts and Medicaid eligibility. All other irrevocable trusts currently created with the intent to transfer assets without spending down run the risk of being disqualified. **This trust is limited to disabled individuals**.

There are two types of Medicaid Disability Trusts:

- **Trust for Disabled Persons Under Age 65**.
  This can be established by a parent, grandparent or legal guardian. You may set up this trust to provide benefits to enhance the life of an individual who is qualified for public benefits. If Medicaid benefits are paid on behalf of the individual, any amount remaining in the trust at the time of death is recoverable by the state up to the amount of such benefits.

- **Pooled Trust Managed by a Non-Profit Association**.
  This is also used to enhance the life of the disabled person while maintaining eligibility for Medicaid. It can be set up by a family member or legal guardian. Funds are pooled for investment, but a separate account must be maintained for each beneficiary. At the time of death the state must be reimbursed for the Medicaid benefits paid on behalf of the beneficiary from the funds remaining in their account. **This trust can be set up for a disabled person over 65 years old.**

The trusts must be properly drafted to effectively accomplish their goals. It is very important that an experienced attorney be consulted.

Medicaid Disability Trust Issues to Consider:

- **Limited to disabled individuals**.
- Medicaid benefits must be reimbursed upon the death of the beneficiary. Not all money in the trust will be sheltered.
- Check with your tax advisor concerning any tax issues.
- Trusts must be properly prepared drafted to effectively accomplish their goal. **You must seek competent legal counsel**.

Charitable Remainder Trusts

These trusts allow you to use your own assets for long term care with the added benefit of reducing taxes. This type of trust is limited to affluent people with specific types of assets that are gifted to a public charity at fair market value. You would receive tax deduction based on the market value of the gift.

Payments to you from the charity are also based on the fair market value. You may use these funds to cover long term care expenses while reducing taxes. Upon your death, the charity receives the balance of the trust.

Charitable Trust Issues to Consider:

- Few people have the assets for this type of trust.
- Payments may be insufficient to cover your long term care needs.
- Assets transferred to the trust are subject to a 60 month look back, which may make you ineligible for Medicaid.

Reverse Mortgage (Home Equity Conversion)

A Reverse Mortgage (RM) is a type of home equity loan that enables homeowners **age 62 and older** to convert some of the equity in their home into cash, and continue to own and live in the home. It operates similar to a traditional mortgage, but in reverse. Instead of paying the lender, the lender pays the home owner.

Because you would retain ownership of the home, **you would be responsible for taxes and repairs**. The loan is paid off by the sale of the property once you move out or die. You can never owe more than the home's value. If there is any equity left, it would go to your heirs.

You are required to be counseled before applying for a RM loan. The counselor's job is to educate you about reverse mortgages, to inform you of other alternatives available to you, and assist you in determining which RM plan is best for you. A list of FHA approved counselors is included in the Long Term Care Portfolio.

Several factors determine the amount borrowed:

- Your age
- Your life expectancy
- The equity in your home
- The location of your home
- The interest rate

The maximum loan amount ranges from 50-70% of the home's fair market value. There are **no income or credit qualifications**; however, the home must be completely or nearly paid off to qualify. Funds may be paid in a lump sum, monthly installments, a line of credit, or a combination of the three. **This money is non-taxable**. It does not count towards income or affect Social Security, Medicare, or Medicaid benefits as long as the payments are spent within the month they are received. The interest on RM payments is not tax deductible until the debt is paid.

There are three types of RMs: FHA–Insured; Lender-Insured; Uninsured.

FHA-Insured Reverse Mortgages

These loans are insured by the Federal Housing Administration (FHA). They are offered by banks, mortgages companies and other private-sector lenders. As they are insured, the **government is required to make the payments if the lender goes out of business**. The most widely available plan is the FHA's Government-insured Home Equity Conversion Mortgage (HECM) program. This RM plan accounts for around 90% of the total market. In order to qualify for this program, you must be 62 years of age and be living in a single-family home or condominium that is your principal residence.

Payment options offered:

- Monthly advances for a fixed term, or life
- A line of credit
- Monthly advance plus a line of credit

Quick Facts:

- Repayment is not due as long as you live in the home.
- With the line of credit option, you may withdraw funds as needed over time.
- Closing costs, mortgages insurance, and sometimes monthly servicing fees are required.
- Interest is at an adjustable rate. Interest rate changes do not affect the monthly payment, but do the rate at which the loan balance grows.

Pros of a FHA Insured RM

You can change the payment method at little cost.
Loan advances are guaranteed to continue even if the lender goes out of business.

Cons of a FHA Insured RM

You may receive smaller advances than lender insured plan's.
Loan costs may be greater than with uninsured plans.

Lender Insured Reverse Mortgage

Lender Insured RM offer monthly loan advances, or monthly loan advances with a line of credit, for as along a you live in your home. One example is the Federal National Mortgage Association's (FNMA, also know as Fannie Mae) Homekeeper plan. This plan may be available to people who have **homes that are more expensive, or those who need to borrow more money**.

Eligible home types include:

- Single-family Homes
- Condominiums
- Units in qualified planned unit developments
- Properties held in trust
- Qualified leasehold properties

Quick Facts:

- Interest rates may be fixed or adjustable.
- Additional loan costs can include a mortgage insurance premium, as well as other fees that you may be able to finance and include in the mortgage.

FNMA also offers a Homekeeper for Home Purchase plan. This plan allows you to obtain a Homekeeper RM in connection to the purchase of a new home-in a single transaction. This transaction would allow you to reduce out of pocket cash needed to buy a new home, eliminate any new monthly mortgage payment, and keep more of the sale proceeds from your older home to use for other expenses. You may want to use this plan if you wish to sell your home and move closer to family, move to warmer climates, or move to a home that provides greater accessibility.

Pros of a Lender-Insured RM

Loan amounts may be larger than those provided by FHA-Insured RM, and you may be allowed to mortgage less than the full value of your home. This process would allow you to preserve equity for your later use or to leave for your heirs.

Cons of a Lender-Insured RM

Loans may involve greater costs than FHA-Insured loans.
Higher cost means the loan balance grows faster, leaving less equity over time.

Uninsured Reverse Mortgage

Uninsured RM are dramatically different from FHA and Lender-Insured RM. You have **only the strength of the lender to back whatever promises are made** as to payments and other terms. If your objective in seeking a RM is future income rather than a lump sum payment up front, a federally insured plan may be a better choice.

Quick Facts:

- Monthly advances are for a **fixed term only** - this is determined when you first take out the loan.
- The loan **balance is due when the loan advances stop**.
- Interest is usually set at a fixed rate, and no mortgage insurance is required.

Pros of an Uninsured RM

If you have a short-term but substantial cash need, this plan can provide a greater monthly advance than the other plans.

Cons of an Uninsured RM

You must pay back the loan by a specific date. It is important to have a source of repayment.
If you are unable to repay the loan, you may have to sell your home and move.

Consumer Tips When Looking at RMs:

- **One size doesn't fit all**. The amount of payment you receive and the real cost can vary from one plan to another.
- **Look at all options**. There are major differences among the plans.
- **Compare total costs**. The total annual loan costs (TALC) rate is the best way to compare the true total costs. The TALC rate declines over time, and can vary from one plan t another.
- **Credit lines are not equal**. The credit lines offered by different plans are not equal. The HECM credit line is the only one in which the remaining credit grows larger every month at no additional cost to you, providing the value of your home increases.
- **A RM is a non-recourse loan**. In other words, when seeking repayment the lender does not have recourse to anything but the house.

RM Issues to Consider:

- RM is a financial resource option if you do not qualify for Long Term Care Insurance.
- Funds can be used to purchase Long Term Care Insurance, or to pay for long term care needs.
- RMs provides cash flow if you are “house rich but cash poor”.
- Your heirs can retain the home by repaying the RM.
- Since your long term care needs are unknown, the loan may be insufficient.
- Loans do not adjust for inflation.
- Your home may need to be sold to pay for long term care needs in excess of the loan amount.
- If the loan contract does not provide **lifetime tenancy**, you may outlive the terms.
- **You are responsible for all taxes, insurance, repairs, and maintenance**. If the home falls into disrepair, repayment may be triggered.
- This may not be an option if you want to leave your home free and clear to your heirs.
- The costs of obtaining RM can be very high, and may have to be paid in cash.
- RM options are confusing and numerous.
- If you are already ill or have a shortened life expectancy, you may not receive the full benefit that a healthy person would receive.
- **Clarify with the lender how long you are allowed to stay away**

Reverse Mortgage Annuity

In a RM Annuity, part of the lump sum loan amount is used to purchase an annuity. Even if you sell or move from the home the annuity payments will continue. The loan must be paid off when you either die, sell, or move from the home. The annuity payments from the separately purchased annuity can continue.

Annuity payments **may be taxable and affect eligibility for SSI (Supplemental Security Income) and Medicaid**. Check with a lawyer and/or tax professional about your situation.

Additional charges based on increases in the value of the home during the term of the loan may be included if an equity participation option is chosen by the borrower in order to lower the interest rate.

Caution - the term “reverse annuity mortgage” is used to refer to RMs that are structured with a monthly income option. **You must be sure to fully understand the type of RM you are considering**. This is important in understanding the tax issues, loan repayment terms, and monthly payment promises.

Sell Home

One way of using your home to pay for long term care is to sell it. The proceeds can be invested to produce a continuous income, pay for long term care expense, or purchase a LTC insurance policy. This option may ideal if you are single, without heirs, or to a married couple wanting a lifestyle or location change. If you have the alternative of a less costly living arrangements, you may find this a viable option.

Issues to Consider:

- You may be uncomfortable selling a major asset.
- You would be unable to pass the family home to children as an inheritance.
- Proceeds may be insufficient to cover long term care expenses.
- Timing may be an issue. Market value may not be at its best.

Leaseback

A leaseback occurs when an investor purchases a home below market value and the investor agreed to rent the house to the seller on a long -term lease. With a leaseback you would no longer have to worry about maintenance or repairs to the home, or paying property taxes. The proceeds can be used as you desire, to finance long term care needs, or to purchase LTC insurance.

The investor is partially reimbursed for the long-term lease through the difference between the selling price and the higher fair market value. Long-term leases or even a life estate have an economic value that can be reflected in the sale price of the home.

Taxes and property maintenance is the responsibility of the investor. Possession goes to the investor once you no longer live in the home.

Leaseback Issues to Consider:

- This may be an option to keep the home in the family by allowing children to take the role of investor.
- You may have to pay taxes on the proceeds of the sale. Check with your tax advisor.
- This may affect your Medicaid status.
- If the property is neglected, you may find it difficult to live there, and you may not have the funds or authority to correct the situation.

Continuing Care Retirement Commnity

A Continuing Care Retirement Community (CCRC) provides full continuum of care in a variety of settings, allowing you to “age in place”. As your needs change, the services offered by the CCRC changes from independent living to assisted living, to nursing home care - all in the same location.

Usually you pay an entrance fee and monthly payments to the CCRC in exchange for housing and defined long term care services. Fees vary by the size of the unit, (studio, one-bedroom, two-bedroom, larger) and by the location. A recent survey reports that the average entrance fees for one and two-bedroom apartments range between $59,000 and $121,000. These fees are subject to increases as operation costs increase.

A percentage of the entrance fee is usually reimbursed to the residents or their estate when they move or die. Interest earned is not paid to you, the resident, although you may be responsible for paying income tax liability on the interest income.

The monthly service fee may increase as the amount of care increases. In many cases LTC insurance is incorporated in the monthly fee. The CCRC collects the benefit to provide care to you. Since the CCRC is planning on residents not needing care for a certain amount of time, in order to keep its fees reasonable, you must be relatively healthy to enter.

Types of CCRC Contracts

While similar in concept, contract provisions differ. It is important for you to review the contract carefully to determine the services included in the entrance and monthly fees. The contract should also state the conditions that allow for increases in monthly fees, as well as procedures for adjusting fees when living accommodations change.

Should you or your spouse move into a nursing facility, the contract should state how long the remaining spouse stays in the living quarters, and how long the living quarters will be maintained. If the contract includes a termination clause, term and procedures should be clearly stated. Contract review requires legal and financial assistance, consul your lawyer, financial planner, and/or tax advisor.

CCRC Contract Types

	All Inclusive	Fee for Service	Modified
Entrance Fee/ Monthly Payment	Covers housing and all LTC fees. Usually higher than other types of CCRC.	Housing, social and recreational services. Access to LTC services. Less expensive than All Inclusive.	Housing, social services and physical assistance included along with a specified amount of nursing home care.
Not Included/ Incremental	Medical services which are usually covered by Medicare or supplemental health insurance.	LTC and medical services are paid by the resident as required. None of services are pre-paid.	Additional LTC services offered for a fee.

Contact your local SHIP site, Area Agency on Aging, or Senior Services for information on CCRC in your area.

CCRC Opportunities to Consider:

- You may not need to worry about long term care needs depending on the CCRC.
- Entrance fee may be refundable at death, or when the independent living unit is occupied by a new resident.
- Monthly fees may be reduced if you have your own LTC insurance.

CCRC Issues to Consider:

- CCRC may provide little or no home care.
-
- May have to meet specific health requirements to qualify for entry.
-
- CCRC usually has preset conditions for when care is received.

- All-Inclusive Life Care Contract may not be available.
- Very important that you understand the terms of the contract.
- Cost of facilities may be out of reach for some.
- Campus lifestyle may not appeal to you.
- Check into the history of rate increases in the monthly fee. You may need to consider if you would be able to afford significant increases in the future.
- Need to consider what would happen if the CCRC were to go bankrupt.

NAVIGATION GUIDE TO OTHER INFORMATION

A Quick Reference Guide for
SHIP Counseling

The Navigation Guides are designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of she/he, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 6 option 1.

MEDICARE for UNDER 65 and DISABLED

SECTION M

MEDICARE ELIGIBILITY
UNDER 65 AND DISABLED

You qualify for Medicare if you are under 65, disabled, and:

- You have been entitled to Social Security or Railroad Retirement Act Disability benefits for **24 months**, making you eligible for Medicare coverage in the 25th month.

- You have been diagnosed as having **End Stage Renal Disease** (**ERSD**), permanent kidney failure, need regular dialysis, or have had a kidney transplant and are receiving Social Security Disability benefits. You will be eligible for Medicare after 3 months of dialysis.

- You have been diagnosed as having **Lou Gehrig's Disease** (**ALS**), and are receiving disability benefits. You will be eligible for Medicare **immediately.**

Enrolling in Medicare

Enrollment in Medicare is automatic once you have met the eligibility requirements. Your Medicare card should arrive approximately 3 months prior to the date Medicare is scheduled to begin. You will be enrolled in both Medicare Parts A and B. You can refuse Part B by contacting your local Social Security Office.

Medicare Costs

While Medicare Part A is premium free, there is a monthly premium for Part B. Beginning in 2007 this premium will be based on your annual income. For most Medicare beneficiaries the 2008 premium will be $96.40 per month (for single beneficiaries with an annual income of $82,000 or less; married $164,000 or less. In addition to the monthly premium, you will be responsible for the deductibles, co-pays, and coinsurance associated with Medicare (See *Navigation Guide 1 Medicare Parts A and B*, sections B and C.)

MEDICARE OPTIONS

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance plans, also known as Medigap plans, are private insurance policies that are specifically designed to fill the “gaps” in Medicare. These gaps include deductibles, co-pays, and coinsurance. There are 12 standardized policies (A through L) currently approved for sale in Indiana.

Only a handful of companies offer Medigap plans to individuals who are under 65 and disabled. The plans offered to those under 65 and disabled are limited to plans A, B, C or F. With few exceptions, you will not have a guarantee right to purchase a Medigap plan without medical underwriting.

You will have a guaranteed right to purchase these Medigap plans if:

- Your employer group health plan or retiree plan either ends, or your benefits are reduced significantly.
- You are enrolled in a Medicare Managed Care plan and the plan ends or no longer serves your area of residence.
- You disenroll from a Medicare Managed Care Plan during the first 12 months.

When you become age 65, you will then have a 6 month enrollment period when you will have a **guarantee issue** for any Medigap plan offered in Indiana. During this time insurance companies cannot charge you a higher premium or impose a waiting period because of your disability or health history. (See Navigation Guide 2 *Medicare Supplemental Insurance*, Section F, for more information on Medigap plans).

SHIIP has a package of information that includes list of companies that offer Medigap plans to individuals under 65 and disabled. This package of information includes Centers for Medicare and Medicaid Services’ (CMS) *Choosing a Medigap Policy*.

Medicare Advantage Plans

Medicare offers beneficiaries the option to receive care through private insurance plans. These private insurance options have been known as Medicare+Choice plans, and are now called Medicare Advantage Plans.

Private insurance companies contract with CMS to manage your health care and to provide your Medicare approved services. **The most common type of Medicare Advantage plans are health maintenance organizations (HMOs), preferred provider plans (PPOs), and private-fee-for-service (PFFSs).**

You have the same rights to enroll in an Advantage Plan as those who receive Medicare due to age. There are **no waiting periods** for pre-existing conditions, and the plan must enroll you unless you have ESRD or the plan is at capacity.

To enroll, you must live in an area that is served by the Advantage Plan. There are two types of service areas, **local and regional**. Local service areas cover specific counties and/or zip codes. In order to enroll in these plans you must live in the specified area. Regional service areas offer coverage on a much larger scale, often state-wide or multi-state coverage. Indiana is in the same region as Kentucky. Any Medicare beneficiary that lives in Indiana or Kentucky, regardless of county or zip code, may enroll in a regional plan.

A list of plans is available from the SHIP website at www.medicare.in.gov; as well as, the Medicare website: www.medicare.gov.

Medicare and Employer Plans

If you have Medicare and you are covered by an employer large group health plan, (sponsored by an employer/employee organization of 100+workers), the employer plan will provide your primary coverage. Medicare will be secondary as long as the covered employee is **actively working**. Otherwise, Medicare is primary.

MEDICARE and MEDICAID

Full Medicaid Benefits

Medicaid is a joint federal and state program that helps pay your medical costs if you have a limited income and have limited assets. If you qualify for both Medicare and Medicaid, most of your medical costs will be covered. Medicaid may also pay for some services that are not covered by Medicare such as nursing home care. The income and asset limits to qualify for Medicaid are:

Full Medicaid effective 4/1/07

	INCOME	ASSETS
SINGLE	$639/month	$1,500
COUPLE	$950/month	$2,250

For a couple with dependents, additional income of $311 per dependent may be allowed. A $15.50 monthly income disregard is included in the figures listed above.

Medicaid Spend-Down

If you meet the assets requirement but your income is above the limits to qualify for Medicaid, you may be able to qualify for Medicaid Spend-Down. Spend-down is a provision that allows a person, whose income is higher than the standard, to receive some assistance with medical bills under Medicaid. The Spend-Down amount is determined by the difference between the Medicaid standard (see above chart) and your monthly income. To be eligible your medical expenses must be greater than the spend-down amount.

Medicare Savings Program

If your income or assets are above the limits to qualify for full Medicaid, you may still be able to qualify for the Medicare Savings Program (also known as Medicare Buy-In Program) This program is set up to assist qualified Medicare beneficiaries in paying their Part B premium, co-pays/ coinsurance, and deductibles.

Medicare Savings figures effective 4/1/07

		INCOME	ASSETS
QMB Qualified Medicare Beneficiary	SINGLE	$851	$4,000
	COUPLES	$1,141	$6,000
SLMB Specified Low Income Medicare Beneficiary	SINGLE	$1,021	$4,000
	COUPLES	$1,369	$6,000
QI Qualified Individual	SINGLE	$1,149	$4,000
	COUPLES	$1,541	$6,000

A $20.00 monthly income disregard is included in the figures listed above.

If you qualify for the QMB program, you will receive assistance in paying for your Part B premium, Medicare deductibles, and co-pays/coinsurance. Those eligible for SLMB and QI receive assistance in paying for their monthly Part B premium,

If you believe that you may qualify for Full Medicaid, Medicaid Spend-down and/or QMB/SLMB, you will need to contact your local Department of Family Resources (formally Office of Family & Children).

COBRA

(Consolidated Omnibus Budget Reconciliation Act-1985)

COBRA is a **temporary extension** of your employer's group health coverage insurance. You must **apply within 60 days** of a specific qualifying event or you will lose your right to extend your group coverage under COBRA. The employer must notify the plan's administrator within 30 days of the qualifying event. The plan administrator must send you a COBRA election notice with in 14 days of receiving notification. To sign up, you should talk to the employer's benefits or human services division. **COBRA can help you if you are under 65 and disabled and qualify. You may find it difficult to buy other health care insurance.**

The employee and their dependent beneficiaries **must be offered the same health insurance benefits** with the same deductibles and benefit limits that they were receiving before the COBRA qualifying event.

You are eligible if:

- The employer has 20 or more employees.
- The employee has worked at least half of working days in the previous year.
- The employee is covered by the group health plan and you are in the employer group health plan on the day before the employee has a "**qualifying event**". (A specific event that causes you to lose employer group health care coverage).

Qualifying Event	Who's Eligible	Length of Eligibility
Voluntary or involuntary termination of employment/ reduction on work hours (other than for "gross misconduct)	Employee Spouse Dependent Child	18 Months
Employee enrolls in Medicare Part A or B	Spouse Dependent Child	36 Months
Employee & covered individual divorce	Spouse Dependent Child	36 Months
Employee dies	Spouse Dependent Child	36 Months
Loss of dependent child status	Dependent Child	36 Months

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. While this can be expensive, **compare the total cost and benefits** of COBRA coverage with the total cost and benefits of other options (including Original Medicare, Medicare Advantage Plans, Medigap policies, ICHIA, and private health care insurance) to determine what will best suit your finances and health needs. Be sure to compare:

- Prescription coverage
- Eye, dental, foot, and other coverage
- Maximum benefit limits (annual & specific types of care)
- Co-pay amounts
- Yearly deductibles

Cobra and Social Security Disability Benefits

The employer group health insurance extends for 18, 29, or 36 months, (depending on qualifying event). If you qualify for Social Security disability benefits, special rules apply to extend the 18 months of COBRA coverage to **29 months.** To receive this special coverage extension, you must notify the former employer insurance division within 60 days of receiving your disability determination.

You pay the entire premium, plus a 2% administrative charge to the continued group health plan for the first 18 months. If your disability started before your COBRA qualifying event, your group coverage could be extended to 29 months. **For the last 11 months, your premium will increase to 150% of the original premium**. If you enroll in Medicare Part A or Part B after already being on COBRA, your COBRA coverage will end.

Special Note: **If you have Medicare prior to the qualifying event, you must be offered COBRA coverage.**

For more information about COBRA, call the SHIP State Office and ask for a COBRA brochure, or call the Department of Labor for COBRA questions, 1-202-219-8784 or 1-202-219-8776. **To learn more about how to apply for Social Security or Medicare benefits, call 1-800-772-1213 (for hearing impaired, TTY: 1-800-325-0778) or visit their website at www.ssa.gov.**

ICHIA

The Indiana Comprehensive Health Insurance Association (ICHIA) is Indiana's state high risk pool plan and provides health insurance for Indiana residents who cannot obtain coverage due to health reasons. Coverage is guaranteed if you meet the eligibility requirements, but expect to pay high premiums.

ICHIA may be a good option for individuals under 65/disabled who have high drug costs, or who have been denied health insurance coverage. To be eligible for ICHIA, you must be under 65, a resident of Indiana, not eligible for Medicaid, and:

- Have been denied coverage by an insurance company;
- Had restrictions placed on coverage;
- Are unable to get an insurance plan with a premium/coverage similar to ICHIA; or
- Have been diagnosed with certain illnesses. (36 chronic, catastrophic, life-threatening diseases such as ESRD)

If you are **65 or older** and eligible for Medicare, you can not get ICHIA insurance.

ICHIA Benefits

ICHIA works through a Preferred Provider Network (PPN). If you go outside the network, benefits will usually be reduced. (Unless you are a Medicare beneficiary). Typically ICHIA will pay 80% of in network approved costs and 60% of out of network approved costs.

There are four plan options available:

Plan Option	Deductible	Out-of-Pocket Maximum*
Plan 1	$500	$1,500
Plan 3A	$1,000	$3,000
Plan 3B	$1,500	$4,000
Plan 4	$2,500	$5,000

* including the deductible and coinsurance

After meeting a deductible which can vary from $500 to $2,500 per year, you are only responsible for coinsurance amounts. Once you reach your annual out-of-pocket maximum (deductibles plus co-insurance) the plan will pay 100% of the allowable expenses for the remainder of the calendar year.

Monthly premium rates vary with age, gender, geographic location, and chosen plan. Monthly rates can range from $112-$825. Medicare beneficiaries under age 65 and disabled do not pay higher premiums due to their disability. Preexisting conditions could be excluded for up to 3 months, if you do not have prior health insurance coverage. **Prescription Drug benefits have a separate deductible** from other ICHIA medical benefits. **Medicare beneficiaries should enroll in a Medicare Prescription Drug Plan (Part D).** By enrolling in a Part D plan, Medicare beneficiaries should see a savings in their ICHIA premium.

Dependent Eligibility

Coverage for your spouse and/or dependent children is available. Your children may be eligible for coverage if they meet one the following criteria:

- Unmarried and under 19 years of age;
- Dependent, unmarried, full time student (up to age 25); or
- Dependent Disabled Adult Child, regardless of age.

Newborns are automatically covered for the first 31 days, after that they will need to be added as an additional dependent and the monthly premium adjusted.

Medicare and ICHIA

After the ICHIA plan deductible is met, ICHIA will usually pay Medicare co-pays and deductibles at 80%. ICHIA may pay 80% of claims that Medicare denies (may pay only 60% if out of network). Individuals who are 65 or older and eligible for Medicare cannot get insurance coverage through ICHIA.

Contact **ICHIA Customer Service -1-800-552-7921**, P. O. BOX 33730, Indianapolis, IN 46203-0730. Or you can apply online at: **www.onlinehealthplan.com** Sign on as a guest, and then select Indiana Comprehensive Health Insurance Association (ICHIA).

Medicare and Permanent Kidney Failure-End Stage Renal Disease (ESRD)

Medicare & ESRD

- You must require dialysis or kidney transplant.
- You can enroll in Medicare for coverage through the Social Security Administration.
- If you are able to get Medicare because of kidney failure, Medicare coverage starts the 3rd month after dialysis begins.
- Medicare coverage ends 12 months after dialysis stops.
- Medicare ends 36 months after a successful kidney transplant.

Medicare Advantage Plans and ESRD

Medicare Advantage Plans **cannot** enroll ESRD Medicare beneficiaries. If you are already in an Advantage Plan and develop ESRD, then the plan must provide coverage.

ESRD and Employer Group Health Plans (EGHP)

Employer group health plans will pay first, for a **coordination period** of 30 months, beginning the month you are eligible for Medicare. If the group plan pays all health expenses, you may want to wait until the end of the 30 -month period to enroll in Medicare. Delaying enrollment means that you will not be paying the Part B monthly premium. However, your Part B premium will be increased by 10% for each year you delay enrollment.

If you are in a group health plan and leave employment, you can continue the group health coverage by taking your COBRA option. At the end of the 30 month coordination period with COBRA and Medicare, you will

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. If you do not elect COBRA when you are eligible, then enrolling in Medicare could be your only option for health insurance coverage.

Medicare Part B - ESRD Coverage

Medicare will cover dialysis treatment at any approved dialysis facility including the cost of equipment, supplies, lab tests, and other services associated treatment.

Special Note:

- If you do not enroll in Medicare Part B at the time that you first become eligible, you will have to wait for the General Enrollment Period (Jan, Feb, or Mar). Medicare Part B coverage would not become effective until July.

- If you do not elect COBRA coverage, you will not have a guaranteed issue for a Medigap policy.

For further information about Medicare and ESRD:

- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services- a supplement to your Medicare Handbook (CMS publication #CMS10128)*

- The Renal Network-to be called **only regarding quality of care complaints** in a dialysis facility, and not for information about Medicare coverage. **1-317-257-8265**

- **AdminaStar Federal**-for information about ESRD coverage. **1-800-622-4792 or online at: www.medicare.gov**

GENERAL INSURANCE INFORMATION

SECTION N

THE INDIANA DEPARTMENT OF INSURANCE

- ***DOES NOT SELL INSURANCE*.** Insurance agencies and agents sell policies that are developed by private insurance companies.
- **Provides consumer service** to help with complaints against and information about various insurance agencies and insurance agents.
- **Supervises** the organization, regulation, examination, rehabilitation, liquidation, and conservation of all insurance companies residing in ("domiciled") or authorized to do business in Indiana. When a company is licensed to do business in Indiana, it is issued a "**Certificate of Authority**" by the Department of Insurance.
- **Enforces, administers, and executes** the insurance laws of Indiana. It also regulates insurance agents' licensing requirements.
- **Regulates Individual Accident and Health Insurance policies** - both policy forms and rates. Group Accident and Health policies have only the policy forms regulated, not rates.

Policies Purchased Outside of Indiana

A policy is regulated by the state in which it is purchased. Regulations vary from state to state and with different types of insurance.

> Ex: You have a policy from another state and move to Indiana. Your policy will still provide all stated benefits and is still regulated by the state in which the policy was purchased. Insurance companies may sell policies in many states and must comply with the regulations of each state.

Counselors should refer persons to the Department of Insurance in the state in which the policy was purchased. For further information, refer to the "*Guide to Health Insurance for People with Medicare*". (Counselors, please note that 800 # s may be usable only within a particular state.)

Individual vs. Group Policies

Individual Policies

As when insuring a home or automobile, you contract directly with an insurance company and receive a policy. You become the **policyholder**.

- The company needs approval from the Department of Insurance to change the policyholder's premiums. Any rate increase affects the entire class of policyholders. Insurance companies define what they mean by class (i.e., all Indiana policyholders, policyholders in the 46260 zip code, etc).

- The company cannot cancel your policy because of your health or claims as long as the premiums are paid on time.

Group Policies

Group insurance may offer lower premiums by having a large number of beneficiaries in one group, thereby spreading the insurance company's risks. The insurance policy is for the group and is called the "**master policy**". The employer or trade association is the "master policyholder".

The **master policyholder** can do any of the following:

- Reduce or change the benefits and coverage
- Increase your share of the premium
- Switch to another insurance company
- Drop the insurance coverage completely

The insurance **contract** (the policy) is between the Group and the insurance company, **not** the individual. The Group should have the master policy available for review by you or anyone within that Group.

When you buy insurance coverage under this Group, you are issued a "**certificate of insurance**", and you become a "**certificate holder**". This certifies that you are a member of the Group and are entitled to insurance benefits under that Group's policy.

Instead of a policy, certificate holders receive a summary of benefits or a benefits handbook. The master policy is the contract; the handbook is only a summary and is not binding on the insurance company.

PARTS TO A POLICY

A.O.S.P.R.

- **A**pplication
- **O**utline of Coverage - overview of the policy, plan description
- **S**chedule of Benefits - specifics of the policy (cost, daily benefit, maximum benefit, individual policy number, benefits purchased)
- **P**olicy
- **R**iders (if applicable)

Policy Form Number

All policy forms are assigned a **policy form number.** This number is found on the **bottom left corner on the cover of the policy**. The Outline of Coverage has a different number. You may need to give the policy form number when talking with your insurance company or Department of Insurance regarding questions about a specific policy.

Important Concepts of Health Insurance Policies

Underwriting-Are You Insurable?

- **Insurance companies are for-profit businesses**. Therefore, they will underwrite to determine their risks if they sell you a policy. The company is trying to predict the likelihood that you will become sick or injured and as a result file claims.

- **Each company has its own underwriting standards.** One company may reject your application while another might accept it.

- **Companies need to verify your answers to questions on insurance application forms**. When you sign an application, you give the insurance company permission to receive confidential information about your health from your doctors or other service providers.

Underwriting factors

AGE - With advancing age comes more frequent illnesses. For this reason, insurance companies usually charge higher premiums, and you may have a harder time buying insurance.

HEALTH - Your current health status and past history of illnesses may cause insurance companies to reject your application, charge an increased premium, or to exclude certain conditions from coverage. Be sure to consider any “guaranteed issues” that you may have.

OCCUPATION - persons with hazardous jobs may find it difficult to buy insurance. Office or school workers will have less trouble buying insurance than a test pilot or a race car driver.

HABITS AND LIFESTYLE - habits such as smoking or drinking can result in expensive health problems. Companies may either charge higher rates or deny you coverage.

A policy may be cancelled or claims not paid if it is found that incomplete or incorrect information was given on the application.

Guaranteed Issue Policies

- Some policies are sold without medical underwriting (without health questions on the application). These policies, known as "guaranteed issue" policies are **sold to anyone who applies and is qualified.** Hospital indemnity and specific disease policies are often guaranteed issue. (See Other Health Insurance.) Some companies sell **guaranteed issue Medicare Supplement** policies.

Preexisting Condition

- **Definition**: **Any medical condition** for which you receive treatment, advice, or medication prior to obtaining insurance coverage.

- When medical conditions are listed on the application, there is usually a waiting period during which time benefits are not paid. Some policies may not cover any preexisting conditions.

Usual, Customary, and Reasonable - UCR

Most insurance companies have their own fee schedule listing the usual, customary, and reasonable (UCR) charges and do not use the actual bills to calculate the amount they will pay. (Similar to Medicare's fee schedule and the Medicare approved amount.)
The UCR is the amount the company believes to be a fair price for the medical services and is often less than the doctor's actual bill.
If a policy promises to pay 80% of approved medical expenses, that means it will pay 80% of the usual, customary, and reasonable amount.

UCR Ex:	Medical bills	$2,000
	Company's UCR	$1,500
	Company pays 80% of UCR	$1,200
	Person's co-payment	$800
	(20% of the UCR + $500 excess charges up to actual cost)	

Coordination of Benefits

- If you are covered under **2 different group health insurance plans**, the total benefits paid for the same service by both plans will be adjusted so that payment does not go above the UCR charge.

- One plan will be “primary”; the other “secondary”. The primary plan will provide its normal benefits. The secondary plan will pay their portion of the difference between what the primary plan pays and the UCR charge.

- The purpose of this coordination is to prevent duplication and/ or excessive payment of benefits.

Renewing Policies

Policies may have different **types of renewal provisions**:

- **TERM** - the policy terminates at the end of a set period of time; it cannot be renewed.

- **CANCELABLE** - the policy can be cancelled by the company at any time.

- **OPTIONALLY RENEWABLE** - the policy can be cancelled at the company's option.

- **CONDITIONALLY RENEWABLE** - there are strings attached. Ex: The policy can be cancelled by the company when you reach age 65.

- **GUARANTEED RENEWABLE -** You may **renew** the policy every year or at the stated time interval. The policy is renewed as long as premiums are paid. Premiums can be raised, but only but only on a **class basis** (for everyone in a pre-set group). Ex: The insurance company can't single you out by raising your rates just because you are getting older or because you are having a lot of claims. **All Medigap and most LTC insurance policies are this type**

- **NON-CANCELABLE-** The policy **cannot be cancelled** for any reason except for nonpayment of premium or misrepresentation on the application, *and* under this provision, the company **may not raise premiums for any reason.**

Rate Regulation

Companies that sell individual insurance policies in Indiana must file their rates with the Department of Insurance.

- **How does an insurance company get a rate increase**? The company files a proposal for new rates on specific individual policies, showing its anticipated income and expenses on those policies. The Department uses rate experts, called 'actuaries", who consider the company's statistics on income and expenses and its predictions of future claims and expenses.

