VIRGINIA

MEDIGAP GUIDE

Prepared By:

SCC
STATE CORPORATION COMMISSION

Bureau of Insurance

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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HOW TO REACH THE BUREAU

Life and Health Consumer Services Section

1-877-310-6560 (Toll-Free)
804-371-9691 (Richmond)
804-371-9944 (Fax)
Website: scc.virginia.gov/pages/Insurance
Email: BureauofInsurance@scc.virginia.gov

Mailing Address

Life and Health Division
P.O. Box 1157
Richmond, VA 23218

Physical Deliveries/Visits

Life and Health Division
1300 E. Main Street
Richmond, VA 23219

Insurance Outreach

1-877-310-6560 (Toll-Free)
804-371-9389 (Richmond)
Email: consumeroutreach@scc.virginia.gov

OTHER IMPORTANT RESOURCES

Social Security Administration (SSA)

The Centers for Medicare & Medicaid Services (CMS) is the agency in charge of the Medicare program, however, Social Security processes your application for Original Medicare (Part A and Part B). Social Security can also give you general information about the Medicare program and help you get a replacement Medicare card.
1-800-772-1213(Toll-Free)
1-800-325-0778 (TTY)
ssa.gov

Virginia Insurance Counseling and Assistance Program (VICAP)

VICAP provides free insurance counseling 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.
1-800-552-3402 (Toll-Free)
804-662-9333 (Richmond)
vda.virginia.gov/vicap.htm

The National Association of Insurance Commissioners (NAIC)

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

INTRODUCTION

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

This Guide has been prepared to help you review the Medigap insurance policies so that you can make decisions about the products that are most appropriate for your needs and budget.

This Guide is a useful tool, but it should not be used alone. 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 the CMS and the National Association of Insurance Commissioners (NAIC.)

The chart provided in this Guide (see page 11) gives you a quick look at the standardized Medigap Plans and the benefits offered under each plan. An insurance company must make Medigap Plans A, and C or F available if it offers any other Medigap Plan.

Use the Medigap Premium Finder to compare plans and the premiums associated with each plan. Contact the Bureau or visit our website to determine whether a company or agent is currently licensed in Virginia at: VA SCC - Online Services & Information.

MEDICARE
THE BASICS

The following information about Medicare is helpful to get a better understanding of Medigap policies and the coverage offered. This information is general and basic, and should not be used as the only 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. The CMS is the agency in charge of the Medicare program. You apply for Medicare at your local Social Security 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 Parts A and B services. Medicare pays its share of the bill and you pay the balance.

PART A

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 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 can contact the SSA to find out if you are eligible to purchase coverage and what the cost will be.

PART B

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 SSA as eligible for Part B must pay a premium based on their income. Part B also has an annual deductible, which can change each year. Also, a coinsurance charge is applied to doctor visits or other qualified medical services.

PART C

Part C, Medicare Advantage, (formerly known as Medicare+Choice), is offered by companies that contract with Medicare to provide you with all your Medicare Parts A and 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

Part D Medicare prescription drug coverage includes both brand name 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.

Generally you will pay a monthly premium for Medicare Prescription Drug Plan (Part D) coverage, and 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 SSA (see Other Important Resources, page 3).

Choosing a Medicare Prescription Drug Plan

When deciding whether to purchase a Part D 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 toward 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 Part D 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 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 SSA for 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 SSA and tell them you want to waive your right to Part B coverage. Before deciding to waive Part B, you should find out some important coverage specifics about 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 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 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.

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.

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.

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.

Plan A covers the basic core benefits. 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. 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 B co-payments 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.

	Plans Available to All Applicants								Only available if first eligible for Medicare before 2020	
Medigap Benefits	A	B	D	G	K	L	M	N	C	D
Medicare Part A Coinsurance & Medigap Coverage for Hospital Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A Deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B Deductible									✓	✓
Medicare Part B Excess Charges				✓						✓
Foreign Travel Emergency (up to plan limits - $50,000)			80%	80%			80%	80%	80%	80%
2024 Out-of-Pocket Limits					$7,060	$3,530				

The chart gives you a quick look at the standardized Medigap Plans and their benefits. an insurance company must make Medigap Plans A, and D or G available if it offers any other Medigap Plan.

