SHIP Navigation Guide

Book 2

LOCAL HELP FOR PEOPLE WITH MEDICARE

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Section G: Medicare Supplement Insurance

Introduction

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

Group Policies

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

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

Individual Policies

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

Medigap Policy Requirements

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

- **Outline of Coverage:** Insurance agents must give each applicant an outline of coverage summarizing the policy's benefits and features.
- **30-Day Free Look:** Once you receive the certificate or policy, you have 30 days to review the policy and return it for a full refund of premiums paid. This is called a "free look period." If the certificate or policy is mailed to you, the 30 day free look begins the date of the postmark on the envelope.
- **Pre-existing Condition:** While the insurance company can't make you wait for all your coverage to start, it may be able to make you wait for coverage for a pre-existing condition. A pre-existing condition is a health problem for which you have received treatment before the date a new insurance policy begins.
    - If you have a health problem before your Medigap policy starts, the insurance company can refuse to cover that health problem for up to six months. This is called a pre-existing condition waiting period.
    - The insurance company can only use this waiting period if your health problem was diagnosed or treated during the six months before the Medigap policy starts.
    - If you buy a Medigap policy during your Medigap Open Enrollment and you had at least six months of health coverage that qualifies as "creditable coverage", the company cannot apply a pre-existing waiting period.
    - If you had less than six months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had four months of creditable coverage, the waiting period would be reduced to two months.
    - Creditable coverage for Medigap policies is defined as any other health coverage you had prior to applying for a Medigap policy, without a break in coverage longer than 63 days.

These types of health coverage may be considered creditable coverage:

- A group health plan (i.e. employer or union plan)
- A health insurance policy
- Medicare Part A or Part B
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- TRICARE (military retirees and dependents)
- A Federal Employees Health Benefit plan
- A public health plan
- COBRA
- SCHIP (State Children's Health Insurance Program)

The following are not considered creditable coverage:

- Hospital indemnity insurance
- Specified disease insurance (i.e. cancer insurance)
- Vision or dental plans
- Long-term care policies

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

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

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

- **Coordination of Benefits:** Medigap policies may not contain benefits that duplicate benefits provided by Medicare. This means the policies will not duplicate any payments Medicare has made. It also means policies will not

usually cover services that Medicare would not approve. Exception: some policies will pay for additional benefits not covered by Medicare (such as foreign travel, preventive care, and Part B excess charges).

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

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

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

- **Medicaid and Medigap:** There are some special situations when it comes to Medicaid and Medigap policies.

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

    - If you already have Medicaid, an insurance company can sell you a Medigap policy only if:

        - Medicaid pays your Medigap policy premium, or

- Medicaid pays your Part B premium as part of the Medicare Savings Program

Medigap Coverage

Pre-Standardized Policies

If you have a Medigap policy purchased before 1992, then it is most likely a pre-standardized policy. In Indiana, the standardization law does not affect the pre-standardized policies. Medicare beneficiaries were not required to purchase a standardized policy. While these policies can no longer be sold, as long as the policies are in effect, the benefits will still be covered. These policies must be reviewed in order to determine what benefits are covered by the policy.

Basic benefits for pre-standardized policies included co-payment coverage for Parts A and B, the first three pints of blood, and coverage for an additional 365 days of hospitalization (paid at 90%). Insurance companies added various other benefits to these policies and combined them in a number of ways. Many of these policies offered excellent prescription drug coverage.

Medigap Standardization

Medigap policies changed with the Omnibus Budget Reconciliation Act (OBRA) of 1990. As of January 1, 1992, insurance companies can sell you a "standardized" Medigap policy.

There are currently ten standardized plans that can be sold in any state. These plans were developed by the National Association of Insurance Commissioners (NAIC). They are labeled Plans A through N.

- Each standardized plan will be identical in benefits from company to company; however, premiums for each plan may vary from company to company.
- A state may limit the number of plans sold in that state to less than ten, but plan A and Plan C or F must be included as one of the plans for sale.
- In Indiana, all Medigap insurance companies must offer Plan A but can choose the sell any of the other nine plans. Other than Plan A, the insurance companies in Indiana are not required to sell any other plan.
- Not all standardized plans are offered in every state.

- Some states are exempted from federal standardization due to programs in place prior to the law being enacted (Minnesota, Massachusetts, and Wisconsin).
- Some states allow additional benefits to be offered by the insurance company,
- The only U.S. areas where standardization is not in effect are Guam, American Samoa, and the Northern Mariana Islands.

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 changed many things about Medigap plans. Basic benefits have changed, there are new plans, and some plans are no longer available for purchase. These changes went into effect for plans with an effective date of June 2010. Plans issued with an effective date 1991 through May 2010 are now called 1990 Plans, and plans with an effective date June 2010 and after are referred to as 2010 Plans.

1990 Plans

Standardized Medigap plans issued 1991 through May 2010 are called 1990 plans. These plans are no longer available for purchase; however, as Medigap policies are Guaranteed Renewable, these plans are still in effect and the benefits covered are not changed by the MIPPA Act. Each standardized Medigap policy must cover basic benefits. Plans A through J have one set of standardized benefits and plans K and L have another set. Most policies pay some, if not all, of the Medicare coinsurance and co-payments

In addition, Medigap policies can offer “Extra Benefits”. These benefits can cover such things as Part A and/or Part B deductibles, skilled nursing co-payments, foreign travel, preventive care, and the Part B excess charge.

Basic Benefits for 1990 Plans

Medicare Part A Co-Payment and Hospital Benefits

The amount you must pay for days 61-150 in a hospital benefit period. This benefit also covers an additional 365 more days after your Medicare benefits are used up.

Part A Deductible

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

Part B Deductible

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

Part B Excess Charge

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

At-Home Recovery

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

- Total number of at-home recovery visits cannot exceed the total number of Medicare covered visits.
- After the date of the last home visit covered by Medicare, the policy will only pay for benefits for up to eight additional weeks.
- The policy pays maximum of $1,600 per year.
- The visits are limited to four hours in duration, $40 per visit and, seven visits per week.

Preventive Care

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

Note: Plans H through J purchased prior to January 1, 2006, included prescription drug benefits. Plans H and I offered a Basic Drug Benefit – You pay an annual $250 deductible and the Medigap plan pays 50% of your prescription drug costs up to a maximum of $1,250 per year. Plan J offered Extended Drug Benefit – You pay an annual $250 deductible and the plan pays 50% of your drug costs up to $3,000 per year.

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

- Keep their Medigap policy and its drug coverage,
- Purchase a Medicare PDP and drop their Medigap policy's drug benefit, or
- If they purchased a Medicare PDP before May 15, 2006, they had a guaranteed issue to switch to another Medigap policy.

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

1990 Medigap Plans

Medigap Benefits	A	B	C	D	E	F*	G	H	I	J*	K	L
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Co-payment	X	X	X	X	X	X	X	X	X	X	50%	75%
Medicare Preventive Care Part B Coinsurance	X	X	X	X	X	X	X	X	X	X	X	X
Blood – first 3 pints	X	X	X	X	X	X	X	X	X	X	50%	75%
Part A Hospital Deductible	X	X	X	X	X	X	X	X	X	X	50%	75%
Skilled Nursing Facility Care Co-payment			X	X	X	X	X	X	X	X	50%	75%
Part B Deductible			X			X				X		
Medicare Part B Excess Charge						X	80%		X	X		
Foreign Travel Emergency (up to plan limits)			X	X	X	X	X	X	X	X		
At Home Recovery				X			X		X	X		
Preventive Care					X					X		
*Denotes that Plans F and J have a high deductible option. The plans pay the same benefits as Plans F and J after you have paid a deductible of $2180, which can change annually.											Out of Pocket Limit	
											$4,960	$2,480

2010 Plans

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 changed many things about Medigap plans. These changes became effective for plans with an effective date June 2010 and are referred to as 2010 plans.

Basic Benefits 2010 Plans

Medicare Part A Co-payment and Hospital Benefits

is the amount you must pay for days 61-150 in a hospital benefit period. This benefit also covers an additional 365 more days after your benefits are used up.

Part B Coinsurance or Co-payment

is the amount you are responsible for after meeting your annual Part B deductible. Plans A through G, plus plan M will pay 100%; Plan K pays 50% and Plan L pays 75%. Plan N will pay 100% of Part B coinsurance except up to $20 co-payment for office visits and up to $50 for emergency room visits. All plans will pay 100% of the coinsurance for preventive services.

Blood

Plans A through G plus M and N will pay 100% of the first three pints of blood per year; Plan K pays 50% and Plan L pays 75%

Hospice Care

Plans A through G plus Plans M and N pay 100% of the cost sharing for all Part A expenses and respite care; Plan K pays 50% and Plan L pay 75%.

Extra Benefits for 2010 Plans

Skilled Nursing Facility Care Co-payment

This is the amount you must pay for days 21-100 in a skilled nursing facility. In Plans C through G Plan M and N will pay 100% of the co-payment; Plan K pays 50%; Plan s L pays 75%.

Part A Deductible

This is the amount you are responsible for before Medicare will begin to pay for an inpatient hospital stay in each benefit period. Plans B through G Plan N will pay 100% of the deductible: Plans K and M pay 50% and Plan L pays 75%.

Part B Deductible

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

Part B Excess Charge

This is the difference between Medicare's approved payment amount and the doctor's or health care provider's actual charge is subject to any limiting charge. Plans F and G pay 100% of the excess charge.

Foreign Travel Emergency

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

Medigap Plans Effective on or After June 1, 2010

Medigap Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B Coinsurance or Co-payment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% **
Part A Hospice Care Coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Blood – first 3 pints	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A Hospital Deductible	100%	100%	100%	100%	100%	100%	50%	75%	50%	100%
Skilled Nursing Facility Care Coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part B Deductible			100%		100%			100%		
Medicare Part B Excess Charge					100%	100%				
Foreign Travel Emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
*Denotes that Plan F has a high deductible option. The plan pays the same benefits after you have paid a deductible of $2180, which can change annually. **Except for co-pay up to $20 for some office visits/ $50 for some ER visits							Out of Pocket Limit 2016			
							$4,960	$2,480		

Medigap Plans and Disability or ESRD

In Indiana, insurance companies can choose to sell Medigap Plans to individuals under 65 and have Medicare due to disability or ESRD (End State Rental Disease). Keep in mind that there is no Guaranteed Issue for Medicare beneficiaries under 64 when they enroll in Medicare. The monthly premium for these plans will cost you more than policies sold to those over the age of 65.

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

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

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

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

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

Medigap Guaranteed Issue (Open Enrollment)

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

During this time, the insurance company cannot:

- deny you any Medigap policy it sells
- make you wait for all your coverage to start
- charge you more than the standard rate for any Medigap policy because of your health problems (medically underwrite your policy).

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

If you buy a Medigap policy during your Medigap open enrollment and you had at least six months of health coverage that qualifies as “creditable coverage,” the company cannot apply a pre-existing waiting period. If you had less than six months of creditable coverage, this waiting period would be reduced by the number of months you had creditable coverage. For example, if you had four months of creditable coverage, the waiting period would be reduced to two months.

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

You can send in your application for a Medigap policy before your open enrollment period begins. This may be important if you currently have coverage

that will end you when turn 65. This will allow you to have continuous coverage without any break.

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

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

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

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

Medigap Policy Pricing

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

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

Type of Pricing	How it's Priced	What Pricing May Mean for You	Examples
Community-rated (also called no-age-rated)	The same monthly premium is charged to everyone who has the Medigap policy, regardless of age.	Premiums are the same no matter your age. Inflation will affect the premium.	Mr. Smith is age 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is age 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium because with this type of policy, everyone pays the same price regardless of age.

Issue-age-rated	The premium is based on the age you are when you buy (are issued) the Medigap policy.	Premiums are lower for younger buyers. Inflation will affect the premium.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is age 72. She buys the same Medigap policy as Mr. Han. Since she is older at the time she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you have "attained") so your premium goes up each year	Premiums are low for younger buyers, but go up every year and can eventually become the most expensive. Inflation will affect the premium.	Mrs. Anderson is age 65. She pays a $165 monthly premium. Her premium will go up every year. At age 66, her premium goes up to $171. At age 67, her premium goes up to $177. At age 72, her premium goes up to $189.

