



MEDICARE SUPPLEMENT INSURANCE

BUYING GUIDE



Helping Oklahomans and their families
make informed decisions about Medicare.

OKLAHOMA INSURANCE DEPARTMENT

1-800-763-2828 | www.map.oid.ok.gov | map@oid.ok.gov

Your Medicare Supplement Buyer's Guide

This booklet is intended as a “guide.” Once you have selected a company, you should consult with the insurance company or its representative to determine policy specifics and review the options that are available with that company.

Consumer brochures are available to Oklahoma residents explaining other insurance coverages. These, too, are available from:

Oklahoma Insurance Department

400 NE 50th Street
Oklahoma City, OK. 73105

Insurance Department Contact Information

Medicare Assistance Program

Toll Free Number (in state only) 1-800-763-2828

Local Number 405-521-6628

For information on Medicare, Medicare Supplemental Policies, Medicare Advantage Plans, and prescription drug coverage

Oklahoma Insurance Department

Toll Free Number (in state) 1-800-522-0071

Local Number 405-521-2828

For complaints and claims, information on Insurance Agents, information on Licensed Insurance Companies Property and Casualty Rates and Policy Information



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CONTENTS

OKLAHOMA BUYER’S GUIDE TO MEDICARE SUPPLEMENT INSURANCE

- Medicare Basics 4
- Supplementing Medicare
 - Open Enrollment 6
 - Medicare Disability and Open Enrollment 7
- Standard Plan Benefits 8
 - Basic Benefits 8
 - Part A Hospitalization..... 8
 - Skilled Nursing Facility Coinsurance 9
 - Part B Medical Expenses 10
 - Foreign Travel Emergency 11
 - Part B Excess Charges..... 11
 - Medigap Plans K & L..... 12
 - Medicare Select 12
- Shopping for Medicare Supplement Insurance..... 14
- How to File a Complaint 17
- Alternative to Medicare Supplement Insurance..... 18
 - Health Maintenance Plans (HMOs) 18
 - Preferred Provider Organizations (PPOs) 18
 - Private Fee-for-Service (PFFS) Plans 19
 - Employer Health Insurance 23
 - Medicare Prescription Drug Plan (Part D) 23
- Be a Wise Consumer 26
- What Factors Affect Insurance Coverage 28

MEDICARE: THE BASICS

Medicare is the federal health insurance program available to all people at age 65. It also is available to people under age 65 who have been on Social Security disability for 24 months or who have end-stage renal disease or Lou Gehrig's (ALS). Medicare is made up of Parts A, B, C & D. Most people over age 65 get Medicare Part A premium-free, but everyone must pay a monthly premium for Medicare Part B. Medicare Part C (Medicare Advantage) gives you another option of how you receive your Medicare, and Part D gives the opportunity to purchase a prescription drug plan.

Approval of covered services for Medicare benefits is usually based on what is medically necessary.

The amounts approved are based on payment schedules established by Medicare. Under Part A, the health care providers who contract with Medicare are not allowed to charge more than what is approved by Medicare. Part B does allow "excess charges" for some services. The maximum excess charge physicians are allowed is 15% more than Medicare's approved amount for claims in which the provider did not accept Medicare Assignment. Refer to your Medicare and You Handbook for more information.

GAPS IN MEDICARE

Gap 1: Deductibles and Coinsurance

Gap 2: Excess Charges

Gap 3: Noncovered Items

Medicare pays a large share of the health care costs for beneficiaries, but there are significant gaps. See the Buyers Guide Addendum for more information on covered benefits and remaining gaps for which you are responsible.

THE FOUR PARTS OF MEDICARE

Medicare Part A

- Inpatient Hospital
- Skilled Nursing Facility
- Home Health Care
- Hospice

Medicare Part B

- Doctor Services
- Outpatient Hospital & Emergency Room
- Durable Medical Equipment
- Other Services & Supplies

Medicare Part C

- Medicare Advantage Plans
 - All Part A and B covered Services
 - Usually Part D prescription drug coverage
 - Sometimes additional supplemental benefits

Medicare Part D

- Prescription Drug Benefit

SUPPLEMENTING MEDICARE

Since January 1, 1992, insurance companies selling Medicare supplement policies in Oklahoma were limited to selling 10 “Standardized Plans.” A company does not have to sell all 10 plans, but every Medicare supplement company must sell “Plan A” (basic benefits only).