- **What are Indiana's legal requirements on rates?** Indiana law states "rates are to be reasonable, adequate, and not unfairly discriminatory." This means that when companies set rates they can only take into account factors such as age, sex, and area of residence if the company can prove that these factors contribute to higher risks.

- **What is a loss ratio?**
  The loss ratio shows what portion of the total premiums the company collects is actually paid out on customers' **claims**. Loss ratios apply only to claims. Companies also have administrative expenses.

- **How often can an insurance company request a rate increase?**
  As often as the company thinks it is necessary. Companies seldom submit more than one rate request per year. Companies must show they will continue to lose money over time at the current rate charged.

- **What can you do if you can't afford the premiums?**
  Shop around. The present company may have a more affordable policy, (with fewer benefits and lower premiums), or another company may be able to match the present benefits, but at a lower price.

GUARANTY ASSOCIATION

Indiana law formed the Indiana Life and Health Insurance Guaranty Association to protect policy owners in the event of a life or health insurance company becoming insolvent (unable to pay debts as they become due - bankrupt).

Responsibilities of the Guaranty Association:

- To pay claims that are unpaid as a result of insolvency.

- To assure policy owners that their policy will continue as long as the premiums are paid, and as long as the maximum benefits as stated in the policy or of the Guaranty Association have not been reached.

All companies writing life and health insurance in Indiana belong to the Indiana Life and Health Guaranty Association. All states, the District of Columbia, and Puerto Rico have guaranty associations.

- When the state of Indiana determines that an insurance company is insolvent, the mechanism that springs into action to protect policyholders is called the **"State Guaranty Association" system.** All 50 states, the District of Columbia, and Puerto Rico have insurance company associations which help pay the claims of financially-impaired companies that operate in that state.

The **total liability** of the Indiana Guaranty Association may not exceed a total of **$300,000** for all benefits on any one person, and **$100,000** in cash value on any one person.

The Guaranty Association is intended to be a form of consumer protection, not an inducement in the solicitation of insurance.

HOW TO CHECK ON AN INSURANCE COMPANY BEFORE BUYING

Complaint Statistics

One way to compare insurance companies is the Complaint Index Ratio. This ratio shows consumer complaints filed with the Department of Insurance in 2000 and 2001 compared with premiums received by insurance companies. A Complaint Index Ratio is available for Health Carriers, Life, Auto, and Homeowners. For detailed information, call the Indiana Department of Insurance-Consumer Services.

1-800-622-4461, or on the internet at **www.in.gov/idoi**

Insurance Rating Reports

These reports are done by **Financial Rating Service** companies that print yearly reports on most insurance companies' **financial stability**. You may call the service directly, or look up its report in the local public library. Always check at least 2 rating services. Each rating service has its own rating system (which will be explained in the front of each report).

These reports also state the types of insurance sold by a company, whether the company once operated under a different name, and the company's invested assets. Companies usually invest their money in stocks, bonds, mortgages, and real estate. The total amount of assets is shown in *thousands of dollars*.

It's a good idea to see if the insurance company's rating has changed over the last couple of years.

Examples of the top rating for 3 of these sources are:

A.M. Best - A++ **Moody's** - Aaa **Standard & Poor's** - AAA

See your Telephone Reference for telephone numbers of these rating services.

HOW TO RETURN AN INSURANCE POLICY

Most health policies have a 10-day free look, except for **Medicare Supplement and Long Term Care Insurance,** which have a *30-day free look*. A '**free look**' means that you have the right to look over your policy and return it within the time limit for a full refund. (If your policy was mailed to you, keep the envelope as proof of the date that you received it.)

You may exercise your right to **return a policy** either by sending it to the insurance company by certified mail and asking for a return receipt, or to your agent who will give you a receipt.

IF A POLICY SEEMS TOO GOOD TO BE TRUE IT PROBABLY IS!

Method of Paying Premium

You may be able to save some money by the way you pay your insurance premiums. The more divided the premium payments are, the more interest the insurance companies charge. Typically, the interest charges are:

Quarterly 5% Monthly 6% Annual 0% Semi-annual 2%

If you pay **monthly** by automatic transfer of funds (where the bank automatically withdraws money from your account and pays the insurance company), the interest charge usually ranges from 0% - 2%. This may mean a savings of 4% - 6% monthly. The agent may ask for a blank check to begin the automatic withdrawal of premium. (Make sure to write "void" on the check.)

Storing Insurance Policies

- Store all insurance policies together.
- Keep a list of the insurance companies, type of policy, and specific policy numbers. (A copy of this list should be given to a trusted friend or relative).
- **Original policies should not be kept in the bank's safe -deposit box**, only copies. In the event of a death you may not have access to the safety-deposit box.

LOW-INCOME ASSISTANCE/ MEDICAID

SECTION O

Introduction to Medicaid

Established in 1965, Medicaid is a state and federally funded health care program designed to assist low income individuals and families. In order to qualify for Medicaid assistance the individual/family must meet certain eligibility requirements. The Medicaid program is administered on the state level; as a result, some requirements and rules vary from state to state.

In Indiana, Medicaid is administered through the Family and Social Services Administration (FSSA) by the Department of Family Resources (DFR). Changes to the Medicaid program come from the Indiana General Assembly as well as the Center for Medicare and Medicaid Services (CMS).

Medicaid Covered Services

Medicaid can help pay for the following types of medical services:

- Physician services;
- Hospital Inpatient and Outpatient care and Rural Clinic services;
- Other clinic, laboratory, and x-ray services;
- Nursing facility services - Skilled and intermediate care, and intermediate care for the mentally retarded;
- Dental;
- Optometric services including eyeglasses and prosthetics devices;
- Podiatry services;
- Chiropractic services;
- Hospice services;
- Home health care services;
- Care coordination services for pregnant women, persons with HIV/AIDS, and persons who are seriously mentally ill/ emotionally disturbed;
- Any other medical or remedial care recognized under Indiana law and specified by federal regulations;
- Prescription drugs;
- Medical supplies and equipment;

Medicaid Services (cont'd)

- Skilled Nursing Home (NH) care;
- Transportation to Medicaid-covered services;
- Nurse midwife services;
- Family planning;
- Health screening follow-up services for children;
- Physical, occupational, speech, and respiratory therapy; and
- Preventive care including screening, diagnosis, or necessary treatment for all medical recipients under age twenty-one.

Qualifying for Medicaid

In Indiana the Department of Family Resources (DFR) determines eligibility and need for Medicaid services. Eligibility for singles, couples, and households is determined by a combination of factors that includes: **medical needs, income levels, and assets** (refer to page O-3 for income and asset figures). To apply for Medicaid, you must contact your local Department of Family Resources. The DFR must rule on your application within 45 days (or 90 days if you are applying because of a disability).

Indiana Medicaid Non-financial Eligibility Requirements
You must be a **resident of the State of Indiana**. In addition to being an Indiana resident, you must be a US citizen or a non-citizen of eligible immigration status. Lawful immigrants, who enter the United States after August 22, 1996, are not eligible for full Medicaid coverage for 5 years. During this time period legal immigrants can receive emergency medical care, if they meet the other Medicare requirements. Immigrants with no proof of legal residence can receive emergency medical care if they meet the other Medicaid requirements.

You must also demonstrate a **medical need** in order to be eligible for Medicaid.

In addition to the residency and medical need requirements, you **must also meet one of the following categories:**

- Individuals who are age 65 or older;
- Blind;
- Disabled;
  Note: Even though you are receiving SSI disability benefits, you still must meet the income requirements of the Department of Family Resources to receive Medicaid.
- Refugees;
- Low-income families with dependent children. Recipients of Temporary Assistance for Needy Families (**TANF**) may be eligible in this category;
- Children under age 19 and individuals age 18,19, and 20 who have special living conditions such as being institutionalized, or living in a family with an income at or below the Federal Poverty Level (FPL).
- Pregnant women and newborns, up to 1 year old, if born to women who are receiving Medicaid.

Indiana Medicaid Financial Eligibility Requirements

Financial eligibility is based on your (and your spouse's) income and assets. If the application is for a child the income and assets of his/her parents are included in determining eligibility.

MEDICAID (effective April 2008)

	INCOME	**ASSETS**
SINGLE	$637/month	$1,500
COUPLE	$956/month	$2,250

- For a individuals with dependents, additional income of $311 per dependent may be allowed.
- ***$15.50 income disregard is included.***
- Income limits change annually based on the Social Security cost of living adjustment.

When applying for Medicaid, you should have ready your medical records, doctors statements of medical needs, statements of income, and information on your assets.

Checklist of Documents You Will Need for Medicaid*

1. Records showing your age and place of birth certificate, baptismal record, insurance policies

2. Your Social Security number, Medicare claim number, Railroad Retirement number, Veterans claim number

3. Record of marriage

4. Property deeds on property which you own but in which you do no live

5. Burial trust or pre-paid funeral arrangements

6. All life and medical insurance policies (for life insurance, you will need a written verification from the company of the current cash surrender value or the policy)

7. Documentation of all property transferred within the past five years

8. Records of your income and the income of spouse and dependent children in the home

    A. SSI benefits: the check or letter or entitlement (if within 12 months). You can request verification from Social Security

    B. Social Security benefits: the check or letter notification (if within 12 months). You can request verification from Social Security

    C. Veterans benefits: the check or letter notification (if within 12 months).

D. Railroad Retirement benefits: the check or letter notification (if within 12 months).

E. Unemployment compensation

F. Retirement or Union benefits: the check or letter notification (if within 12 months).

G. Income from rental property

H. Earnings: name of employer, pay stubs, covering the last three months, verification of work expense

9. Bank statements showing the balance in any and all accounts owned (checking, savings, CD's, Christmas Club, etc.) for each month for which coverage is sought

10. Verification of ownership and current value of any stocks or bonds owned (includes U.S. Savings Bonds)

11. Documents pertaining to any trust or which either applicant or spouse is the beneficiary or for which either is the trustee

12. Verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned jointly or individually by applicant or spouse

13. A listing of the contents of any safety deposit box rented by either spouse (further documentation may be required depending on the contents)

14. A signed statement of the amount of cash both spouses currently hand on hand

15. Description and verification of the current value of any other available resource not listed

*From list provided by the Senior Law Project.

Assets Typically Counted by Medicaid:

- Cash
- Money in the bank; checking, savings, etc.
- Stocks
- Bonds
- Cash surrender values of insurance policies

Eligibility depends on how many resources you own on the first day of any calendar month. You are then either eligible or in-eligible for the rest of the month regardless of any resource changes during the month.

Exempted Assets

When applying for Medicaid, some assets are not counted and are therefore classified as being "**exempt**". **Exempt Assets** may include:

- **Your Home:** Your home is exempt:

    1. When it is the principal residence for the applicant, or for their spouse or children (if these children are under age 21, or are disabled or blind).

    2. If a sibling with equity interest in the home resided in the home for at least one year prior to the patient's NH admission.

    3. If a child was living in the home for at least 2 years prior to the NH admission with the purpose of providing needed care to the parent.

- **Life Insurance Cash Surrender Values** are exempt if the death benefit (face value) of all policies, (excluding term life insurance) is $10,000 or less, and the beneficiary is one's estate or the funeral home. The $10,000 limit is reduced by any amount that is in an irrevocable funeral trust.

- **Burial or funeral trusts** are exempt if irrevocable, regardless of their value, as long as the trust money is tied to specific services.

- **Income producing property** is exempt if the income produced is greater than the expenses of ownership. The income from these properties may be considered by Medicaid. Other real estate that is in the name of the community spouse is exempt.

- **Household goods** such as furniture, appliances, etc., and personal effects such as clothing are exempt.

- **One vehicle**, regardless of value, is exempt if it is necessary for employment, medical treatment, or if you are disabled, and the vehicle has been altered to accommodate your disability.

If you feel that you qualify under the assets limits but your monthly income is above the accepted Medicaid limits, you may be able to qualify using the **"Spend-Down" provision**.

Spend-Down

Medicaid Spend-Down provision allows a person, whose income is above the standard, to receive assistance with medical bills from Medicaid. You will still need to meet the asset standard in order to qualify. In order to be eligible for Medicaid with a spend-down your monthly medical bills would need to be higher than your monthly income. **Amounts paid by insurance, such as Medicare or Part D drug plans, are not eligible to be counted toward the spend-down amount.**

The Spend-Down amount is determined by subtracting the medical expenses from your monthly income; thereby possibly lowering your income to within the Medicaid guidelines. Example:

Your actual monthly total income	= $900
Maximum income to qualify for Medicaid (single)	= $639
Your spend-down amount is	= $261

In this example, if your total incurred medical expense this month is greater than $281, you may qualify for Medicaid under the spend-down rule.

Beginning January 1, 2006, **Spend-Down works like an insurance deductible**. Medical providers file their claims for services with Medicaid and the Spend-Down amount is deducted. A claim to Medicaid is filed after Medicare or other insurance has processed the claim. Once the spend-down amount is satisfied in a month, Medicaid will pay for all other covered services. In a few situations you must provide bills or receipts to your local Department of Family Resources.

Medical expenses that cannot be filed directly with Medicaid are referred to as "non-claims". You must submit the documentation of these non-claims to the Medicaid office. Be sure to ask your caseworker how to submit non-claims.

Types of Non-Claims

- Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance.
- Medical services received from a provider who does not participate in the Medicaid program.
- Medical services received by non-member spouses and parents whose income was used to determine the Spend-Down.
- Bills for medical services received before the member became eligible for Medicaid.
- Co-payments required by other insurance coverage and Medicare.

Medicaid Spend-Down Summary Notice

On the 2nd business day of the month, a notice will be sent to you. This notice will include the claims applied toward the spend-down, months for which the spend-down is applied, and providers who must be paid. Only claims used to meet the spend-down will be included on the summary notice. Providers cannot expect payment until after the Summary Notice has been sent to you. See example on pages O10 & O11.

In determining Medicaid eligibility, **Supplemental Security Income (SSI)** does not count as income. **SSI** is Social Security income to people who are age 65 or older, or blind, or have a disability, and who have low incomes and little assets.

The spend-down process is on a month-to-month basis. You may qualify for one month, not the next, and then qualify again the next month.

Examples of allowable expenses to qualify for Medicaid:

- Doctor visits
- Inpatient or outpatient medical care
- Prescription drugs
- Medical supplies & medical equipment
- Laboratory tests
- X-rays
- Health insurance premiums (including Medicare)
- Cost of transportation to medical appointments
- Hospice teams

Marion County D.F.R.
129 E Market, Suite 1000
Indianapolis, IN 46205

MEDICAID SPEND-DOWN SUMMRY NOTICE

XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXX

Indianapolis, IN 46202

Mailing Date of Notice: June 2, 2006
Member Name:XXXXXXXXXXXXXXXXXX
Medicaid ID Number: XXXXXXXXXXXX
Case Worker ID; W12345

This is a summary of your medical bills that were processed from 05/01/06 through 05/31/06 for spend-down. Some bills are not filed with Medicaid until after Medicare or other insurance had paid. This notice includes claims filed by your medical providers. It also includes non-claims, which are any medical expenses that you submitted to your local Office of Family Resources.

THIS IS NOT A BILL

Keep this notice and compare it to bills sent by your medical providers.

Your medical providers my bill you for the amounts shown in the column marked “Amount Applied to Spend-down”. Medicaid will not pay the amounts in this column.

Medical Expenses Processed for you May 2006 Spend-down

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
04/20/06	05/23/06	BIOSCRIP PHARM COPAY	$0.87	$0.00	$0.00	$0.87	C		

Date of Service	Date Processed	Provider/ Service	Amount Charged	Paid by Other Insurance	Billed to Medicaid	Amount Applied to Spend-down	See Notes Section	Future Credit	Possible Refund
04/20/06	05/23/06	BIOSCRIP PHARM COPAY	$3.00	$0.00	$0.00	$3.00	C		
04/20/06	05/23/06	BIOSCRIP PHARM COPAY	$3.00	$0.00	$0.00	$3.00	C		
04/20/06	05/23/06	BIOSCRIP PHARM COPAY	$3.00	$0.00	$0.00	$3.00	C		
04/26/06	05/23/06	DIALYSIS CLINIC DIALYSIS	$18,914.16	$0.00	$609.28	$349.13	B		

Notes Section:

B: Any amount of the provider's bill to Medicaid that is more than your append-down obligation Will be paid by Medicaid in accordance with reimbursement rules.

C: This co-payment amount is itemized in the Summary Notice as a separate line item and is part of The total medical expense for the service you received.

Summary of your spend-down status for the months listed in this notice as of 06/01/06.

Month/Year	Spend-down Amount	Status
May 2006	$359.00	Spend-down satisfied

Medicaid Nursing Home Assistance

Prior to entering a nursing home, discuss whether the NH is a Certified facility, and if there is a waiting list for beds.

To qualify for Medicaid nursing home assistance (NH) costs, you must meet the asset criteria. If you qualify, your income except for a **personal needs allowance of $52/month** will go towards paying for your care in the NH. Medicaid would then pay for any medical costs over and above your income.

See "**Spousal Impoverishment**" brochure for income and asset protections for the spouse at home.

Your medical criteria is assessed by case managers to determine if you are able to receive assistance, and what level of medical care you may require. The preadmission screening (**PAS**) results also determine whether you need to be in a nursing home, or with the proper assistance you can stay at home. If you refuse the PAS, you will not be eligible for Medicaid assistance for one full year from the date that you are admitted into a nursing home.

An **Elderlaw** attorney who is knowledgeable about Medicaid may be of help with planning, application, and appeals. These services may be obtained at a reduced cost through the **Legal Services Organization**, the **Senior Law Project**, **1-800-869-0212**, or through your local **Area Agency on Aging (AAA).**

Spousal Impoverishment Provision

The Spousal Impoverishment Amendments occurred in 1989. The purpose of these amendments is to **protect spouses of nursing home residents from losing all of their income and assets** to pay for the NH spouse's care. The law allows the spouse living in the community to keep some assets and income and still be able to get Medicaid assistance for the NH spouse. Income and assets are each treated a little differently under the Spousal Impoverishment Provision.

Income

The couple's income falls into two categories: Personal and Jointly Owned:

1. **Personal Income**: Income in one's own name remains that person's personal income. Ex: checks made out in the wife's name would be considered her income.

2. **Jointly Owned Income:** Jointly owned income from dividends, interest, or any jointly owned income is divided in half.

If you are the spouse at home, you may retain all of your personal income, plus half of the jointly owned income. As the spouse at home, (community spouse) when your income is less than **$1,712** per month, you may keep part of the income of your spouse who is in the nursing home, in order to bring your income up to that amount. (**$1,712** level). This standard increases annually on July 1st.

The community spouse who needs more income to pay for mortgages, utilities, rent, etc. is able to appeal to Medicaid to keep more from what was to be paid to the nursing home. In order to appeal the shelter expenses must be greater than $495 per month. The total income limit is then **$2,610** per month. Other dependent family members my also be able to keep some of the nursing home spouse's income.

For special needs, the community spouse may appeal to keep more money.

For Example:

Let's look at Charles and Hazel. Hazel lives at home; Charles is entering the nursing home. Their combined monthly income is $2,325.

	Charles (NH Spouse)	Hazel (At HomeSpouse)	Joint
Soc Sec checks	$900	$600	$0.00
Rental Property	$0.00	$0.00	$450
Charles' IRA	$375	$0.00	$0.00

Charles has $1,500 in income (personal income plus 1/2 jointly owned income). Hazel has $825 in income. Under the Spousal Impoverishment Provisions Hazel would be able to keep enough of Charles' income to bring her to the minimum standard of $1,712. In this example Hazel would get to keep $887 of Charles' income.

Assets

In determining the assets of a couple for the Spousal Impoverishment Provision **a "Snapshot" Date must be determined**. The Snapshot Date is the first day of the first month a spouse is institutionalized for at least 30 days, or likely to be in a facility for at least 30 days. This date could be several years in the past. The snapshot is of the couple's assets on that date. The division of the assets is based on the what the couple owned on the Snapshot Date. Details of the assets would need to be recreated for a Snapshot Date in the past.

For Example:

Let's go back to Charles and Hazel. Hazel lives at home; Charles entered the nursing home May 15, 2006. The Snapshot Date for Charles and Hazel is May 1, 2006. The division of Charles and Hazel's assets will be based on what they owned on May 1, 2006.

Most assets are considered joint assets between husband and wife (regardless of whose name they are in). The exception is real estate owned in one spouse's name. This real estate is considered personal property. The home and one car of any value are considered exempted assets, and are not counted in the division of assets. The Department of Family Resources sets a budget for the community spouse.

The community spouse is able to keep the highest of the following:

- **Half of all countable assets**, up to a maximum limit of **$104,400**.
- **A minimum of $20,880.**

The nursing home spouse is allowed to keep $1,712 in assets. Once a notice of Medicaid approval is received, the share of the at home spouse's

assets must be transferred into their name within 90 days. So that only the allowed $1,500 remains in the nursing home spouse's name.

At Home Spousal Resource Limits

Total Couple's Assets	At Home Spouse's Share
$208,800 or more	Maximum limit $104,400
$208,800 to $41,760	½ Total Assets
$20,880 to $41,760	Minimum limit $20,880
$20,880 or less	All

Assets over the above amounts are applied towards the NH spouse's share of assets. The nursing home spouse's share must be spent towards their own care, until their total assets have reached **$1,500**. Medicaid would then assist with paying for their care. The nursing home spouse's income will pay first, then Medicaid will help with the costs.

For Example:

Charles and Hazel have $75,000 in countable assets as of May 1, 2006. Hazel will be allowed to keep half of the assets, $37,500. Charles will be allowed to keep $1,500 of his share of the assets. They will have to "spend down" $36,000 before Medicaid will begin paying. They can use the $36,000 to pay for home improvements, purchasing new appliances or furniture, in addition to paying for Charles' nursing home care.

Hazel's Assets	Charles' Assets	Spend-down Assets
$37,500	$1,500	$36,000

Once the initial Medicaid eligibility has been determined, the at home spouse's assets are not taken into consideration for Medicaid eligibility again. Only the nursing home spouse's assets will be reviewed. Protection under Spousal Impoverishment will not apply after the death of the NH spouse, or if the community spouse enters a nursing home.

Transferring of Assets

When applying for Medicaid, Medicaid will look back over a period of time to see whether there has been any **transfer of assets** for less than the fair market value of those assets. If assets have been transferred (other to a spouse), there may be a period of ineligibility for Medicaid assistance.

Transfers made before February 8, 2006, are subject to a **36 month (**or 3 year look back period). The exception to this is for trusts. Transfers into or out of **trusts are subject to a 60 month** or 5 years look back period. The number of months if ineligibility is calculated by dividing the uncompensated value of the asset transferred by $3,898 (the average monthly cost of nursing home care). The period pf ineligibility begins with the month after the asset is transferred. A partial calendar month is "rounded down" to the lower month (7.45 months would be rounded down to 7 months). If all assets transferred are returned and then spent-down, there will be no penalty for Medicaid assistance.

All transfers made on or after February 8, 2006 are subject to a 5 year look back period. The ineligibility period will not begin until you are eligible for Medicaid and would be receiving nursing home level care. The months of ineligibility is calculates the same as the pre-2/6/06 transfers. There is no "rounding down." The Medicaid office is required to offer a hardship waiver process. Contact the Division of Family Resources for more information on the hardship waiver.

Transfers of property affect eligibility of only nursing home residents and persons who receive Home and Community-Based Services ("waivered services"). Other applicants or recipients are not affected by transfers.

Paying Back Medicaid

Medicaid has a legal right to file claims to recover its costs from the estate of a deceased Medicaid beneficiary. This is called a **preferred claim.** The value of exempt resources may be recovered from your estate to cover the cost of any care/services that were provided and paid by Medicaid (**Preferred Lien)**.

SUPPLEMENTAL SECURITY INCOME (SSI)

SSI is a Federal Program that:

- Pays a monthly income to you if you are in financial need, aged 65+, blind, or disabled. You may receive both Social Security and SSI.

- Income, assets, and support from other sources will determine your SSI benefits.

- Exempted assets may differ from those used for Medicaid eligibility.

How is SSI different from Social Security?

- Unlike Social Security, SSI is not based on your prior work experience, or the work experience of a family member.

- SSI is financed through the general funds of the US Treasury - personal income taxes, corporate taxes, and other taxes. **Social Security taxes** (FICA - Federal Insurance Contribution Act) **do not fund SSI benefits.**

- You must be blind, disabled, or at least 65 years old, and have limited income and assets.

SSI 2008 (effective January 2008)

	INCOME BENEFIT RATE	ASSETS
SINGLE	$637/month	$2,000
COUPLE	$956/month	$3,000

To apply for SSI, contact the Social Security Administration.

WHEN MEDICAID PAYS FOR MEDICARE
Medicare Savings Program (aka Medicare Buy-In)

QMB - Qualified Medicare Beneficiary

Under the QMB program, elderly and disabled Medicare beneficiaries with low incomes and limited resources may be eligible to have Medicaid pay for their:

Medicare Part B Premium **Medicare Deductibles**
Medicare Co-insurance

- There is **no Spend-Down** with the QMB Program. You must meet the income guidelines.
- **You must be eligible for Medicare Part A premium-free**. (If you are not eligible due to low work credits but you meet the other qualifications, the state may buy Part A for you.
- Supplemental Security Income (**SSI**) **is not counted as income**.
- Income and assets must be at or below the levels given on page O-19

Specified Low-Income Medicare Beneficiary - SLMB
Qualified Individual - QI

For those whose incomes are just above the QMB amount, SLMB and QI are other State Buy-In programs for low-income Medicare beneficiaries that pays for:

Medicare Part B Premium Only

- Supplemental Security Income (**SSI**) **is not counted** when applying for **SLMB or QI.**
- There is no Spend-down for **SLMB or QI.**

To Apply for QMB, SLMB, or QI

If you feel that you may qualify for QMB, SLMB or QI contact your local Department of Family Resources. Contact Social Security Administration if you do not already have Medicare Part A.

Normally when you qualify for a Medicare Savings Program, benefits will begin the month after the month in which approval occurred.

MEDICARE SAVINGS PROGRAM (Effective April 2008)

		INCOME	ASSETS
QMB Qualified Medicare Beneficiary	SINGLE	$887	$4,000
	COUPLES	$1,197	$6,000
SLMB Specified Low Income Medicare Beneficiary	SINGLE	$1,060	$4,000
	COUPLES	$1,420	$6,000
QI Qualified Individual	SINGLE	$1,190	$4,000
	COUPLES	$1,595	$6,000

- Figures for Medicare Savings Program change every Spring.
- **$20.00 income disregard is included.**
- There is no "spend-down" for Medicare Savings Program.
- You can have QMB/SLMB **AND** Full Medicaid. QMB/SLMB will pay every month. Full Medicaid pays only in months that you meet the spend-down.

Losing Eligibility for Medicaid/QMB/SLMB

The Cost-of-Living Adjustment (**COLA**) with Social Security (SS) retirement benefits occurs in January and increases your SS income; however, new income levels for Medicaid/QMB/SLMB are effective in April. So, an increase in your SS income due to COLA may result in your getting a letter stating that you are no longer eligible for Medicaid/QMB/SLMB/QI. If you get a letter, contact your local Medicaid office for an explanation.

MEDIGAP SUSPENSION WITH MEDICAID

You may ask your insurance company to suspend Medigap premiums (benefits will therefore be suspended also) for a period of up to 24 months (if your Medigap policy was purchased after 11/91). This suspension will not result in a cancellation.

Suspension Requests

- **You must make the request** for a policy suspension to the insurance company that issued your Medigap policy within 90 days of your becoming eligible for Medicaid
- The suspension may last up to **24 months** if the policy was purchased after 11/1991.
- During the suspension period the Medigap insurance company may not charge the policyholder for premiums and does not provide benefits.
- If Medicaid eligibility stops, the Medigap insurance company must reinstate the Medigap policy effective as of the date of losing Medicaid eligibility. You must notify the insurance company of the loss of Medicaid eligibility within 90 days of the loss.
- Medicaid may encourage you to keep your Medigap policy in force, allowing you to count the amount of the monthly premium towards your monthly spend-down for Medicaid eligibility.
- In some cases, Medicaid may pay your Medigap premiums.

It is possible for an individual to be receiving Medicare benefits, have a Medigap policy, and **also be receiving Medicaid**. In this instance, Medicare pays first, the Medigap policy pays second, and Medicaid pays third.

ALTERNATIVES TO NURSING HOME CARE

OPTIONS - Your Long Term Care Solution

Indiana has waivers from the federal government which allows Medicaid in Indiana to offer alternatives to nursing home care. These alternatives are **In-home Services and Community-type Care.** In the past, it was easier to be approved for Medicaid funding for nursing home care. Now through the Indiana Family and Social Services Administration (FSSA) Division of Aging, the OPTIONS program has been developed to promote a full range of long-term care options.

The idea behind OPTIONS is to have the funds follow the individual, allowing them to choose their own care. These options include Assisted Living, Adult Day Care, and Adult Foster Care.

Assisted Living

Assisted Living is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver and the Assisted Living Medicaid Waiver. If you receive this service, you will reside in **an independent setting** provided by a licensed provider. Services include :

- Personal Care
- Homemaker Services
- Attendant Care
- Medication Oversight
- Social and Recreational programming

Adult Day Services

Adult Day Services is a comprehensive **non-residential service** provided through the Aged and Disabled Medicaid Waiver. Under this waiver, you will receive services in a community setting at a **minimum of 3 hours a day, and maximum of 12 hours per day**. This service will allow you to live with family and allow your caregiver to maintain routine activities and responsibilities. Services include:

- Health, social, recreational and therapeutic activities
- Supervision
- Support Services
- Meals and/or snacks

Adult Foster Care

Adult Foster Care is a comprehensive, residential service provided through the Aged and Disabled Medicaid Waiver. If you receive services through this service, you will reside in home with an unrelated primary caregiver and family. There may be up to two other consumers living at the residence as well. Services include:

- Personal Care
- Homemaker Service
- Attendant Care
- Companionship
- Medication Oversight
- Transportation
- Meals

Eligibility for OPTIONS

You must be participating in the Medicaid Waiver, and these services must be on an approved Individual Plan of Care. Eligibility depends on meeting the following requirements:

- Eighteen years of age or older;
- Meet financial guidelines for Medicaid;
- Nursing Facility level of care; and
- Have a Level of Service rating of 1, 2 or 3. If the Level of Service rating is above a 3, then the level of care needed is too high for the services provided.

The **Area Agencies on Aging (AAA)** administer the waiver programs in addition to providing other community and in-home services. AAAs are responsible for individual assessments to determine medical needs. A case manager will be assigned to you. **The case manager will complete and assessment to determine your edibility as well as your Level of Service rating.** Case managers will work with you, your family, physician, and other health works to make sure your are receiving the services that meet your needs.

For more information:

- www.LTCOPTIONS.in.gov
- Area Agency on Aging 1-800-986-3505
- FSSA Division of Aging 1-800-545-7763

Other Programs Administered by Area Agencies on Aging:

- Family Support Services
- Social Service Block Grant
- Title III– the Older Americans Act
- Other local and privately supported services

Indiana Township Trustees:

- **There are 1,008 Townships in Indiana.**
  Call **1-888-482-4639** for locations or visit their website: **www.indianatownshipassoc.org**
- Indiana law requires that the Township Trustees provide essential services to the residents to quickly meet the needs of an individual in an emergency.
- Poor relief – health care assistance, utilities, housing, blood, and burial assistance when no other means of payment are available.

Community Health Centers

- Community Health Centers provide medical services to people on a sliding fee scale. Community Health Centers can waive the Part B deductible. For a complete listing of these centers in Indiana, refer to section P-33 thru P-40.

Counselor's Note: It can get Complicated!!

When you are assisting a client who is considering applying for Medicaid services: **Get the facts**.

Ask your client about what health-care and/or insurance coverage they currently have, or for which they may be eligible. (For example: Medicare, Medigap, group health, retirement health plans, military (VA) benefits, retired Railroad, Federal, and teachers plans)

Remind them to have copies of payments for incurred medical bills, receipts for prescription drug purchases, income statements, and statements of incurred medical bills for which they are making payments. All of these materials are needed by the Medicaid office in order to determine Medicaid eligibility.

PRESCRIPTION ASSISTANCE

SECTION P

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PLEASE NOTE: The State Health Insurance Assistance Program (**SHIP**) does not guarantee the quality of services provided by any of the private programs listed in this booklet. In choosing any option, the consumer is ultimately responsible for researching and selecting the company and/or program offered.

SHIP Services and information packets, brochures, and materials are FREE! For information and assistance contact **SHIP** by calling **Toll Free**:

SHIP (State Health Insurance Assistance Program)
1-800-452-4800

LOCAL HELP FOR PEOPLE WITH MEDICARE

INTRODUCTION

Senior adults and individuals with disabilities are particularly affected by the high cost of prescription drugs. This booklet is intended to be a guide for these individuals and all Indiana residents who:

- □ Are receiving Medicare.
- □ Need assistance finding and understanding ways to get prescription drug coverage.
- □ Need assistance in paying for their prescription drugs.

For assistance and additional information, call one of the **SHIP** counselors in your local area from the list on **pages 4, 5, & 6** in this booklet or call **SHIP 1-800-452-4800**.

SOME TIPS TO HELP YOU START YOUR SEARCH:

- □ **Talk to your doctor and/or pharmacist.**
  Before choosing any source for filling your prescriptions, talk to your doctor and local pharmacist. They may be able to recommend a program that can help cover the costs of your prescription drugs.

- □ **Keep a list of your medications.**
  Keeping a list of your medications including prescription drugs and over the counter drugs saves you time and guesswork. It is also important to your doctor when prescribing medications, and the medication list can be a critical factor should you need emergency care.

- □ **Generic or brand name drugs?**
  Not all brand name drugs have a generic drug substitute and are not always less expensive than brand-name drugs. Ask your doctor and/or pharmacist if a generic medication can be substituted for a brand name, then compare prices.

- **Consider a local pharmacy, a mail order program, or both.** Some prescription drug services offer savings through local pharmacies. Another option is to use a mail order prescription drug service.

  - Local pharmacy programs are often beneficial for short -term, acute care prescriptions when convenience is desired.

  - Mail order programs often provide greater savings for long-term maintenance drugs.

  - Some companies and programs offer both mail-order and local pharmacy services.

