

Volunteer Basic Training

January 27, 2017

Welcome to Basic

- Welcome to Basic Training
- Health insurance 101
- Medicare introduction:
 - Part A
 - Part B
 - Part D
 - Medigaps
 - Part C

Welcome to Basic

- After you complete this training, you will take an open book exam.
- Get more information about this from your Volunteer Coordinator or Regional Training Consultant (RTC).
- Once you pass this exam, we will certify you as a SHIBA Volunteer.
- This is not the end of your training, it's just the start of a rewarding journey!

SHIBA History

- First State Health Insurance Program (SHIP) began in our state in 1979
- All states have a SHIP program
- Funded by the federal government
- In Washington state, we are also funded by the state legislature



SHIBA History – how it works

- Funding comes from SHIBA through federal and state resources
- SHIBA uses these funds to award grants to Sponsors in our state to provide SHIBA services statewide
- SHIBA provides volunteer training and education
- Each sponsor site has a Volunteer Coordinator that manages the SHIBA program in their area
- These programs are staffed by volunteers

SHIBA mission statement

SHIBA provides free, unbiased information about health care coverage and access to help improve the lives of all Washington residents. We cultivate community commitment through partnership, services, and volunteering.

Insurance terms

Health coverage and medical terms

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold** text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your [provider](#) charges more than the allowed amount, you may have to pay the difference. (See [Balance Billing](#).)

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

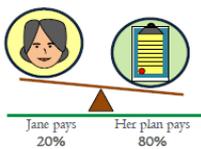
When a [provider](#) bills you for the difference between the provider's charge and the [allowed amount](#). For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A [preferred provider](#) may *not* balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

The general term that refers to the share of costs for services covered by a [plan](#) or [health insurance](#) that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of cost sharing include [copayments](#), [deductibles](#), and [coinsurance](#). Other costs, including your [premiums](#), penalties you may have to pay or the cost of care not covered by a plan or policy are usually *not* considered cost sharing.

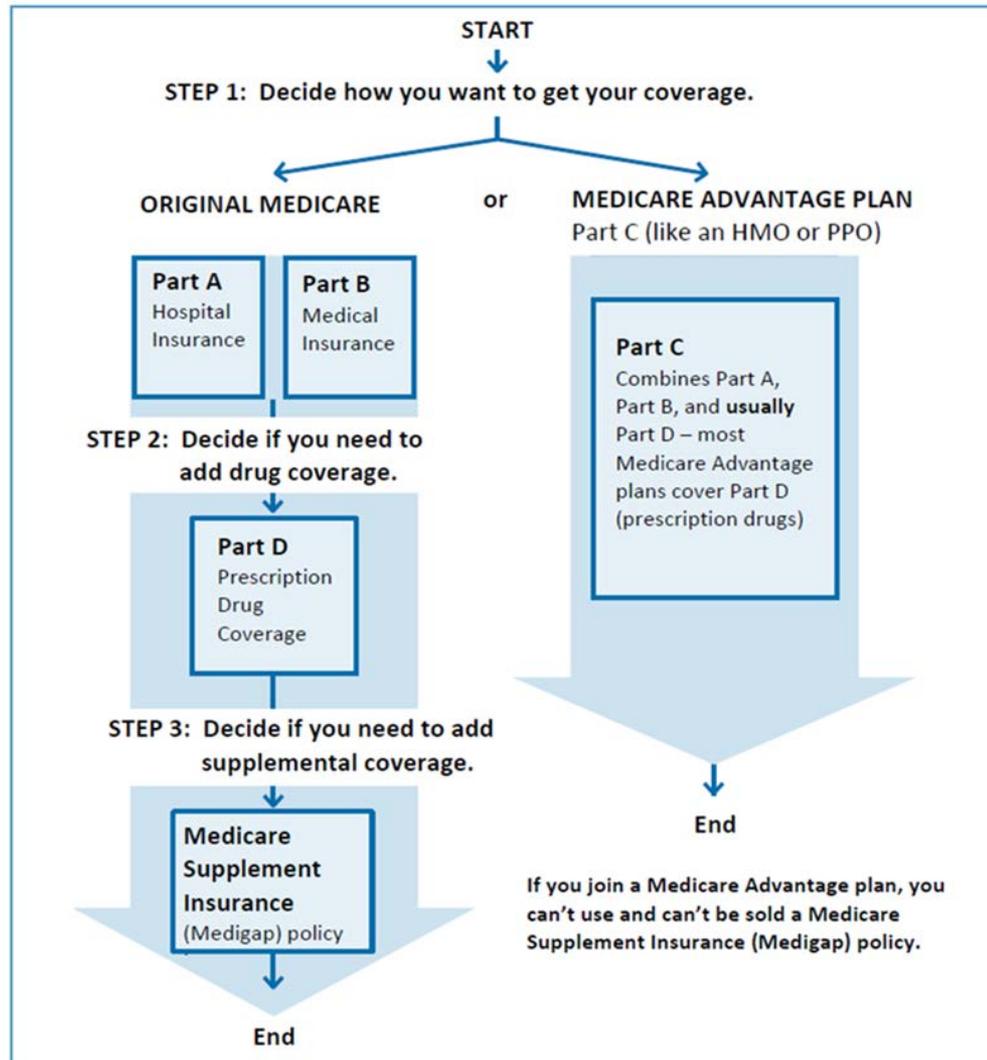
Cost-sharing Reductions

Discounts that lower [cost sharing](#) for certain services covered by individual [health insurance](#) purchased through the [Marketplace](#). You can get these discounts if your income is below a certain level, and you choose a Silver level health [plan](#). If you're a member of a federally recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for cost-sharing reductions on certain services covered by a Marketplace policy of any metal level and may qualify for additional cost-sharing reductions depending upon income.