Medicare Rights and Protections

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

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

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

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

There are seven situations in which you may qualify for a guaranteed issue right.

Situation 1

You are in a Medicare Advantage Plan rather than Original Medicare Program and it stops giving care in your area.

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

If you decide to switch to Original Medicare:

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

Situation 2

You have Original Medicare and an employer group health plan, retirement plan, union coverage or COBRA coverage that pays after Medicare pays and that plan is ending.

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

- If you lose coverage for one of the following reasons:
    - The employer goes out of business
    - The employer stops offering the health plan
    - You are no longer eligible for the health plan (i.e. if your coverage is from your spouse and you divorce or your spouse dies)
    - You have COBRA coverage that is ending.
- You have the right to buy a **Medigap Plan A, B, C, F, K or L**.
- You must apply for the policy **within 63 days after** the latest of these dates:
    - The date your coverage ends,
    - The date on your notice that coverage is ending, or
    - The date on your claim denial, if this is the only way you know that your coverage has ended.
- If the employer offers you COBRA coverage, you can either buy a Medigap policy right away or you can wait until the COBRA coverage ends. Then you will have another right to buy a Medigap policy.

Situation 3

You have Original Medicare and a Medicare SELECT plan, or you are in a Medicare Advantage Plan and your coverage ends because you move out of the plan's service area.

If you receive your health coverage from a Medicare Advantage Plan, and you move out of the plan's service area, you will have to end your coverage.

If you have a Medicare SELECT policy, you can keep your policy because it is guaranteed renewable. However, because you have moved, you may not be able to use a hospital or other providers that are no in the policy's network. If this is the case, you may want to consider switching to another Medigap Plan.

You have the right to buy **Medigap Plans A, B, C, F, K or L**.

You must tell your current plan that you are moving and give them a date when your coverage will end. It is best to do so in writing.

You may apply for a Medigap policy as early **as 60 days before your coverage ends**.

You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Situation 4
Trial Right

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

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

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

Situation 5

Trial Right

You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time. You have been in the plan less than a year and want to switch back.

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

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

Situation 6

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

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

You have the right to purchase a **Medigap Plan A, B, C, F, K or L**.

You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Situation 7

You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules or it misleads you.

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

You have the right to purchase a **Medigap Plan A, B, C, F, K or L**.

Generally, to have this right, you must have filed a grievance with the Medicare Advantage Plan, Medicare, or the Indiana Department of Insurance and received a decision that the Medicare Advantage plan was at fault.

You must tell the Advantage Plan that you want to leave (disenroll) and give them a date to end coverage.

You must apply for a Medigap policy **no later than 63 days after** your coverage ends.

Laws for Insurance Companies and Agents

Advertising

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

An agent must:

- Identify themselves as insurance agents (with name, address and telephone number) and identify the company for which they work.
- Give the consumer a receipt for materials (documents, cash, checks, etc.) given to them by the customer.
- Completely disclose the purchaser's medical history on the application (when medical history is required).
- Give the purchaser an Outline of Coverage at the time of application. This is an overview of what the policy covers.
- If an existing Medigap policy is to be replaced, give the applicant a Notice Regarding Replacement of Medicare Supplement Insurance.
- Not use any false, deceptive, or misleading representation to induce a sale; nor use any methods of marketing having an effect of or tending to induce the purchase of insurance through force, fright or threat; whether explicit or implicit.

Please report any violations by agents to:

Indiana Department of Insurance's Consumer Services 1-800-622-4461.

Illegal Insurance Practices

It is illegal for any company or individual to:

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

Discrimination

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

Financial Stability

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

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

A.M. Best Company

Three options to access this service:

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

Duff & Phelps (Fitch Investors Service, Inc.)

1-800-853-4824, ex. 199. Free rating of a single company.

Fitch Investors Service, Inc.

1-800-892-4824, ext. 199. Up to five verbal ratings at no charge.

Moody's Investor Service

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

Standard & Poor's Services

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

Weiss Research, Inc.

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

Section H: Medicare Managed Care - HMO

Medicare Advantage Plans

Introduction

Medicare Advantage Plans are health plan options that are approved by Medicare and offered through private insurance companies. They are another way of getting your Medicare Part A and Part B covered services. Medicare pays a set amount of money each month to these private companies for member's health care services. These plans are also known by several names, such as:

- Medicare Part C
- Medicare +Choice
- Medicare Managed Care Plans
- Medicare Health Plans
  - Note: these plans are commonly referred to as Medicare Health Plans on the Medicare website www.medicare.gov

How do Medicare Advantage Plans work?

If you join one of these plans, you will generally get all of your Medicare-covered health care through that plan. These plans must cover medically-necessary Medicare Part A and Part B services. The plans may have special rules that members need to follow in order for their provider service to be covered, which means you may have to receive services within the network in order to have the services covered by the plan. You need to review the plans information for details on any rules that may apply.

In addition to the Medicare-covered services, Medicare Advantage Plans may offer extra benefits that Medicare does not cover, such as routine vision and dental services. Some plans also include Medicare prescription drug coverage.

When you join a Medicare Advantage Plan you may pay a monthly premium in addition to your Medicare Part B premium. However, some Medicare Advantage Plans may offer an additional benefit by reducing the amount its members pay for

their Medicare Part B premiums. The Federal government pays plans a set amount each month to cover services the plan members may receive. The Part B premium a member pays is included in the monthly payment the Federal government sends to the plan.

As a member of a Medicare Advantage Plan, your cost share, deductibles, co-payments and coinsurance, for services may differ from Original Medicare. A few examples:

Doctor's visit

- Under Original Medicare, you would pay 20% of the Medicare approved amount after the Part B annual deductible had been met.
  - Part B deductible for 2016 is $166
- Under your Medicare Advantage Plan, you may pay a co-pay of $10 for the visit with no annual deductible to meet.

Inpatient Hospital stay

- Under Original Medicare, you would pay a deductible for the first 60 days of a benefit period and daily co-pays for days 61-150.
- Original Medicare cost share for 2016
  - Part A deductible is $1,288 in 2016 for the first 60 days of the benefit period
  - Co-pay of $0 for the first 60 days of each benefit period.
  - Co-pay of $322 per day for days 61-90 in a benefit period.
  - Co-pay of $644 per day for days 91-150 in a benefit period.
- Under your Medicare Advantage Plan, you may pay $200 per day for the first 10 days and nothing for the remainder of the benefit period.

While your cost share for most covered services can differ from Original Medicare, Medicare Advantage Plans cannot charge a higher cost share than Original Medicare for chemotherapy, dialysis, and skilled nursing facility care. Plans must also limit members' out-of-pocket costs for Part A and Part B covered services. Because the cost share for services is specific to each plan, it is very important that you review plan materials carefully for details about co-payments, coinsurance, and deductibles.

Understanding your cost share is a very important factor in determining the right plan for you. You should consider how often you may need medical

services and how much those services will cost in Original Medicare versus Medicare Advantage Plans. Knowing what you will be responsible for paying when you receive services help make a better consumer choice.

Who can join a Medicare Advantage Plan?

Medicare Advantage Plans are available to most people on Medicare. To be eligible to join a Medicare Advantage Plan, you must:

- Live in the plan's service area
- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B and
- Not have End-Stage Renal Disease (ESRD – permanent kidney failure requiring dialysis or a kidney transplant)

There are a few exceptions:

- If you are already in a Medicare Advantage Plan when you are diagnosed with ESRD, you may either stay in your current plan or join another plan offered by the same company
- If you have ESRD and are in a Medicare Advantage Plan that leaves Medicare or no longer provides coverage in your area, you have a one time right to join another Medicare Advantage Plan. You do not have to use your one-time right immediately; you can choose to join at a later date as long as the plan is still accepting new members.
- You may join a Special Needs Plan designated for people with ESRD.
- A person who receives a kidney transplant and no longer requires a regular course of dialysis treatment is not considered as having ESRD for purposes of Medicare Advantage Plan eligibility.

To join a Medicare Advantage Plan, you must also agree to:

- Provide necessary information to the plan
- Follow the plan's rules and
- Belong to only one plan at a time

When can I join a Medicare Advantage Plan?

You can only join (or disenroll from) a Medicare Advantage Plan during a designated enrollment period. Unless the plan has a capacity waiver, Medicare Advantage Plans must accept eligible new members. A capacity limit waiver means the plan has been authorized to close enrollment because it already has reached a certain number of enrollees. There are four types of enrollment periods, which are as follows:

- Initial Coverage Election Period
- Annual Election Period (AEP)
- Annual Disenrollment Period
- Special Enrollment Period (SEP)

Initial Coverage Election Period

When you first become eligible for Medicare, you will have a seven month Initial Coverage Enrollment Period.

- If you are eligible for Medicare due to age (turning 65), your Initial Coverage Enrollment Period will begin three months before the month you turn 65 and will end three months after the month you turn 65.
  - For example, if you turn 65 in October, your Initial Coverage Enrollment Period will begin July and end January.
- If you are eligible for Medicare due to disability, your Initial Coverage Enrollment Period will begin three months before your 25th month of Social Security Disability eligibility and will end three months after your 25th month of disability eligibility.
  - For example, if you become eligible for Social Security Disability April 2012, your 25th month of disability would be April 2014. Your Initial Coverage Enrollment Period will begin January 2014, and will end July 2014.

Annual Election Period (AEP)

Every year during the period of October 15th to December 7th, you can make changes in your plan enrollment. You may choose to join a Medicare Advantage

Plan, switch to another Medicare Advantage Plan, or disenroll and return to Original Medicare. Changes will be effective the first day of the following January.

Annual Disenrollment Period

If you belong to a Medicare Advantage Plan, you can leave your Medicare Advantage Plan and go back to Original Medicare from January 1st through February 14th.

If you switch to Original Medicare during this enrollment period, you may join a Medicare Prescription Drug Plan (Medicare Part D). Your Part D coverage will begin the first day of the month after the plan receives your enrollment form.

To disenroll from a Medicare Advantage Plan and return to Original Medicare during this period, you can

- Call 1-800-Medicare (1-800-633-4227)
- Make a request to your Medicare Advantage Plan or
- Enroll in a stand-alone Part D drug plan.

Special Enrollment Period (SEP)

You can join, disenroll, or switch a Medicare Advantage Plan under special circumstances. These include the following situations:

- If you move out of your plan's service area
- If your plan decides to leave the Medicare program
- Your plan reduces its service area and your area is no longer covered by the plan

Special Trial Rights are available to you if you joined a Medicare Advantage Plan for the first time.

- If you joined a Medicare Advantage Plan when you first aged into Medicare (age 65), you can disenroll anytime during the first 12 months after your coverage started. You would also have a Guarantee issue Right to purchase any Medigap policy A through L.

- If you dropped a Medigap policy to enroll in a Medicare Advantage Plan for the first time, you can disenroll anytime during the first 12 months and have a Guarantee Issue Right return to your original Medigap policy if it is still available, or choose policy A, B, C, F, K, or L, if your original policy is not available.

During these situations you may also have a Guarantee Issue Right to purchase a Medigap policy – refer to Centers for Medicare and Medicaid Services (CMS) booklet “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” or go to Medicare’s website http\\www.medicare.gov for more information on Medigap policies and Guarantee Issue Rights.