OPEN ENROLLMENT

Every new Medicare recipient who is age 65 or older has a guaranteed right to buy a Medicare supplement policy during “open enrollment.” A company cannot reject you for any policy it sells, and it cannot charge you more because of a pre-existing health condition.

Your open enrollment period for Medicare Supplemental policies starts when you are age 65 or older and enroll in Medicare Part B for the first time. It ends 6 months later. For example, if you turn 65 in February and enroll in Part B, your Medicare supplement open enrollment period would start the first of February and end the last day of July. However, if you turn 65 in February but delay enrolling in Part B until January of the following year, your Medicare supplement open enrollment period would start January 1st and end the last day of June. If you apply for a policy after the open enrollment period, some companies may refuse coverage because of health reasons.

Even though you are guaranteed a policy during open enrollment, pre-existing conditions may not be covered for up to six months after the effective date but may be waived during open enrollment with some companies. However, companies cannot impose a pre-existing waiting period during the initial open enrollment period if you had previous eligible health insurance coverage and you purchase your Medigap policy within 63 days. Also, a new pre-existing condition waiting period is not allowed when you replace one Medicare supplement with a similar one if you had the first policy at least six months.

MEDICARE DISABILITY AND OPEN ENROLLMENT

Some individuals become eligible for Medicare because of a disability rather than by turning 65. The federal government did not include this group in the requirements which mandate an open enrollment period. However, effective July 1, 1994, Oklahoma requires an open enrollment for Medicare disability enrollees. Each company must offer at least one of the 10 standardized plans for Medicare disability beneficiaries. The open enrollment period begins the date the person is first eligible for Medicare Part B (when the coverage takes effect—or the date on the award letter from Social Security) and ends six months later.

During the 2017 legislative session, the Oklahoma Insurance Department amended OAC 365:10-5-129(d), the rule provision requiring insurance carriers to offer at least one of the ten standardized Medicare supplement plans to all applicants who qualify by reason of disability. Effective September 15, 2017, insurance carriers issuing Medicare supplement policies in the State of Oklahoma may not charge a premium rate for a disabled person that exceeds the lowest available aged premium rate for the standardized plan that is offered to individuals on Medicare due to disability.

This rule helps bridge the gap for many of Oklahoma's disabled Medicare beneficiaries. Oklahoma was one of the first 3 states to successfully undertake the challenge of this reform.

Federal law permits individuals who qualified for Medicare under age 65 another open enrollment period at age 65. This allows disabled Medicare beneficiaries a new opportunity to change to a different Medicare Supplemental plan that may provide more benefits, lower premiums, or both.

STANDARD PLAN BENEFITS

BASIC BENEFITS

Eight of the 10 standard plans have the following “Basic Benefits” included in the plan:

PART A HOSPITALIZATION (PER BENEFIT PERIOD)

Part A Deductible (Per Benefit Period)

Medicare requires you pay the Part A deductible (see Addendum) when you are hospitalized. This amount can change each year. The deductible is charged on the basis of a benefit period rather than a calendar year. Plans B through N include the “Part A Deductible Benefit.”

Days 61–90

Basic Benefits pay the daily coinsurance coverage (see addendum). After 60 days of hospitalization in a “benefit period” (defined below), the policy pays the coinsurance and Medicare pays the rest. The first 90 days of Medicare coverage are renewable for each new benefit period.

Days 91-150 (Lifetime Reserve Days)

Basic Benefits continue to pay the daily coinsurance at the higher rate (see addendum) for these “Lifetime Reserve Days.” Lifetime Reserve Days are 60 nonrenewable days of Medicare benefits that are available when a hospital stay extends beyond the 90 renewable days in a benefit period. The policy pays the coinsurance and Medicare pays the rest.



Benefit Period:

A benefit period begins the first day of inpatient hospital care. It ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days.

