2012

WYOMING BUYER'S GUIDE

TO

MEDICARE SUPPLEMENT "MEDIGAP" INSURANCE

WYOMING DEPARTMENT OF INSURANCE

WYOMING STATE HEALTH INSURANCE INFORMATION PROGRAM
sponsored by
WYOMING SENIOR CITIZENS, INC.
www.wyomingseniors.com

THE STATE OF WYOMING

Matthew H. Mead
Governor

Insurance Department

Ken Vines
Insurance
Commissioner

106 East 6th Avenue ♦ Cheyenne, Wyoming 82002

November 1, 2011

Dear Fellow Citizens of Wyoming:

I am pleased to provide you the *2012 Wyoming Buyer's Guide to Medicare Supplement Insurance.* The Buyer's Guide is a part of my commitment to keep Wyoming insurance consumers aware of the latest changes in the Medicare program and Medicare Supplement insurance.

This Buyer's Guide was developed with financial assistance, in whole or in part, through a grant from the Centers for Medicare and Medicaid Services (CMS), the Federal Medicare agency. It was prepared with the cooperation of the Wyoming Insurance Department and the Wyoming Senior Citizens, Inc., Riverton, Wyoming.

The Medicare program is under constant scrutiny and with the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act), prescription drug coverage (Medicare Part D) is now available for all people in the Medicare program. Wyoming has 17 private companies offering a choice of 33 free-standing prescription drug plans (PDPs) and 4 health plans [Medicare Advantage (MA) plans] offering some 9 plans, 6 of which include drug coverage. In addition, the Act resulted in the offer of two Medicare supplement plans, standardized Plans K and L which have increased cost sharing in exchange for a lower premium.

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 made significant changes to the previous Medicare supplement standardized plans, effective June 1, 2010, and introduced two new standardized plans, M and N. In addition, purchasers of these "modernized" Medicare supplement plans are afforded additional consumer protections under the Genetic Information Nondiscrimination Act (GINA) of 2008 which prohibits the use of genetic testing and/or information when underwriting and pricing a Medicare supplement policy.

It is important that you be an informed consumer and possess the necessary tools to be an informed purchaser. The Buyer's Guide, used in conjunction with the *Guide to Health Insurance for People with Medicare,* provides a great deal of information about the Medicare program and the modernized Medicare supplement benefit plans. It includes charts that illustrate what Medicare pays for and what you are responsible for paying. It also includes a comparison of the ten "modernized" Medicare supplement benefit plans plus the high-deductible F plan, premiums and consumer protections brought about by federal laws.

I am confident that you will find this Buyer's Guide invaluable as you consider your available options.

Should you have questions or require further assistance, please contact the Wyoming State Health Insurance Information Program (WSHIIP) toll-free at 1-800-856-4398 or the Wyoming Insurance Department at 1-800-438-5768.

Best regards,

Kenneth G. Vines
Insurance Commissioner

KGV/dw

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TO
MEDICARE SUPPLEMENT "MEDIGAP" INSURANCE

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INTRODUCTION

The 2012 Wyoming Buyer's Guide to Medicare Supplement Insurance is provided by the Wyoming Insurance Department and Wyoming Senior Citizens, Inc., to assist Wyoming consumers in selecting an insurance plan to supplement Medicare. This comparison should be used in conjunction with the *Guide to Health Insurance for People with Medicare* prepared by the National Association of Insurance Commissioners (NAIC) and the Centers for Medicare and Medicaid Services (CMS). You can obtain the guide prepared by the NAIC and CMS from the Wyoming Insurance Department and Wyoming Senior Citizens, Inc. The *Guide to Health Insurance for People With Medicare* provides an explanation of what Medicare covers, the "gaps" in Medicare, the "standardized" and "modernized" plans, including the new increased cost-sharing plans, K, L, M and N, that are available. The primary purpose of this comparison is to show companies that offer Medigap plans in Wyoming, which plans are offered, and the rates for individuals for ages 65 and 75.

There are some companies that have Medigap plans approved for sale in Wyoming, but are not included in this comparison. For example, some companies do not offer Medigap plans to the general public. Their plans are used in groups or associations. There may also be companies that had their plans approved after this comparison was prepared. Generally, however, we recommend that you contact the Wyoming Insurance Department or Wyoming Senior Citizens, Inc., if you are approached by a company that is not shown in this comparison to confirm that the company's plan has been approved for sale within Wyoming. You can contact the Insurance Department at 1-800-438-5768 or (307) 777-7401. You can contact Wyoming Senior Citizens, Inc., at 1-800-856-4398 or at (307) 856-6880 or on its web site, www.wyomingseniors.com.