Special Enrollment Period Chart

Changes in Where You Live		
If this describes you,	**you can…**	**at this time…**
You move to a new address that isn't in your plan's service area. or You move to a new address that is still in your plan's service area but you have new plan options in your new location.	Switch to a new Medicare Advantage or Medicare Prescription Drug Plan.	If you tell your plan before you move, your Special enrollment Period begins the month before the month you move and continues for two full months after you move. If you tell your plan after you move, your Special Enrollment Period begins the month you tell your plan and continues for two more full months.
You move back to the United States after living outside the country.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special enrollment Period lasts for two full months after the month you move back to the United States.
You are released from jail.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you are released from jail.
You just moved into, currently live in, or just moved out of an institution – such as a skilled nursing facility or long-term care hospital.	• Join a Medicare Advantage or Medicare Prescription Drug Plan. • Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. • Drop your Medicare Advantage Plan and return to Original Medicare. • Drop your Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts as long as you live in the institution and for 2 full months after the month you move out of the institution.

Changes That Cause You to Lose Your Current Coverage		
If this describes you,	**you can…**	**at this time…**
You are no longer eligible for Medicaid.	• Join a Medicare Advantage or Medicare Prescription Drug Plan. • Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. • Drop your Medicare Advantage Plan and return to Original Medicare. • Drop your Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you find out you are no longer eligible for Medicaid. If you lose your coverage for the following year, your Special Enrollment Period is January 1 to March 31.
You leave coverage from your employer or union – including COBRA coverage.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for 2 full months after the month your coverage ends.
You involuntarily lose other drug coverage that is as good as Medicare drug coverage (creditable coverage), or your other coverage changes and is no longer creditable.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you lose your creditable coverage or are notified of the loss of creditable coverage, whichever is later.
You have drug coverage through a Medicare Cost Plan and you leave the plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment period lasts for two full months after the month you drop your Medicare Cost Plan.
You drop drug coverage in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you drop your PACE Plan.
You Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare is not renewed.	Join another Medicare Advantage Plan or Medicare Prescription Drug Plan.	October 1-January 31

Changes Due to Other Special Situations		
If this describes you,	**you can…**	**at this time…**
You are eligible for both Medicare and Medicaid.	Join, switch or drop Medicare Advantage or Medicare drug coverage.	Anytime.
You qualify for Extra Help paying for your Medicare prescription drug coverage.	Join, switch or drop Medicare Advantage or Medicare prescription drug coverage.	Anytime.
You are enrolled in a State Pharmaceutical Assistance Program – Hoosier Rx in Indiana.	Join either a Medicare Advantage or Medicare prescription drug coverage – in Indiana must be a plan that agrees to work with HoosierRx.	Once during the calendar year.
You dropped a Medigap policy the first time you joined a Medicare Advantage Plan.	Drop your Medicare Advantage Plan and enroll in Original Medicare.	Your Special Enrollment Period lasts for 12 months after you join the Medicare Advantage Plan for the first time.
You have a severe or disabling condition and there is a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with your condition.	Join a Medicare Chronic Care Special Needs Plan.	You can join anytime, but once you join, your chance to make changes using this Special Enrollment Period ends.
You are enrolled in a Special Needs Plan and no longer have a condition that qualifies as a special need that the plan serves.	Switch from your Special Needs Plan to a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period starts from the time you lose your special needs status, up to three months after your Special Needs Plan's grace period ends.
You join a plan or chose not to join a plan due to an error by a Federal employee.	• Join a Medicare Advantage or Medicare Prescription Drug Plan. • Switch to a new Medicare	Your Special Enrollment Period lasts for two full months after the month you get a

	Advantage or Medicare Prescription Drug Plan. • Drop your Medicare Advantage Plan and return to Original Medicare. • Drop your Medicare Prescription Drug Plan.	notice of the error from Medicare.
You were not properly told that your other private drug coverage was not as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you get a notice of the error from Medicare.
You were not properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you get a notice of the error from Medicare.

Types of Medicare Advantage Plans

There are five main types of Medicare Advantage Plans available; however, not every type may be available throughout the state. These types are:

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

Medicare HMOs have been an option for Medicare beneficiaries since the 1970's. The Balanced Budget Act of 1997 authorized new plans such as PPO, PFFS and MSA plans. Regional PPO plans and SNP were created with the Medicare Modernization Act of 2003.

Medicare Health Maintenance Organizations (HMO)

In a Medicare HMO plan, you generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). When you join a Medicare HMO plan, you may be asked to choose a primary care doctor. Your Primary care doctor is the doctor you will see first for most health problems.

In many HMOs you must see your primary care doctor before you can see any other health care provider. You will usually need to get a referral from your primary care doctor. Your primary care doctor is the doctor you will see first for most health problems.

In many HMOs, you must see your primary care doctor before you can see any other health care provider. You will usually need to get a referral from your primary care doctor to see a specialist (i.e. cardiologist). If the type of specialist you need is not available in the plan's network, the plan will arrange for care outside the network. If you are considering joining a Medicare HMO and want to keep seeing your current doctor, you should call and ask your doctor (usually the doctor's billing department) to see if he is in the network. Contact the plan for information on providers and facilities in their network. Keep in mind doctors can

join or leave a network. If your primary care doctor leaves the HMO plan, the plan will notify you in advance and provide and opportunity to pick a new doctor.

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

If you are in a Medicare HMO, you will not be able to join a separate Medicare prescription drug plan. If you want Medicare prescription drug coverage, you must join a plan that includes Part D. You will pay a co-payment or coinsurance for each covered prescription.

Medicare Preferred Provider Organizations (PPO)

In a Medicare PPO plan, you have network doctors and facilities, but you can also use out-of-network providers for covered services, usually for a higher cost. You do not need to choose a primary care doctor. You do not need a referral to see a specialist. Every PPO plan must pay for all covered services received out-of-network, but every plan is different in what your cost share will be.

PPO plans can be either local or regional plans. Local plans cover PPO plans can be either local or regional plans. Local plans cover individual counties chosen by the PPO plan to include in its service area. Regional plans are one of 26 regional plans set by Medicare. Regionals can cover an entire state or multiple states. Indiana and Kentucky are considered one region (INKY).

As a PPO member, you may get your Medicare prescription drug coverage from the PPO plan. If you want drug coverage, you must join a plan that offers Part D coverage. You will not be able to join a PPO and have a separate Part D drug plan.

Medicare Private Fee-for-Service Plans (PFFS)

In a Medicare PFFS plan, you can go to any Medicare approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. For each service, make sure your doctors, hospitals, and other providers agree to treat you under the plan and accept the plan's payment terms. In an emergency, doctors, hospitals and other providers must treat you.

You do not need to choose a primary care doctor, and you do not need a referral to see a specialist. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You can get your Medicare prescription drug coverage from a PFFS if offered, or you can join a standalone Medicare prescription drug plan.

Medicare Special Needs Plans (SNP)

Special Needs Plans are Medicare Advantage Plans specially designed for people with certain chronic diseases and other specialized health needs. If you join a SNP, you will need to choose a primary care doctor, you will also need a referral in order to see a specialist. As with HMO plans, referrals are not needed for certain services such as annual mammograms. There are three types of SNP:

Institutional Plans – plans designed to meet the needs of people who live in certain institutions such as nursing homes.

Chronic Disease Plans – plans designed to meet the needs of specific chronic or disabling conditions such as ESRD, diabetes, or high blood pressure.

Dual-Eligible Plans – plans designed to meet the needs of people who are eligible for both Medicare and Medicaid.

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

- An SNP for people with diabetes might have
  - Additional providers with experience caring for people with diabetes
  - Have focused special education or counseling
  - Have nutrition and exercise programs designed to help control the condition
- An SNP for people with both Medicare and Medicaid might help members
  - Access community resources
  - Coordinate many of their Medicare and Medicaid services

SNP must include Medicare prescription drug coverage. You must generally get your care from doctors and facilities in the plan's network.

Medicare Medical Savings Account Plans (MSA)

MSA plans became available in 2007. These plans are similar to Health Savings Accounts available outside of Medicare. Generally, most Medicare beneficiaries are eligible to join a MSA. You would not be eligible to join a MSA if you fall into any of the following situations:

- You have health coverage that would cover the MSA plan deductible, including benefits under an employer or union group health plan.
- You get benefits from TRICARE for Life (Department of defense) or VA Health benefits through the Department of Veterans Affairs.
- You are a retired Federal government employee and part of the Federal Employee Health Benefits Plan (FEHBP)
- You have ESRD, unless you are a former enrollee of a Medicare Advantage Plan that left the Medicare Program and you haven't joined another Medicare Advantage Plan.
- You are currently receiving hospice care.
- You live outside of the United States more than 183 days a year.

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

The second part is a special type of savings account. The plan receives funds from Medicare that are deposited into a special savings account; however, you are not able to make additional deposits into this account. You can choose to use money from this account to pay your health costs even before you meet the deductible. Money left in your account at the end of the year stays in the account and can be used for health care costs in future years.

Once you have decided to join a MSA plan, your first step is to set up a special account with the bank your plan chooses. The plan makes the deposit once at the beginning of the calendar year or in the first month your coverage begins if you become entitled to Medicare in the middle of the year and enroll in a MSA plan at that time.

You can use the money in your account to pay for medical expenses, but only Medicare covered Part A and Part B services count toward your deductible. If you use the money in your account for expenses other than qualified medical expenses you must pay taxes on these amounts and there may be additional penalties. For more tax information, contact your tax professional or the Internal Revenue Service (IRS) 1-800-TAX-FORM (1-800-829-3676) or go to their website www.irs.gov.

MSA plans do not cover Medicare Part D prescription drugs. If you want Part D coverage, you may enroll into a standalone prescription drug plan. You may use your MSA account to pay for your monthly premium, as well as for co-pays and coinsurance. This does count toward your Part D out-of-pocket costs. However, using the funds in this manner does not count toward your MSA plan's deductible.

For more information, refer to the CMS booklet "Your Guide to Medicare Medical Savings Account Plans" by calling 1-800-MEDICARE (1-800-633-4227) or visit the Medicare website at www.medicare.gov.

Medicare Cost Plans

There are other types of Medicare Health Plans that provide health care coverage that are not Medicare Advantage Plans but are still part of Medicare. In Indiana, we have Medicare Cost Plans. These plans provide Part A and/or Part B coverage and some also include Part D drug coverage.

Medicare Cost Plans, also known as Cost HMO plans, have many of the same rules as Medicare HMO plans with some notable differences:

- If you go to an out of network provider, the services are covered under Original Medicare.
- You can join a Cost Plan any time it is accepting new members, and you can leave anytime to return to Original Medicare; in other words, Cost HMO plans are not governed by the enrollment period that Medicare Advantage Plans must follow.
- You can get Medicare Prescription Drug Coverage from your plan if it is offered, or you can join a standalone Medicare drug plan.

These are general rules for Cost Plans. Be sure to read plan materials carefully for more details.

Comparing Plans

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

Doctors, Hospitals, and Other Health Care Providers

- Will I be able to use my doctors? Are they in the plan's network?
- Do doctors and providers I want to see in the future take new patients who have this plan?
- If providers are not in the network, will the health plan cover my visits if I choose to see them?
- Do my doctors recommend joining this plan?
- Which specialists, hospitals, home health agencies and skilled nursing facilities are in the plan's network?

Access to Health Care

- Who can I choose as my primary care physician?
- Does my doctor need to get approval from the plan to admit me to a hospital?
- Do I need a referral from my primary care physician to see a specialist?

Benefits

- What extra benefits does the plan offer?
- What rules do I have to follow to get them?

Prescription Drugs

- Does the plan cover outpatient prescription drugs?
- Are my prescription drugs on the plan's formulary?
- Does the plan require that I get prior authorization before my prescription will be covered?
- Do I have to pay a deductible before the plan will cover my drugs?
- How much will I have to pay for brand-name drugs? How much for generic drugs?

- What will I pay for my drugs during the coverage gap?
- Will I be able to use my pharmacy?
- Can I get my drugs through mail order?
- Will the plan cover my prescriptions when I travel?

Cost

- How much is my monthly premium?
- Will I pay a higher premium because of my income? Starting in 2011, individuals with yearly income above $85,000 and couples with yearly income above $170,000 pay more for both Part B and Part D.
- What is the annual out-of-pocket limit for in network and out of network care?
  - PPOs have different out-of-pocket before coverage begins (what of the deductible)?
- How much is my co-payment for a visit with my primary care physician or a visit with a specialist?
- How much will I pay if I use an out of network doctor or hospital?
- Are there higher co-pays for certain types of care, such as hospital stays or home health care?

