Virginia Medigap Policies
Premium Comparison Guide

Prepared by

Commonwealth of Virginia
State Corporation Commission

This consumer's Guide should be used for educational purposes only. Nothing in this Guide is intended to be an opinion, legal or otherwise, of the State Corporation Commission, nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this Guide.

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February 2018 Edition

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IMPORTANT CONTACT INFORMATION
HOW TO REACH THE BUREAU OF INSURANCE

State Corporation Commission
Bureau of Insurance

Physical Deliveries/Visits:
Life and Health Division
1300 E. Main Street
Richmond, VA 23219

Mailing Address:
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Fax: 804-371-9944

Health Insurance Consumer Services Section

(VA Toll Free) 1-800-552-7945
(Nationwide Toll Free) 1-877-310-6560
(In Richmond) 804-371-9691
Fax: 804-371-9944

Insurance Outreach

(Toll Free) 1-877-310-6560
(In Richmond) 804-371-9092

Web site:

http://www.scc.virginia.gov/boi

OTHER IMPORTANT RESOURCES

Social Security Administration

1-800-772-1213 (TTY at 1-800-325-0778)
Web site: http://www.ssa.gov

Virginia Insurance Counseling and Assistance Program (VICAP)

VICAP is available to provide insurance counseling, free of charge, to individuals over age 60 and their families. The program provides assistance in making decisions about Medicare, Medigap insurance, Medicare Advantage (Part C), Medicaid, medical bills and long-term care insurance. You may obtain additional information about this program by calling the Virginia Department for Aging and Rehabilitative Services at 804-662-7000 or 1-800-552-5019, or you can visit their web site www.vadrs.org.

The National Association of Insurance Commissioners (NAIC)

Helpful consumer information may be found on the NAIC's web site: http://www.naic.org under Consumer Resources or by calling 1-816-783-8300.

INTRODUCTION

Understanding Medicare and the insurance policies that provide benefits that supplement Medicare, (generally referred to as Medicare Supplement or "Medigap" policies), are critically important factors in making sound and informed insurance purchasing decisions.

This Guide has been prepared to assist you in evaluating the costs of Medigap insurance policies offered in Virginia so that you can make informed decisions about the products that are most appropriate for your needs and budget. It includes information provided by those insurers that elected to be represented in this Guide.

This Guide is a useful tool, but it should not be used exclusively. Although this Guide provides some basic information about Medicare and Medigap policies, it does not provide specific information about Medicare or what Medicare covers. It is intended to be used as a reference with and in addition to the following publications:

Medicare and You, developed by the Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services, and *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, developed jointly by CMS and the National Association of Insurance Commissioners (NAIC).

The premium figures provided in this Guide are intended to give you an idea of the range of premiums normally charged for Medigap policies. These figures should only be used as general guidance in comparing plans and policies. Telephone numbers have been provided so that you can contact companies directly for more specific information about their Medigap policies in Virginia. All of the information provided in the charts included in this guide is subject to change.

You may also contact us or visit our web site to determine whether a company or a particular agent is currently licensed in Virginia at: http://www.scc.virginia.gov/boi/online.aspx.

MEDICARE – THE BASICS

The following information about Medicare is helpful to gain a better understanding of Medigap policies and the coverage they provide. This information is general and basic, and should not be used as an exclusive resource to understand Medicare.

Medicare is a federal program that provides health insurance for people age 65 or older. Most American citizens who have paid into Medicare through their employment are eligible for Medicare. Medicare is financed by a portion of the payroll taxes paid by workers and their employers. It is also financed in part by monthly premiums deducted from Social Security checks. CMS is the agency in charge of the Medicare program. You apply for Medicare at your local Social Security Administration Office.

People younger than age 65 who have certain disabilities, and people of all ages who have permanent kidney failure requiring dialysis or a kidney transplant (End-Stage Renal Disease - ESRD), or Amyotrophic Lateral Sclerosis-ALS (Lou Gehrig's Disease), are eligible for Medicare. The program helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care.

Medicare has four parts: Part A, Part B, Part C and Part D

The Original Medicare Plan is a traditional health insurance program, run by the federal government that covers Part A and Part B services. Medicare pays its share of the bill and you pay the balance.

Part A is commonly known as hospital insurance. It helps pay for inpatient hospital care, inpatient care in a skilled nursing facility (following a hospital stay), some home health care, and hospice care. There are however, definite limits and exclusions to what Medicare covers.

For most people, there is not a monthly premium for Part A coverage because they or their spouse paid Medicare taxes for at least ten years while they were working. If you have less than ten working years of credit, you should contact the Social Security Administration to find out if you are eligible to purchase coverage and what the cost will be.

Part B is commonly known as medical insurance. It helps pay for inpatient and outpatient doctors' fees, medical services and equipment, clinical lab services, physical and occupational therapy, and outpatient mental health care.