Beyond 150 days

Basic Benefits pay 100% of eligible Part A charges for an additional 365 days. After Medicare's benefits are exhausted for one benefit period, the policy provides for 365 additional lifetime days that are nonrenewable.

Blood

Basic Benefits combine with Medicare to cover all blood expenses (except the Part B deductible) both in and out of the hospital.

SKILLED NURSING FACILITY COINSURANCE (SNF)

Medicare only covers approved skilled nursing care in a Medicare-approved facility. These benefits are available when you satisfy the guidelines as defined by Medicare. Standardized Plans C through N include the "Skilled Nursing Coinsurance Benefit."

Qualifying Requirements:

- An inpatient hospital admission of at least three consecutive days occurring prior to the need for skilled care. The need for SNF care must be related to the cause of the inpatient hospital admission.
 - Care must be provided by a Medicare-certified SNF
 - Need for daily skilled care certified by a physician
- Medicare pays all eligible costs for the first 20 days. For days 21 through 100, Medicare pays all but the SNF coinsurance amount (see addendum). The "Skilled Nursing Coinsurance Benefit" pays the coinsurance amount.

Medicare does not provide coverage beyond 100 days. Standardized Plans cannot pay benefits beyond 100 days; however, some older policies may offer additional coverage. Only a small portion of Medicare beneficiaries require skilled

care in a skilled nursing facility, and the average stay in skilled care is less than 30 days.

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

PART B MEDICAL EXPENSES (PER CALENDAR YEAR)

Part B Deductible

Part B has an annual deductible which is the portion of the cost of Part B covered services which must be paid by the beneficiary before Medicare pays (see the addendum). Under plans C and F, the “Part B Deductible” is covered by the supplement plan.

Basic Benefits

20% Coinsurance: Paid after the annual deductible. Medicare Part B payments are based on the amount approved by Medicare according to a fee schedule. Medicare will pay 80% of the approved costs. The Medicare supplement policy covers the remaining 20% coinsurance.

(If charges exceed the approved amount, Basic Benefits will not cover them. See “Part B Excess Charges” on page 11.)

PART B EXCESS CHARGES

An important gap in Medicare Part B is medical charges that are in excess of approved amounts. Plans F and G pay 100% of allowed excess charges. Excess physician charges have limits. Excess charges equal the difference between the Medicare-approved amount and the limiting charge. The maximum limiting physician charge for Medicare Part B eligible services is 15% over the Medicare-approved amount.

Some doctors are participating physicians, which means they accept assignment (they accept Medicare's approved amount). If most of your doctors are participating physicians, you may prefer to self-insure for the excess charges instead of paying additional insurance premiums for this benefit. One way to control your medical costs is to use doctors who accept assignment.

FOREIGN TRAVEL EMERGENCY

Medicare does NOT cover care received outside the United States. Standard plans C through G and M and N include a "Foreign Travel Emergency Benefit". (see addendum for coverage, deductible, and limits)

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

PLANS WITH MODIFIED BENEFITS

Medigap Plans K & L

Medigap Plans K and L provide different cost-sharing for items and services than Medigap Plans A through G. You will have to pay some out-of-pocket costs for some covered services until you meet the yearly limit. Once you meet the yearly limit, the Medigap policy pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. Refer to the chart for the standardized plans (see the addendum) for out-of-pocket costs.

Medigap Plans M & N

Medigap Plans M and N are other choices. Refer to the chart of standardized plans located in the addendum.

Medicare SELECT—Another Option

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



- **Another type of Medicare supplement insurance** - Medicare SELECT is the same as standard Medicare supplement insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard plans identified by letters A through G.
- **Restricted provider network** - With Medicare SELECT you must use specific hospitals and, in some cases, specific doctors to receive full benefits. Hospitals or doctors specified by a Medicare SELECT policy are called “participating or preferred providers.” When you go to the preferred provider, Medicare pays its share of the approved charges. The Medicare SELECT policy then pays the full supplemental benefits described in the policy.
- **Medicare is not restricted** - You can go to a provider outside the network for non-emergency care, and Medicare still pays its share of approved charges. However, the Medicare SELECT policy is not required to pay under these circumstances, although some companies may have a provision that allows a limited payment.
- **Emergencies outside the network** - Generally Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider. The only exception is in the case of an emergency* (See page. 21 for definition of emergency).
- **Designated service area** - Medicare SELECT requires that you live in a designated service area to be eligible for enrollment which is the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.
- **Lower Premiums** - Medicare SELECT policies generally have lower premiums because service areas and providers are limited. If you live in a designated area and agree to receive your care from the preferred providers for your plan, a Medicare SELECT plan may save you money.

