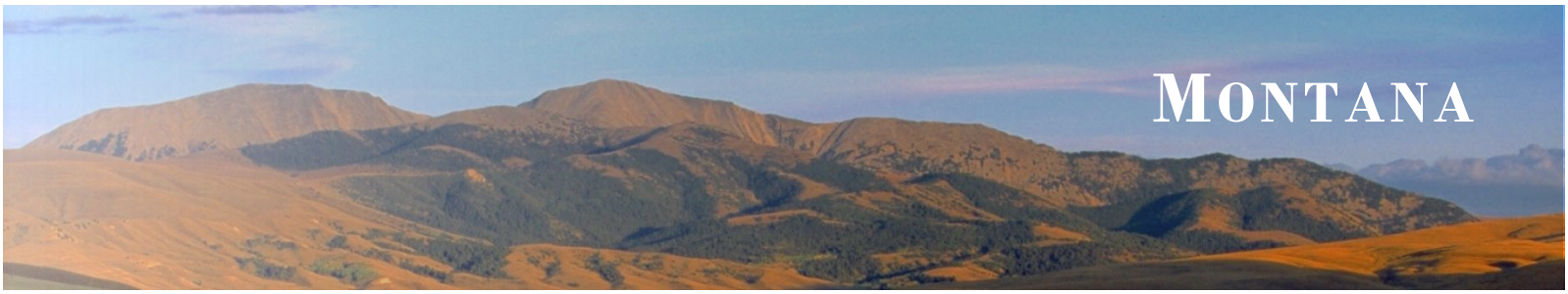

Consumer Guide to MEDICARE SUPPLEMENT INSURANCE

Helping Montana seniors and their families make informed decisions about Medicare

Office of the Montana State Auditor

CSI

Commissioner of Securities & Insurance

COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

MONTANA STATE AUDITOR

One of my goals as Commissioner of Securities & Insurance is to help you be an informed buyer.

Dear Montana Senior:

I am pleased to provide you with a copy of the Montana *Consumer Guide to Medicare Supplement Insurance*. This guide includes tips on choosing a Medicare Supplement, the current coverage provided by Medicare and a chart comparing many of the Medicare Supplement policies sold in Montana.

Please be aware that Medicare Supplement plans recently underwent several important changes. The total number of plans has been reduced to 11 from the 14 that were previously offered. Plans E, H, I, J and high deductible J have been eliminated. Medicare Part D and Medicare Part C, the Medicare Advantage Plans, are still available.

Recent changes also include the creation of Plans M and N, which have higher beneficiary cost-sharing. Plan N has benefits similar to Plan D but with a $20 co-pay for doctor visits and a $50 co-pay for emergency room visits. Plan M is similar to Plan D but only covers half of the Part A deductible.

As you use this guide, please keep in mind that it is just that, a guide, to assist you with your purchasing decision. Shop carefully, take your time and contact our office if you have questions. Knowledgeable staff is dedicated to assisting you with a wide range of insurance questions or problems. The toll-free number is 1-800-332-6148. Helena residents may reach us at 444-2040. You will also find more useful information on the agency website at www.csi.mt.gov.

Sincerely,

Monica J. Lindeen

Commissioner of Securities & Insurance
Office of the Montana State Auditor

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Consumer Guide to
MEDICARE SUPPLEMENT INSURANCE

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Please note: The *Consumer's Guide to Medicare Supplement Insurance* is a joint effort of the Office of the Montana State Auditor, Commissioner of Securities and Insurance, (CSI) and the State Health Insurance Assistance Program (SHIP) to assist seniors in understanding Medicare and Medicare Supplement insurance.

What is Medicare?

Medicare is a health insurance plan sponsored by the federal government.

To qualify, people must be one of the following:

- age 65 or older and a US citizen or a permanent legal resident for at least 5 continuous years;
- under age 65 with certain disabilities;
- or any age with End Stage Renal Disease.

Medicare Part A covers inpatient hospital, skilled nursing facility, home health care and hospice care.

Medicare Part B covers almost all reasonable and necessary medical services, including doctors' services, laboratory and x-ray services, durable medical equipment (wheelchairs, hospital beds, etc.), ambulance services, outpatient hospital care, home health care, blood and medical supplies.

Medicare Part C is called "Medicare Advantage" and is an *optional* plan that combines all the benefits of Medicare Parts A & B, as well as, in some cases, prescription drug coverage provided by Part D, and may provide some additional benefits previously available through a standardized Medicare Supplement plan. These Medicare Advantage Plans may be "Managed Care" type plans such as HMO, PPO, or Private Fee-for-Service plans.

Medicare Part D is the *optional* Prescription Drug coverage available to all people with Medicare.

Frequently asked Questions

What is a benefit period?
A benefit period begins on the first day of a Medicare-covered inpatient stay. It ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. A new benefit period begins and the beneficiary must pay a new inpatient hospital deductible. There may be as many as five benefit periods in a calendar year.

Will Medicare cover all medical expenses?
No. Medicare only covers a portion of health care costs. A Medicare Supplement helps with expenses not fully paid by Medicare.

Do Supplement plans cover all charges Medicare doesn't?
No. Supplements will not cover expenses if Medicare does not pay a portion of the bill, with some exceptions. See the chart on page 13 for certain exceptions.