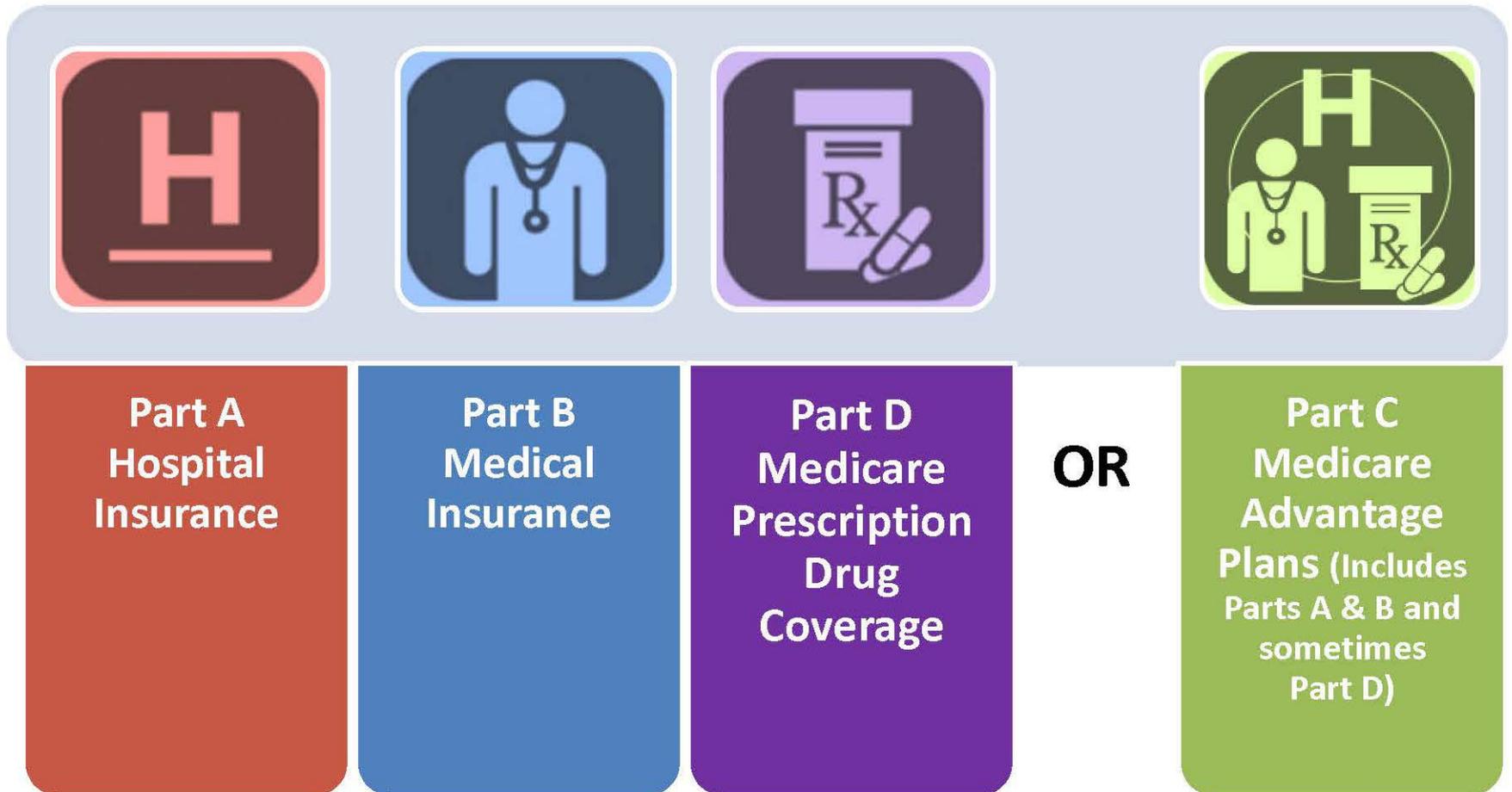
Please reference handout (also posted on My SHIBA)

Medicare introduction

Choose your path!



The four parts of Medicare



Who is eligible for Medicare?