- **Replacing a Medicare SELECT policy** - You can replace a Medicare SELECT policy with a regular Medicare supplement insurance policy if you move out of the service area. You also may choose to change after a Medicare SELECT policy has been in effect for six months. The insurance company must allow you to purchase a regular Medicare supplement policy with equal or lesser benefits, regardless of your health condition.

SHOPPING FOR MEDICARE SUPPLEMENT INSURANCE

PRICE COMPARISON: QUESTIONS TO ASK

- **What are the premium differences between plans?**
In deciding which standard plan to choose, you will find trade-offs of additional benefits for additional premium. Which balance best suits your needs and your budget?
- **What are the premium differences for the same plan?**
Premium amounts for the same plan can vary significantly.
- **Does the premium increase because of your age?**
Normal increases occur because of company losses and changes in Medicare deductibles and coinsurance. Some companies also base premiums on age. Check to see if the premium is based on your age at the time the policy is issued or if it goes up as you get older. Compare premiums for your current age and for at least the next 10 years. A bargain today may be a burden later.
- **Does the company sell through an agent or by mail?**
An agent can help you when completing your application and with problems later. If you have companies with which you prefer to do business, contact them and ask them for a list of the local agents who represent those companies.

- **Is a service office conveniently located?**
A local agent with a good reputation, preferably one you know and trust, is more likely to take a personal interest in providing you good service.
- **Is a toll-free telephone number available for questions?**
This is especially important if you don't have a local agent.
- **What letter grade does the company have from a financial rating service?**
The financial stability of insurance companies is evaluated by a number of different rating services such as A.M. Best, Moody, and Standard and Poor. The rating does not tell how good a policy is or what kind of service the company provides; it reflects only the financial stability of the company. Insurance companies have to pay a fee to these rating services, and they aren't required by regulators to obtain these ratings. Not having a rating does not mean an insurance company is not financially sound.
- **Is crossover claims filing available so Medicare sends claims directly to your insurance company?**
Yes. Once Medicare has paid its share of the bill, the claim is sent directly to the insurance company for you.
- **Is a waiting period required for pre-existing conditions?**
Some policies have waiting periods for pre-existing conditions. If you have a pre-existing condition, you may want to look for a policy that does not require a waiting period before benefits are paid for that condition.

The maximum pre-existing waiting period for people age 65 or older is six months. A company may have a shorter period or may have no waiting period at all. Many companies waive the waiting period for new Medicare Part B enrollees during their open enrollment periods.

It's possible to avoid or shorten your waiting period for a pre-existing condition if you buy a Medigap policy during your Medicare Open Enrollment Period and you're replacing certain kinds of health coverage that counts as "creditable coverage". Prior creditable coverage is generally any other health coverage you recently had before applying for a Medigap policy. If you've had at least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing conditions.

There are many types of health care coverage that may count as creditable coverage for Medigap policies, but they'll only count if you didn't have a break in coverage for more than 63 days. Your Medigap insurance company can tell you if your previous coverage will count as creditable coverage for this purpose. You can also contact the Medicare Assistance Program at 1-800-763-2828.

Keep in mind, as you move from one policy to another, you will get "credit" for the time that you were covered under your first Medicare supplement policy. If you have had a policy for at least six months, your new policy will not have a waiting period for pre-existing medical conditions.