MEDICARE

Medicare is the federal health insurance program for persons age 65, certain disabled persons under age 65, and persons with permanent kidney failure. There are approximately 79,800 Wyoming residents who are Medicare enrollees. There are four parts of Medicare: Parts A, B, C and D.

Part A of Medicare can be thought of as hospital insurance. Part A provides benefits for medically necessary services furnished by Medicare-approved hospitals, skilled nursing facilities, home health agencies and hospices.

Part B helps pay for physician services and other medical services and supplies that are not covered by Part A.

Part C is Medicare Advantage (MA) plans. MA plans are offered by private companies that contract with Medicare. Medicare pays a set amount to these private health benefit plans. MA plans may also offer extra benefits that Medicare does not cover, such as vision and dental services.

Part D is the Medicare prescription drug benefit. The prescription drug benefit is obtained from private companies who contract with Medicare.

The chart on pages 17 through 18 shows services covered by Medicare, what Medicare pays and what you are responsible for paying.

The amounts that you are responsible for are also called the "gaps" in Medicare. Medicare Supplement Insurance Policies, also called "Medigap" policies, are designed to help relieve some of the financial burden remaining after Medicare has paid its portion of the claim. There are four types of gaps in Medicare: 1) deductibles for both Part A and B, 2) the copayments, 3) charges exceeding the Medicare allowable charge, and 4) expenses not covered by Medicare. The chart on page 16 illustrates how the different Medicare supplement plans fill the gaps left by Medicare.

THE "GAPS" IN MEDICARE COVERAGE

1. **DEDUCTIBLES**
2. **COINSURANCE AMOUNTS**
3. **CHARGES IN EXCESS OF MEDICARE'S APPROVED AMOUNTS OR ALLOWABLE CHARGES**
4. **MEDICAL SERVICES AND SUPPLIES THAT MEDICARE DOES NOT COVER**

STANDARDIZATION OF MEDIGAP PLANS

Reference was made above to the "standardized" and "modernized" Medigap plans. Following the models developed by the NAIC, Wyoming's regulations regarding Medigap insurance limit the number of different Medigap policies that can be sold to no more than 10 standard benefit plans plus high-deductible plan F. The plans are labeled "A" through "N." The benefit for consumers is that upon deciding which plan you want, you can compare different companies' specific plans so that you are comparing "apples to apples."

Each company must offer plan A, which is a basic or "core" plan and either standardized plan C or F. Medigap insurers do not have to offer all of the other plans. This comparison shows which plans each company offers. If you have decided that you wish to purchase Plan F, this guide shows which companies offer it, and allows you to compare the rates.

Beginning June 1, 2010, new laws brought further changes to Medigap policies, however plan formats remain standardized. Those changes gave more choices in health care coverage to fill gaps in services that Original Medicare doesn't cover. See page 16 for the new benefit charts.

DEFINITIONS

To help you understand the benefits provided by Medicare and Medigap policies, we will concentrate on explaining the following terms that are frequently used with Medicare and Medigap policies:

ASSIGNMENT
BENEFIT PERIOD
COINSURANCE
DEDUCTIBLE
DRGs (DIAGNOSTIC-RELATED-GROUPS)
EXCLUSIONS
FREE LOOK
MEDICARE-APPROVED CHARGE
OPEN ENROLLMENT
PARTICIPATING PHYSICIANS
PREEXISTING CONDITIONS
SNFs (SKILLED NURSING FACILITY)
SPECIAL ENROLLMENT PERIOD - THE WORKING AGED

ASSIGNMENT - When benefits are assigned to a health care provider, the benefit is paid directly to the provider. A health care provider that accepts assignment for Medicare also agrees to accept Medicare's allowance for covered services. The policyholder would then be responsible for any unmet deductible applied to the charge, for the coinsurance and for any services which were not covered. The policyholder is not required to pay the health care provider the difference between the provider's normal fee and the Medicare-approved charge.

BENEFIT PERIOD - Medicare Part A benefits are paid on the basis of "benefit periods" and apply to hospital and skilled nursing facility (SNF) care. A benefit period begins on the day you are hospitalized and ends after you have been out of a hospital or SNF for 60 continuous days. A benefit period also ends if you remain in a SNF, but do not receive any skilled care for 60 continuous days. If you enter a hospital again after 60 days, a new benefit period begins.