- Age 65 and older
- Under age 65 and deemed disabled (SSDI) by SSA
 - 24-month waiting period
 - No waiting period if diagnosed with ESRD or ALS
- Must be a US citizen or legal permanent resident (LPR)
 - If a client is a LPR, they must be for 5 continuous years

Medicare card

MEDICARE  **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER SEX
000-00-0000-A **FEMALE**

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE → *Jane Doe*

Enrollment and enrollment periods

Some people are automatically enrolled

- Automatic enrollment for people who turn 65 and are receiving:
 - Social Security benefits (\$)
 - Railroad Retirement Board benefits (\$)
- Automatic enrollment also occurs for people:
 - Diagnosed with ALS (starts the month their disability benefits start – aka SSDI)
 - Under age 65 and disabled, after getting disability benefits (aka SSDI) for 24 months
- Will receive an enrollment packet, including a Medicare card in the mail

When enrollment is NOT automatic

- If client is not receiving SSA retirement income
 - He/she will need to enroll with Social Security:
 - Online at www.ssa.gov
 - Call 1-800-772-1213
 - Visit local SSA office
- If a client has any questions about enrollment, have them contact Social Security
 - Ideally, about 3 to 4 months before their 65th birthday

Three main Medicare enrollment periods

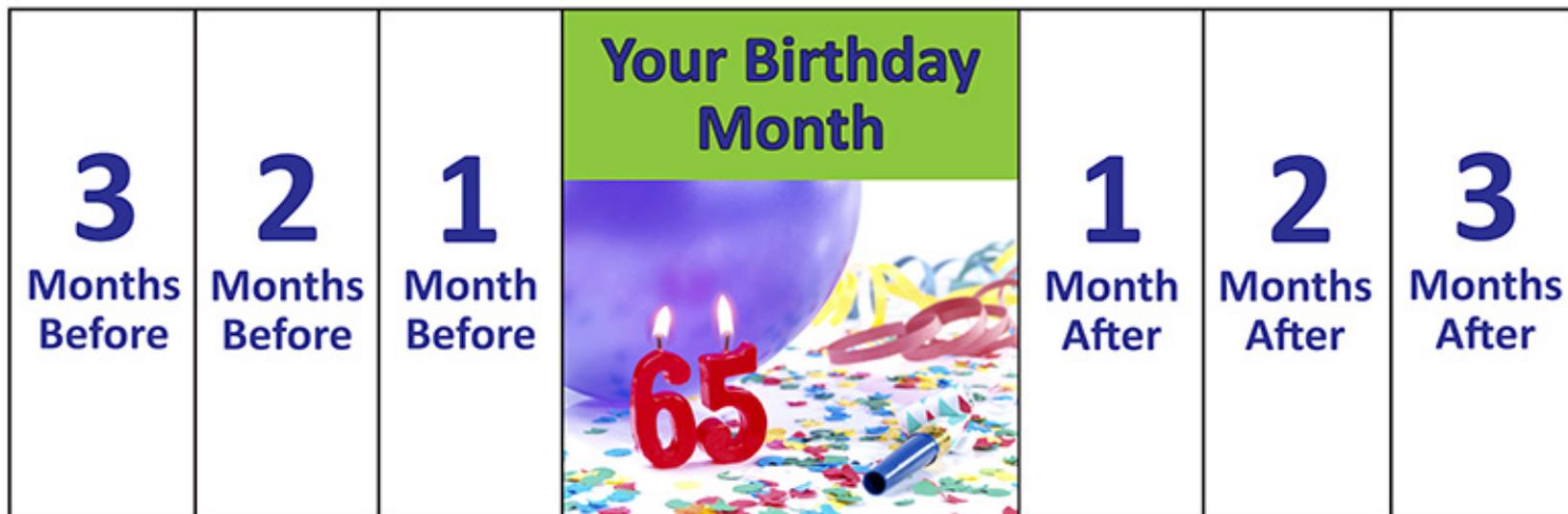
1. Initial Enrollment Period (IEP)
2. Special Enrollment Period (SEP)
3. General Enrollment Period (GEP)

This is just the beginning. The client will have more decisions to make along their path!

Initial Enrollment Period

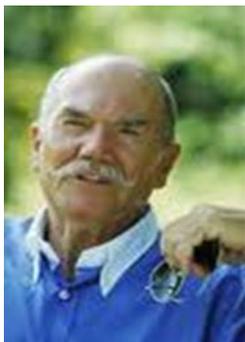
- Lasts 7 months
- Starts 3 months before client's 65th birthday
- Ends 3 months after client turns 65

Initial Enrollment Period



- The later a client enrolls, the later coverage starts
 - Could be up to a 3-month wait

Example



George will turn 65 in May. He enrolled in Medicare in February and it will begin on May 1.



Sally turned 65 in May as well, but she did not enroll in Medicare until August. Sally faces no penalty, but her Medicare will not start until December 1.

Special Enrollment Period

- Special Enrollment Period (lasts 8 months)
- Occurs after IEP ends
- For people who are covered by a group health insurance plan based upon current employment
 - Their own, spouse's or if disabled, or another family member's
- Can enroll in Part A and/or B
 - Any time still covered by the group plan
 - During the 8 month period that begins the month after employment ends or the coverage ends, whichever happens first

Medicare card – Part B

- Follow instructions on back of card
- Client keeps card to accept Parts A and B

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical, or health services under **Medicare**.
3. Your card is good wherever you live in the United States.