Service Area

- What service area does the plan cover?
- What kind of coverage do I have if I travel outside of the service area?

Coordination of Benefits

- How does the plan work with my current coverage?
- If I join, could I lose my retiree/employer health coverage?

Keep in mind that Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure you understand the plan's rules. To find information about Medicare Advantage Plans offered where you live, you can call and speak to a Medicare customer service representative at 1-800-MEDICARE (1-800-633-4227) or visit the Medicare website at www.medicare.gov.

Your Rights in a Medicare Advantage Plan

All people with Medicare have certain guaranteed rights and protections. They have them whether they are in Original Medicare, in a Medicare Advantage Plan, have a Medicare drug plan, or have a Medigap policy. These following rights are guaranteed:

- To get the health care services they need
- To receive easy-to-understand information
- To have their personal medical information kept private

If you are in a Medicare Advantage Plan, in addition to the rights and protections previously described, you have the right to:

Choose health care providers in the plan so you can get covered health care.

Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need.

Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.

Know how your doctors are paid if you ask your plan provider. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.

File a grievance about other concerns or problems with your plan—for example, if there are not enough specialists in the plan to meet your needs. Check your plan's membership materials or call your plan to find out how to file a grievance.

Get a coverage decision or coverage information from your plan before getting services to find out if it will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.

You are entitled to privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.

Appeals in Medicare Advantage

Your Medicare Advantage Plan must tell its members in writing how to appeal the plan's decision. You can appeal if your plan will not pay for, does not allow, stops or reduces a course of treatment that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, you can ask the plan for an expedited appeal decision.

If a request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. You or the plan may extend the time frame up to 14 days to get more medical information. After an appeal is filed, the plan will review its decision. Then, if the plan does not decide in your favor, an independent organization that works for Medicare, not for the plan, reviews the decision. In Indiana, this independent organization is MAXIMUS.

In addition to providing you written information on the appeals process, the plan must also provide notices after every adverse coverage determination (plan's initial decision) or appeal. All appeal entities are required to send written notice when they make adverse decisions. These notices will explain:

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

If you are filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your file. Look at your Evidence of Coverage, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.

Appeal Levels

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "Organization Determination"). You will receive a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so. After each level, you will receive instructions on how to proceed to the next level of appeal. The five levels are as follows:

- Plan Reconsideration
  - Must be filed within 60 days of the date of the Initial Determination notice.
  - No minimum amount in controversy needed.
  - The plan will make the determination.
- Independent Review Entity (IRE)
  - This is automatic if the Plan Reconsideration does not change the Initial Determination.
  - No minimum amount in controversy needed.
  - An independent organization will make the determination. In Indiana, this organization is MAXIMUS.
- Administrative Law Judge Hearing (ALJ)
  - Must be filed within 60 days of the date of the Independent Review Entity notice.
  - There is a minimum dollar amount in controversy in order to proceed to this level of appeal. This amount is adjusted annually.
- Medicare Appeals Council Review (MAC)
  - Must be filed within 60 days of receiving the Administrative Law Judge Hearing notice.
  - There is no minimum amount in controversy needed.
  - Jurisdiction falls under the Department of Health and Human Services Department Appeals Board.
- Judicial Review
  - This is the final step of appeal.
  - The appeal must be filed within 60 days of receiving the Departmental Appeals Board (Medicare Appeals Council Review).
  - There is a minimum dollar amount in controversy in order to proceed to this level of appeal. This amount is adjusted annually.
  - Under the jurisdiction of U.S. District Court.

Fast Track Appeals

With the Medicare Advantage Plan Fast Track Appeals Process, you have the right to ask your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, or in a comprehensive outpatient rehabilitation facility. Your service provider must deliver a Notice of Medicare Non-Coverage at least two days before Medicare covered care will end.

If you think services are ending too soon, contact your Quality Improvement Organization (QIO) no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your Quality Improvement Organization must notify you of its decision by close of business of the day after it receives all necessary information. You have the right to ask for reconsideration by the Quality Improvement Organization if you are dissatisfied with the results of the fast appeal.

Inpatient Hospital Appeals

For inpatient hospital appeals, your provider or plan must provide a Notice of Discharge and Medicare Appeal Rights at least the day before services end if you disagree with the discharge decision or if the provider or plan is lowering the level of your care within the same facility. You can then appeal by sending a request to the Quality Improvement Organization by noon of the first day after receiving the notice. The decision from the Quality Improvement Organization is usually received within two days.

You remain in the hospital pending the Quality Improvement Organization's decision and will generally incur no cost while waiting for the decision. If the Quality Improvement Organization's decision agrees with the discharge notice, you should be aware that you could be financially liable for inpatient hospital services if you remain in the hospital after noon of the day after the Quality Improvement Organization's decision.

Medicare Advantage Plan Marketing Guidelines

Medicare Advantage Plans are required to follow standardized marketing material language and format, without modification. Marketing standards include the following:

- Plan companies must include the plan type in each plan's name using standard terminology effective January 1, 2010.
- Companies must display the plan type on all marketing materials that include the plan name.
- All plans are required to conduct outbound verification calls to most new enrollees enrolled by agents and brokers. Description of verification process must be explained to beneficiaries during the application process.
- Plans must include plan mailing statements on all marketing materials:
  - Advertisement – "This is an advertisement"
  - Plan Information – "Important information about your enrollment"
  - Health – "Health or wellness or prevention information"

To ensure that beneficiaries receive comprehensive plan information regarding their healthcare options, Medicare requires that Medicare Advantage Plans and Prescription Drug Plans disclose certain plan information, both at the time of enrollment and at least annually, 15 days prior to the Annual Enrollment Period.

- Comprehensive formulary or abridged formulary including information on how each beneficiary can obtain a complete formulary
- Pharmacy directory
- Provider directory
- Membership card – required only at time of enrollment

Companies can offer gifts to potential enrollees as long as such gifts are of nominal value and are provided whether or not they enroll in the plan. Nominal value currently is defined as an item worth $15 or less, based on the retail purchase price of the item regardless of the actual cost. This nominal value can be adjusted to account for inflation and other relevant factors.

Door-to-door sales are prohibited. This limit has been extended to include the following:

- Outbound marketing calls, unless the beneficiary requested the call. This includes existing members to market other Medicare products except as permitted below.
- Calls to former members who have disenrolled or current members who are in the process of disenrolling to market plans or products, except as permitted below.
- Calls to beneficiaries to confirm acceptance of appointments made by a third party or independent agent.
- Approaching beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit.
- Marketing health care related products such as annuities and life insurance during the Medicare Advantage Plan sales activity or presentation – cross-selling.

Plans may do the following:

- Conduct outbound calls to existing members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.
- Contact by phone or mail former members after disenrollment effective date to conduct disenrollment survey for quality improvement purposes, but contact may not include sales or marketing information.
- Under limited circumstances and subject to advance approval from the Medicare Regional Office, call low income subsidy eligible members that a plan is prospectively losing due to reassignment to encourage them to remain in their current plan.
- Call beneficiaries who have expressly given permission for a plan or sales agent to contact them, for example by filling out a business reply or asking a Customer Service Representative to have an agent contact them.

Important Points to Remember

If you join a Medicare Advantage Plan:

- You are still in the Medicare program.
- You still have Medicare rights and protections.
- You will still receive complete Medicare Part A and Part B coverage.
- You may be able to get your Medicare prescription drug coverage from your Medicare Advantage Plan.
- You may be able to get extra benefits offered by the plan, such as coverage for vision, dental, hearing and health and wellness programs.
- You still pay for your Part B premium, along with any premium for your Medicare Advantage plan.
- You will usually have some cost share when you receive services.
- You do not need to buy a Medigap policy. If you have a Medigap policy and decide to join a Medicare Advantage Plan, you can choose to keep your Medigap policy, but there is little reason to do so. Your Medicare Advantage Plan will be the primary insurance; the Medigap policy would not pay any co-pays and deductibles.
- In some cases, your costs could be higher than Original Medicare.
- Every Fall, the plan will send you information about any changes in benefits, costs or service areas.

Section I: Medicare Prescription Drug Plans

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for Medicare beneficiaries, known as Part D. All Medicare beneficiaries are eligible to enroll in these drug plans (people who live outside of the United States or who are incarcerated are not eligible to enroll in a plan). Drug coverage is offered through private plans approved by Centers for Medicare and Medicaid Services (CMS). Medicare prescription drug coverage helps you pay for both brand name and generic drugs. To get Medicare prescription drug coverage, you must choose and join a Medicare drug plan.

This drug benefit is offered through two types of private plans: stand-alone prescription drug plans (PDP) and Medicare Advantage Plans (MAPD).

- Medicare PDP adds coverage to Original Medicare, some Medicare Private-Fee-for Service (PFFS) plans that don't offer Medicare drug coverage, some Medicare Cost Plans, and Medicare Medical Savings Account Plans.
- Many Medicare Advantage plans, such as HMO's and PPO's include coverage for prescription drugs. You will generally receive all your health care and drug coverage through your plan.

After you join the Medicare PDP of your choice, the plan will mail you membership materials including a member's card. You will use this card when you get your prescriptions filled.

Are all drug plans the same?

Medicare drug plans vary based on which drugs are covered, what your out-of-pocket costs will be and which pharmacies you can use. Plans can be flexible in the benefit design, as long as what the plan offers is at least as good

as the standard benefit. Most plans offer different benefits structures, including tiers, co-payments, and/or lower deductibles.

Enhanced plans can even offer coverage for generic and/or brand name drugs in the coverage gap and may also cover non-Part D covered medications for an additional cost. Benefits and costs may change from year to year, but plans must offer at least a standard level of coverage.

Standard Benefit

Each year, the Medicare releases the Medicare Part D Standard Benefit parameters. These parameters include the Deductible, Initial Coverage Limit, Coverage Gap and Catastrophic Coverage.

- **Deductible** – This is the amount you will pay for your drugs before you receive assistance from your drug plan. No drug plan can charge a deductible larger than the limit set by the Standard Benefit.
- **Initial Coverage Limit** – Amounts you pay for your prescription after you meet your deductible. Co-payments refer to specific dollar amount; coinsurance is the percentage of the drug cost.
- **Coverage Gap (the Donut Hole)** – Some plans have a coverage gap. This means after you have spent a certain amount of money for your covered drugs.
  - Prior to 2011, you would have paid 100% of the total drug cost until you reached the threshold for the year.
  - In 2016, you will have to pay 45% of the drug costs for brand name drugs and 58% of the drug costs for generics.
  - There will be additional savings, for people who reach the coverage gap, each year until it's completely closed in 2020.

  This includes your deductible, co-payments, and coinsurance. This amount does not include your monthly premium. There are plans available that offer some coverage during the donut hole. Coverage during the gap will also affect the premium.

- **Catastrophic Coverage** – Once you have reached your Part D plan's out-of-pocket limit, you will have "catastrophic coverage." This means that you will only pay a small coinsurance or co-payment for the rest of the calendar year.

2016 Standard Drug Benefit

Benefit Parameters	2016
Deductible	$360
Initial Coverage Limit	$3,310
Out-of-Pocket Threshold	$4,850
Total Covered Drug Cost at Out-of-Pocket Threshold	$7,515.22
Minimum Cost-Share in Catastrophic Coverage	$2.95/$7.40 or 5%

What counts toward out-of-pocket costs?

Payments that count toward your out-of-pocket costs include payments for drugs in the plan's formulary made by:

- You, the plan member
- Your family members or other individuals
- Most State Pharmacy Assistance Programs
- Extra Help (Low Income Subsidy)
- Charities, unless established, run, or controlled by a current or former employer or union
- Indian Health Services and AIDS Drug Assistance Programs

Sometimes you may hear Part D out-of-pocket costs referred to as "true out-of-pocket costs" or "TrOOP" costs.