INSURANCE COMPLAINTS

Any Oklahoma citizen who feels he or she has not been treated properly in an insurance transaction may write to the Oklahoma Insurance Department. All complaints are investigated. Examples of possible complaints include:

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

How to File a Complaint



Address complaints to:

Oklahoma Insurance Department - Attn: Consumer Assistance
400 NE 50th Street, Oklahoma City, OK 73105

*To print a copy of the form or fill out an online form visit:
<https://www.oid.ok.gov/consumers/file-an-online-complaint/>*

Include the following information:

- Your name and address
- The insurance company name
- Your policy number (if applicable)
- The name and address of your insurance agent (if applicable)
- A detailed description of the problem
- Supporting documentation

MEDICARE COVERAGE OPTIONS

MEDICARE ADVANTAGE PLANS

You may elect a Medicare Advantage option if you are entitled to Part A and enrolled in Part B of Medicare, and you live in a geographic area served by the MA plan in which you are interested in enrolling. Beneficiaries enrolled in a MA plan may pay a monthly premium to the plan. MA plans have specific rules by which enrollees must agree to abide when enrolled in their plan, such as you must live in the plan's geographic service area. Frequently, MA plans also offer coverage for prescription drugs, and some limited coverage for additional services, such as dental or vision. Below are some of the most common MA plans available:

Health Maintenance Organizations (HMOs)

HMOs provide coverage for the medical services and equipment that are typically covered by Parts A and B of traditional Medicare. The monthly premiums for HMOs can be very cost-effective. However, enrollees must agree to seek medical care through the physicians, therapists and medical facilities that are directly contracted with the HMO. Beneficiaries who receive medical care outside of the contracted network may be held accountable for the full costs of those medical services. Also, enrollees may be required to see their primary care physician before seeing a specialist to receive a referral to an in-network specialist. In an emergency, HMO enrollees may go to the nearest emergency room to seek treatment.

Preferred Provider Organizations (PPOs)

Generally in a PPO you can see any doctor or provider that accepts Medicare. However, if you see a doctor or provider who is contracted with the PPO plan, it is less expensive. You don't need a referral to see a specialist or any provider out-of-network. If you go to doctors, hospitals or other providers who aren't part of the plan (out-of-network or non-preferred), you will usually pay more.

Private Fee-For-Service (PFFS) Plans

In a Private Fee-For-Service (PFFS) plan, you can go to any Medicare-approved doctor or hospital that agrees to accept the terms of the plan's payment. However, the beneficiary is responsible for making sure the provider will accept their insurance each time they seek medical care. The PFFS company, rather than the Medicare program, decides how much it will pay and what you pay for the services you receive. If you are in a Medicare Private Fee-For-Service Plan, you can get your Medicare prescription drug coverage from the plan if it's offered, or you can join a separate Medicare Prescription Drug Plan to add prescription drug coverage if it isn't offered by the plan.

ENROLLMENT/DISENROLLMENT

Enrollment

Most Medicare beneficiaries are eligible for enrollment in a Medicare Advantage plan, and most parts of the country are served by one or more plans that have contracts with the Centers for Medicare and Medicaid Services (CMS) to serve Medicare beneficiaries. Beneficiaries may enroll in an MA plan when they first become eligible for Medicare or during the annual Open Enrollment period, which occurs October 15th through December 7th. The enrollment requirements are as follows:

- You must be entitled to Part A
- You must be enrolled in Medicare Part B and continue to pay the Part B monthly premium.
- You cannot have elected care from a Medicare-certified hospice.
- You must live within the area in which the plan has a Medicare contract to provide services.
- The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries without health screening.

Disenrollment

How and when can a beneficiary disenroll?

Once you are enrolled in an MA plan, you may wish to disenroll at some point. Whether you stay enrolled or leave an MA plan is your decision. Your MA plan cannot try to keep you from disenrolling, nor can the MA plan try to get you to leave. In most cases, beneficiaries must wait until the annual Open Enrollment period to disenroll from a MA plan. They can also disenroll or change MA plans during the Medicare Advantage Open Enrollment Period from January 1st through March 31st.