What if Medicare considers a service to be unnecessary?
If physicians recommend a procedure that they are (or should be) aware is not covered by Medicare, they are required to notify you in writing that Medicare will not cover the service. Similarly, if a surgeon does not accept assignment for elective surgery, the physician must give you a written estimate if the charge will exceed $500.

What is assignment?
It is the acceptance of the charges allowed by Medicare as payment-in-full.

What is limiting charge?
Physicians who do not accept assignment are limited to charging 115% of the fee schedule for non-participating doctors.

What is issue age?
The premium is based on your age at the time your policy is issued. The premium you pay will not increase due to your age at subsequent renewals. However, your premium may still increase based on inflation or other factors other than age.

What is attained age?
The premium is based on your current age and increases automatically as you grow older. Typically, these plans are less expensive for younger individuals, but may cost considerably more in later years.

Can I be eligible if I am under 65?
A person can qualify for Medicare under age 65 if they meet certain criteria for disability. If you receive continuing dialysis for permanent kidney failure or need a kidney transplant you could be eligible for Medicare. You may also be eligible if you are disabled and have been receiving Social Security Disability payments for at least 2 years or if you have Amyotrophic Lateral Sclerosis (ALS).

How do I know how much coverage to buy?
It is important to know how to assess your need for insurance in every type of coverage you buy. With a Medicare Supplement policy, you should review your medical care costs for the preceding year, assess your current health status and choose a plan that is affordable. You may want to consider enrolling in a Medicare Part D plan if you currently take prescription medications.

Medicare and Obamacare

If you currently have Medicare (Parts A & B), you can keep it and you do not need to make any changes due to Obamacare. In fact, companies that sell marketplace plans are prohibited from selling these plans to anyone known to be covered by Medicare.

Most importantly, Obamacare strengthens Medicare and helps seniors take charge of their health. The law provides important benefits such as free preventive services, free annual wellness visits, and, in 2015, a 55% discount on brand-name prescription drugs for Medicare recipients in the coverage gap known as the "donut hole." (Between now and 2020, continuous Medicare coverage is available for prescription drugs. The donut hole will be closed completely by 2020.)

Other Changes

Medicare Advantage Plans

Obamacare makes some changes to the Medicare Advantage program. This program is an alternative to traditional Medicare, in which someone on Medicare can choose to enroll in a private plan, such as an HMO or PPO, to receive their Medicare-covered benefits. The law reduced payments to these plans to bring them closer to the average costs of traditional Medicare. The law also provides additional payments to plans that earn high quality ratings. (All plans will be assigned a "quality rating" by the federal government to help consumers determine which plan is best for them.)

Whether the plan that you are enrolled in will respond to these payment changes will depend on several factors, but rest assured that your plan is still required to provide all the benefits that are covered by traditional Medicare. But your plan might charge higher premiums, increase the cost-sharing amounts that you pay for services, reduce the number of providers in the plan's network, or reduce additional benefits that the plan might cover, such as dental exams or eyeglasses.

The law also included new protections for people enrolled in Medicare Advantage plans. Plans are now limited in how much cost-sharing they can charge enrollees for certain services, and there are new limits on how much plans can spend on administrative expenses and profits.

Finally, between January 1 and February 14 of each year, any individual enrolled in a Medicare Advantage plan may dis-enroll in their coverage and return to original Medicare (Parts A and B) and enroll in Part D prescription drug coverage.

Part D Prescription Drug Coverage

Premiums for Part D coverage will increase, on a sliding scale, for individuals who earn $85,000 or more each year, and for couples who earn $170,000 or more each year.

Please note:

Medicare Advantage plans, Medicare Part D and Medicare Supplement policies will not be sold through the online Montana federal Health Insurance Marketplace. These will continue to be available as they are today, through www.medicare.gov or directly from a company that offers the plan.

Medicare Savings Programs

The Qualified Medicare Beneficiary (QMB) Program and Spousal Impoverishment Program are available to assist seniors. These are important benefits if you have limited income and assets or if your spouse is in a long-term care facility.

The **Qualified Medicare Beneficiary (QMB)** Program is designed to provide Medicare premiums, deductibles and coinsurance for seniors with limited incomes. The federal government sets the income level for individuals and couples each year. To find out if your income qualifies, contact the Office of Public Assistance in your county. This program will not pay for expenses that Medicare does not allow.

You may suspend your Medicare Supplement policy upon enrollment in the Qualified Medicare Beneficiary Program. You will need to notify your insurance company in writing of your eligibility within 90 days. If you lose your eligibility for the beneficiary program, you may reactivate your Medicare Supplement policy by notifying the insurer in writing and paying the premium within 90 days of the termination of your eligibility.

The **Specified Low Income Beneficiaries Program (SLMB)** assists individuals with slightly more income than those who are Qualified Medicare Beneficiaries by paying their Part B premiums each month. Individuals and couples can qualify with a monthly income in a range specified by the federal government. In addition to the income limit, financial resources, including bank accounts and stocks and bonds, cannot exceed $6,940 for an individual or $10,410 for a couple.

Under the **Spousal Impoverishment Program**, when a spouse enters a long-term care facility, there are rules for the division of the couple's assets. The spouse at home may retain a maximum of half the couple's resources, not to exceed a maximum set by the federal government. Certain assets are exempt, including the home, household goods and one car. There are regulations concerning the amount of income the spouse at home may retain on a monthly basis. Either spouse may request an assessment of resources when one spouse enters a nursing home. Contact your county Office of Public Assistance for more information or the State Aging Services Bureau at 800-332-2272.