State Health Insurance Assistance Program In Indiana

LOCAL HELP FOR PEOPLE WITH MEDICARE

HELP WITH PRESCRIPTION COSTS

SHIP is part of a Federal program that provides **free** information and counseling on health related topics including **Finding Help With Prescription Costs**. Trained SHIP counselors are available throughout Indiana at sites that are listed on the following pages. To speak with a counselor or to leave a message including your name and telephone number call the site in your area; contact our state office at **1-800-452-4800;** or go to our Internet site

County	Site Name	Telephone	Ext
Adams	Adams County Memorial Hospital Healthy Lifesteps	(260) 724-2145	4352
Allen	Parkview Hospital Senior Health Services	(260) 373-7952	
Bartholomew	Aging & Community Services of South Central IN. (AAA XI)	(866) 644-6407	
Blackford	LifeStream Services Area Agency on Aging 6	(800) 589-1121	
Boone	Boone County Senior Services, Inc.	(765) 482-5220	
Brown	Aging & Community Services of South Central IN. (AAA XI)	(866) 644-6407	
Cass	Cass County Senior Center	(574) 722-2424	
Clark	Life Span Resources	(888) 948-8330	
Clay	Area VII Agency on Aging and Disabled	(800) 489-1561	
Daviess	Generations Network, Inc. (Area Agency on Aging)	(800) 742-9002	
Decatur	Aging & Community Services of South Central IN. (AAA XI)	(866) 644-6407	
Dekalb	DeKalb County Council on Aging/Heimach Center	(260) 925-3311	
Delaware	High Street United Methodist Church	(765) 747-8500	
Delaware	LifeStream Services Area Agency on Aging 6	(800) 589-1121	
Dubois	Generations Network, Inc. (Area Agency on Aging)	(800) 742-9002	
Elkhart	Council on Aging of Elkhart County	(574) 295-1820	
Floyd	Life Span Resources	(888) 948-8330	
Fulton	RSVP of Fulton County	(574) 223-3716	
Gibson	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
Grant	LifeStream Services Area Agency on Aging 6	(800) 589-1121	
Grant	Marion Grant County Senior Center	(765) 662-6772	
Greene	Generations Network, Inc. (Area Agency on Aging)	(800) 742-9002	
Hamilton	PrimeLife Enrichment Inc.	(317) 815-7000	209
Hancock	Hancock County Senior Services, Inc.	(317) 462-3758	
Hancock	Hancock Regional Hospital Social Services	(317) 468-4531	
Harrison	Harrison County Community Services	(812) 738-8143	
Hendricks	Hendricks County Senior Services	(317) 745-4303	
Henry	Raintree Square	(765) 521-3491	

State Health Insurance Assistance Program In Indiana

County	Site Name	Telephone	Ext
Howard	St. Joseph Hospital & Health Center	(765) 456-5092	
Huntington	Huntington County Council on Aging	(260) 356-3006	
Jackson	Aging & Community Services of South Central IN. (AAA XI)	(866) 644-6407	
Jasper	Jasper County Hospital	(219) 866-5141	2130
Jay	Jay County Hospital, Social Services	(260) 726-1844	
Jennings	Aging & Community Services of South Central IN. (AAA XI)	(866) 644-6407	
Johnson	Johnson Memorial Hospital	(317) 346-3184	
Knox	Generations Network, Inc. (Area Agency on Aging)	(800) 742-9002	
Kosciusko	Kosciusko Community Senior Services	(574) 267-2012	
Lake	St. Anthony Medical Center	(219) 864-2653	
Lake	St. Catherine Hospital	(219) 392-7777	
Lake	St. James the Less Church	(219) 838-4873	
Lake	St. Margaret Mercy-Dyer	(219) 864-2653	
Lake	St. Margaret Mercy-Hammond	(219) 933-2100	
LaPorte	LaPorte Hospital and Health Services	(219) 326-2338	
LaPorte	Michigan City Senior Center	(219) 873-1504	
Lawrence	Bloomington Hospital of Orange County	(812) 723-7474	
Madison	Community Hospital of Anderson Education Center	(765) 298-2536	
Madison	LifeStream Services Area Agency on Aging 6	(800) 589-1121	
Marion	Community Hospitals of Indianapolis—East	(317) 355-1530	
Marion	Heritage Place of Indianapolis, Inc.	(317) 283-6662	
Marion	Indianapolis Senior Citizen's Center, Inc.	(317) 263-6272	
Marion	Robin Run Village	(317) 293-5500	
Marion	St. Vincent Hospital & Health Care Services	(317) 338-2198	
Marshall	Marshall County Council on Aging (Older Adult Services)	(574) 936-9904	
Martin	Bloomington Hospital of Orange County	(812) 723-7474	
Monroe	Bloomington Hospital-Community Health Education	(812) 353-9300	
Noble	Noble County Council on Aging	(260) 347-4226	
Orange	Bloomington Hospital of Orange County	(812) 723-7474	

State Health Insurance Assistance Program In Indiana

County	Site Name	Telephone	Ext
Owen	Bloomington Hospital-Community Health Education	(812) 353-9300	
Parke	Area VII Agency on Aging and Disabled	(800) 489-1561	
Perry	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
Pike	Generations Network, Inc. (Area Agency on Aging)	(800) 742-9002	
Porter	Porter County Community Services Inc.	(219) 464-1028	
Posey	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
Putnam	Putnam County Hospital	(765) 653-5121	
Randolph	LifeStream Services Area Agency on Aging 6	(800) 589-1121	
Ripley	Margaret Mary Community Hospital, Inc.	(812) 934-6624	5043
Scott	Life Span Resources	(812) 752-5457	
Shelby	Shelby Senior Services	(317) 398-0127	
Spencer	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
St. Joseph	REAL Services	(574) 251-2592	
St. Joseph	SJRMC Community Outreach	(574) 239-5299	
Starke	Community Services of Starke County, Inc.	(574) 772-7070	
Steuben	Steuben County Council on Aging	(260) 665-9856	
Sullivan	Area VII Agency on Aging and Disabled	(800) 489-1561	
Tippecanoe	Hanna Community Council	(765) 742-0191	
Vanderburgh	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
Vermillion	Area VII Agency on Aging and Disabled	(800) 489-1561	
Vigo	Area VII Agency on Aging and Disabled	(800) 489-1561	
Vigo	Union Hospital	(812) 238-7000	
Wabash	Wabash County Council on Aging	(260) 563-4475	
Warrick	SWIRCA, Area Agency XVI Agency on Aging	(800) 253-2188	
Wayne	Centerville Senior Center	(765) 855-5651	
White	White County Council on Aging	(800) 913-3582	
Whitley	Whitley County Council on Aging	(260) 244-5522	

2008 MEDICARE PRESCRIPTION COVERAGE (Medicare Part D)

On January 1, 2006, the new Medicare Prescription coverage started. This new program is available **to everyone with Medicare regardless of income, assets, or health.**

- **Medicare Part D** is Medicare's prescription drug insurance that can help reduce your prescription drug costs. Through Medicare, private companies are offering plans.

- **Joining is optional;** however, you may have to pay a higher premium (+1% per month) if you choose to join after your initial enrollment period. If you already have prescription coverage that offers the same or better benefits than the standard Medicare Part D plans, you can keep that coverage and you won't have to pay a higher premium if you decide to join later. The annual enrollment period is from November 15 through December 31 of each year.

- To enroll in a Part D prescription plan **contact the company** that is offering the plan either by telephone or by using their Internet address.

- When you join a Part D plan, you will pay a **monthly premium,** an **annual deductible (**if this is a condition of the plan), and **co -pays** which are your share of each prescription cost.

- Medicare's "Model" Prescription Drug Coverage Plan for 2008that companies offering Part D Plans have to equal or exceed includes:

  A. Plans may require an annual deductible not to exceed $275.

  B. After you have paid the deductible out of pocket, the Part D plan pays at least 75% of the drug costs until the total drugs costs reach **$2,510 for the year**. Then begins the **"GAP"** or period of no coverage.

C. The GAP continues until your total prescription costs reach **$5,726.25 for the year,** then your plan **re-starts coverage** and pays at least 95% of covered prescription costs for the rest of the year.

- During the GAP, plans **may** cover brand name drugs at a higher cost, generic drugs, or both. For a list of Medicare prescription drug plans, see pages 12-14.

- If your income and assets are under certain levels, **The Social Security Administration offers Extra Assistance** that will pay all or part of your Part D Plans **premiums and deductibles** and **eliminates the GAP** in coverage. For details, refer to the charts on pages 23-26 in this booklet.

After January 1, 2006, Medigap policies providing drug coverage are not available for purchase.

Medicare supplemental insurance **policies A through L will be available**. You may continue current policies, but please note: **the prescription coverage under Plans H, I, or J is not considered to be creditable coverage** by Medicare, and there may be an increase in premiums if you decide to enroll later in Part D.

Those individuals having Plans H, I, or J with prescription coverage may decide to join a Medicare Part D prescription plan. In this case, the **prescription coverage through their H,I, or J plan will end**, and the company will adjust the premium.

Companies that sell Medigap policies may offer a separate discount program, unrelated to specific policies covering prescription drugs. Check with your insurance company for information on additional benefits that may be offered.

Do Medicare Advantage Plans, (Medicare Managed Care Plans) Cover Prescription Drugs?

Some Medicare managed care plans cover prescription drugs. **There may be an additional monthly premium increase for the prescription coverage.**

Do Retiree Plans Cover Prescription Drugs?

Some do. If you have a retiree plan that supplements Medicare coverage, you may have some prescription drug coverage. For information about your plan's prescription drug coverage, contact your former employer's human resources representative or benefit specialist. If your retiree prescription drug coverage is equal to or better than Medicare's drug coverage, you can keep your retiree drug coverage without penalty.

CAUTION: Before dropping the prescription part of a retirement or group health plan, check to see if this action will affect the other parts of the plan.

THE COVERAGE GAP
"DONUT-HOLE"

What is the Coverage Gap, or Donut-hole?

This is the phase in your coverage were you have reached the total drug cost (your share and the plan's share) of $2,510. In most cases, the drug plan will pay nothing and you will now be responsible for 100% of the drug costs.

As the drug plan company will keep track of your out-of-pocket expenses, it is **important for you to continue to use your Medicare Prescription Drug Plan Card during the coverage gap**. By using your plan card you will get your drugs at the plan's discounted rate and the cost will be counted toward getting out of the gap. Once you have spent $3,216.25, you will enter the Catastrophic Coverage phase. During this phase you will pay 5% of the drug costs for the remainder of the calendar year.

Can I use a discount card or other pharmacy discount? Will this count toward my out-of-pocket expenses?

Yes, if you use a network pharmacy. Many pharmacies will accept a discount card and provide a cash discount. Be sure to advise the pharmacist that you are in the coverage gap. Compare the cost savings of the discount card or cash discount with your plan's discounted rate, in order to get the best price. If you are able to get a cash discount that is lower than your drug plan's rate, you will need to send your receipt to the drug plan to have the amount applied toward your out-of-pocket expenses. **Check with your plan for specific details** on how to submit the receipt for consideration.

For example:

> Mrs. Jones is in the coverage gap. Under her drug plan her prescription cost $100. She learns that by using a discount card offered by her pharmacy she can get the drug for $95. Mrs. Jones uses the discount card to get the lower price and sends her receipt to her drug plan. The drug plan counts the $95 toward her out-of-pocket expenses.

What if another plan pays for my medicine?

Not all additional coverage will count toward the out-of-pocket expense.

Costs that DO count:

- Cost paid for by family members
- Some costs that are paid for by state pharmacy assistance programs (in Indiana HoosierRx)
- Costs paid for by charities not affiliated with employers or unions.

Costs that DO NOT count:

- Employers
- Unions
- Workman Compensation
- Government Programs

Ways to Lower Costs in the Coverage Gap

Keep using your Medicare drug plan card.
As the drug plan company will keep track of your out-of-pocket costs it is important that you continue to use your plan's card during the Coverage Gap. By using your plan's card you will be able to get your drugs at the plan's discounted rates.

Consider switching to a generic, over-the-counter, or less expensive brand name drug.
Check with your doctor to see if you can switch to a generic, over-the-counter, or less expensive brand name drug, which will work well with your other medications. Generic drugs are usually as effective as brand name drugs in treating medical conditions and are generally much less expensive.

Check with your pharmacy to see if they offer a discount program.
You may be able to get a lower price for your drugs by using a discount card or pharmacy discount. You may use this discount and have it apply to your Part D plan's out-of-pocket costs. In order to do this you must use a pharmacy that is in the plan's network. Also, be sure to let your pharmacist know that you are in the Gap. You can submit your receipt to have the amount applied to your out-of-pocket expense. Check with your plan for specific details on how to submit your receipt.

Check out the National and Community Based Programs.
Several pharmacies have drastically reduced the cost of generic drugs – for example Meijer, Wal-Mart, Sam's Club, Kmart, and Target. Many organizations offer programs to assistance in paying for drug costs. Information on Federal, state and private programs available can be found from the following:

- **Rx for Indiana** – website www.RxforIndiana.org or call 1-877-793-0765.
- **Partnership for Prescription Assistance** – website www.pparx.org or call 1-888-477-2669.
- **Benefits CheckUp** - website www.BenefitsCheckUp.org

Look into Pharmaceutical Assistance Programs.
Many pharmaceutical companies offer programs that provide free or low cost drugs to those in need regardless of age. Most of these programs have the following requirements:

- You do not have insurance that cover prescription drugs
- You do no qualify for government assistance
- Your income is within their stated guidelines

Information is also available from **Rx for Indiana**, **Partnership for Prescription Assistance**, and **Benefits CheckUp.**

Apply for Extra Help.
If you meet the income and resource requirements, you may pay as little $1.05 to $5.60 for each drug. There is no Coverage Gap if qualify for Extra Help. You can apply through Social Security www.ssa.gov or call 1-800-772-1213 (TTY users call 1-800-325-0778).

Shop around for a Part D drug plan.
Each year you will have any opportunity to change drug plans during the Annual Coordinated Election Period (November 15-December 31). Compare the coverage you currently have with other plans that are available to determine if you need to switch plans. You will be able to compare plans online at www.medicare.gov or by calling Medicare at 1-800-633-4227; TTY users 1-800-486-2048.

While there are ways to help lower your drug costs during the Coverage Gap, it is not always in your best interest to do so.
Once you have met the total out-of-pocket cost of $4,050 for 2008, you will enter Catastrophic Coverage. During Catastrophic Coverage your co-pays in 2008 will be $2.25/$5.60. You will pay this amount through the end of the calendar year.

INDIANA

2008 MEDICARE PRESCRIPTION DRUG PLANS

The Medicare Prescription Drug Benefit is available to anyone who is eligible or enrolled in Part A and Part B of Medicare.

Medicare Part D is available either through:

- Private companies that are contracted by Medicare to offer prescription plans, called **Stand Alone** or Private Drug Plans (**PDPs**), or
- As an option with Medicare Managed Care plans called **Medicare Advantage Plans** (**MAs**).

When considering a Medicare Prescription Plan, please keep in mind:

- Does the plan **cover** your medications?
- Is the prescription coverage from a **Stand Alone** plan; separate from a Medicare Advantage Plan, or is it an option with a **Medicare Advantage Plan?**
- Is the plan **available in** your county of residence?
- Is a **pharmacy** that accepts the plan **convenient** to you and/or does a pharmacy that accepts the plan have **mail-order service**?
- What is the **monthly premium for the plan**?
- Compare **co-pays and/or coinsurance** (the amount you pay per prescription) with other plans.
- Does the plan require an **annual deductible**? (An amount that you must pay out-or-pocket before the plan starts to pay.

To get a comparison of these plans, call **1-800-633-4227(1-800-MEDICARE),** or go online to **www.medicare.gov.**

2008 Stand Alone Medicare Prescription Drug Plans

COMPANY INFORMATION	PLAN NAME	MONTHLY PREMIUM	YEARLY DEDUCTIBLE	GAP COVERAGE?
AETNA LIFE INSURANC COMPANY* 800-445-1796	AETNA MEDICARE RX ESSENTIALS	$26.30	$275	
	AETNA MEDICARE RX PLUS	$42.90	$0	
	AETNA MEDICARE RX PREMIER	$80.80	$0	All GENERICS
ANTHEM BLUE CROSS AND BLUE SHIELD* 800-467-8065	BLUE MEDICARE RX VALUE	$31.50	$275	
	BLUE MEDICARE RX PLUS	$39.30	$0	
	BLUE MEDICARE RX PREMIER	$73.00	$0	SOME GENERICS
CIGNA HEALTH CARE* 800-735-1459	CIGNATURE RX VALUE	$30.60	$275	
	CIGNATURE RX PLUS	$38.40	$0	
	CIGNATURE RX COMPLETE	$61.80	$0	SOME GENERICS
COVENTRY ADVANTRA RX* 800-882-3822	ADVANTRA RX VALUE	$24.30	$0	
	ADVANTRA RX PREMIER	$38.60	$0	
	ADVANTRA RX PREMIER PLUS	$50.80	$0	ALL PREFERRED
ENVISION RX PLUS* 866-250-2005	ENVISION RX PLUS STANDARD	$72.00	$275	
	ENVISION RX PLUS GOLD	$98.00	$0	ALL PREFERRED
FIRST HEALTH SERVICES* 800-588-3322	FIRST HEALTH PREMIER	$28.70	$0	
	FIRST HEALTH SECURE	$17.30	$175	
	FIRST HEALTH SELECT	$46.70	$0	ALL PREFERRED
HEALTH NET* 800-606-3604	HEALTH NET ORANGE OPTION 1	$27.90	$275	
	HEALTH NET ORANGE OPTION 2	$38.00	$0	
HEALTHSPRING* 888-802-2415	HEALTHSPRING PLAN-REG15	$21.90	$275	
HUMANA INC. * 800-706-0872	HUMANA PDP STANDARD	$27.40	$275	
	HUMANA PDP ENHANCED	$30.80	$0	
	HUMANA PDP COMPLETE	$87.60	$0	ALL PREFERRED
MEDCO PRESCRIPTION SAVINGS PLAN* 800-758-3605	MEDCO MEDICARE - VALUE	$25.10	$275	
	MEDCO MEDICARE - CHOICE	$32.80	$0	
	MEDCO MEDICARE - ACCESS	$68.70	$0	ALL GENERICS
MEMBERHEALTH* 866-684-5353	COMMUNIITY CARE RX BASIC	$27.60	$275	
	COMMUNITY CARE RX CHOICE	$43.40	$0	
	COMMUNITY CARE RX GOLD	$51.60	$0	ALL GENERICS

2008 Stand Alone Medicare Prescription Drug Plans

COMPANY INFORMATION	PLAN NAME	MONTHLY PREMIUM	YEARLY DEDUCTIBLE	GAP COVERAGE?
PENNSYLVANIA LIFE INSURANCE COMPANY 800-978-9500	PRESCRIPTION PATHWAY BRONZE PLAN	$28.40	$275	
	PRESCRIPTION PATHWAY GOLD PLAN	$31.40	$0	
	PRESCRIPTION PATHWAY PLATINUM PLAN	$64.80	$0	ALL GENERICS
RX AMERICA* 877-279-0370	ADVANTAGE STAR	$26.40	$275	
	ADVANTAGE FREEDOM	$30.80	$0	
	ADVANTAGE ALLEGIANCE	$48.60	$0	ALL PREFERRED
SIERRA RX 866-789-0565	SIERRA RX BASIC	$41.30	$275	
SILVERSCRIPT INSURANCE CO. * 866-552-6106	SILVERSCRIPT	$19.90	$275	
	SILVERSCRIPT PLUS	$49.90	$0	ALL GENERICS
	SILVERSCRIPT COMPLETE	$56.10	$0	ALL GENERICS
STERLING PRESCRIPTION DRUG PLAN 888-909-1713	STERLING RX	$33.00	$275.	
	STERLING RX PLUS	$84.50	$100	ALL GENERICS
UNICARE* 866-892-5335	MEDICARE RX REWARDS STARPARD	$29.60	$275	
	MEDICARE RX REWARDS VALUE	$33.00	$0	

2009 MEDICARE PRESCRIPTION DRUG PLANS FOR INDIANA

COMPANY INFORMATION	PLAN NAME	MONTHLY PREMIUM	YEARLY DEDUCTIBLE	GAP COVERAGE?
AETNA LIFE INSURANCE COMPANY* 800-445-1796	AARP MEDICARERX SAVER	$34.40	$275	
	AETNA MEDICARE RX ESSENTIALS	$33.90	$200	NO GAP COVERAGE
	AARP MEDICARE RX PREFERRED	$37.40	$0	
	AETNA MEDICARE RX PLUS	$58.80	$0	SOME GENERICS
	AETNA MEDICARE RX PREMIER	$100.90	$0	MANY GENERICS
	UNITED HEALTH RX BASIC	$44.60	$0	
	AARP MEDICARE RX PLAN	$66.30	$0	ALL GENERICS
ANTHEM BLUE CROSS AND BLUE SHIELD* 866-803-5153	BLUE MEDICARE RX VALUE	$37.70	$130	NO GAP COVERAGE
PLANS 888-423-5252	WELLCARE CLASSIC	$32.00	$250	
	BLUE MEDICARE RX PLUS	$44.30	$0	NO GAP COVERAGE
	WELLCARE SIGNATURE	$35.10	$0	
	BLUE MEDICARE RX PREMIER	$79.10	$0	MANY GENERICS
BRAVO HEALTH	BRAVO RX	$32.50	$295	NO GAP COVERAGE
CIGNA HEALTH CARE* 800-735-1459	CIGNA MEDICARE RX PLAN 1	$33.50	$295	NO GAP COVERAGE
	CIGNA MEDICARE RX PLAN 2	$41.20	$0	NO GAP COVERAGE
	CIGNA MEDICARE RX PLAN 3	$66.10	$0	SOME GENERICS
COVENTRY ADVANTRA RX* 800-882-3822	ADVANTRA RX VALUE	$24.40	$0	NO GAP COVERAGE
	ADVANTRA RX PREMIER	$40.50	$0	NO GAP COVERAGE
	ADVANTRA RX PREMIER PLUS	$55.50	$0	MANY GENERICS
ENVISION RX PLUS* 866-250-2005	ENVISION RX PLUS SILVER	$35.00	$295	NO GAP COVERAGE

*** Indicates company offers national plans**

MEDICARE ADVANTAGE PLANS

In addition to Stand Alone prescription drug plans, another way to get Medicare Part D is to enroll in a Medicare Advantage Plan that has prescription coverage as an option.

Note: If you decide to purchase a plan without the optional prescription coverage, you may still decide to purchase another Medicare Part D Prescription Plan that is separate from your chosen Medicare Advantage Plan.

You are still in Medicare

If you decide to purchase a Medicare Advantage Plan with or without the prescription drug option, you still have Medicare. What changes when you purchase a Medicare Advantage Plan is that those medical costs that would have been paid for by either Medicare Parts A & B or both will now be paid by your new Medicare Advantage Plan. Each plan determines what your benefits and costs will be.

When considering a Medicare Advantage Plan, consider:

- □ The monthly premium for the plan with or without the prescription coverage option.
- □ Annual deductibles for health care and/or prescriptions, co-pays for drugs, GAP prescription coverage.
- □ Extra benefits such as mail-order availability.

Medicare Advantage Plans available in Indiana are listed on the following pages. Look for a plan that is offered in your area, keeping in mind that "Regional" plans are available in any area of Indiana.

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
Local PPO: Allen, Boone, Hamilton, Hendricks, Johnson, Marion, Morgan, Shelby, and St. Joseph	**Advantage Health Solutions, Inc.** **ADVANTAGE Preferred Plus** 9490 Priority Way W. Drive Indianapolis, IN 46240 **1-800-201-8342** **TTY 1-800-573-4990** **www.advpreferredplus.com**	**Local PPO** $45 without drugs **Local PPO** $99 with drugs $0 deductible
PFFS Advantra Freedom 1 (H0846-004); Freedom 2 (H0846-005); Freedom 5 (H5227-001): Adams, Allen, Brown, Cass, Dearborn, Decatur, DeKalb, Dubois, Elkhart, Fayette, Fountain, Franklin, Fulton, Gibson, Hamilton, Hancock, Harrison, Huntington, Jackson, Johnson, Kosciusko, LaGrange, Madison, Marshall, Monroe, Morgan, Noble, Ohio, Orange, Posey, Putnam, Randolph, Ripley, Scott, St. Joseph, Wabash, Warrick, Washington, Wells, Whitley **PFFS Advantra Freedom 3 (H0846-006):** Bartholomew, Boone, Clark, Delaware, Floyd, Grant, Hendricks, Henry, Jasper, Jay, Jefferson, Jennings, Knox, LaPorte, Lawrence, Marion, Martin, Miami, Montgomery, Newton, Owen, Parke, Porter, Pulaski, Shelby, Spencer, Steuben, Union, Vanderburgh, Vermillion, Wayne **PFFS Advantra Freedom 2 (H0846-010) & Freedom 3 (H0846-013):** Benton, Carroll, Clay, Clinton, Crawford, Daviess, Lake, Pike, Rush, Starke, Switzerland, Tippecanoe, Warren, White **MSA - Advantra Savings (H7206-001):** Dearborn, Ohio	**Advantra® Freedom** PO Box 690 Mahwah, NJ 07430 **PFFS Plans 1-800-711-1607** **MSA Plan 1-800-474-5993** **TTY 1-866-788-4010** **www.advantrafreedom.com**	**PFFS Advantra Freedom 1 (H0846-004)** $98 without drugs **PFFS Advantra Freedom 2 (H0846-005)** $0 without drugs **PFFS Advantra Freedom 5 (H5227-001)** $32 with drugs $0 deductible **PFFS Advantra Freedom 3 (H0846-006)** $0 without drugs **PFFS Advantra Freedom 2 (H0846-010)** $46 without drugs **PFFS Advantra Freedom 3 (H0846-013)** $19 without drugs **MSA Advantra Saving (H7206-001)** $0 without drugs
PFFS: Dearborn, Franklin, Ohio Lake, PorterLake, Porter $266	**Aetna Medicare** 151 Farmington Ave Hartford, CT 06156 **1-800-832-2640** **TTY 1-800-628-3323** **www.aetnamedicare.com**	**PFFS Dearborn, Franklin, Ohio** $181 with drugs $0 deductible $20 or $115 w/o drugs **PFFS Lake, Porter** $181 with drugs $0 deductible $0, $100, or $205 without drugs

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
Local PPO: Allen, Boone, Clark, Floyd, Hamilton, Hancock, Harrison, Hendricks, Johnson, Marion, Morgan, Shelby, and St. Joseph **Regional PPO:** all counties **SmartSaver MSA:** all counties **HMO:** Clark, Floyd, Harrison **PFFS:** Elkhart	**Anthem Blue Cross and Blue Shield, Medicare Preferred, or Anthem Senior Advantage** 1351 William Howard Taft CN14B-818 Cincinnati, OH 45206 **1-800-803-5153** **TTY 1-888-853-7754** **PFFS SmartValue, or SmartSaver MSA** PO Box 9092 Oxnard, CA 93031 **1-800-765-2585** **TTY 1-888-844-5530 PFFS** **TTY 1-888-247-1657 MSA** **www.anthem.com**	**Local PPO** $0 or $18 with drugs $0 deductible **Regional PPO** $24 or $55 with drugs $0 deductible **SmartSaver MSA** $0 without drugs **HMO** $0 with drugs $0 deductible **PFFS** $24 or $55 with drugs $0 deductible
Arnett HMO: Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Pulaski, Tippecanoe, Warren, White	**Arnett HMO** 415 N 26th Street Suite 101 PO Box 6108 Lafayette, IN 47903 **1-800-440-7440** **TTY 1-800-743-3333** **www.arnettplans.com**	**HMO** $101 or $104 without drugs
PFFS Plan 001, 002, 003: Allen, DeKalb, Huntington, Putnam, Wells, Whitley **PFFS Plan 004, 005, 006:** Adams, Elkhart, Fulton, Kosciusko, LaGrange, Marshall, Noble, Posey, St. Joseph, Wabash **PFFS Plan 007, 008, 009:** Cass, Gibson, Madison, Monroe, Morgan, Randolph, Warrick **PFFS Plan 010, 011:** Hamilton, Hancock, Hendricks, Jay, Johnson, Vanderburgh	**CIGNA Medicare Access** PO Box 22172 Tempe, AZ 82585 **1-800-577-9409** **TTY 1-800-576-1314** **www.cingamedicare.com**	**PFFS Plans 001, 004 & 007** $0 without drugs **PFFS Plan 002** $20 without drugs **PFFS Plan 003** $78 without drugs **PFFS Plan 005** $30 without drugs **PFFS Plan 006** $112 without drugs **PFFS Plan 008** $45 without drugs **PFFS Plan 009** $118 without drugs **PFFS Plan 010** $42 without drugs **PFFS Plan 011** $75 without drugs
Local HMO: Clark	**Essence Healthcare** 2301 River Road Suite 102 Louisville, KY 40206 **1-888-896-0333** **TTY 1-866-597-9561** **www.essencehealthcare.com**	**Local HMO** $0 with drugs $0 deductible

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
PFFS: Adams, Allen, Cass, Dearborn, Decatur, DeKalb, Dubois, Elkhart, Fayette, Fountain, Franklin, Fulton, Gibson, Hamilton, Hancock, Harrison, Huntington, Jackson, Jay, Jefferson, Johnson, Kosciusko, LaGrange, Madison, Marshall, Monroe, Morgan, Noble, Orange, Posey, Putnam, Randolph, Ripley, Scott, St. Joseph, Wabash, Warrick, Washington, Wells, Whitley	**HealthMarkets Care Assured** PO Box 37677 Philadelphia, PA 19101 **1-800-892-3351** **TTY 1-800-216-1307** **www.HMCareAssured.com**	**PFFS** $0 or $49.40 without drugs **PFFS** $29.40 or $93 with drugs $0 deductible
Regional PPO: all counties **Local PPO:** Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan **Local PPO:** Clark, Floyd, Shelby **PFFS Humana Gold Choice (H1804-067; H1804-184):** Adams, Allen, Bartholomew, Brown, Dearborn, Decatur, DeKalb, Elkhart, Fountain, Franklin, Fulton, Gibson, Huntington, Jackson, Jennings, Kosciusko, LaGrange, Marshall, Martin, Monroe, Montgomery, Noble, Ohio, Orange, Owen, Posey, Putnam, Ripley, St. Joseph, Steuben, Union, Vanderburgh, Wabash, Warrick, Washington, Wells, Whitley **PFFS Humana Gold Choice (H1804-068; H1804-185):** Benton, Blackford, Boone, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Delaware, Dubois, Fayette, Floyd, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Jasper, Jay, Jefferson, Johnson, Knox, LaPorte, Lake, Lawrence, Madison, Marion, Miami, Morgan, Newton, Parke, Perry, Pike, Porter, Pulaski, Randolph, Rush, Scott, Shelby, Spencer, Starke, Sullivan, Switzerland, Tippecanoe, Tipton, Vermillion, Vigo, Warren, Wayne, White	**Humana Choice** 500 W. Main St. Louisville, KY 40202 **1-800-833-2364** **TTY 1-877-833-4486** **www.humana-medicare.com**	**Regional PPO** $65 with drugs $0 deductible **Local PPO** $50 with drugs $0 deductible **Local PPO: Clark, Floyd, Shelby** $0 with drugs $0 deductible **PFFS H1804-067** $0 with drugs $0 deductible **PFFS H1804-184** $20 with drugs $0 deductible **PFFS H1804-068** $85 with drugs $0 deductible **PFFS H1804-067** $105 with drugs $0 deductible
PPFS: all counties	**Mennonite Mutual Aid** PO Box 483 Goshen, IN 46527 **1-800-348-7468 or 1-574-533-9511** **www.mma-online.org**	**PFFS** $10 without drugs **PFFS** $25 with drugs $100 deductible

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
AARP Local PPO: Adams, Allen, Boone, Fulton, Hamilton, Hancock, Hendricks, Johnson, Kosciusko, St. Joseph, Madison, Marion, Wells **PFFS :** Adams, Allen, Bartholomew, Benton, Boone, Brown, Cass, Dearborn, Decatur, DeKalb, Dubois, Elkhart, Franklin, Fulton, Gibson, Hamilton, Hancock, Harrison, Hendricks, Huntington, Jackson, Jay, Johnson, Kosciusko, LaGrange, Madison, Marshall, Martin, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Posey, Putnam, Randolph, Scott, St. Joseph, Union, Vanderburgh, Wabash, Warrick, Washington, Wells, Whitley	**SecureHorizons Direct** **AARP/UnitedHealthCare Local PPO** PO Box 458156 Sunrise, FL 33323 **1-800-547-5514** **TTY 1-866-832-8671** **www.aarpmedicarecomplete.com** **SecureHorizons Direct** **Medicare Direct PFFS** 13621 NW 12th Sunrise, FL 33323 **1-800-555-5757** **TTY 1-888-858-8567** **www.SecureHorizons.com**	**AARP Local PPO** $0 with drugs $0 deductible **PFFS Plans** $0 without drugs **PFFS Plans** $0 with drugs $0 deductible
PFFS Option II: all counties **PFFS Option I, III, & IV:** Adams, Allen, Boone, Clark, DeKalb, Delaware, Dubois, Elkhart, Floyd, Fulton, Gibson, Hamilton, Hancock, Harrison, Hendricks, Henry, Huntington, Johnson, Kosciusko, LaPorte, LaGrange, Madison, Marion, Marshall, Miami, Morgan, Noble, Pike, Posey, Rush, Shelby, Spencer, St. Joseph, Starke, Steuben, Vanderburgh, Wabash, Warrick, Wells, Whitley	**Sterling Life Insurance Company** 2219 Rimland Drive PO Box 1917 Bellinghom, WA 98227 **1-888-858-8572** **TTY 1-888-858-8567** **www.sterlingpalns.com**	**PFFS Option II** $28 with drugs $100 deductible **PFFS Option I** $15 without drugs **PFFS Option III** $45 without drugs **PFFS Option IV** $56 with drugs $100 deductible
Cost HMO: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby	**M-Plan - Senior Smart Choice** 8802 N. Meridian St., Suite 100 Indianapolis, IN 46260-5318 **1-317-580-4520** **TTY 1-317-580-4680** **www.mplan.com**	**Cost HMO** $78, $85, or $95 without drugs
PFFS County Set 1: Allen, Brown, Dearborn, DeKalb, Franklin, Huntington, Putnam, Wells, Whitley **PFFS County Set 2:** Adams, Fulton, Jackson, Kosciusko, LaGrange, St. Joseph, Wabash, Washington **PFFS County Set 3:** Elkhart, Gibson, Harrison, Noble, Orange, Posey	**Today's Options** 1001 Heathrow Park Lane Suite 5001 Lake Mary, FL 32746 **1-800-996-8867** **TTY 1-800-777-9083** **www.todaysoptions.com** **- continued on next page -**	**PFFS County Set 1** $0 without drugs **PFFS County Set 1** $32, $22.20 or $29.20 with drugs $0 deductible $22.70 with drugs $275 deductible

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
PFFS County Set 4: Bartholomew, Boone, Cass, Clark, Decatur, Delaware, Dubois, Fayette, Floyd, Fountain, Grant, Hamilton, Hancock, Hendricks, Henry, Jasper, Jay, Jefferson, Johnson, Lawrence, Madison, Marion, Marshall, Martin, Monroe, Montgomery, Morgan, Newton, Ohio, Owen, Parke, Porter, Pulaski, Randolph, Ripley, Scott, Shelby, Spencer, Steuben, Union, Vanderburgh, Warrick, Wayne **PFFS County Set 5:** Benton, Carroll, Clay, Clinton, Crawford, Daviess, Jennings, Knox, LaPorte, Miami, Pike, Rush, Switzerland, Tippecanoe, Vermillion, Warren **PFFS County Set 6:** Blackford, Greene, Howard, Lake, Perry, Starke, Sullivan, Tipton, Vigo, White	**Today's Options** 1001 Heathrow Park Lane Suite 5001 Lake Mary, FL 32746 **1-800-996-8867** **TTY 1-800-777-9083** www.todaysoptions.com **Today's Options Powered by CCRx** 1001 Heathrow Park Lane Suite 5001 Lake Mary, FL 32746 **1-866-234-3801** **TTY 1-866-903-7421** www.todaysoptionsccrx.com	**PFFS County Set 2** $0 or $19 without drugs **PFFS County Set 2** $22.20, $22.70, $48.20 or $51 with drugs $0 deductible $22.70 with drugs $275 deductible **PFFS County Set 3** $0, $15 or $38 without drugs **PFFS County Set 3** $20.20, $35.20, $67.20 or $70 with drugs $0 deductible $22.70 or $37.70 with drugs $275 deductible **PFFS County Set 4** $0, $10, $30 or $49 without drugs **PFFS County Set 4** $30.20, $50.20, $78.20 or $81 with drugs $0 deductible $22.70 or $52.70 with drugs $275 deductible **PFFS County Set 5** $20, $25, $50 or $75 without drugs **PFFS County Set 5** $40.20, $70.20, $104.20 or $107 with drugs $0 deductible $47.70 or $72.70 with drugs $275 deductible **PFFS County Set 6** $35, $40, $65 or $90 without drugs **PFFS County Set 6** $55.20, $85.20, $119.20 or $122 with drugs $0 deductible $62.70 or $87.70 with drugs $275 deductible

MEDICARE ADVANTAGE IN INDIANA

January 1 through December 31, 2008

Covered Counties	*Name/Address/Phone*	*Type of Program Monthly Premium*
PFFS County Set 1: Adams, Allen, Brown, Dearborn, Decatur, DeKalb, Elkhart, Fayette, Franklin, Fulton, Gibson, Harrison, Huntington, Jackson, Kosciusko, LaGrange, Madison, Marshall, Morgan, Noble, Ohio, Orange, Posey, Ripley, St. Joseph, Wabash, Warrick, Washington, Wells, Whitley **PFFS County Set 2:** Benton, Carroll, Dubois, Grant, Hamilton, Hendricks, Jay, Martin, Monroe, Newton, Owen, Pulaski, Scott, Union, Vanderburgh	**Unicare Life & Health Insurance Company** **Security Choice** PO Box 9092 Oxnard, CA 93031 **1-888-949-5384** **TTY 1-800-297-1538** www.unicare.com	**PFFS County Set 1** $0 or $29 without drugs **PFFS County Set 1** $0 or $62 with drugs $0 deductible **PFFS County Set 2** $35 or $60 without drugs **PFFS County Set 2** $35 or $93 with drugs $0 deductible
SNP Low Income: Adams, Allen, Boone, Fulton, Hamilton, Hancock, Hendricks, Johnson, Kosciusko, Madison, Marion, St. Joseph, Wells **SNP Chronic Disease:** Adams, Allen, Fulton, Kosciusko, St. Joseph, Wells **SNP Institutional:** Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion **(SNP– Special Needs Plan)**	**Secure Horizons by UnitedHealthcare** **Evercare Health Plans** 130 W. Main Street Ft. Wayne, IN 46802 **1-888-834-3721** **TTY 1-888-685-8480** www.evercarehealthplans.com	**SNP Low Income** $0-$24 (depending on income) with drugs $0 deductible **SNP Chronic Disease** $0 with drugs $0 deductible **SNP Institutional** $33.50 with drugs $0 deductible
Cost HMO: Gibson, Posey, Spencer, Vanderburgh, Warrick **Local HMO:** Gibson, Knox, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick	**Welborn Health Plans** 101 S.E. Third Street Evansville, IN 47708 **1-800-521-0265** **TTY 1-800-743-3333** www.welbornhealthplans.com	**Cost HMO** $100 or $110 without drugs **Local HMO** $0 without drugs **Local HMO** $31 with drugs $0 deductible
Local HMO: Allen, Johnson, Kosciusko, Lake, Marion, St. Joseph **PFFS:** Elkhart **PFFS:** Adams, Allen, Brown, Cass, Clark, Dearborn, Decatur, DeKalb, Dubois, Fayette, Franklin, Fulton, Gibson, Grant, Hamilton, Harrison, Huntington, Jackson, Johnson, Kosciusko, LaGrange, Madison, Marshall, Martin, Morgan, Noble, Ohio, Orange, Owen, Parke, Posey, Putnam, Randolph, Scott, Shelby, St. Joseph, Tippecanoe, Union, Vanderburgh, Wabash, Warrick, Washington, Wells, Whitley	**Wellcare HMO** PO Box 25885 Tampa, FL 33622 **1-866-360-8139** **TTY 1-877-247-6272** www.wellcare.com **Wellcare PFFS** 8735 Henderson Road Tampa, FL 33634 **1-866-360-8139** **TTY 1-877-247-6272** www.wellcarepffs.com	**Local HMO** $0 with drugs $0 deductible **PFFS Elkhart** $19, $29 or $45 without drugs **PFFS** $0 or $10 with drugs $0 deductible

HELP WITH PART D PLAN COSTS
"EXTRA HELP"

The Social Security Administration (SSA) provides extra assistance to cover all or part of Part D Prescription Plan monthly premiums and deductibles and eliminates the coverage gapm(a period of non-coverage) if your income and assets are within stated categories.