Individuals who are determined by the Social Security Administration to be eligible for Part B must pay a premium based on their income. Part B also has an annual deductible, which is subject to change each year. Also, a coinsurance charge is applied to doctor visits or other qualified medical services.

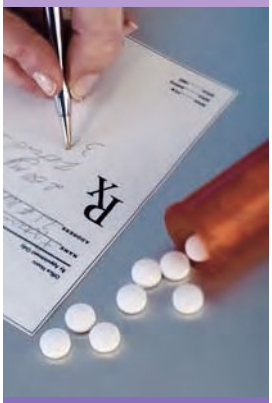
Part C, Medicare Advantage, (formerly known as Medicare+Choice), is offered by companies that contract with Medicare to provide you with all your Medicare Part A and Part B benefits. Some Part C plans also cover prescription drugs. More information on these plans may be found in the booklet, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* developed jointly by the CMS and NAIC.

A list of Medicare Advantage plans in Virginia is available in the *Medicare and You Guide* published by the CMS. The monthly premiums for Medicare Advantage plans vary by company.

Part D Medicare prescription drug coverage includes both brandname and generic prescription drugs at participating pharmacies in your area. Everyone with Medicare is eligible for this coverage regardless of income and resources, health status, or current prescription expenses. Medicare has contracted with private companies to offer prescription drug plans. There are two ways to obtain coverage:

1. You can choose to receive your medical benefits from the traditional Medicare program (Medicare Parts A and B), and receive prescription drug coverage through a Medicare Prescription Drug plan.
2. You can join a Medicare Advantage Plan (Part C) with drug coverage. A Medicare Advantage Plan can be a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Medical Savings Account Plan (MSA), Private-Fee-For-Service Plan (PFFS) or a Medicare Special Needs Plan.

Like other insurance, generally you will pay a monthly premium for Medicare Part D coverage, as well as a yearly deductible. You will also pay a part of the cost of your prescriptions, including a copayment or coinsurance. All these costs will vary depending on which drug plan you choose. Some plans may offer more coverage and additional drugs for a higher monthly premium. If you have limited income and resources, and you qualify for extra help, you may not have to pay a premium or deductible. You can get more information about the extra help by calling the Social Security Administration, (see *Other Important Resources*, page 3).



Choosing a Medicare Prescription Drug Plan

When deciding whether to purchase a Medicare Prescription Drug plan and what plan best suits your needs, you should consider the following:

- Do you currently have military retiree or veterans prescription drug benefits?

  These plans are considered to be comparable to Medicare's Prescription Drug coverage, so the purchase of a Medicare Prescription Drug plan may not be necessary.

- What are the costs of your prescriptions and what type of benefits will be paid for them under the plans you are considering?
- How much will the monthly premium be?
- How much will you have to pay towards prescription drug costs before the Medicare Prescription Drug plan pays benefits (the deductible)?
- How much will you pay for prescriptions once the deductible has been met?

Most Medicare Prescription Drug plans have a tiered formulary. This means that your share of the costs will vary depending on the drug.

- Can you fill your prescriptions at the pharmacy you use regularly? Can you fill your prescriptions when you travel?

Medicare Enrollment

You enroll in Medicare when you apply for your Social Security Retirement Income, usually at age 65. If you are not sure of your current enrollment status, call your local Social Security Administration Office.

There are several important time periods to consider when enrolling in Medicare plans. The following are general considerations. You should consult other resources or contact the Social Security Administration for more specific information.

Your **Initial Enrollment Period** begins three months before your 65th birthday month and ends three months after your birthday month. The federal government advises signing up for Medicare three months before your 65th birthday so that Medicare will be effective on the first day of the month of your birthday. If you fail to enroll in Medicare during this seven-month eligibility period, you can enroll between January 1 and March 31 of any year after you become eligible. This is called the **General Enrollment Period**. However, you will have to pay a penalty for late enrollment. The cost of Part B will go up ten percent for every 12 months you could have had Part B coverage but did not sign up for it. You will have to pay this extra ten percent for the rest of your life.

When to Waive Part B

Everyone who enrolls in Part A is automatically eligible to be enrolled in Part B as well. If you are over age 65, are still working and are covered under an employer's health plan (or are covered under a working spouse's health plan), you can delay enrolling in Medicare Part B coverage. You will not have to pay the Part B monthly premium until you need it. If you want to delay in enrolling in Part B, you must contact the Social Security Administration and tell them you want to waive your right to Part B coverage. Before deciding to waive Part B, find out what your coverage is under your employer's plan. You should ask if there is a dollar limit to the coverage, how much out-of-pocket costs you will have to pay, how long the coverage will last, and if your spouse is included in your coverage.