A beneficiary can disenroll by contacting the plan in which they are enrolled or by contacting the Medicare Assistance Program (800-763-2828), or by contacting the Social Security Administration (or the Railroad Retirement Board, for railroad retirees). This can be done in writing or by phone. If the individual was receiving prescription drug coverage under the MA plan, they should enroll in a Part D prescription drug plan at the time they disenroll from the MA plan to avoid a penalty.

If you disenroll from a MA plan, return to original Medicare and do not purchase a Medicare supplemental insurance policy, you will have to pay any applicable deductibles or coinsurance under the payment rules of the traditional Medicare program.

MEDICARE ADVANTAGE PLANS DO NOT WORK WITH

Medicare Supplement plans and vice versa. You can choose to have either a Medicare Advantage plan or a Medicare Supplement policy, but not both. There is no financial advantage in having a Medicare Advantage plan AND and Medicare Supplement plan.

ADVANTAGES AND DISADVANTAGES OF MEDICARE ADVANTAGE PLANS

Advantages of Plan Membership

- Getting all services through one source can be easier (for example, doctor's services, hospital care, laboratory tests, X-rays).
- Quality of care may be enhanced because of the coordination of services.
- You can budget medical costs more easily because you know the amount of any premiums in advance, and the other out-of-pocket expenses are likely to be less than under the fee-for-services system.
- A beneficiary pays only a nominal copayment/coinsurance when using a service.
- A beneficiary will not need Medigap insurance to supplement Medicare coverage because the plan provides all or most of the same benefits at no additional cost.
- Paperwork is reduced.
- MA plans generally must accept all Medicare applicants.

Disadvantages of Plan Membership

- The Medicare beneficiary may not be free to go to any physician or hospital. You generally must use the plan's providers or the plan will not pay, except in emergencies* or out-of-area urgently needed care. A beneficiary may need to have the prior approval of his or her primary physician to see a specialist, have elective surgery, or obtain equipment or other medical services.
- Contracted providers may elect to terminate their contract with the MA plan in the middle of the plan year, but beneficiaries generally cannot.
- Disenrollment can take up to 30 days, and you must continue to use the HMO providers until you are disenrolled. You must disenroll in writing.

*An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

- If you decide to return to fee-for-service Medicare, depending on your health status, you may not be able to purchase a Medicare Supplement plan.
- You may only change a Medicare Advantage plan during the Annual Open Enrollment period (October 15th through December 7th) and the Medicare Advantage Open Enrollment Period (January 1st through March 31st). Changes made during the Annual Open Enrollment Period will be effective January 1st of the following year. Changes made during the Medicare Advantage Open Enrollment Period will be effective the first of the month following the month of the requested change.

Questions to Ask When Considering a Medicare Advantage Plan

- What is covered by the plan? What is not?
- What additional benefits (dental, vision, hearing, transportation, etc.) does the plan offer, if any.
- If it covers prescriptions, where is the list of covered prescription drugs (formulary) and how often is it updated?
- What are the costs and financial arrangements of the plan?
- What physicians and hospitals are available to me through the plan?
- What are the rules on the primary care physician (PCP)? May I change PCPs and, if so, when?
- What can I do if my physician requests a referral or medical test and the plan denies the request?
- Are physicians/specialists I currently see on the plan and, if so, may I continue to see them?
- If one of my physicians/providers is dropped from my plan's network, will I be comfortable switching to a different contracted provider?
- How long does it take to get an appointment with a physician or specialist?
- Do you know anyone on the health plan and, if so, what do they think about it?
- How does the plan define "emergency or urgently needed care"?
- How does the plan handle complaints and grievances?

EMPLOYER HEALTH INSURANCE

If you or your spouse continues to work after your 65th birthday, you may be able to continue under an employer group health insurance plan. In many situations your employer plan will be primary (it will pay first). In that case, you may not need to sign up for Medicare Part B or buy a Medicare supplement. Contact Social Security at 1-800-772-1213 with any questions regarding enrollment in Medicare Part B.

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

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

MEDICARE PRESCRIPTION DRUG PLAN (PART D)

On January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. You choose the drug plan and pay a monthly premium. Like other insurance, if you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later. You may compare drug plan coverage on www.Medicare.gov.

