Medicare Supplement Insurance

A Guide for Consumers

PRINTED 6/02

The Florida Department of Insurance

Are You Prepared?

Contents

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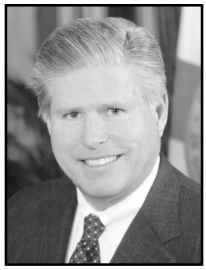

Dear Consumer:

The need for insurance is a fact of life in many situations. Knowing how our insurance policies work, in addition to having the correct type and amount of insurance, can help us recover financially when our lives are beset by such things as illness, car accidents, natural disasters or even death. And since the insurance industry and insurance policies often change, it's essential to keep abreast of new developments.

The Florida Department of Insurance publishes a variety of consumer guides to help you in this task. They include: *Automobile Insurance* (also available in Spanish), *Life and Annuities, Small-Business Owner's Insurance, Insuring Your Home, Health Maintenance Organization, Long-Term Care Insurance and Other Options for Seniors* and *Medicare Supplement Insurance.* Each guide contains basic information, definitions of common terms and tips on selecting an insurance agent and company. Each guide also details your rights and responsibilities as an insurance consumer. You can have any of our guides sent to you by filling out and mailing the order form at the back of this guide, or by calling the Florida Department of Insurance Consumer Helpline toll-free at 1-800-342-2762.

If you have questions after reading this guide, please call our Insurance Consumer Helpline toll-free at 1-800-342-2762 between 8 a.m. and 4:45 p.m. Monday through Friday. The hearing impaired may use a TDD to call 1-800-640-0886. You may also contact the service office in your area (listed inside the back cover of this guide).

Sincerely,

Tom Gallagher
Florida's Treasurer, Insurance Commissioner
and State Fire Marshal

If you have an insurance question or problem, call the:

INSURANCE

CONSUMER *Helpline*

1-800-342-2762

TDD Users Only

Telecommunications **D**evice for the **D**eaf

1-800-640-0886

Internet

Browse the Florida Department of Insurance Web site at:
www.fldoi.com

Service Offices

DAYTONA BEACH
955 Orange Ave., Suite E
Daytona Beach 32114-4674
(386) 254-3920

FORT LAUDERDALE
499 N.W. 70th Ave.
Suite 301B
Plantation 33317-7574
(954) 327-6027

FORT MYERS
2295 Victoria Ave.
Suite 163
Fort Myers 33901-3867
(941) 332-6948

JACKSONVILLE
9000 Regency Square Blvd.
Suite 201
Jacksonville 32211-8100
(904) 727-5505

MIAMI
401 N.W. 2nd Ave.
Suite N-307
Miami 33128-1700
(305) 377-5235

ORLANDO
400 W. Robinson St.
Suite N-401
Orlando 32801-1794
(407) 245-0870

PENSACOLA
160 Governmental Center
Suite 515
Pensacola 32501-5739
(850) 595-8040

ST. PETERSBURG-LARGO
11351 Ulmerton Rd.
Suite 240
Largo 33778-1636
(727) 588-3638

TALLAHASSEE
Larson Building
200 E. Gaines St.
Tallahassee 32399-0323
(850) 922-3132

TAMPA
5309 E. Fowler Ave.
Tampa 33617-2221
(813) 987-6741

WEST PALM BEACH
400 N. Congress Ave.
Suite 210
West Palm Beach
33401-2913
(561) 681-6392

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Medicare Supplement Insurance

What Is Medicare Supplement Insurance?

Chances are, if you picked up this guide, you are somewhat familiar with Medicare – a federally funded health insurance program for those age 65 and older, and for the disabled. Although Medicare may pay a large part of your health care expenses, it does not pay for them all. Some services and medical supplies are not fully covered. You must also pay certain amounts, called co-payments and deductibles. Please contact your local Social Security office for a free copy of the Medicare handbook and an explanation of what it covers.

Private insurers offer Medicare supplement policies under 10 different standard plans, which fill some of the gaps not covered by Medicare. Two of the 10 standard plans have an additional option (See Chart B on pages 24 and 25 for an outline of the 10 plans and

additional options.) These are the only plans that may be sold as Medicare supplement insurance policies in Florida. Insurers may offer "group" and/or "individual" policies. **Group** insurance covers a number of people or groups under one policy, usually through employers or associations. **Individual** insurance covers one person. Both types of policies are sold by agents and through the mail. Coverage and prices vary widely among policies.

Federal and state governments do not sponsor Medicare supplement insurance. Do not believe agents or insurance advertisements that imply otherwise.

Do I Really Need Medicare Supplement Insurance?

Not everyone needs Medicare supplement insurance. You may have other options. For example:

- **You may not need any insurance.** Your savings may cover health care expenses that exceed what Medicare will pay.

- **You may qualify for full Medicaid benefits.** If your income falls below a certain level, you may qualify for Medicaid, a federal and state health care program. If you fully qualify, you probably should not buy Medicare supplement insurance. However, you should enroll in the federal Medicare program because the

two programs combined will cover most of your health care costs. If you qualify for both Medicare and standard Medicaid benefits, an insurance company cannot sell you a Medicare supplement policy unless the state pays your premiums.

In addition to the standard Medicaid program, the state Medicaid offices offer two other programs to help certain low-income Medicare beneficiaries meet health care costs.

You may qualify for the **Qualified Medicare Beneficiary (QMB)** program. Individuals with income at or below the federal poverty level may qualify for the QMB program. This program pays Medicare's premiums, deductibles and coinsurance amounts for certain elderly and disabled persons who qualify for Medicare Part A, whose annual income falls below the federal poverty level and whose savings and other resources are very limited. If you qualify for this program, insurers may not sell you a Medicare supplement policy unless it includes coverage for prescription drugs, such as plans H, I or J.

Or, you may qualify for the **Specified Low-Income Medicare Beneficiary (SLMB)** program. The SLMB program is for persons entitled to Medicare Part A, and whose incomes are slightly higher than the national poverty level. If you qualify for assistance under the SLMB program, the state will pay your Medicare Part B premium. You will be responsible for Medicare's deductibles, coinsurance and other related charges. For more information on these two programs,

contact your Medicaid office, call 1-800-MEDICARE (1-800-633-4227), or log on to www.medicare.gov.

You may belong to or join a Medicare-contracted health maintenance organization (HMO). HMOs are health care alternatives to traditional health insurance. Some HMOs in Florida contract with the federal Centers for Medicare & Medicaid Services, or CMS (formerly the Health Care Financing Administration) to provide supplemental health care. If you belong to a Medicare HMO, you do not need Medicare supplement insurance. Such an HMO will provide both Medicare hospital and medical benefits. Please be aware that Medicare HMOs are not available in all counties. In some cases, the HMO will provide services that Medicare doesn't cover, such as preventive care (i.e., annual physical exams and health education). The HMO will pay all medical professionals (such as anesthesiologists, x-ray technicians, etc.) who provide covered services. You should not receive bills from such professionals. In addition, the HMO membership may help you save money on prescription drugs. However, HMOs will generally require that you use certain hospitals and doctors.

During a Medicare HMO's open enrollment period, you cannot be denied coverage because of health conditions, other than permanent kidney failure. The specific rules that guide Medicare HMO subscribers differ from fee-for-service health care and Medicare supplement insurance. For more information on eligibility, premiums and membership rules,

contact your local Social Security office. You may use the form in the back of this booklet to order a free consumers' guide on HMOs, which contaings a listing of approved Medicare HMOs by county. You may also get a copy of the 2002 Medicare handbook from your local Social Security office.

Because of recent changes in federal law, the Florida Department of Insurance has heard from many consumers with concerns about the withdrawal of Medicare HMO service in a number of counties. However, the Department has no jurisdiction over these federal contracts.

Consumers ages 65 and older whose HMO coverage expires may choose from several alternative courses of action. Such choices may include enrolling in another Medicare HMO, if available; returning to the traditional Medicare program; and obtaining one of the following types of Medicare supplement plans – A, B, C or F – located on pages 24-25. For a list of other options, you may request the guide *Health Insurance for People with Medicare* by calling the Insurance Consumer Helpline toll-free at 1-800-342-2762, or by calling Medicare directly at 1-800-MEDICARE (1-800-633-4227). You may also access Medicare's Web site, www.medicare.gov. You must exercise the option to buy the policy within 63 days of the cancellation of your Medicare HMO contract.

Your group policy may provide adequate coverage. If you are covered by a group insurance policy before you retire, you may be able to continue that policy after retirement.

