Missouri

Medigap Shopping Guide

Medigap (Medicare Supplement) insurance plans

Medigap rate information

Part D drug plans

Missouri Rx program

Medicare Advantage plans

DIFP

Department of Insurance,
Financial Institutions &
Professional Registration

Jeremiah W. (Jay) Nixon
Governor

John M. Huff
Director

Medicare questions? Get answers for free

Call **800-390-3330**

or

Visit **missouriclaim.org**

This free nonprofit Medicare counseling program will answer questions about:

- Medigap insurance (Medicare Supplement)
- Enrollment and billing
- Medicare prescription drug plans
- Long-term care planning and insurance
- Medicare Advantage plans
- Appeals and grievances
- Limited income assistance programs
- Suspected waste, fraud and abuse

Trained volunteers throughout Missouri will help answer your questions.

CLAIM is sponsored by the federal Centers for Medicare and Medicaid Services and the Department of Insurance, Financial Institutions and Professional Registration (DIFP)

Book designed to answer questions about Medicare, related insurance

Dear Missourian,

At the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP), we work to provide complete information about insurance to people on Medicare.

As you have learned, becoming Medicare eligible does not mean all of your health care needs expenses are covered. Medigap insurance, also called Medicare Supplement, can be an important part of your overall health insurance plan. It is available to Missourians who are at least 65 years old or disabled.

Medigap is sold by private insurance companies, and the prices those companies charge are listed in our supplemental Medigap Rate Guide.

This book also walks you through the different parts of Medicare and assistance that's available for those who need help paying for medication.

Along with this guide, the DIFP funds a statewide volunteer program to help Medicare consumers with these tough decisions. I urge you to contact the CLAIM program for help answering your Medicare questions. More information about the program and its contact number can be found on the previous page.

Medicare can be complicated and at times confusing, but with good resources like this booklet and the CLAIM program, you can sort through the options and make decisions that best meet your health care needs.

Sincerely,

John M. Huff
Director, DIFP

DIFP's Insurance Consumer Hotline

If you have questions about your insurance policy or want to file a complaint against an insurer, contact us:

800-726-7390 or **difp.mo.gov**

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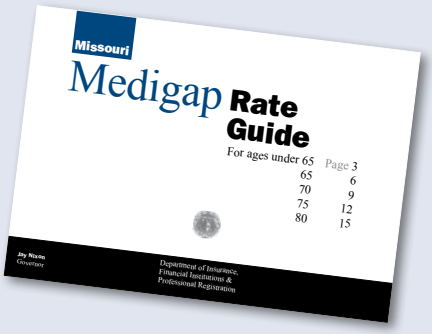

1 Use supplemental rate guide

Compare prices using Medigap insurance rate charts

Rate guide lists statewide average rates of the 11 available Medigap plans. Also listed: Consumer complaint history for Medigap insurers.

2 Use online tool to view current Medigap rates

http://insurance.mo.gov/consumers/seniors/

Click on "Medigap (Medicare Supplement) insurance" to view the searchable rates.

DIFP

Department of Insurance,
Financial Institutions &
Professional Registration

Insurance Consumer Hotline: 800-726-7390
Missouri TTY user: 800-735-2966 **or** 711 for Relay Missouri
Web: insurance.mo.gov
Address: Consumer Affairs Division
Truman State Office Building, Room 830
PO Box 690
Jefferson City, MO 65102
Hours: 8 a.m. to 5 p.m. weekdays

Other resources

CLAIM HELP LINE (State Health Insurance Assistance Program)

Phone: 800-390-3330
Web: missouriclaim.org

MEDICARE
Phone: 800-MEDICARE (800-633-4227)
Web: medicare.gov

U.S. SOCIAL SECURITY ADMINISTRATION
Phone: 800-772-1213
Web: socialsecurity.gov

MISSOURI Rx Plan (state pharmacy assistance program)
Phone: 800-375-1406
Web: morx.mo.gov

MISSOURI VETERANS COMMISSION
Phone: 866-838-4636 or 573-751-3779
Web: mvc.dps.mo.gov

TRICARE
Phone: 888-874-9378
Web: tricare.mil

RAILROAD RETIREMENT BOARD (eligibility and enrollment)
Phone: 877-772-5772
Web: www.rrb.gov

About Medigap insurance

Also known as Medicare Supplement insurance, consumers can buy a Medigap policy to cover deductibles required under their traditional Medicare benefits. The companies selling Medigap insurance in Missouri can offer up to 11 plans.

How to use this guide

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) regulates the insurance companies that offer Medigap policies in Missouri.

The **Missouri Medigap Shopping Guide** explains the basics of Medigap policies and the 11 plans offered in Missouri. It also lists the companies authorized to sell these policies in the state. The statewide, average annual premium charged for each plan can be found in the accompanying **Medigap Rate Guide**. Charges can vary for a number of reasons including age at time of application, where you live and what company you will be using.