Preventive Health Benefits

All newly enrolled Medicare beneficiaries will be covered for certain potentially life-saving preventive benefits. Benefits include an initial wellness examination, the "Welcome to Medicare" physical, which includes a baseline measurement of height, weight and blood pressure, an electrocardiogram, education counseling and referral to other Medicare-covered preventive services, such as vaccinations, screening mammography, pap smears and pelvic exams and prostate and colon cancer screening as well as blood tests required for cardiovascular screening, glaucoma screening and diabetes screening, medical nutritional therapy with no deductible or co-pay. Bone density screenings and smoking cessation programs may also be covered.

Open Enrollment

Insurance companies that sell Medicare Supplement insurance are required to issue policies to seniors who qualify for Medicare Part B because they have reached age 65, without regard to their current health status. **This open enrollment period lasts six months beginning with eligibility for Medicare Part B**.

Please Note: Companies may not refuse to issue a Medicare Supplement policy to you or delay the issue of the policy based on your medical condition, health status, claims experience or receipt of health care during this open enrollment period. The company may impose a six-month pre-existing condition clause during the first six months of the policy, if you did not have previous creditable coverage.

If you delay enrollment in Medicare Part B and are covered by a plan provided by your or your spouse's employer, you will have an open enrollment period starting with the month in which you no longer are covered by the employer's plan. Your open enrollment period will start when your Part B coverage becomes effective. If you miss your open enrollment period, contact your local Social Security office. There may be a waiting period for coverage and premium payments due.

The initial open enrollment period for Medicare Part D is the same as for Part B. If you are enrolled in Medicare Part B but choose not to enroll in a Part D prescription drug plan, be aware that should you decide to enroll in Part D at a later date, there may be a penalty imposed on your premium for late enrollment. Each year from October 15th - December 7th you have the option to change your Part D plan. If you are newly entering the Medicare system, you will have open enrollment for a Part D plan that coincides with the open enrollment period for Medicare Part B.

If you do not have coverage for prescription drugs through a current health plan such as a retiree plan from a former employer or a Medicare Advantage plan with a drug benefit, you should consider enrolling in Medicare Part D. If you do not have other creditable drug coverage and do not enroll in a Medicare Part D plan when you are first eligible, you may be subject to substantial late enrollment penalties.

If you currently have "original" Medicare with a Medicare Supplement policy and choose to cancel that policy and enroll in a Medicare Advantage plan, and you decide within the first 12 months that you no longer wish to remain enrolled in the Medicare Advantage plan, you may be able to return to your previous Medicare Supplement policy without prejudice for age and/or pre-existing medical conditions if certain requirements are met.

Supplement plans for people with disabilities

Some individuals under age 65 are eligible for Medicare due to a disability; however these individuals do not have the same access to Medicare Supplement policies as individuals who are eligible for Medicare because they are 65. If you are under age 65 and eligible for Medicare due to disability, you will have open enrollment for a Medicare Supplement policy for 6 months upon reaching age 65.

Medicare Coverage

Medicare Part A

Hospital

For 2015, Medicare pays for all but $1,260 of your hospital stay during each benefit period for reasonable and necessary care in the first 60 days of confinement. For the next 30 days, it pays all but $315/day for covered services. Medicare pays expenses in excess of $630/day during the 91st through 150th days. These are Lifetime Renewable Days and may be used only once. If you are hospitalized more than 150 days, Medicare pays nothing.

> **Please note:** A benefit period begins the first day of hospitalization and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. It is possible to have more than one benefit period and more than one hospital deductible in a calendar year.

Skilled nursing facility

Charges for skilled nursing facility stays may be paid by Medicare if the facility is a Medicare-certified facility. To qualify for this benefit, you must have been hospitalized for at least three days and have been admitted to the nursing facility within 30 days of discharge from the hospital. The first 20 days are covered at 100% provided you are receiving skilled care. The next 80 days Medicare pays $157.50/day. Beyond the 100th day, Medicare pays nothing.

Home health care

Under certain conditions, home health care is available for homebound beneficiaries. Coverage includes: skilled nursing services, occupational therapy, and physical and speech therapy if provided by a Medicare-certified home health service and if determined to be medically necessary. If your physician establishes a care program that requires durable medical equipment, Medicare will pay 80% of the Medicare-approved cost of the equipment. Call Medicare at **1-800-633-4227** for more information.

Hospice care

Medicare provides coverage for hospice care for patients certified as terminally ill. This benefit is divided into two 90-day hospice benefit periods and one 30-day benefit period. A subsequent extension also may be covered. You may have a co-payment of up to $5 for outpatient prescription drugs provided by hospice and a co-payment of 5% of the Medicare approved amount for inpatient respite care. You may have to pay the room and board charges if you receive hospice care in a facility other than for short term general inpatient care or respite care.

Blood

You pay for the first three pints of blood after which Medicare pays 80% of the approved amount for additional blood.

Medical Insurance (Medicare Part B)

Medicare Part B covers physician services, outpatient hospital services, lab services, x-ray, radiation and therapy services, home health visits, physical therapy, speech pathology services, some forms of vaccinations, durable medical equipment, limited ambulance services, prosthetic devices, and immunosuppressive drugs for the first year following an organ transplant, and other medical supplies and equipment.

