GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

SPECIFIED DISEASE LIMITED POLICY

OUTLINE OF COVERAGE
For Policy Form G1132-WI
Rider Forms RG11CAN, RG11HAS, RG11NH, RG07ROP (D)

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Wisconsin Guide to Health Insurance for People with Medicare, given to you when you applied for this policy.

This Is A Limited Policy – Read Your Policy Carefully

- This outline of coverage provides a very brief description of the important features of your policy. This is not an insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY**!

SPECIFIED CRITICAL ILLNESS COVERAGE – Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a specified critical illness. The policy provides coverage for loss resulting from specified covered conditions, based upon the benefit plan chosen. See *BENEFIT PLANS* below for the covered conditions included for each benefit plan. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS

BENEFIT PLANS	COVERAGE INCLUDED FOR
Plan A – Comprehensive	Covered Conditions: Cancer, Coronary Artery Bypass Surgery, Heart Attack, Stroke, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan A Covered Conditions.
Plan B – Cancer Care+	Covered Conditions: Cancer, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan B Covered Conditions.
Plan C – Cardiac Care+	Covered Conditions: Coronary Artery Bypass Surgery, Heart Attack, Stroke, Alzheimer's disease; kidney failure, paralysis, coma, major organ transplant. Nursing Home and Assisted Living Facility benefits when confinement is due to the Plan C Covered Conditions.

Upon the diagnosis of a covered condition, we will pay the monthly benefit amount you choose for the policy and any attached riders after the waiting period has been satisfied. We will pay this amount for the number of months you choose from 6 months to 24 months. A limited benefit period applies to cancer in situ, coma and heart attack (3 month benefit period) and coronary artery bypass (2 month benefit period.)

The monthly benefit amount is subject to:

1. The applicable maximum benefit period or limited benefit period;
2. The lifetime maximum benefit amount; and
3. The definitions, limitations, exclusions and other provisions of this policy.

For benefits to be payable, the following requirements must be met:

1. The diagnosis must be made while this policy is in force, and
2. The diagnosis must be made after the expiration of the waiting period, if any, and
3. All terms and conditions of this policy must be met.

We will pay the monthly benefit amount for only one covered condition during any one benefit period. We won't pay benefits for multiple covered conditions during any one benefit period.

Payment of any benefits under this policy and / or any attached riders will reduce the lifetime maximum benefit amount by the amount of any monthly benefit paid under this policy and /or any attached riders. When we have paid the applicable lifetime maximum benefit amount, the policy and any attached riders end.

In the event of your death during the maximum benefit period or limited benefit period, any remaining benefit payable under the policy and / or riders for that benefit period will be paid in a lump sum to your designated beneficiary.

RESTORATION OF POLICY BENEFITS
This Policy's Maximum Benefit Period or Limited Benefit Period for any One Benefit Period will be fully restored when there has been no payment of benefits of a Covered Condition for twelve (12) consecutive months. The Restoration of Policy Benefits does not apply to Alzheimer's disease or Paralysis.

If the Policy includes coverage for Cancer, as shown on the Policy Schedule Page, benefits for the reoccurrence of a previously diagnosed Cancer are subject to Documented Medical Evidence that supports a Cancer's Period of Remission. We retain the right to have such Documented Medical Evidence reviewed by an Oncologist of Our choice.

The Restoration of Policy Benefits is subject to the Lifetime Maximum Benefit shown in the Schedule.

OPTIONAL RETURN OF PREMIUM RIDER - In the event you die before the first policy anniversary which follows your eightieth (80^{th}) birthday, a Return of Premium Benefit may be payable to your named beneficiary or estate. Benefit payment under this rider is subject to the policy being in force with this rider at the time of your death.

The actual amount of premium that will be returned, if any, will equal:

1. The sum of all premiums you paid for the policy, including premiums paid for this rider and any other benefit rider(s) attached to the policy (unless expressly excluded), while this rider was in force (except for any application and annual policy fees). Premium also includes premiums paid for any dependent(s) insured under the policy. The sum of all premiums is without interest accumulation. MINUS

2. The sum of all benefits paid or then payable under the policy, including benefits paid or payable under any attached benefit riders, to you or on your behalf while this rider was in force.

If we receive a claim for benefits after proceeds have been paid under the terms of this rider, the amount of claim benefits due, if any, will be reduced by the amount of the Return of Premium Upon Death Benefit that has already been paid.

ADVANCE LUMP SUM PAYMENT BENEFIT RIDER
This benefit is made available without cost. At time of claim, it allows you to request policy benefits to be paid in a single lump sum payment in lieu of receiving benefits that would otherwise by payable in Monthly Benefit Amount installments.

The Advance Lump Sum Payment benefit:
1. Is limited to one payment per Covered Person, for the life of the Policy.
2. Cannot be requested once benefits have commenced as individual Monthly Benefit Amount installments.
3. Is subject to the Lifetime Maximum Benefit amount under the Policy.
4. Is not available for benefits payable under the Nursing Home and Assisted Living Facility Benefit Rider, if attached as part of Your Policy.

WAITING PERIOD – There is a 30 day waiting period before we will pay benefits for a loss covered by the policy and attached riders. We will not pay benefits for covered conditions diagnosed or procedures performed during the waiting period.