Continuation of existing coverage can mean you will not have to wait before "pre-existing" medical conditions are covered. Group policies are sometimes less expensive than individual policies, and may offer benefits such as prescription drugs and routine dental care. But employer group insurance is not necessarily Medicare supplement insurance, and does not fall under the same rules. Furthermore, group insurance may not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. If you can continue your employer group coverage, be sure to ask how it covers the gaps not covered by Medicare, for what length of time benefits continue, and whether your spouse will remain covered in the event of your death. If you have a spouse younger than 65 who was covered under an earlier policy, make sure you know what effect your continued coverage will have on his or her insurance protection. Your employer or group insurance representative can answer these questions.

You may obtain a Medicare supplement plan even if it duplicates your retiree health plan benefits. However, this may not serve your best interests. Medicare supplement policies must pay full benefits even if the retiree plan pays for the same service. However, if the retiree health plan contains a coordination of benefits clause, it will not pay duplicate benefits.

Basic Facts about Medicare Supplement Insurance

Florida residents can buy any one of 10 standard Medicare supplement plans as their Medicare supplement insurance. Chart B on pages 24 and 25 summarizes the benefits of each plan. Under Florida law, any sale that will provide an individual with more than one Medicare supplement policy is prohibited. Any additional supplement coverage sold must include a signed statement from the individual that it will replace the existing policy. This standardization of Medicare supplement policies offers many advantages to Florida consumers, including:

Simplification – Insurance companies that sell Medicare supplement policies in Florida can only provide 10 standard plans for you to choose from. All companies that sell Medicare supplements in Florida must offer Plan A. Remember, you can buy only one Medicare supplement policy.

Consistency – All companies must consistently label their plans. This labeling includes Plans A through J, depending upon what each company offers. The benefits for each plan are identical from company to company. For example, Plan B offered by one company has the same coverages and benefits as Plan B offered by another company. Only the companies' services and premiums may vary.

Premiums

For policies currently being issued in Florida, premiums are established on an issue-age basis. **Issue age** means the premiums depend on the policyholder's age at the time of purchase. Premiums may increase due to benefit changes or overall premium adjustments, but not due to advancing age.

Before Oct. 1, 1993, however, Floridians could buy policies on an **attained** or **uniform** age basis. This meant the premiums depended on their age at the latest policy anniversary, or on other factors. Insurance companies no longer use such methods to calculate premiums, except for policies sold before this date that remain intact.

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

When a company increases its premiums, it must do so for an entire policy class. It cannot single you out and raise your premiums based on your health or the number of claims you have filed.

Protection against duplicate coverage – Duplicate coverage is expensive and unnecessary. Therefore, companies and their agents may provide you, by law, only one policy. Agents may not sell you a Medicare supplement policy if you already have one and do not want to replace it.

Pre-existing conditions – A **pre-existing condition** refers to an illness diagnosed or treated, or an illness for which an ordinary, prudent person would have sought treatment or diagnoses within six months before a policy's issue date. Florida law limits the reduction or limitation of coverage for these conditions to six months.

Credit for Continuing Coverage – Florida law protects consumers changing from one policy to another. If a Medicare supplement policy replaces another Medicare supplement policy or other creditable coverage, the replacing insurer must waive any time periods applicable to a pre-existing conditions clause by the length of time under the previous coverage. Most major medical insurance will qualify as creditable coverage.

Therefore, if an individual has six months or more of continuous coverage when applying for a new policy, the insurer would not apply

the pre-existing condition exclusion. If the individual has three months of previous continuous coverage, the insurer would reduce the pre-existing condition exclusion from a six-month period to three months.

Guaranteed renewal – All individual Medicare supplement plans sold in Florida must be **guaranteed renewable**. This means Florida law prohibits companies from canceling these policies except for nonpayment of premium or for a "material misrepresentation" on your original application. **Material misrepresentation** means deliberately providing false information or leaving out key facts.

Open enrollment periods – Many companies offering Medicare supplement policies reserve the right to underwrite your application — to ask you questions about your health and habits — when deciding whether or not to issue you one of their policies. Although underwriting is a legal and acceptable business practice, federal law requires all companies to provide residents with an **open enrollment period** when the company must accept your application and cannot discriminate in the pricing of the policy, regardless of your medical history, health status or claims experience.

Your open enrollment period for Medicare supplement insurance begins the first day of the month in which you turn 65 and are enrolled in Medicare Part B. If your birthday falls on the first day of the month, however,

your Medicare Part B coverage and your Medicare supplement insurance open enrollment begin the first day of the previous month.

In addition, if you are 65 years or older and enrolled in Medicare Part B, you have a two-month open enrollment period when you are changing from a group health insurance policy to a Medicare supplement insurance policy.

Persons receiving Medicare before age 65 because of a disability or end-stage renal disease can also take advantage of open enrollment when they turn 65. If you fall into this category, you will qualify for a six-month open enrollment period for Medicare supplement insurance as outlined above.

For most others, you can determine whether you are in your open enrollment period by checking your Medicare card for your Part B coverage effective date. Add six months to that date. If the current date falls within that six-month period, you may participate in open enrollment.

During open enrollment, a company cannot refuse to issue you any of their Medicare supplement policies or discriminate in the pricing of these benefits because of health status, claims experience, receipt of health care or medical condition. Although this provision guarantees that your policy will be issued, Medicare supplement insurance companies may impose the same waiting period for pre-existing conditions that they apply to policies sold outside the open enrollment period.

Regulations for your protection — A number of statements must appear on any Medicare supplement application (or on a separate form) to help ensure that Florida policyholders are aware of their Medicare supplement options. These statements include the following:

- You do not need more than one Medicare supplement policy.

- If you are 65 or older, you may qualify for benefits under Medicaid and may not require a Medicare supplement policy.

- The benefits and premiums under your Medicare supplement policy will be suspended for 24 months during your entitlement to benefits under Medicaid.You must request the suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

- Counseling services may be available in your community to provide advice

concerning your purchase of Medicare supplement insurance.

- Be sure you read and understand these statements before you sign the form.

- Agents who sell Medicare supplement insurance plans must ask questions to determine if you have other Medicare supplement or health insurance policies. Your responses are important. Companies must report this information to the Florida Department of Insurance.

What about Medicaid Eligibility?

You may buy Medicare supplement insurance and later qualify for Medicaid. If so, you may suspend your Medicare supplement coverage for up to 24 months. To do so, you must make a written request to the insurance company within 90 days of qualifying for Medicaid. During the suspension period, you are not charged premiums and you do not receive benefits from the Medicare supplement policy.

You may become ineligible for Medicaid within 24 months of the suspension of your Medicare supplement policy. If so, your insurer must reinstate your Medicare supplement policy. You must notify your company, however, within 90 days after becoming ineligible for Medicaid.

What about New Medicare Options?

The options you have to choose from for covering the expenses that Medicare does not change from time to time.

Seniors may choose between original Medicare and several health care alternatives. Here are some of the options currently available.

Medicare + Choice (Medicare Plus Choice) – These plans provide health care services to enrolled members under a contract with Medicare. These plans offer care in return for regular payments from Medicare, and may reduce your out-of-pocket expenses or provide additional benefits.

There are two Medicare + Choice options:

- *Medicare "managed care" plans* – This option features a network of Medicare-approved doctors and hospitals, which includes Medicare HMOs and provider sponsored organizations (PSOs). Some plans may restrict your health care access

to only those professionals within the network, while others may allow you to use outside doctors or hospitals for an extra fee.

- *Private "fee-for-service" plans* – With these plans you choose a private insurance plan that accepts Medicare beneficiaries. The plan provides benefits in return for federal compensation. Plan administrators decide how much to pay for covered services; however, your health-care provider may charge you a limited fee for what your plan does not pay. You will also likely owe a regular premium in addition to your Medicare Part B premium.

In considering Medicare + Choice, seniors should realize that the availability of some options depends upon private business and marketing decisions. It may take several years, if ever, for some of these options to become available in your area. If you enroll in a Medicare + Choice plan, then you do not need any other Medicare supplement coverage.

Religious fraternal benefit plan – Only members of a particular society may join one of these plans. The society must meet Medicare and federal tax standards.

Medicare medical savings account (MSA) – You obtain a health insurance policy with a high yearly deductible. Medicare pays a regular premium, which it deposits into your savings account. You can build up this account to pay for extra medical costs. However, you

must pay a "high deductible," which often costs several thousand dollars for covered services. In addition, providers can charge you any amount beyond what your plan will pay.

"High deductible" plans –"High deductible" plans – Some beneficiaries may like controlling costs through a high deductible, but may not want to obtain an MSA. The law allows — but does not require —insurance companies to offer two new Medicare supplement plans. These "high deductibile" options that fall under plans F and J, like the remaining standard plans, fill some costs not covered by Medicare. For 2002, the policyholder must pay a $1,620 deductible annually for covered services. This amount will increase in future years.