In 2015, the Part B monthly premium is $104.90 if your income is less than $85,000 for an individual or $170,000 for a couple. If your income exceeds this amount, your Part B premium will increase on a sliding scale. This income scale is provided in the "Medicare & You" handbook. Purchase of Part B is not required, but it is an excellent value since the federal government pays most of the actual cost.

The Part B annual deductible for 2015 is the first $147.00 of expenses in a calendar year. After the deductible, Medicare pays 80% of most approved charges. Some exceptions are Medicare generally pays 100% of approved charges for clinical laboratory and home health care charges and 80% of approved charges for most outpatient mental health services. Your co-payment may vary for certain other outpatient services.

Health care providers are required to bill Medicare directly for beneficiaries. If your provider accepts "Medicare assignment" he may only bill you or your Medicare Supplement policy for the remaining portion of the Medicare allowable amount. If your provider accepts Medicare but does not accept "Medicare assignment", he/she may not bill for more than 115% of the Medicare allowable amount.

> **Please note:** If you do not enroll in Medicare Part B when you are first eligible to do so, you may incur a late enrollment penalty of 10% of the base premium for each 12-month period in which you were eligible but not enrolled.

Medicare Advantage (Medicare Part C)

Medicare Advantage plans are a different way to get Part A and B. Under these plans, clients get Part A and B through a private insurance company. Clients continue to pay Part A premiums (if it applies), Part B premiums, and the plan's premium (if any). The plan pays for all medically necessary care covered by original Medicare (Part A and B). Medicare Advantage plans may include a prescription drug plan equal to or better than a standard Medicare Part D plan or they may require participants to enroll in a separate Medicare Part D plan. A company that offers Medicare Advantage plans may offer coverage with a national, regional or local service area.

If you consider switching from original Medicare with a standardized Medicare Supplement policy to a Medicare Advantage plan, you need to carefully compare the bottom line. Calculate your total out-of-pocket expense with original Medicare + Supplement and compare that to the total out-of-pocket expense for the Medicare Advantage plan. There are many Medicare Advantage plans available and they will all differ slightly from one another and from original Medicare. There is no right or wrong choice, only the choice that is BEST FOR YOU.

Something to think about . . .

You should not have a standardized Medicare Supplement policy in addition to being enrolled in a Medicare Advantage plan. Your standardized Medicare Supplement policy was only designed to work together with "original" Medicare and will NOT provide benefits in addition to or in conjunction with a Medicare Advantage policy.

Prescription Drug Coverage (Medicare Part D)

Medicare Prescription Drug Coverage helps cover the cost of your prescription drugs. You must first enroll in Medicare Part A or B, or both, to be eligible to enroll in Part D. All plans must offer at least the minimum standard benefits determined by Medicare but some may offer significantly more coverage. The monthly *average* premium for this coverage is $33.00 and there may be an annual deductible of *up to* $320.00 in 2015. However, many plans are available that have lower or zero deductibles.

Most Medicare drug plans have a coverage gap ("donut-hole")—after you and your plan have spent a certain amount of money for covered drugs ($2,960.00 in 2015), you pay all costs for your drugs out-of-pocket (up to a limit). **Not everyone will reach the coverage gap.** Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. In 2015, individuals in the "donut hole" will pay 45% of the plan's cost for brand name drugs and 65% of the plan's cost for covered generic brands as part of changes due to the Affordable Care Act (ACA). Once an individual pays $4,700.00 out-of-pocket for the year, the coverage gap ends.

For beneficiaries with lower incomes, Extra Help (Low Income Subsidy or "LIS") is available to pay all or part of the Part D premiums and co-payments. Contact your local Social Security office or call 800-772-1213. Most significantly, people with Medicare who are also eligible for Medicaid, will receive full premium subsidy, full subsidy of the deductible and minimal co-pays, usually $3-$6 per prescription. Additional assistance is available through the Big Sky Rx program **(1-866-369-1233),** administered by the State of Montana, for people who do not qualify or only qualify for partial assistance through Social Security. The Big Sky Rx program can still help many Montanans pay for all or part of their Part D Premiums. For further information, call the CSI at **1-800-332-6148** or the Montana SHIP (State Health Insurance Assistance Program) at **1-800-551-3191**.

Get Help

For assistance in choosing the Medicare Part D plan that best suits your needs, contact Medicare at 1-800-633-4227 or visit www.medicare.gov and use the helpful "Plan Finder" link or call your local State Health Insurance Assistance Program (SHIP) for more information on rates and available plans.
Call 1-800-551-3191 to speak to a SHIP counselor.

Please Note: If a Medicare beneficiary currently has a Medicare supplement policy plan H, I or J which contains a limited benefit for prescription drugs, these policies will not be considered as creditable coverage with regard to the late enrollment penalty for Medicare Part D. Although these Medicare supplement plans are no longer sold, some Montanans may have elected to keep their plans with drug benefits and may continue them as long as they wish.

Hospital Insurance: Medicare Part A

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
HOSPITALIZATION Semi-private room and board, general nursing, and misc. hospital services and supplies.	First 60 days 61st - 90th day 91st - 150th day* Beyond 150 days	All but $1,260 All but $315/day All but $630/day Nothing	$1,260 $315/day $630/day All costs
POST HOSPITAL NURSING CARE You must have been in a hospital for at least 3 days and enter a Medicare approved facility within 30 days of discharge.	First 20 days The next 80 days Beyond 100 days	100% of approved amount All but $157.50/day Nothing	Nothing $157.50/day All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Medically necessary skilled care, home health aide services, medical supplies etc.	Full cost of approved services; 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 a doctor certifies the need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited during a benefit period if medically necessary.	All but the first three pints in a calendar year.	The first three pints in a calendar year.