Another publication you may find helpful is **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.** Written by Medicare and the National Association of Insurance Commissioners, it has excellent information about Medicare as well as health insurance. Any agent or company that offers to sell you Medigap insurance **must** give you a copy of the guide.

The guide can be found at medicare.gov/Publications/Pubs/pdf/02110.pdf.

Contact CLAIM for free answers

For any questions about Medicare, you can contact CLAIM, a free, nonprofit service that counsels Missourians with Medicare and their caregivers.

Trained volunteers throughout Missouri will help answer your questions.

Call: 800-390-3330
Visit: missouriclaim.org

This free Medicare counseling program will answer questions about:

- Medigap insurance
- Enrollment and billing
- Medicare prescription drug plans
- Long-term care planning and insurance
- Medicare Advantage plans
- Appeals and grievances
- Limited income assistance programs
- Suspected waste, fraud and abuse

CLAIM services are funded by the Federal Centers for Medicare and Medicaid Services and the DIFP.

Medicare basics

Medicare is a federal program that provides health insurance for those 65 and older, and some people under 65 with certain disabilities. It is the largest health insurance program in the U.S.

Medicare was signed into law by President Lyndon Johnson on July 30, 1965, in Independence, Mo. The first person enrolled in the program was former President Harry S. Truman, who was from Missouri.

Am I eligible?

Most people can join Medicare when they turn 65. You also can join if you:

- Receive Social Security disability checks for 24 months, or
- Have permanent kidney failure, known as end-stage renal disease (ESRD), or
- Have Lou Gehrig's Disease, known as Amyotrophic Lateral Sclerosis (ALS)

PARTS OF MEDICARE

Medicare Part A (hospital insurance): No monthly premium with exceptions

- Helps pay for inpatient care in hospitals.
- Helps cover home health, hospice and skilled nursing facility care (but not long-term care).

A deductible and copays may apply.

Medicare Part B (medical insurance): Monthly premium with right to delay enrollment

- Helps pay for medical care not covered by Part A, such as doctor visits, outpatient hospital services and medical equipment.
- Helps cover some preventive services to maintain health.

The monthly premium is usually withheld from your monthly Social Security check.
A deductible and coinsurance may apply.

Medigap insurance: Optional coverage with monthly premium

Also called Medicare Supplement insurance, these plans are offered by private insurance companies. Generally anyone with Parts A & B is eligible. These plans are assigned letters A-N. This is not to be confused with "parts" of Medicare, such as Parts A & B. Most of these plans cover the deductibles and/or coinsurance required in Parts A & B.

Medicare Advantage plans (like an HMO or PPO)**:** Optional coverage with monthly premium

Also called Medicare Part C, these plans are offered by private insurers that contract with Medicare to provide your benefits. You must have Parts A & B to qualify. The company handles all aspects of a beneficiary's health care – from enrollment to payment of providers. You cannot buy a Medigap **and** a Medicare Advantage policy. Deductibles, copays and coinsurance can apply.

Medicare Part D: Optional coverage with monthly premium

Helps pay for medicine through a plan offered by a private insurer approved by Medicare. You normally will pay some money when you pick up your medicine.
You must have Medicare Part A and/or Part B.

Medigap plans

Several changes were made to Medigap plans in 2010. These policies give you choices in health care coverage to fill gaps in payment of deductibles, copayments and coinsurance that Original Medicare does not pay. There are 11 plans from which to choose. (Plans E, H, I, J and high-deductible J are no longer being offered to new clients, which means future rate increases may be very high since there will be fewer policyholders in the plans.)

Lower premium plans M and N

Plans M and N are designed to give you a lower premium:

- **Plan M** covers 50 percent of the Part A deductible but none of Part B deductible.
- **Plan N** includes full coverage of the Part A deductible but no coverage for the Part B deductible.
- Coverage for Part B coinsurance (as part of basic benefits) is subject to a new copay structure. The copay obligation is up to $20 for office visits and up to $50 for emergency room visits.

Basic benefits

Hospice Part A coinsurance (outpatient prescription drug and inpatient respite care coinsurance) is now covered as a basic benefit. You will **not** have to pay:

- Copay of $5 or less for outpatient prescription drug plans for pain and symptom management.
- 5 percent of the Medicare-approved amount for inpatient respite care (not including room and board).
- Plan K will cover 50 percent, and Plan L will cover 75 percent of these costs.

Part B coinsurance: Plans K, L and N now require you to pay a portion of Part B coinsurance and copayments, which may result in lower premiums for these plans. All other Medigap policies pay Part B coinsurance or copayments at 100 percent.

Open enrollment for new policies

If you have a Medigap policy but would like to switch companies, you have an annual guaranteed open enrollment period. See **page 8** for more information.

Plans D and G

Plans D and G bought on or after June 1, 2010, have different benefits than the D or G plans bought earlier. If you bought Plan D or G before June 1, 2010, you can keep that plan and the benefits won't change. For plans bought later:

- At-home recovery benefit has been eliminated from plans D and G.
- Part B excess charge benefit in Plan G increases from 80 percent to 100 percent.