The following payments do not count as true out-of-pocket costs:

- Group health plans, including employer or union retiree coverage
- Government funded programs, including TRICARE or Veterans Administration coverage

- Manufacturer sponsored Patient Assistance Programs that provide free or significantly reduced price products. People with Medicare Part D plans can still take advantage of these programs, but the amount of this in-kind assistance will not count toward true out-of-pocket costs. Any co-payment charged when providing this in-kind assistance may count toward TrOOP.

What Drugs Are Included?

Medicare drug plans cover both generic and brand-name drugs. To be covered by Medicare drug plans a drug:

- Must be available only by prescription,
- Approved by the Food and Drug Administration,
- Sold in the United States,
- Used for medically-accepted indication in 35 different therapeutic classes and categories of drugs.
    - Plans must cover at least two drugs, one of which must be a generic, in each class and categories.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze, are also covered. Medicare has also clarified that supplies associated with inhalation of insulin may be covered by Part D plans.

Medicare Part D drug plans must include all commercially available vaccines on their drug formularies, including the shingles vaccine – but not vaccines such as the flu and pneumococcal pneumonia shots that are covered under Part B.

Medicare requires drug plans to cover “all” medications in the following six categories:

- Cancer medication
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions

- Immunosuppressant drugs

Not all drugs are included in Medicare drug plans. Drugs for the following conditions and drug types are excluded by law from Medicare prescription drug coverage:

- Anorexia
- Weight loss or weight gain
- Erectile dysfunction
- Fertility
- Cosmetic or lifestyle purposes – e.g. hair growth
- Symptomatic relief of coughs and colds
- Prescription vitamin and mineral products – except prenatal vitamins and fluoride preparations
- Non-prescription drugs

However, plans may choose to cover them at their own cost, share the cost, or share the cost with their members.

Part D can only cover Medicare Part A or Part B covered drugs if you do not meet the Part A or Part B coverage requirements. Drugs covered under Part B include immunosuppressive drugs after an organ transplant, some oral anti-cancer drugs, hemophilia clotting factors and drugs that are not self-administered.

All plans must cover the same categories of drugs, but plans can choose what specific drugs to cover in each category. Generally, not all Part D drugs are covered by each plan. Plans can use the following to design their drug plans:

- Formularies – list of covered drugs
- Prior Authorization – Doctor requests before service
- Step Therapy – type of prior authorization
- Quantity Limits – limits quantity for period of time

Formularies

Virtually all plans have a formulary or list of approved drugs. Plans' formularies must include a range of drugs in each prescribed category to make sure people with different medical conditions can get the treatment they need. A formulary

may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

To lower costs, many plans place drugs into different “tiers” or cost levels, which vary based on the cost of the drug. Each plan can set its tiers based in company policy; there is no standard format the plans must use. In some plans with these different cost levels or tiers, you can often save money by choosing a generic drug instead of the brand-name drug. Here is an example of how a plan might form its tiers:

Tier	**You Pay**	**Prescription Drugs Covered**
1	Lowest co-payment	Most generics
2	Medium co-payment	Preferred, brand-name
3	Higher-copayment	Non-preferred, brand-name
Specialty	Highest co-payment or coinsurance	Unique-very high-cost

Tier 1 Generic Drugs – Tier 1 drugs will cost the least amount. A generic drug:

- The same as a brand-name drug in active ingredients, dosage, safety, strength, how it is taken, how it works in the body, quality, performance and intended use
- Safe and effective
- Has the same risks and benefits as the original brand-name drug

Generic drugs are less expensive because of market competition.

Generic drugs are thoroughly tested and must be approved by the Food and Drug Administration. Today, almost half of all prescriptions in the United States are filled with generic drugs.

Tier 2 Preferred Brand-Name Drugs – Tier 2 drugs will cost more than Tier 1 drugs.

Tier 3 Preferred Brand-Name Drugs – Tier 3 drugs will cost more than Tier 2 drugs.

Specialty Tier – These drugs are unique and have a high cost.

Note: In some cases, if your drug is in a higher tier and your doctor thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower co-payment.

Formulary Changes

Medicare has instructed Part D plans to not change their therapeutic categories and classes in a formulary other than at the beginning of each plan year, except to account for new therapeutic uses and newly approved Part D drugs. A plan year is a calendar year, January through December.

Part D plans can make maintenance changes to their formularies, such as replacing brand-name drugs with new generic drugs or modifying formularies as a result if new information in drug safety or effectiveness. Those changes must be made according to the prescribed approval procedures and following 60 days notice to Medicare, State Pharmaceutical Assistance Programs (HoosierRx in Indiana), prescribing physicians, network pharmacies, pharmacists, and affected members.

Medicare has issued guidance to Medicare drug plans indicating that no plan members should be subject to a discontinuation or reduction in coverage of drugs they are currently using for the remainder of the plan year. However, this is not true in the case of drugs removed from the formulary due to Food and Drug Administration or the manufacturer's withdrawal of the drug from the market. Part D plans are not required to obtain Medicare's approval or give 60 days notice when removing formulary drugs that have been withdrawn from the market by either the Food and Drug Administration or a product manufacturer.

Prior Authorization

Plans may have rules that require prior authorization before it will cover a drug. Prior authorization means that before the plan will cover a prescription, your doctor will first have to contact the plan and show that there is a medically-necessary reason you must have this drug. Plans can have their own forms that need to be filled out to request a prior authorization.

Step Therapy

Step Therapy is a type of prior authorization. With step therapy, in most cases, you must first try certain less expensive drugs. However, if you have already tried the drugs and they did not work, or your doctor believes that, because of your medical condition, it is medically-necessary for you to be on a step therapy drug, you can contact the plan to request an exception. If the request is approved, the originally prescribed step-therapy drug will be covered.

Quantity Limits

For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. For example, people prescribed Nexium ® should take one tablet a day. Therefore, a plan may only cover 30 tablets for a 30 day supply. If your doctor believes that, because of your medical condition, an additional amount is medically necessary, your doctor can request an exception. If the exception is approved, the amount of prescribed by your doctor will be covered.

If a plan changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan is required to notify you at least 60 days before the change is effective.

How much will my drug coverage cost?

Your cost will depend greatly on your prescription drugs and the drug plan you choose. Costs you will incur with a drug plan include:

- **Monthly Premium** – Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. It is possible that some plans charge no premium. Others may have higher than average premiums, but may offer better coverage.
- **Yearly Deductible** – This is the amount you pay for your prescription before your plan begins to pay. Some plans charge no deductible; this may affect the monthly premium. No plan can have a higher deductible than the standard benefit limit set for the year.
- **Co-Payments or Coinsurance** – Amounts you pay for you prescription after you meet your deductible. Co-payments refer to specific dollar

amount; coinsurance is the percentage of the drug cost. You will pay co-payments or coinsurance during Initial Coverage Gap, and Catastrophic Coverage.

The amount you pay in some plans may vary depending on how much you spend during the year. Under the standard benefit, once you have met the deductible, you will pay 25% coinsurance until you reach the coverage gap/donut hole. For 2016 during the coverage gap you will pay 45% coinsurance for brand-name drugs and 58% coinsurance for generic drugs. After the coverage gap, you will pay very little for each prescription for the rest of the calendar year.

How do I pay my monthly premiums?

In general, there are three ways to pay your premiums:

- You can have the premium deducted every month from your Social Security benefits.
- You can have the plan send you a bill each month. Many times, the plans will bill quarterly.
- You can give permission to the plan to have your premiums automatically deducted from a savings or checking account, or charged to a credit or debit card.

If your drug coverage is through a Medicare Advantage Plan, the monthly premium you pay to the plan may include an amount for drug coverage.

What if I cannot afford a drug plan?

There is help available for those beneficiaries who need it most. If you have limited income and resources, you may qualify for Extra Help (sometimes called Low Income Subsidy) to pay for your Medicare prescription drug costs. If you qualify, you will receive help in paying your monthly premiums and, possibly, your deductible, co-pays, coinsurance and eliminate the coverage gap/donut hole.

Ways You May Qualify for Extra Help

You may automatically qualify for Extra Help and do not need to apply.

- You have Medicare, full Medicaid coverage and live in a nursing home.
- You have Medicare and full Medicaid.
- You get help paying your Medicare premiums from the Medicare Savings Program (QMB, SLMB, QI).
- You have Medicare and receive Supplemental Security Income (SSI) but are not receiving Medicaid coverage.

Each month, Medicaid will send verification of the previously mentioned categories. All other people with Medicare must file an application to get Extra Help.

If your annual income is $17,505 or less ($23,595 if married and living with your spouse) and your resources are $13,440 or less ($26,860 if married and living with your spouse), you may qualify for Extra Help. You will need to apply. You can do this by calling the Social Security Administration (1-800-772-1213), visit www.ssa.gov on the web or apply at your local Medicaid office.

Extra Help (Low Income Subsidy)	**2015**
Co-payments	
Institutionalized	$0
Full Subsidy up to or at 100% Federal Poverty Level	$2.55/ $6.35
Full Subsidy above 100% Federal Poverty Level	$2.55/ $6.35
Partial Subsidy Deductible/Cost Share	$63/ 15%

Extra Help is not available to people in U.S. territories. The territories have their own rules for providing help with Medicare drug plan costs to their residents. See charge on following pages for detail on Extra Help.

2015 Medicare Prescription Drug Extra Help Benefit (Part D)

Full Subsidy Extra Help		
If you have…	**What do you get?**	**What should you do?**
Medicaid only	You are not eligible for Medicare Prescription Drug Benefits	Medicaid will continue to cover your prescriptions
Medicaid & Medicare OR: or Medicare Savings Program QMB, SLMB, or QI or Medicare & SSI	You are eligible for Extra Help You will pay: No premium * No deductible No gap in coverage	You do NOT need to apply for Extra Help. You are already eligible.
AND:		
Yearly Income above $11,670 (single) or $15,730 (married)	$1.20- $3.60 co-pay for prescriptions	
OR:	**OR:**	
Yearly Income below $17,505 (single) or $23,595 (married)	$2.55 - $6.35 co-pay for prescriptions ***No premium if the Standard Plan's premium is at or below the state benchmark.**	
If you have…	**What do you get?**	**What should you do?**
Medicare with no prescription coverage Yearly income below: $15,754.50 (single) or $21,235.50 (married) AND Resources less than $8,660 (single) or	You are eligible for Extra Help, but you must apply. No premium* No deductible No gap in coverage Co-pay of $2.55 or $6.35 *No premium if the Standard Plan's premium	Apply for Extra Help Select and enroll in a Drug Plan. You may want to also apply for the Medicare Savings Program. This program can help you with paying your monthly

$13,750 (married)	is at or below the state benchmark.	Part B premium.
Partial Subsidy Extra Help		
If you have…	**What do you get?**	**What should you do?**
Medicare with no prescription coverage Yearly income below $17,505 (single) or $23,595 (married) AND Resources less than $13,440 (single) or $26,860 (married)	You are eligible for Extra Help, but you must apply. $63 deductible 15% coinsurance No gap in coverage Sliding Scale Premium** (see chart on next page)	Apply for Extra Help Select and enroll in a Drug Plan.

Partial Subsidy Extra Help Sliding Scale Premium**			
If your income is:	**Single Income**	**Married Income**	**What you will pay in monthly premium**
135% Federal Poverty Level or lower	Below $15,754.50	Below $21,235.50	0% of the premium
135% - 140% Federal Poverty Level	$15,754.50 - $16,338	$21,235.50 - $22,022	25% of the premium
140% - 145% Federal Poverty Level	$16,338 - $16,921.50	$22,022 - $22,808.50	50% of the premium
145% - 150% Federal Poverty Level	$16,921.50 - $17,505	$22,808.50 - $23,595	75% of the premium

What if my application is denied?

