

1. What are the basic benefits on a Medicare Supplement Policy?

For 2010, Medicare Supplement Basic Benefit Plans A, B, C, D, E, F, G, H, I, and J coverage includes:

- a.) First 3 Pints of Blood when provided during a covered stay,
- b.) Medicare Part A coinsurance amount for days 61-90 (\$275 per day) and days 91-150 (\$550 per day) of a hospital stay,
- c.) Coverage of up to 365 more days of a hospital stay during lifetime after all Medicare hospital benefits are exhausted, paid at the Diagnostic Related Group (DRG) outlier per diem or other appropriate standard of payment, and
- d.) The coinsurance or co-payment amount for Medicare Part B services after the \$155 yearly deductible is met.

2. What additional benefits are available?

- a.) Medicare Part A Deductible: Plans B, C, D, E, F, G, H, I, and J coverage includes the deductible for Part A hospitalization (\$1,100 per benefit period).
- b.) Medicare Part B Deductible: Plans C, F, and J coverage includes the deductible for Part B medical expenses (\$155 in a calendar year).
- c.) Medicare Part B Excess Charges: Plans F, I, and J coverage includes 100% of the difference between the actual charges and the Medicare-approved amount for Part B services. Plan G provides a benefit for 80% of excess charges.
- d.) Skilled Nursing Facility Care: Plans C, D, E, F, F*, G, H, I, J, and J* coverage provides \$137.50 per day for days 21-100
- e.) Foreign Travel Emergency: Plans C, D, E, F, G, H, I, and J pay emergency medical care during the first 60 days of a trip outside the U.S. The supplement policy will pay 80 percent of the actual billed charges for covered care after the \$250 emergency medical deductible is satisfied (in addition to other deductibles under Plans F* or J*);
- f.) At-Home Recovery: Plans D, G, I, and J pay up to eight weeks of at-home help after skilled nursing care is no longer provided. The Plans will pay up to \$40 each visit and \$1,600 per year;
- g.) Preventative Care: Plans E and J pay up to \$120 per year for procedures not covered by Medicare, but determined by the physician to be medically appropriate. For example, hearing tests, diabetes screenings, and physical exams.

h.) Basic Drug Benefit: Plans H and I pay 50 percent of the actual charges for prescription drugs after the \$250 outpatient calendar year deductible is satisfied. The maximum Benefit is \$1,250 per calendar year. (This benefit was available only on policies issued before January 1, 2006.)

i.) Extended Drug Benefit: Plan J pays for 50 percent of the actual charges for prescription drugs after the \$250 outpatient calendar year deductible is satisfied. The maximum benefit is \$3,000 per calendar year. Plan J* does not cover the separate prescription drug deductible. (This benefit was available only on policies issued before January 1, 2006.)

j.) Plans F and J also have an option called High Deductible Plan F (F*) and High Deductible Plan J (J*). Benefits from high deductible plans F and J will not begin until after out of pocket expenses reach \$2,000 (in 2010).

3. Are there plans with more cost-sharing?

Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels. They have annual out of pocket maximum limits of \$4,620 and \$2,310 (in 2010) respectively, after which the policy pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year.

Plans will pay for physician expenses that exceed the Medicare-approved amount, but still fall within charged limitations established by Medicare.

Please note that these figures change every year. Please contact the Consumer Helpline (1-877-693-5236) for more information or updated figures.

4. How does Medicare coordinate with other insurance?

Contact Medicare for coordination of benefits at 1-800-633-4227. TTY users call 1-877-486-2048.

5. I am on Social Security Disability and under 65 years of age. Do I qualify for a guaranteed issue Medicare Supplement policy?

As of October 1, 2009, Individuals with Medicare Part B benefits, before age 65, due to disability or End Stage Renal Disease (ESRD) (permanent kidney failure treated with dialysis or a kidney transplant), have guaranteed issue rights for a Medicare Supplement policy for a limited time. This 6 month open enrollment period for Medicare Supplement insurance begins on date of enrollment in Medicare Part B. For those enrollees already on Medicare on October 1, 2009, the open enrollment period extends through March 31, 2010. After the open enrollment period, some companies will issue a policy after medically underwriting a person on disability. The company will review the health history in order to decide if they will underwrite a policy.