COINSURANCE - Medicare generally pays 80 percent of the approved charge and you are responsible for paying the remaining 20 percent. The portion of the Medicare approved charge that you pay is called coinsurance.

DEDUCTIBLE - The deductible is the amount that you pay for eligible medical expenses before Medicare benefits begin to be paid. In 2012 the Medicare Part A deductible is $1,156 per benefit period. The deductible for Part B is $140 for the calendar year 2012.

DRGs - DRGs are the initials for "Diagnostic-Related-Groups" which is a classification and payment system used by Medicare to pay hospitals for different kinds of treatment. The treatment you receive at a hospital falls into one of several hundred DRG classifications. Hospitals are prohibited from charging Medicare patients for any difference between the actual cost of performing a procedure and the amount approved by Medicare.

EXCLUSIONS - There are certain conditions, circumstances, or services that are not covered by Medicare. These are referred to as "exclusions."

FREE LOOK - Wyoming's law provides you the right to return a Medigap policy within 30 days after you receive it. This is called the Free Look Provision. If you have paid the first premium and decide that you do not want to keep the policy, you are entitled to a full refund as long as you return the policy within 30 days after you receive it. To better assure the premium refund, you should consider returning the policy to the company by certified mail within the 30 days.

MEDICARE-APPROVED CHARGE - Medicare bases benefit payments upon the lower of the health care provider's charge or the prevailing charge in the region for the particular service. In this guide, we will refer to this as the "approved charge." It is also referred to as Medicare's approved amount. If a nonparticipating provider's fee is higher than the Medicare-approved charge, you are responsible for payment of the difference, or the excess charge.

OPEN (INITIAL) ENROLLMENT - Every new Medicare recipient who is age 65 or older has a guaranteed right to buy a Medicare supplement policy during open enrollment. A company cannot reject you for any policy it sells, and it cannot charge you more than anyone else your age.

Your open enrollment period starts when you are age 65 or older and first enroll in Medicare Part B. It ends six months later. If you apply for a policy after the open enrollment period, some companies may refuse coverage because of health reasons. You will be eligible for an open enrollment period when you become 65 if you have had Medicare Part B coverage before age 65 (e.g. Medicare disability or end-stage renal disease).

Even though you are guaranteed a policy during open enrollment, preexisting conditions may not be covered for up to 90 days after the effective date. A new preexisting condition waiting period is not allowed when you replace one Medicare supplement policy with another, and you had the first policy at least 90 days.

PARTICIPATING PHYSICIAN - Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Even if the health care provider does not participate in Medicare, he or she may accept assignment of your Medicare claim. Many physicians or suppliers accept assignment on a case-by-case basis. You should ask before you receive any services whether or not assignment will be accepted. Health care providers who

take assignment on a Medicare claim agree to accept the Medicare-approved charge. You are not responsible for paying more than the 20 percent of the Medicare-approved charge.

> **Physicians who do not accept assignment of Medicare claims are limited as to the amount they can charge a Medicare beneficiary for covered services. In 2011 the most these physicians could charge for services covered by Medicare was 115 percent of the fee schedule amount for nonparticipating physicians.**

PRE-EXISTING CONDITIONS - Wyoming law restricts the limitations Medigap insurance policies can specify regarding conditions that existed prior to the policy's effective date, i.e., preexisting conditions.

1. **A preexisting condition cannot be defined as being more restrictive than a condition for which medical advice or treatment was received within 90 days prior to the policy's effective date.**

2. **A Medigap policy cannot deny a claim for treatment pertaining to a preexisting condition when treatment is received more than 90 days after the policy's effective date.**

3. **If the Medigap policy was purchased to replace another Medigap policy, the new policy cannot apply any limitations on preexisting conditions.**

SNF - Medicare Part A can help pay for up to 100 days of extended care services in a skilled nursing facility (SNF) during a benefit period.

SPECIAL ENROLLMENT PERIOD FOR THE WORKING AGED – If you are covered by a group health plan when you are first eligible for Medicare, you may be able to delay enrollment in Part B or Premium Part A without a premium surcharge and without waiting for a general enrollment period. The group plan must be based upon current employment. It cannot be a retiree plan.

If you have chosen to delay enrolling in Part B or premium Part A because you don't need Medicare coverage while you are covered under a group health plan, you may enroll during a special eight-month period subsequent to when your coverage under the group health plan ends. You should contact your local Social Security District Office as soon as employment ends or the plan coverage ends or changes.