Medigap enrollment information

Enrolling for the first time

To be eligible for Medigap coverage, you generally must be enrolled in Medicare Parts A and B. You have a six-month open enrollment period from the date when your Part B takes effect. This applies to those who are disabled as well as those 65 or older.

During open enrollment, an insurance company cannot refuse to sell you any Medigap policy it carries.

The insurer may impose up to a six-month waiting period before paying for any treatment related to a pre-existing condition.

You must be given credit for prior creditable coverage to offset any six-month waiting period.

Renewing

Each year, you have the right to renew your current plan. While your rates may increase, your insurance company cannot refuse to renew your coverage or impose any waiting period based on pre-existing conditions, as long as you stay in the same plan as before.

Changing to a new company

You have the right to switch insurance companies each year during the 30 days **before or after** your policy's **anniversary date** (the date on which your policy first started). For example, if your policy expires June 30, you can switch policies between June 1 and July 30. You can call the insurance company to get your anniversary date.

If you change to the same-lettered plan – for example, from Plan F at Insurer XYZ to Plan F at Insurer ABC, the new insurer cannot deny you coverage and cannot impose a waiting period based on pre-existing conditions.

To demonstrate that you qualify to change insurers, you are required to show only minimal proof. Simply produce a renewal notice (from your old insurer), invoice, the old policy **or** other confirmation of policy ownership to the agent or new company.

Make sure you get a simple outline of coverage when buying a Medigap policy.

If you are told that you don't qualify, immediately call the Insurance Consumer Hotline at 800-726-7390.

If you change to a plan with fewer benefits, such as from Plan F to Plan C, you **may or may not** be subject to underwriting when an insurance company considers your health. Not all insurers allow you to change to a plan with fewer benefits.

If you elect to go with a more extensive plan (later in the alphabet, such as from Plan C to Plan F) you will likely be subject to underwriting, and may be denied coverage or the insurance company may impose a waiting period, based on a pre-existing condition, for any new benefits under your new plan.

Once you receive the new policy and you are certain it meets your needs, you should cancel the old policy.

Note: If you switch to a Medicare Advantage plan, you will lose the benefits of your Medigap policy.

Make sure your new policy has taken effect before your old policy is canceled.

Premium information

- Most companies will allow you to pay premiums monthly.
- If you pay annual premiums, a new law signed by Gov. Nixon requires insurers to refund your premium if you cancel coverage before the end of the policy year. For example, if you pay your annual premium and cancel six months later, you'll get a refund for six months of premiums.
- Premiums for all policies likely will increase each year to account for changes in Medicare benefits or increasing medical costs. If your insurer raises your premiums, it must do so for all policyholders of your rating class for the company.

Special rates for disabled Missourians

Everyone under age 65, who has been approved for Social Security disability, also has the guaranteed right to buy Medigap insurance when they enroll in Part B.

The cost may differ from policies available to seniors. Pricing information for disabled Missourians under age 65 is in the accompanying **Medigap Rate Guide**.

When disabled Medigap policyholders turn 65, they have a second open enrollment period, and can exercise the rights of any 65-year-old becoming eligible for Medicare for the first time. They may pick the plan of their choice from any insurer and pay the same rates as other Medicare beneficiaries.

"Select" plans

A few Medigap policies are called "select" plans. Similar to an HMO, they require you to go to specific health care providers for covered services, but the benefits offered under select plans A-N are the same as those in regular Medigap plans.

The rates for these plans are usually lower than regular Medigap policies. Select plans are not available in all parts of Missouri.

Make sure you compare plans in the Medigap Rate Guide. Such factors as where you live and gender could affect your rates. You can go to insurance.mo.gov to find the most recent rates.

Where you live could affect insurance rates

Premium rates in the rate guide are based on statewide, average yearly rates.

- **Actual rate:** Your rate may vary based on factors such as where you live, your gender, whether you smoke and whether the policy is for an individual or a group.
- **Individual insurance:** An individual Medigap policy is a direct contract between you and the insurer. It provides the maximum number of consumer protections. These policies are either "guaranteed renewable" or "non-cancelable."
- **Group insurance:** Group Medigap insurance is a contract between the insurer and a group master-policyholder such as AARP or an employer. You receive a certificate rather than a policy. The group negotiates the terms of the insurance and has the option to terminate the policy or change insurance carriers. Some insurance policies will require you to join a group or association.

Guaranteed issue rights for Medigap policies

In all eight situations below, your insurance company cannot:

- Deny you the Medigap (Medicare Supplement) policy.
- Place conditions on the Medigap policy, such as waiting periods.
- Apply a pre-existing condition exclusion.
- Discriminate in the price of the Medigap policy based on your health status.