- To see if you may qualify for assistance look at the charts on the following pages.

- Find your situation under the column headed "IF YOU HAVE", then follow the chart across to the right for benefits.

To apply for the Extra Assistance Program, contact your local Social Security Office, or go to the Social Security website at **www.ssa.gov.**

Applications may be obtained by calling **SSA at 1-800-772-1213, for TTY users 1-800-325-0778.**

You may also fill out and submit an application on the website at: www.ssa.gov.

Note: Even after studying the Extra Help charts on the following pages, you feel that you do not qualify for the Extra Help, **you still qualify for a Medicare Prescription Coverage Plan if you have Medicare.**

2008 Medicare Prescription Drug Benefit (Part D)
Eligibility & Enrollment Chart for Indiana

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
No Medicare Coverage	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Call SHIP 1-800-452-4800	N/A
Medicaid Only	You are not eligible for Medic*are* Prescription Drug Benefits	N/A	**N/A**	Medi*caid* will continue to cover your prescriptions	N/A
Medicaid & Medicare (Dual-Eligible) **AND:** Yearly Income below $10,640 (single) or $14,240 (married) → **OR:** Yearly Income above $10,640 (single) or $14,240 (married) →	You are eligible for Extra Help No premium No deductible No gap in coverage $1.05 - $3.10 co-pay for prescriptions $2.25 - $5.60 co-pay for prescriptions	**New to Medicare** You will be auto-enrolled in a plan for coverage first day of Medicare entitlement unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Medicaid** You will be auto-enrolled into a plan if you are not already in a drug plan. Coverage will be retroactive to the month your Medicaid coverage began.	CMS will notify you by mail if you are to be auto-enrolled. (CMS—Centers for Medicare & Medicaid Services)	You do <u>not</u> need to apply for Extra Help. You are already eligible.	**New to Medicare** - You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Medicaid** - If you are auto-enrolled into a plan that does not cover your medication you may switch plans.

The 2008 Medicare Prescription Drug Benefit Enrollment & Eligibility Chart for Indiana is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare Savings Program **QMB, SLMB, or QI** (Medicaid helps pay for your Medicare) **AND**… Yearly income below $10,640 (single) or $14,240 (married) Yearly income above $10,640 (single) or $14,240 (married)	You are eligible for Extra Help No premium No deductible No gap in coverage $1.05 - $3.10 co-pay $2.25 - $5.60 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	You do not need to apply for Extra Help. You are already eligible.	**New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** If you are facilitated into a plan that does not cover your medication you may switch plans.
Medicare with no prescription coverage Yearly income below: $14,280 (single) or $19,140 (married) **AND** Resources less than $7,790 (single) or $12,400 (married)	You are eligible for Extra Help, but you must apply. No premium No deductible No gap in coverage $2.25 or $5.60 co-pay	**New to Medicare** - You will be auto-assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan. You may want to also apply for the Medi*care* Savings Program if your resources are below $4,000 or $6,000 if married.	Any time **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

IF YOU HAVE...	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medicare with no prescription coverage Yearly income below $15,840 (single) or $21,240 (married) **AND** Resources less than $11,990 (single) or $23,970 (married)	You are eligible for Extra Help, but you must apply. $56 deductible 15% co-pay No gap in coverage Sliding Scale Premium * (see chart below)	**New to Medicare** - You will be auto -assigned (or facilitated) plan unless you choose your own plan during the first three months of your initial enrollment period (during the 3 months before your Medicare coverage starts). **New to Extra Help -** If you do not already have a drug plan you will be facilitated into a plan and notified of the effective date.	CMS will notify you by mail if you are to be facilitated into a plan.	Apply for Extra Help Select and enroll in a Drug Plan	Any time. **New to Medicare** You to ensure your new drug plan best suits your needs, you should enroll into a plan during the first 3 months of your initial enrollment period. **New to Extra Help -** You may choose your own plan prior to facilitated enrollment.

If your income is:	Single Income	Married Income	What you will pay in monthly premium
135% FPL or lower	Below $14,280	Below $19,140	0% of the premium
135% - 140% FPL	$14,280 - $14,800	$19,140 – $19,840	25% of the premium
140% - 145% FPL	$14,800 - $15,320	$19,840 - $20,540	50% of the premium
145% - 150% FPL	$15,320 - $15,840	$20,540 - $21,240	75% of the premium

IF YOU HAVE…	WHAT DO YOU GET?	PART D PLAN ENROLLMENT	HOW WILL YOU BE NOTIFIED?	WHAT SHOULD YOU DO?	WHEN SHOULD YOU ACT?
Medic*are* but your income and/or resources are above the Medicare Prescription Drug Benefit limits for Extra Help…	You are not eligible for Extra Help. • Est. $35/mo premium • $275 deductible • gap in coverage from $2,250 to $5,100 in drug expenses • After gap, you pay greater of 5% or $2/$5 co-pay	You will need to enroll in a Drug Plan	**N/A**	Consider selecting and enrolling in a Drug Plan	11/15/08-12/31/08
Medic*are* with other prescription coverage	Your current prescription drug coverage may or may not change.		N/A	**Consider whether you should keep current coverage or enroll in the Medic*are* Prescription Drug Benefit	See chart below

****Medigap Policy** (Medic*are* Supplement Policy)	If you have a Medigap policy with prescription drug coverage, it may or may not continue in 2006. **Contact your insurance company for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****Retirement Insurance Plan**	Your retirement insurance plan may or may not change in 2006. **Contact your plan for information.** Your insurance company must notify you by 11/15/05 whether or not your coverage is as good as or better than the Medicare Prescription Drug Benefit, and when late penalties would apply if you choose to enroll in a Drug Plan later.
****HoosierRx** (IN State Pharmaceutical Assistance Program)	HoosierRx members will receive a letter about changes to the HoosierRx program in October 2005. Call Indiana's Pharmaceutical Assistance Program toll-free at 1-866-267-4679 for more information.
****VA Prescription Benefits** (Veteran's Administration)	If you receive VA Prescription Drug Benefits, you do not need to enroll in a Medicare Prescription Drug Plan. You will not have a late penalty if you decide to enroll later.

HoosierRx Helps Pay for your Medicare Part D Plan

Indiana's State Pharmaceutical Assistance Program, HoosierRx, can help pay the monthly Part D premium, up to $70 per month, for members enrolled in a Medicare Part D Plan working with HoosierRx.

To be eligible for HoosierRx you must:

1. be an Indiana resident, 65 years old or older.
2. have a yearly income of $15,840 or less for a single person, or $21,240 or less for a married couple living together.
3. have applied for the "Medicare Extra Help" through Social Security to pay for your Medicare Part D plan, and received either a "Notice of Award" or "Notice of Denial" from Social Security.
   - Your Social Security "Notice of Denial" must be because your **resources are above the limit established by law**.
   - Your Social Security "Notice of Award" must state that you are receiving **partial extra help** subsidy to help pay for your Medicare Part D premium.

If you think you meet these eligibility requirements please call a HoosierRx representative at 1-866-267-4679 or visit the HoosierRx website at www.IN.gov/HoosierRx .

Companies offering Prescription Drug Plans working with HoosierRx: AARP/United Healthcare, CIGNA Healthcare, Coventry AdvantraRx, First Health, Humana, MemberHealth, Prescription Pathway, SilverScript, and WellCare.

When speaking to the plan companies, remember to refer to HoosierRx as the **State Pharmacy Assistance Program**.

Jan 2008

MEDICAID AND PRESCRIPTION DRUGS

Does Medicaid Cover Prescription Drugs?

- If you have both Medicare and Medicaid ("Dual Eligible"), you will be assigned to a new Medicare prescription plan (**MEDICARE Part D)**. If your new Medicare Prescription Plan is not right for your situation, you will have the option of changing plans.

- Your new plan will pay for your prescription costs unless your medication is not one of the classifications covered by Medicare (for example the barbiturates and benzene drugs).

- Medicaid may cover some over the counter drugs.

- If your new Part D plan doesn't cover a particular brand name, you (or doctor or pharmacist) can appeal to Medicare to have the brand covered. For example, drugs for mental illness require a stabilization period. To change drugs, may cause a set back so the doctor or pharmacist can appeal to have the current drug covered. The Part D plan has to provide an emergency supply during the 72-hour appeal process.

- It is **not** a requirement that you have Medicare to qualify for Medicaid, and you do not automatically qualify for Medicaid if you have Medicare.

- If you are approved for Medicaid and do not have Medicare, Medicaid will continue helping with your prescription drug costs.

- In 2008, you may be eligible for Medicaid if you have income and assets below the following amounts:

	INCOME	*ASSETS
SINGLE	$637/month	$1,500
COUPLE	$956/month	$2,250

* Assets normally do not include your home and one vehicle.

Medicaid Spend-Down:

If your income is too high for Medicaid, you may be able to deduct medical bills, out-of-pocket prescription costs, and certain other expenses from the excess income (amount that you are over the limit), to qualify for Medicaid. This process is called **Spend-Down**. Amounts paid by Medicare will not count toward your Medicaid Spend-Down.

For more information contact your local **Division of Family Resources** or call **SHIP** at **1-800-452-4800.**

PHARMACEUTICAL MANUFACTURERS' ASSISTANCE PROGRAMS

Many drug companies sponsor programs to help you obtain prescription medications. If you qualify for a given program, you may receive prescription drugs either free or at a very low cost.

If you are receiving medications through one of more of these drug programs, check with the program to see how their services are affected by Medicare Part D. Plans/companies may change their status in relation to Medicare Part D.

Who is Eligible?
Anyone can apply; age and/or disabilities are not factors. Most companies require that you live in the United States and that:

- □ You have no insurance that covers outpatient prescription drugs.
- □ You do not qualify for a government assistance program, (Medicaid, for example) that covers prescription drug costs.
- □ Your income and/or assets are within their stated guidelines.

How Do I Apply?
The application process is different for each company. Usually a doctor must sign your completed application form and have his/her office submit it for you. Most applications (and the instructions for filling out the application) are available to you or your doctor's office through **Rx For Indiana:**

1-877-793-0765 or at their Website **www.RxforIndiana.org**

Other websites you may find helpful include:
www.needymeds.com
www.RxHope.com

SHIP counselors at sites throughout Indiana can guide you in getting and completing applications from drug companies. Simply call **SHIP** toll free at **1-800-452-4800** or local number listed on pages 3-5.

INDIANA LOCAL ASSISTANCE

Township Trustees

- **Eligibility:** Please visit your local Township Trustee office for information regarding eligibility.
- **Benefits:** Emergency loan assistance for health care, prescription drugs, food, clothing, etc.
- **Information:** For eligibility requirements and information, visit your local Trustee office. Call **1-888-482-4639** for locations or visit their website **www.indianatownshipassoc.org**

Indiana Area Agencies on Aging

Indiana's Area Agencies on Aging provide case management, information, and referrals to various services for individuals who are aging or are developmentally disabled. These services may include:

Transportation - Meals - Employment - Legal Services
Adult Protection - Attendant and/or Respite Care
Affordable Housing - Home Modification

To apply and for more information contact the Area Agencies on Aging nearest you or call toll free **1-800-986-3505**. A listing of local agencies can also be found at **www.in.gov/fssa/elderly/aaa/index**

Community Health Centers

Community Health Centers provide medical services to people on a sliding fee scale. The centers do not have a pharmacy; however, they may have samples of prescription medication available for patients. Some centers may be able to help patients access prescription drugs at discount prices.

The centers are also federally qualified to waiver Medicare Part B deductibles. The Indiana State Department of Health has been able to use the State Funded Community Health Center Program to build a strong network of primary and preventive health care providers throughout the state. **Check the following pages for a local Indiana Community Health Center.**

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

County	Name	Address	Additional Site Address	Services
Statewide	Indiana Rural Health Association (other name) IRHA	P.O. Box 10366 Terre Haute IN 47801 (812) 238-4937		T.A., Training
Allen	Neighborhood Health Clinics, Inc.	P.O. Box 11949 1717 S. Calhoun St. Fort Wayne, IN 46862 (260) 458-2641		Primary Medical and Dental
Brown	Brown County Health Support Clinic	5029 N. State Rd. 135 Morgantown, IN 46160 (812) 988-6678		Health Promotion, Health Education, disease prevention and management, Diagnostic and treatment of comon illnesses, lab, pharmacy assistance
Carroll	Family Health Clinic of Carroll County (other name) Purdue University Sponsored Program Services	610 Purdue Mall West Lafayette, IN 47907-2040 (765) 494-6204	1544 West US 421 N. Delphi, IN 46923-0597	Primary Medical
Cass **St. Joseph, Grant, Howard**	Indiana Health Centers	1700 Dividend Drive Logansport, IN 46947 (574) 722-7407		Primary Medical
	St. Joseph Indiana Health Centers	South Bend 1901 #B Western Ave. South Bend, IN 46619 (574) 234-9033		Primary Medical
	Grant Indiana Health Centers	Marion 925 South Nebraska St. Marion, IN 46953 (765) 644-7492		Primary Medical
	Howard Indiana Health Centers	Kokomo 3118 South LaFountain St. Kokomo, IN 46902 (765) 864-4160		Primary Medical

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

County	Name	Address	Additional Site Address	Services
Clark (Need proof live in Clark Co.)	Family Health Center of Clark County, Inc.	1301 Akers Avenue Jeffersonville IN 47130 (812)283-2308	Charlestown, Pending 2 days a week	Dental, optometry, primary health care, preventive health care, health ed, medications, Pregnancy tests, STD testing
Crawford	Hoosier Uplands Economic Development Corporation (other name) Patoka Family Health Care Center	521 West Main St. Mitchell, IN 47446 (812) 849-4457	307 South Indiana Ave. English, IN 47118	
Delaware & surrounding east central counties	Open Door/BMH Health Center, Inc. (other name) Open Door Health Services	905 South Walnut St. Muncie, IN 47302 (765) 286-7000 920 W. Main Street (765) 747-2972 424 W. Jackson St. (765) 281-4263		Open Door Dental Clinic Dental Services and Administration; Open Door Family Planning Clinic Beds and Britches Prenatal and Child Incentive Program;
Elkhart	Heart City Health Center	236 Simpson Ave. Elkhart IN 46516 (574) 293-0052		Primary Medical
Elkhart	Maple City Health Care Center, Inc.	213 Middlebury Street Goshen, IN 46258 (574) 534-3300		Primary Medical
Floyd (Subsidized care) Any county for non-subsidized care)	Family Health Center of Floyd County, Inc	1000 East Spring St. New Albany, IN 47150 (812)941-1701		Preventive health care: pap smears, mammograms, health education, treatment for acute and chronic health care.
Gibson	Tulip Tree Family Health Services of Gibson County, Inc.	123 N. McCreary Street Ft. Branch, IN 47670 (812) 753-1039		Family Planning, PAP Smears, Breast exams, Drug assistance, moderately complex lab.

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

Henry **Hancock, Rush**	Hancock Memorial Hospital and Health Services (other name) Knightstown Rural Healthcare Center	801 North State St. Greenfield, IN 46140 (765) 468-4552	427 N. McCullum Knightstown, IN 46148	Primary Medical
Howard	Howard Community Hospital (other name/s) Healthy Children, Healthy Teens	3500 South LaFountain Kokomo, IN 46902 (765) 854-2440		Primary Medical
Johnson Bartholomew, Brown, Morgan, Shelby	Trafalgar Family Health Center, Inc. (other name) Trafalgar Family Health Center, Edinburgh Family Health Center	14 Trafalgar Square Trafalgar, IN 46181 (317) 878-2301	911 East Main Cross Street Edinburgh, IN (812) 526-9999	Primary Medical and Dental
Lake	East Chicago Community Health Center	100 W. Chicago Ave. East Chicago, IN 46132 (219) 392-4900	1313 W. Chicago Avenue (To be oral health and administration)	Primary medical
Lake	Gary Community Health Center Inc.	1021 West 5th Ave. Gary, IN 46402 (219) 880-1190		Primary Medical
LaPorte	LaPorte Dental	1007 Lincolnway LaPorte, IN 46350 (219) 326-2504	310 Homer St., Michigan City, IN 46360	Dental
Lawrence	Dunn Memorial Hospital (other name) Community Health and Wellness Center/ WIC	1600 23rd. St. Bedford, IN 47421 (812) 279-6222	2415 Mitchell Road (812) 279-6222	
Madison	Madison County Community Health Centers, Inc	1547 Ohio Ave. PO Box 349 Anderson, IN 46015	1817 1/2 South A St. PO Box 349 Elwood, IN 46036	Not listed

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

County	Name	Address	Additional Site Address	Services
Marion	Citizens Primary Care Health Center	1650 N. College Ave. Indianapolis, IN 46202 (317)396-0279		Primary Health care: Prenatal, Pharmacy, Pediatrics, Family College Ave.:Practice, Dental, Podiatry, Optometry, Chronic disease Mgmt. Patient Ed & Social Services
	Citizens Primary Care Health Center		Colman Middle School 1740 E. 30th St Indianapolis, IN 46205	School based: Primary Adoles-cent Care, .
	Citizens Primary Care Health Center		Barton Clinic 501 North East St. Indianapolis, IN 46202	Barton Clinic Comprehensive array of primary health care services
Marion	Health and Hospital	3838 North Rural St. Indianapolis, IN 46205 (317) 221-2037	Separate listings below	
	Health and Hospital		**Blackburn Health Center** 2700 Dr. Martin Luther King Drive, Indianapolis, IN 46298 (317) 221-2327	Dental
	Health and Hospital		**Forest Manor Health Center** 3840 North Sherman Drive Indianapolis, IN 46226 (317) 541-3434	Primary medical and dental
	Health and Hospital		**Pecar Health Center** 6904 North Michigan Road Indianapolis, IN 46268 (**NOTE: not open yet)**	Primary medical and dental
	Health and Hospital		**Westside Health Center** 2732 West Michigan Indianapolis, IN 46222 (317) 554-4600	Bi-lingual primary care

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

Marion	HealthNet Inc.	3401 E. Raymond St. Indianapolis, IN 46203 (317) 781-4918	**Barington Health Center**, same address	Primary Medical & Dental
	HealthNet Inc.		**Martindale/Brightwood Health Center**, 2855 N. Keystone Ave. Indianapolis, IN 46218 (317) 920-5760	Primary Medical & Dental
	HealthNet Inc.		**Southeast Health Center** 901 Shelby St Indianapolis,IN 46203 (317) 488-2040	Primary Medical & Dental
	HealthNet Inc.		**People's Health Center** 2340 E. 10th. St. Indianapolis, IN 46201 (317) 633-7360	Primary Medical & Dental
	HealthNet Inc.		**Health Center** 2202 W. Morris St. Indianapolis, IN 46221 (317) 488-2020	Primary Medical & Dental
	HealthNet Inc.		**OB-GYN Care Center** 1633 N. Capitol Ave, Suite 500 Indianapolis, IN 46202 (317) 962-5014	**OB-GYN**
Marion	Learning Well, Inc. (other name) Learning Well School Base Health Services	342 Massachusetts Ave. Indianapolis, IN 46204 (317) 472-1473		
Marion	Raphael Health Center	401 East 34th St. Indianapolis, IN 46205 (317) 926-1507		Primary Medical

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

County	Name	Address	Additional Site Address	Services
Marion	Shalom Health Care Center, Inc.	3737 N. Meridian Street Suite 402 Indianapolis, IN 46208 (317) 923-4915	2301 N. Park Ave. Indianapolis, IN 46205 (317) 924-4978 Patricia Street Indianapolis, IN 46221 (317) 226-4194	Immunizations, chronic disease management, cancer screening, adolescent sick behavior, STD screening, accute illness,
Marion	Sisters of St. Francis Health Services, Inc. (other name) St. Francis Neighborhood Health Center Grant	1600 Albany Street Beech Grove, IN 46107 (317) 781-9669		Primary Medical and Preventative Services
Monroe	Bloomington Hospital, Inc. dba Community HealthServices (other name) Community Health Services (CHAP)	333 E. Miller Dr. Bloomington IN 47401 (812) 353-2901		Primary Medical
Parke & Vermillion	Community Health Intervention Education Foundation, Inc. (other name) Family Health and Help Center	109 South Jefferson St. (765) 569-4008		Primary Medical
Porter & Lake LaPorte, Starke, Jasper, Marshall, St. Joseph, Newton.	Hilltop Community Health Center Inc.	460 S. College Ave. Valparaiso, IN 46383 (219) 462-7173		Primary medical and dental.
Porter	Portage Township Community Health Care, Inc.	6450 U.S. Highway 6 Portage, IN 46368 (219) 763-8112		Primary medical and dental, prenatal and Midwifery, Medication Assistance
Randolph	St. Vincent Randolph Hospital (other name) Family Health Center of Winchester	407 Greenville Avenue Winchester, IN 47394 (765) 584-0141	409 Greenville Ave. Winchester, IN 47394,	Primary Care
Rush & Fayette, Franklin	Mother and Baby Care of Rush County, Inc. (other name) Family Health Services	509 Harcourt Way P.O. Box 21 Rushville, IN 46173 (765) 932-3699	911 Central Ave, Connersville, IN 47331, (765) 827-1164	Primary Medical

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

Rush & Fayette, Franklin	Mother and Baby Care of Rush County, Inc. (other name) Family Health Services	509 Harcourt Way P.O. Box 21 Rushville, IN 46173 (765) 932-3699	911 Central Ave, Connersville, IN 47331, (765) 827-1164	Primary Medical
St. Joseph	Memorial Health System (other name) Memorial Neighborhood Health Centers	707 N. Michigan St. South Bend, IN 46601 (574)237-6640	Southeast 1708 S. High St. South Bend, IN 46613	Family practice, dental, prenatal, PNCC, also HIV,smoking, family health navigation. also,smoking,
	Memorial Health System (other name) Memorial Neighborhood Health Centers		Central 813 S. Michigan South Bend, IN 46601	Family practice, PNCC,HIV,
	Memorial Health System (other name) Memorial Neighborhood Health Centers		Harrison Elementary School 3302 W. Western Ave. South Bend, IN 46619	Family health navigation
St. Joseph	St. Joseph Regional Medical Center, Inc. (other name) Health Family Center	215 W. Fourth St. Mishawaka, IN 46544 (574)254-2799		Primary Medical Care Services, Assisted Drug Program, Sliding Fee Scale Program
	St. Joseph Regional Medical Center, Inc. (other name) Health Family Center		201 Lincolnway West Mishawaka, IN 46544	Primary Medical Care Services, Assisted Drug Program, Sliding Fee Scale Program
Switzerland	Switzerland County Nurse Managed Clinic	727 US Highway 56 Suite 300 PO Box 14 Vevay, IN 47043 (812)427-4038		Primary Health Care Services for Children and Adult uninsured, underinsured and medically indigent
Tippecanoe	Tippecanoe Community Health Clinic	1716 Hartford St. Lafayette, IN 47904-2138 (765) 742-1567		Primary Medical and Dental

STATE FUNDED COMMUNITY HEALTH CENTER PROGRAM

County	Name	Address	Additional Site Address	Services
Vanderburgh **Posey, Gibson**	Echo Community Health Care, Inc.	501 John St. Suite 12 Evansville, IN 47713 (812) 421-7489	118 Third St, Mt. Vernon, 47670	Primary Care including prenatal, pediatrics, and prevention services
	Echo Community Health Care , Inc.		907 SE 8th Suite B Evansville, IN 47713	Primary Care including prenatal, pediatrics, and prevention services
	Echo Community Health Care, Inc.			
	Echo Community Health Care, Inc.		107 State St. Princeton, In, 47670	Primary Care including prenatal, pediatrics, and prevention services
Vigo **Clay, Greene, Parke, Vermillion, Owen, Sullivan**	Union Hospital, Inc. (other name) Midwest Center for Rural Health	1433 N. 6-1/2 St. Terre Haute, IN 47807 (812) 238-7479		Primary Medical and Preventative Services
			Terre Haute, IN (812) 238-7631	Primary Medical and Preventative Services
			Worthington (812) 875-2000	Primary Medical and Preventative Services
			Clay City ,47841 (812) 939-2126	Primary Medical and Preventative Services
Wayne	Wayne County Health Department Nursing Division Clinic	301 East Main Old Courthouse Richmond, IN 47374 (765) 973-9292		Primary Medical and Health Education

MILITARY
VETERANS/RETIRED

Veterans' Benefits

Outpatient pharmacy services are **provided free** to veterans receiving medications for treatment of services-connected conditions. Other honorably discharged veterans may be charged **$8 for each 30-day supply**. In order to receive these benefits, you must fill out an application to enroll in the VA health care system. An application may be obtained by calling **1-877-222-8387**. You must see a doctor at the VA before a prescription will be filled; a prescription from a non-VA doctor will not be accepted. For general information about VA pharmacy services, contact the Veterans Administration at **1-800-827-1000.**

Military Retiree Benefits

Any active duty or retired U.S. military person, (i.e. U.S. Air Force) and/or their dependents are entitled to prescription drug coverage as a part of their benefits. For more information, contact your local military installation or your specific military branch retirement division. Veterans in Indiana can call Toll Free **1-888-878-6889 Ext 5404**, or in the Indianapolis area call **317-554-0000-Ext 5404.**

TRICARE Senior Pharmacy Program

Uniformed services beneficiaries age 65 and over may obtain low cost prescription medications from the **National Mail Order Pharmacy (NMOP**) and **TRICARE** network and non-network civilian pharmacies. Beneficiaries can continue to use military hospital and clinic pharmacies. To qualify:

- □ You must be age 65 or over.
- □ You must be registered in the Defense Enrollment Eligibility Reporting System (**DEERS)**. Enrollment can be completed on-line at www.tricare.osd.mil
- □ You must be enrolled in Medicare Part B if you were age 65 or over after April 1, 2002.

For specific information, contact **TRICARE** at **1-800-941-4501**, or use the Internet at **www.tricare.osd.mil**

DISCOUNT PRESCRIPTION PROGRAMS

Discount programs are not considered to be equal coverage to Medicare's prescription drug program. If you are enrolled in a drug discount plan and decide to join a Medicare prescription drug plan, your current plan benefits may change or be cancelled. Contact your current plan for details.

MEDICARE PRESCRIPTION PLAN MAIL ORDER

An important option you may have with a Medicare prescription drug plan is being able to obtain your prescription drugs through the plan's mail order service. Your prescriptions are delivered to you by mail, or if you are willing to pay extra for shipping, you may have the option of other delivery services.

Questions to ask about a Medicare prescription plan's mail order service option include:

- □ Are there **additional costs** to use the mail order service, for example shipping charges, and what is the delivery schedule?
- □ Do you provide access to a pharmacist for consultation about my medication and for drug interaction screening/ information?
- □ Does the mail order service cover both my generic and brand name drugs? Are all of my prescription drugs on your list?
- □ **If I live part of the time in another state** can I have my medications sent directly to the alternate address, and are there extra charges for this service?
- □ What are your business contact hours?

ABOUT MY ORDERS...

- □ What if my order is out of stock, or what if there is an emergency, (i.e. my drugs get lost or ruined)) and I need the prescription right away? How will I get more? Will there be an extra charge for refilling my prescription in an emergency?

- □ After I place an order, how long before I can pick it up or expect it to arrive by mail?

- □ Does the plan have a 30-day, 60-day, or 90-day supply option? If these options are available, can I change options without penalty? Do I save more by ordering larger amounts? (For example, a 90-day supply instead of a 30-day supply)

- □ Do you include information on the drugs when they are sent?

WHAT ABOUT REFILLS...

- □ Do you automatically refill long-term prescriptions on a scheduled basis?

- □ If you do not automatically refill prescriptions, will you remind me when a refill is due? How much advance notice do you need?

Medicine Record Form

Write down the name of each medicine you take, the reason you take it, and the dosage in the spaces below. Add new medicines as you receive them. You can show the list to your doctors. You may want to make copies of the blank form so you can create a new list when your medications change.