There are two types of Medicare plans that provide insurance coverage for prescription drugs: Medicare Advantage Plans

that offer prescription drug coverage (MA-PD), and stand-alone Medicare Part D Prescription Drug plans (PDP). MA-PDs offer the medical coverage provided by Medicare Advantage plans, including HMOs, PPOs, and private fee-for-service plans (PFFS). The prescription coverage is included in the Medicare advantage plan. However, if you only need coverage for your prescriptions, a Part D prescription drug plan can provide that without additional medical coverage.

For example, if you have a Medicare Supplement policy, you would only need a Part D prescription drug plan because your Medicare supplement covers your medical costs. Whether you get your prescription drug coverage through an MA-PD or PDP, please review the plans that are offered to make sure that they cover the prescriptions you take in a cost-efficient manner.

Like other insurance, if you join a plan offering Medicare drug coverage, there is a monthly premium. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. You will also pay a share of the cost of your prescriptions. All drug plans will have to provide coverage at least as good as the standard coverage which Medicare has set.

Limited Benefit Policies Are Not a Substitute for a Medicare Supplement Policy

Limited benefit policies such as hospital indemnity, dread disease (cancer, stroke, heart disease, etc.), and accident plans do not cover the gaps in Medicare benefits. They provide benefits only in limited circumstances and duplicate coverage from Medicare and Medicare supplement insurance. You may want to carefully evaluate these plans to determine if they are necessary for your health care needs.

Guaranteed Issue

The Balanced Budget Act of 1997, which was formally adopted by the state of Oklahoma, increases Medigap portability by providing for guaranteed issue rights without a preexisting conditions limitation in the following circumstances*:

- Individuals enrolled in an employee welfare benefit plan, where the plan terminates or ceases providing supplement benefits (opens plans A, B, D, G, K and L)
- Individuals enrolled in a Medicare Advantage plan or a Medicare SELECT policy that is discontinued because (a) the organization terminates its Medicare contract or ceases serving a geographic area, (b) the individual moves outside of the service area of the plan, or (c) the individual disenrolls with the organization due to cause (opens plans A, B, D, G, K and L)
- Individuals who are enrolled under a Medigap policy that is terminated due to the insolvency or bankruptcy of the issuer (opens plans A, B, D, G, K and L)
- Individuals enrolled in a Medigap Supplement who terminate the plan to enroll in a Medicare Advantage or Medicare SELECT and then terminate that plan within the first 12 months of enrollment (opens old plan if available; if not, any A, B, D, G, K and L plan)
- Individuals who first become eligible for Medicare at age 65, enroll in a Medicare Advantage plan, and disenroll within one year, may enroll in any of the standardized Medigap plans within 63 days of disenrollment (unless the individual is within six months of purchasing Part B, in which case they may have a slightly longer period of guaranteed issue).

*Supplemental plan must be purchased within 63 days of termination of previous coverage.

BE A WISE CONSUMER

ASSESS YOUR NEEDS

Review your own health profile and decide what benefits and services you are most likely to need. If a poor decision is made, you may have more limited choices in the future.

BUY JUST ONE

You only need one Medicare Supplement policy. You are paying for unnecessary duplication if you own more than one.

TAKE YOUR TIME

Do not be pressured into buying a policy. If you have questions or concerns, ask the agent to explain the policy to a friend or relative whose judgement you trust, or call the MAP program. If you need more time, tell the agent to return at some future date. Do not fall for the age-old excuse, “I’m only going to be in town today so you’d better buy now.”

CHECK THE AGENT’S INSURANCE LICENSE

An agent must have a license issued by the state of Oklahoma to be authorized to sell insurance in Oklahoma. Do not buy from a person who cannot show proof of licensing. A business card is not a license. You can contact the Oklahoma Insurance Department to check on an agent’s license.

READ THE OUTLINE OF COVERAGE

The outline of coverage, which is required to be delivered with every solicitation for Medicare supplement insurance, includes specific details about each of the benefits in the policy. If purchased by direct mail, your outline of coverage must be delivered with the policy.