In considering Medicare + Choice, seniors should realize that the availability of some options depends upon private business and marketing decisions. It may take several years, if ever, for each option to become widely available.

Medicare HMOs

See "Medicare + Choice" in this section, or page 4 of this guide.

Seniors with general Medicare questions may call 1-800-MEDICARE (1-800- 633-4227), or the Elder Helpline at 1-800-96-ELDER (1-800-963-5337). They may also log on to the Medicare's Web site at www.medicare.gov.

Medicare Select Policies

"Medicare Select" began as a demonstration program in 15 states, including Florida, but was later expanded to include all 50 states.

Medicare Select offers the same basic coverage as the 10 standard plans available through traditional Medicare supplement insurance. However, companies may require consumers who obtain Medicare Select policies to use a specific network of health care providers and/or facilities. Except for an emergency case, it depends upon the company policy whether your coverage will include care from a physician outside the network. Insurance companies usually charge lower premiums for Medicare Select policies than for traditional Medicare supplement policies.

When a Medicare Select policyholder receives covered services from a network provider, Medicare will pay its share of the approved charges. The Medicare Select plan will cover the rest up to the limits of the policy. In general, Medicare Select polices will deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges in such situations.

Medicare Select Companies

The following list shows some of the companies offering Medicare Select policies in Florida as of December 2001. This list may change due to factors such as consumer demand and marketing decisions. Companies other than those listed here may offer Medicare Select policies. You may wish to contact companies that offer Medicare supplement insurance in Florida to see if they also offer Medicare Select policies.

American Pioneer Life Insurance Co.
(407) 628-1776

Bankers Life and Casualty Co.
1-800-621-3724

Blue Cross and Blue Shield of Florida, Inc.
1-800-876-2227

Continental Life Insurance Co. of Brentwood, Tenn.
(615) 377-1300

Gerber Life Insurance Co.
1-800-253-3074

Mutual of Omaha
1-800-775-6000

Physicians Mutual Insurance Co.
1-800-228-9100

Pyramid Life Insurance Co.
1-800-444-0321

State Mutual Insurance Company
1-888-717-6200

***United Healthcare Insurance Co.**
(860) 702-5000

*Available only to members of the American Association of Retired Persons

If You Have a Policy Other than one of the Standard Plans

Medicare supplement policies sold in Florida on or after Jan. 1, 1992 must be one of 10 standard plans. However, policies issued with an effective date before 1992 are still valid.

If you have a policy issued before 1992, you may replace it with one of the 10 standard plans. However, if you switch to one of the standard plans, you will not be allowed to go back to your old policy.

You do not need to replace your existing policy with one of the 10 standard plans. Many policies with an effective date before 1992 include coverages and benefits not found in any of the 10 standard plans. Also, their premiums may cost less than a comparable new policy. Before you make any changes, compare all benefits and rates between your existing policy and any new policy. (See page 46 for a comparison-shopping checklist and contact your current company for any additional questions about your existing policy.) To ensure continuous coverage, do not cancel your existing policy until you receive confirmation that your new policy has taken effect.

Effects of Other Coverage on Your Medicare Supplement Policy

In addition to your Medicare supplement policy, you may be considering or have already bought other health coverage, such as a major medical plan, indemnity plan, or a limited benefit plan such as a cancer-expense plan. Although a Floridian may own any of these plans, this may create a duplication of coverage when combined with Medicare and a Medicare supplement policy. This means you may pay twice for the same coverage. Federal law now requires that a statement appear on the policy that discloses this information. Policyholders who obtain Medicare supplement insurance usually do not need other coverage.

Comparison Shopping Examples for Medicare Supplement Insurance

The next few pages contain charts and other benefit summaries that:

- describe what Medicare pays,
- outline the 10 standard Medicare supplement plans and
- offer a checklist for comparison shopping.

You may use the checklist on pages 49-50 to compare the services and costs among companies once you become familiar with the

benefits of Medicare and supplemental insurance plans A-J.

Each of the 10 standard Medicare supplement plans offers a different combination of benefits. Be sure you understand plan differences.

All companies selling Medicare supplement insurance in Florida must provide Plan A. In addition, they may provide any of the remaining nine standard plans, but do not necessarily have to do so. Discuss the combination of benefits for each plan with your agent.

Chart A — Medicare Pays

What Medicare Pays		
Services	**Medicare Pays in 2002**	**For Each Period**
***HOSPITALIZATION (PART A)**		
Semiprivate room and meals, general nursing and miscellaneous services and supplies	All but $812	First 60 days
	All but $203/day	61st-90th days
	All but $406/day	91st day and after: while using 60 reserve days
	Nothing	After 150 days
***SKILLED NURSING FACILITY CARE**		
Semiprivate room and meals, skilled rehabilitative and nursing services and miscellaneous services and supplies (after a three-day hospital stay)	All approved costs	First 20 days
	All but $101.50/day	21st-100th days
	Nothing	101st day and after
BLOOD		
When provided during a covered stay	Blood– First three pints	Per calendar year

**Payments depend upon a "benefit period," which begins on the first day you receive services as an inpatient in a qualified hospital. This period ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.*

Chart A — Medicare Pays (continued)

What Medicare Pays		
Services	**Medicare Pays in 2002**	**For Each Period**
HOSPICE CARE		
Care for the terminally ill (pain and symptom relief and other services)	All but very limited charges for outpatient drugs and inpatient respite care	Available as long as your doctor certifies need
MEDICAL EXPENSES (PART B)		
Physician's services, inpatient and outpatient services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment	80 percent of approved amount after an annual $100 deductible; 50 percent for most outpatient mental health services	Per calendar year
CLINICAL LABORATORY SERVICES		
Blood tests, urinalysis, etc.	Generally 100 percent of approved amount	Per calendar year
****HOME HEALTH CARE FOR MEDICARE-APPROVED SERVICES**		
Medically necessary skilled care, home health aid services and medical supplies	100 percent	Unlimited
Durable medical equipment	80 percent	Unlimited

***Available if you lack Part A.*

Chart B — Outline of Standardized Plans

Plan A	Plan B	Plan C	Plan D	Plan E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

Chart B — Outline of Standardized Plans (continued)

Plan F / F*	Plan G	Plan H	Plan I	Plan J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care

** Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses reach $1,620. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plan J the Plan's separate prescription drug deductible or, in Plans F and J, the Plan's separate Foreign Travel Emergency deductible.*

Do you need Part B?

You may not need to buy Medicare Part B if you work and otherwise qualify for Medicare, as long as you maintain coverage under your employer's group health insurance.

Before you obtain Part B, you should review what your group plan covers and how it coordinates with what Medicare pays. You will pay a monthly premium of $54 for 2002 once you enroll. Most enrollees have this premium deducted from their monthly Social Security check.

Except for the time you are covered by your employer's group plan, *your Part B premiums increase 10 percent for each year you delay enrollment past the year of your 65th birthday*.

If this situation applies to you, contact your local Social Security office before your 65th birthday.

Explanation of Standard Medicare Supplement Insurance Plans

Basic Benefits (Plans A-J)

Basic benefits must be covered in all standard plans. Basic benefits include:

- *Blood* - The first three pints, when provided during a covered stay;
- *Hospitalization (Part A)* - The coinsurance for Part A is $203 per day for days 61-90, and $406 per day for day 91 up to day 150, depending upon the lifetime-reserve days you use. You may use up to 60 of these days on a non-renewable basis. Coverage is for a lifetime maximum of 365 additional days after Medicare benefits end;
- *Medical Expenses (Part B)* - Part B coinsurance, generally 20 percent of Medicare-approved expenses after you satisfy a $100 deductible.

Optional Benefits

The standard plans carry a variety of optional benefits, including:

At-Home Recovery (Plans D, G, I, J)

Medicare provides coverage for certain home health services. This coverage applies to patients who are confined to their homes and

no longer need hospitalization, but still require intermittent skilled medical care, physical therapy, or speech therapy. A physician must recommend and monitor the treatment plan in order for Medicare to approve and cover these medically necessary services. *This coverage does not include personal care, such as assistance with activities of daily living (i.e. bathing, dressing, eating, or housekeeping services).*

Medicare supplement plans, however, with the at-home recovery benefit, do provide coverage on a short-term basis to help a person with activities of daily living. To receive this benefit, you must be recovering from injuries or surgery. You must also currently receive care under a Medicare-approved home health care plan, or you must have received care within the past six weeks.

If these requirements are satisfied, this benefit will pay actual charges up to $40 per visit for visits received under the Medicare-approved treatment plan. Maximum benefits include no more than seven visits in any one week (four hours constitute one visit), and $1,600 in any one calendar year. These benefits can be used up to eight weeks after your Medicare-covered home health care visits stop.