WARNING: Issued only for use of the named beneficiary. Intentional misuse of this card is unlawful and will make the offender liable to penalty. If found, drop in nearest U.S. Mail box.



**Centers for Medicare &
Medicaid Services**
Baltimore, MD 21244-1850
Form CMS-1966 (01/2002)

**If you have questions
about Medicare,
call 1-800-MEDICARE
(1-800-633-4227;
TTY/TDD: 1-877-486-2048)
or visit us at
www.medicare.gov.**

Example

Jonathan has been working for a large employer and is getting ready to retire this year. He is 68 years old and has not signed up to collect Social Security or Medicare. However, Jonathan can sign up for Medicare at any time now, using his SEP. His SEP will end when he has been retired for 8 months.

General Enrollment Period

- General Enrollment Period (GEP)
 - If client missed Initial Enrollment Period
 - If client missed, or is not eligible for a Special Enrollment period (i.e. employer coverage)
- Can enroll during the GEP
 - January 1 – March 31 each year
 - Coverage won't start until July 1 of each year
 - Possible higher premiums for Part A and/or Part B for late enrollment

Example

Charlie is 68 years old. He stopped working over a year ago from a large employer and he signed up for COBRA coverage when he retired. Charlie's COBRA coverage will end in a few months and now he wants to sign up for Medicare. He is past his Initial Enrollment Period, and it's been more than 8 months since he was covered by active employer insurance, so he is past his Special Enrollment period. Charlie will have to wait for the General Enrollment Period to enroll in Medicare.

Original Medicare

Parts A and B are referred to as Original Medicare

Original Medicare

Part A – Hospital insurance:

- Inpatient hospital
- Skilled nursing facility (limited)
- Home health care
- Hospice care
- Blood



Medicare hospital insurance (Part A)

Washington State Office of the Insurance Commissioner • Statewide Health Insurance Benefits Advisors (SHIBA)

2017 Medicare hospital insurance (Part A) covered services

Services	Benefit	Medicare pays	You pay
Hospitalization Semi-private room and board, general nursing and other hospital services and supplies (Medicare payments based on benefit periods) <i>(See comments 1 & 2)</i>	First 60 days	All but \$1,316	\$1,316
	61st to 90th day	All but \$329/day	\$329/day
	91st to 150th day (<i>60 reserve days may be used only once</i>)	All but \$658/day	\$658/day
	Beyond 150 days	Nothing	All costs
Skilled Nursing Facility Care Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies (Medicare payments based on benefit periods) <i>(See comments 1 & 2)</i>	First 20 days	100% of approved amount	Nothing
	Next 80 days	All but \$164.50/day	up to \$164.50/day
	Beyond 100 days	Nothing	All costs
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements for home health care benefits	100% of approved amount 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
Hospice Care Pain relief, symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care
Blood♦ When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	For first 3 pints

1 - Neither Medicare nor Medigap insurance pay for most nursing home care (See *Medicare & You* booklet, page 39).

2 - A benefit period starts the first day you receive a Medicare-covered service in a qualified hospital. It ends when you've been out of a hospital (or other facility that provides skilled nursing or rehab services) for 60 days in a row. It also ends if you stay in a facility (other than a hospital) that provides skilled nursing or rehab services, but do not receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period starts.

♦ If the hospital gets blood from a blood bank at no charge, you won't pay for replacing it. If the hospital buys blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Premium for Part A: Most people don't pay a premium, because they (or their spouse) worked for over 40 quarters. If you have fewer than 30 quarters of coverage, you pay \$413/mo. For 30-39 quarters of coverage, you pay \$227/mo.

Medicare Part A (hospital insurance)

What does Part A cost?

- Most people get Part A premium-free
 - They or their spouse must have paid FICA taxes for at least 10 years
- **IF** they paid into Medicare less than 10 years, they:
 - Can pay a premium to get Part A



Medicare and You: Page 27

Example

Evelyn is a widow and has contributed to Medicare for the last 20 years through her job. She's earned 40 working credits throughout her active work. When Evelyn enrolls in part A, it will be premium-free.

Vivian is single and has acquired only 35 credits for Medicare, therefore she doesn't qualify for premium-free Part A. Vivian will have to pay a monthly premium of \$227 to receive Part A. Vivian can also continue to earn more credits.