If you choose to delay Part B, remember that when you retire or when your job-related insurance coverage ends, you then have eight months to notify Medicare and sign up for Part B without

getting a late enrollment penalty charge added to your premium. If you miss the eight-month **Special Enrollment Period**, you will have to wait until the next **General Enrollment Period**. Once you enroll in Part B, you have six months to purchase Medigap insurance without medical underwriting. This means you cannot be denied coverage because of health problems during the six-month open enrollment period.

Medicare Eligibility

Persons under age 65 who suffer from certain disabilities or diseases, and who are receiving benefits under Social Security Disability Insurance or Railroad Retirement, may be eligible for Medicare benefits after a 24-month waiting period. The exception to the 24-month waiting period applies to persons diagnosed with chronic kidney failure (ESRD) and require dialysis or a kidney transplant, and to persons diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's disease.

Supplementing Your Medicare Coverage (Medigap Insurance)

Buying Medigap insurance is not required, but it is recommended if you are covered by traditional Medicare (Parts A and B).

In Virginia, there are two ways to supplement your Medicare coverage: 1) You can purchase a Medigap policy from a private insurance company, or 2) Your most recent employer may offer Medigap coverage through a retiree health plan. You need only select one of these two options. Coverage purchased through either of these options should pay most or all of the coinsurance and deductible amounts under the traditional Medicare Plan. The difference is in who manages the benefits and the billing for you.

Medigap insurance is meant to supplement Medicare but not to replace any part of Medicare coverage. Regardless of the policy or plan you choose, you will most likely pay a premium (annual or monthly) for Medigap insurance, which will vary depending on the plan you buy. This is in addition to your Part B and Part D Medicare premiums.

MEDIGAP INSURANCE

Medicare does not cover all health care costs. Medigap insurance is designed to fill some of the gaps in health care coverage that Medicare Parts A and B do not cover. Medigap insurance pays the deductible, copayments, some other out-of-pocket costs, and some other extra benefits that Medicare does not cover.

The standardized Medigap Plans and the benefits they provide are included in the premium comparison charts which is a separate insert to this Guide.

Plan A covers the basic core benefits (as shown on the chart). The remaining Plans B-D, F, High Deductible F, G, K-N cover the basic benefits. They also may contain coverage for additional benefits such as the Part A deductible and doctors' charges that exceed the amount "approved" by Medicare. Please refer to the "What Medigap Plans Cover" chart contained in the Premium Charts insert for this information. Plans K and L have annual out-of- pocket limits that change each year. After you meet the annual out-of-pocket limit, these Plans will pay all Medicare Parts A and Part B copayments and coinsurance amounts for the rest of the calendar year. Any "excess charges" above the Medicare approved amount will not count toward the out-of-pocket limit and you will have to pay those charges yourself.

Each company can choose which Plans it offers. The benefits in any of the Plans are the same for any insurance company. This Guide allows you to compare the premium for certain ages for the Plans offered by each company.

The chart **(see insert)** gives you a quick look at the standardized Medigap Plans and their benefits. An insurance company must make Medigap Plans A, and C or F available if it offers any other Medigap Plan.

How to read the chart: If an "X" mark appears in the column, this means that the Medigap policy pays that benefit up to 100% of the Medicare-approved amount. If a column lists a percentage, this means the Medigap policy covers that percentage rate of the described benefit. If no percentage appears or if the column is blank, this means the Medigap policy doesn't include that benefit.

Note: The coverage of coinsurance only begins after you have paid the deductible unless the Medigap policy also pays the deductible.

Generally, when you buy a Medigap policy, you must have Medicare Parts A and B. You will have to pay the monthly Medicare Part B premium and a premium for the Medigap policy. If you want Medigap coverage for you and your spouse, you will need to buy separate policies, one for each of you.

It is important to remember that none of the Medigap plans will cover long-term care services such as care to help you bathe, dress, eat or use the bathroom, nor will they cover private duty nursing. The plans also do not cover vision, dental care, hearing aids, or eye glasses unless the policy provides new or innovative benefits.

Medigap Insurance Options for the Disabled Under Age 65

Under federal law, if you become eligible for Medicare Part B benefits before age 65 because of a disability including End-Stage Renal Disease – (ESRD) or Amyotrophic Lateral Sclerosis-ALS (Lou Gehrig's Disease) you are guaranteed the Medigap policy of your choice when you reach age 65. Beginning with the first day of the first month in which you become 65 years of age, and you are enrolled for benefits under Medicare Part B, you cannot be refused a Medigap insurance policy because of your disability or for other health reasons. Since Medicare counts as creditable coverage, you will not have to wait for coverage of pre-existing conditions unless you have been covered under Medicare for less than six months.

With only a few exceptions, Medigap policies for the disabled under the age of 65, are not guaranteed issue. This means that the company will ask medical questions and may refuse to cover some types of medical conditions.

Some companies may offer Medigap insurance to you if you are a disabled person on Medicare and are currently insured with them. You may wish to check with your present insurance company to see if it will provide you with a Medigap policy.