Basic Drugs ($1,250 Limit) (Plans H, I)

This benefit pays for 50 percent of the actual charges for prescription drugs after you satisfy the $250 outpatient calendar year deductible. The maximum benefit is $1,250 each calendar year.

Extended Drugs ($3,000 Limit) (Plan J)

This benefit pays for 50 percent of the actual charges for prescription drugs after you satisfy the $250 outpatient calendar year deductible. Plan J "High Deductible" does not cover the separate prescription drug deductible. The maximum benefit is $3,000 each calendar year.

Foreign Travel Emergency (Plans C-J)

This benefit covers emergency medical care. Coverage begins during the first 60 days of your trip outside the United States. Your Medicare supplement policy will pay 80 percent of the actual billed charges for covered care after you satisfy the $250 emergency medical care calendar year deductible. This benefit deductible is not covered under Plans F or J "High Deductible."

Part A Deductible (Plans B-J)

The 2002 deductible for Part A (hospitalization) is $812 per benefit period. Medicare supplement plans with the Part A deductible benefit will pay this deductible.

Part B Deductible (Plans C, F, J)

The 2002 deductible for Part B (medical) is $100 in a calendar year. Plans covering the Part B deductible will pay the $100 deductible.

Part B Excess (100 percent) (Plans F, I, J)

Plans with this benefit will pay 100 percent of the difference between the actual charges and

the Medicare-approved amount for Part B services. Such plans will pay for physician expenses that exceed the Medicare-approved amount, but still fall within charge limitations established by Medicare.

Part B Excess (80 Percent) (Plan G)

Plans with this benefit will pay 80 percent of the excess charges (described above).

Preventive Care (Plans E, J)

This option pays up to $120 per year for procedures not covered by Medicare, but determined by your physician to be medically appropriate. Examples include hearing tests, diabetes screenings, physical examinations, serum cholesterol screenings and thyroid function tests.

Skilled Nursing Coinsurance (Plans C-J)

Medicare pays 100 percent of approved skilled nursing care for days one to 20, and then it pays all but $101.50 per day (the coinsurance) for days 21-100. Medicare supplement plans with this benefit pay the $101.50 per day coinsurance for days 21-100.

Chart C – Sample Annual Premiums

Many companies sell Medicare supplement insurance in Florida. The sample premiums in the following list show company rates available as of December 2001. These companies may offer coverage in any county. This list may change since companies regularly enter or withdraw from the market.

The chart only includes premiums for individual contracts. The premiums shown are based on an issue-age policy for a 65-year-old male living in the Tampa area. Call your agent or company to determine your actual annual premium.

Inclusion of a company name here does not constitute an endorsement by the Department of Insurance.

Note: *These are only sample premiums*. In addition to age, premiums depend on many factors, such as place of residence, gender, smoking habits, and whether you buy the policy through an agent or directly from the company. Some companies charge less for direct sales, but a few charge more. You should check with each company for more information.

In addition, a company may be licensed to sell Medicare Supplemental insurance in Florida, but may not write coverage.

Key

The insurance companies listed on the following chart have differing underwriting criteria.

Some companies sell policies based on you meeting extensive **underwriting (U/W)** criteria. This means you will be required to answer questions concerning your health or take a medical exam to qualify for coverage. A pre-existing condition provision may still apply. However, all policies issued during the open enrollment period are sold on a guaranteed issue basis.

Other companies offer policies based on you meeting **limited-underwriting (L/U)** criteria. You may be required to answer a few questions concerning your health to qualify for coverage. A pre-existing condition provision may apply.

Finally, some companies sell policies on a **guaranteed-issue (G/I)** basis, which means you will not be required to answer health questions or take a medical exam to qualify for benefits. A pre-existing condition provision may still apply. Individual companies may have different requirements and conditions regarding guaranteed issue. Call the company for more information.

The criteria of individual companies are subject to change, and may vary according to your health.

SM – Smoker **NS** – Non-Smoker

* Policy sold directly by company

** Policy sold directly by company, but only to members of the American Association of Retired Persons

*** Policy available to members of the Mennonite Church in Florida

Chart C — Sample Annual Premiums

Plan A

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$1,220.10
(407) 628-1776	NS	$1,186.50
L/U		
Bankers Fidelity Life Insurance Co.		
Annual Premium:		
1-800-241-1439		
L/U		$1,330
U/W		$1,196
Bankers Life and Casualty Co.		
Annual Premium:		$1,369.30
1-800-621-3724		
U/W		
Blue Cross and Blue Shield of Florida Inc.		
Annual Premium:		$1,047.60
1-800-876-2227		
G/I		
Central States Health and Life Company of Omaha		
Annual Premium:		
1-800-541-2363		
SM		$987.46
NS		$897.69
Combined Insurance Company of America		
Annual Premium:		$1,126.76
1-800-544-5531		
L/U		
Conseco Direct Life Insurance Co.		
Annual Premium:		$1,397
1-800-523-4000		
L/U		

Company Name		Annual Premium
Constitution Life Insurance Co.		
Annual Premium:		
(407) 628-1776		
L/U		
SM		$1,273.65
NS		$1,158.15
Continental General Insurance Co.		
Annual Premium:		$1,157
(402) 397-3200		
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$1,041.60
(615) 377-1300		
U/W		
5 Star Life Insurancy Company		
Annual Premium:		
1-800-776-2322		
L/U		
SM		$936
NS		$864
Guarantee Trust Life Insurance Co.		
Annual Premium:		$1,596.15
1-800-338-7452		
U/W		
Medico Life Insurance Co.		
Annual Premium:		$1,003.95
(402) 391-6900		
L/U		

Plan A *(continued)*

Company Name	Annual Premium
Mennonite Mutual Aid Association Annual Premium: 1-800-348-7468 L/U	$581.39
Mutual of Omaha Insurance Co. Annual Premium: 1-800-775-6000 L/U	$1,260.86
Mutual Protective Life Insurance Co. Annual Premium: 1-800-228-6080 L/U	$1,003.95
National States Insurance Co. Annual Premium: 1-800-868-6788 U/W	$1,134
Nationwide Life Insurance Co. Annual Premium: 1-800-535-8600 L/U	$1,035
Order of United Commercial Travelers of America Annual Premium: 1-800-848-0123 L/U	$1,155.13
Oxford Life Insurance Company Annual Premium: (602) 263-6666 L/U	$1,482.98
Peoples Benefit Life Insurance Co. Annual Premium: 1-800-356-6271 G/I	$1,007.40
Physicians Mutual Insurance Co. Annual Premium: 1-800-228-9100 L/U	$1,077.60 $1,466.40*
Pyramid Life Insurance Co. Annual Premium: 1-800-444-0321 L/U	$1,020.80
Standard Life and Accident Insurance Co. Annual Premium: SM 1-888-350-1488 NS L/U	$1,399.66 $1,259.69
State Farm Mutual Automobile Insurance Co. Annual Premium: (309) 766-2311 L/U	$1,135.50
State Mutual Insurance Company Annual Premium: SM 1-800-321-0102 NS L/U	$1,358 $1,235
Union Bankers Insurance Co. Annual Premium: 1-800-824-3577 L/U	$1,159

Plan A *(continued)*

Company Name	Annual Premium
United American Insurance Co. Annual Premium: (972) 529-5085 L/U	$1,161
United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	$900**
USAA Life Insurance Co. Annual Premium: SM 1-800-531-8000 NS L/U	$1,062.35 $905.76

Plan B

Company Name	Annual Premium
American Pioneer Life Insurance Co. Annual Premium: SM (407) 628-1776 NS L/U	$1,668.45 $1,615.95
Bankers Fidelity Life Insurance Co.Annual Premium: 1-800-241-1439 L/U U/W	 $1,800 $1,620
Bankers Life and Casualty Co. Annual Premium: 1-800-621-3724 U/W	$1,797.26
Blue Cross and Blue Shield of Florida Inc. Annual Premium: 1-800-876-2227 G/I	$1,360.80
Central States Health and Life Company of Omaha Annual Premium: SM 1-800-541-2363 NS U/W	$1,535.12 $1,395.56
Conseco Direct Life Insurance Co. Annual Premium: 1-800-523-4000 L/U	$1,650
Continental Life Insurance Company of Brentwood, Tenn. Annual Premium: (615) 377-1300 U/W	$1,440
Constitution Life Insurance Company Annual Premium: SM (407) 628-1776 NS L/U	$1,735.65 $1,577.10