You have the right to appeal the decision. To request an appeal, call Social Security toll free at 1-800-772-1213. You can also get a copy of the form SSA-11021, "Appeal of Determination for Help with Medicare Prescription Drug Costs" from www.ssa.gov on the Internet. If you want to file an appeal, remember the following:

- You have 60 days to ask for an appeal.
- The 60 days start the day after you receive your letter from Social Security denying your application. Social Security will assume you receive the letter five days after the date on the letter.
- You can have a lawyer, friend or someone else help you.

Whose Income and Resources Count?

Your income and resources are counted. If you are married and live with your spouse, both of your incomes and resources are counted, even if only one of you is applying for Extra Help. If you are married but do not live with your spouse when you apply, only your income and resources are counted.

What Counts as Income?

Income is any cash or service that can be used to meet your needs. Countable income includes, but is not limited to the following:

- Wages (counted at 50%)
- Earnings from self-employment (counted at 50%)
- Social Security or Railroad Retirement Benefits
- Veterans Benefits
- Pensions
- Annuities
- Alimony
- Rental Income
- Worker's Compensation

Income not counted:

- Income tax refunds
- Assistance based on need funded by a state or local government

- Foster care payments
- The value of expenses which a blind or disabled person needs to work

What resources are counted?

The resources counted in deciding if you qualify for Extra Help include cash and other things that can be converted into cash within 20 days.

Types of resources counted include, but are not limited to:

- Savings, checking, and money market accounts
- Certificates of Deposit (CD's)
- Retirement accounts, such as IRA or 401K accounts
- Stocks, Bonds, Savings Bonds
- Mutual Fund Shares
- Equity value of property not connected to home.

Resources not counted:

- The home you live in and the land it is on.
- Resources such as family heirlooms, wedding/engagement rings.
- Property of a trade or business which is essential to your means of self-support.
- Non-business property that is essential to your means of self-support.
- Funds received and saved to pay for medical and/or social services

How long will I receive Extra Help?

If you qualify for Extra Help, the decision remains in effect for the calendar year as long as you are enrolled in a Medicare Part D plan and you do not have a change in your marital status. Changes in marital status include:

- Marriage
- Divorce
- Annulment
- Separation (not temporary)
- You and your spouse resume living together
- Death of a spouse

Any changes to your marital status could cause the amount of your Extra Help to increase, decrease or end. You should notify Social Security of any changes in your status.

New to Extra Help

You can apply for Extra Help at any time. You can also reapply if your circumstances change. When people with Medicare who are already enrolled in a Medicare drug plan are found eligible for Extra Help, the plan is notified. The plan will refund the deductibles, premiums and coinsurance or co-pays back to the month they were found eligible for Extra Help.

LI-NET

The Limited Income Newly Eligible Transition Program is called LI-NET. It is a new Medicare program that combines and improves upon Medicare's existing Auto-Enrollment process for all Extra Help (Low-Income Subsidy) eligible beneficiaries. The LI-NET Program will provide Part D prescription drug coverage for all uncovered Full Dual Eligible (having prescription drug coverage for all uncovered Full Dual Eligible (having both Medicare and Medicaid) and SSI only beneficiaries on a retroactive basis; and all uncovered Extra Help beneficiaries on a current basis. The LI-NET Program will be operated by Humana, Inc. on behalf of Medicare.

There are three ways to access the LI-NET Program:

- Auto-Enrollment by Medicare – Medicare has performed Auto-Enrollment of Full Dual Eligibles on a daily to monthly basis since the start of the Part D program. Medicare will continue to generate Auto-Enrolments, but to the LI-NET Program only.
- Point of Service Use – Beneficiary presents at the pharmacy with an immediate prescription drug need.
    - Coverage between 30 days and 36 months prior to date of submission.
    - Exception to the 36 month rule: beyond 36 months for those who had a recent Medicaid determination (within 90 days) with an effective date greater than 36 months in the past, as far back as January 1, 2006.
- Submitting a receipt or prescriptions already paid for out-of-pocket during eligible periods.

LI-NET Coverage and Enrollment

Enrolment in LI-NET provides temporary coverage; individuals should enroll in a standard Medicare Part D plan for future coverage. LI-NET coverage periods:

- Full Dual Eligible or SSI only – up to 36 months
  - Full Dual Eligible and SSI only beneficiaries will have an enrollment effective date of the first day of full dual status or the last uncovered month, whichever is later.
- Partial Dual Eligible or Extra Help Applicants – up to 30 days
  - Partial Dual Eligible or Extra Help Applicants will not be automatically enrolled into the LI-NET Program.
- Unconfirmed – up to seven days
  - Unconfirmed beneficiaries are those who show evidence of Medicaid or Extra Help eligibility to the pharmacy at point of sale, but for whom there is no evidence of Medicaid or extra Help eligibility in Medicare's systems
  - Coverage up to seven days prior to the date of submission of the claim to LI-NET
  - If the beneficiary is determined to be ineligible, they will be responsible for cost of the claim unless they can provide proof of eligibility to the LI-NET program.

Benefits available on the LI-NET Program include an open formulary, no prior authorization, no pharmacy restrictions, standard Part D rights for enrollees, and eligibility reviews for non-enrollees.

HoosierRx

Indiana's State Pharmaceutical Assistance Program is Hoosier Rx. Hoosier Rx can help you pay your monthly Part D premium up to $70 per month. You must be enrolled in a plan that has agreed to work with HoosierRx. To be eligible for HoosierRx you must:

1. Be an Indiana resident, 65 years old or older.
2. Have a yearly income of $17,895 or less for a single person, $24,135 or less for a married couple living together.
3. Have applied for Extra Help through Social Security to pay for your Part D plan and received either a "Notice of Award" or "Notice of Denial" from Social Security.

    - Your Social Security "Notice of Award" must state that you are receiving partial Extra Help subsidy to help pay for your Part D premium.
    - Your Social Security "notice of Denial" must be because your resources are above the limit established by law.

If you think you meet these eligibility requirements, please call a HoosierRx representative at 1-866-267-4679 or visit the HoosierRx website at www.IN.gov/HoosierRx.

Companies offering Part D plans working with HoosierRx:

- AARP/United Healthcare
- CIGNA Healthcare
- EnvisionRx
- First health
- Indiana University health Plans (with Part D coverage)
- SilverScript
- Community CCRx
- Wellcare

If you are enrolled in a plan that is not working with HoosierRx, you will have a Special Enrollment Period to change to a plan that is working with HoosierRx.

Choosing a Drug Plan

Everyone on Medicare has a decision to make about prescription drug coverage. If you are new to Medicare and have prescription drug coverage, you have new choices to consider. If you are not new to Medicare, you have the opportunity to review your drug coverage and join or switch plans during Open Enrollment – October 15 – December 7 each year. When considering a Part D plan, you should keep four points in mind: Coverage, Cost, Convenience, and Peace of mind.

Coverage

Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose what specific drugs are covered in each drug category.

Cost

Monthly Premiums and your share of the cost of your prescriptions vary depending on which plan you choose. If you have limited income resources, you may qualify for Extra Help in paying your drug costs, through the Social Security Administration (SSA).

Convenience

Drug plans must contract with pharmacies in your area. Check with the plan to make sure the pharmacies in the plan are convenient to you. Some plans allow you to get your drugs through mail order.

Peace of Mind

Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan. As we age, most people need prescription drugs to stay healthy.

What do I need to think about before I decide if I need a drug plan?

Before you make a decision if you need a Part D drug plan, you should answer the following questions:

- If you have drug coverage now, is it creditable coverage (is it as good as Medicare PDP)? Your current plan can tell you.
- If you have drug coverage now, should you keep it?
- If you choose to enroll in a Part D plan, will it affect your other retirement health benefits?
- How would a Part D plan affect your out-of-pocket costs?
- Are your drugs covered by plans in your area?
- Is there a particular pharmacy you want to use?
- Do you spend part of each year in another state?
- Does the plan you're interested in offer national coverage?

How do I find the drug plans in my area?

Information about specific drug plans is included in the Medicare & You handbook. You can also get this information online at www.medicare.gov or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

When can I enroll in a plan?

You can only enroll into a plan (or disenroll from a plan) during an enrollment period. Medicare Prescription Drug Plans have four types of enrollment periods. They are as follows:

- Initial Enrollment Period
- Annual Coordinated Election Period
- Annual Disenrollment Period
- Special Enrollment Period

Initial Enrollment Period

If you are new to Medicare, you have a 7 month Initial Enrollment Period. This period begins 3 months prior to the month your Medicare coverage begins, the month your Medicare coverage begins, and ends 3 months after the month your Medicare coverage begins. This is the case if you are eligible for Medicare due to age or disability.

Annual Coordinated Election Period

Every October 15 through December 7, you will have an Annual Coordinated Election Period (sometimes called Annual Open Enrolment). During this

enrollment period, you may join, switch, or disenroll from any stand-alone plan or Medicare Advantage plan with prescription drug coverage. Changes made during this time period will be effective January 1 the following year.

Annual Disenrollment Period

If you belong to a Medicare Advantage Plan, you can leave your Medicare Advantage Plan and go back to Original Medicare from January 1 through February 14. If you choose to go back to Original Medicare during this time, your coverage will begin the first day of the following month.

If you switch to Original Medicare during this enrollment period, you may join a Medicare Prescription Drug Plan (Medicare Part D). Your Part D coverage will begin the first of the month after the plan receives your enrollment form.

To disenroll from a Medicare Advantage Plan and return to Original Medicare during this period, you can

- Call 1-800-Medicare (1-800-633-4227),
- Make a request to your Medicare Advantage Plan, or
- Enroll in a standalone Part D drug plan.

Special Enrollment Period

There are a number of situations that will allow you to have a Special Enrollment Period. During a Special Enrollment Period, you can join, change, or disenroll from a Part D plan. The following is a list of situations that will open a Special Enrollment Period

- Changes in where you live
- Changes that cause you to lose your current coverage
- You have a chance to get other coverage
- Changes in your plan's contract with Medicare
- Changes due to other special situations

Note: situations that open up a Special Enrollment Period for Part D plans will also apply to Medicare Advantage Plans.

Special Enrollment Period Chart

Changes in where you live…		
If this describes you,	**you can…**	**at this time…**
You move to a new address that isn't in your plan's service area. or You move to a new address that is still in your plan's service area, but you have new plan options in your new location.	Switch to a new Medicare Advantage of Medicare Prescription Drug Plan.	If you tell your plan before you move, your Special Enrollment Period begins the month before the month you move and continues for two full months after you move. If you tell your plan after you move, your Special Enrollment Period begins the month you tell your plan and continues for two more full months.
You move back to the United States after living outside the country	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you move back to the United States.
You are released from jail.	Join a Medicare Advantage or Medicare Prescription Drug plan.	Your Special Enrollment Period lasts for two full months after the month you are released from jail.
You just moved into, currently live in, or just moved out of an institution, such as a skilled nursing facility or long-term care hospital.	Join a Medicare Advantage or Medicare Prescription Drug Plan. Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. Drop your Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts as long as you live in the institution and for two full months after the month you move out of the institution.

Changes that cause you to lose your current coverage…		
If this describes you,	**you can…**	**at this time…**
You are no longer eligible for Medicaid.	Join a Medicare Advantage or Medicare Prescription Drug Plan. Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. Drop your Medicare Advantage Plan. Drop your Medicare Advantage Plan and return to Original Medicare. Drop your Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you find out you are no longer eligible for Medicare. If you lose your coverage for the following year, your Special Enrollment Period is between January 1 and March 31.
You leave coverage from your employer or union – including COBRA coverage.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month your coverage ends.
You involuntarily lose other drug coverage that is as good as Medicare drug coverage (creditable coverage), or your other coverage changes and is no longer creditable.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you lose your creditable coverage or are notified of the loss of creditable coverage, whichever is later.
You have drug coverage through a Medicare Cost Plan and you leave the plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you drop your Medicare Cost Plan.
You drop drug coverage in a Program of All-Inclusive care for the Elderly (PACE) plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you drop you PACE plan.