You have a Medigap guaranteed issue right if ...	You have the right to buy ...	You can/must apply for a Medigap policy ... (DAYS ARE CALENDAR DAYS)
1 You have a Medicare Advantage plan and: ● Your plan is leaving Medicare; or ● Stops giving care in your area; or ● You move out of plan's service area. **Note:** If you immediately join another Medicare Advantage plan, you can stay in that plan for up to one year and still have the rights described in situations 4 and 5.	Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage plan.	As early as **60** days before your health care coverage ends but no later than **63** days after it ends. Medigap coverage can't begin until your Medicare Advantage plan coverage has ended.
2 You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) **or** union coverage. The employer group or you are terminating coverage.	Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. If you have COBRA coverage, you can either immediately buy a Medigap policy or wait until COBRA coverage ends.	No later than **63** days after the latest of these dates: ● Date coverage ends. ● Date on notice telling you coverage is ending (if you get one). ● Date on a claim denial, if this is only way your were informed.
3 You have Original Medicare **and** a Medicare Select policy. You move out of the Medicare Select policy's service area. You can keep your Medigap policy, however the hospitals in your new area may not be a network provider, **or** you may want to switch to another Medigap policy.	Medigap policy A, B, C, F, K or L sold by any insurance company in the state to which you are moving.	As early as **60** days before your health care coverage ends but no later than **63** days after it ends.

You have a Medigap guaranteed issue right if ...	You have the right to buy ...	You can/must apply for a Medigap policy ...
4 **(Trial right)** You joined a Medicare Advantage plan **or** Program of All-inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A at age 65, and within the first year of joining, you decide to switch to Original Medicare.	Any Medigap policy sold in Missouri by any insurance company.	As early as **60** days before your health care coverage ends but no later than **63** days after it ends. **Note:** Your rights may last for an extra 12 months under certain circumstances. Also, Medigap coverage can't begin until your Advantage plan coverage has ended.
5 **(Trial right)** You dropped a Medigap policy to join a Medicare Advantage plan or switch to a Medicare Select policy for the first time; you have been in the plan for less than a year and want to switch back.	The Medigap policy you had before you obtained the Advantage plan or Select policy, if the same company you had **before** still sells it. (Drug coverage won't be included.) If it isn't available, you can buy Medigap policy A, B, C, F, K or L sold in Missouri by any insurer.	As early as **60** days before your health care coverage ends but no later than 63 days after it ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
6 Your Medigap policy ends through no fault of your own, such as bankruptcy by your insurance company.	Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company.	No later than **63** days after coverage ends.
7 You leave a Medicare Advantage plan or drop a Medigap policy because your company hasn't followed the rules **or** misled you.	Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company.	No later than **63** days after coverage ends.
8 You can change your Medigap policy to another insurance company 30 days before or 30 days after your policy's annual anniversary date.	The Medigap policy you had before switching. If it isn't available, you can buy a Medigap policy A, B, C, F, K or L sold in Missouri by any insurance company. This also applies to persons switching from a discontinued plan.	As early as **30** days before the anniversary date of your policy and no later than **30** days after the anniversary date.

Medigap plan shopping tips

Shop for benefits and price

Check the benefits in each of the 11 plans. Every company must use the same letters (A through N) to label its policies. **Plan A is always a company's lowest-priced Medigap policy.** It contains basic benefits and must be sold by every company.

Plans B through N add other benefits to fill different gaps in your Medicare coverage. Options K and L provide a product for those who can afford a higher deductible and are healthy.

Few companies sell all policies. The charts in the Medigap Rate Guide show the statewide average premiums for companies' plans.

Research insurance company

Besides rates, consider a company's complaint index (see Medigap Rate Guide). This numerical score helps you understand how many consumer complaints an insurer receives, compared to other companies its size.

When you cancel a policy: It is your responsibility to request cancellation (in writing) with your prior insurer. Do not rely on the insurance agent.

A complaint index of 100 is average. Below 100 means the company gets fewer complaints than average, and a score above 100 means the insurer gets more complaints than average.

This information also is available by calling DIFP's Insurance Consumer Hotline at 800-726-7390 and by visiting insurance.mo.gov.

Do's and don'ts of buying Medigap

What to do

- Ask questions of friends and family.
- Know what you are buying. Insist on getting a simple outline of coverage.
- Choose the benefits you want and need. Benefits are standardized in Medigap policies. For example, the Plan C policy has exactly the same benefits with any company.
- Compare benefits for different policies before buying. Consider family and medical history.
- Check a company's consumer complaint history with DIFP at 800-726-7390.
- Keep proof of prior creditable coverage.
- Keep the agent's name and information for later reference.

Carefully read the policy. You have a 30-day "free look" period. If you are unsatisfied and cancel, you can get a full refund.

What not to do

- Don't feel pressured to buy now. You have a six-month open enrollment period.
- Don't drop a current insurance policy until you have your new coverage.
- Don't buy more than one Medigap policy.
- Never pay cash. Always use a check made out to the insurance company, **not** the agent.
- Don't buy from agents who claim to be from the government. The government does not sell insurance.
- Don't buy a Medigap policy if you have a Medicare Advantage plan. They won't work together.