BALANCED BUDGET ACT (BBA) OF 1997
Changes in the Medigap Program

The BBA was signed by President Clinton on August 5, 1997. It contained provisions that allowed buyers to be assured issuance of certain Medigap policies under certain conditions, regardless of health status. It eliminated the application of preexisting condition exclusions during the initial six month open enrollment period and added two new high-deductible Medigap policies: high-deductible Plan F and high-deductible Plan J.

Medigap Protections:
Guaranteed Issue

The BBA guarantees issuance of Medigap Plans A, B, C or F for an individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare, if the plan terminates or ceases to provide such benefits. The individual must enroll in one of the above-mentioned Medigap plans within ninety (90) days of the employer plan termination or cessation of benefits.

There are a number of other conditions under which guarantee issues applies. However, they involve individuals in Medicare managed care [HMO, PPO] and Private Fee-For-Service (PFFS) plans.

Limitation on Preexisting Condition Exclusion

This provision of the BBA limits the application of a preexisting condition exclusion period during the initial six month open enrollment period for Medicare individuals age 65 or over. A preexisting condition exclusion period cannot be imposed upon an individual who, on the date of application, had a continuous period of at least ninety (90) days creditable health insurance coverage.

Creditable coverage is defined as:

- **a group health plan**
- **private health insurance coverage**
- **Part A or Part B of Medicare**
- **Medicaid**
- **the Indian Health Service or a tribal Act organization**
- **a state health benefits risk pool**
- **a public health plan**
- **TRICARE for Life**
- **the Federal Employees Health Plan**
- **a plan under the Peace Corp**

High-Deductible Medigap Plans

The BBA created the addition of two new high-deductible plans. They are Plan F and Plan J. The benefits of these two plans are identical to standard Plans F and J. The only

difference is that the individual has a [$2,000] deductible (indexed to inflation) to satisfy before any plan benefits are available. Once the deductible has been met, the plan pays 100 percent of covered out-of-pocket expenses. For 2012, this deductible has increased to $2070.

Out-of-pocket expenses are expenses are those that would ordinarily be paid by a Medigap plan. These expenses include the Medicare deductibles for Part A and B and coinsurances, but *do not include in Plans F and J, the plan's separate foreign travel emergency deductible of $250.*

Insurance companies are not required to offer these new high-deductible plans.

THE BALANCED BUDGET REFINEMENT ACT (BBRA) OF 1999

Changes in the Medigap Program

This legislation puts in place the hospital outpatient department prospective payment system that was effective August 1, 2000. A beneficiary's Part B coinsurance amount for most hospital outpatient services is now calculated using either a set copayment amount for services, 20 percent of the national median amount for a particular outpatient payment category grouping, or a hospital-elected reduced copayment amount. Medigap policies reimburse this new copayment amount for the affected outpatient services. Not all hospital outpatient services are reimbursed on a prospective payment basis.

THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)

Help has arrived in paying for prescription drugs. Effective January 1, 2006, everyone with Medicare is eligible for prescription drug coverage. Medicare has contracted with private entities to provide this coverage. In 2011 in Wyoming, there were 4 health plans (Medicare Advantage plans), one Cost plan and 16 entities offering 44 Prescription Drug Plans (PDPs). For more information on these PDPs, please see your *Medicare & You 2012* handbook . You may also visit www.medicare.gov on the Internet or call 1-800-MEDICARE (1-800-633-4227)

The MMA also extends guarantee issue rights, for qualifying individuals, to standardized plans A, B, C, F, (including high-deductible F), K and L.

THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA) OF 2008

MIPPA encompassed significant changes to the standardized Medicare supplement plans (also called "modernized" plans, with effective dates beginning June 1, 2010). This Act introduced two new standardized plans M and N, broadened opportunities for low income Medicare beneficiaries, required Medicare Advantage plans to include the type of plan using standard abbreviations (e.g. HMO, PPO, PFFS), and increased Medicare coverage of

psychiatric services from 50 percent to 55 percent. The Act extended the timeframe for the Welcome to Medicare Physical to 12 months from Part B enrollment and eliminated the application of the Part B deductible. It expanded the types of services included in the physical to include a discussion of end-of-life planning and body mass index assessments. Among other things, it placed prohibitions and limitations on certain sales and marketing activities under Medicare Advantage (MA) and Prescription Drug Plans (PDPs).