Original Medicare

Part B – Medical insurance:

- Doctor visits
- Outpatient hospital services
- Tests, labs, x-rays, etc.
- Durable medical equipment (DME) and supplies
- Preventive services



Medicare and You: Pages 36-61

Medicare medical insurance (Part B)

Washington State Office of the Insurance Commissioner • Statewide Health Insurance Benefits Advisors (SHIBA)

2017 Medicare medical insurance (Part B) covered services

Services	Benefit	Medicare pays	You pay
Medical Expenses Doctor services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, most outpatient mental health services, and other services	Unlimited if medically necessary	80% of approved amount (after \$183 deductible)	\$183 deductible,* plus 20% of approved amount and limited charges above approved amount**
Clinical Laboratory Services Blood test, urinalysis, and more	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount* for durable medical equipment
Outpatient Hospital Treatment Services for the diagnosis or treatment of an illness or injury	Unlimited if medically necessary	Medicare payment to hospital based on hospital costs	20% of billed amount*
Blood♦	Unlimited during a benefit period if medically necessary	80% of approved amount (after \$183 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount for additional pints♦*

- * After you pay the yearly deductible of \$183, you typically pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy and durable medical equipment for the rest of the year.
- ** Federal law limits charges for physician services.
- ♦ If the hospital gets blood from a blood bank at no charge, you won't pay for replacing it. If the hospital buys blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Monthly Part B premium: The standard Part B premium amount in 2017 is \$134 (or higher depending on your income). However, most people who get Social Security benefits will pay less (\$109 on average). Social Security will tell you the exact amount you'll pay. For more information, go to: <https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>.

We attempt to provide the most current information possible. Due to frequent changes, always check with Medicare at www.medicare.gov or at 1-800-MEDICARE (1-800-633-4227) for the latest premiums and deductibles. If you want personalized help, call SHIBA at 1-800-562-6900 and ask to speak with a SHIBA counselor in your area. SHP520FR-SHIBA Part A&B-Rev. 11.17.16

Medicare Part B (medical insurance)

What does Part B cost?

- In 2017, most people will pay approximately \$109 per month
 - Most people new to Medicare will pay the standard premium of \$134
 - People with higher incomes could pay more
- Social Security will notify clients if they have to pay more or less than the standard premium
 - The amount may change depending on the client's yearly income



Examples

In 2015, William drew a \$1,500 monthly Social Security (SS) benefit, enrolled in Medicare Part B, and had the Part B monthly premium of \$104.90 deducted from his SS benefit. He continued to pay \$104.90 a month in 2016 as part of the hold harmless group because there was no COLA.

In 2016, Natasha drew \$2,040 monthly SS benefit, enrolled in Medicare Part B, and had the Part B monthly premium of \$121.80 deducted from her SS benefit. In 2017, the hold harmless provision will limit the increase in her Part B premium. She will pay a slightly higher monthly premium of \$127.92 since her net SS benefit cannot decrease.

See <https://www.ncoa.org/wp-content/uploads/medicare-parts-a-and-b.pdf>

Does a client need Part B?

Yes, if:

- They don't have coverage from active employment (their own or their spouse's)
 - Delaying Part B may mean:
 - Higher premiums (late enrollment penalty)
 - Waiting for GEP
 - Paying for their health care out-of-pocket

Does a client need Part B?

Potentially no, if:

- They have coverage through active employment
 - Their own job, their spouse's job, if disabled and under 65, or another family member's job

Things to consider:

- Some of the decision is based upon rules about when Medicare would pay BEFORE the employer plan pays.
- People should check with their employer, in some cases, small employers will pay AFTER Medicare pays, even with active employment.

Examples

Maggie plans to keep working until she is 68. She is covered by her employer's insurance. Maggie will sign up for Part A, but defer Part B until she stops actively working.

Barbara retired at age 63 and has been paying for a private insurance plan. At the age of 65, she will start her Medicare Parts A and B.

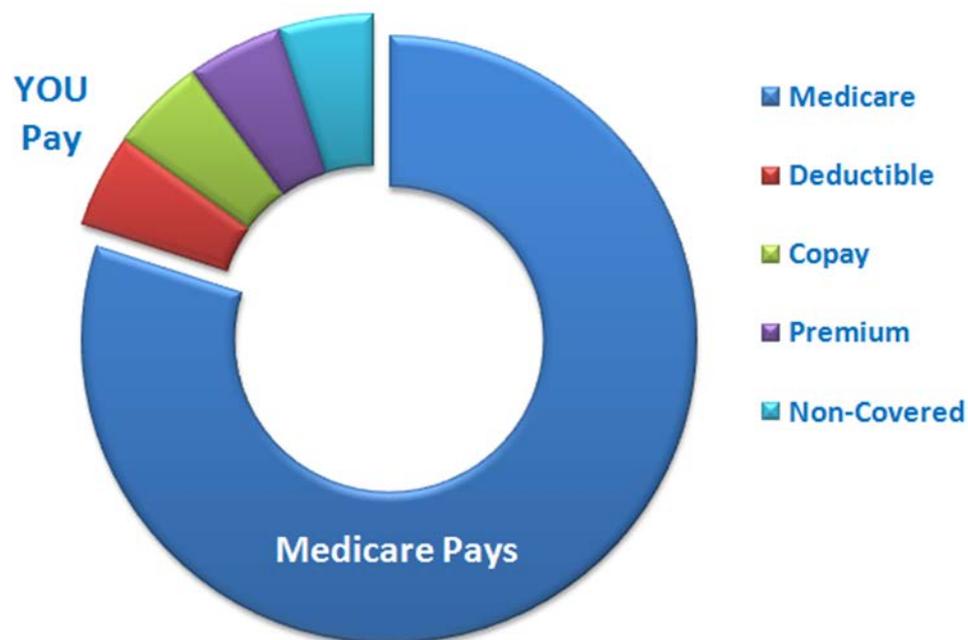
Paying for Parts A and B

In addition to Part B premiums (sometimes Part A)

- Client pays:
 - Part A hospital deductible
 - Part B yearly deductible
 - 20% coinsurance for most services
 - May be other costs

Remember!