Plan B *(continued)*

Company Name	Annual Premium
5 Star Life Insurance Company Annual Premium: SM 1-800-776-2322 NS L/U	 $1,296 $1,200
Guarantee Trust Life Insurance Co. Annual Premium: 1-800-338-7452 U/W	 $2,131.30
Mutual Protective Life Insurance Co. Annual Premium: 1-800-228-6080 L/U	 $1,414.26
National States Insurance Co. Annual Premium: 1-800-868-6788 U/W	 $1,530
Nationwide Life Insurance Co. Annual Premium: 1-800-535-8600 L/U	 $1,370
Order of United Commercial Travelers of America Annual Premium: 1-800-848-0123 U/W	 $1,657.37
Oxford Life Insurance Co. Annual Premium: (602) 263-6666 L/U	 $1,918.80

Company Name	Annual Premium
Peoples Benefit Life Insurance Co. Annual Premium: 1-800-356-6271 G/I	 $1,631.40
Physicians Mutual Insurance Co. Annual Premium: 1-800-228-9100 L/U	 $1,767.60 or $1,784.28*
Pyramid Life Insurance Co. Annual Premium: 1-800-444-0321 L/U	 $1,421.20
State Mutual Insurance Company Annual Premium: SM 1-800-321-0102 NS L/U	 $1,804 $1,641
Union Bankers Insurance Co. Annual Premium: 1-800-824-3577 L/U	 $1,659
United American Insurance Co. Annual Premium: (972) 529-5085 L/U	 $1,609
United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	 $1,338**

Plan C

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$2,021.25
(407) 628-1776	NS	$1,971.90
L/U		
Bankers Fidelity Life Insurance Co.		
Annual Premium:		
1-800-241-1439		
L/U		$2,169
U/W		$1,952
Bankers Life and Casualty Co.		
Annual Premium:		
1-800-621-3724		
U/W		$2,053.51
Blue Cross and Blue Shield of Florida Inc.		
Annual Premium:		$1,815.60
1-800-876-2227		
G/I		
Central States Health and Life Company of Omaha		
Annual Premium:	SM	$1,774.95
1-800-541-2363	NS	$1,613.59
U/W		
Combined Insurance Company of America		
Annual Premium:		$1,829.75
1-800-544-5531		
L/U		
Conseco Direct Life Insurance Co.		
Annual Premium:		$1,881
1-800-523-4000		
L/U		

Company Name		Annual Premium
Constitution Life Insurance Company		
Annual Premium:	SM	$2,106.30
(407) 628-1776	NS	$1,915.20
L/U		
Continental General Insurance Co.		
Annual Premium:		$1,859
(402) 397-3200		
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$1,806
(615) 377-1300		
U/W		
5 Star Life Insurance Company		
Annual Premium:	SM	$1,512
1-800-776-2322	NS	$1,392
L/U		
Guarantee Trust Life Insurance Co.		
Annual Premium:		$2,389.50
1-800-338-7452		
U/W		
Medico Life Insurance Co.		
Annual Premium:		$1,848.82
(402) 391-6900		
L/U		
Mutual of Omaha Insurance Co.		
Annual Premium:		$1,970.76
1-800-775-6000		
L/U		
Mutual Protective Life Insurance Co.		
Annual Premium:		$1,848.82
1-800-228-6080		
L/U		

Plan C *(continued)*

Company Name	Annual Premium
National States Insurance Co. Annual Premium: 1-800-868-6788 U/W	$1,758
Order of United Commercial Travelers of America Annual Premium: 1-800-848-0123 U/W	$1,859.73
Oxford Life Insurance Co. Annual Premium: (602) 263-6666 L/U	$2,294.67
Physicians Mutual Insurance Co. Annual Premium: 1-800-228-9100 L/U	$2,020.80 or $2,175*
Pyramid Life Insurance Co. Annual Premium: 1-800-444-0321 L/U	$1,754.50
Standard Life and Accident Insurance Co. Annual Premium: SM 1-888-350-1488 NS L/U	$2,021.44 $1,819.30
State Farm Mutual Automobile Insurance Co. Annual Premium: (309) 766-2311 L/U	$1,542.20

Company Name	Annual Premium
State Mutual Insurance Company Annual Premium: SM 1-800-321-0102 NS L/U	$2,197 $1,998
Union Bankers Insurance Co. Annual Premium: 1-800-824-3577 L/U	$1,997
United American Insurance Co. Annual Premium: (972) 529-5085 L/U	$1,987
United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	$1,473**

Plan D

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$1,934.10
(407) 628-1776	NS	$1,876.35
L/U		
Bankers Life and Casualty Co.		
Annual Premium:		$1,967.87
1-800-621-3724		
U/W		
Blue Cross and Blue Shield of Florida Inc.		
Annual Premium:		$1,484.40
1-800-876-2227		
G/I		
Central States Health and Life Company of Omaha		
Annual Premium:	SM	$1,562
(402) 397-1111	NS	$1,420.10
L/U		
Conseco Direct Life Insurance Co.		
Annual Premium:		$1,771
1-800-523-4000		
L/U		
Constitution Life Insurance Company		
Annual Premium:	SM	$2,011.80
(407) 628-1776	NS	$1,829.10
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$1,903.20
(615) 377-1300		
U/W		

Company Name		Annual Premium
5 Star Life Insurance Company		
Annual Premium:	SM	$1,464
1-800-776-2322	NS	$1,356
L/U		
Guarantee Trust Life Insurance Co.		
Annual Premium:		$2,499.75
1-800-338-7452		
U/W		
Mutual of Omaha Insurance Co.		
Annual Premium:		$1,717.58
1-800-775-6000		
L/U		
Oxford Life Insurance Company		
Annual Premium:		$2,180.59
(602) 263-6666		
L/U		
Pyramid Life Insurance Co.		
Annual Premium:		$1,585.10
1-800-444-0321		
L/U		
State Mutual Insurance Company		
Annual Premium:	SM	$2,035
1-800-321-0102	NS	$1,850
L/U		
Union Bankers Insurance Co.		
Annual Premium:		$1,624
1-800-824-3577		
L/U		
United American Insurance Co.		
Annual Premium:		$1,803
(972) 529-5085		
L/U		

Plan D

Company Name	Annual Premium	Company Name	Annual Premium
United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	$1,473**	USAA Life Insurance Co. Annual Premium: SM 1-800-531-8000 NS L/U	$1,702 $1,544

Plan E

Company Name	Annual Premium	Company Name	Annual Premium
American Pioneer Life Insurance Co. Annual Premium: SM (407) 628-1776 NS L/U	$1,911 $1,854.30	Mennonite Mutual Aid Association Annual Premium: 1-800-348-7468 L/U	$1,141.97
Bankers Life and Casualty Co. Annual Premium: 1-800-621-3724 U/W	$2,010.42	Physicians Mutual Insurance Co. Annual Premium: 1-800-228-9100 L/U	$1,975.20
Continental Life Insurance Company of Brentwood, Tenn. Annual Premium: (615) 377-1300 U/W	$1,850.40	Union Bankers Insurance Co. Annual Premium: 1-800-824-3577 L/U	$1,682
5 Star Life Insurance Company Annual Premium: SM 1-800-776-2322 NS L/U	$1,524 $1,416	United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	$1,350**

Plan F

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$2,097.90
(407) 628-1776	NS	$2,044.35
L/U		
Bankers Fidelity Life Insurance Co.		
Annual Premium:		
1-800-241-1439		
L/U		$2,500
U/W		$2,250
Bankers Life and Casualty Co.		
Annual Premium:		
1-800-621-3724		
U/W		$2,210.27
Blue Cross and Blue Shield of Florida Inc.		
Annual Premium:		$2,056.80
1-800-876-2227		
G/I		
Central States Health and Life Company of Omaha		
Annual Premium:	SM	$2,001.69
1-800-541-2363	NS	$1,819.72
U/W		
Combined Insurance Company of America		
Annual Premium:		$2,102.40
1-800-544-5531		
L/U		
Conseco Direct Life Insurance Co.		
Annual Premium:		$2,002
1-800-523-4000		
L/U		
Constitution Life Insurance Company		
Annual Premium:	SM	$2,190.30
(407) 628-1776	NS	$1,991.85
L/U		
Continental General Insurance Co.		
Annual Premium:		$2,371
(402) 397-3200		
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$1,998
(615) 377-1300		
U/W		
5 Star Life Insurance Company		
Annual Premium:	SM	$1,656
1-800-776-2322	NS	$1,536
L/U		
Guarantee Trust Life Insurance Co.		
Annual Premium:		$2,983.40
1-800-338-7452		
U/W		
Medico Life Insurance Co.		
Annual Premium:		$1,952.61
(402) 391-6900		
L/U		
Mennonite Mutual Aid Association		
Annual Premium:		$1,477.54
1-800-348-7468		
L/U		
Mutual of Omaha Insurance Co.		
Annual Premium:		$2,003.63
1-800-775-6000		
L/U		