EXCLUSIONS - This Policy does not cover any loss caused by the following:

1. Any loss due to injury, disease or incapacity, unless related to or attributable to the Covered Conditions as defined.
2. Intentionally self-inflicted injury, while sane or insane.
3. Alcohol or drug abuse (unless drug abuse was a result of the administration of drugs as part of treatment by a Doctor).
4. Committing or attempting to commit a felony.
5. War (declared or undeclared) or any act of war, or service in any armed forces.
6. Engaging in an illegal occupation.
7. Participating in a riot or insurrection.
8. Injury sustained while taking part in any of the following activities:
   (a) Amateur or professional sports or athletics, except this does not include Amateur sports or athletics which are non-contact or undertaken solely for leisure, recreational, entertainment or fitness purposes.
   (b) Mountaineering where ropes or guides are normally used or at elevations of 4,500 meters or higher.
   (c) Aviation, except when travelling solely as a passenger in a commercial aircraft.
   (d) Hang gliding, sky diving, parachuting or bungee jumping.
   (e) Snow skiing or snowboarding, except for recreational downhill and /or cross-country snow skiing or snowboarding (no coverage provided whilst skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body);
   (f) Racing by any animal or motorized vehicle;
   (g) Spelunking;
   (h) Operating, riding in or upon, mounting or alighting from, any two, three, or four wheeled motor/engine driven snowmobile or all terrain vehicle (ATV).

Exclusion 8 applies only to the Covered Conditions of Paralysis and Coma.

RENEWABILITY – You may keep the policy and any attached riders, (except the Return of Premium Upon Death Benefit Rider, which ends the first policy anniversary date after the 80^{th} birthday) in force during your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

PREMIUMS SUBJECT TO CHANGE - We may change your premium rates by giving you at least 31 days prior written notice. We can change the premiums this way only if we change them on a class basis for all policies/riders of this class in your state. If a change in premium should exceed 25%, we will notify you 60 days in advance of the premium change.

INITIAL PREMIUM

☐ **PLAN A – COMPREHENSIVE**		**$_____**
☐ **PLAN B – CANCER CARE+**		**$_____**
☐ **PLAN C – CARDIAC CARE+**		**$ _____**
☐ **RETURN OF PREMIUM RIDER**		**$ _____**
ANNUAL POLICY FEE:		**$ _____**
	TOTAL PREMIUM	**$ _____**

A SHOPPER'S GUIDE TO CANCER INSURANCE

Prepared by the National Association of Insurance Commissioners which is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of consumers.

This Guide Does Not Endorse Any Company Or Policy

Reprinted by: **Guarantee Trust Life Insurance Company**

Should You Buy Cancer Insurance?

Cancer Insurance Is Not a Substitute for Comprehensive Coverage.

Caution: Limitations On Cancer Insurance.

CANCER INSURANCE...

Cancer insurance provides benefits only if you get cancer. No policy will cover cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE...

Cancer treatment accounts for about 10% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE?. . . MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low income people who are Medicaid recipients don't need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first such as a major medical policy. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May Not Be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Misled by Emotions. While three in ten Americans will get cancer over a lifetime,, seven in ten will not. In any one year, only one American in 250 will get cancer. The odds are against your receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

CAUTION: LIMITATIONS OF CANCER INSURANCE...

If your decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, since the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two to three years.

FOR ADDITIONAL HELP...

If you are considering a cancer policy, the company or agent should answer your questions. You do not need to make a decision to purchase the policy the same day you talk to the agent. Be sure to ask how long you have to make your decision. If you do not get the information you want, call or write:

Office of the Commissioner of Insurance 121 East Wilson Street P.O. Box 7873
Madison, WI 53707-7873 (608) 266-0103

If you have a complaint against an insurance company or agent, write the Office of the Commissioner of Insurance at the address above, or call the Complaints Hotline, 800-236-8517.

GUARANTEE TRUST LIFE INSURANCE COMPANY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you the different ways in which Guarantee Trust Life Insurance Company ("GTL") may use and disclose your protected health information.

Among other things, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to:

- Maintain the privacy of your protected health information.
- Provide notice of GTL's legal duties and privacy practices with respect to your protected health information.
- Comply with the terms of the Notice currently in effect; and
- Provide you with this Notice.

You have a right to a paper copy of this Notice which will be provided to you upon request, even if this Notice was provided to you electronically.

Protected health information is information about you that is either held or transmitted by GTL, including demographic information, that identifies you (or can reasonably be used to identify you), and that relates to (i) your past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present or future payment for the provision of health care to you.

GTL understands that your protected health information is personal. We protect the privacy of that information in accordance with all federal and state privacy laws. If a use or disclosure of protected health information described within this Notice, which is required by federal law, is prohibited or materially restricted by state law, GTL will abide by the more stringent law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION

GTL will not use or disclose your protected health information without your written authorization unless the use or disclosure is described within this Notice.

If you have given us written authorization to use or disclose your protected health information, you have the right to revoke that authorization, at any time, except to the extent that: (1) we have already acted in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself. Your written request to revoke an authorization should be directed to the address listed in the "Contact Information" section below.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Payment

We may request, use and disclose your protected health information, as needed, to determine or fulfill our responsibility for coverage and reimbursement for the provision of benefits under your health plan. This may include, but is not limited to:

- determinations of eligibility of coverage (including coordination of benefits with other insurers or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;
- risk adjusting based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;

- disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; policy/account number; and name and address of the health care provider and /or health plan.

For example, if your coverage has a coordination of benefits or other type of cost sharing provision, we may request and disclose protected health information about you to the other health plan carrier to determine the benefits due under the terms of your health plan with us. We may also contact your provider regarding your medical treatments and request details to determine if your coverage will pay for the treatments.