Medicare (generally) covers 80% of the cost for services that are "medically necessary"



Example

Sarah is diagnosed with glaucoma. Regularly scheduled eye exams are considered “medically necessary” for her.



Help paying for Parts A and B

- There is a program to help clients pay for Medicare Parts A and B:
 - It's called the Medicare Savings Program (MSP)
 - Available to clients with limited income and resources
 - Find MSP at: www.washingtonconnection.org

Example

Sam received Social Security retirement of \$1,000 per month, and has less than \$7,000 in the bank. The Medicare Savings Program will pay his Part B premium – saving him over \$1,200 per year



Medicare prescription drug coverage

Also called Part D

Medicare Part D

- Available for all people with Medicare Parts A and/or B
- Provided through:
 - Stand-alone Part D plans (PDP)
 - Medicare Advantage Plans (MAPD)



Who can enroll in Part D?

Clients must:

- Have Part A or Part B or both
- Live inside the U.S. and can't be incarcerated

Enrollment is not automatic for most



Medicare and You: Pages 85-86

Do all clients need Part D?

It Depends...

- Do they already have creditable drug coverage from another source?
- Creditable means it's as good as Medicare's
 - For example, through an employer plan
- Without creditable coverage
 - May have to wait to enroll
 - May have a penalty



Medicare and You: Pages 85-86

Part D covers

- Prescription brand-name and generic drugs
- Each plan has its own formulary
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan



Medicare and You: Page 33-96

Example

Bob was told by his doctor to take a low-dose aspirin daily. Since this is an over-the-counter (OTC) medication, Part D plans do not cover it.

Medicare drug plan costs

What do clients pay?

- Cost varies by plan
- Most people pay:
 - A monthly premium
 - A yearly deductible
 - Copayments or coinsurance
 - Coverage gap (donut hole)



Medicare and You: Pages 88-91

When can clients enroll in Part D?

- During 7-month Medicare Initial Enrollment Period (IEP)
- During Open Enrollment Period (OEP)
 - October 15 – December 7
 - Coverage starts January 1
- Can possibly join at other times
 - Special Enrollment Period (SEP)
 - Examples: move to a new area, gain or lose employer or retiree coverage, are eligible for Extra Help/Low Income Subsidy (LIS)

Help paying for Part D

- “Extra Help” or “Low-income-subsidy” (LIS) is a program available to clients with limited income and resources.
- Extra Help or LIS will pay for part or all of premiums, deductible and copay for eligible clients.
 - Part D penalties waived for LIS clients
 - LIS enrollees can change plans monthly
 - Find LIS applications at: www.ssa.gov

Example

Samantha receives \$1,400 per month in Social Security retirement. She has less than \$10,000 in savings. Extra Help could save her a lot of money. The program could help pay some or all of her Part D premium, pay most or all of her deductible, make it so she has small drug co-pays, and could allow her to change her drug plans at any time.

How do clients choose a Part D plan?



Research the online Plan Finder at:
www.medicare.gov



Contact the plan to find out if the clients medications are on their formularies and the costs.

Additional training is offered to SHIBA volunteers in this area – it's the best way for clients to compare plans.

Medigaps

Also called Medicare Supplement Plans

What is a Medigap plan?

- Medigaps (also called Medicare Supplement plans) are sold by private insurance companies
- They help pay for “gaps” in Original Medicare
- Gaps include:
 - Deductibles, coinsurance and copayments
- Medigaps are standardized and designated by letters A-N

Example

Fred had Original Medicare Parts A and B and a Medigap plan. As long as Fred's doctor accepts Medicare and Medicare Parts A and B cover the care he gets, his Medigap will pay its part after Medicare pays. Then, if there is anything left over, Fred will be billed for the remaining. Medicare coordinates its payments with most Medigap plans, so the doctor or Fred most likely will not have to take any other action to get the Medigap to pay.

Who is eligible?

- Any Medicare client with both Parts A and B
- Medicare clients under age 65 have limited choices
 - There are no “guaranteed issue” protections for people under age 65 in Washington state



Do clients need a Medigap?

- If a client is NOT covered under an employer plan (active or retired) and does not have any other source to pay for the balances after Original Medicare has paid, he/she may want to consider a Medigap.

When to enroll in a Medigap

- Clients may enroll any time after enrolling in Medicare Parts A & B if a company agrees to sell them one
- Medigaps don't have an annual OEP

When to enroll in a Medigap

- Clients are guaranteed to get a Medigap without a health screening during the following:
 - The 6-month period that starts first day of the month that you're 65 or older AND enrolled in Part B
 - Have a Medigap plan B through N can join any Medigap plan – except Plan A
 - Have Medigap Plan A can join any Medigap Plan A

The Office of Insurance Commissioner has health compliance analysts on staff who can interpret and explain the laws about Medigaps and health screenings to SHIBA volunteers and clients.