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) OF 2010

PPACA made many improvements to Medicare, while helping to ensure that the Medicare program remains strong. Among the improvements are the reduction and eventual elimination of the coverage gap, or "donut hole" in Medicare Part D prescription drug coverage, the addition of annual wellness exam coverage, and the elimination of coinsurance on most preventive services. PPACA also made changes to Medicare Advantage Plans, preventing those plans from charging more than Original Medicare for cancer treatment and certain other services.

TIPS FOR BUYING A MEDICARE SUPPLEMENT POLICY

Before comparing different plans available to supplement Medicare, you should consider whether or not you need to have a supplement. If you are uncertain about whether or not you need to purchase a Medigap policy, you may want to discuss your situation with someone who understands Medicare and Medigap options. It would be best to do so before you reach age 65. The Wyoming Insurance Department 1-800-438-5768 or (307) 777-7401 and Wyoming Senior Citizens, Inc., 1-800-856-4398 or (307) 856-6880 can provide you assistance.

Medicare Savings Programs

If your income is low, you may qualify for a government program which will fill in the gaps in your Medicare coverage. Check with your county Department of Family Services to find out if you qualify for Medicaid or if you are a Qualified Medicare Beneficiary (QMB) or a Specified Low-Income Medicare Beneficiary (SLMB). Persons who qualify for Medicaid or the QMB program should not purchase a Medigap policy. If you qualify as a SLMB, the state will pay your Medicare Part B premium. Qualification as a SLMB would not change your need for a Medigap plan, but would provide you more spendable income that could be used to purchase a Medigap plan.

Employer Sponsored Insurance

If your employer provides group insurance, you may be able to continue coverage through that plan. Employer-provided group plans may not be the same as the Medigap plans. Ask for an explanation of how benefits are paid. Employer-provided group plans may provide different, but better benefits than any of the Medigap plans. For example, employer

provided group plans may cover private duty nurses or provide benefits for out-patient prescriptions that are better than the benefits provided under the Medicare standard prescription drug benefit.

***You do not need more than one policy*. If you already have a Medicare supplement policy and want better benefits, you can replace it with a new one. Once you receive the new policy you should drop the old one. Duplicating coverage is costly, and benefits received may be coordinated so that the total benefit from several policies may be the same as the benefit from one policy.**

Except for Plan A, all of the standardized Medigap policies will pay the deductible you are liable for under Part A. During 2012 the Part A deductible is $1,156. The Part A deductible is based upon what the typical cost is for one day in the hospital. You can thus anticipate the Part A deductible to increase each year. Keep in mind that it is possible to have more than one Part A deductible per calendar year.

With the exception of many preventive services, for Part B benefits, you will be liable for a separate deductible. The 2012 Part B deductible is $140. The Part B deductible is for a calendar year; you only need to satisfy it once within a year before Medicare benefits begin. Of the standardized plans, C and F pay the Part B deductible. (You should keep in mind that you are essentially trading dollars for those plans. In other words, the potential cost to the insurance company is $140 to pay the deductible; chances are the premium includes most, if not all, of that cost.)

Another variable that alters the cost of Medigap insurance pertains to what is paid after the deductible. Plans A, B, C, D, and M, will only pay 20 percent of the Medicare-approved charge. These plans do not pay any charges that are in excess of the Medicare-approved charge. Plans F and G pay 100 percent of the excess. To determine which type of plan you need, you should find out if your normal medical care provider is a participating physician, and if he or she accepts assignment for Medicare. If your normal physician is a participating physician or accepts assignment, you would only be responsible for payment of 20 percent of the Medicare-approved charge after the Part B deductible has been satisfied.

Even if the physician you normally see is a participating physician, there may be times that you need to see a physician who is neither a participating physician nor willing to accept Medicare assignment. If you have purchased a Medigap policy that only pays 20 percent of the Medicare-approved charge, you would then be responsible for the difference between the actual fee and the Medicare-approved charge.

You should also keep in mind that all physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. In addition, starting in 2010, charges for services covered by Medicare can only be 115 percent of the fee schedule amount for nonparticipating physicians.

Assume that you see a nonparticipating physician who charges $345 for a service for which the Medicare-approved charge is only $300. You would have to pay the $45 excess charge ($345 - $300 = $45). If this service was the first health care received during the year, you would be responsible for paying the $140 deductible, the $60 coinsurance ($300 x 20 percent), plus the $45 excess charge for a total out-of-pocket cost of $245.

When you shop for Medigap insurance, it is good to call several companies. With the standardization of Medigap plans, each company's products are alike. They are competing solely on service, reliability, and price. It is also important to have an agent available when you have questions about benefit payments, rate changes or new options that may become available. Working with an agent that you have confidence in may be as important as the company you select.