** Lifetime Reserve Days may be used only once.*

Medical Insurance: Medicare Part B

Per calendar year 2015 (monthly premium $104.90)

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSES Physician services, in/out patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Unlimited if medically necessary	80% of approved amount (after $147 deductible)	$147 deductible plus 20% of the approved amount (and limited charges above the approved amount)
CLINICAL LABORATORY SERVICES Blood test, urinalysis, and more.	Unlimited if medically necessary	Full cost of services	Nothing for most 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	Full cost of services; 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 (after $147 deductible)
BLOOD	Unlimited if medically necessary	80% of approved amount (after $147 deductible and starting with the fourth pint)	First three pints plus 20% of approved amount for additional pints (after $147 deductible)*

** To the extent that the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.*

Medicare Supplement Insurance

Medicare supplement is an insurance policy sold by private insurance companies to help pay some of the costs not covered by original Medicare, such as deductibles, doctor and hospital co-insurance and emergency care outside the country. You can also sometimes continue insurance coverage through a former employer.

Federal regulations mandate that all Medicare supplement policies offer the same set of benefits. Therefore, when deciding what company to buy from, the most important factors to consider are cost and stability.

There are 10 standard Medicare supplement plans, labeled A-N** (except in Massachusetts, Minnesota and Wisconsin.) Plan A offers the fewest benefits and is usually the least expensive; Plan F offers the most benefits and is usually the most expensive.

All the plans MUST include the following basic benefits:

- Hospital co-insurance coverage;
- 365 days of full hospital coverage;
- Reimbursement for the 20% of the cost of your medical care that Medicare does not cover;
- The first 3 pints of blood you need each year.

Depending on which Medicare supplement plan you choose, you can get extra coverage for the expenses that Medicare does not cover, such as:

- Hospital deductible;
- Skilled nursing facility co-insurance;
- Emergency care outside the U.S.;
- At-home recovery care;
- Part B excess charges;
- Preventive care.

*** See the chart on page 13 for details of the benefits covered by plans A-N.*

Consumer Tip

The Commissioner of Securities and Insurance, Montana State Auditor (CSI) can provide a list of companies that sell Medicare Supplement insurance in Montana. Call 1-800-332-6148. Also, the Montana State Health Insurance Assistance Program or SHIP (1-800-551-3191) volunteer counselors are trained to provide the most current Medicare information.

Medicare Supplement Plans K & L

Plans K and L provide different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include provider charges that exceed Medicare-approved amounts, called "excess charges."

Plan K:

50% co-pay for Medicare eligible expenses including your Part A deductible, skilled nursing co-insurance, your first three pints of blood, hospice care, and Part B deductible until such time as your out-of-pocket expenses reach $4,940.00 (for 2014). *Plan K does not pay the Part B deductible.*

Plan L:

75% co-pay after the deductible is met until the out-of-pocket expenses reach the Plan L threshold of $2,470.00 (for 2015). After the out-of-pocket threshold is reached, Plan L pays 100% of Medicare eligible expenses. The 75% co-pay applies to Medicare Part A deductible as well as skilled nursing care co-insurance, your first 3 pints of blood and hospice care. *Plan L does not pay the Medicare Part B deductible.*

Both Plans K & L include coverage for an additional 365 days of inpatient hospital care after other Medicare benefits are exhausted. The out-of-pocket thresholds for both plans K & L are indexed to inflation and may increase over time.

Medicare Supplement Plans M & N

Plan M:

100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end; 100% of Part A hospice cost-sharing; 100% Medicare-eligible expenses for the first three pints of blood; 100% of Medicare Part B coinsurance or co-payment; 100% skilled-nursing facility coinsurance; 50% coverage of the Medicare Part A deductible; 80% coverage for medically necessary emergency care in a foreign country, after a $250.00 deductible.

Plan N:

Full 100% coverage of the Part A deductible, but no coverage for the Part B deductible, similar to Plan D. Coverage of Part B services is subject to a new co-pay structure. The co-pay is up to $20.00 for office visits and up to $50.00 for emergency room visits (waived upon admission to the hospital). Plan N provides no coverage for Part B Excess Charges (costs above the Medicare Approved amount).

Compare Medicare Supplement Insurance Rates

Use the Commissioner of Securities & Insurance website for quick and easy comparisons of Medicare Supplement insurance rates:

www.csi.mt.gov or call **1-800-332-6148** to request a printed rate comparison guide

10 Standard Medicare Supplement Benefit Plans

Basic Benefits	A	B	C	D	F*	G	K	L	M	N
Part A: Hospital coinsurance (Days 61 - 90)	X	X	X	X	X	X	X	X	X	X
Part A: Hospice care coinsurance	X	X	X	X	X	X	50%	75%	X	X
Medicare preventive care Part B coinsurance	X	X	X	X	X	X	X	X	X	X
Parts A and B: Blood	X	X	X	X	X	X	50%	75%	X	X
Part B: Coinsurance	X	X	X	X	X	X	50%	75%	X	X**
Additional Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Skilled nursing facility care			X	X	X	X	50%	75%	X	X
Part A deductible		X	X	X	X	X	50%	75%	50%	X
Part B deductible			X		X					
Part B excess charges					X	X				
Foreign travel emergency			80%	80%	80%	80%			80%	80%
Out-of-pocket yearly limit							$4,940	$2,470		

Core benefits pay the patient's share of Medicare's approved amount for physician services (Part B) 20% after a $147 annual deductible in 2015, the patient's cost of a long hospital stay ($315/day for days 61-90, $630/day for days 91-150, all approved costs not paid by Medicare after day 150 to a total of 365 days lifetime) and charges for the first three pints of blood not covered by Medicare.