Supplemental Medicare Coverage Through a Retirement Plan

Some people have the option of supplementing their Medicare coverage through an employer's retirement plan. If your retiree policy provides unlimited prescription drug benefits, or other benefits not covered by Medicare or the supplemental options covered in this Guide, you should think seriously before dropping the policy for a less expensive choice. In most cases, you will not be able to get the retiree policy back once you have dropped it. Make sure to find out the policy's limitations and if it includes coverage for spouses.

Insurance Outreach

The Life and Health Division of the Bureau of Insurance offers free consumer outreach programs on a number of insurance topics. Speakers will talk to your group or organization on the insurance topic you choose, and will try to help answer any general questions you have about insurance.

For more information, please contact:

Bureau of Insurance
Life and Health Division
Insurance Outreach Coordinator
P.O. Box 1157
Richmond, VA 23218
Toll Free 1-877-310-6560
Local 804-371-9092
Web site – http://www. scc.virginia.gov/boi
E-mail address – L&HOutreach@scc.virginia.gov

Insurance Company Ratings

In addition to the information we have provided in this Guide, many consumers inquire as to how they may obtain independent ratings on insurance companies. Information is available from a number of rating services, and may be obtained from many local university libraries free of charge. Reference librarians at these facilities are usually available to provide assistance to consumers. The Bureau of Insurance does not maintain its own rating services, but can tell you if a company is licensed in Virginia. You may contact the following rating organizations by telephone or website. There may be a fee:

A.M. Best **1-908-439-2200**
Web site – http://www.ambest.com

Standard & Poor's **1-877-772-5436**
Web site – http://www.standardandpoors.com **1-212-438-2400**

Moody's **1-212-553-0377**
Web site – http://www.moodys.com

Fitch Ratings **1-800-893-4824**
Web site – http://www.fitchratings.com

TheStreet.com/Ratings **1-800-706-2501**

The Bureau of Insurance does not endorse any of the above rating services. If you choose to subscribe to any rating services, please keep in mind that their ratings serve as an indicator and not as a guarantee of solvency.

VIRGINIA MEDIGAP POLICIES
HOW TO READ THE CHARTS

The following information is provided for each company:

Insurance Company Name/Telephone Number/ Web site Address:

Information included in this Guide was compiled through a survey of all companies licensed to sell Medigap policies in Virginia. If a company is not listed in this Guide, it may not be authorized to sell Medigap insurance products in Virginia or chose not to have its rates included in this Guide. The telephone number and website address identified in the charts should be used to obtain information from a company about its Medigap policies.

Policy Fee:

A policy fee is a one-time charge; it is in addition to and separate from the premium. It usually is intended to cover some of the insurer's administrative costs in issuing the policy.

Area:

"A" means the company does not differentiate rates by area and charges the same premium in all parts of Virginia.

"Z" means the premiums can differ by zip code or area of the state in which you live. For those insurers whose premiums vary by zip code, premium figures shown are for Richmond residents.

Sex:

Unless otherwise stated, premiums are the same for male and female.

Prem Type (Premium Type):

All health insurers must choose a method to "rate" your Medigap premiums. The "rating" method is used in calculating your initial premium and indicates whether your premium will change each year due to a change in your age. Three different premium types (Attained Age, Issue Age, Community) are represented in the comparison tables and are explained below. When deciding which premium type best suits your needs, you should carefully consider the potential differences in premiums over the long term of the policy rather than simply comparing initial costs.

"AA" (Attained Age) Premiums are based on the covered individual's age at the time of application of the policy or certificate. Premiums will increase as he or she ages, regardless of his or her age when he or she first enrolled.

"IA" (Issue Age) Premiums are based upon the covered individual's age at the time of purchase of the policy or certificate. Premiums do not increase due to increases in age.

"COMM" (Community) means the premium will be the same for all ages in the same geographical area.

Guar Issue (Guaranteed Issue):

"Y" means the company cannot reject you for health reasons.

"N" means you can be rejected for health reasons (after the six-month open enrollment period).

Crossover:

"Y" means that Medicare will forward your claims directly to the insurance company through which you have your Medigap policy because the company is included in a crossover contract with Medicare.

"N" means that Medicare will not forward your claims directly to the company through which you have your Medigap policy except when required to do so when you use a participating provider. When you do not use a participating provider, you must submit your claims to the insurance company.

Pre-Ex Wait (Pre-existing Condition Waiting Period):

This shows the number of months you will have to wait before the conditions will be covered (medical conditions that existed, were diagnosed, or were being treated before you applied for Medigap insurance).

Date Approved:

This column shows the date the premium rates were approved by the Bureau of Insurance.

Premiums:

Annual premiums shown are subject to change. We recommend you contact the insurance company to verify product information and current rates.

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