Insurance Company Ratings

Ratings of companies are available. The A.M. Best Company, Inc., provides in-depth reports on many insurance companies. The ratings are a basis for comparing an insurance company's ability to meet its financial liabilities. The rating is based upon the risk involved with the financial commitments of a company due to the types of insurance sold, the quality of a company's investments, and other factors that may affect the financial standing of a company. Since A.M. Best Company, Inc., does not rate all companies you should not assume that not having a rating means the company is not sound financially. However, whenever you are shopping for insurance, whether it is for your home, car, or health care, many insurance professionals recommend using the rating organizations such as A.M. Best Company, Inc., as one area for comparison. Since 1992, the ratings have ranged from "A++" and "A+" (Superior) to "F" (In Liquidation). You may contact the Wyoming Insurance Department at 1-800-438-5768 to acquire ratings of specific companies not shown in this Guide.

"Best's Credit Ratings are under continuous review and subject to change and/or affirmation. For the latest Best's Credit Ratings and Best's Credit Reports (which include Best's Credit Ratings), visit the A.M. Best website at http://www.ambest.com. See Guide to Best's Credit Ratings for explanation of use and charges."

Premiums

The premiums that are charged for a Medigap policy are based upon either "Issue Age" or "Attained Age." You can anticipate the rates to increase each year with either system. Rates increase with increases in the Part A deductible, the cost of health care, and the utilization of health care. With the issue age method, your rates are always based upon the rate for the age when you purchased the plan. With attained age rates, your rates increase periodically because of your age. With some companies, your rates could increase each year.

With most companies the initial rates are the same for all policyowners ages 65-69, but are higher for policyowners ages 70-74, and higher yet for policyowners ages 75-89, etc. With companies using the issue age method, your rates are always based upon the age when you purchased the plan. If you were age 65 when you purchased the policy, your rates are based upon that age. If you purchase a plan from a company using the attained age method, the age that your rates are based upon changes as you grow older. At age 65, companies using the attained age system may offer lower rates, but the cost of insurance will increase as you grow older regardless of changes in the Part A deductible or the cost and utilization of health care.

COMPARISON WITH EXISTING COVERAGE

If you already have a Medigap policy, the benefits or rates may not be the same as shown in this guide. Wyoming adopted new regulations on Medigap insurance in July 1992, and again in June 2009. Policies that were sold prior to the adoption of those regulations can no longer be sold in the state. If you purchased a policy prior to 1992, and further for plans purchased prior to June 1, 2010, it is likely that the rates and benefits differ somewhat from the modernized plans that all insurance companies now sell in Wyoming. You may also have a Medigap policy with a company that is not listed in this guide. Some companies elected to not be included. There are also some companies that previously sold Medigap insurance that no longer do so, although they continue to renew and service existing policies. Also, if you purchased a policy in another state, it could be that the company does not do business in Wyoming, but the company continues to renew your policy.

If you purchased a plan before 1992, you do not have to switch to a standardized plan. Some plans that were offered before 1992 have advantages over any of the standardized plans, or offer comparable benefits. Just because your plan is not a standardized plan does not mean you should replace it. If an agent tells you so, we urge that you call the Wyoming Insurance Department 1-800-438-5768, or Wyoming Senior Citizens, Inc., 1-800-856-4398 or at (307) 856-6880, to discuss the advantages and disadvantages of doing so.

WYOMING STATE HEALTH INSURANCE INFORMATION PROGRAM (WSHIIP)

The Wyoming State Health Insurance Information Program, or WSHIIP, is a federally funded program. This program has recruited and trained volunteer counselors across the state of Wyoming to assist senior citizens who have problems or questions with their health insurance. Along with Medicare Supplement Insurance, these volunteer counselors can answer questions about Medicaid, Social Security, Long-Term Care Insurance, and Medicare. This program is free to the citizens of Wyoming. Counseling services are performed on a one-on-one basis, and the information is kept strictly confidential. Counselors are able to assist senior citizens with questions about different insurance products, assist with the submission of insurance and Medicare claims, and may act as an advocate for the client in matters with the insurance company. You can get more information about WSHIIP by contacting your local senior center or WSHIIP facility, or by calling Wyoming Senior Citizens, Inc., at 1-800-856 - 4398 at (307) 856-6880.