Plan Availability changes due to MACRA (Medicare Access and CHIP Reauthorization Act) of 2015

As a result of the passage of the federal law, MACRA in 2015, Medicare eligibles will see changes to plan offerings as of January 1, 2020. While the benefits under the current Medicare Supplement plans do not change, PLAN AVAILABILITY does change.

While the year 2020 may seem a ways off, miscommunication about the impact of MACRA is already stirring. So, please read the following carefully so you know your options and rights.

Only those Medicare eligible on or after January 1, 2020 are impacted by the changes to plan availability. Those Medicare eligible prior to January 1, 2020 are not impacted and can keep their current plans. MACRA prohibits coverage of the Part B deductible under Medicare Supplement plans as of 1/1/2020.

Impacts of MACRA on those eligible for Medicare PRIOR to January 1, 2020:

- All Medicare Supplement plan options are available to you.
- If you are enrolled in Plans C and F, you can keep your plan. These plans remain available to you.
- You can buy Plans C and F after January 1, 2020.
- Can purchase the new Plan G High Deductible Plan in 2020.

Impact of MACRA on those eligible for Medicare ON or AFTER January 1, 2020:

- Cannot buy Plans C and F;
- Creates a new Plan G High Deductible;
- Re-designates the guaranteed issued plans from Plans C and F to Plans D and G;
- Makes Plan G High Deductible available to all eligible for Medicare.

Medigap insurance plan options

PLANS A	B	C	D	F	F high deductible
Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	This option has the same benefits as Plan F but a high deductible first must be paid. The trade-off is a lower monthly premium. The beneficiary pays the plan's deductible each year before the supplemental policy pays for any services. This deductible amount is subject to increase each year.
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	
		Skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance	
		Part B deductible		Part B deductible	
				Part B excess (100%)	
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	

Explanation of Medigap plan benefits

Basic benefits
(Plans A-N)

- Coverage for coinsurance for day 61-90 of inpatient hospitalization.
- Coverage for coinsurance for lifetime reserve days 91-150.
- Coverage for an additional 365 days of inpatient hospital care in your lifetime.
- Coverage for first three pints of blood.
- Coverage for 20% coinsurance for Part B services.
- Coverage for the hospice 5% coinsurance for Medicare-approved charges for inpatient respite care and 5% coinsurance for prescription pain medications.

Part A deductible
(Plans B, C, D, F, G, N)
(Partial coverage on K, L, M)

- Coverage for inpatient hospital deductible for each benefit period.
- Partial coverage on Plans K, L and M.

Medigap insurance plan options continued

G	K	L	M	N
Basic benefits	Hospitalization, preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization, preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits	Basic benefits, except up to $20 copay for office visit & up to $50 copay for ER
Part A deductible	50% of Part A deductible	75% of Part A deductible	50% of Part A deductible	Part A deductible
Skilled nursing coinsurance	50% of skilled nursing coinsurance	75% of skilled nursing coinsurance	Skilled nursing coinsurance	Skilled nursing coinsurance
Part B excess (100%)				
Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
	Benefits paid at 100% after out-of-pocket limit reached	Benefits paid at 100% after out-of-pocket limit reached		

Explanation continued

Skilled nursing coinsurance
(Plans C, D, F, G, M, N)
(Partial coverage on K, L)

- Coverage for skilled nursing coinsurance for days 21-100 for each benefit period.
- Partial coverage on Plans K & L.

Part B deductible (Plans C, F)

- Coverage for the yearly deductible.

Part B excess
(Plans F, G)

- Coverage for Part B charges over approved amount.
- Plan F pays for 100% of excess charge.
- Plan G pays for 100% of excess charge.

Foreign travel emergency
(Plans C, D, F, G, M, N)

- Coverage for emergency care for first 60 days of a trip outside the U.S.
- Beneficiary pays for $250 deductible and 20% of cost up to $50,000.

QUESTIONS TO ASK

Buying a Medigap plan worksheet

When you call an insurance company about a Medigap policy, here are some questions you might want to ask. Write down the responses for later reference.

DATE	PHONE NUMBER	PLAN LETTER	COMPANY NAME

COMPANY REPRESENTATIVE'S NAME and TITLE _____

How much is the monthly premium for plan? _____

How long has the company been selling Medigap policies? _____

When did the plan's rate last increase? How many increases in last three years? _____

When do you expect to have another rate increase? _____

How many complaints has your company received in the last 12 months? _____

What is the most common complaint your company receives? _____

Why should I buy a policy from this company? _____

How long does it take for your company to pay a claim? _____

What is A.M. Best's financial rating of your company? (They range from A++ to F) _____

Is this plan underwritten? (See page 22 for definition.) _____

Is this a group plan and, if so, how do I join the group? _____

Know who pays first if you have other health insurance or coverage

If you have Medicare and other health insurance coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The primary payer pays what it owes on your bills, and then sends them to the second payer. There may be a third payer.