Plan F *(continued)*

Company Name	Annual Premium
Mutual Protective Life Insurance Co. Annual Premium: 1-800-228-6080 L/U	$1,952.61
National States Insurance Co. Annual Premium: 1-800-868-6788 U/W	$1,886
Nationwide Life Insurance Co. Annual Premium: 1-800-535-8600 L/U	$1,896
Order of United Commercial Travelers of America Annual Premium: 1-800-848-0123 U/W	$2,059.15
Oxford Life Insurance Co. Annual Premium: (602) 263-6666 L/U	$2,454.08
Peoples Benefit Life Insurance Co. Annual Premium: 1-800-356-6271 G/I	$2,351.40
Physicians Mutual Insurance Co. Annual Premium: 1-800-228-9100 L/U	$2,284.20 or $2,665.20*
Pyramid Life Insurance Co. Annual Premium: 1-800-444-0321 L/U	$1,894.20
Standard Life and Accident Insurance Co. Annual Premium: SM 1-888-350-1488 NS L/U	$2,170.14 $1,953.13
State Farm Mutual Automobile Insurance Co. Annual Premium: (309) 766-2311 L/U	$1,773.50
State Mutual Insurance Company Annual Premium: SM 1-800-321-0102 NS L/U	$2,276 $2,068
Union Bankers Insurance Co. Annual Premium: 1-800-824-3577 L/U	$2,258
United American Insurance Co. Annual Premium: (972) 529-5085 L/U	$2,117
United Healthcare Insurance Co. Annual Premium: (860) 702-5000 L/U	$1,626**
USAA Life Insurance Co. Annual Premium: SM 1-800-531-8000 NS L/U	$2,072 $1,888

Plan F *(High Deductible)*

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$1,198
(407) 628-1776	NS	$1,089
L/U		

Company Name	Annual Premium
Bankers Life and Casualty Co.	
Annual Premium:	$925.96
1-800-621-3724	
U/W	

Plan G

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$1,995
(407) 628-1776	NS	$1,934.10
L/U		
Bankers Life and Casualty Co.		
Annual Premium:		$1,781.77
1-800-621-3724		
U/W		
Continental General Insurance Co.		
Annual Premium:		$2,119
(402) 397-3200		
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$1,814.40
(615) 377-1300		
U/W		
5 Star Life Insurance Company		
Annual Premium:	SM	$1,584
1-800-776-2322	NS	$1,464
L/U		
Guarantee Trust Life Insurance Co.		
Annual Premium:		$2,821.30
1-800-338-7452		
U/W		

Company Name	Annual Premium
Medico Life Insurance Co.	
Annual Premium:	$1,914.78
(402) 391-6900	
L/U	
Mutual Protective Life Insurance Co.	
Annual Premium:	$1,914.78
1-800-228-6080	
L/U	
Peoples Benefit Life Insurance Co.	
Annual Premium:	$2,123.40
1-800-356-6271	
G/I	
Physicians Mutual Insurance Co.	
Annual Premium:	$2,037.60
1-800-228-9100	
L/U	
Pyramid Life Insurance Co.	
Annual Premium:	$1,637.90
1-800-444-0321	
L/U	
Union Bankers Insurance Co.	
Annual Premium:	$1,871
1-800-824-3577	
L/U	

Plan G *(continued)*

Company Name		Annual Premium
United American Insurance Co.		
Annual Premium:		$1,865
(972) 529-5085		
L/U		
United Healthcare Insurance Co.		
Annual Premium:		$1,590**
(860) 702-5000		
L/U		

Company Name		Annual Premium
USAA Life Insurance Co.		
Annual Premium:	SM	$1,938
1-800-531-8000	NS	$1,766
L/U		

Plan H

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$3,216.15
(407) 628-1776	NS	$3,130.05
L/U		
Bankers Life and Casualty Co.		
Annual Premium:		$3,770.04
1-800-621-3724		
G/I		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$2,492.40
(615) 377-1300		
U/W		
5 Star Life Insurance Company		
Annual Premium:	SM	$2,796
1-800-776-2322	NS	$2,580
L/U		

Company Name	Annual Premium
Union Bankers Insurance Co.	
Annual Premium:	$3,186
1-800-824-3577	
L/U	
United Healthcare Insurance Co.	
Annual Premium:	$2,136**
(860) 702-5000	
L/U	

Plan I

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$3,421.95
(407) 628-1776	NS	$3,331.65
L/U		
Bankers Life and Casualty Co.		
Annual Premium:		$5,032.21
1-800-621-3724		
G/I		
Continental General Insurance Co.		
Annual Premium:		$2,921
(402) 397-3200		
L/U		
Continental Life Insurance Company of Brentwood, Tenn.		
Annual Premium:		$3,442.80
(615) 377-1300		
U/W		
5 Star Life Insurance Company		
Annual Premium:	SM	$3,012
1-800-776-2322	NS	$2,772
L/U		

Company Name	Annual Premium
Mennonite Mutual Aid Association	
Annual Premium:	$2,354.18
1-800-348-7468	
L/U	
Oxford Life Insurance Co.	
Annual Premium:	$3,548.03
(602) 263-6666	
L/U	
Peoples Benefit Life Insurance Co.	
Annual Premium:	$2,675.40
1-800-356-6271	
G/I	
Union Bankers Insurance Co.	
Annual Premium:	$4,263
1-800-824-3577	
L/U	
United Healthcare Insurance Co.	
Annual Premium:	$2,178**
(860) 702-5000	
L/U	

Plan J

Company Name		Annual Premium
American Pioneer Life Insurance Co.		
Annual Premium:	SM	$4,510.80
(407) 628-1776	NS	$4,400.55
L/U		
5 Star Life Insurance Company		
Annual Premium:	SM	$5,340
1-800-776-2322	NS	$4,884
L/U		

Company Name	Annual Premium
United Healthcare Insurance Co.	
Annual Premium:	$2,172**
(860) 702-5000	
L/U	

Comparison Shopping Checklist

Your comparison-shopping checklist should evaluate various companies' premium rates and services, since coverage and benefits are standard.

The term "services" is broad, but your checklist should include such questions as:

- Will you buy your policy from a local agent or through the mail?
- Does the company have a toll-free number for answering your questions?
- Does the company have a conveniently located service office?
- What is the company's rating according to rating services? (See "How To Select An Insurance Company," page 58).
- How long is the pre-existing condition waiting period?
- Who will complete the paperwork for claims—you or the company?

Other Insurance for Seniors

Long-Term Care Insurance

Long-term care encompasses a wide range of medical, personal and social services. A person

may need this care if they suffer from prolonged illnesses, disabilities, or cognitive impairment.

Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a range of services generally not covered by your regular health insurance, or by Medicare or Medicare supplement insurance. Although long-term care policies are not standard like Medicare supplement insurance, resulting in a wide variety of policy designs, there are some standard provisions that long-term care policies sold in Florida adhere to. For the free guide *Long-Term Care Insurance and Other Options for Seniors*, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Home Health Care Policy

This type of policy covers services prescribed by a physician and from a Medicare-certified or a state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment (such as Alzheimer's disease or senility). Some companies offer home health care as an option or rider to a long-term care policy. A few companies offer policies that cover only home health care.

You may obtain more information about policy options from your agent.

Nursing Home Care Policy

This limited-benefit insurance policy offers an alternative for some people and covers either one level or several levels of care. The inability to perform one or more of the activities of daily living or cognitive impairment activates the benefit trigger of this care.

Also, in Florida, nursing homes must be licensed for both skilled nursing care and intermediate care. To verify whether a nursing home is licensed, call the Agency for Health Care Administration at 1-888-419-3456.

Life Insurance

A few companies offering life insurance policies also may offer long-term care coverage as a payout option. Under this

arrangement, a certain percentage of your life insurance benefits help to pay for long-term care.

Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs) offer independent living and usually maintain a long-term nursing care facility on the premises for residents who need it. Many CCRC facilities also offer amenities such as health clubs, transportation and social activities.

These facilities agree to furnish a resident shelter, food and health care in return for an entrance fee and monthly fees. Entrance fees cost $2,000 to more than $500,000, and monthly fees range from $250 to $5,000 or more.

For the free guide *Long-Term Care Insurance and Other Options for Seniors*, contact your local service office or call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Types of Care

As people begin to plan for their long-term care needs, they will hear references to various types of care, including skilled, intermediate and custodial.

Skilled care generally involves medical conditions that require care by trained medical

personnel, such as registered nurses or professional therapists. A physician orders this care, available 24 hours a day. It also involves a treatment plan.

People may need skilled care for a short time after an acute illness or injury, such as a stroke or hip fracture. However, some may require it for longer periods. A patient may obtain such care in a skilled nursing facility, nursing home or in a person's home with help from visiting nurses or therapists. Medicare and Medicaid each have separate definitions of skilled care that may differ from this definition.