For Health Care Operations

We may use and disclose protected health information about you to support our business operations or the business operations of another insurer. These uses and disclosures are necessary to run the company and make sure all of our policyholders receive the services and benefits provided by their health plan coverage. These activities include, but are not limited to:

- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, however, we are prohibited from using or disclosing genetic information about you for underwriting purposes;
- ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services, and auditing functions, including fraud investigations;
- business planning and development, such as conducting cost-management studies and analyses related to managing and operating the company, including development or improvement of methods of payment or coverage policies; and
- business management and general administrative activities of the company, including, but not limited to:
  - customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  - resolution of internal grievances; and
  - the offer of an enhancement or upgrade to your existing coverage.

To Individuals Involved in Your Care

We may use and disclose your protected health information with your family, friends, personal representative or other individual you identify who are involved in your care or payment of a claim, unless you object. In addition, GTL may use and disclose your protected heath information to persons requesting such information if we can reasonably infer from the circumstances that you would not object to the disclosure. If you are not available to give your consent to a disclosure, or in an emergency, we may disclose your protected health information that is directly relevant to such person's involvement in your care or payment for such care.

To Our Business Associates

We may also share your protected health information to an affiliate or business associate outside of GTL if they need protected health information in order to provide services to us (e.g., billing, claim adjudication and underwriting services.) Whenever an arrangement between GTL and a business associate involves the use or disclosure of your protected health information we will have a written contract that sets forth the terms regarding the use and disclosure of your protected health information and will require them to follow the HIPAA rules relating to the protection of protected health information.

For Other Uses and Disclosures

In addition to the above, we are permitted or required by law to use or disclose your protected health information, without your permission, for the following:

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process. We may also disclose your protected health information if we suspect child abuse or neglect; we may also disclose your protected health information if we believe you to be a victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities:** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights with respect to the protected health information we maintain about you.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to us or to the business associate who maintains the medical information. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent and your agreement in advance to the fees imposed, if any. You may request your records be in paper or electronic format. We may charge a fee for the costs of copying, mailing or other supplies associated with mailing or copying your protected health information. We may deny your request in whole or in part to inspect and copy records in certain circumstances. If you are denied access to medical information, we will provide a written notice explaining the basis for the denial. You may also request that the denial be reviewed. Such request for review will either be approved or denied based on the grounds for denial. If the initial denial is reviewable, the person conducting the review will not be the same person who denied your original request. We will comply with the determination of the representative performing the review.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request and we retain the right to terminate an agreed to restriction. Such termination is only effective with respect to protected health information created or received after GTL has informed the individual of its termination of the restriction. Additionally requesting certain limitations may affect payment of benefits under your health plan. To request restrictions, you must make your request in writing to our Customer Service Department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to request and receive confidential communications. We will accommodate reasonable requests to send your protected health information to you at a different address, or other method of contact. We will not request an explanation from you as to the basis for the request. For example, you can ask that we only contact you at work or by mail. Requests for confidential communications must be made in writing, signed by you and sent to GTL. Your request must specify how or where you wish to be contacted.

You have the right to request an amendment of your protected health information. You may request an amendment of your health information contained in a designated record set for as long as the information is kept by GTL or any of our business associates. To request an amendment, you must send us your request in writing to the address included in the "Contact Information" section below, giving details of your request and why you are making it. If we deny your request for amendment in whole or in part, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. In certain cases, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the designated record set kept by us; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

You have the right to receive an accounting of certain disclosures. You have the right to request an accounting of most disclosures of protected health information made by us during the six years prior to the date the accounting is requested, subject to certain exceptions. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a cost-based reasonable fee.

You have the right to be notified following a breach of unsecured protected health information. You have the right to and will receive a notification of a breach of your unsecured protected health from GTL, or one of its business associates.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint in writing to us at the address shown below in the "Contact Information" section. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

THIS NOTICE IS SUBJECT TO CHANGE
We reserve the right to change the terms of this Notice and our privacy policies at any time. If we do, the new terms will be effective for all protected health information maintained by us, including protected health information received by GTL before the effective date of the new terms. If we do revise our privacy notice, a copy of the new notice will be posted on our web site at www.gtlic.com and/or sent to you if the changes are material.

EFFECTIVE DATE
This Notice is effective September 23, 2013.

CONTACT INFORMATION
If you have questions regarding this Notice or require further information, you may contact our Customer Service Department at 1-800-338-7452. Any written complaints should be directed to Guarantee Trust Life Insurance Company, Attention: Privacy Office, 1275 Milwaukee Avenue, Glenview, Illinois 60025.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Wisconsin *Guide to Health Insurance for People with Medicare*", available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Wisconsin Guide to Health Insurance for People with Medicare

2016

Free health insurance counseling for seniors:

Medigap Helpline
1-800-242-1060

Medigap Part D and Prescription Drug Helpline
1-855-677-2783

These are statewide toll-free numbers set up by the Wisconsin Board on Aging and Long Term Care and funded by the Office of the Commissioner of Insurance to answer questions about health insurance, other health care benefits, and prescription drug benefits for people with Medicare. They have no connection with any insurance company.

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

OCI's Web Site:
oci.wi.gov

PI-002 (R 12/2015)

The mission of the Office of

the Commissioner of Insurance . . .

Leading the way in informing and protecting

the public and responding to their insurance needs.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

To file a complaint online or to print a complaint form:
OCI's Web Site
oci.wi.gov

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

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

Electronic Mail
ocicomplaints@wisconsin.gov
Please indicate your name, phone number, and e-mail address.

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

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

The Office of the Commissioner of Insurance does not represent that the information in this publication is complete, accurate or timely in all instances. All information is subject to change on a regular basis, without notice.

Publications are updated annually unless otherwise stated. Publications are available on OCI's Web site **oci.wi.gov**. If you need a printed copy of a publication, use the online order form or call 1-800-236-8517.