Whether Medicare pays first depends on several factors, including those listed in the chart. This chart does not cover every situation. Make sure to tell your doctor and other health care providers if you have coverage besides Medicare. This will help them send your bills to the correct payer to avoid delays.

Call Medicare

If you have questions about who pays first or if your insurance changes, call:

800-MEDICARE (800-633-4227)

Ask for a Medicare coordination of benefits contractor.

If you ...	And you are ...		Who pays first?	Who pays second?
Are 65 or older, working and covered by group health plan; or covered by group health plan of a working spouse of any age	Enrolled in Medicare and your employer has 20 or more employees		Group health plan	Medicare
	Enrolled in Medicare and your employer has fewer than 20 employees, or is part of multi-employer plan where one employer has 20 or more employees		Medicare	Group health plan
Have an employer group health plan after you retire and are 65 or older	Enrolled in Medicare	Enroll in Medicare as soon as you can. Your group health plan may stop covering expenses once you are eligible for Medicare.	Medicare	Retirement coverage
Are disabled and covered by a large group health plan from work, or by a family member who is working	Enrolled in Medicare and your employer has 100 or more employees		Large group health plan	Medicare
	Enrolled in Medicare and your employer has fewer than 100 employees and isn't part of a multi-employer plan where any employer has 100 or more employees		Medicare	Group health plan
Are 65 or older **or** disabled and covered by Medicare and COBRA	Enrolled in Medicare		Medicare	COBRA

Know who pays first continued

If you ...	And you are ...	Who pays first?	Who pays second?
Have end-stage renal disease (permanent kidney failure) and group health plan coverage – including retirement plan	In your first 30 months of Medicare eligibility or enrollment	Group health plan	Medicare
	Past your first 30 months of Medicare eligibility or enrollment	Medicare	Group health plan
Have end-stage renal disease (permanent kidney failure) and COBRA coverage	In your first 30 months of Medicare eligibility or enrollment	COBRA	Medicare
	Past your first 30 months of Medicare eligibility or enrollment	Medicare	COBRA
Have been in an accident where no-fault or liability insurance is involved	Enrolled in Medicare	No-fault or liability insurance, for services related to accident claim	Medicare
Are covered under workers' compensation because of job-related illness or injury	Enrolled in Medicare	Workers' compensation for claim-related services	Medicare will not pay in most cases
Have veteran's benefits	Enrolled in Medicare	VA, for VA-authorized services	Medicare **may** pay second at any non-VA facility
		Medicare, for non-VA-authorized services	
Are enrolled in TRICARE	Enrolled in Medicare	Medicare, for Medicare-covered services	TRICARE
		TRICARE, for services from military hospital or other federal provider	
Are enrolled in Federal Black Lung Program	Enrolled in Medicare	Federal Black Lung Program, for services related to black lung	Medicare

Medicare Part D prescription drug plans

Medicare offers prescription drug plans (PDPs) for everyone with Medicare. This coverage is called "Part D." Like Medicare Advantage and Medigap insurance, Medicare Part D plans are sold by private insurance companies with the approval of Medicare.

Each plan may vary in cost and drugs covered. Each plan requires a monthly premium, and some plans require a deductible and copays.

Drug coverage gap (doughnut hole)

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

This amount doesn't include your plan's monthly premium that you must continue to pay while you are in the coverage gap. Once you've reached your plan's out-of-pocket limit, you will have "catastrophic coverage." A reduced coinsurance amount or copayment will apply.

Medicare drug plans vary in which drugs they cover, what your out-of-pocket costs will be, and which pharmacies you can use.

Make sure you compare plans so you find a plan that best meets your needs. Look at:

- Coverage (formularies).
- Cost (premiums, deductibles and copays).
- Convenience (some plans offer network and mail-order pharmacies).
- Quality (plans' performance ratings can be found at medicare.gov).

Annual open enrollment is Oct. 15 to Dec. 7. There are exceptions, such as if you move to another state or reach Medicare age. Policies generally take effect Jan. 1.

Get help finding a drug plan

Contact CLAIM: **missouriclaim.org**
800-390-3330
Contact Medicare: **medicare.gov**

Enrollment

- If you don't join a Medicare drug plan when you are first eligible for Medicare Part A and/or Part B, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage.
- You can switch your Medicare Part D plan during the annual open enrollment period, which is Oct. 15 to Dec. 7. Your new coverage will begin Jan. 1.
- There are circumstances that can generate a special open enrollment period. Call CLAIM at 800-390-3330 for information.
- You should review your drug coverage during every annual open enrollment period, to make sure you still have the best plan for you.
- Before you buy a drug plan, it is important to make sure the plan you are considering is approved by Medicare. Contact CLAIM at 800-390-3330 or visit Medicare's website at medicare.gov.