Examples

Toby is 69 years old and just enrolled in Medicare Part B. Toby is retiring from his job, therefore he is going to use his Special Enrollment Period. His 6-month Medigap Open Enrollment Period starts as soon as his Medicare Part B starts.

Samantha is 63 years old, disabled and on SSDI. She was automatically enrolled in Medicare Parts A and B because she has been on SSDI for 24 months. Her 6-month Medigap Open Enrollment Period will not start until the month she turns 65.

Examples

Bonnie purchased a G plan with Pear Company. Bonnie now wants an F plan that Pear Company provides. She can call Pear Company and purchase the F plan to replace her G plan.

Jack purchased a G plan with Pear Company, but wants a G plan from Grape Company. He can call the Grape Company and enroll. Once his new plan activates, it is **his responsibility** to cancel with Pear Company.

Standardized Medigap plan

Washington State Office of the Insurance Commissioner • Statewide Health Insurance Benefits Advisors (SHIBA)

10 Standardized Medicare Supplement (Medigap) plans chart

Effective on or after Jan. 1, 2017

How to read the chart:

- ✓ = policy covers 100% of benefit
- % = policy covers that percentage
- Blank = policy doesn't cover that benefit

Note: The Medicare Supplement policy covers coinsurance only after you've paid the Medicare deductible (unless the policy also covers the deductible).

Basic benefits	A	B	C	D	F*	G	K	L	M	N
Part A: Hospital coinsurance (plus costs up to an additional 365 days after Medicare benefits end)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Hospice care coinsurance or copay	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B: Coinsurance or copay	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Medicare preventive care Part B coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Parts A & B: Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Additional benefits	A	B	C	D	F*	G	K	L	M	N
Skilled nursing facility care coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible: \$1,316		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible: \$183			✓		✓					
Part B excess charges					✓	✓				
Foreign travel emergency (lifetime limit of \$50,000)			80%	80%	80%	80%			80%	80%
Out-of-pocket yearly limit**							\$5,120	\$2,560		

*Plan F offers a high-deductible plan. You pay for Medicare-covered costs up to the deductible amount (\$2,220 in 2017) before your plan pays anything.

**After you meet your out-of-pocket yearly limit and Part B deductible, the plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance except up to \$20 copays for some office visits and up to \$50 copays for emergency room visits (if the hospital admits you, the plan waives your emergency room copays).

Need more help?

There is no yearly open enrollment period for Medicare Supplement (Medigap) plans. You may apply to buy or switch plans at any time.

However, insurers may require you to pass a health questionnaire. If you have questions about who needs to take the questionnaire, call our Insurance Consumer Hotline.

If you want individual help understanding all of your options, call our hotline and ask to speak with a SHIBA counselor in your area.

Insurance Consumer Hotline: 1-800-562-6900



This publication may have been partially funded by grants from the Centers for Medicare & Medicaid Services and the U.S. Administration for Community Living.



SHP521-SHIBA-Mediga-plans-Rev.12/19/16

Approved Medigap plans

Washington State Office of the Insurance Commissioner • Statewide Health Insurance Benefits Advisors (SHIBA)

January 2017 Approved Medicare Supplement (Medigap) plans

By federal law, the high-deductible plan F has a \$2,220 deductible for the year 2017

People who:

- Have a Medigap plan B through N can join any Medigap plan – except Plan A.
- Have Medigap Plan A can join any Medigap Plan A.
- Have more comprehensive health coverage than the Medigap plan they're buying, can join any comprehensive Medigap plan – except Plan A.

There's no yearly open enrollment period for Medicare Supplement (Medigap) plans. You may apply to buy or switch plans at any time. However, outside of special enrollment periods, insurers may require you to pass a written health screening. Not sure whether you will need to take a health screening? Call our Insurance Consumer Hotline at 1-800-562-6900 and ask for a health compliance analyst.

Company	Pre-X ¹	Health screen ³	Standardized Benefit Plans & Costs									
AETNA HEALTH AND LIFE (AAA)^{2, 4} 1-855-523-3107			A	B	C	D	F	G	K	L	M	N
Age 65 and older	No	Yes	\$136	\$167			\$202	\$186				\$141
ASSURED LIFE ASSOCIATION 1-888-397-7786			A	B	C	D	F	G	K	L	M	N
Age 65 and older	No	Yes	\$210	\$227	\$283	\$233	\$284	\$235				\$204
ASURIS NORTHWEST HEALTH² 1-866-704-2708			A	B	C	D	F	G	K	L	M	N
Age 65 and older	No	Yes	\$148		\$208		\$209		\$113			
Notes about Asuris Northwest: These plans are offered in the following counties: Adams, Asotin, Benton, Chelan, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman counties.												
COLONIAL PENN² 1-800-800-2254			A	B	C	D	F	G	K	L	M	N
Age 65 and older	No	Yes	\$219	\$267			\$296	\$273	\$102	\$177	\$238	\$173
With a high deductible	No	Yes					\$72					

Note: Plans and premium costs listed are filed and approved by the Washington State Office of the Insurance Commissioner.