Table of Contents

Page

Introduction 4

What is Medicare? 5

What is Medicare Part D? 8

Coverage Options Available When You Are Eligible for Medicare 11

What Are Wisconsin Mandated Benefits? 12

Individual Policy Options 14

Group Insurance Options 19

Basic Benefits Included in Medicare Supplement Policies 22

Basic Benefits Included in Medicare Select Policies 23

Policy Description 24

Basic Facts About Medicare Supplement Policies 31

Your Grievance and Appeal Rights 36

Prescription Drug Discount Options 38

Consumer Buying Tips 39

What if I Can't Afford a Medicare Supplement Policy? 42

Limited Policies 44

State Health Insurance Assistance Program (SHIP) 45

Filing a Claim 46

What if I Have Additional Questions? 47

Glossary of Terms 50

Acronyms 54

Introduction

This booklet briefly describes the Medicare program. It also describes the health and prescription drug insurance available to those on Medicare. A list of companies that offer Medicare supplement insurance to Wisconsin Medicare beneficiaries, and have chosen to be included in the list, is available on the OCI Web site at oci.wi.gov/pub_list/pi-010.htm.

Our Web site also includes information and booklets regarding other types of consumer insurance policies, including long-term care insurance, life insurance, automobile, and homeowner's insurance.

You may also find companies that offer Medicare supplement insurance and Prescription Drug Plans (PDPs) on the Medicare Web site at https://www.medicare.gov/find-a-plan/questions/home.aspx.

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers, you can file a complaint with our Office.

You can find information on filing a complaint with the Office of the Commissioner of Insurance:

OCI's Web site at oci.wi.gov

or call the Insurance Complaint Hotline
1-800-236-8517 (Statewide)
(608) 266-0103 (Madison)

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

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

IMPORTANT NOTICE

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

What is Medicare?

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

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

Medicare Part A

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

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

Medicare Part B

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

Medicare Part C/Medicare Advantage

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

Medicare Part D/Prescription Drug

Medicare Part D is the Medicare program to provide assistance for Medicare beneficiaries to pay for outpatient prescription drug costs. It is an optional program available to Medicare beneficiaries eligible for Medicare Part A and/or enrolled in Medicare Part B. Additional information about Medicare Part D is included on pages 8-10 of this booklet.

What Are Specific Limitations Under Medicare?

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

Skilled Nursing Care Limitations

Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as defined by Medicare. For more information, visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

Home Health Limitations

Medicare pays limited benefits for home health care services that are considered "medically necessary" by Medicare. For more information, visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

What Preventive Care Is Covered Under Medicare?

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

What Is Meant by Out-of-Pocket Expenses?

Out-of-pocket refers to costs, bills, fees, or expenses you will have to pay yourself. Out-of-pocket expenses occur when you receive a service not covered by Medicare. There are three types of out-of-pocket expenses. First, you will have to pay out-of-pocket expenses to cover the Medicare deductibles, coinsurance, and copayments. In other cases you will have out-of-pocket expenses when you choose a provider whose fees exceed Medicare-approved amounts. Finally, you may receive services not covered by Medicare; in those cases you will have to pay the entire cost of the services. There are insurance policies you can purchase that will cover some out-of-pocket expenses not covered by Medicare called supplement policies. Medicare supplement policies are described in the "Individual Policy Options" of this guide.

What Does Accepting Assignment Mean?

Sometimes a doctor or other provider accepts "assignment." This means that the doctor or provider is paid directly by Medicare and accepts the "Medicare-approved" amount.

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

What is Medicare Part D?

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

Enrollment

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

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

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

The cost of your Medicare Part D coverage will vary based on the PDP that you choose. PDP plans may have deductible, coinsurance and copayment amounts (out-of-pocket expenses) that must be met before the PDP pays for your outpatient prescription drug costs.

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

Premiums

The cost of your Medicare Part D coverage will vary based on the PDP that you choose. If you are not eligible for low-income assistance (referred to as Limited

Income Subsidy), you will pay a monthly premium, an annual deductible, and a percentage of your drug costs. Your PDP will pay for your outpatient prescription drug expenses after you have met deductible and coinsurance amounts. Deductible and coinsurance amounts are those expenses you must pay out-of-pocket before Medicare Part D will pay any money for your outpatient prescription drugs.

Coverage

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

The Donut Hole

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

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

Out-of-Pocket Limit

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

Extra Help for People with Limited Income and Resources

If your income is low, you may qualify for Extra Help, also called Low Income Subsidy or LIS. This is a federal program that helps you pay for most of the costs of Medicare prescription drug coverage. If your income is below $17,655 ($23,895 for couples) and your resources are less than $13,640 ($27,250 for couples), you may qualify for Extra Help. The amount of assistance you qualify for will depend on your income.

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

Tips to Remember

- Participation in the Medicare Part D program is voluntary. However, if you do not enroll in a Part D plan when you are first eligible and you decide to join later, you may have to pay a late enrollment penalty unless you have had creditable drug coverage.
- You do not have to pay an enrollment fee or pay for assistance to enroll in Medicare Part D.
- You will have to pay for Medicare Part D coverage, which may include monthly premiums and cost-sharing, such as annual deductibles, coinsurance and copayments.
- You may be eligible for help to pay for your Medicare Part D prescription drug coverage based on your income.
- You do not have to enroll in Medicare Part D in order to keep your Medicare Part A and Part B coverage.
- You do not have to buy any additional insurance products to be eligible to enroll in Medicare Part D and should be wary of any individual who uses a Part D sales pitch to sell other insurance products.