PERSONS WITH MEDICARE DUE TO A DISABILITY - There are some insurance companies that will consider applicants for Medicare Supplement Insurance who are eligible for Medicare *by reason of disability* under age 65. These companies are able to underwrite (examine the health history and health status) the applicant. The insurance company is not required to issue a policy to these applicants, but may do so if they desire. The insurance company usually limits the choice of policies that they offer to the under-age 65 applicants, normally Plans A and B. Companies who sell Medicare Supplement policies in Wyoming that will consider new applicants who are eligible for Medicare due to disability under age 65 are:

Liberty National Life – Plan B, 800-331-2512

United American Insurance Co. – Plans B & High-deductible F, 800-654-5433

Wyoming Health Insurance Pool (WHIP)*, 888-557-2519

(See company listings for contact information.)

***The Wyoming Health Insurance Pool (WHIP) is a state program to provide health insurance to those citizens of Wyoming who are unable to purchase insurance primarily due to poor health. Those who are eligible for Medicare due to disability and are under the age of 65 are also eligible for WHIP coverage. This is the only program for which individuals cannot be denied coverage. Benefits are paid in accordance with Wyoming Insurance Regulations. For more information on this program, contact the Wyoming Insurance Department at 1-800-438-5768 or Wyoming Senior Citizens, Inc., at 1-800-856-4398 or at (307) 856-6880.**

CONCLUSION

The chart on page 16, along with the *Guide to Health Insurance for People with Medicare* illustrate how each of the standardized plans fill different gaps left by Medicare. Looking at the options that are available, selection of the best plan is still difficult. Although unable to recommend any specific companies or plans, the Wyoming Insurance Department and Wyoming Senior Citizens, Inc., are available to assist you as you make your comparisons. You can reach the Insurance Department at 1-800-438-5768 or (307) 777-7401. You can reach Wyoming Senior Citizens, Inc. at 1-800-856-4398 or at (307) 856-6880.

Each of the 10 plans has a letter designation ranging from "A" through "N".

Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans, they must make Plan A available if they sell any of the other ten plans in Wyoming.

COMPANY	A.M. BEST @ 10/11
AARP - UnitedHealthCare **P.O. Box 130** **Montgomeryville, PA 18936** **800-272-2146**	**A**
American Continental Insurance **101 Continental Place** **Brentwood, TN 37027** **800-264-4000**	**A-**
Blue Cross Blue Shield of Wyoming **P.O. Box 2266** **Cheyenne, WY 82003** **800-442-2764**	**NR**
Equitable Life and Casualty Insurance **P.O. Box 2460** **Salt Lake City, UT 84110** **800-352-5150**	**B**
Family Life Insurance Company **10700 Northwest Freeway** **Houston, TX 77092** **800-877-7703**	**B+**
Gerber Life Insurance Co. **3316 Farnam Street** **Omaha, NE 68175** **877-778-0839**	**A**
Government Personnel Mut Life **P.O. Box 659567** **San Antonio, TX 78265** **800-929-4765**	**A-**
Guarantee Trust Life Ins. Co. **1275 Milwaukee Ave.** **Glenview, IL 60025** **800-338-7452**	**B+**

COMPANY	A.M. BEST @10/11
Heartland National Life Ins. Co. **10689 N. Pennsylvania Street** **Indianapolis, IN 46280** **816-478-0120**	**NR**
Humana Insurance Company **Attn: Medicare Enrollments** **P.O. Box 70329** **Loiusville, KY 40202** **800-866-0581**	**A-**
Liberty National Life Ins. Co. **10306 Regency Parkway Drive** **Omaha, NE 68114** **800-331-2512**	**A+**
Loyal American Life Ins. Co. **P.O. Box 559004** **Austin, TX 78755** **800-633-6752**	**A-**
Medico Insurance Company **1515 S. 75th Street** **Omaha, NE 68124** **800-695-5976**	**B-**
Mutual of Omaha Insurance Company **Mutual of Omaha Plaza** **Omaha, NE 68175** **800-693-6093**	**A+**
Order of United Commercial Travelers **632 North Park Street** **Columbus, OH 43215** **800-848-0123**	**B+**
Physicians Mutual Ins. Co. **2600 Dodge Street** **Omaha, NE 68131** **402-633-1188**	**A**

COMPANY	A.M. BEST @ 10/11
Reserve National Insurance Company **P.O. Box 18448** **Oklahoma City, OK 73154** **800-874-1431**	**A-**
Royal Neighbors of America **230 16th Street** **Rock Island, IL 61201** **800-627-4762**	**A-**
Sentinel Security Life Ins. Co. **2121 South State Street** **Salt Lake City, UT 84115** **855-478-4037**	**B++**
Standard Life and Accident Insurance Company **421 Northwest 13th Street** **Oklahoma City, OK 73193** **888-290-1085**	**A**
State Farm Mutual Auto Insurance Company **One State Farm Plaza** **Bloomington, IL 61701** **309-766-2311**	**A++**