How to read the chart:

If a ✓ 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.

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.

Remember that none of the Medigap plans cover long-term care services such as:

- care to help you bathe
- care to help you dress
- care to help you eat
- private duty nursing
- vision
- dental
- hearing aids

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

MEDIGAP
DISABLED UNDER 65

Virginia law requires insurers, health services plans or health maintenance organizations issuing Medicare Supplement (also known as Medigap) plans in Virginia to offer individuals the option of buying at least one of its Medigap plans if they are:

- Under age 65 and live in Virginia,
- Medicare eligible by reason of disability, amended by the General Assembly for 2024 to include End-stage Renal Disease (ESRD); and
- Either enrolled or will be enrolled in Medicare Parts A and B by the effective date of coverage.

Effective January 1, 2024, Virginia law establishes a new and separate six-month open enrollment period for individuals under the age of 65 and Medicare eligible by reason of disability due to ESRD. Under this open enrollment period:

- Individuals who became eligible prior to January 1, 2024, will have a six-month period to apply beginning January 1, 2024;
- In the case of a retroactive eligibility decision, individuals will have a six-month period beginning January 1, 2024, or the month the person receives the retroactive eligibility decision, whichever is later; or
- At the individual's request, a 63-day period following voluntary or involuntary termination of coverage under a group health plan, or a six-month period beginning January 1, 2024, whichever period provides the later date to enroll.

NOTE: The new and separate open enrollment period established for ESRD does not impact the open enrollment period previously established on January 1, 2021, for individuals qualifying for disability as defined by 42 U.S.C. §426(b).

Under that open enrollment period:

- Individuals eligible on or after January 1, 2021, by reason of disability have six months to apply beginning with the first month they are Medicare eligible by reason of disability;
- In the case of a retroactive eligibility decision, individuals have six months from the month the person receives the retroactive eligibility decision; or
- At the individual's request, a 63-day period following voluntary or involuntary termination of coverage under a group health plan

The insurer must issue the coverage to eligible individuals and maintain coverage as long as premiums are paid on the policy or certificate. In addition, insurers cannot exclude benefits based on pre-existing conditions if there is at least a six-month period of continuous creditable coverage. If the individual has less than six months of creditable coverage, the pre-existing waiting period will be reduced by the amount of creditable coverage the individual had. Creditable coverage includes Medicaid, Medicare Parts A and B, and group and individual health insurance coverage.

In Virginia, individuals have a 30-day "free look" period for a Medigap policy that allows them to return the policy for a full premium refund if not satisfied. The 30-day period starts the day they receive the policy.

For coverage obtained during the open enrollment period or renewed on or after January 1, 2024, the premium rate charged to Medicare-eligible individuals under 65 may not be higher than the premium rate charged for the same plan to Medicare-eligible individuals aged 65.

Individuals who have purchased a Medigap policy under the pre-65 coverage option will receive a new six-month open enrollment period to purchase any of the standardized Medigap plans when they turn 65. This new open enrollment period may offer a wider choice of plans.

Under federal law, if you become eligible for Medicare Part B benefits before age 65 because of a disability including 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, if 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.

Medigap 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, benefits not covered by Medicare or a Medicare Supplement plan, 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.

Contact
Bureau of Insurance
Outreach and Education Manager
P.O. Box 1157 Richmond, VA 23218
1-877-310-6560 (Toll-Free) or 804-371-9389 (Richmond)
E-mail: consumeroutreach@scc.virginia.gov

INSURANCE RATING COMPANIES

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:

STANDARD & POOR'S
1-212-438-2400
standardandpoors.com

A.M. BEST
1-877-772-5436 or 1-908-439-2200
ambest.com

MOODY'S
1-212-553-0377
moodys.com

FITCH RATING
1-800-893-4824
fitchratings.com

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