Contacts

Information regarding Medicare Part D can be obtained by contacting a prescription drug helpline listed on page 48 of this booklet.

Coverage Options Available When You Are Eligible for Medicare

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

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

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

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

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

Generally, if you are eligible for Medicare, you are not eligible for coverage on the Federally Facilitated Marketplace (FFM). Information regarding Medicare and FFM coverage can be found at www.healthcare.gov/medicare/.

What Are Wisconsin Mandated Benefits?

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

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

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

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

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

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

Medicare supplement and Medicare select policies issued prior to January 1, 2006, for individuals who do not enroll in Medicare Part D cover prescription medication, insulin, and supplies associated with the injection of insulin. Prescription drug

expenses are subject to the $6,250 deductible for drug charges. This deductible does not apply to insulin.

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

Chiropractic Care—Medicare supplement and Medicare select policies cover the usual and customary expense for services provided by a chiropractor under the scope of the chiropractor's license. This benefit is available even if Medicare does not cover the claim. The care also must meet the insurance company's standards as medically necessary.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care—Medicare supplement and Medicare select policies cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care for an individual with a chronic disability or an individual with a medical condition that requires hospitalization or general anesthesia for dental care. The care also must meet the insurance company's standards as medically necessary.

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

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

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

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

Individual Policy Options

Many insurance companies offer to individuals eligible for Medicare individual policies that supplement the benefits available under Medicare. These policies are referred to as Medicare supplement or Medigap policies. Common names for these policies include Medicare select or supplemental and Medigap policies.

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

What are Medicare Supplement Policies?

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

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

Outline of Coverage

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

Medicare Supplement Policies

Individual Medicare supplement policies are designed to supplement the benefits available under the original Medicare program. Medicare supplement policies pay the 20% of Medicare-approved charges that Medicare does not pay. These Medicare supplement policies do not restrict your ability to receive services from the doctor of your choice. However, these policies may require that you submit your claim to the insurance company for payment.

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

Some insurance companies offer Medicare supplement or Medicare select cost-sharing policies. These plans require that you pay a portion of the costs for Medicare-covered services until you reach an out-of-pocket limit. For 2016, the out-of-pocket limit for 25% cost-sharing plans is $2,480, and the out-of-pocket limit for 50% cost-sharing plans is $4,960. The out-of-pocket limits for Medicare supplement or Medicare select cost-sharing policies are updated each year and are based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program published by CMS.

Some insurance companies offer Medicare supplement high-deductible plans. High-deductible Medicare supplement plans offer benefits after you have paid a calendar year deductible of $2,180. This deductible consists of expenses that would ordinarily be paid by the policy.

Medicare Select Policies

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

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

In general, Medicare select policies will deny payment or pay less than the full benefit if you go outside the network for nonemergency services. However, this will not impact Medicare payments. Medicare still pays its share of approved charges if the services you receive outside the network are services covered by Medicare.

Medicare Cost Policies

Medicare cost policies are offered by certain HMOs that have entered into a special arrangement with the federal Centers for Medicare & Medicaid Services (CMS). Insurers that market Medicare cost policies offer both basic Medicare cost policies and enhanced Medicare cost policies. The basic Medicare cost policies supplement only those benefits covered by Medicare and do not provide the benefits mandated under Wisconsin insurance law.

You must live in the plan's geographic service area to apply for Medicare cost insurance. The HMO plan doctors or other providers are selected by the HMO. The HMOs agree to provide Medicare benefits and may provide additional benefits at additional cost. Medicare cost insurance will only pay full supplemental benefits if covered services are obtained through HMO plan doctors or other providers, called the plan's "network."

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

Medicare Advantage Plans (Medicare Part C)

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

It is important to note that your Medicare Advantage plan can terminate at the end of the contract year if either the plan or CMS decides to terminate their agreement.

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

Medicare Advantage plans are not regulated by the State of Wisconsin, Office of the Commissioner of Insurance. Therefore, these plans are **NOT** required to cover Wisconsin mandated benefits, nor are the plans guaranteed renewable for life like Medicare supplement policies. Information regarding benefits mandated by Wisconsin insurance laws is available on pages 12-13 of this booklet or by contacting OCI at oci.wi.gov or the phone numbers listed on page 47 of this booklet.

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

You may also find private companies that contract with Medicare to offer Medicare Advantage Plans on the Medicare Web site at https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html.

Medicare Advantage Health Maintenance Organization Plans

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

Medicare Advantage Preferred Provider Organization Plans

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

Medicare Advantage Private Fee-For-Service Plans

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

Group Insurance Options

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

Employer Group Plans

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

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

Employer Plans

Federal law determines when Medicare is the primary payer and when it is the secondary payer. This determination is based on whether you are defined as the employee or dependent under the group insurance policy and on whether the group insurance policy is offered by an employer with 20 or more employees. In some cases, your employer may offer a supplement to Medicare through a group retiree plan.

Employers With 20 or More Employees

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

In either of these cases, when the employee (you or your spouse) retires and is no longer considered an active employee, each Medicare eligible beneficiary (you and/or your spouse) will have a Special Enrollment Period and should enroll in Medicare Part B (if not already enrolled). If you don't enroll in Medicare Part B and are allowed to continue your employer's group health plan, the group policy may pay only the 20% and you will be responsible for paying the 80%. This is because your group policy may calculate its benefit payment as if you are enrolled in Medicare Part B regardless of whether you sign up for Medicare Part B. Also, to apply for a Medicare supplement or Medigap policy, most insurance companies require that you have both Medicare Part A and Part B.