You have a chance to get other coverage…		
If this describes you,	**you can…**	**at this time…**
You have a chance to enroll in other coverage offered by your employer or union.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan to enroll in the private plan offered by your employer or union	Whenever your employer or union allows you to make changes in your plan.
You have or are enrolling in other drug coverage as good as Medicare prescription drug coverage – such as TRICARE of VA Coverage.	Drop your current Medicare Advantage Plan with drug coverage or your Medicare Prescription Drug Plan.	Anytime.
You enroll in a Program of All-Inclusive Care for the Elderly (PACE) plan.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan.	Anytime.
Changes in Your Plan's Contract with Medicare		
If this happens,	**you can…**	**at this time…**
Medicare takes official action (called a sanction) because of a problem with the plan that affects you.	Switch from your current Medicare Advantage or Medicare Prescription Drug plan.	Your Special Enrollment Period is determined by Medicare on a case-by-case basis.
Medicare ends (terminates) your plan's contract.	Switch from your current Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your special Enrollment Period lasts one full month after Medicare ends the plan's contract.
Your Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan's contract with Medicare is not renewed.	Join another Medicare Advantage Plan or Medicare Prescription Drug Plan.	October 1 – January 31

Changes Due to Other Special Situations		
If this describes you,	**you can…**	**at this time…**
You are eligible for both Medicare and Medicaid.	Join, switch or drop Medicare Advantage or Medicare drug coverage.	Anytime.
You qualify for Extra Help paying for your Medicare prescription drug coverage.	Join, switch or drop Medicare Advantage or Medicare prescription drug coverage.	Anytime.
You are enrolled in a State Pharmaceutical Assistance Program -Hoosier Rx in Indiana.	Join either a Medicare Advantage or Medicare prescription drug coverage – in Indiana, must be a plan that agrees to work with HoosierRx.	Once during the calendar year.
You dropped a Medigap policy the first time you joined a Medicare Advantage Plan.	Drop your Medicare Advantage Plan and enroll in Original Medicare.	Your Special Enrollment Period lasts for 12 months after you join the Medicare advantage Plan for the first time.
You have a severe or disabling condition and there is a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with your condition.	Join a Medicare Chronic Care Special Needs Plan.	You can join anytime, but once you join, your chance to make changes using this Special Enrollment Period ends.
You are enrolled in a Special Needs Plan and no longer have a condition that qualifies as a special need that the plan serves.	Switch from your Special Needs Plan to a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period starts from the time you lose your special needs status, up to three months after your Special Needs Plan's grace period ends.
You join a plan or chose not to join a plan due to an error by a Federal employee.	Join a Medicare Advantage or Medicare Prescription Drug Plan. Switch to a new Medicare Advantage or Medicare Prescription Drug Plan. Drop your Medicare Advantage Plan and return to	Your Special Enrollment Period lasts for two full months after the month you get a notice of the error from Medicare.

	Original Medicare. Drop your Medicare Prescription Drug Plan.	
You were not properly told that your other private drug coverage was not as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you get a notice of the error from Medicare.
You were not properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your Special Enrollment Period lasts for two full months after the month you get a notice of the error from Medicare.

Late Enrollment Penalty

If you do not enroll in a Part D Plan when you are first eligible, you must wait until your next enrollment period to join a drug plan, and you may have a break in drug coverage of 63 days or more, your premium may be increased by a penalty for being without creditable coverage.

The penalty is calculated at 1% for every month you did not have a Part D plan but were eligible. The percentage is based on the national average benchmark premium. For 2016, this benchmark is $34.10. The 1% equals $.34. Since the benchmark may increase each year, the penalty amount may also increase every year. You may have this penalty for as long as you have a Medicare Part D Plan.

Penalty Example

Mrs. Martinez is currently eligible for Medicare, and her Initial Enrollment Period ended on May 31, 2012. She doesn't have prescription drug coverage from any other source. She didn't join by May 31, 2012, and instead joined during the Open Enrollment Period that ended December 7, 2014. Her drug coverage was effective January 1, 2015.

Since Mrs. Martinez was without creditable prescription drug coverage from June 2012–December 2014, her penalty is 31% (1% for each of the 31 months) of $34.10 (the national base beneficiary premium for 2016) or $10.57. Since the

monthly penalty is always rounded to the nearest $0.10, she will pay $10.60 each month in addition to her plan's monthly premium in 2016.

What can new members expect?

When you enroll in a plan, you can expect to receive an enrollment letter and membership materials from the plan. The materials will contain an identification card and customer service information including a toll free phone number and website address.

Sometimes as a new member, you may already be taking a drug that is not on your plan's formulary, is a step therapy drug or has prior authorization. Medicare requires the plans to provide a standard 30 day transition (temporary) supply of all Medicare covered drugs, a 90 day supply if you are a resident in a long-term care facility. This will give you time to work with your doctor to find a different drug that is on the plan's formulary. If an acceptable drug is not available, you or your doctor can request an exception from the plan, and if your request is denied, you can appeal that decision.

Your Medicare Drug Plan Rights and Appeals

What if my plan won't cover a drug I need?

You have the right to ask for a decision called a Coverage Determination.

Coverage Determination

A Coverage Determination is the initial decision made by the plan about benefits a plan member is entitled to receive, the amount (if any) a member is required to pay for a benefit, or the amount a plan reimburses a member for Part D drugs they have already purchased.

A plan also makes a Coverage Determination when it decides whether a member:

- Has satisfied a prior authorization requirement
- Has met step therapy requirements
- Can obtain a drug subject to a plan's coverage rules by either satisfying the coverage rule criteria or requesting and obtaining an exception to the rule based on medical necessity.

Exceptions

An exception request is a kind of Coverage Determination. You or your doctor may request an exception if you need a drug that is not on the plan's formulary, the plan to waive a coverage rule, or cover a non-preferred drug at a preferred co-pay amount because you cannot take the preferred alternative. There are two types of exceptions – Tier Exceptions and Formulary Exceptions.

Tier Exceptions

If a plan uses a tiered cost-sharing structure to manage its Medicare drug benefit, it must provide exception procedures that permit you to obtain a non-preferred drug at the more favorite cost-sharing level for drugs in the preferred tier. A plan must grant a tier exception when it determines that the preferred drug for

treatment of your condition would not be as effective for you as the requested drug and/or it would have adverse effects.

When a tier exception is approved, the plan must provide coverage at the cost-sharing level that applies for preferred drugs, but not at the generic cost-sharing level. Also, if a plan maintains a formulary tier in which it places very high cost and unique items, it may design its exception process so that drugs placed in the tier are not eligible for a tier exception.

Formulary Exception

Formulary exceptions ensure you have access to Medicare covered drugs that are not included in your plan's formulary or drugs for which the plan has special coverage rules. These special rules include prior authorization, quantity limits and step therapy. When a formulary exception is approved, the plan has the flexibility to determine the level of cost-sharing that will apply for the non-formulary drug. For example, the plan may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.

A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or would have adverse effects. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused or is likely to cause harm to the enrollee.

Approved Exceptions

If an exception request is approved, the exception is valid for refills for the reminder of the plan year, so long as:

- You remain enrolled in the plan,
- Your doctor continues to prescribe the drug, and
- The drug remains safe for treating your condition.

Your plan may choose to extend coverage into a new plan year. If it does not, your plan must provide written notice to you either at the time the exception is approved, or at least 60 days before the plan year ends. The written notice must tell you about the date coverage will end, the right to request a new exception, and the process for making a new exception request. If coverage is not extended, you should consider switching to a drug on the plan's formulary, request a new

exception, or change plans during the Annual Coordination Election Period (Open Enrollment).

Denied Exceptions

If the plan decides against you, you can appeal the decision. You can follow the appeals process.

Coverage Determination Timeframe

A plan must notify you of its coverage determination as quickly as your health condition requires, but no later than 72 hours for standard requests or 24 hours for expedited requests after receiving your request. If the coverage determination involves an exception the time clock starts when the plan receives the doctor's supporting statement. If the plan fails to meet these timeframes, it must automatically forward the request and case file to the Independent Review Entity for review, and the request will skip the first level of appeal (redetermination by the plan). The Independent Review Entity is MAXIMUS. Their contact information is at www.medicareappeals.com.

Medicare Part D Appeals Process

If you receive an unfavorable initial decision, you have the right to appeal the decision. There are five levels of appeals.

- **Redetermination with the Part D Plan** – appeal through your plan; must be requested within 60 days from the date of the adverse decision; can be made in writing or over the phone; has seven days for a standard request, 72 hours for an expedited request. For some types of redeterminations called exceptions, you will need a supporting statement from your doctor explaining why you need the drug that you are requesting.
- **Independent Review Organization (IRO)** - must be submitted within 60 days of the adverse redetermination decision; must be in writing; once a request has been filed, the IRO has seven days for a standard request, 72 hours for an expedited request.
- **Administrative Law Judge Hearing (ALJ)** – Must be requested in writing with 6- days of the adverse IRO decision; there is a minimum dollar amount.
- **Medicare Appeals Council (MAC)** – if you receive an adverse ALJ decision, you will be advised on the process to request a review by the MAC.

- **Federal Court** – if you receive an adverse MAC decision, you will be advised on the process to request a review by a federal court.

How do I file a complaint?

You have the right to file a complaint with a plan. You should file your complaint within 60 days of the event that led to your complaint. Examples of why you might file a complaint:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The pharmacy charges you more than it is supposed to. If you think you have been charged too much, call your plan for the up-to-date price.
- The plan does not make a determination about a coverage determination or appeal within the required time frame.
- You disagree with the plan's decision not to expedite your request for a coverage determination of first-level appeal.

You should first contact your plan with your complaint. If the plan does not take care of your complaint, call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Prescription Drug Plans and Other Private Insurance

Employer or Union Health Coverage

Health coverage could be from your, your spouse's, or other family member's current or former employer or union. If you have prescription coverage based on your current or previous employment, your employers or union will notify you each year to let you know if your prescription drug coverage is creditable (as good as or better than Medicare Part D plans). Keep the information you receive. Call your benefits administrator for more information before making any changes to your coverage. If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage.

COBRA

Federal laws that may allow you to temporarily keep union or employer health coverage after the employement entd or after you lose coverage as a dependent of the covered employee. If you have COBRA and it includes creditable prescription drug coverage, you will have a special enrollment period to join a Medicare Part D plan without paying a penalty when the COBRA coverage ends.

Section J: Employer Group Health Plans

Special Enrollment Period (age 65 and still working)

This period is available if you are eligible for Medicare and wait to enroll in Medicare Part B because you or your spouse were working and had group coverage through the employer or union. You can sign up for Part B anytime you are still covered by the employer or union health plan, or during the 8 month Special Enrollment period following the month your employer or union coverage ends, or when the employment ends (whichever is first).

Note: Employers are the group health plan policyholders. As long as they do not violate discrimination laws, they are not legally restricted from discontinuing the policy, increasing premiums, altering the plan coverage or excluding employees who are in certain categories (i.e. age 65 or older). They can convert your group health plan to another plan; for example a Medicare Supplement policy. In fact, conversion to a group supplement plan along with your Medicare may offer you more coverage than having your combination of Medicare and Medigap plan.

After retirement Medicare becomes the primary payer. If the group health plan is continued after retirement, the group health plan is the secondary payer.

Group Health Plan for Retirees – Continuation or Conversion

Retired workers age 65 or older may or may not be continued under an employer group plan for coverage secondary to Medicare. Some employers offer continuation or conversion of the health insurance as a retirement benefit. This allows retirees to continue the group coverage or convert to an individual plan.

Continued group plans are not subject to federal and state minimum standards for Medicare Supplement Policies.

Conversion of the group plan to an individual plan means the individual plan is subject to government minimum standards. It would be a standardized Medigap policy. The conversion can be paid by you or the employer.

Questions You Might Ask

- Is the employer stable? Is the plan likely to be terminated due to financial pressures?
- Does the plan have a lifetime maximum benefit?
- What will the plan pay if you have Medicare?
- Does the plan act as a supplement to Medicare; does it coordinate benefits?
- How is the plan affected by guarantee issue provisions?