Companies may change their rates at various times throughout the year, so always check with the company for the latest availability and premiums. Plans issued before June 1, 2010 have different rates due to changes in Medicare.

Questions? Call our Insurance Consumer Hotline at 1-800-562-6900

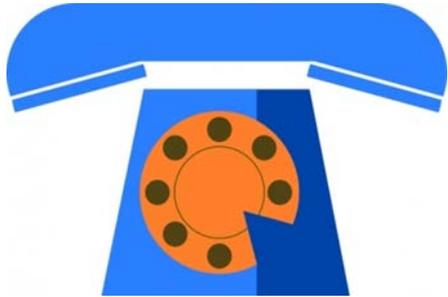
Things to consider

- Medigaps are good nationwide
- A client should make sure the providers they use are contracted to accept Medicare assignment
- Once a client buys a Medigap, it's theirs as long as they pay the premium
- There is portability in Medigaps

Things to consider

- Insurance companies can only sell the client a “standardized” plan (letters A – N)
- Medicare Standardizes Medigaps
 - Plans with the same letter designation all cover the same benefits
 - Different insurance companies may charge different premiums for the exact same plan
- Medigaps sold today DO NOT pay for prescription drugs
 - Most should consider buying a drug plan (Part D)

How to find the right Medigap plan



Research what benefits each plan letter provides.



Compare the plans cost to what is affordable to the client.

Medicare Advantage plans

Also called Medicare Health Plans or Part C

Medicare Advantage (Part C)

Part C (Medicare Advantage) is another way to get Medicare coverage

- Sold by private insurance companies
- Most plans require clients to use a defined network of providers
- Clients can check with a plan before they get a service to find out if it's covered and get an estimate of costs
- Choice of plans varies depending on what county the client lives in
 - Some counties don't offer plans

Medicare and You: Pages 67-80

How Medicare Advantage plans work

- Provides all the same rights and protections as Original Medicare
- Medicare pays a private plan to provide the services
 - Client pays Part B premium and may also pay plan premium
- Delivers Part A and Part B benefits
- Most include Part D prescription drug coverage
- May include extra benefits
 - Vision, dental, hearing and health club memberships

Medicare and You: Page 67-80

Who is eligible?

- Anyone enrolled in Parts A and B (OM) who has not been diagnosed with End Stage Renal Disease (ESRD) and lives in the plan's service area.
 - The only health screening question plans will ask is if the client has ESRD.

When can clients enroll in a MA Plan?

- During 7-month Medicare Initial Enrollment Period (IEP)
- During Open Enrollment Period (OEP)
 - October 15 – December 7
 - Coverage starts January 1
 - May be able to join at other times
 - Special Enrollment Period (SEP)
 - Examples: move to a new area, gain or lose employer or retiree coverage, are eligible for Extra Help/Low Income Subsidy (LIS)
- Depending on what county the client lives in, MA plans may not be available
- The annual Maximum out-of-pocket limit can protect clients from catastrophic health costs

Examples

Sally checked with her doctor's office about Medicare and they told her they only accept 3 Medicare Advantage plans. They gave her the list. They do not accept Original Medicare. Sally wants to continue to see her doctor when her Medicare starts, so she will choose one of the Medicare Advantage plans.

Bob checked with his doctor's office about Medicare and they told him that they only accept Original Medicare. They do not accept any Medicare Advantage plans. Bob wants to continue to see his doctor when his Medicare starts, so he will not enroll in a Medicare Advantage plan.

Medicare and You: Pages 67-80

Example

Morgan is 57 years old and is on Medicare because he is disabled. He has a lot of health problems and is not able to buy a Medigap plan. He does not have End Stage Renal Disease (ESRD). Choosing a Medicare Advantage plan can help protect him from catastrophic health care costs.

What are the costs?

Medicare pays a fixed monthly payment to the private plan for the client's care

- Clients continue to pay Part B premium
- Clients may also pay a monthly premium
- Copay
- Coinsurance
- Deductible
- Maximum out-of-pocket
- Non-covered services

Four most common types of MA plans

1. Health Maintenance Organization (HMO) plans
2. Preferred Provider Organization (PPO) plans
3. Private Fee-for-Service (PFFS) plans
4. Special Needs Plans (SNPs)

Things to consider

- MA plans offer comprehensive coverage (including Part D coverage)
- May require a referral to see a specialist
- Doesn't work with Medigap plans
- Not all providers are included in the MA's network
- MA plans require clients to pay some of the cost

Medicare and You: Pages 67- 80

Shopping for MA plans

- Look at **BOTH** health benefits and drug benefits of each plan separately
- Clients can do this on the medicare.gov website (SHIBA Volunteers may assist with this)
- Look at MA plans' websites for summary of benefits and provider lists
 - Always verify provider participation by contacting the provider

Where do clients enroll?

- Online at www.medicare.gov
- 1-800-633-4227 (1-800-MEDICARE)
- Call the plan
- Contact a licensed agent

We can help clients choose their path!