Changes in Your Medicare Part D Prescription Drug Plan Closing the Coverage Gap

The Affordable Care Act outlines major changes to your Medicare Part D Prescription Drug Plan. These changes are designed to assist consumers with their prescription drug costs. Between 2015 and 2020, the amount you pay while in the "doughnut hole" is going to decrease. Please see the chart below to determine what percentage you will pay for brand-name and/or generic drugs during your coverage gap.

YEAR	% You'll Pay for Brand-Name Drugs	% You'll Pay for Generic Drugs
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%

For more information on the upcoming changes to your Medicare Part D Prescription Drug Plan, please visit the Centers for Medicare & Medicaid Services (CMS) website at: https://www.medicare.gov/Pubs/pdf/11493.pdf.

You may also contact CMS by calling 1-800-MEDICARE (1-800-633-4227).

Missouri Rx Plan: Help with drug costs

Basic facts

The Missouri Rx Plan (MoRx) helps cover some of the out-of-pocket costs you pay with Medicare Part D. It is available to qualifying elderly and disabled Medicare beneficiaries. The Missouri Department of Social Services, MO HealthNet Division, administers the program.

Members must be enrolled in a Medicare prescription drug plan to receive benefits from the Missouri Rx Plan.

Benefits

- MoRx pays for half of the deductible and half of all copays, including the coverage gap (see previous page). It does not provide assistance with the monthly premium.
- The MoRx benefit is not available for mail order prescription service through the Part D plan.
- MoRx covers a maximum of a 31-day supply per prescription fill per month. The MoRx benefit is not available for 90-day supply purchases.

Enrollment

- No cost or enrollment fee to join.
- Look for MoRx one-page applications at pharmacies, Area Agencies on Aging, county health departments and public libraries, Department of Revenue license bureaus and MFA Agri-Service centers.
- MoRx applications can also be obtained by calling toll-free 800-375-1406, calling CLAIM at 800-390-3330 or downloaded from morx.mo.gov.
- MoRx enrollment is ongoing. No annual re-enrollment is required.

How to get a MoRx application

Call: **800-375-1406**
Visit: **morx.mo.gov**
Local businesses, agencies that might have applications:

- Pharmacy
- Area Agency on Aging
- County health department
- County public library
- Motor vehicle license bureau
- MFA Agri-Service Center

Eligibility requirements

Medicare beneficiaries with incomes at or below:

- $21,660 annual income for an individual.
- $29,140 annual (combined) income for a married household.
- No asset or resource limitations apply.

Medicare Advantage plans: What you need to know

Medicare Advantage plans are available from private companies that contract with the Centers for Medicare and Medicaid Services to provide Medicare benefits to enrollees. The plans must provide all benefits provided by Medicare. They may also provide additional benefits.

Members pay the plan premium, if any. Plans may charge copayments or coinsurance amounts for various services.

At the end of each year, companies offering plans may change the premium, the services offered, the service area or they may choose to leave the Medicare program entirely.

The annual open enrollment period to join or leave a Medicare Advantage plan is Oct. 15 to Dec. 7.
Your new coverage will begin Jan. 1 of the following year.

Study your choices and sales material carefully before enrolling in a Medicare Advantage plan. Compare each plan to others available in your area. If you already have insurance, do not cancel it before you receive notice the new plan has been issued and that it offers the promised benefits.

ENROLLMENT

To enroll in a Medicare Advantage plan, you must:

- Have Medicare Parts A and B; **and**
- Pay a Part B premium; **and**
- Not have end-stage renal disease (kidney failure)

Have questions about Medicare Advantage plans? Call CLAIM for a referral to a CLAIM counselor in your local area. It is free.

800-390-3330

Medicare with

Medigap vs. Medicare Advantage

	Traditional Medicare A & B plus Medigap policy	Medicare Advantage Plan
What health care benefits are covered?	All Medicare A and B benefits. Medigap policy benefits depend on the plan purchased. Refer to each policy for details.	All the Medicare A and B benefits and perhaps others, depending on the plan. Some plans may offer other coverage. Refer to plan for details.
Are outpatient prescription drugs covered?	No.	It depends on the plan. See each plan for any drug coverage.
Can I go to any doctor or hospital?	You can go to any doctor, specialist or hospital that accepts Medicare.	You may go to any doctor, specialist or hospital that has a contract with the plan.
Does the policy/ plan let doctors or hospitals charge more than Medicare's deductibles, coinsurance and copayments?	Not for hospitals, but possibly for doctors. Doctors who do not accept Medicare assignment may charge up to 15 percent more than Medicare's approved amount. (Part B excess charges are covered under plans F and G.)	Medicare Advantage sets the rates for deductibles, coinsurance and copayments for the plan. Refer to plan for details.
How are claims paid?	The provider sends the claim to Medicare. Medicare approves the amount of the claim and pays its portion. Medicare or the provider forwards the claim to the Medigap policy which, according to the policy requirements, may or may not pay the remaining balance.	Prior to receiving care, the plan member pays a copayment/ deductible amount. The provider sends the claim to the Medicare Advantage plan. The plan approves the claim amount and pays its share. The member pays any remaining share – such as a deductible, coinsurance or copayment – if the plan allows balance billing. Refer to plan for details.