*In addition, Plan F offers a *high deductible* plan. You pay for Medicare covered costs up to the deductible amount ($2,180 in 2015) before your Medicare Supplement plan pays anything. Out-of-pocket expenses include the Medicare deductibles for Part A and B that would ordinarily be paid by the policy, but do not include the foreign emergency travel deductible.

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

Please note: Plans H, I and J are no longer sold to new policyholders. Current policyholders may choose to remain in their existing plan H, I or J, or they may retain the plan without the drug benefit and enroll in Part D, or they may choose to change to a different Medicare supplement plan or enroll in a Medicare Advantage Plan.

Shopping Tips

Changes in federal law make it easy to shop for Medicare Supplement insurance coverage. Before you start comparing policies, consider these five suggestions:

1. Learn about Medicare's basic coverage and gaps.

2. Study the 10 standard Medicare Supplement insurance plans. Decide what coverage best meets your health needs and financial circumstances.

3. Compare only the policies that meet your needs. Although the benefits are identical for all Medicare Supplement insurance plans of the same type, premiums vary widely among companies and so does the potential for premium increases.

4. Consider your alternatives. If you have limited income and assets, you may qualify for free coverage through other government programs. To find out if you qualify, call State Health Insurance Assistance Program (SHIP) at **1-800-551-3191**.

5. Contact SHIP at **1-800-551-3191** for an impartial, free review of your existing coverage.

Don't be a Victim of Insurance Fraud

Insurance bills are a costly monthly expense. That is why Commissioner Monica J. Lindeen encourages Montana consumers to keep a watchful eye on insurance statements. Information is the key to avoiding insurance problems and scams. The Office of the Montana State Auditor, Commissioner of Securities and Insurance, serves as an objective source of information; we are here to help consumers understand the complexities of insurance coverage. Consumers are urged to call **1-800-332-6148** to confirm whether a policy is legitimate. Suspected Medicare fraud should be reported to the Montana SMP program at 800-551-3191.

Common Insurance Schemes:

- Overcharging for premiums;
- Collecting annual premiums but submitting only quarterly payments to insurance companies;
- Not returning refunds from companies to the insured person.

To Avoid Becoming a Victim:

- Insist on delivery of documents within 30 days of the application;
- Call the company yourself to confirm coverage;
- Read the documents you receive and ask questions. Make agents and companies reply to inquiries in writing;
- Remember, Medicare will NEVER call or visit your home to solicit personal information such as your social security number or your credit card numbers.

If you have questions about your insurance policy or agent, please call the Office of the Montana State Auditor, Commissioner of Securities and Insurance, at 1-800-332-6148 or at 444-2040 (in Helena).

Buyer's Checklist

The majority of insurance companies and agents are highly ethical; however, a few are not. Not all of the following activities are illegal or unethical, but if after reviewing this checklist, you think an agent has acted improperly, please contact the Office of the Montana State Auditor, Commissioner of Securities and Insurance.

- ✓ Did the agent try too hard to convince you of the possibility of bankruptcy, of your plans for retirement being disrupted, or of your savings and that of your children or relatives being wiped out because of extended illness?
- ✓ Did the agent lead you to believe he/she was a representative of the Medicare program, state Insurance Department or other government agency?
- ✓ Did the agent suggest you drop a policy you already have in order to buy the policy he/she was selling?
- ✓ If you already have purchased a policy from an agent, has that agent changed companies and suggested you change your policies over to one offered by the agent's new company?
- ✓ Did the agent suggest you falsify any information on the policy?
- ✓ Did the agent discourage you from shopping around or researching the policy thoroughly before deciding whether to buy it? Did he/she make you feel like you had to sign up the same day?
- ✓ Did the agent ask you to pay in cash or make your check out to him/her personally or to the agency, instead of the company?
- ✓ Did the agent fail to explain the policy to you or to thoroughly answer your questions?
- ✓ Did the agent complete your health history information on the application exactly as you explained it before you signed the application?
- ✓ Check with a reliable source if you have questions about the authenticity of any Medicare prescription drug card being offered - *before you buy*!

If you answered *Yes* to any of these questions or if you feel an agent has acted improperly, contact one of the CSI consumer advocates in the Policyholder Services Bureau to discuss the matter:

Call 1-800-332-6148 or 444-2040 (in Helena)

Definitions

In order to make a wise purchase, it is important to understand terms used by Medicare and Medicare Supplement policies. You may wish to familiarize yourself with the following terms:

ASSIGNMENT *The transfer by the policyholder of some or all of his or her rights under a policy to another party.* If assignment is noted on the claim form, the insurance company will pay the health care provider directly. Medicare assignment means the provider will accept the Medicare-approved amounts for covered services as payment-in-full. The beneficiary would then be responsible for any unmet deductible applied to the charge, for the co-insurance and for any services that were not approved.

COPAYMENT/COINSURANCE *The patient's portion or percentage of a health care expense*. For example, the insurance would pay 80 cents of every dollar on the provider's charges. The patient pays the remaining 20 cents. With Medicare, the co-insurance is based on Medicare-allowable charges.