Intermediate care refers to treatment needed daily but not necessarily for the entire 24-hour day. A physician orders this care, and registered nurses provide supervision. It involves less specialization than skilled care, but often requires more personal care.

Custodial care involves helping a person perform the activities of daily living, such as help with bathing, eating, dressing, going to the bathroom, and transferring (i.e., moving into or out of a bed, chair or wheelchair). It involves less intensive or complicated service than skilled or intermediate care, and can take place in many settings, including nursing homes, adult day care centers, or at home. Custodial care is sometimes called personal care.

Protecting your Privacy

Your Insurers and Financial Institutions

Under federal law, some banks and insurance companies may have the right to share sensitive and personal information about you with other entities and business interests - without your permission.

Fortunately, Florida laws, and rules established by the Florida Department of Insurance, provide a way for you to protect this personal information. As the policyholder, you must take the lead in protecting your personal information.

You may have already received, or soon will receive, a privacy notice from the financial and insurance companies you do business with. These forms give you the opportunity to tell the company that you want your personal information kept private. Unless you complete and return these forms, your personal financial and medical information may be shared with other companies. You may receive these forms on an annual basis, and be required to complete them to keep your information confidential.

When you receive a privacy notice form, read it carefully before signing it to avoid unintentionally giving the company permission to share information about you. If you have questions or concerns about these forms, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Medical Privacy and Medical Information Bureau

The Medical Information Bureau (MIB) is a data bank of medical and non-medical information on nearly 15 million Americans. Are you one of them? You may be if you have ever applied for health insurance from any of the MIB's 800 insurance company members.

The companies send the MIB any information you have written on any applications, enrollment forms, or requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports, when such information is legally obtainable.

If you have been denied life or disability insurance and wonder why, your file at the MIB may be the answer. Although the MIB's database seems like an invasion of your privacy, it prevents fraud and abuse of the nation's private insurance system. However, you have the right to make sure the information in your MIB file is correct. Call the MIB and ask for a copy of your records at (617) 426-3660, or access its Web site at www.mib.com.

Now that you know about the MIB, you understand why it is important to provide truthful information on any insurance application. If an insurer spots false information on an MIB report, that insurer may cancel your policy. Even worse, you may find it difficult to find coverage in the future.

Your Rights and Responsibilities

When you buy insurance, you have certain rights and responsibilities.

Your Rights

You have the right to receive an outline written in easy-to-understand language. The outline explains your policy's benefits, exclusions and limitations.

You have the right to receive copies of all forms and applications signed by you or the agent.

You have the right to receive your policy within 30 days. If you do not, contact the company and request a written explanation. If you haven't received an explanation within 60 days, contact the Insurance Consumer Helpline toll-free at 1-800-342-2762. Follow the same process if you return a policy and do not receive a refund.

You have the right to have 30 days to review a policy. This is called a free-look period. If you decide you do not want to keep the policy, return it to the company by certified or registered mail with the return receipt requested. You must do this within 30 days of receiving the policy to be eligible for a full refund.

You have the right to have your policy renewed unless you don't pay your premiums or deliberately give misleading information on your application. Your rate may change, but only if the company changes everyone else's premium in your policy class. You cannot be singled out and have your premium increased because of your health or the number of claims you have filed. A company cannot cancel your policy because of your age or any medical condition that occurs after you obtain your policy. Your policy will state the conditions under which the company may raise your premiums.

You have the right to appeal any claim denied as not medically necessary to a licensed physician designated by your insurer.

You have the right to receive a free copy of the federally approved buyer's publication *Guide to Health Insurance for People with Medicare* from the agent who sells the policy. This guide explains the Medicare program, Medicare supplement insurance, HMOs and other health insurance options for Medicare beneficiaries.

You have the right to have your claims paid promptly. If you use a participating Medicare physician or provider, he or she must file your Medicare and Medicare supplement claims for you. If you use a non-participating Medicare physician or provider, he or she must file your Medicare claim, but is not obligated to file your Medicare supplement claim. The physician or provider cannot charge you for filing claims.

You have the right to obtain a prompt refund of unearned premiums if you or your company cancels your policy.

You have the right to have pre-existing conditions excluded for no more than six months after your policy goes into effect. A pre-existing condition is an illness known about, diagnosed or treated before you buy a policy. Report all illnesses when applying for insurance. If your company learns of an unreported pre-existing condition, it may either refuse to pay claims or cancel your policy.

You have the right to a 30-day grace period to pay premiums. When this period expires, your insurance company may only cancel your policy for nonpayment of premium.

Your Responsibilities

You are responsible for reading and understanding your insurance policy.

You are responsible for reading and understanding any "explanation of benefits" forms sent by your insurance company. Such a form will usually state: "This is not a bill." However, you should still closely study it to find out whether you actually received the services described. You should contact your company for help if you don't understand the form or have trouble reading or speaking English. If your company doesn't send such forms, call to ask why; after all, careful scrutiny of these forms can help you and the insurer detect and fight fraud.

You are responsible for reporting suspected fraud to the Department of Insurance. For example, you might examine your health insurance records and find out that your insurance company was billed for services never rendered. If you suspect such a crime has occurred, call our Fraud Hotline toll-free at 1-800-378-0445.

You are responsible for making sure your application is correct. This includes information on pre-existing conditions. If you make a fraudulent misstatement, the company may cancel your policy or refuse to pay a claim.

You are responsible for knowing what your policy covers and excludes.

You are responsible for maintaining continuous coverage. Do not cancel your old policy before the company has accepted your application and your new policy is in force.

You are responsible for paying your premiums, even while involved in a dispute with your company. You are responsible for paying the deductibles outlined in your policy.

You are responsible for verifying licenses of an insurance agent and company by calling the Insurance Consumer Helpline toll-free at 1-800-342-2762. A business card is not a license.

Help with Your Insurance Questions

The Florida Department of Elder Affairs has developed a program to help seniors with their Medicare and health insurance questions.

SHINE (Serving Health Insurance Needs of Elders) trains senior volunteers to assist other seniors with their questions about Medicare, Medicare supplement, long-term care and other health insurance issues.

The Florida Department of Insurance serves as SHINE's technical advisor and recommends the program to senior consumers. To find out if a SHINE program is operating in your community, please contact the Elder Helpline toll-free at 1-800-96-ELDER (1-800-963-5337) or the Florida Department of Elder Affairs at (850) 414-2060.

How to Select an Insurance Agent

Most agents are reputable professionals who have been trained in their area of expertise. Insurance agents must take classes and pass certain tests to become licensed. Some agents choose to take further courses to obtain additional professional designations. These designations include:

LUTCF ... Life Underwriting Training Council Fellow
CFP ..... Certified Financial Planner
CEBS ..... Certified Employee Benefits Specialist
CIC ..... Certified Insurance Counselor
CLU ..... Chartered Life Underwriter
CPCU ..... Chartered Property and Casualty Underwriter
RHU ..... Registered Health Underwriter
ChFC ..... Charted Financial Consultant

When selecting an agent, choose one who is licensed to sell insurance in the state of Florida. Also, choose one with whom you feel comfortable and who will answer your questions. To verify whether an agent is licensed, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

How to Select an Insurance Company

When selecting an insurance company, it is wise to check on a company's rating. Several organizations publish insurance company

ratings, available in your local library or on the Web. These organizations include: A. M. Best Company, Standard and Poor's Corp. (S&P), Weiss Ratings Inc., Moody's Investors Service and Duff & Phelps. Companies are rated on a number of elements, such as financial data (including assets and liabilities), management operations and history. You may also wish to review a company's stock analysis reports.

Before buying insurance, verify whether a company is licensed to sell insurance in Florida by calling the service office in your area (listed on the back page of this guide) or the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Consumer Tips

- **Shop carefully before you buy.** Compare benefits, services and costs.

- **Take your time.** Professional agents do not pressure their customers. If you are unsure about a policy, ask your agent to explain it to you again in the presence of a friend or relative whose judgment you respect.

- **Mail-order policies may lack service.** Companies that sell mail-order policies may not have local agents or toll-free numbers, thus making it difficult to get answers to your questions. If a policy is sold through the mail, be sure to obtain contact information with a telephone number.

- **Read your policy and be sure you understand what it covers and excludes.** Know how your policy coordinates with other coverage you have.

- **Make sure all information on your application form is correct.** An incorrect form may cause your insurance company to cancel your policy or leave you with unpaid claims. Don't be misled by agents who tell you that your health history doesn't matter.