Insurance terms

Appeal: A complaint you file with your insurance company or Medicare if you disagree with a decision about coverage. You can appeal if you are denied coverage for a treatment, supply or drug prescription, or if the coverage is less than you think it should be. You can also appeal if you are already receiving coverage and the plan stops paying.

Coinsurance: The amount you pay for services after you pay deductibles. In Original Medicare, this is a percentage (like 20 percent) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a prescription drug plan (Part D), the coinsurance will vary.

Copayment: In some Medicare plans, the amount you pay for each medical service such as a doctor's visit or prescription. A copayment is usually a set amount, for example $10 or $20. Copayments are also used for some hospital outpatient services.

Creditable prescription drug coverage: Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible: The amount you pay for health care or prescriptions before insurance benefits kick in. So if you have a $1,000 deductible, you have to pay that much out of your pocket during the year before insurance begins paying. These amounts can change every year.

Make a connection: Seniors who have questions about their insurance policy are encouraged to call DIFP's hotline.

Insurance
Consumer
Hotline

800-726-7390

Formulary: A list of drugs covered by a plan.

Guaranteed issue rights: Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company cannot deny you a Medigap policy and you cannot be charged more because of a past or present health problem. Coverage of pre-existing conditions starts immediately if you have had at least six months of prior coverage. The pre-existing condition period is offset month for month if you have had less than six months of coverage.

Health maintenance organization (HMO) plan: A type of Medicare Advantage plan. Extra benefits like dental or vision coverage may be offered. In most HMOs, you can only go to network doctors, specialists or hospitals on the plan's list except in an emergency.

Long-term care: Assistance with everyday functions, like bathing and dressing, usually provided in a nursing home or at home through a home-health service. Generally, Medicaid pays for long-term care, but Medicare does not.

Medicaid: A joint federal and state program that helps with medical costs for some people with limited income and resources.

Medicare Advantage plan (Part C): A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage plans are HMOs, PPOs, private fee-for-service plans, or Medicare medical savings account plans. Some Medicare Advantage plans offer prescription drug coverage.

Medicare-approved amount: In Original Medicare, this is the amount a doctor or supplier that accepts assignment is paid. It includes what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare prescription drug plan (Part D): A stand-alone drug plan offered by insurers and other private companies to those who get benefits through Original Medicare. Medicare Advantage plans may also offer prescription drug coverage and must follow the same rules as Medicare prescription drug plans.

Medigap: Medicare Supplemental insurance sold by private insurance companies to pay deductibles, copayments and coinsurance in Original Medicare coverage. Medigap policies only work with Original Medicare.

Original Medicare: Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). It is a fee-for-service health plan. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance, copayments and deductibles).

Network: A group of physicians, hospitals and other health care professionals who provide health care services for Medicare Advantage plans and select plans.

Penalty: An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan (Part D), if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-service plan: A health maintenance organization (HMO) option that lets you use doctors and hospitals outside the plan for an additional cost.

Preferred provider organization (PPO) plan: A type of Medicare health plan available in a local or regional area in which you pay less if you use doctors, hospitals and providers that belong to the network. You can use doctors, hospitals and providers outside of the network for an additional cost. Extra benefits like dental or vision coverage may be offered. Many Medicare Advantage plans are PPOs.

Insurance terms (continued)

Premium: Your periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage. Example: $179 per month.

Preventive services: Care intended to keep you healthy (for example, Pap tests, pelvic exams, flu shots and cancer screenings).

Primary care doctor: Also known as a gatekeeper, the primary care physician is responsible for coordinating your care in a managed care plan. He or she makes sure you get the care you need to keep you healthy. In many Medicare Advantage plans, you must see your primary care doctor before you see a specialist or other health care provider.

Private fee-for-service (PFFS) plan: A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than Medicare, decides how much it will pay and what you pay for the services you get. Extra benefits like dental or vision coverage may be offered. You may pay more or less for Medicare-covered benefits.

Skilled nursing facility care: This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples include intravenous injections and physical therapy. The need for only custodial care (help with daily living activities such as bathing and dressing) cannot qualify you for Medicare coverage in a skilled nursing facility.

State Health Insurance Assistance Program: A state program funded by federal and state grants to give free counseling to people on Medicare. In Missouri, this is the CLAIM program. See inside front cover for details.

Underwriter: Insurance company employee who figures out how risky it is to insure clients. Underwriters decide what coverage an applicant qualifies for and what rates you should pay, or whether to accept or deny your application.

We're here to help you

Seniors and other Missouri consumers who have questions about their insurance policy or want to file a complaint against an insurance company or agent are encouraged to call DIFP's hotline:

Insurance
Consumer
Hotline

800-726-7390

Contact DIFP's Insurance Consumer Hotline

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difp.mo.gov

800-726-7390

DIFP

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