DEDUCTIBLE *The amount of covered expenses you must pay before benefits become payable by the insurers.*

EXCLUSIONS OR LIMITATIONS *Specified conditions, circumstances or services not covered by the policy.*

GUARANTEED RENEWABLE *The insurance company agrees to continue insuring you if you always pay the premium.* The company reserves the right to non-renew all contracts in the state.

MEDICARE-ALLOWABLE CHARGES *The amount deemed reasonable by Medicare for a given medical service.* Benefits are based on Medicare-allowable charges, which may be less than the provider's charges.

PRE-EXISTING CONDITION *A physical condition that existed before the policy became effective.* Montana law does not allow Medicare Supplement polices to exclude coverage for more than six months after the effective date of the policy on the grounds that a condition existed prior to the effective date of coverage. Companies that replace a Medicare Supplement policy must waive the pre-existing waiting period on the replacement policy. If the insured has not completed the waiting period on the first policy, any period of time that was completed must be credited on the new policy. This does not apply to the following: anyone who has not purchased a Medicare Supplement policy; anyone who has not had a policy within the last 31 days; or anyone who has lost or been removed from group coverage within the preceding 63 days.

MEDICARE ADVANTAGE POLICY *An alternative to original Medicare.* May have HMO/PPO features that would require you to see a provider in that plans network. Carefully compare your out-of-pocket expenses with original Medicare + Supplement versus Medicare Advantage to see which one is best for you.

Understanding the CSI Consumer Complaint Process

The Office of the Montana State auditor, Commissioner of Securities and Insurance, has staff dedicated to helping consumers resolve complaints against insurance companies, agents and agencies. Before you file an insurance complaint with the CSI, please read the important information below.

Before filing a complaint

1. Contact the insurance company or agent and bring the problem to their attention. Document your phone calls by noting the name of the person you speak to, the date of the call and a brief summary of the conversation. Keep copies of all written communications.
2. If you are not satisfied with the results you receive, contact the Department of Insurance for assistance. Compliance Specialists are available to answer general questions by phone at our toll-free Consumer Assistance Hotline (800) 332-6148 or in Helena 444-2040. **However, official complaints must be submitted in writing.**

How to file a complaint

1. Click the 'File an Insurance Complaint' tab on either the CSI website Home page or the Consumer page (www.csi.mt.gov) or complete the hard-copy *Insurance Complaint Form*.
2. When your complaint is received, a file number will be assigned and you will be sent written notification of that number. Please refer to the complaint file number when you call or write to the Commissioner.
3. When a response to the complaint is received from the company or producer, a Compliance Specialist will review the complaint and response.

This review will result in one of the following actions:

- If the complaint has been resolved, the complaint will be closed and you will be sent a letter;
- If an insurance law has been violated, the Commissioner will request corrective action;
- If the company is not abiding by the policy, the Commissioner will request corrective action;
- If the insurer or producer has not responded to all questions or has not investigated the complaint thoroughly, the Commissioner will require them to do so;
- If no violation of Montana insurance law is found, a letter will be sent to you with an explanation of the finding and notice that the investigation is being closed;
- In each instance, you will receive a written response from the Commissioner's office explaining the results of our investigation.

Types of complaints the Commissioner can handle

The Commissioner handles most insurance problems involving home, business, auto, health, life, etc. Those problems may include coverage issues, claim disputes, premium problems, sales misrepresentations, policy cancellations, and refunds, just to name a few. The Commissioner will also investigate complaints against insurance agents, adjusters and consultants.

The Commissioner's office can assist consumers with appeals of denied health insurance claims. For more information, refer to the Commissioner's guide to internal appeals and external review on the agency website www.csi.mt.gov. If you have questions about appealing a denied claim, please call the Commissioner's office at 800-332-6148.

Actions the Commissioner *cannot* take on your behalf

- Act as your legal representative or give you legal advice;
- Intervene in a pending lawsuit, on your behalf;
- Consult with you if you are represented by an attorney unless we have your attorney's written permission;
- Recommend an insurance company, producer or policy;
- Identify another person's insurance company;
- Resolve a dispute between you and your insurance agent or company when the only evidence is your word against the word of the producer or company;
- Make medical judgments;
- Determine the value of damaged or stolen property or conclude who was at fault for an accident;
- Establish the facts surrounding a claim (such as who is being truthful when there are differing accounts of what happened);
- Investigate an insurance complaint filed by a medical service provider, contractor, auto repair shop or any other outside party without the written authorization of the consumer; or
- Address plans that the Commissioner has no regulatory authority over, including MMIA (Montana Municipal Insurance Authority) and rental car agencies.

Plans over which the Commissioner's Office has no authority

- Federal employees' health plan and life insurance - Call 1-202-606-1800
- Medicare Advantage or Medicare Part D – Call 1-800-633-4227
- Medicaid – Call 1-800-362-8312
- State Fund worker's compensation – Call 406-444-1574
- Worker's compensation claims disputes – Call 406-444-1574
- Self-funded employee health benefit plans – Call 866-444-3272
- State-sponsored, self-insured health plan for teachers and state employees – Call 406-444-7462
- Any self-insured governmental plans – Call your employer

NOTE: If the Commissioner's office does not have authority over your complaint, you will be referred to the proper authority. If you have questions about the types of complaints the Commissioner has the authority to resolve, please call 800-332-6148.