MEDICAL QUESTIONS MAY BE IMPORTANT

Do not be misled by the phrase “no medical examination required.” You may not have to go to a physician for an exam, but medical statements you make on the application might prevent you from getting coverage after your open enrollment period.

DO NOT PAY WITH CASH

Pay by check, money order, or bank draft. Make it payable to the insurance company only, not the agent. Completely fill in the check before presenting it to the agent.

COMPLETE THE APPLICATION CAREFULLY

Before you sign an application, read the health information recorded by the agent. Do not sign it until all health information is completed and accurate. If you leave out requested medical information, the insurance company could deny coverage for that condition or cancel your policy.

APPROVAL TAKES TIME

You may not be insured by a new Medicare supplement policy on the day you apply for it. Generally, approval takes 10 to 30 days.

DO NOT CANCEL A CURRENT POLICY...

until you have been accepted by the new insurer and have a policy in hand. Consider carefully whether you want to drop one policy and purchase another.

EXPECT TO RECEIVE THE POLICY WITHIN A REASONABLE TIME

A policy should be delivered within a reasonable time after application (usually 30 days). If you have not received the policy or had your check returned in that time, contact the company and obtain in writing a reason for delay. If a problem continues, contact the Oklahoma Insurance Department.

Use your 30-day free look period. The 30 days start when you have a policy in your hand. Review it carefully. If you decide not to keep it, return it to the company and request a premium

refund. After the “free look” period, insurance companies are not required to return unused premiums if you decide to drop the policy. If an agent tries to sell you a new policy saying you can get a premium refund for your current policy, report the agent to the Oklahoma Insurance Department.

Your policy is guaranteed renewable if you bought it after December 13, 1991.

That means the company cannot drop you as a policyholder unless you fail to pay the premium.

WHAT FACTORS AFFECT INSURANCE COVERAGE

HOW INSURANCE COMPANIES SET PRICES FOR MEDIGAP POLICIES

Each insurance company sets its own monthly premiums and decides how it will set the price. You should ask how an insurance company prices Medigap policies. The way it sets the prices affects how much you pay now and in the future. Medigap policies can be priced or “rated” in three ways:

1. Community-rated (also called “no-age-rated”)
2. Issue-age-rated
3. Attained-age-rated

Community-rated (also called “no-age-rated”)

The same monthly premium is charged to everyone who has the Medigap policy, regardless of age. The premium is the same no matter how old you are. The premium may go up because of inflation and other factors, but not based on your age.

Issue-age-rated

The premium is based on the age you are when you buy the Medigap policy. Premiums are lower when you buy at a younger age and won’t change as you get older. The premium may go up because of inflation and other factors, but not because of your age.

Attained-age-rated

The premium is based on your current age so your premium goes up as you get older. The premium is low when you buy at a young age, but goes up as you get older. It may be the least expensive at first, but it can eventually become the most expensive. The premium may also go up because of inflation and other factors.

Gender

Some companies have different premiums for men and women.

Area

Some companies charge different premiums based on where you live, zip codes, and/or counties.

Other Factors to Consider

Some companies have lower prices for people who do not use tobacco products. A few companies require membership in a specific organization before a policy can be issued. Some companies offer different levels of premium based on underwriting criteria. Once you have narrowed your choices, you should check with the companies to verify the actual premium.

Choosing the right health coverage is an important decision, and the answers are not the same for everyone. Every beneficiary has their own unique needs and circumstances. We hope the information in this publication will help you navigate the options available to you so that you can make informed choices about your healthcare coverage. If you have additional questions or would like information about premium comparisons, please contact us at 1-800 763-2828, or by email at MAP@oid.ok.gov.



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The Medicare Assistance Program (MAP) is a division of the Oklahoma Insurance Department (OID), under general direction of the Insurance Commissioner Glen Mulready. The program is funded by a federal grant from the Administration for Community Living. The division helps inform the public about Medicare and other senior health insurance issues.

OID is responsible for enforcing the insurance related laws of the state. OID protects consumers by providing accurate, timely and informative insurance information. OID promotes a competitive marketplace and ensures solvency of the entities we regulate including insurance producers and adjusters, funeral directors, bail bondsmen and real estate appraisers.

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