- **Describe your health status accurately.** It is best to fill out this information yourself. If the agent fills it out, don't sign it until you've made sure all the information is correct. If you pay someone to fill out health insurance claim forms, be sure the Department of Insurance has licensed that person to perform the service.

- **Do not pay cash.** Pay by check, money order or bank draft made payable to the company, not the agent. Don't give your agent a blank check or access to your account. If you have an automatic teller machine (ATM) card, don't give out your access number.

- **If you don't receive your policy in 45 to 60 days, contact the company or agent.** If you have no success in receiving your policy, or suspect fraud, contact the Insurance Consumer Helpline toll-free at 1-800-342-2762.

- **Get help.** If you have questions or can't resolve a problem with your insurance company or agent, call the Insurance Consumer Helpline toll-free at 1-800-342-2762. You may also contact the Consumer Service Office in your area. See the list at the back of this guide.

Health Insurance Claim Denials

If you are in a dispute with an insurance company or agent, the Department of Insurance can help you resolve the situation by presenting your concerns to the company and/or agent, or by suggesting actions you can take on your own.

While the Department may ask the company to reconsider its position when the facts of a situation are in doubt, the Department cannot make a final determination about the facts of a situation or act as your legal representative.

There are steps you can take to lower the chances of your claim being denied:

- Know before receiving treatment what your health insurance will and will not cover. Read your health plan's requirements, outlined in its handbook. This way, you can find out whether the treatment you are considering is covered before you get the treatment.

- Make sure your pre-authorization requests contain correct patient information. Insurers often return or deny pre-

authorization requests because of missing data. **Pre-authorization** (also called pre-certification) is the insurer's prior approval of an insured entering a hospital. Many health policies or contracts require pre-authorization as part of an effort to control costs. Pre-authorization is not a guarantee of payment.

- Your physician will need to request the pre-authorization for you, or at least provide all necessary medical documentation.

- Document all communication involving any health insurance problems or questions, including names of people you talk to, when you talked to them, and photocopies of any paperwork.

If Your Claim is Denied

You may consider an appeal if your claim is denied under your Medicare supplement policy. Your insurance company should outline their appeals process in your policy or contract. Be sure to follow any timeline requirements specified in the appeals procedure.

Note: If you disagree with a decision made by your Medicare HMO, check your member handbook for your HMO's appeal procedures. You can also contact the Medicare program for more appeal information at www.medicare.gov or 1-800-MEDICARE (1-800-633-4227).

Insurance Fraud Costs Us All!

Insurance fraud costs each Florida family an additional $1,500 per year* in increased premiums. In fact, it can inflate your premiums by as much as 30 percent, according to the National Insurance Crime Bureau. This includes the money you pay for life, auto, health, homeowners' and other types of insurance.

You can protect your personal and family pocketbook by learning about the many different types of fraud schemes and scams.

Some common examples include:

***Fictional visit* –** A home health care provider bills the Medicare program for unnecessary, unauthorized or fictional visits to a patient.

***Receipt of kickbacks* –** A nursing home receives illegal kickbacks from a mental health hospital for new patient referrals.

***Agent stacking* –** An insurance agent commits "stacking" by selling a senior unnecessary health insurance which duplicates Medicare supplement coverage.

***Unauthorized referral* –** A laboratory bills Medicare for a patient's tests using information stolen from a referring physician. In actuality, the physician has never seen the patient.

***Deceptive billing* –** A senior sells insurance information to a health care provider who bills Medicare for services never rendered. In some cases, such providers bill for as many as 800 phony services for one senior in a three-month period.

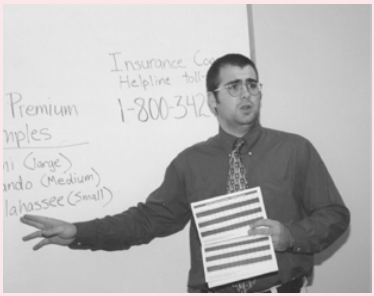
There are many other types of insurance fraud. If you suspect such a crime has occurred, call the Florida Insurance Department's Fraud Hotline toll-free at 1-800-378-0445.

*Source: The Coalition Against Insurance Fraud

Community Outreach Programs (COPs)

The Department of Insurance offers free Community Outreach Programs on a number of insurance topics. Speakers will talk to your group or organization on the insurance topic you choose, and will answer any general questions you have about insurance. For more information, please contact the service office in your area or write to:

Department of Insurance
Consumer Services Division
COPs Coordinator
200 E. Gaines St.
Tallahassee, FL 32399-0323
(850) 413-5765



Insurance Topics:
Health Insurance
Automobile Insurance
Disaster Preparedness
Small-Business Insurance
Life Insurance
Health Maintenance Organizations (HMOs)
Medicare Supplement Insurance
Long-Term Care
Insurance Fraud

Glossary

The following definitions will help you make a more informed decision when buying Medicare supplement insurance.

Actual Charge

An actual charge is the amount a health care provider bills a patient for a particular medical service or procedure. It often differs from the Medicare allowable charge (see below).

Allowable Charge

An allowable charge is the maximum fee Medicare uses in reimbursing a provider for a given service. Allowable charges are sometimes called "reasonable charges."

Assignment

An assignment is a method by which your doctor or medical supplier receives the medical insurance payment directly from Medicare. Under assignment, you can save time and money because your doctor or medical supplier agrees to charge Medicare's approved fees for covered services. Not all doctors take Medicare assignment or charge Medicare's reasonable fees. To find out if your doctor takes such assignment, call the toll-free Medicare number at 1-800-333-7586.

Benefit Maximum

A benefit maximum is the limit a policy will pay for a given benefit. A benefit maximum can be expressed either as a length of time; for example, four years, or as a dollar amount; for example, $1 million.

Coinsurance

Coinsurance is a percentage or dollar amount of an expense or service covered by insurance that you are required to pay.

Coordination of Benefits

Coordination of benefits is a method of integrating payments by more than one insurance policy so that benefits from all sources do not exceed 100 percent of the bills.

Deductible

A deductible is the amount you must pay for medical expenses before your insurance will pay. This fixed amount must be paid by you or your Medicare supplement policy. For example, with Medicare you must pay an $812 deductible for each hospital stay unless your supplemental policy pays this cost.

Duplication of Coverage

Duplication of coverage is when an agent sells you more insurance than you need. It is also called “overselling” or “stacking.”

Exclusion

An exclusion is any condition or expense for which the policy will not pay. For example, long-term care policies will not pay for treatment that should be paid for by the government (except Medicaid).

Free-Look Period

A free-look period is a period of time after receiving a policy that you have to decide whether or not to buy it. The law allows you 30 days to make your decision. If you have paid a premium during that 30 days and decide not to keep the policy, you may receive a full refund. Be sure to return the policy to the company by certified mail within 30 days to guarantee your refund.

Group Insurance

Group insurance is insurance that covers a number of people or groups under one policy. Most health insurance available from employers is group insurance. Group insurance usually costs less than individual insurance.

Guaranteed Renewable Policy

A guaranteed renewable policy is a policy in which the insurance company agrees to insure a policyholder for life. Premiums may change, however, if changed for all people within the same class of risks in the state. The company may cancel a guaranteed renewable policy for two reasons: The policyholder or a secondary addressee, if chosen, failed to pay premiums within 30 days of receiving a notice of possible lapse in coverage; or the policyholder deliberately misrepresented or left out key information on the application. All Medicare supplement policies sold in Florida are “guaranteed renewable.”

Home Health Care
Home health care is intermediate or custodial care received at home from a nurse, therapist or home health aide under a doctor's supervision.

Individual Insurance
Individual insurance is insurance that covers one person under one policy.

Lapse
A lapse is voluntary termination of a policy by the policyholder.

Lifetime Reserve Days
Lifetime reserve days are 60 extra days of Medicare Part A coverage, provided when a patient is confined to the hospital for more than 90 days. You do not have to use the 60 days all at once. These reserve days are not renewable; once used, they cannot be used again.

Long-Term Care
Long-term care is everyday care an individual needs in the event of a chronic illness or disability. Long-term care can be provided in a nursing home, a private home or community setting.

Medicare-Eligible Charges
Medicare-eligible charges are expenses approved by Medicare. Policies that stipulate this term will pay only for these expenses. Medicare-approved charges are often less than actual billed charges. Be sure you understand what Medicare does and does not cover.

Pre-existing Condition
A pre-existing condition is a condition in which medical advice or treatment was needed, recommended by or received from a health care provider within a six-month period before the date the insured person's coverage took effect. This phrase can also refer to an illness for which an ordinary, prudent person would have sought treatment. Pre-existing conditions usually are not covered until some time after the policy has been in effect.

Rider
A rider is an attachment to an insurance policy that adds benefits to the original contract.

Skilled Nursing Care
Skilled nursing care is daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or doctor.