Carve Out Employer Group Plans

The employer group policy may "carve out" or "wrap around" Medicare. Another phrase used is "integrate." Medicare and the group plan may both cover a particular treatment; however when one pays, the other does not. A group plan may pay for some services that are not covered by Medicare.

Employer group plans can be misunderstood and may not act as a Medicare supplement policy. This means that your group plan does not normally pay for Medicare co-pays and deductibles. You may have an option to convert your group plan to a Medigap policy. Read your plan carefully to see how your plan "fills in" Medicare gaps. Copies of your plan or information about plan coverage can usually be obtained by calling the employer's benefits coordinator.

Options for a Spouse Under 65 and Losing a Group Plan

Many employers have terminated health coverage for retirees leaving them and their spouses without medical coverage. Medicare, unlike most employers' group plans, covers only you, if you qualify. There are no provisions for your dependents. Some options to consider:

- Try the employer. Sometimes they will continue coverage for your spouse. You may have to pay part or the entire premium.
- COBRA – You only have 60 days to agree to keep coverage under COBRA. You will pay the entire premium plus a 2% administrative fee.
- Private health plan. If your spouse is in good health, you may be able to purchase a policy until he/she qualifies for Medicare.
- Would the employer group plan allow the spouse to convert to an individual plan?

- Seek employment that offers health insurance benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act-1985)

COBRA is a **temporary extension** of your employer's group health coverage insurance. You must **apply within 60 days** of a specific qualifying event or you will lose your right to extend your group coverage under COBRA. The employer must notify the plan's administrator within 30 days of the qualifying event. The plan administrator must send you a COBRA election notice within 14 days of receiving notification. To sign up, you should talk to the employer's benefits or human services division. **COBRA can help you if you are under 65 and disabled and qualify. You may find it difficult to buy other health care insurance.**

The employee and their dependent beneficiaries **must be offered the same health insurance benefits** with the same deductibles and benefit limits that they were receiving before the COBRA qualifying event.

You are eligible if:

- The employer has 20 or more employees.
- The employee has worked at least half of working days in the previous year.
- The employee is covered by the group health plan and you are in the employer group health plan the day before the employee has a "**qualifying event**". (A specific event that causes you to lose employer group health care coverage.)

Qualifying Event	Who's Eligible	Length of Eligibility
Voluntary or involuntary termination of employment/reduction of work hours (other than for "gross misconduct")	Employee Spouse Dependent Child	18 Months
Employee enrolls in Medicare Part A or B	Spouse Dependent Child	36 Months
Employee & covered individual divorcee	Spouse Dependent Child	36 Months
Employee dies	Spouse Dependent Child	36 Months
Loss of dependent child status	Dependent Child	36 Months

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. While this can be expensive, **compare the total cost and benefits** of COBRA coverage with the total cost and benefits of other options (including Original Medicare, Medicare Advantage Plans, Medigap policies, and private health care insurance) to determine what will best suit your finances and health needs. Be sure to compare:

- Prescription coverage
- Eye, dental, foot, and other coverage
- Maximum benefit limits (annual & specific types of care)
- Co-pay amounts
- Yearly deductibles

Cobra and Social Security Disability Benefits

The employer group health insurance extends for 18, 29, or 36 months (depending on qualifying event). If you qualify for Social Security disability benefits, special rules apply to extend the 18 months of COBRA coverage to **29 months**. To receive this special coverage extension, you must notify the former employer insurance division within 60 days of receiving your disability determination.

You pay the entire premium, plus a 2% administrative charge to the continued group health plan for the first 18 months. If your disability started before your COBRA qualifying event, your group coverage could be extended to 29 months. **For the last 11 months, your premium will increase to 150% of the original premium**. If you enroll in Medicare Part A or Part B after already being on COBRA, your COBRA coverage will end.

Special Note: **If you have Medicare prior to the qualifying event, you must be offered COBRA coverage.**

For more information about COBRA, call the SHIP State Office and ask for a COBRA brochure, or call the Department of Labor for COBRA questions, **for Social Security or Medicare benefits, call 1-800-772-1213 (for hearing impaired, TTY: 1-800-325-0778) or visit their website at www.ssa.gov**.

Public Programs

Railroad Retirees

If you are a railroad retiree, you must apply to the Railroad Retirement Board instead of the Social Security Office to sign up for Medicare. Medicare benefits are the same, but claims are processed differently.

- Part A claims are processed by Palmetto GBA
- Part B claims are processed by United Healthcare

TRICARE For Life (formerly CHAMPUS)

TRICARE For Life (TFL) is a health insurance plan offered through the Department of Defense for active duty and retired military personnel and qualified family. TFL is for all TRICARE beneficiaries who are eligible for Medicare because of disability, ESRD or age. Like Medicare, TFL is designed to cover health care for injuries and illnesses. TFL will generally cover the same services that Medicare covers.

TRICARE beneficiaries, upon attaining the age of 65 and becoming entitled to Medicare Part B, will transfer from TRICARE to TRICARE For Life. TFL will pay secondary to Medicare, beginning the first day of the first month you turn 65.

To be eligible for TFL you must be one of the following:

- Medicare eligible uniformed service retirees, including retired Guard and Reservists;
- Medicare eligible family members, including widows/widowers; or
- Medicare eligible un-remarried former spouses, if they were eligible for TRICARE before age 65
- Dependent parent and parent-in-laws are not eligible for TFL.

TFL pays in general like a Medigap policy –

- Medicare deductibles, coinsurance and co-payments
- First 3 pints of blood each year
- 80% of costs at TFL network
    - for inpatient hospital care from day 151

  - skilled nursing facilities (SNF) from day 101
- 75% of costs at non-TRICARE network from day 151 for hospital, or day 101 for SNF

Who Pays First?

- For services payable by both Medicare and TFL, Medicare will pay first and the remaining out-of-pocket expenses will be paid by TFL.
- For services payable by TFL, but not Medicare, TFL will pay the same as if you were age 65. You will be responsible for the TFL annual deductible and cost shares.
- For services payable by Medicare, but not TFL, Medicare will pay the usual, TFL will pay nothing. You will be responsible for Medicare deductibles and co-pays.
- For services not payable by TFL or Medicare, you are responsible for the full medical costs.

The Defense Eligibility Reporting System notifies you within 90 days prior to your 65th birthday that your benefits are about to change. You are expected to contact your nearest SSA Office to enroll in Medicare. It is important to remember that you must elect to enroll in Medicare Part B in order to be eligible for TFL benefits. If you are older than age 65 and have only Part A, you can enroll in Part B during the General Enrollment Period (January 1 through March 31).

For more information about veterans benefits please contact your Indiana Veterans County Service Officer, or the Indiana Department of Veterans Affairs office by phone (317) 232, 3910, toll free call 1-800-400-4520; or online at www.in.gov/veteran.

VA Benefits for Non-Active and Non-Retired Veterans

If you have or can get both Medicare and Veterans benefits, you may choose to receive treatments under either program.

In October 1996, the Veterans' Health Care Eligibility Reform Act paved the way for the creation of a Medical Benefits Package for honorably discharged veterans, based on a Priority Group Basis. This system assigns each enrolling veteran a Priority Group (ranging from 1 to 8) based on the percentage of service connected disability, former POW status, severity of needs and/or their ability to pay.

Medicare cannot pay for services you receive from VA hospitals or other VA facilities, or when the VA pays for VA authorized services you receive at a non-VA facility or from a non-VA physician. As a veteran you may be able to fill your prescriptions at your VA pharmacy, even when Medicare is paying for other services. Call 1-800-827-1000, or visit http://www.va.gov

Widows or Widowers

Veterans' benefits are also available to widows of veterans who were eligible for VA benefits, including the state VA Veteran's Home (long term care facility).

State of Indiana Retired Employees

State employee retirees may purchase various health plans. If you are a State retiree and want more information, contact your former department or employing agency or the health insurance carrier if you continued coverage.

RIPEA (Retired Indiana Public Employees Assoc.)

RIPEA provides one insurance option for retired state government employees. For retirees on Medicare, RIPEA offers a plan to supplement Medicare. You can buy additional benefits. RIPEA is a not-for-profit corporation created by the Indiana Legislature in 1972. Eligibility requirements:

- You must be an Indiana state retiree, receiving a monthly check from PERF (Public Employers' Retirement Fund).
- You must pay the annual membership dues.

For more information call 1-800-345-9214, or online at www.ripea.org

Federal Employees – NARFE

Retired federal employees become eligible for Medicare at age 65. The Federal Employee Health Benefit Plan (FEHBP) then becomes secondary payer. There are several plans from which to choose. You may change carriers once a year during "open season". Specific information for retirees' health benefits may be obtained through the administrative office of the former employing branch of the federal government.

Teachers – ISTRF (Indiana State Teachers' Retirement Fund)

Upon retirement as an Indiana teacher, if you are eligible, you may enroll in the Anthem Blue Cross and Blue Shield health care plan. To qualify you must be a retired Indiana teacher, and a member of the Indiana State Teachers' Retirement Fund.

To see if you qualify for this coverage or for details on specific covered services, contact the Teacher's Retirement Fund at 1-800-382-4037, or online at www.ista-in.org.

Private Programs

Hospital Indemnity Insurance

These policies are not designed to act as Medigap policies. They pay a fixed amount for specified time periods that you are hospitalized. Payments are usually made directly to you. Amounts and requirements are stated in each policy and vary from company to company. These plans may fail to keep pace with inflation and rising hospital costs.

Major Medical Insurance Plans

Covers major medical expenses for high cost illnesses. These plans usually have a high deductible but may pay very large total payments. They have limited availability to people over age 65, unless you are continued under an employer group health plan. Major Medical plans are rarely sold as individual policies.

Specific Disease Insurance

At times these are called “dread disease” policies. They pay benefits for the diseases that are named in the policy (i.e. cancer). They usually pay either a fixed amount for each type of treatment, or reimburse for expenses up to a fixed amount for each type of treatment. Coverage generally does not keep pace with inflation. Benefits are not designed to fill gaps in Medicare.

Personal Expense Policies

These policies are marketed to seniors along with Medigap plans. They are not Medigap policies. These policies provide some coverage for routine physical, dental, vision and hearing exams. These exams are not covered by Medicare. Some coverage is also available towards the cost of eyeglasses and hearing aids. There are limits as to the amounts of coverage per services, as well as limits to how often services may be received.

Filing for Benefits

Patients with private health insurance are responsible for filing any claims for benefits received under the terms of their policy. All Medicare claims must be

submitted by the Physician or other service provider, even when Medicare assignment is not accepted.

A Quick Look: Know Who Pays First if You Have Other Health Insurance Coverage

If you have Medicare and other health insurance coverage, be sure to tell your doctor and other providers so your bills can be sent to the appropriate payer to avoid delays. Some of the most common situations where Medicare can pay second are listed below; however, this chart does not cover every situation.

If you…	Condition	Pays First	Pays Second
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	The employer has less than 20 employees The employer has 20 or more employees	Medicare Group Health Plan	Group Health Plan Medicare
Have an employer retiree plan and are age 65 or older, or are disabled age 65 or older	Eligible for Medicare	Medicare	Retiree Coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working	The employer has less than 100 employees Employer has 100 or more employees	Medicare Group Health Plan	Group Health Plan Medicare
Have End-Stage-Renal-Disease (permanent kidney failure) and group health plan coverage (including retirement plan)	First 30 months of eligibility or entitlement to Medicare After 30 months	Group Health Plan Medicare	Medicare Group Health Plan
Are covered under worker's compensation because of a job related illness or injury.	Eligible for Medicare	Worker's compensation related service	Medicare
Have Black Lung disease and covered under the Federal Black Lung Program	Eligible for Federal Black Lung Program	Federal Black Lung Program for Black Lung related services	Medicare
Have been in an accident where no-fault or liability insurance is involved	Eligible for Medicare	No-fault Liability insurance for accident related services	Medicare
Are age 65 or older, or disabled and covered by Medicare and COBRA	Eligible for Medicare	Medicare	COBRA