Where else can I go for help?

For more help with specific issues, check the list of organizations below.

- If you are covered under a **Medicare, Medicare Advantage, or Medicare Part D drug plan**, contact the Centers for Medicaid and Medicare Services at 1-800-MEDICARE (1-800-633-4227.) Or, contact a **SHIP counselor at 1-800- 551-3191** with specific questions concerning your Medicare coverage.
- If your complaint involves a **workers' compensation claim,** contact the Workers' Compensation Claims Assistance Bureau (406) 444-1574.
- If your complaint involves a **federal health or life insurance plan,** contact the U.S. Office of Personnel Management at (202) 606-1800.
- If you are insured through the **U.S. military** and a Montana resident**,** contact TRICARE 1-888-874-9378.
- If you bought your policy in **another state,** contact that state's insurance commissioner's office.
- If you are covered by a **self-funded employer health plan**, contact the U.S. Department of Labor at 1-866-444-3272 or your employer.

MONICA J. LINDEEN
COMMISSIONER OF SECURITIES & INSURANCE
MONTANA STATE AUDITOR
840 HELENA AVE., HELENA, MT 59601
Telephone (406) 444-2040/Toll free 1-800-332-6148
www.csi.mt.gov

INSURANCE INQUIRY/COMPLAINT FORM

If you need assistance, please complete this form and mail to the above address to the attention of PHS (Policy Holder Services). (An online complaint form is also available at www.csi.mt.gov.) It often takes several weeks for the Department to complete the review and take appropriate action. *You will hear from a Compliance Specialist, in writing, as soon as the review is complete.*

Your Name _____ Phone No._____

Address_____
Mailing Address City State Zip Code
E-Mail _____

Insurance Company's Name_____

Policy No._____ Claim No._____

Kind of Policy: __Auto __Life __Health __Property __Other_____

Agent's Name_____ Date of Loss:_____

****

Please indicate which of the following is applicable:

My complaint is against: ___COMPANY ___AGENT ___ADJUSTER

1. ____The company has unfairly rejected my claim or has not paid the full benefits to which I am entitled.
2. ____The company has delayed processing my claim and I am unable to obtain a response from them concerning it.
3. ____The company has not refunded premium moneys that are due to me.
4. ____I believe the company's action of cancellation or non-renewal of my policy is not justified.
5. ____Other_____

Do you have an attorney handling this for you?_____ If not, in your own words, describe your problem. If more space is needed, please add additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved. By signing this form, I hereby give the Office of the Montana State Auditor permission to investigate this complaint on my behalf and forward it to the insurance company/agent for a formal response.

_____

_____

_____

_____

_____

_____

Signature_____Date_____

Use reverse side for additional comments

INSURANCE INQUIRY/COMPLAINT FORM (cont.)

Consumer Resources

For information on Medicare eligibility, a new Medicare card, how to apply for Medicare or to receive Extra Help for Medicare Part D premium assistance contact a local Social Security office listed below or call toll-free 1-800-772-1213.

Billings 1-866-895-1795
Bozeman 1-877-405-5473
Butte 1-888-632-7068
Glasgow ..... (406) 228-8272
Great Falls 1-877-583-4114
Havre ..... (406) 265-9511
Helena 1-866-563-9496
Kalispell 1-888-487-0150
Missoula 1-866-931-9029
Premium problems 1-800-833-6364

S.H.I.P.

State Health Insurance Assistance Program

1-800-551-3191

For questions about:

Medicare Parts A & B, Medicare Advantage, or Medicare Part D, all Medicare claims for services, equipment or home health care contact:

1-800-MEDICARE (800-633-4227) or go to www.mymedicare.gov.
Or call your local SHIP counselor at 1-800-551-3191.

Medicare Part D Plan Finder: www.mymedicare.gov

Medicaid: 1-800-362-8312 (or 444-1700 in Helena)

Centers for Medicare and Medicaid Services: www.cms.gov or 1-800-633-4227

Peer Review Organization (PRO) Mountain Pacific Quality Health Foundation: If you think you have a problem with quality of care from a physician or health care professional, call 1-800-497-8232 or (406) 443-4020.

Qualified Medicare Beneficiary (QMB): 1-800-362-8312

Supplemental Insurance questions for federal employees: 1-800-634-3569 or (406) 791-1400

Travelers Medicare (Railroad Retirement): 1-877-772-5772 (Your Medicare number will have an alpha character before your Social Security number.)

United Mine Workers Health and Retirement Funds: 1-800-291-1425

Big Sky Rx: 1-866-369-1233

For general questions about insurance:

Call the Office of the Montana State Auditor, Commissioner of Securities and Insurance:
1-800-332-6148

Contact Us

Monica J. Lindeen
Commissioner of Securities & Insurance
Office of the Montana State Auditor

840 Helena Avenue, Helena MT 59601

Consumer Hotline
(Outside Helena)
1-800-332-6148
In Helena: 444-2040

Fax: 406-444-3497
TDD Phone: 406-444-3246
E-mail: csi@mt.gov

www.csi.mt.gov

The Office of the Montana State Auditor, Commissioner of Securities and Insurance, attempts to provide reasonable accommodation for any known disability that may interfere with a person's ability to participate in any service, program or activity of the agency. Alternative accessible formats of this document will be provided upon request. For more information call (406) 444-2040 or TDD (406) 444-3246.