Prescription Medications **Date Form Was Completed: _____**

Name of Prescription	Reason Taken	Date Started	Dosage	Times per Day	Doctor

Medicine Record Form Continued

Prescription Medications **Date Form Was Completed: _____**

Name of Prescription	Reason Taken	Date Started	Dosage	Times per Day	Doctor

Over-the-Counter Medicines (Check if you use any of these)

☐ Allergy relief medicine

☐ Antacids

☐ Aspirin

☐ Cold/Cough Medicine

☐ Diet Pills

☐ Laxatives

☐ Vitamins

☐ Other_____

PROCEDURES

SECTION Q

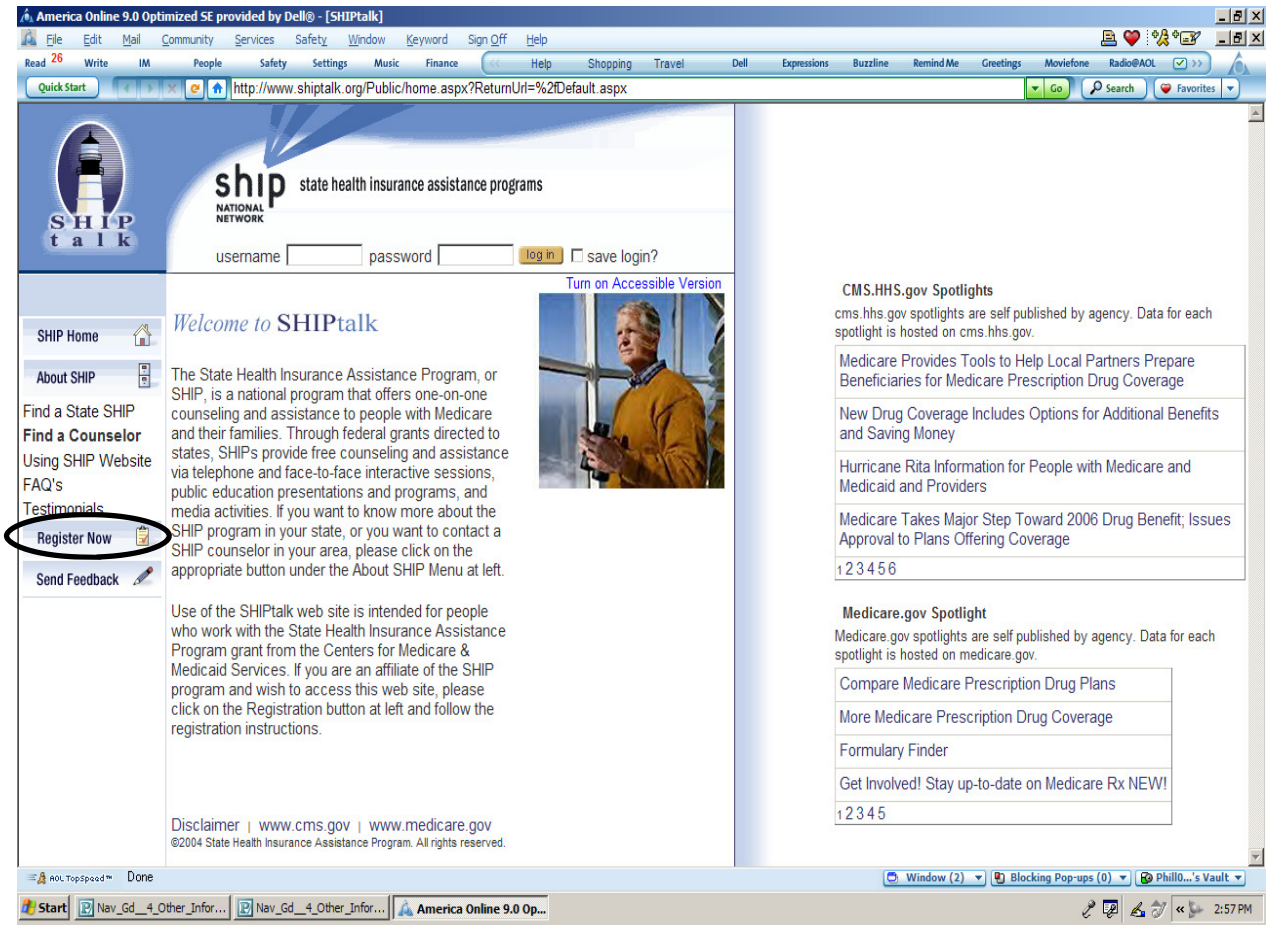
Unique ID Number

(For SHIP Counselor use only)

An Unique ID Number will allow you to identify yourself as a SHIP Counselor; as well as, access the articles on the National SHIP website. In order to receive a Unique ID Number you must first log onto the SHIP Talk website at:

www.shiptalk.org

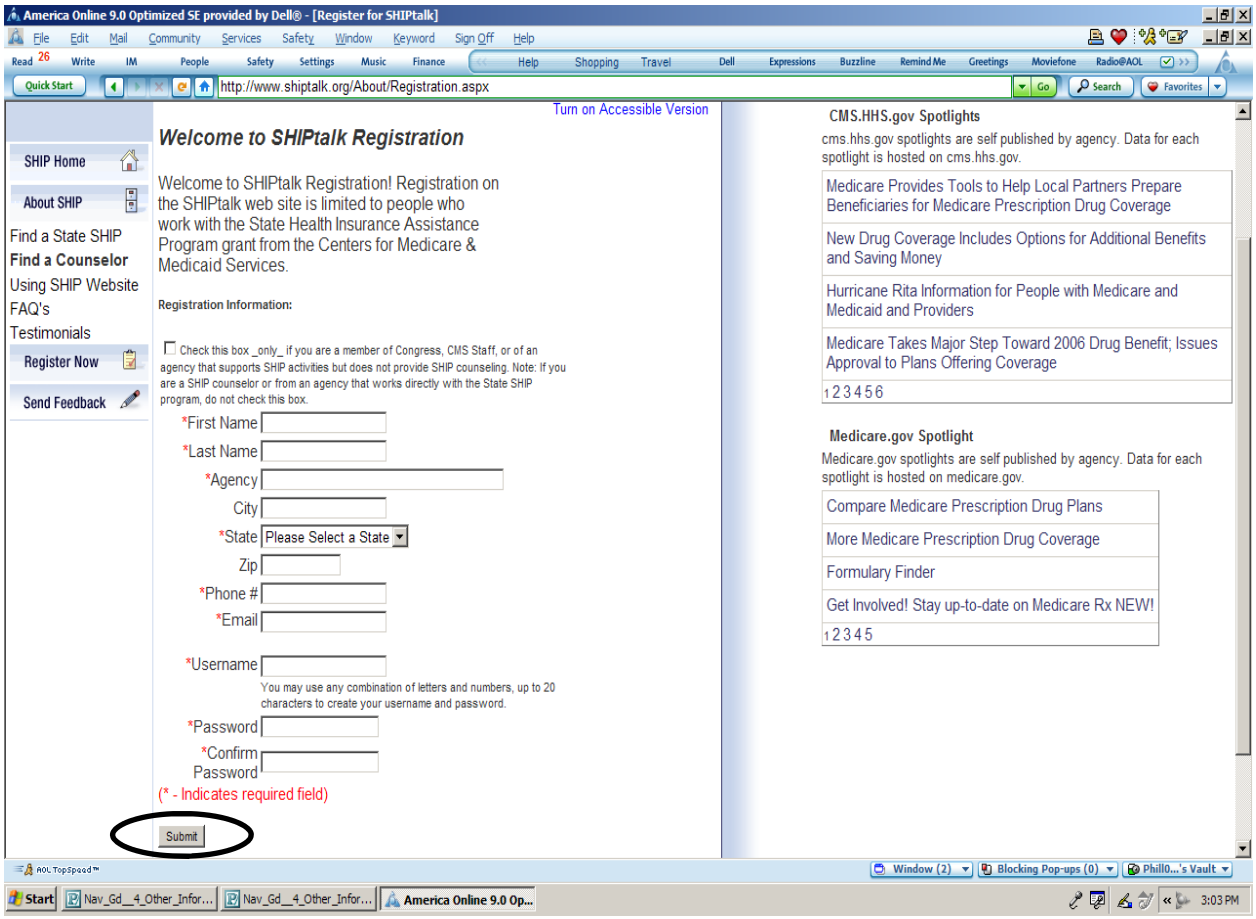
Click on “Register Now” button in the side bar.



Complete the registration form and hit “Submit”. Fields with a red * are required information that is necessary to complete the form. These required fields include:

- First and last name
- Agency
- State
- Phone number
- Email
- Choose an Username and password

In a day or two, you should receive an e-mail from the SHIP Director with your Unique ID Number.

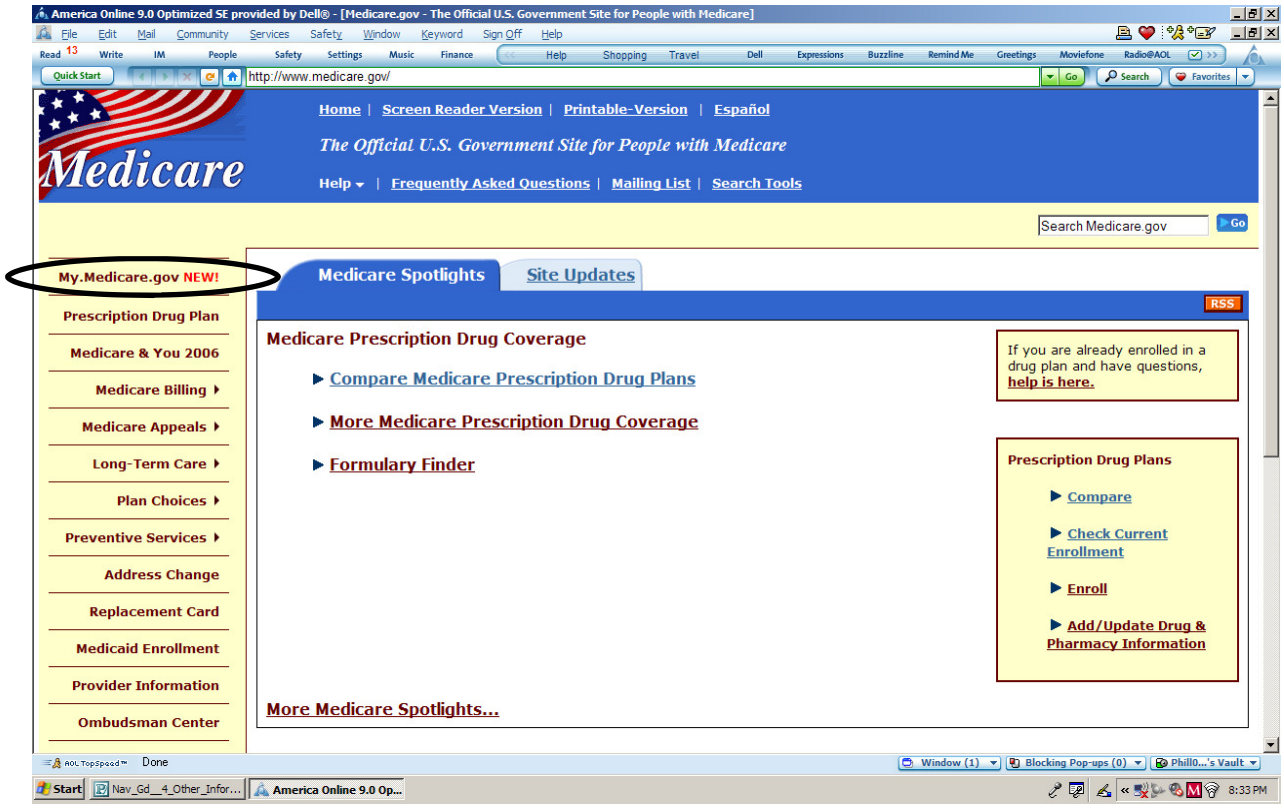


My.Medicare.gov

My.Medicare.gov is a secure, online service for accessing your own Medicare information. In order to access your information, you must first register online at:

www.medicare.gov

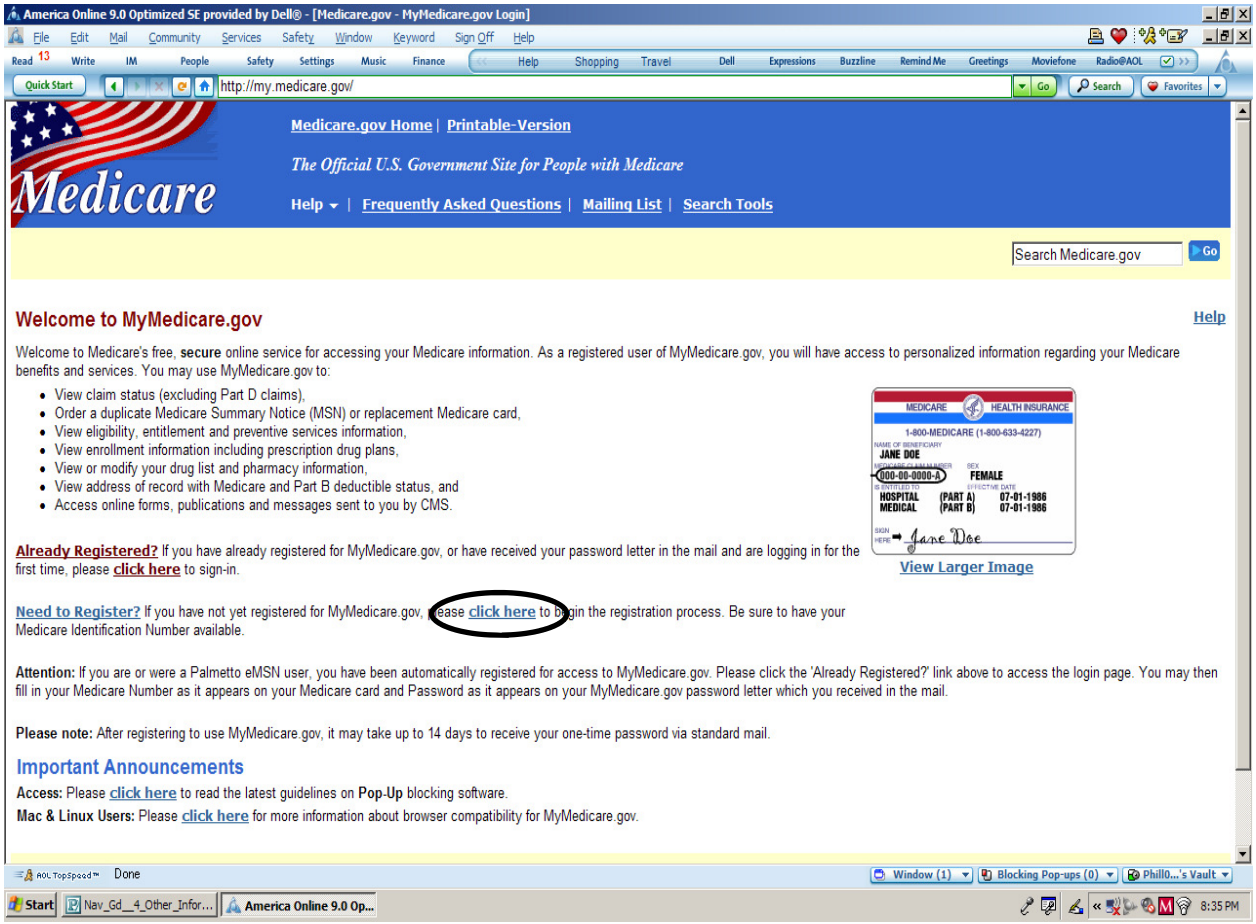
Click on the "My.Medicare.gov NEW" button on the side bar. This will take you to the web page pictured on the next page.



This page allows you to register for My.Medicare.gov, and advises you about the information you will be able to access once your are registered and receive your password. This information includes the following:

- View claims status (excluding Part D claims),
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card,
- View eligibility, entitlement and preventive services information,
- View enrollment information including prescription drug plans,
- View and modify your drug list and pharmacy information,
- View address of record with Medicare and Part B deductible status, and
- Access online forms, publications and messages sent to you by CMS (Centers for Medicare and Medicaid Services).

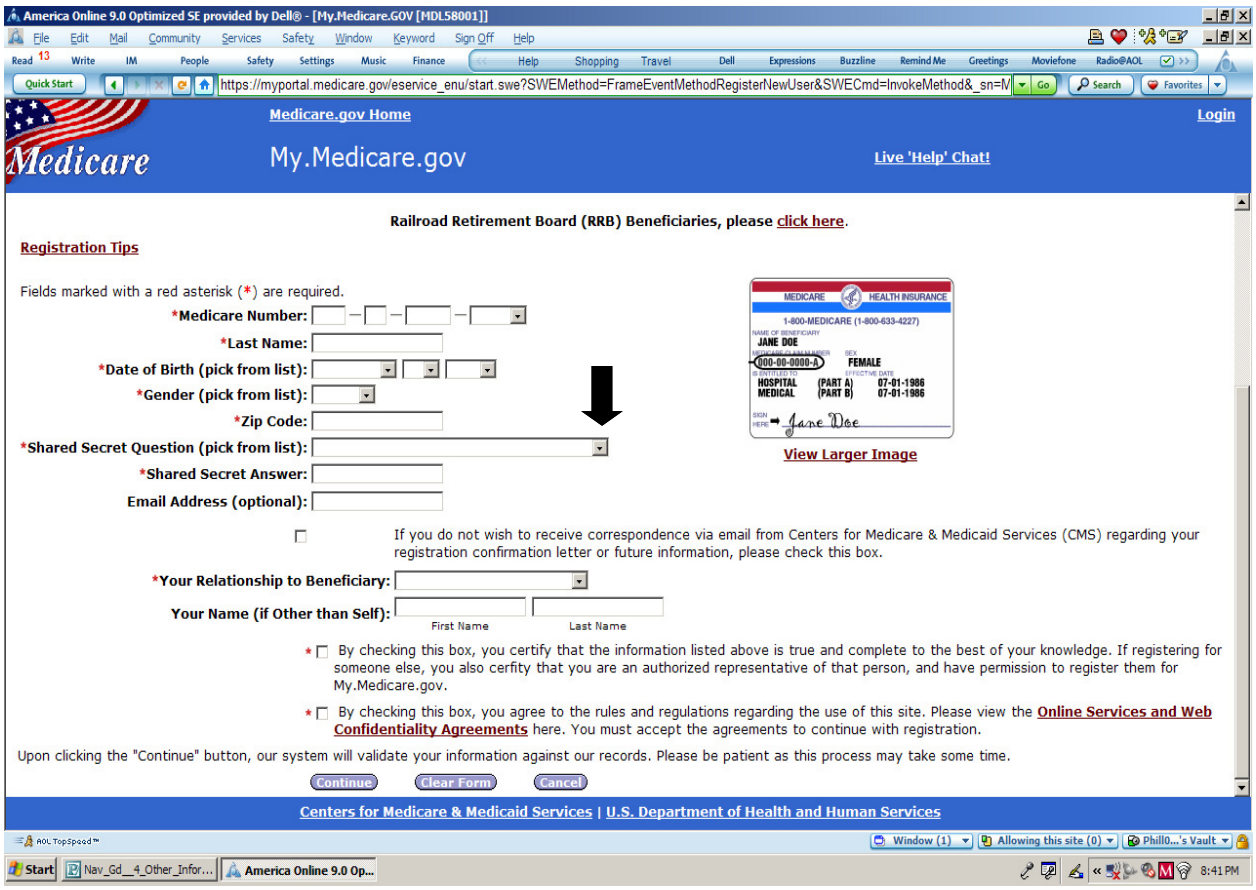
Go half way down the page to the line that reads, "Need to Register? If you have not register for My.Medicare.gov, please click here to begin the registration process". Click on the highlighted "click here".



Complete the registration form pictured below. All fields marked with a red * must be completed. The required information includes the following:

- Your Medicare Number
- Your last name
- Your date of birth
- Your Gender
- Your zip code
- Choose a “Shared Secret Question” from the drop menu
- The answer to the chosen question
- Your relationship to the beneficiary

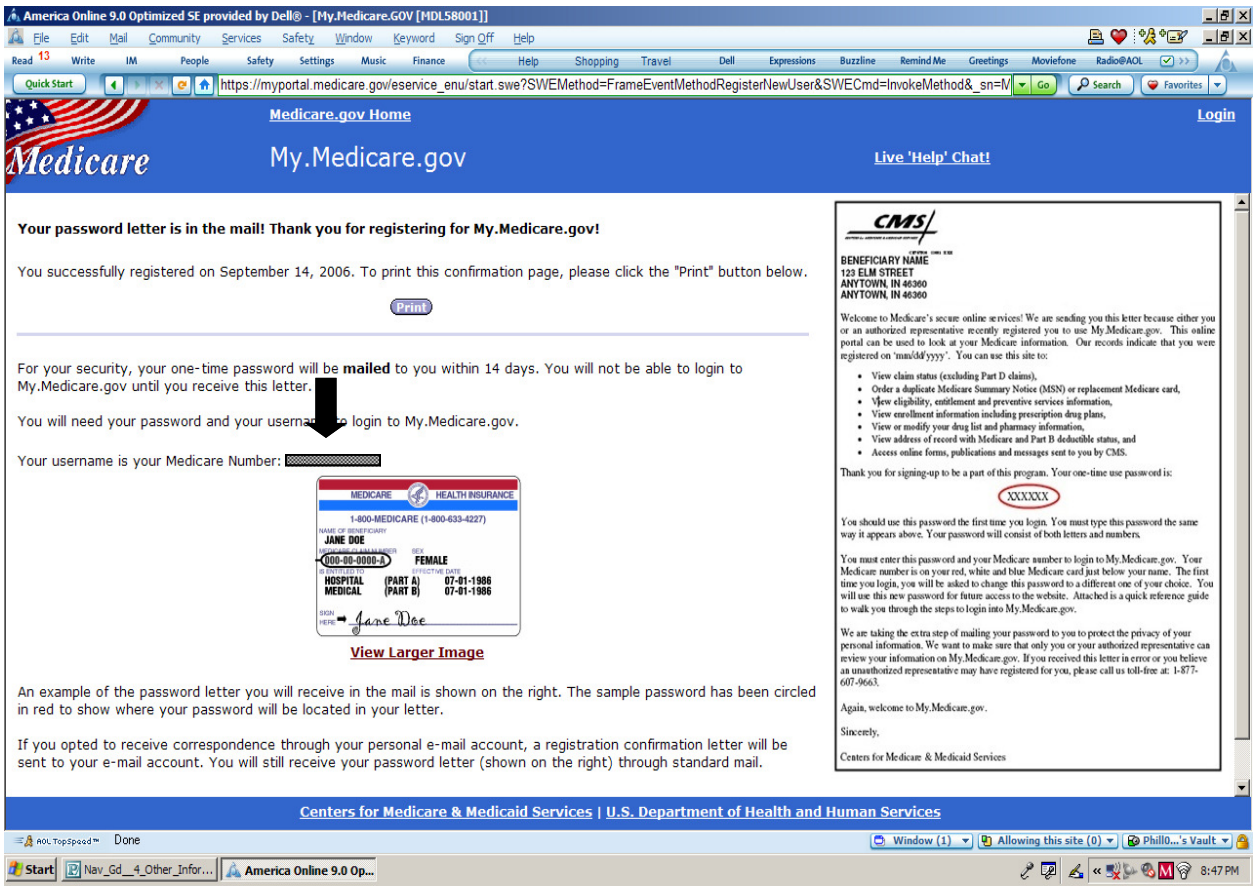
Once all fields are completed, use your mouse to click on the “Continue” button.



After clicking the “Continue” button, the information you provided will be compared to the information in CMS’s records.

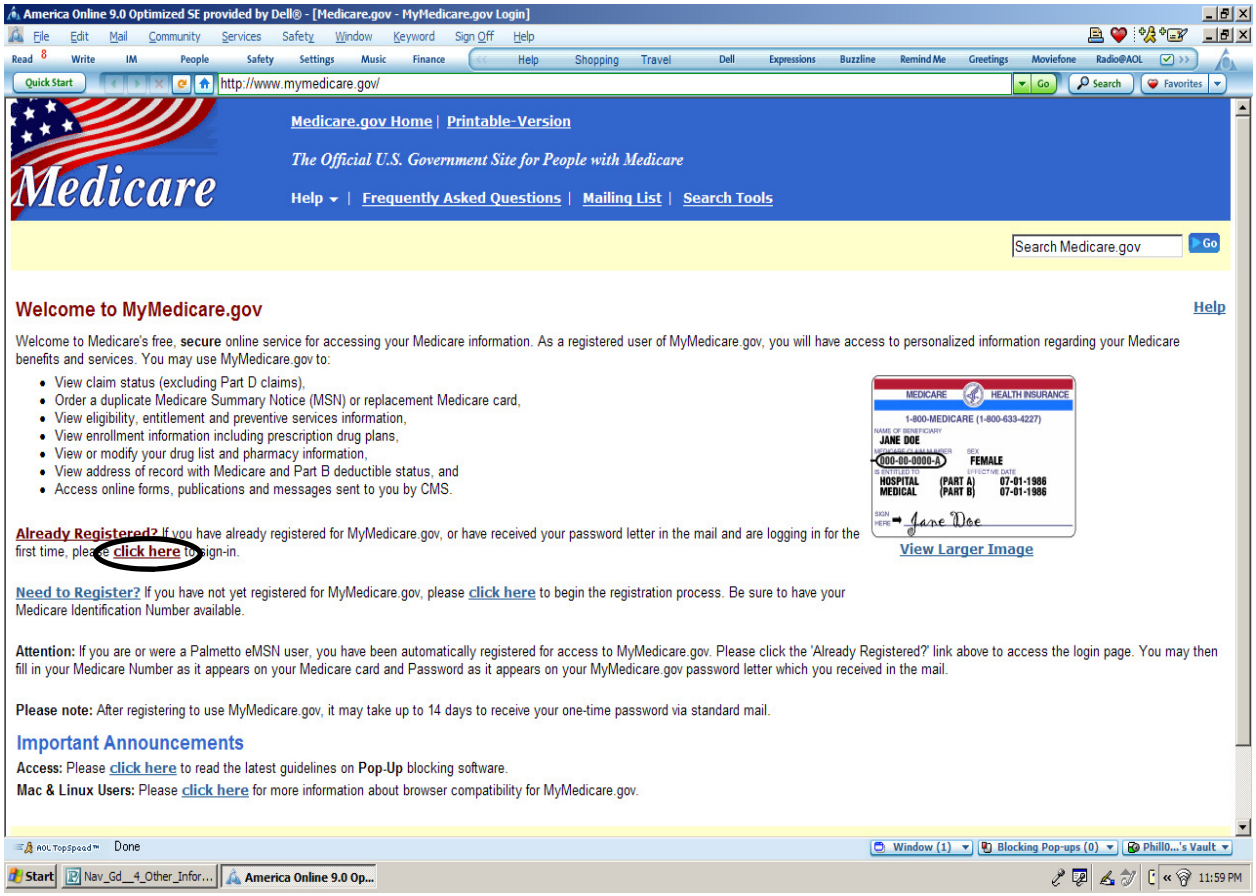
Once the comparison has been made you will received a confirmation page, like the one to the left. This confirmation page will include your **username, which is your Medicare claim number**. To the right of the page you will find a copy of the welcome letter you will receive with your password.

For security purposes, **you will receive your password via mail in approximately 14 days.** This password is a one time only password. You will not be able to access your Medicare information online until your receive your password. The first time you log on you will be asked to change your password to a password of your choice.



The first time you logon, with the password you receive through the mail from CMS, you will need to go to the line that reads, "Already Registered? If you have already registered for MyMedicare.gov or have received your password in the mail and are logging on for the first time click here to sign-in".

Using your mouse click on the highlighted "click here".

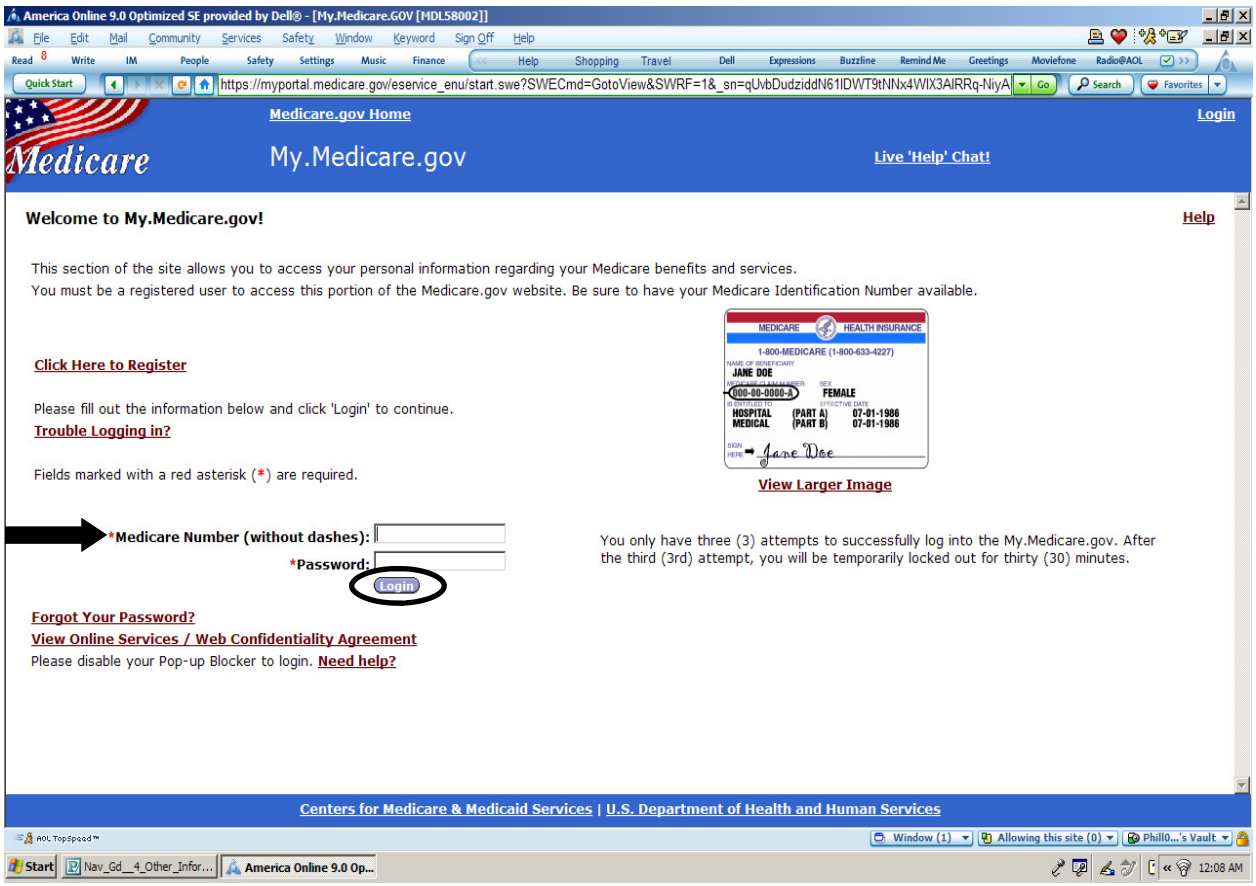


To login you need to type in your **Medicare number without dashes** as it appears on your red, white and blue Medicare card. Be sure to **type in your one-time password exactly** as it appears on your welcome letter.

After you enter your Medicare Number and one-time password make sure you click on the "**login" button only once**. You should see a pop-up window informing you that your request is being processed. You will have three chances to login successfully, after the third attempt you will be temporally locked out for 30 minutes.

Once you have successfully logged in you will be asked to change your password. Your password must follow CMS guidelines:

- Be at least 6 characters in length, but no longer than 8 characters,
- Be a mixture of letters and numbers, but **must begin and end with a letter**, and
- Be different from the previous six passwords.



My.Medicare.gov Dashboard Reference Guide

Click here for technical assistance

Click for help here

A B C D E F G H

America Online 9.0 Optimized SE provided by Dell® - [My.Medicare.GOV [MDL58002]]

https://myportal.medicare.gov/eservice_enu/start.swe?SWECmd=Login&SWEPL=1&SWETS=

Medicare My.Medicare.gov

Logout

Live 'Help' Chat!

6

Home | My Claims | My Drugs | My Enrollment | My Preventive Services | My Messages | My Profile | My Links

Search Medicare.gov Go

Help

1

Welcome [redacted]
Today is Thursday, September 21, 2006.

To change the text size, click on an "A".

To change the appearance of this page, click on the arrows to the right.

Page Layout
Text Size A A A
Change Page Layout

7

2

You have 0 new message(s).
To view all of your message(s), please click here.

You are currently eligible for 5 preventive services.
To view more details, please click here.

8

September is 'Prostate Cancer Awareness' Month!
Click here for more information.

9

3

Your 5 Most Recent Claims History

Please click the 'My Claims' tab to do a broader search for Part A claims (Hospital Inpatient, Hospital Outpatient, Home Health, Hospice), Part B claims or DMERC claims.

Claim Number	Provider Name	Service Start Date	Service End Date	Amount Charged	Medicare Approved	Provider Paid	You May be Billed	Claim Type
1106256094800	HWANG JAMES K	9/8/2006	9/8/2006	$2,313.00	$285.96	$231.54	$54.42	PartB
1106256098370	HWANG JAMES K	9/8/2006	9/8/2006	$60.00	$14.55	$14.55	$0.00	PartB
1106250650680	HWANG JAMES K	8/11/2006	8/11/2006	$173.00	$100.88	$80.71	$20.17	PartB
1106228469870	HWANG JAMES K	8/11/2006	8/11/2006	$555.00	$92.87	$74.29	Click on Claim Number for details	PartB
1106206177010	HWANG JAMES K	7/14/2006	7/14/2006	$2,313.00	$285.96	$231.54	$9.92	PartB

Click on any of the claim numbers above to see additional details on that specific claim

4

My Part B Deductible Status

This table shows your Outpatient (Part B) Deductible. The dollar amount shown in the "Deductible Remaining" column is what you have left to pay for your Outpatient (Part B) Deductible for the year listed.

Note: Your current year's deductible is still effective even if not shown in this table. The dollar amount for the current year's deductible will be displayed after a claim has been processed.

Deductible Year	Deductible Amount	Deductible Remaining	Deductible Amount Met
2006	124.00	0.00	124.00
2005	110.00	0.00	110.00

5

My Eligibility Information

Date of Birth	Part A Effective Date	Part B Effective Date
02/29/1944	9/1/2001	9/1/2001

Centers for Medicare & Medicaid Services | U.S. Department of Health and Human Services

The Home screen displays:

1. A personalized greeting with your name, day, and date.

2. A message notification alerting you to the number of messages in your Inbox sent to you by CMS. A link is also provided which will take you to the "my Messages" tab where you can view your Inbox.

3. Your 5 most recent claims.

4. Your Part B deductible status.

5. Your Medicare eligibility.

6. A search box in order for you to search for Medicare related information on Medicare.gov.

7. A Page Layout table where you can change the font size of the text on My.Medicare.gov or the order of the information shown on the Home Page.

8. A Preventive Services notification alerting you to the number of preventive services which you are currently eligible to receive. A link is also provided which will take you to the "My Preventive Services" tab.

9. Monthly health observance announcements with link to Medicare.gov where you can obtain more information regarding the health observance. **NOTE**: Some months may not have an associated announcement.

The Tabs on the Home screen:

A. The "Home" view displays the information listed on the left (Items 1 through 9).

B. Select the "My Claims" tab to do a broader search for Part A, Part B and DMERC (Durable Medical Equipment Regional Carriers) claims which have been received, processed and finalized by Medicare.

C. Select the "My Drugs" tab to view or modify your drug list and pharmacy information.

D. Select the "My Enrollment" tab to display your Medicare enrollment information.

E. Select the "My Preventive Services" tab to obtain information about your Medicare covered preventive services.

F. Select the "My Messages" tab to view messages sent to your by CMS.

G. Select the "My Profile" tab to view the address SSA has on file for you, update your email address, change your password or request a replacement Medicare card.

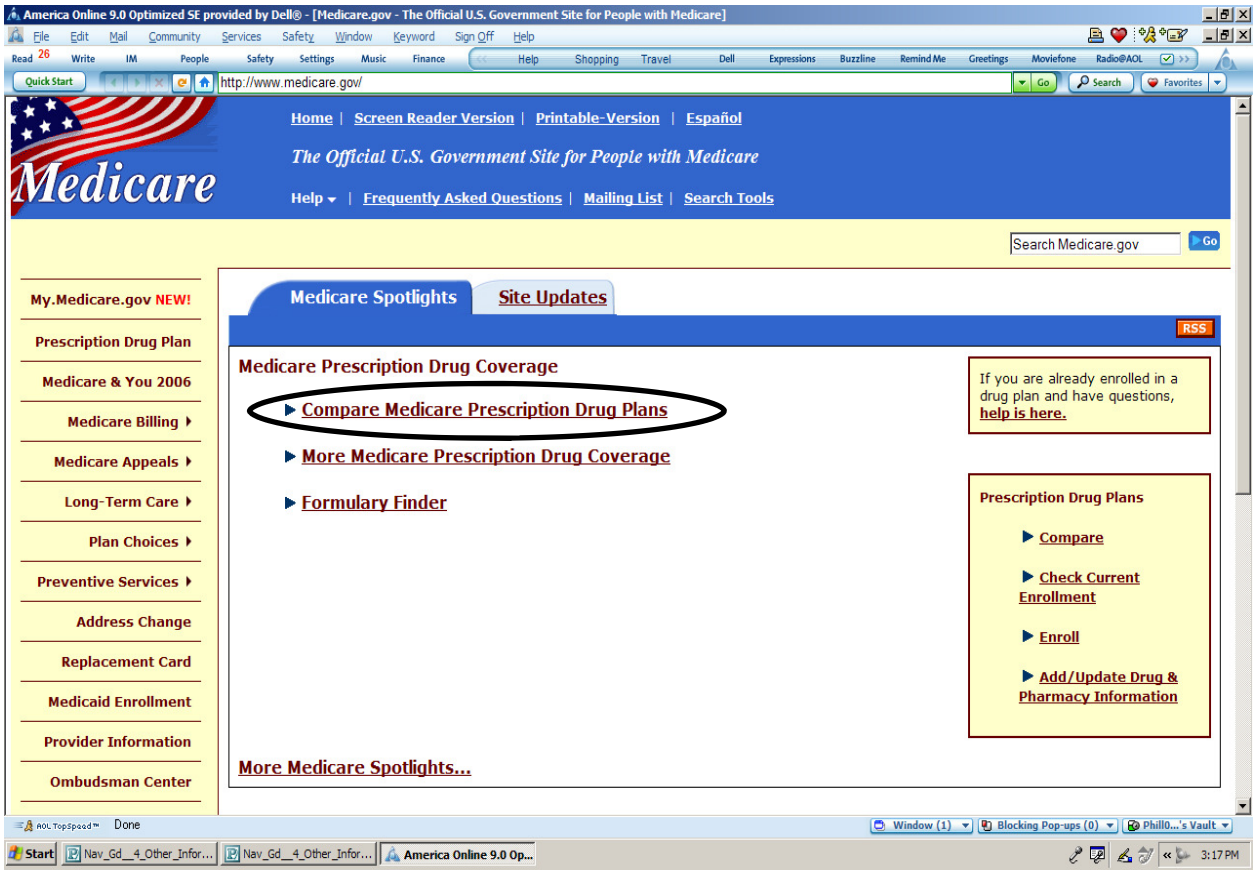
H. Select the "My Links" tab to obtain additional information, such as how to file a claim or an appeal.