Employers With Less Than 20 Employees

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

You should contact your local Social Security office for the publication *Medicare and Other Health Benefits: Your Guide to Who Pays First*. You may view this publication online at www.medicare.gov and key in the title of the publication.

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

COBRA Coverage

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

Special Enrollment

If you didn't take Medicare Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your

spouse's employer or union, you can sign up for Medicare Part B during a Special Enrollment Period. You can sign up anytime you are still covered by the employer or union group health plan through your or your spouse's current or active employment during the eight months following the month the employer or union group health plan coverage ends or when the employment ends (whichever is first).

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

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

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

Voluntary Association Plans

Many associations offer group health insurance coverage to their members. Association plans are not necessarily less expensive than comparable coverage under an individual policy. Be sure you understand the benefits included and then compare prices. Association groups that offer Medicare supplement insurance must comply with the same rules that apply to other Medicare supplement policies.

Basic Benefits Included in Medicare Supplement Policies

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

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

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

Basic Benefits Included in Medicare Select Policies

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

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

Policy Description

The charts on pages 25 - 30 provide a brief description of benefits of Medicare supplement and Medicare select policies offered in Wisconsin. Check the Outline of Coverage that you receive from the company and the policy itself for details. A booklet entitled *Medicare & You* is available free from your Social Security office and explains Medicare benefits in detail.

For information on Medicare supplement insurance policies approved by the Office of the Commissioner of Insurance (OCI), visit our Web site or contact OCI and request a copy of the booklet *Medicare Supplement Insurance Approved Policies*. The booklet includes only policies offered by companies that have agreed to be listed in the booklet and is updated on an annual basis.

Medicare supplement insurance companies can only sell standardized Medicare supplement policies. Each standardized Medicare supplement policy must offer the same basic benefits, no matter which insurance company sells it. The optional benefits and cost are the major difference among the Medicare supplement policies sold by different insurance companies.

POLICY BENEFITS—TRADITIONAL INSURERS

All **Medicare supplement** policies offered by traditional insurance companies provide the following benefits:

Basic Benefits

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
4. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
5. First 3 pints of blood
6. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
7. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments
8. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction . The care also must meet the insurance company's standards as medically necessary.
9. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Optional Benefits

Insurance companies may offer the following optional benefits as a separate benefit for an additional premium:

1. Part A deductible **($1,288)**
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less
5. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
6. Medicare 50% Part A deductible
7. Part B copayment or coinsurance rider

POLICY BENEFITS—TRADITIONAL INSURERS COST-SHARING 50% AND 25%

Medicare supplement cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. The out-of-pocket limits for 2016 are $4,960 or $2,480 for 50% or 25% cost-sharing policies, and the 2016 Part B deductible is $166.

All **Medicare supplement cost-sharing** policies offered by traditional insurance companies provide the following benefits:

Basic Benefits

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)** (50% or 25%)
4. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
5. First 3 pints of blood (50% or 25%)
6. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
7. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments
8. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
9. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Optional Benefits

Insurance companies may offer the following optional benefits as a separate benefit for an additional premium:

1. Part A deductible **($1,288)** (50% or 25%)
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less

5. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.

POLICY BENEFITS—MEDICARE SELECT

All **Medicare select** policies provide the following benefits:

Basic Benefits

1. Part A deductible **($1,288)**
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood
7. Part B deductible **($166)**
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Optional Benefits

Insurance companies may offer the following optional benefits as a separate benefit for an additional premium:

1. Medicare 50% Part A deductible
2. Part B copayment or coinsurance rider

POLICY BENEFITS—MEDICARE SELECT COST-SHARING 50% AND 25%

Medicare select cost-sharing policies provide benefits after you have met your out-of-pocket limit and your calendar year Part B deductible. The out-of-pocket limits for 2016 are $4,960 or $2,480 for 50% or 25% cost-sharing policies, and the 2016Part B deductible is $166.

All **Medicare select cost-sharing** policies provide the following benefits:

1. Part A deductible **($1,288)** (50% or 25%)
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)** (50% or 25%)
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood (50% or 25%)
7. Part B deductible **($166)**
8. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
9. 365 home health care visits including those paid by Medicare. The care also must meet the insurance company's standards as medically necessary.
10. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
11. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
12. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

POLICY BENEFITS—COST INSURANCE - BASIC AND ENHANCED

Basic Plan

1. Copayment for 61st to 90th day of hospitalization **($322 a day)**
2. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
3. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
4. First 3 pints of blood
5. 40 home health care visits in addition to Medicare. The care also must meet the insurance company's standards as medically necessary.
6. 20% of Medicare's Part B services with no lifetime maximum or, in case of hospital outpatient department services under a prospective payment system, applicable copayments

Note: Policies may also include preventive health care services, such as routine physical examinations, immunizations, health screenings, and private duty nursing services.

Enhanced Plan

Insurance companies may offer additional benefits for an additional premium:

1. Part A deductible **($1,288)**
2. Additional home health care (up to 365 visits per year). The care also must meet the insurance company's standards as medically necessary.
3. Part B deductible **($166)**
4. Part B excess charges up to the actual charge or the limiting charge, whichever is less
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
7. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
8. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet medical necessity requirements. The care also must meet the insurance company's standards as medically necessary.

POLICY BENEFITS—HIGH-DEDUCTIBLE PLAN

High-deductible Medicare supplement plans offer benefits after you have paid a calendar year deductible of $2,180. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the separate foreign travel emergency deductible of $250.