Individuals on disability or with ESRD that exercised his/her open enrollment upon Medicare eligibility will have another open enrollment period once he/she turns age 65. Medicare Supplement rates for individuals with ESRD or on disability are generally higher than for those eligible for Medicare due to age. The individual will be eligible for the lower rate once he/she turns 65 years of age. In order to receive a lower premium, the Medicare beneficiary should verify with the current insurer if he/she must reapply in order to receive a lower premium. They may also choose to apply with a new company.

If individuals live in a county that has a Medicare Advantage plan, they may obtain coverage through the insurer or HMO during the annual enrollment period. The annual enrollment usually begins in mid-November of each year and runs until December 31.

6. Do I need more than one Medicare Supplement policy?

It is illegal for anyone to sell a second Medicare Supplement policy to a person when they know the person already has an existing policy. The only exception to this is if the individual notifies the insurance company, in writing, that they plan to cancel their existing Medicare Supplement policy.

7. I purchased a Medicare Supplement policy and do not wish to keep it. Can I return it to the company and get a refund?

A 30 day free-look period is provided on all Medicare Supplement plans. The free-look provision starts from the day the policy is delivered. A Medicare Supplement policy issued or delivered in Florida must contain a provision which allows the insured to return the policy or certificate within 30 days and receive a full refund.

8. What does guaranteed issue mean relating to a Medicare Supplement policy?

If one of the following circumstances apply, an individual is guaranteed coverage under plans A, B, C, F, F*, K, and L:

- a.) Your Medicare managed care plan (HMO), Private Fee-for-Service plan, PACE provider, or Medicare managed care demonstration project coverage ends because the plan is leaving the Medicare program or stops giving care in your area. You must apply for other coverage between the date you receive notice your coverage will be ending, and no later than 63 calendar days after your coverage ends.
- b.) Your Medicare Supplement policy terminates because the insurance carrier becomes insolvent.
- c.) You move out of the service area of your Medicare managed care plan (HMO), Private Fee-for-Service plan, Medicare SELECT policy or PACE program.

d.) You leave the health plan because it failed to meet its contract obligations to you (Example: the marketing materials were misleading or quality standards were not met).

e.) You dropped your Medicare Supplement policy to join a Medicare managed care plan (HMO), Private Fee-for-Service plan, or PACE program and then leave the plan within one year after joining.

f.) You joined a Medicare health plan (like a Medicare managed care plan (HMO) or a Private Fee-for-Service Plan) or PACE program when you first became eligible for Medicare at age 65 and you leave the plan within one year of joining.

PLEASE NOTE: For e.) and f.), this must be the first time you have ever been enrolled in one of these types of plans. If so, you are also eligible to return to your former Medicare Supplement policy, if the same insurance company still sells the plan, or if not so available you have the right to purchase any Medicare Supplement policy that has a benefit package described as plan A, B, C, F, F*, K, or L, that is sold in your state.

9. Can my Medicare Supplement policy be cancelled by the insurance company?

All Medicare Supplement Policies sold in the State of Florida must be "Guaranteed Renewable." Florida law prohibits companies from canceling these policies except for nonpayment of premium or for material misrepresentation, such as incomplete or incorrect information on the original application.

10. I have been notified by my Medicare HMO that they are withdrawing from my county. Do I have any other options?

If a Medicare Health Maintenance Organization (HMO) withdraws from a county and there are no other Medicare HMOs accepting new enrollees in the county, or the insured does not want to enroll in another Medicare HMO, the insured is eligible to obtain a Medicare Supplement policy on a guaranteed issue basis.