Finding a Medicare Prescription Drug Plan

The Medicare website is an important tool in choosing a drug plan. The Medicare website is found at:

www.medicare.gov

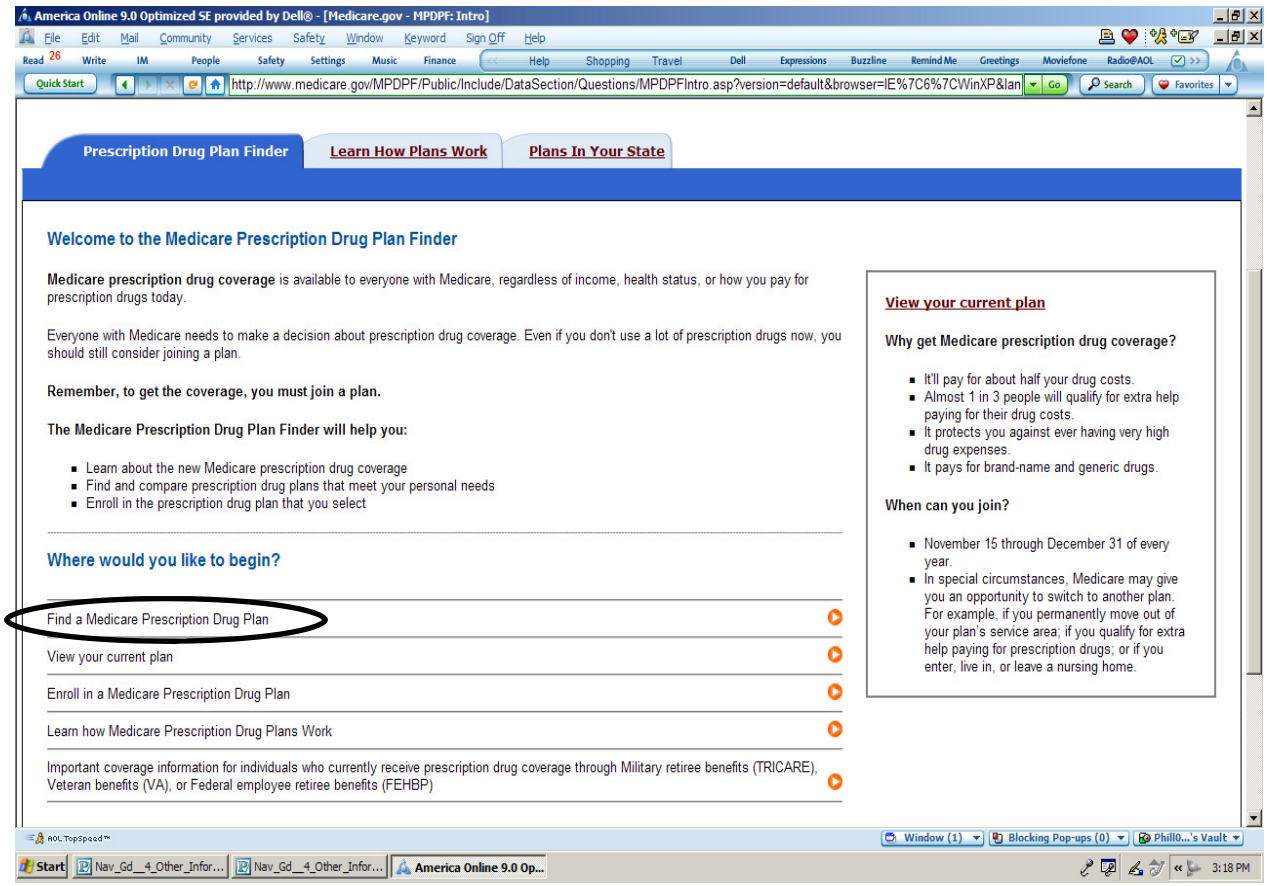
To access the plan finder tool go to the line that reads, “Compare Medicare Prescription Drug Plans”. Using your mouse click on this line.



To compare drug plans go to the line that reads, “Find a Medicare Prescription Drug Plan”. Using your mouse, click on the line. This will take you to the plan search page.

This page will also allow you to do the following:

- View your current plan
- Enroll in a Medicare Prescription Drug Plan
- Learn how the Medicare Prescription Drug Plans work
- View important coverage information for individual who currently receive prescription drug coverage through Military retiree benefits (TRICARE), Veteran benefits (VA) or Federal employee retiree benefits (FEHEP).

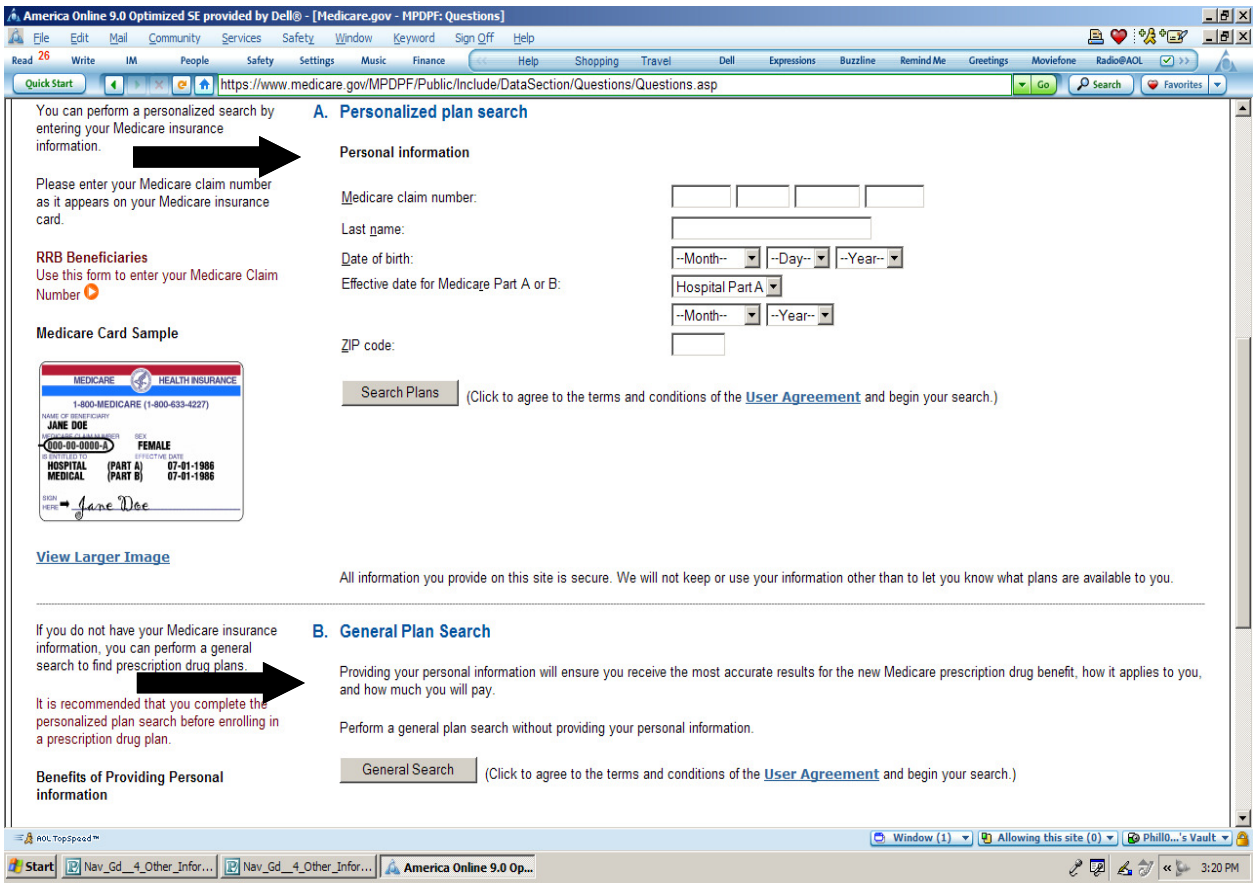


On this page you can choose to do a personalized or general search.

In a personalized search you will type the following information:

- Your Medicare claim number
- Your last name
- Your date of birth
- The effective date for your Medicare coverage
- Your zip code.

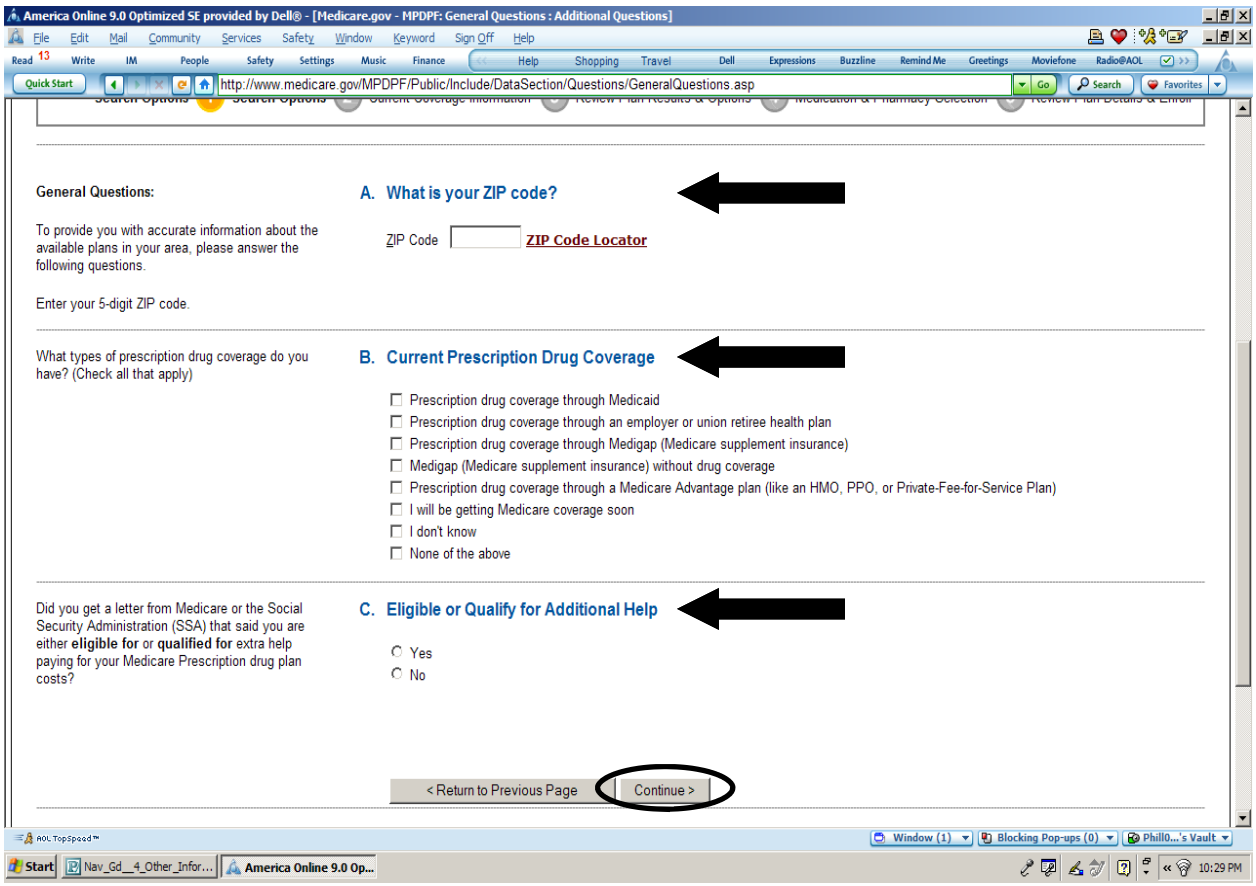
A general search will take you to the next page.



On this page you will need to type the following information:

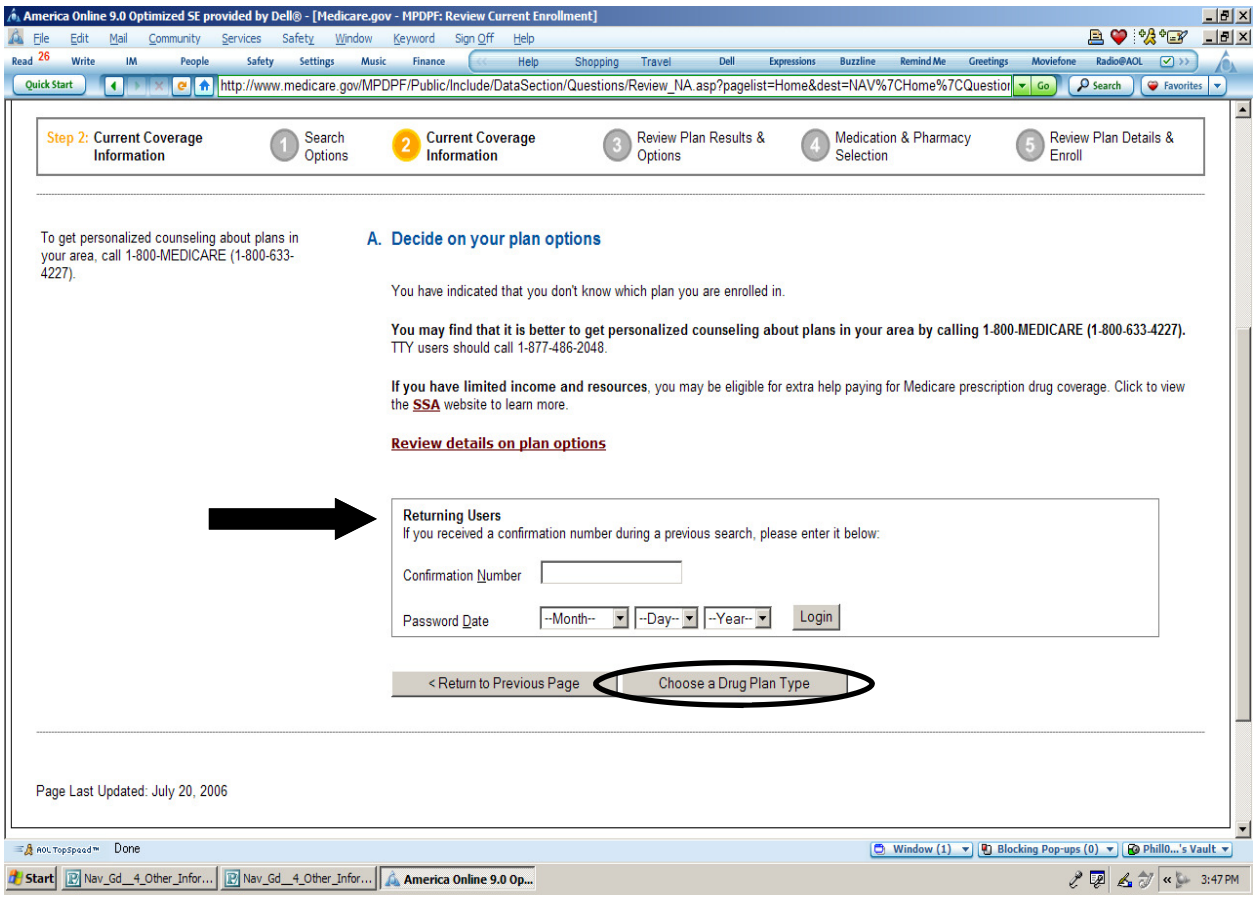
- Section A - your zip code
- Section B - your current prescription drug coverage
- Section C - your eligibility for additional Help (Extra Help through Social Security).

Click the “Continue” button, to go to the next page where you will input your county of residence, and click “Continue” button.



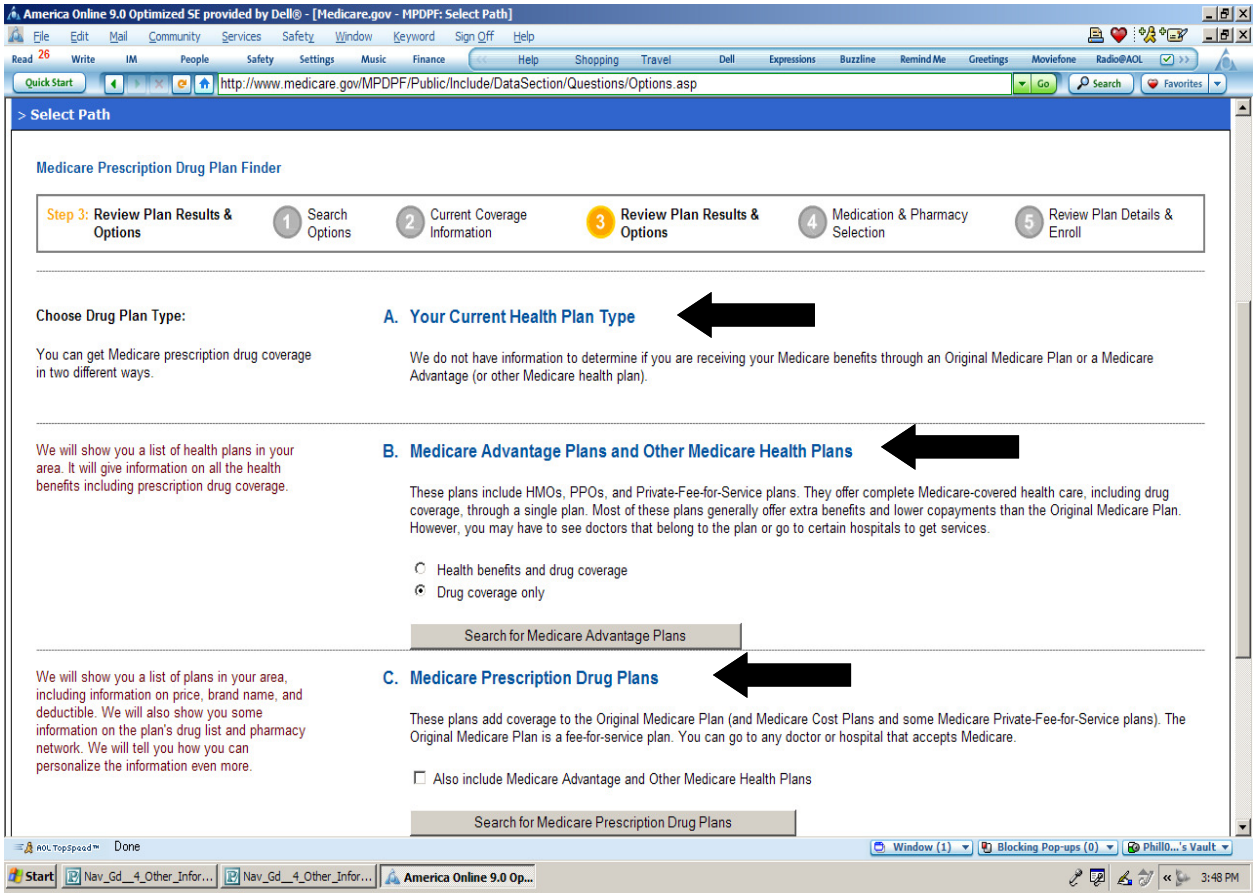
First time users will need to go to the “Choose a Drug Plan Type” button and click.

Note for returning users: When you input information you will be given a confirmation number. When you return to the plan finder you may use this to keep from having to re-enter your medications. See page Q - X for password information.



This page allows you to choose to search for drug plans only and/or to search for Medicare Advantage plans.

- Choice A you will find information on you current health plan type, if known.
- Choice B you will be able to search for advantage plans or drug plans only.
- Choice C you can choose to include drug plans offered through advantage health plans in your search for a drug plan.

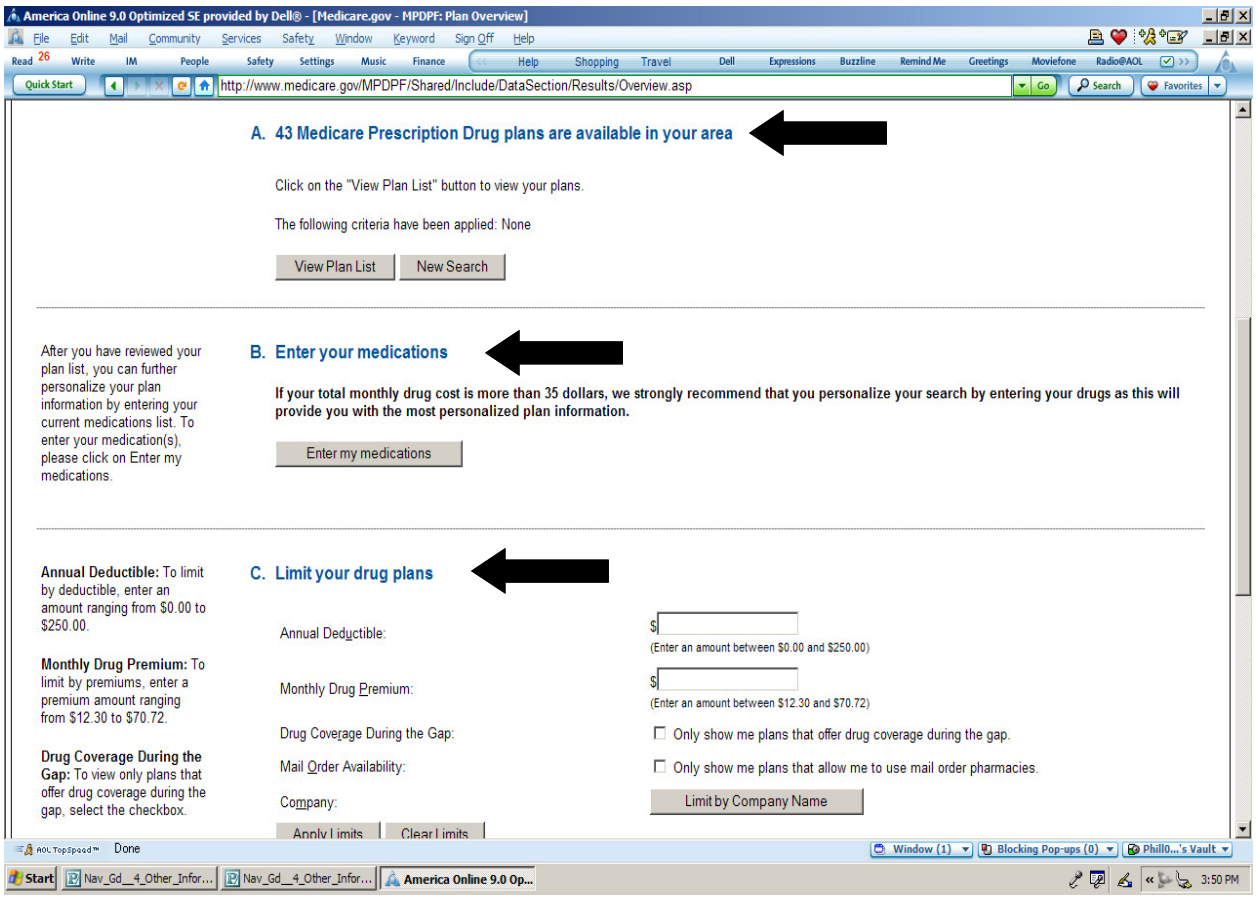


This page gives you the following options:

- Choice A - allows you to view a list of the drug plans,

- Choice B - go to the page where you can enter your medications, or

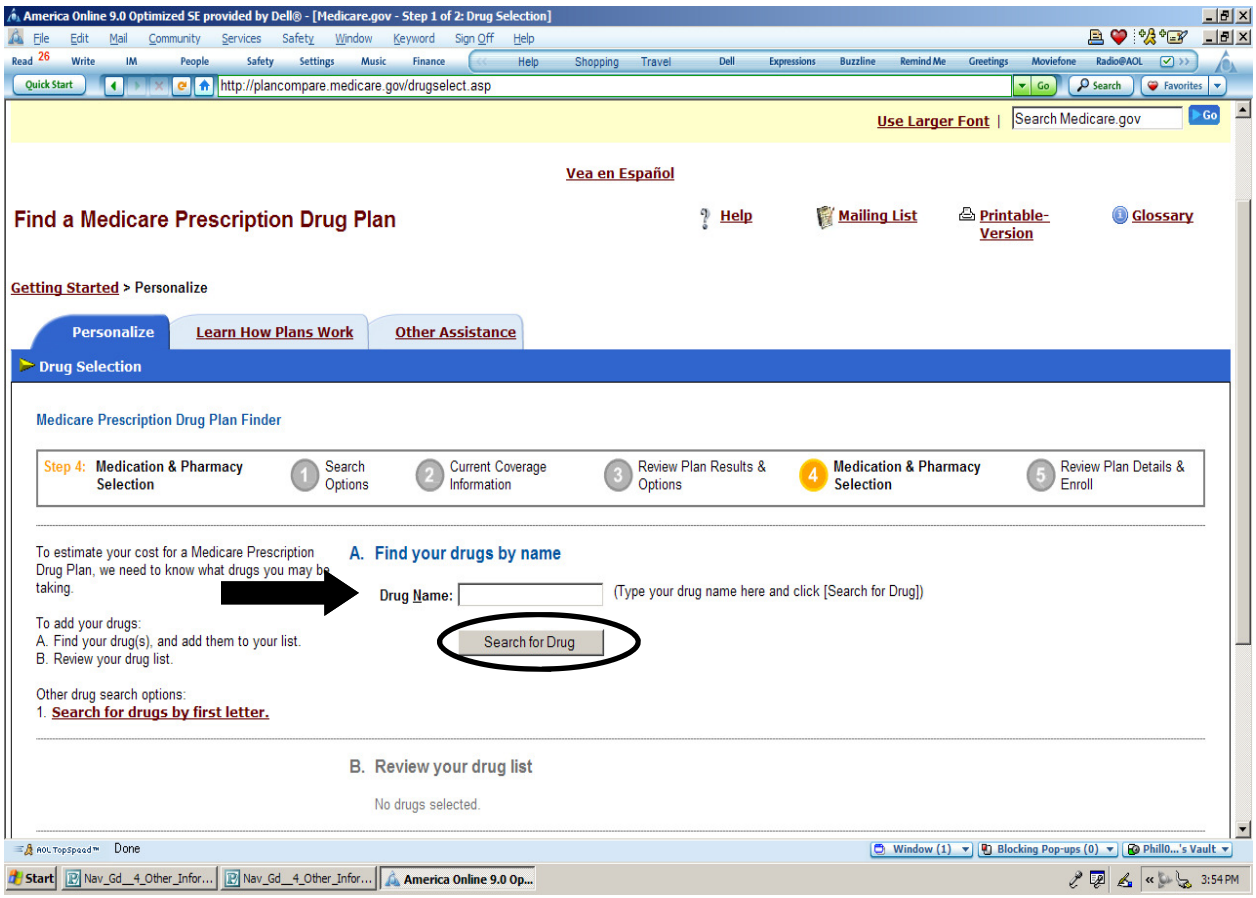
- Choice C - narrow your search by setting certain limits These limits include:
  - Deductible limit
  - Premium limit
  - Only show the plans that offer coverage during the benefit gap
  - Only show the plans that offer mail order



In order to determine the best drug plan for you, you will need to see if your current medications are included in the drug plan's formulary (list of approved drugs).

To find your medication by name, you need to input the name of your medication. You may type the full name, or just the first few letters of the name. You will then need to click the " Search for Drug".

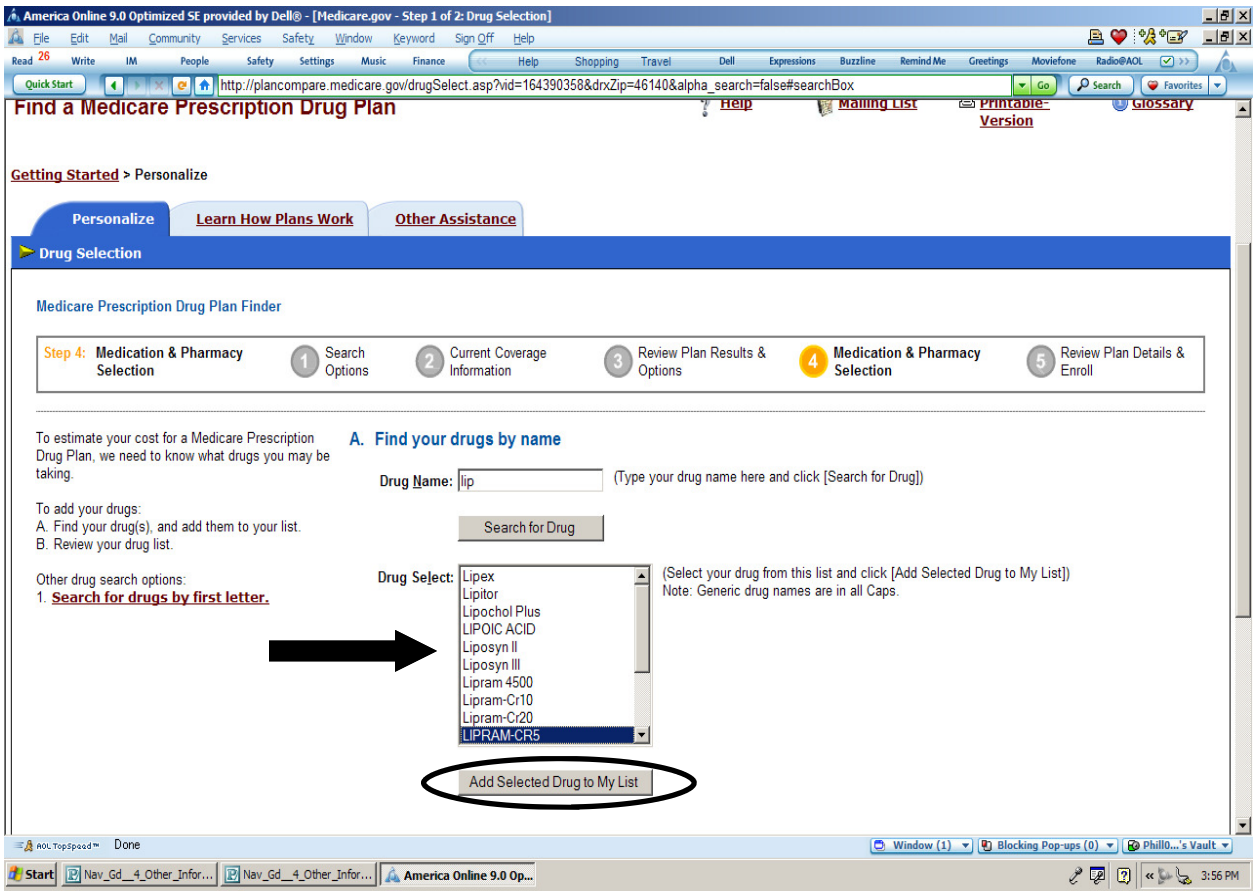
Note: if you are currently taking a generic you will need to enter the name of the generic, rather than the brand name.



Once you click the “Search for Drug” button from the previous page, a menu will drop down allowing you to choose the specific drug.

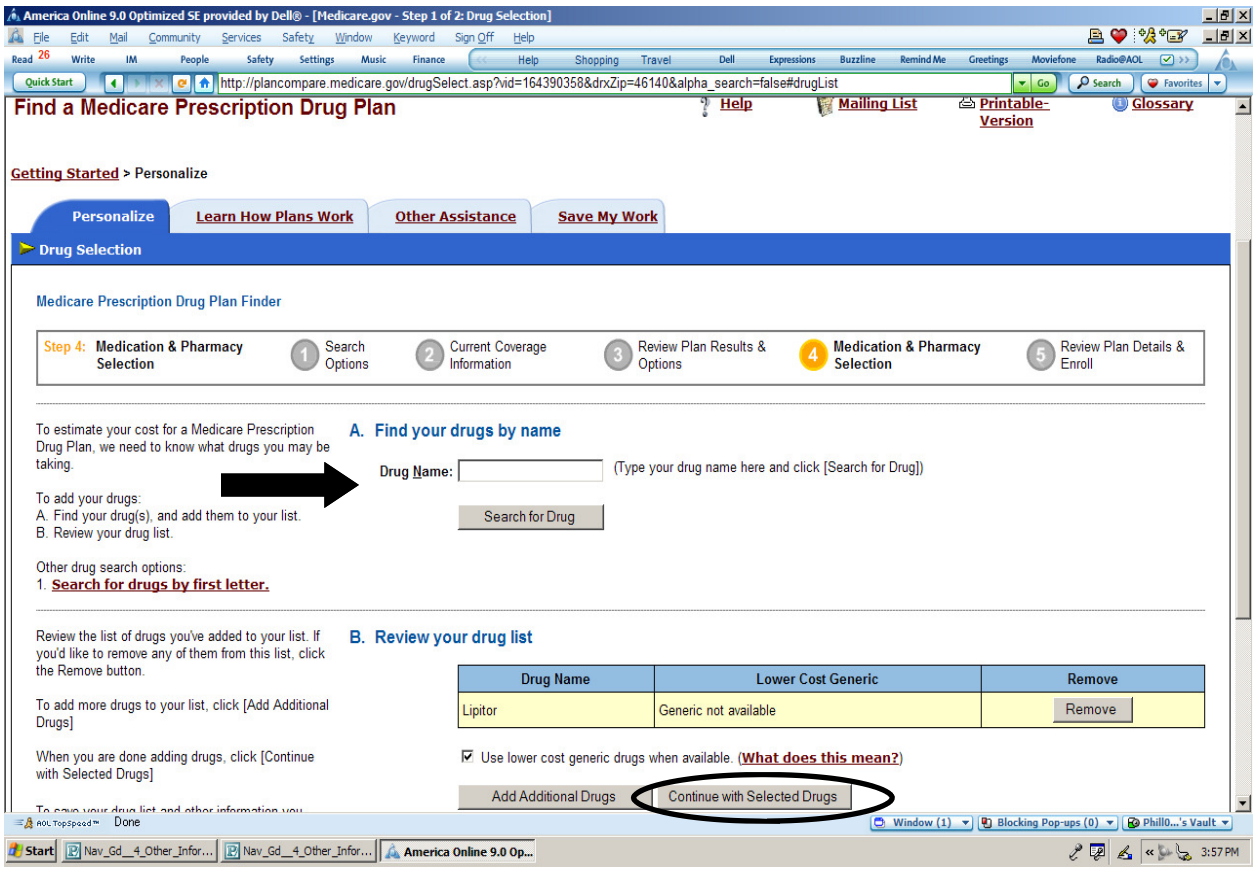
You will need to use your mouse to click on the correct drug to highlight the name. You will then need to click on the “Add Selected Drug to My List” button.