Benefits

1. Part A deductible included
2. Copayment for 61st to 90th day of hospitalization **($322 a day)**
3. Copayment for 91st to 150th day of hospitalization **($644 a day)** - full coverage after Medicare days are exhausted
4. Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility **($161 a day)**
5. 175 days per lifetime of inpatient psychiatric care in addition to Medicare's 190 days per lifetime
6. First 3 pints of blood
7. Part B deductible included
8. Part B excess charges up to the actual charge or the limiting charge, whichever is less, included
9. 20% of Medicare's Part B services with no lifetime maximum and actual charges for authorized referral services
10. 365 home health care visits including those paid by Medicare. he care also must meet the insurance company's standards as medically necessary.
11. Foreign Travel Emergency: May have a deductible of up to $250. Must pay at least 80% of billed charges for Medicare-eligible expenses for medically necessary emergency care received outside the U.S. Emergency care must begin during the first 60 days of a trip outside the U.S. Benefit limit must be at least $50,000 per lifetime.
12. Coverage for full usual and customary cost of non-Medicare covered chiropractic care, non-Medicare hospital and ambulatory surgery center charges and anesthetics for dental care, and non-Medicare breast reconstruction. The care also must meet the insurance company's standards as medically necessary.
13. Coverage for 30 days non-Medicare skilled nursing facility care - no prior hospitalization required but must meet the insurance company's standards as medically necessary

Basic Facts About Medicare Supplement Policies

Open Enrollment

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

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

Guaranteed Issue

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

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

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

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

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

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

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

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

- Must cover you for all preexisting conditions, and

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

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

Suspension of Medicare Supplement Policy

Medicare supplement and Medicare select policies must allow Medicare beneficiaries with coverage the right to suspend their Medicare supplement coverage when they have employer group health plan coverage. This option was created by federal law and is referred to as a Ticket to Work provision. If you are a Medicare beneficiary with Medicare supplement coverage and you want to suspend your Medicare supplement policy, you can do so by calling your Medicare supplement insurance company.

If you later lose your employer group health plan coverage, you can contact the Medicare supplement insurance company within 90 days of losing your employer coverage and get your Medicare supplement policy back.

30-day Free Look

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

Renewability

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

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

Midterm Cancellation

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

Waiting Periods, Limitations, and Exclusions

Many Medicare supplement insurance policies have waiting periods before coverage begins. If your policy excludes coverage for preexisting conditions for a limited time, it must provide this information on the first page of the policy. The waiting period for preexisting conditions may not be longer than **six months**, and only conditions treated during the six months before the effective date of the policy may be excluded.

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

Creditable Coverage

Health Creditable Coverage

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

Prescription Drug Creditable Coverage

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

Common Exclusions

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

Some services that are frequently excluded under these policies are:

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

Medicare supplement policies include two other exclusions that are frequently misunderstood:

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

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

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

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

2. **Custodial Care—**Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare **if your doctor certifies that it is medically necessary and the care meets the insurance company's standards as medically necessary.** There are **no** benefits for custodial care. In general, Medicare supplement, Medicare select, Medicare cost, and Medicare Advantage plans cover only skilled care and do not cover custodial or intermediate care. Skilled nursing care is quite narrowly defined.

Your Grievance and Appeal Rights

Medicare Supplement Mandated Benefits

Grievance Procedure

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

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

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

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

Benefit Appeal

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

Independent Review

For Wisconsin mandated benefits under Medicare supplement policies, if you are not satisfied with the outcome of a grievance and the grievance involves a dispute regarding medical necessity or experimental treatment, you or your authorized

representative may request that an independent review organization (IRO) review your insurance company's decision. The independent review process provides you with an opportunity to have medical professionals who have no connection to the insurance company review the dispute. The IRO has the authority to determine whether the treatment should be covered by the insurance company.

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

Original Medicare Part A and Part B and Medicare Prescription Drug Coverage

Information can be found at https://www.medicare.gov/claims-and-appeals/.

Prescription Drug Discount Options

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

SeniorCare Prescription Drug Assistance Program

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

SeniorCare's eligibility requirements include:

1. Must be a Wisconsin resident.

2. Must be 65 years of age or older.

3. You must be a U.S. citizen or qualifying immigrant.

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

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

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

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

Consumer Buying Tips

Cost of Policies

When buying a Medicare supplement policy, you should find out exactly what the premium will be. A few insurance companies charge everyone the same amount. Most companies charge different premiums based on your age at the time of application. Several companies also use other factors, such as different rates for men and women or different rates in different parts of the state. Companies also charge different premiums if you currently use, or have a history of using, tobacco (if you are not applying during your open enrollment period).

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

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

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

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

Under Age 65. Your premium is calculated for individuals who, due to a disability, are eligible to enroll in Medicare under age 65. (If you are under age 65 and enrolled in Medicare due to disability or end stage renal disease, you are entitled to another six-month open enrollment period upon reaching age 65.)

Policy Delivery and Refunds

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

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

Policy Storage

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

Duplicate Coverage

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

Health History

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

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

Payment

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

Replacing Existing Coverage

Make sure you have a good reason for switching from one policy to another. You should only replace existing coverage for different benefits, better service, or more affordable premiums. Do not terminate your existing policy until your new policy is in effect. You should also make sure to cancel the policy you are replacing. An agent generally cannot cancel your existing policy. If you have questions about the process, you should contact the company.

If you are replacing a Medicare Advantage plan, you must follow the plan's cancellation procedure. You will be responsible for paying premiums for the Medicare Advantage plan if you do not follow the plan's cancellation procedure. If you have questions about the process, you should contact the company.

Insurance Agents and Companies

Insurance agents and companies must be licensed to sell Medicare supplement and other insurance. Keep the agent's business card and information regarding the insurance company's address and telephone number.