Eligibility is limited to Plans A, B, C, F, F*, K, or L from any carrier offering the plans in the State of Florida. The term "Guaranteed Issue" means the company:

- 1.) Cannot exclude benefits based on a pre-existing condition;
- 2.) Cannot deny coverage or impose a waiting period on the policy;
- 3.) Cannot discriminate in the price of the policy because of health status, claims experience, receipt of health care, or a medical condition; and
- 4.) Individuals have 63 days from the cancellation date of prior policies to apply for a Medicare Supplement policy.

11. What is a Medicare + Choice PPO plan?

In January, 2003, Medicare began offering people new Preferred Provider Organization health plans (PPO) in Florida as part of a Medicare demonstration project.

Benefits vary depending upon what each individual PPO offers in each market, but some of the common features of the PPOs are:

- 1.) Networks of preferred providers (hospitals, physicians and other providers);
- 2.) Access to providers outside the network;
- 3.) A balance of monthly premiums and some cost sharing amounts paid by the plan enrollees;
- 4.) Fees paid to out-of-network providers will be no more than they would get in fee-for-service Medicare;
- 5.) Premiums vary but will be priced between existing Medicare HMO premiums and premiums charged by Medicare Supplement insurance carriers.

12. Do I need Medicare Part B?

While employed, individuals may not need to purchase Medicare Part B if they are covered by their employer's group health insurance.

Before purchasing Part B, review what the group plan covers and how it coordinates with what Medicare pays. It is important that a prospective Medicare recipient contact the local Social Security office before their 65th birthday to discuss possible problems if they delay selection of Medicare Part B coverage. Contact the Social Security Administration at 1-800-772-1213 to discuss potential penalties for not enrolling for Part B upon turning age 65.

13. What is a Medicare Select policy?

Medicare Select offers the same plans as standardized plans offered through traditional Medicare Supplement insurance. Consumers who purchase Medicare Select policies are required to agree to use a specific network of health-care providers, facilities or both for some benefits. This generally means they cannot receive care from a hospital or physician other than one in the network.

In an emergency, coverage will apply to care from a provider outside of the network if it is not reasonable to obtain services through a network provider. In general, Medicare Select policies will deny payment for non-emergency services outside of the network.

In return for using in-network providers, Medicare Select policyholders usually are charged lower premiums than policyholders of traditional Medicare Supplement insurance. Medicare always pays its portion of covered services regardless of whether the providers chosen were in or out-of-network.

14. I have a Medicare Supplement policy and qualified for Medicaid. What will happen to my Medicare Supplement policy?

The benefits and premiums in a Medicare Supplement policy will be suspended for 24 months during the entitlement to benefits under Medicaid. The insured must request

suspension within 90 days of becoming eligible for Medicaid. If the insured is no longer entitled to Medicaid, the policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

Whether or not to keep a Medicare Supplement while entitled to Medicaid is dependent upon several factors including:

- 1.) If Medicaid only pays the Medigap premium, individuals may wish to keep the policy;
- 2.) If Medicaid pays your Medicare premiums, deductibles, and coinsurance individuals may wish to discontinue the policy;
- 3.) If Medicaid pays all or part of your Medicare Part B premium, individuals may wish to keep the policy;
- 4.) If Medicaid pays all of your medical expenses, then individuals should suspend the Medicare Supplemental Policy.

Medicaid Assistance - Medicaid programs pay for some or all of Medicare's premiums, deductibles and coinsurance for certain people who have a low income and are entitled to Medicare. If insureds have Part A and their financial resources are not more than \$5,000/single or \$6,000/couple, you may qualify for assistance. Call the Elder Helpline at 1-800-963-5337 and ask the local Department of Children and Families.

15. When I turn 65, what time frame do I have to enroll in a Medicare Supplement policy on a guaranteed issue basis?

Federal law requires companies provide an "open-enrollment period" to accept applications and not discriminate in the pricing of the policy, regardless of the enrollee's medical history, health status or claims experience.

The open-enrollment period for Medicare Supplement insurance begins the first day of the month a person turns 65 and is enrolled in Medicare Part B. If a birthday falls on the first day of the month, Medicare Part B coverage and Medicare Supplement insurance open enrollment begins the first day of the previous month.