You can enter additional drugs by clicking the “Add Additional Drugs” button.



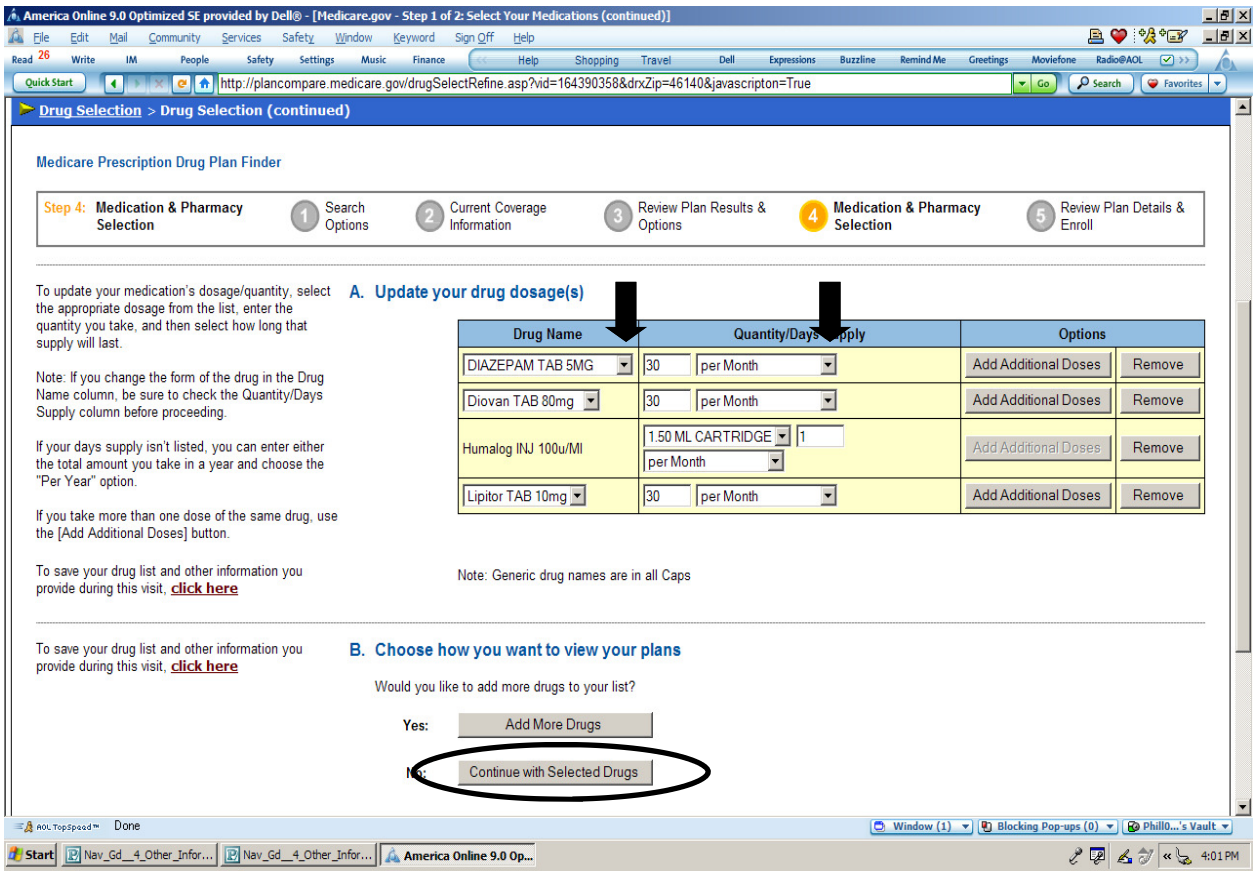
You will repeat the process for entering medications until all of your drugs are listed.

Once all your medication is entered you will need to click “Continue with Selected Drugs” button.



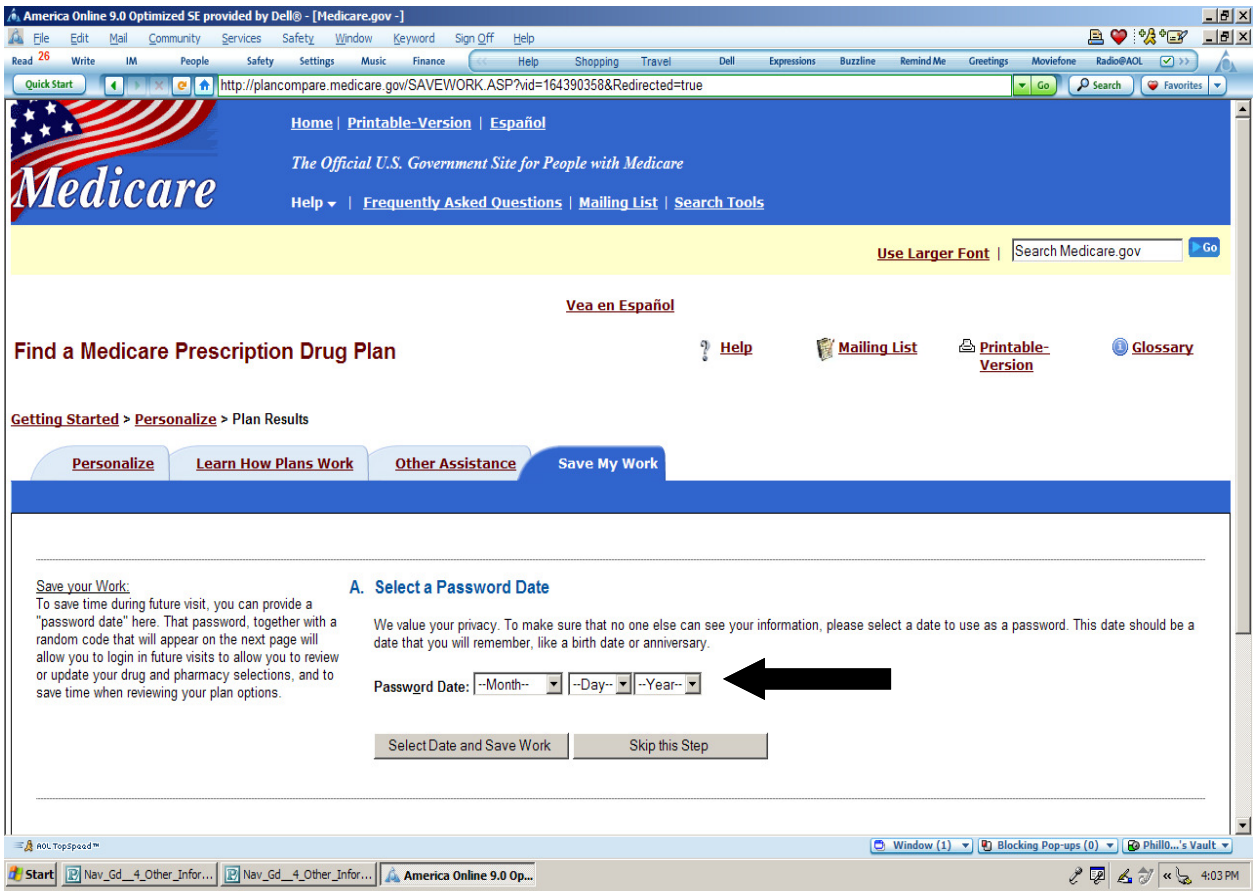
This page allows you to enter the dosage and quantity amounts. This page defaults to the most common prescribed amounts. You can change the dosage amounts by clicking the little arrows following the drug name.

You are also able input additional drugs at this stage. Once all information has been updated you can continue by clicking “Continue with Selected Drugs”.



At this point you may save the information you have input by selecting a password date. **This date can be any date,** not just the current date. You will then be send to another page with a random code. This will allow you to return and complete the drug finder or review the information. This step is optional and not required to continue.

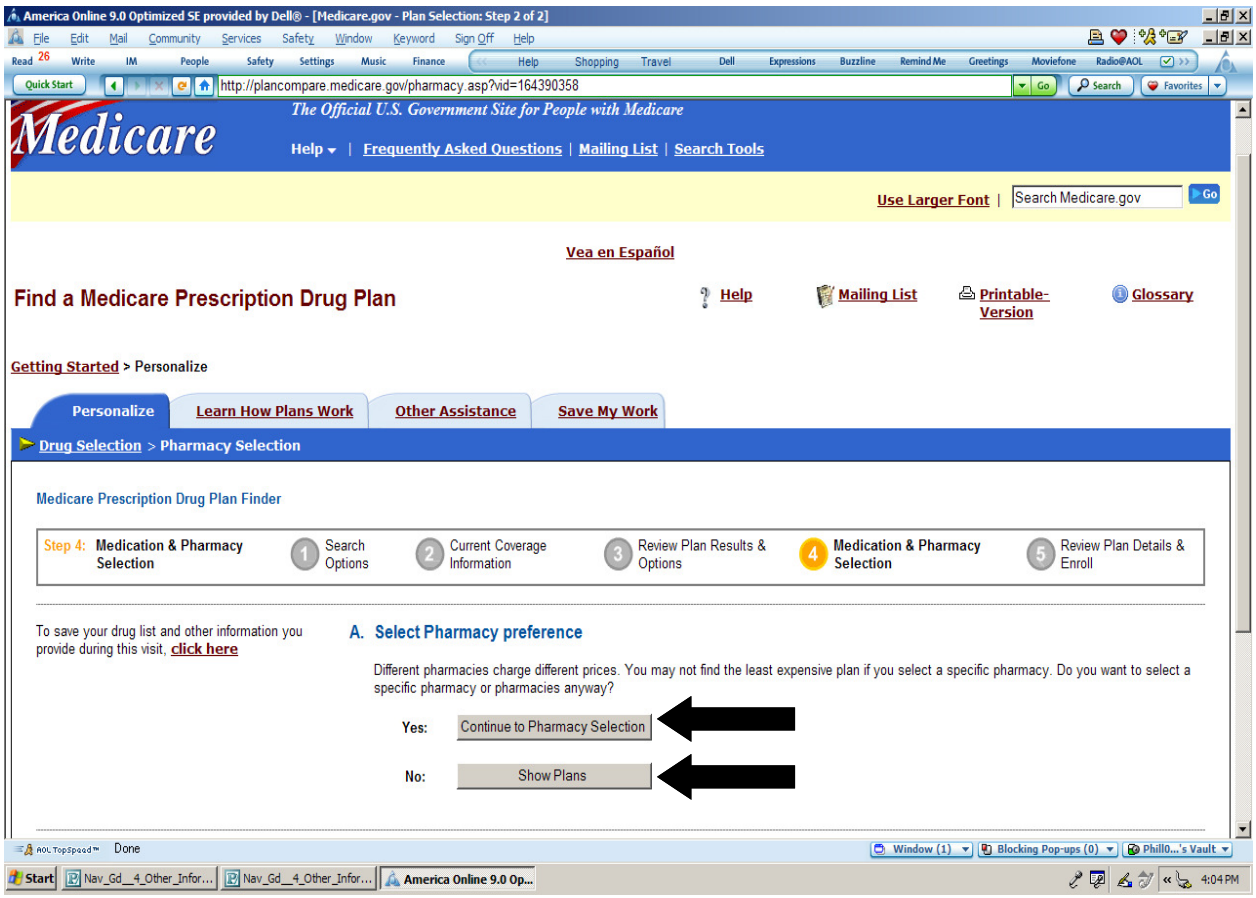
This is the password that is referred to on page Q - X.



This page allows you to select a specific pharmacy, or to continue to the plan compare.

To select a pharmacy click on “Continue to Pharmacy Selection”.

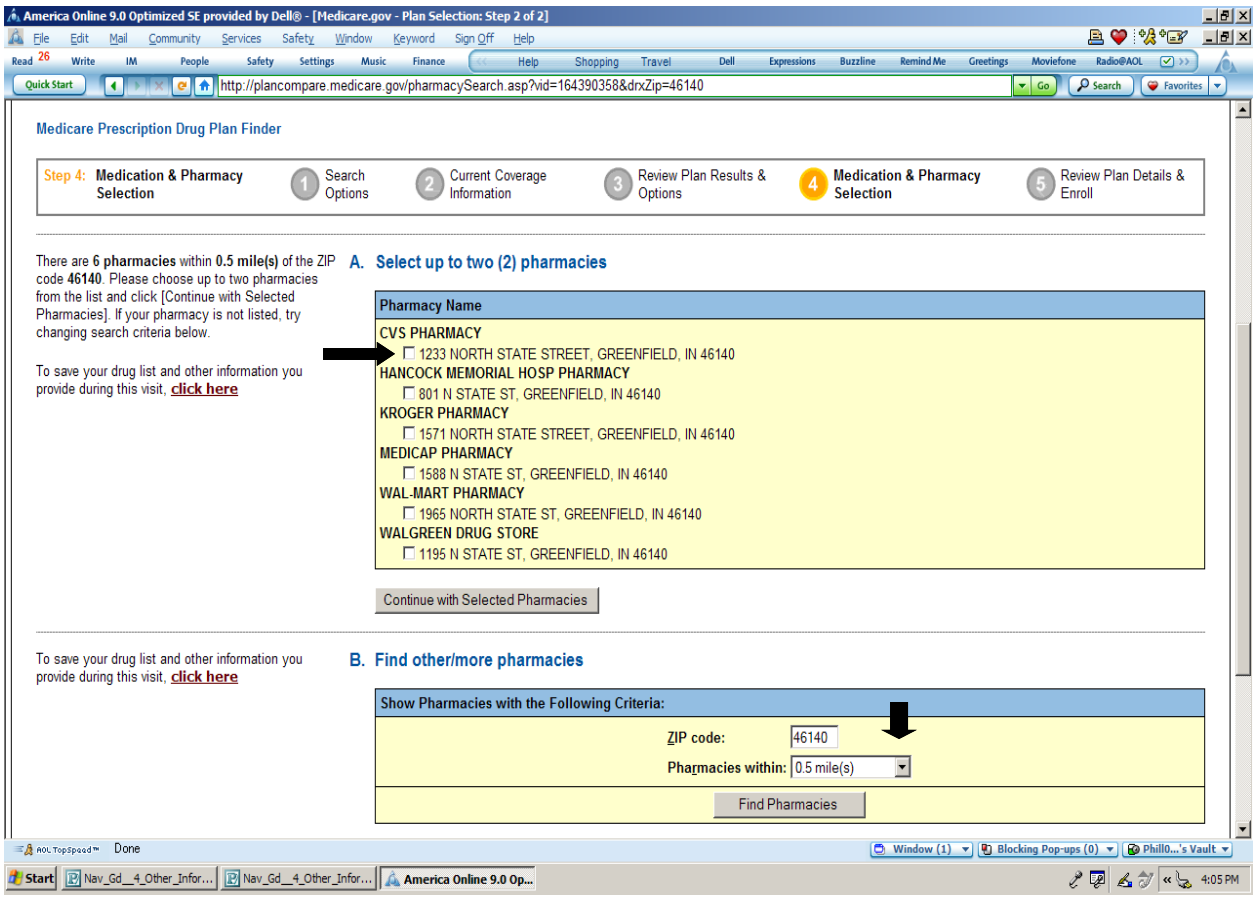
To view the plans click on “Show Plans”.



To select a pharmacy you will need to click on the small white box next to the address in choice A. You may select up to two pharmacies. The pharmacies within 0.5 miles of your zip code will be listed in choice A.

To increase the search are for pharmacies, you can click on the small arrow in choice B.

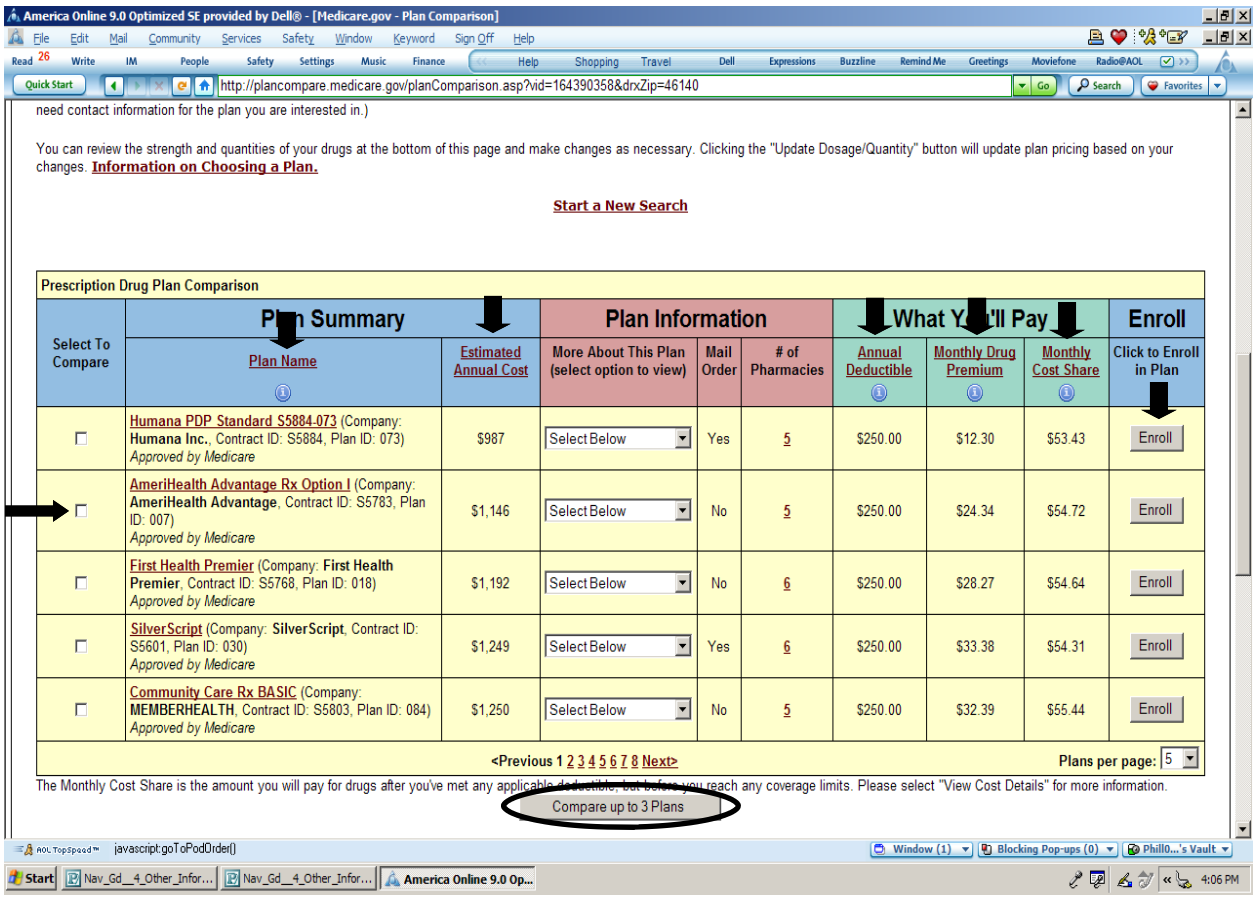
Note: **By selecting specific pharmacies you may not find the least expensive plan**. You will be limiting yourself to the prices negotiated between the drug plans and the pharmacies your have selected.



This page offers several options. You can compare plan details by clicking the small white boxes to the left of the plan name and clicking “Compare up to 3 Plans”. You can enroll in an plan by clicking of the “Enroll” button. You can sort plans by any of the following categories:

- Plan Name
- Estimated Annual Cost
- Annual Deductible
- Monthly Drug Premium
- Monthly Cost Share (amount you’ll pay for the co-pay or co-insurance).

You can sort by any of these categories by clicking on the column title.



This page gives you a side by side comparison of up to three plans. As you scroll down the page, you will be able to compare the plans in each of the phases of drug plan coverage:

- Phase 1 - the deductible or the first $250 in total drug cost);
- Phase 2 - partial coverage (the next $2,000 in total drug cost);
- Phase 3 - benefit gap (the next $2,850 in total drug cost); and
- Phase 4 - catastrophic coverage.

"View Important Notes" and "View Drug Details" will give you important information that should be considered in choosing a plan. See next page.

Step 5: Review Plan Details & Enroll | 1 Search Options | 2 Current Coverage Information | 3 Review Plan Results & Options | 4 Medication & Pharmacy Selection | 5 Review Plan Details & Enroll

Compare Plans

Click the **View Important Notes** button to view additional information on the selected plan. To enroll in a plan, click the **Enroll** button for the selected plan.

Plan Information			
Plan Information	**AmeriHealth Advantage Rx Option I** (Company: **AmeriHealth Advantage**, Contract ID: S5783, Plan ID: 007) *Approved by Medicare* P.O. Box 41514 Philadelphia, PA 19101 Non-Members: (866) 456-1694 (866) 456-1683(TTY/TDD) Members: (888) 457-3007 (888) 457-3002(TTY/TDD) View Important Notes View Drug Details	**First Health Premier** (Company: **First Health Premier**, Contract ID: S5768, Plan ID: 018) *Approved by Medicare* 2222 Ewing Road Moon Township, PA 15108 Non-Members: (800) 588-3322 (800) 508-9548(TTY/TDD) Members: (866) 865-0662 (866) 236-1069(TTY/TDD) View Important Notes View Drug Details	**Humana PDP Standard S5884-073** (Company: **Humana Inc.**, Contract ID: S5884, Plan ID: 073) *Approved by Medicare* 500 West Main Street Louisville, KY 40202 Non-Members: (800) 706-0872 (877) 833-4486(TTY/TDD) Members: (800) 281-6918 (800) 833-3301(TTY/TDD) View Important Notes View Drug Details
Your Total Annual Drug Plan Cost	$1,146	$1,192	$987
Fixed Cost Details:			
Monthly Prescription Drug Premium	$24.34/month	$28.27/month	$12.30/month
Deductible	$250.00	$250.00	$250.00
Your Monthly Drug Costs after you have met your deductible but before your total drug costs reach the Initial Coverage Limit			
DIAZEPAM TAB 5MG	$19.01	$18.66	$18.26

"View Drug Details" will provide the following details on each medication:

- Price tier - where the drug falls price-wise on the formulary.
- Drug cost - the current price the drug is available with the drug plan.
- Prior authorization - if yes, while the drug is on the plan's formulary, the plan must give prior approval before the drug will be covered under to plan.
- Quantity limits - if yes, the places certain limits on the amount of the drug will cover for a 30 day supply. This is usually for safety reasons.
- Step therapy - the requirement of the use of lower cost drugs, before the plan will cover a more expensive drug.

America Online 9.0 Optimized SE provided by Dell® - [Drug Details]

http://plancompare.medicare.gov/planDrugInformation.asp?Plan=2453&vid=164390358&drxzip=46140&subsidyId=4&subsidyPercent=0&plan

Drug Details

Please review the following important information about your selected drugs in this plan.

First Health Premier (Company: **First Health Premier**, Contract ID: S5768, Plan ID: 018)
Approved by Medicare
2222 Ewing Road
Moon Township, PA 15108
Phone: (800) 588-3322

Detailed Drug Information

Drug Name	Tier	Full Cost of Drug	Restrictions		
			Prior Authorization	Quantity Limits	Step Therapy
DIAZEPAM TAB 5MG	NOT ON FORMULARY [2, 4]	$18.66	No	No	No
Diovan TAB 80mg	Tier 3 [1]	$52.92	Yes	Yes	No
Humalog INJ 100u/MI	Tier 3 [1]	$15.58	Yes	No	No
Lipitor TAB 10mg	Tier 3 [1]	$75.43	Yes	Yes	No

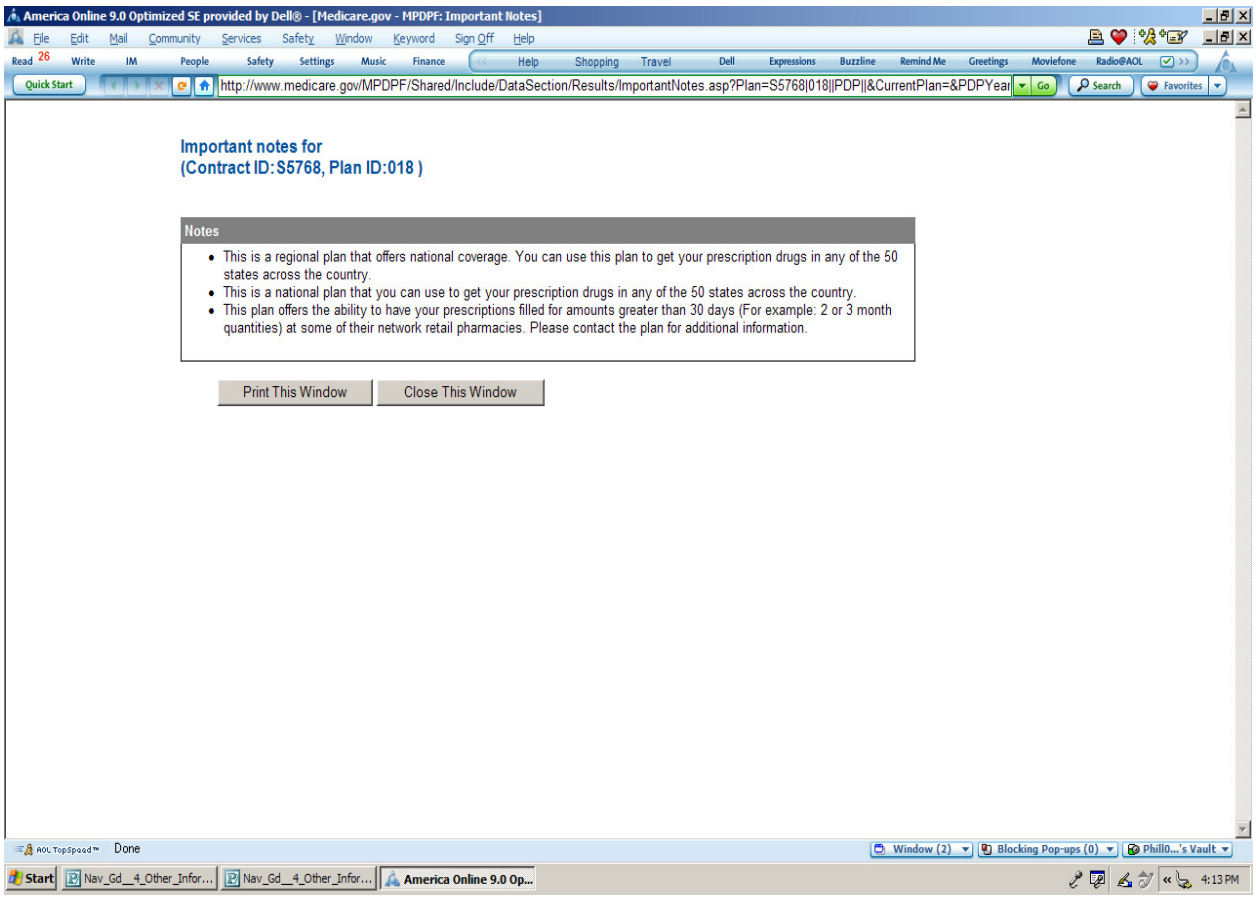
Cost Sharing Information

Drug Name	Tier	Deductible (The amount you will pay before your $250 deductible is met.)	Initial Coverage Level (The amount you will pay after you've met your deductible, but before your total drug costs reach $2,250.)	Gap (The amount you will pay after you reach $2,250 in full drug costs, but before you reach $3,600 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $3,600 in out of pocket costs.)
DIAZEPAM TAB 5MG	NOT ON FORMULARY [2, 4]	$18.66	$18.66	$18.66	$18.66
Diovan TAB 80mg	Tier 3 [1]	$52.92	$13.23	$52.92	$5.00
Humalog INJ 100u/MI	Tier 3 [1]	$15.58	$3.89	$15.58	$5.00
Lipitor TAB 10mg	Tier 3 [1]	$75.43	$18.86	$75.43	$5.00

[1] This drug may be subject to prior authorization, step therapy or quantity limits. Please contact the plan for more information.
[2] By law, this drug is excluded from being covered under the Medicare program. Certain plans may cover this as a supplemental benefit to their plan. For more information about the Medicare law and coverage of drugs, click here.

"View Important Notes" will give you details such as:

- Is the plan a regional, or national plan?
- If this is a regional plan, does it offer national coverage?
- Does the plan have network pharmacies?
- Is there an additional cost for going to out of network pharmacies?



Returning to the side by side compare, by scrolling to the bottom of the page you will find the option to enroll in the plan of your choice.

You may also return to the plan list and do a side by side comparison of three additional plans.

America Online 9.0 Optimized SE provided by Dell® - [Medicare.gov - Compare Plans]

http://plancompare.medicare.gov/planComparisonDetail.asp?vid=164390358&drxZip=46140

Deductible	$250.00	$250.00	$250.00
Your Monthly Drug Costs after you have met your deductible but before your total drug costs reach the Initial Coverage Limit			
DIAZEPAM TAB 5MG	$19.01	$18.66	$18.26
Diovan TAB 80mg	$13.29	$13.23	$12.93
Humalog INJ 100u/MI	$3.49	$3.89	$3.81
Lipitor TAB 10mg	$18.92	$18.86	$18.42
Total Monthly Cost (Hide Details)	$54.71	$54.64	$53.42
Pharmacy Network:			
Pharmacy Network:	5 network pharmacies in your ZIP code 5 preferred.	6 network pharmacies in your ZIP code 6 preferred.	5 network pharmacies in your ZIP code 5 preferred.
Mail Order:			
Mail Order:	No	No	Yes
Drug Information			
DIAZEPAM TAB 5MG	NOT ON FORMULARY [2, 4]	NOT ON FORMULARY [2, 4]	NOT ON FORMULARY [2, 4]
Diovan TAB 80mg	Tier 1	Tier 3 [1]	Tier 3 [1]
Humalog INJ 100u/MI	Tier 1	Tier 3 [1]	Tier 2
Lipitor TAB 10mg	Tier 1	Tier 3 [1]	Tier 2 [1]
Actions:	Enroll in this Plan	Enroll in this Plan	Enroll in this Plan

[1] This drug may be subject to prior authorization, step therapy or quantity limits. Use the drug detail link to view more information or contact the plan.

[2] By law, this drug is excluded from being covered under the Medicare program. Certain plans may cover this as a supplemental benefit to their plan. For more information about the Medicare law and coverage of drugs, click here.

[4] This drug is not on this plan's formulary. If you purchase this drug, you will pay the full price of the drug, and the amount you pay will not be counted towards your deductible or out of pocket cost limits. The plan may grant an exception and provide coverage under special circumstances, contact the plan for more information.

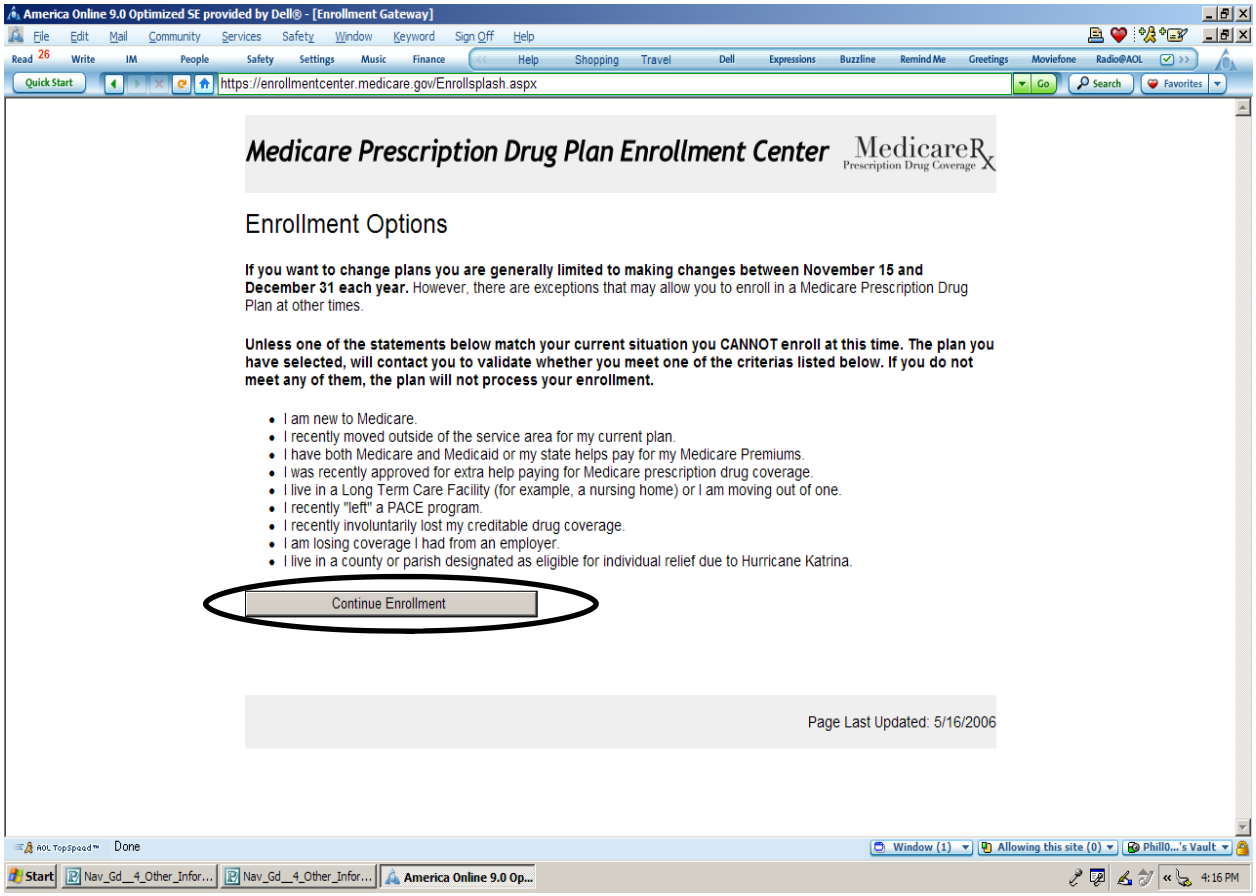
Return to Personalized Plan List

Return to Previous Page

Enrolling in a plan can be done online through Medicare's website, or through the plans website.

You can also enroll by calling 1-800-Medicare (1-800-633-4227).

To enroll you will need information from your Medicare card.



FORMS

SECTION R

CLIENT AGREEMENT FORM

I understand that:

- The Senior Health Information Program (SHIIP) is a state-sponsored, *non-profit* program for Medicare beneficiaries, persons about to be eligible for Medicare, and persons interested in long term care insurance information.