You can check with the Office of the Commissioner of Insurance Web site at oci.wi.gov to see if they are licensed.

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

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

Medicaid Program

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

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

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

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

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

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

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

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

Limited Policies

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

Long-Term Care Coverage—These policies cover long-term nursing home and/or home health care. Visit our Web site or contact OCI and request a copy of the booklet *Guide to Long-Term Care*.

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

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

ATTENTION

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

State Health Insurance Assistance Program (SHIP)

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

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

Filing a Claim

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

- Keep an accurate record of all your health care expenses. Store this information with your Medicare supplement insurance or other health insurance policies.
- Whenever you receive treatment, present your Medicare card and any other insurance card you have.
- File all claims promptly. You will receive a Medicare Summary Notice (MSN) in the mail every 3 months. If the insurance company requests a copy of the Medicare Summary Notice, make a copy of the MSN and record the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.
- You do not have to submit your claims to Medicare. Your doctor, supplier, or other Medicare provider must submit claims to Medicare for you.
- If you enroll in a health maintenance organization (HMO), you will not have to file claims for services covered by HMO providers. All claims for covered services will be handled by the HMO.
- Some Medicare supplement insurance companies have an automatic claims filing program. This means that the insurance company receives a copy of your claim as soon as it is processed by Medicare. There may be a charge for this service.
- For more information on filing claims, you may want to contact the benefit specialist at your county or tribal aging office.

NOTE

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

What if I Have Additional Questions?

If you have questions or complaints about:

Health Insurance

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

  This is the Wisconsin Senior Health Insurance Assistance Program (SHIP) with a statewide toll-free number staffed by the Wisconsin Board on Aging and Long Term Care (BOALTC) and funded by the Office of the Commissioner of Insurance. BOALTC provides free insurance counseling services to Medicare beneficiaries and can answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

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

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

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

  OCI publishes several consumer guides to assist seniors in shopping for insurance. The publications should be used only as a guide. These guides are not legal documents and do not represent your rights under any insurance policy or government program. Your policy, contract, or federal or state laws establish your rights. Consult an attorney for legal guidance about your specific rights. Legal assistance may also be available through your county or tribal aging office which can be found at https://www.dhs.wisconsin.gov/benefit-specialists/index.htm.

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

Web Site
oci.wi.gov

Mailing Address
P.O. Box 7873
Madison, WI 53707-7873

Street Address
125 South Webster Street
Madison, WI 53703

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

Elder Benefit Specialists
Disability Benefit Specialists

All benefit specialists can help people with Medicare questions and concerns. Elder Benefit Specialists are trained to help anyone 60 years of age or older who is having a problem with private or government benefits and are available at either an Aging and Disability Resource Center (ADRC) or a county/tribal aging unit. Disability Benefit Specialists are available at all ADRCs and they serve Medicare beneficiaries ages 18-59.

All local contact information can be found on https://www.dhs.wisconsin.gov/benefit-specialists/index.htm.

Medicare

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

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

  Address
  7500 Security Boulevard
  Baltimore MD 21244-1850

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

- **Medicare Claim Appeal for Part A and Part B**

  The Medicare contractor that processed your Medicare claim(s) appears on your Medicare Summary Notice (MSN). Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. You will get an MSN in the mail every 3 months, and you must file your appeal within 120 days of the date you get the MSN. For more information about filing a Medicare appeal, visit the Medicare Web site https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html.

- **SeniorCare**

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

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

- **Prescription Drug Helplines for Medicare Beneficiaries**

  Medicare Part D and Prescription Drug Helpline
  Toll-free information line that provides free counseling to all Wisconsin Medicare beneficiaries age 60 and over on prescription drug coverage options in Wisconsin, including Medicare Part D.

  Wisconsin Board on Aging and Long Term Care
  1402 Pankratz Street, Suite 111
  Madison, WI 53704-4001

  1-855-677-2783 (toll-free)
  E-mail: BOALTC@wisconsin.gov

  Disability Drug Benefit Helpline
  Toll-free information line that provides free counseling to Wisconsin Medicare beneficiaries under age 60 with a disability.

  Disability Rights Wisconsin
  1-800-926-4862
  www.disabilityrightswi.org

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

covered by a policy you buy during your Medicare supplement open enrollment period or guarantee-issue period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Open enrollment period: A one-time only six-month period when you can buy any Medicare supplement policy you want that is sold in Wisconsin. It starts when you sign up for Medicare Part B and you are age 65 or older.

You cannot be denied coverage or charged more due to present or past health problems during this time period.

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

Preexisting condition: A medical condition diagnosed or treated up to 6 months prior to the purchase of an insurance policy. Medicare supplement policies may impose up to a 180-day waiting period before coverage for that condition begins.

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

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

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

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

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

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

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

Acronyms

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

ADRC Aging and Disability Resource Center

BOALTC Board on Aging and Long Term Care

CMS Centers for Medicare & Medicaid Services

COB Coordination of Benefits

COBRA Consolidated Omnibus Budget Reconciliation Act

DME Durable Medical Equipment

EOB Explanation of Benefits

EOMB Explanation of Medicare Benefits

HMO Health Maintenance Organization

IRO Independent Review Organization

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

MSN Medicare Summary Notice

OCI Office of the Commissioner of Insurance

PDP Prescription Drug Plan

PFFS Private Fee for Service Plan

PPO Preferred Provider Organization Plan

QMB Qualified Medicare Beneficiary Program

SHIP State Health Insurance Assistance Program

SLMB Specified Low-Income Medicare Beneficiary Program

SNF Skilled Nursing Facility