Persons who are 65 years of age or older who reside in Florida should have an open enrollment period of 2 months following termination of coverage under a group health insurance policy.

Persons receiving Medicare before age 65, may take advantage of open enrollment when they turn 65. Open-enrollment can be determined by checking the Medicare card for Part B coverage effective date and adding six months. If the current date is within that six-month period, the open-enrollment period is in effect.

Even if an individual exercised his/her open enrollment right when originally eligible for Medicare by reason of disability or ESRD, he/she is eligible for another open enrollment opportunity upon turning age 65. He/she must reapply with the same company or switch to a new company during the open enrollment period in order to get a guaranteed issue policy at the generally less expensive age 65 premium rate.

Medicare Supplement insurance companies may impose the same pre-existing condition restrictions that they apply to policies sold outside the open-enrollment period.

16. If I replace my Medicare Supplement policy with one from another carrier, will there be a pre-existing condition on the new policy?

If one Medicare Supplement policy is replaced by another, the pre-existing condition exclusion of the second policy must allow credit for the time satisfied under the first policy. The maximum pre-existing time period is 6 months minus credit for prior coverage.

17. I applied for a Medicare Supplement policy and had no prior coverage. How long can the company exclude pre-existing conditions?

The insurer may not exclude benefits based on a pre-existing condition for more than 6 months. A pre-existing condition is defined as a condition for which medical advice was given or treatment recommended by or received from a physician within 6 months before the effective date of coverage.

An insurance carrier cannot impose a pre-existing condition exclusion if an individual has a continuous period of creditable coverage, as defined in Florida Statute 627.6561(5), of at least 6 months as of the date of application for coverage.

18. Can the insurance company increase the premiums on my Medicare Supplement policy?

Most companies will reserve the right to adjust premiums due to inflation, poor experience, or because of benefit adjustments in a policy as Medicare benefits change. For example, when the Medicare Part A deductible increases, a company usually raises its premiums to pay for the increased deductible it covers in its Medicare Supplement policy.

A company can increase its premiums only if it does so for the entire premium class. It cannot single out and raise premiums based on health or the number of claims filed. The Office of Insurance Regulation has to approve any rate increase before it goes into effect.

19. Is there any type of service available that offers assistance in shopping for or selecting a Medicare Supplement policy and company?

If you need assistance shopping for or selecting a Medicare Supplement policy contact the Department of Financial Services (DFS) at 1-877-693-5236 and the Department of Elder Affairs SHINE hotline at 1-800-963-5337 for assistance.

DFS also has a shoppers guide to assist understanding the different policies and compare premiums. The Medicare Supplement insurance guide is available on the DFS website at http://www.floir.com/pdf/MedicareSupGuide01_2007.pdf.

20. If I change my Medicare Supplement plan to another insurance company and buy the same plan, will the benefits change?

The benefits for Medicare Supplement Plans A-L are standardized, and cannot vary by company. This means that plan B issued by one company has the same coverage and benefits as Plan B offered by another company. This applies for all 14 plans sold by insurance companies.

PLEASE NOTE: Group coverage through an employer, an individual policy, Medicare Choice Plus (HMO), Medicare Part B, and Medicaid are not Medicare Supplement plans.

For a complete description of each plan's benefits, please refer to the Department of Financial Services (DFS) Medicare Supplement guide on our website at http://www.floir.com/pdf/MedicareSupGuide01_2007.pdf or contact the DFS at 1-877-693-5236.

21. I dropped my Medicare Supplement policy and enrolled in an HMO. Can I go back to my Medicare Supplement policy I had prior to enrolling in the HMO?

If an insured dropped their Medicare Supplement policy and enrolled in a Health Maintenance Organization (HMO) plan, the insured may go back to their Medicare Supplement policy within the established guidelines. For current guidelines call Medicare at 1-800-633-4227. TTY users call 1-877-486-2048.