- Counseling services are intended to *help me understand* Medicare, Medicare supplement insurance, long term care insurance, and other health insurance options in an objective manner that supports my independent decisions.

- Counseling services are provided by trained volunteer counselors acting in good faith, to provide information about health insurance policies to me, the client. This information shall not be construe to be legal advice.

- Trained volunteer counselors are neither affiliated with the insurance industry nor financial planners. Counselors do not sell, recommend, or endorse any specific insurance product, agent, insurance company or provider of service.

- Counseling is confidential and free of charge.

- The volunteer *counselor assumes no responsibility* for decisions nor actions taken by me, as a result of counseling.

I, therefore, hold harmless the Senior Health Insurance Information Program, the Indiana Department of Insurance, the Indiana Family and Social Services Administration, the State of Indiana, the Sponsoring Organization, and the volunteer counselor, for any losses, claims, costs, damages, or liability arising out of or in connection with any act or omission of the volunteer counselor, the Sponsoring Organization, the State of Indiana, the Indiana Family and Social Services Administration, the Indiana Department of Insurance, and SHIIP, in connection with this Agreement.

_____ _____

Client's Signature Date

_____ _____

Counselor's Signature Date

POLICY RETURN LETTER

Date: _____

Insurance Company:_____

Address: _____

_____

Re: Your Policy Number: _____

The enclosed policy was received by me on _____.
After examining the policy, I am not satisfied with it and request a full refund in the amount of $_____ that I paid on _____.
(Date)

Respectfully Yours,

_____
Client's Signature

Client's Name: _____

Address: _____

_____

Note to Client: Be sure to enclose your policy, a copy of your receipt or cancelled check, and keep a copy of this letter for your records.

INDIANA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
311 West Washington Street, Suite 300
Indianapolis, Indian 46204-2787
(317) 232-2395 or (800) 622-4461

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address.

COMPLETE BOTH SIDES OF THIS FORM.
TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name: _____

Your Address: _____

_____
City State Zip Code

Daytime Telephone Number: (_____) _____

1. (A) Type of Insurance (Please Check One) :

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life

☐ Health ☐ Medicare Supplement ☐ Business ☐ Other

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy (A through L) _____

2. My complaint is against:
Name of Insurance Company _____

3. If an agent is involved, please give the agent's name and address.

Name: _____

Address: _____

4. Policy Number: _____

Claim Number (If known): _____

5. Named Insured: _____

6. If group insurance, please give the name of employer.
Name: _____

7. If a loss or an accident is involved, please give the location and/or date of the loss:
Date: _____/_____/_____

Location: _____ _____
City State Zip Code

8. Briefly describe your problem. If more space is needed, please attach additional sheets.

I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records WILL NOT be public record at any time.

Date: _____/_____/_____ Signature: _____

05/97 IF YOU HAVE ANY QUESTIONS, PLEASE CALL US

SHIP'S Claims Record Form

			Medicare							Medicare Supplement		Balance of Bill		
	Provider of Service (Doctor, hospital, etc)	Date of Service	Assign-ment? Y or N	Actual Charge	Medicare Approved Amount	Limit-ing Charge	Applied to Medicare Deductible	Amount paid by Medicare	Amount of bill leftover	Date bill sent to Med-Sup	Amount paid by Med-Sup	Amount paid upfront to Provider	Balance due to Provider	Date balance paid to Provider
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														

Notes:_____

_____

ACRONYMS & GLOSSARY

SECTIONS

ACRONYMS

AAA	Area Agency on Aging
ADL	Activities of Daily Living
ALJ	Administrative Law Judge
BHA	Bureau of Hearings and Appeals
CHOICE	Community and Home Options to Institutional Care for the Elderly and Disabled.
CMP	Comprehensive Medical Plan
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Reconciliation Act
DFC	Division of Family and Children
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOI	Department of Insurance
DRG	Diagnosis Related Groups
EOB	Explanation of Benefits (Part A)
EOMB	Explanation of Medicare Benefits Form (Part B)
FEHBP	Federal Employee Health Benefit Plan
HCPP	Health Care Prepayment Plan
HHC	Home Health Care

HMO	Health Maintenance Organization
ICHIA	Indiana Comprehensive Health Insurance Association
ILTCP	Indiana Long Term Care Program
LTC	Long Term Care
MA	Medicare Advantage Plan
MA-PD	Medicare Advantage Prescription Drug Plan
MEDIGAP	Medicare Supplement Insurance
MEDPARD	Medicare Participating Physicians and Suppliers Directory
NAIC	National Association of Insurance Commissioners
NH	Nursing Home
OBRA	Omnibus Budget Reconciliation Act
PAS	Preadmission Screening
PDP	Prescription Drug Plan
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary Program
RWJ	Robert Wood Johnson Foundation (ILTCIP
SAG	Self-Assessment Guide to Long Term Care Insurance
SHIP	State Health Insurance Assistance Program

SLMB	Specified Low-Income Medicare Beneficiary Program
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TrOOP	True Out of Pocket
UCR	Usual, Customary, and Reasonable Charges
VA	Veterans' Affairs or Veterans' Administration

GLOSSARY

Term	Definition
A "TIER"	Is a specific list of drugs. Your plan may have several tiers, and your co-payment amount depends on which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.
ABUSE	A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report
ACCESS	Your ability to get needed medical care and services.
ACCESSIBILITY OF SERVICES	Your ability to get medical care and services when you need them.
ACCESSORY DWELLING UNIT (ADU)	A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.
ACCREDITATION	An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.
ACT/LAW/STATUTE	Term for legislation that passed through Congress and was signed by the President or passed over his veto.

ACTIVITIES OF DAILY LIVING (ADL)	Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.
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. (See Approved Amount; Assignment.)
ADDITIONAL BENEFITS	Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare covered services. Additional benefits are specified by the MA Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, co-payments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.
ADMINISTRATIVE LAW JUDGE (ALJ)	A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.
ADMISSION DATE	The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
ADMITTING DIAGNOSIS CODE	Code indicating patient's diagnosis at admission.

ADMITTING PHYSICIAN	The doctor responsible for admitting a patient to a hospital or other inpatient health facility.
ADULT LIVING CARE FACILITY	To be used when billing services rendered at a residential care facility that houses beneficiaries who cannot live alone but who do not need around-the-clock skilled medical services. The facility services do not include a medical component (Program Memo B-98-28).
ADVANCE BENEFICIARY NOTICE (ABN)	A notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment. If you do not get an ABN before you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABN's only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.
ADVANCE COVERAGE DECISION	A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.
ADVANCE DIRECTIVE (HEALTH CARE)	Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.
ADVOCATE	A person who gives you support or protects your rights.
AFFILIATED PROVIDER	A health care provider or facility that is paid by a health plan to give service to plan members.

AMBULANCE (AIR OR WATER)	An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
AMBULANCE (LAND)	A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
AMBULATORY CARE	All types of health services that do not require an overnight hospital stay.
AMBULATORY SURGICAL CENTER	A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.
ANCILLARY SERVICES	Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.
ANESTHESIA	Drugs that a person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.
APPEAL	An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

APPEAL PROCESS	The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)
APPROVED AMOUNT	The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."
AREA AGENCY ON AGING (AAA)	State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.
ASSESSMENT	The gathering of information to rate or evaluate your health and needs, such as in a nursing home.
ASSETS	Treasury notes and bonds guaranteed by the federal government, and cash held by the trust funds for investment purposes.
ASSIGNED CLAIM	A claim submitted for a service or supply by a provider who accepts Medicare assignment.

ASSIGNMENT	In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.
ASSISTED LIVING	A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they get.
ATTENDING PHYSICIAN	Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient's medical care and treatment.
AUTHORITATIVE APPROVAL	Method or type of approval that requires a determination that the service is likely to have a diagnostic or therapeutic benefit for patients for whom it is intended.
AUTHORITATIVE EVIDENCE	Written medical or scientific conclusions demonstrating the medical effectiveness of a service produced by the following: Controlled clinical trials, published in peer-reviewed medical or scientific journals; Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals; Assessments initiated by CMS; Evaluations or studies initiated by Medicare contractors; Case studies published in peer-reviewed medical or scientific journals that present treatment protocols.

AUTHORIZATION	MA approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MA whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)
AUTOMATED CLAIM REVIEW	Claim review and determination made using system logic (edits). Automated claim reviews never require the intervention of a human to make a claim determination.
BALANCE BILLING	A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.
BASIC BENEFITS	Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.
BASIC BENEFITS (MEDIGAP POLICY)	Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies. (See Medigap Policy.)
BENEFICIARY	The name for a person who has health care insurance through the Medicare or Medicaid program.
BENEFIT PERIOD	The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

BENEFITS	The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.
BENEFITS DESCRIPTION (PLAN)	The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.
BIOLOGICALS	Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.
BOARD AND CARE HOME	A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.
BOARD-CERTIFIED	This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.
CAPITATION	A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.
CAPPED RENTAL ITEM	Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than $150, and the supplier rents it to people with Medicare more than 25 percent of the time.
CARE PLAN	A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well being.
CAREGIVER	A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

CARRIER	A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Medicare Part B.)
CASE MANAGEMENT	A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.
CASE MANAGER	A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.
CATASTROPHIC ILLNESS	A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.
CATASTROPHIC LIMIT	The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.
CENTERS FOR DISEASE CONTROL AND PREVENTION	An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)	The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
CERTIFICATE OF MEDICAL NECESSITY	A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

CERTIFIED (CERTIFICATION)	This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.
CERTIFIED NURSING ASSISTANT (CNA)	CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom.
CIVILIAN HEALTH AND MEDICAL PROGRAM (CHAMPUS)	Run by the Department of Defense, in the past CHAMPUS gave medical care to active duty members of the military, military retirees, and their eligible dependents. (This program is now called "TRICARE")
CLAIM	A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare Part A; Medicare Part B.)
CLAIM ADJUSTMENT REASON CODES	A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.
CLAIM ATTACHMENT	Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.
CLINICAL BREAST EXAM	An exam by your doctor/health care provider to check for breast cancer by feeling and looking at your breasts. This exam is not the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

CLINICAL PERFORMANCE MEASURE	This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.
CLINICAL PRACTICE GUIDELINES	Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
CLINICAL TRIALS	Clinical trials are one of the final stages of a long and careful research process to help patients live longer, healthier lives. They help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. The trials help doctors and researchers see if the new care works and if it is safe. They may also be used to compare different treatments for the same condition to see which treatment is better, or to test new uses for treatments already in use.
COGNITIVE IMPAIRMENT	A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.
COHORT	A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common one is the birth cohort, a group of individuals born within a defined time period, usually a calendar year or a five-year interval.
COINSURANCE (MEDICARE PRIVATE FEE-FOR-SERVICE PLAN)	The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).
COINSURANCE (OUTPATIENT PROSPECTIVE PAYMENT SYSTEM)	The percentage of the Medicare payment rate or a hospital's billed charge that you have to pay after you pay the deductible for Medicare Part B services.

COMMUNITY MENTAL HEALTH CENTER	A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility; 24 hour a day emergency care services; Day treatment, other than partial hospitalization services, or psychosocial rehabilitation services; Screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission; and Consultation and education services.
COMPLAINT (OF FRAUD OR ABUSE)	A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)	A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.
CONDITIONAL PAYMENT	A payment made by Medicare for services for which another payer is responsible.
CONSENT AND AUTHORIZATION (BASIC RULE)	A covered entity may use or disclose PHI only: With the consent of the individual for treatment, payment, or health care operations; With the authorization of the individual for all other uses or disclosures; As permitted under this rule for certain public policy purposes.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)*	A law that lets some people keep their employer group health plan coverage for a period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, or getting a divorce. You may have to pay both your share and the employer's share of the premium. Generally, you also have to pay an administrative fee.
CONTINUING CARE RETIREMENT COMMUNITY (CCRC)	A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRCs require a large payment before you move in and charge monthly fees.
CONTRACTOR	An entity that has an agreement with CMS or another funding agency to perform a project.
COORDINATION OF BENEFITS	A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.
COORDINATION PERIOD	A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.
COST SHARING	The cost for medical care that you pay yourself like a co-payment, coinsurance, or deductible. (See Coinsurance; Co-payment; Deductible.)

COST-BASED HEALTH MAINTENANCE ORGANIZATION	A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.
COVERED BENEFIT	A health service or item that is included in your health plan, and that is paid for either partially or fully.
COVERED CHARGES	Services or benefits for which a health plan makes either partial or full payment.
CREDITABLE COVERAGE	Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions.)
CRITERIA	The expected levels of achievement or specifications against which performance can be assessed.
CRITICAL ACCESS HOSPITAL	A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.
CUSTODIAL CARE	Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.

CUSTODIAL CARE FACILITY	A facility, which provides room, board, and other personal assistance services, generally on a long-term basis and which does not include a medical component.
CUSTODIAN	The person responsible for the security and safeguard of CMS data for the duration of the project.
DATE OF FILING AND DATE OF SUBMISSION	The day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined.
DATE OF RECEIPT	The date on the return receipt of "return receipt requested" mail, unless otherwise defined.
DEDUCTIBLE (MEDICARE)	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. (See Benefit Period; Medicare Part A; Medicare Part B.)
DEEMED	Providers are deemed when they know, before providing services that you are in a Private Fee-for-Service Plan, and they agree to give you care. Providers that are deemed agree to follow your plan's terms and conditions of payment for the services you get.
DEFICIENCY (NURSING HOME)	A finding that a nursing home failed to meet one or more federal or state requirements.
DEMOGRAPHIC DATA	Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ ethnicity, and primary language.
DEPARTMENT OF HEALTH AND HUMAN SERVICES	DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

DESIGNATED CODE SET	A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.
DETERMINATION	A decision made to either pay in full, pay in part, or deny a claim.
DIABETIC DURABLE MEDICAL EQUIP-MENT	Purchased or rented ambulatory items, such a glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, as covered by Medicare.
DIAGNOSIS	The name for the health problem that you have.
DIAGNOSIS CODE	The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. The condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.
DIAGNOSIS-RELATED GROUPS	A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.
DIALYSIS	Dialysis is a treatment that cleans your blood when your kidneys don’t work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure

DIALYSIS CENTER (RENAL)	A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.
DIALYSIS FACILITY (RENAL)	A unit (hospital based or freestanding) which is approved to furnish dialysis services directly to ESRD patients.
DIALYSIS STATION	A portion of the dialysis patient treatment area which accommodates the equipment necessary to provide a hemodialysis or peritoneal dialysis treatment. This station must have sufficient area to house a chair or bed, the dialysis equipment, and emergency equipment if needed. Provision for privacy is ordinarily supplied by drapes or screens.
DIGITAL IMAGING AND COMMUNICATIONS IN MEDICINE	A standard for communicating images, such as x-rays, in a digitized form. This standard could become part of the HIPAA claim attachments standards.
DISABILITY	For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare.
DISABILITY INSURANCE	See "Old-Age, Survivors, and Disability Insurance (OASDI)."
DISABLED ENROLLEE	An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in the SMI program.

DISCHARGE PLANNING	A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.
DISCLOSURE	Release or divulgence of information by an entity to persons or organizations outside of that entity.
DISCLOSURE HISTORY	Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.
DISCOUNT DRUG LIST	A list of certain drugs and their proper dosages. The discount drug list includes the drugs the company will discount.
DISENROLL	Ending your health care coverage with a health plan.
DISPROPORTIONATE SHARE HOSPITAL	A hospital with a disproportionately large share of low -income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.
DRG CODING	The DRG categories used by hospitals on discharge billing. See also "Diagnosis-related groups (DRGs)."
DRUG TIERS	Drug tiers are definable by the plan. The option “tier” was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the “tier” option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

DUAL ELIGIBLES	Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.
DURABLE MEDICAL EQUIPMENT	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicare.
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)	A private company that contracts with Medicare to pay bills for durable medical equipment.
DURABLE POWER OF ATTORNEY	A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.
ELECTION PERIODS	Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare Advantage plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.
ELIGIBILITY	Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

ELIGIBILITY/ MEDICARE PART A	You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if: You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or You or your spouse had Medicare-covered government employment, or You are under 65 and have End-Stage Renal Disease (ESRD). If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if: You are age 65 or older, and You are enrolled in Part B, and You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.
ELIGIBILITY/ MEDICARE PART B	You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.

EMERGENCY CARE	Care given for a medical emergency when you believe that your health is in serious danger when every second counts.
EMERGENCY ROOM (HOSPITAL)	A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.
EMPLOYEE	For purposes of the Medicare Secondary Payer (MSP) provisions, an employee is an individual who works for an employer, whether on a full- or part-time basis, and receives payment for his/her work.
EMPLOYER	Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.
EMPLOYER GROUP HEALTH PLAN (GHP)	A GHP is a health plan that: Gives health coverage to employees, former employees, and their families, and Is from an employer or employee organization.
END-STAGE RENAL DISEASE (ESRD)	Permanent kidney failure. That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.
ENROLLMENT PERIOD	A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

ENROLLMENT/ PART A	There are four periods during which you can enroll in premium Part A: Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP). Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts 3 months before you first meet all the eligibility requirements for Medicare and continues for 7 months. General Enrollment Period: January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll. Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up for premium Part A at any time you are covered under the Group Health Plan based on current employment. If the employment or group health coverage ends, you have 8 months to sign up, whichever comes first.
ESRD ELIGIBILITY REQUIREMENTS	To qualify for Medicare under the renal provision, a person must have ESRD and either be entitled to a monthly insurance benefit under Title II of the Act (or an annuity under the Railroad Retirement Act), be fully or currently insured under Social Security (railroad work may count), or be the spouse or dependent child of a person who meets at least one of the two last requirements. There is no minimum age for eligibility under the renal disease provision. An Application for Health Insurance Benefits Under Medicare for Individuals with Chronic Renal Disease, Form HCFA-43 (effective October 1, 1978) must be filed.

EXCESS CHARGES	If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.
EXCLUSIONS (MEDICARE)	Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.
EXPEDITED APPEAL	A Medicare Advantage plan organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.
EXTENDED CARE SERVICES	In the context of this report, an alternate name for "skilled nursing facility services."
EXTERNAL QUALITY REVIEW ORGANIZATION	Is the organization with which the State contracts to evaluate the care provided to Medicaid managed eligibles. Typically the EQRO is a peer review organization. It may conduct focused medical record reviews (i.e. Reviews targeted at a particular clinical condition) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they may also use eligibility data and claims/encounter data to conduct specific analyses.
FACILITY CHARGE	Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

FEE SCHEDULE	A complete listing of fees used by health plans to pay doctors or other providers.
FEE-FOR-SERVICES	A plan or PCCM is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.
FISCAL INTERMEDIARY	A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")
FORMULARY	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.
FORMULARY DRUGS	Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees.
FRAUD	The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).
FRAUD AND ABUSE	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.
FREE LOOK (MEDIGAP POLICY)*	A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.
GAPS	The costs or services that are not covered under the Original Medicare Plan.

GATEKEEPER	In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.
GENERAL ENROLLMENT PERIOD (GEP)	The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.
GENERIC DRUG	A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.
GRIEVANCE	A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).
GRIEVANCES AND COMPLAINTS	Information about grievances and complaints submitted to the health plan.
GROUP HEALTH PLAN	A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.
GROUP OR NETWORK HMO	An health plan that contracts with group practices of doctors to give services in one or more places.
GUARANTEED ISSUE RIGHTS (ALSO CALLED "MEDIGAP PROTECTIONS")	Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

GUARANTEED RENEWABLE	A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don't pay your premiums.
HEALTH CARE PROVIDER	A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
HEALTH CARE QUALITY IMPROVEMENT PROGRAM	HCQIP is a program, which supports the mission of CMS to assure health care security for beneficiaries. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and health care providers, practitioners, and plans to promote informed health choices, protecting beneficiaries from poor care, and strengthening the infrastructure.
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)	A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health. HIPAA also: limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; usually gives you credit for health coverage you have had in the past; may give you special help with group health coverage when you lose coverage or have a new dependent; and generally guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

HEALTH MAINTENANCE ORGANIZATIONS (HMO)	A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.
HEARING	A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing. Hearings are provided for in §1842(b)(3)(C) of the Act.
HOME AND COMMUNITY-BASED SERVICE WAIVER PROGRAMS (HCBS)	The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.
HOME HEALTH AGENCY	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
HOME HEALTH CARE	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
HOMEBOUND	Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

HOSPICE	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
HOSPICE CARE	A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
HOSPITAL COINSURANCE	For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see "Lifetime reserve days").
HOSPITAL INDEMNITY INSURANCE	This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. Indemnity insurance doesn't fill gaps in your Medicare coverage.
HOSPITAL INSURANCE	The Medicare program that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.
HOSPITAL INSURANCE (PART A)	The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
HOSPITALIST	A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

IMMUNOSUPPRES-SIVE DRUGS	Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives.
INITIAL COVERAGE ELECTION PERIOD	The 3 months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in the number of members. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods; Enrollment/Part A; Initial Enrollment Period (IEP).)
INITIAL ENROLLMENT PERIOD	The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.
INPATIENT CARE	Health care that you get when you are admitted to a hospital.
INPATIENT HOSPITAL	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
INPATIENT HOSPITAL DEDUCTIBLE	An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.
INPATIENT HOSPITAL SERVICES	These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

INPATIENT PSYCHIATRIC FACILITY	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a doctor.
INSOLVENCY	When a health plan has no money or other means to stay open and give health care to patients.
INTEREST	A payment for the use of money during a specified period.
INTERMEDIARY	A private company that has a contract with Medicare to pay Part A and some Part B bills.
INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care available in a hospital or skilled nursing facility.
INTERNIST	A doctor who finds and treats health problems in adults.
LARGE GROUP HEALTH PLAN	A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.
LETTER OF REQUEST	A formal request from the requestor on organizational letterhead detailing their data needs and purposes. Additionally, if this project is federally funded a letter of Support is required from the federal Project Officer on their organizational letterhead.
LIABILITY INSURANCE	Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.
LICENSED (LICENSURE)	This means a long-term care facility has met certain standards set by a State or local government agency.

LIFETIME RESERVE DAYS	In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.
LIMITING CHARGE	In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.
LIVING WILLS	A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.
LONG-TERM CARE	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.
LONG-TERM CARE INSURANCE	A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."
LONG-TERM CARE OMBUDSMAN	An advocate (supporter) for nursing home and assisted living facility residents who works to resolve problems between residents and nursing homes or assisted living facilities.

MA PLAN	Health benefits coverage offered under a policy or contract offered by a Medicare Advantage Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan. See 42 C.F.R. § 422.2. An MA plan may be a coordinated care plan (with or without point of service options), a combination of an MA medical savings account (MSA) plan and a contribution into an MA MSA established in accordance with 42 CFR part 422.262, or an MA private fee-for-service plan. See 42 C.F.R. § 422.4(a).
MANAGED CARE	Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare
MANAGED CARE ORGANIZATION	Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. Stands for Managed Care Organization. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics. Is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization, which meets the requirements of §1902 (w) to provide comprehensive services.
MANAGED CARE PLAN	In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

MANAGED CARE PLAN WITH A POINT OF SERVICE OPTION (POS)	A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan.)
MASS IMMUNIZATION CENTER	A location where providers administer pneumococcal pneumonia and influenza virus vaccination and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician's office setting (4408.8, Part 3 of MCM).
MAXIMUM ENROLLEE OUT-OF-POCKET COSTS	The beneficiary's maximum dollar liability amount for a specified period.
MAXIMUM PLAN BENEFIT COVERAGE	The maximum dollar amount per period that a plan will insure. This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.
MEDICAID	A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
MEDICAL INSURANCE (PART B)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
MEDICAL REVIEW/ UTILIZATION REVIEW	Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MEDICAL UNDERWRITING	The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge you for that insurance.
MEDICALLY NECESSARY	Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.
MEDICARE	The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
MEDICARE ADVANTAGE PLAN	A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.
MEDICARE BENEFITS	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.
MEDICARE BENEFITS NOTICE	A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)
MEDICARE CARRIER	A private company that contracts with Medicare to pay Part B bills.

MEDICARE CONTRACTOR	A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)
MEDICARE COORDINATION OF BENEFITS CONTRACTOR	A Medicare contractor who collects and manages information on other types of insurance or coverage that pays before Medicare. Some examples of other types of insurance or coverage are: Group Health Coverage, Retiree Coverage, Workers' Compensation, No-fault or Liability insurance, Veterans' benefits, TRICARE, Federal Black Lung Program, and COBRA.
MEDICARE COVERAGE	Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare Part A (Hospital Insurance); Medicare Part B (Medical Insurance).)
MEDICARE DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.
MEDICARE HANDBOOK	The Medicare Handbook provides information on such things as how to file a claim and what type of care is covered under the Medicare program. This handbook is given to all beneficiaries when first enrolled in the program.
MEDICARE MANAGED CARE PLAN	A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.
MEDICARE MEDICAL SAVINGS ACCOUNT PLAN (MSA)	A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

MEDICARE PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
MEDICARE PART A FISCAL INTERMEDIARY	A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.
MEDICARE PART B (MEDICAL INSURANCE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
MEDICARE PART B CARRIER	A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.
MEDICARE PRE-FERRED PROVIDER ORGANIZATION (PPO) PLAN	A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
MEDICARE PREMIUM COLLECTION CENTER (MPCC)	The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.
MEDICARE PRIVATE FEE-FOR-SERVICE PLAN	A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.
MEDICARE SAVINGS PROGRAM	Medicaid programs that help pay some or all Medicare premiums and deductibles.

MEDICARE SAVINGS PROGRAMS	There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if: You have Medicare Part A (Hospital Insurance). (If you are eligible for Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.), you are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include money in a savings or checking account, stocks, or bonds and You are an individual with limited monthly.
MEDICARE SECONDARY PAYER	Any situation where another payer or insurer pays your medical bills before Medicare.
MEDICARE SELECT	A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.
MEDICARE SUMMARY NOTICE (MSN)	A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.
MEDICARE SUPPLEMENT INSURANCE	Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 12 standardized policies labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan. (See Gaps and Medigap Policy.)
MEDICARE-APPROVED AMOUNT	In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

MEDIGAP POLICY	A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan. (See Gaps.)
MILITARY TREATMENT FACILITY	A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
MULTI-EMPLOYER GROUP HEALTH PLAN (MULTIPLE EMPLOYER PLAN)	A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.
NATIONAL HEALTH INFORMATION INFRASTRUCTURE	This is a healthcare-specific lane on the Information Superhighway, as described in the National Information Infrastructure (NII) initiative. Conceptually, this includes the HIPAA A/S initiatives.
NEBULIZERS	Equipment to give medicine in a mist form to your lungs.
NEGLECT	When care takers do not give a person they care for the goods or services needed to avoid harm or illness.
NETWORK	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
NO-FAULT INSURANCE	No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

NON-COVERED SERVICE	The service: does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage on ground other than 1862(a)(1), or is not reasonable and necessary under 1862 (a)(1).
NON-FORMULARY DRUGS	Drugs not on a plan-approved list.
NONPARTICIPATING PHYSICIAN	A doctor or supplier who does not accept assignment on all Medicare claims.
NURSE PRACTITIONER	A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.
NURSING FACILITY	A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
NURSING HOME	A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.
OCCUPATIONAL THERAPY	Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after illness.
OFFICE	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE	The Social Security programs that pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).
OMBUDSMAN	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.
OPEN ENROLLMENT PERIOD	A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can?t be denied coverage or charged more due to past or present health problems.
ORIGINAL MEDICARE PLAN	A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
OUT OF NETWORK BENEFIT	Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plans contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.
OUT-OF-POCKET COSTS	Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

OUTPATIENT CARE	Medical or surgical care that does not include an overnight hospital stay.
OUTPATIENT HOSPITAL	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Part of the Hospital providing services covered by SMI, including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, laboratory tests billed by the hospital, etc.
OUTPATIENT HOSPITAL SERVICES (MEDICARE)	Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including: blood transfusions; certain drugs; hospital billed laboratory tests; mental health care; medical supplies such as splints and casts; emergency room or outpatient clinic, including same day surgery; and x-rays and other radiation services.
OUTPATIENT SERVICES	A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.
PAP TEST	A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.
PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

PART A OF MEDICARE	Medicare Hospital Insurance also referred to as "HI." Part A is the hospital insurance portion of Medicare. It was established by §1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.
PART A PREMIUM	A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in the Medicare HI program. These individuals are those who are aged 65 and older, are uninsured for social security or railroad retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).
PART B (MEDICAL INSURANCE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
PART B (MEDICARE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. (See Medical Insurance (Part B).)
PART B OF MEDICARE	Medicare Supplementary Medical Insurance also referred to as "SMI." Medicare insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

PARTICIPATING HOSPITALS	Those hospitals that participate in the Medicare program.
PARTICIPATING PHYSICIAN OR SUPPLIER	A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts.
PATIENT ADVOCATE	A hospital employee whose job is to speak on a patient's behalf and help patients get any information or services they need.
PAYER	In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO.
PELVIC EXAM	An exam to check if internal female organs are normal by feeling their shape and size.
PERIODS OF CARE (HOSPICE)	A set period of time that you can get hospice care after your doctor says that you are eligible and still needs hospice care.
PERSONAL CARE	Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.
PHYSICAL THERAPY	Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.
PHYSICIAN ASSISTANT (PA)	A person who has 2 or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.

PHYSICIAN GROUP	A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is considered to be a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.
PHYSICIAN SERVICES	Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.
PLAN OF CARE	Your doctor's written plan saying what kind of services and care you need for your health problem.
POINT OF SERVICE (POS)	An additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.
POWER OF ATTORNEY	A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.
PRE-EXISTING CONDITION	A health problem you had before the date that a new insurance policy starts.
PREFERRED PROVIDER ORGANIZATION (PPO)	A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM SURCHARGE	The standard Medicare Part B premium will go up ten percent for each full 12-month period (beginning with the first month after the end of your Initial Enrollment Period) that you could have had Medicare Part B but didn't take it. The additional premium amount is called a "premium surcharge." There will be a surcharge for Part D also.
PREVENTIVE SERVICES	Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).
PRIMARY CARE	A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.
PRIMARY CARE DOCTOR	A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.
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.
PRIVACY ACT OF 1974	Without the written consent of the individual, the Privacy Act prohibits release of protected information maintained in a system of records unless of 1 of the 12 disclosure provisions apply.

PRIVATE CONTRACT	A contract between you and a doctor, podiatrist, dentist, or optometrist who has decided not to offer services through the Medicare program. This doctor can't bill Medicare for any service or supplies given to you and all his/her other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.
PRIVATE FEE-FOR-SERVICE PLAN	A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it pays and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.
PROCEDURE	Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.
PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)	PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must: Be 55 years old, or older, Live in the service area of the PACE program, Be certified as eligible for nursing home care by the appropriate state agency , and Be able to live safely in the community. The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.
PROSPECTIVE PAYMENT SYSTEM	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

PROVIDER	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.
PROVIDER NETWORK	The providers with which an M+C Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.
PROVIDER SPONSORED ORGANIZATION (PSO)	A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)
PSYCHIATRIC FACILITY (PARTIAL HOSPITALIZATION)	Partial hospitalization (location 52) is a program in which a patient attends for several hours during the day (example: 8:30-3:30) the patient is not there on a 24 hours basis.
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
QUALIFIED MEDICARE BENEFICIARY (QMB)	This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

QUALIFYING INDIVIDUALS (1) (QI-1S)	This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.
QUALIFYING INDIVIDUALS (2) (QI-2S)	This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.
QUALITY ASSURANCE	The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.
QUALITY IMPROVEMENT ORGANIZATION	Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.
RAILROAD RETIREMENT	A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

REASONABLE COST	FIs and carriers use CMS guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees. Reasonable cost is based on the actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program.
RECIPIENT	An individual covered by the Medicaid program, however, now referred to as a beneficiary.
RECOUPMENT	The recovery by Medicare of any Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.
REFERRAL	A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.
REFERRAL	A plan may restrict certain health care services to an enrollee unless the enrollee receives a referral from a plan-approved caregiver, on paper, referring them to a specific place/person for the service. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.
REGIONAL HOME HEALTH INTERMEDIARY (RHHI)	A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.
REHABILITATION	Rehabilitative services are ordered by your doctor to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

REHABILITATION (AS DISTINGUISHED FROM VOCATIONAL REHABILITATION)	A restorative process through which an individual with ESRD develops and maintains self-sufficient functioning consistent with his/her capability.
RESERVE DAYS	(See Lifetime Reserve Days.)
RESPITE CARE	Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off.
RIGHTS OF INDIVIDUALS	Receive notice of information practices; See and copy own records; Request corrections; Obtain accounting of disclosures; Request restrictions and confidential communications; File complaints
RISK-BASED HEALTH MAINTENANCE ORGANIZATION/ COMPETITIVE MEDICAL PLAN	A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/ member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/ member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.
RURAL HEALTH CLINIC	An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

SANCTIONS	Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.
SECOND OPINION	This is when another doctor gives his or her view about what you have and how it should be treated.
SECONDARY PAYER	An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.
SELF-INSURED	An individual or organization that assumes the financial risk of paying for health care.
SERVICE	Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42 CFR 400.202).
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.
SERVICE AREA (PRIVATE FEE-FOR-SERVICE)	The area where a Medicare Private Fee-for-Service plan accepts members.
SIDE EFFECT	A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.

SKILLED CARE	A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care.
SKILLED NURSING CARE	A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
SKILLED NURSING FACILITY (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
SKILLED NURSING FACILITY CARE	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.
SNF COINSURANCE	For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.
SPECIAL ELECTION PERIOD	A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as: you move outside the service area, your Medicare Advantage organization violates its contract with you, the organization does not renew its contract with CMS, or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period (SEP).)

SPECIALIST	A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.
SPECIALTY PLAN	A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.
SPECIFIED DISEASE INSURANCE	This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.
SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)	A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
SPEECH-LANGUAGE THERAPY	Treatment to regain and strengthen speech skills.
STATE INSURANCE DEPARTMENT	A state agency that regulates insurance and can provide information about Medigap policies and any insurance related problem.
STATE OR LOCAL PUBLIC HEALTH CLINIC	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
SUBSIDIZED SENIOR HOUSING	A type of program, available through the Federal Department of Housing and Urban Development and some States, to help people with low or moderate incomes pay for housing.

SUPPLEMENTARY MEDICAL INSURANCE	The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Part B.
SUPPLIER	Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.
TERM INSURANCE	A type of insurance that is in force for a specified period of time.
THIRD PARTY ADMINISTRATOR	An entity required to make or responsible for making payment on behalf of a group health plan.
TRANSIENT PATIENTS	Patients who receive treatments on an episodic basis and are not part of a facilities regular caseload (i.e. patients who have not been permanently transferred to a facility for ongoing treatments).
TREATMENT	Something done to help with a health problem. For example, medicine and surgery are treatments.
TREATMENT OPTIONS	The choices you have when there is more than one way to treat your health problem.
TRICARE	A health care program for active duty and retired uniformed services members and their families.
TRICARE FOR LIFE (TFL)	Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don?t have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
UNASSIGNED CLAIM	A claim submitted for a service or supply by a provider who does not accept assignment.
URGENTLY NEEDED CARE	Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.
VOCATIONAL REHABILITATION	The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational rehabilitation can also mean to preparing an individual regardless of age, status (whether U.S. citizen or immigrant) or physical condition (disability other than ESRD) to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent (homemaker).
WAITING PERIOD	The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.
WORKERS COMPENSATION	Insurance that employers are required to have to cover employees who get sick or injured on the job.