COMPANY	A.M. BEST @10/11
Sterling Investors Life Ins. Co. **210 East 2nd Ave. Suite 105** **Rome, GA 30161** **706-235-8706**	**B**
Thrivent Financial for Lutherans **4321 North Ballard Road** **Appleton, WI 54919** **800-225-5225**	**A++**
United American Insurance Company **P.O. Box 810** **Dallas, TX 75221** **800-654-5433**	**A+**
USAA Life Insurance Company **USAA Building** **San Antonio, TX 78288** **800-531-8000**	**A++**
United World Life Insurance Co. **3316 Farnam Street** **Omaha, NE 68175** **1-877-845-0892**	**A+**

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Benefit Chart of Medicare Supplement Plans Sold on or after June 1, 2010 - With 2012 Deductible/Coinsurance Data

A	B	C	D	F / F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%, other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%, other basic benefits paid at 50%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-Pocket limit $[4660]; paid at 100% after limit reached	Out-of-Pocket limit $[2330]; paid at 100% after limit reached		

CORE BENEFITS

In-patient Hospitalization:

1. Coinsurance of $289/day for days 61-90
2. Coinsurance of $578/day for days 91-150
3. Additional 365 days of in-patient hospital expenses for days over 150
4. Blood (First 3 pints each year) (Plan K-50%, Plan L-75%)*
5. Hospice --Part A coinsurance

- Plan K has a [$4,660] out-of-pocket annual limit.
- Plan L has a [$2,330] out-of pocket annual limit.
  (These out-of-pocket amounts may change annually.)

Medical Expenses:

1. Part B coinsurance
   Plans A - N: 20% of Medicare approved espenses.
   Plan K: 10% of Medicare approved expenses.**
   Plan L: 15% of Medicare approved expenses. **
2. Blood (First 3 pints each year) (Plan K--50%, Plan L--75%)**

** Plans K and L cover the total coinsurance for Part B preventive services covered by Medicare.

* Plan F also has an option called a high deductible Plan F. (2012 Deductible is $2070)

MEDICARE PART A: HOSPITAL INSURANCE COVERED SERVICES FOR 2012

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION **Semi-private room and board, general nursing and other hospital services and supplies. (Medicare coverage based on benefit periods.)**	**First 60 days** **61st to 90th day** **91st to 150th day***	**All but $1156** **All but $289 a day** **All but $578 a day**	**$1156** **$289 a day** **$578 a day**
SKILLED NURSING FACILITY CARE **You must have been in a hospital for at least 3 days, enter a Medicare-approved facility generally within 30 days after discharge, and meet other program requirements.** (Medicare coverage based on benefit periods.)**	**First 20 days** **Additional 80 days** **Beyond 100 days**	**100% of approved amount** **All but $144.50** **Nothing**	**Nothing** **Up to $144.50 a day** **All costs**
HOME HEALTH CARE **Medically necessary skilled care, home health aide services, medical supplies, etc.**	**For as long as you meet Medicare requirements for home health care benefits.**	**100% of approved amount; 80% of approved amount for durable medical equipment.**	**Nothing for services; 20% of approved amount for durable medical equipment.**
HOSPICE CARE **Pain relief, symptom management and support services for the terminally ill.**	**For as long as a doctor certifies need.**	**All but limited costs for outpatient drugs and inpatient respite care.**	**Limited cost sharing for outpatient drugs and inpatient respite care.**
BLOOD	**Unlimited if medically necessary.**	**All but first 3 pints per calendar year.**	**For first 3 pints.*** **

***** **60 reserve days may be used only once.**

****** **Neither Medicare nor Medigap insurance will pay for most nursing home care.**

******* **To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.**

MEDICARE PART B: MEDICAL INSURANCE COVERED SERVICES FOR 2012

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES **Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, and other services.**	**Medicare pays for medical services in or out of the hospital.**	**80% of approved amount (after $140 deductible); 55% of approved charges for most outpatient mental health services.**	**$140 deductible,* plus 20% of approved amount and limited charges above approved amount. ** 55% of approved charges for mental health services.**
CLINICAL LABORATORY SERVICES **Blood tests, urinalysis, and more.**	**Unlimited if medically necessary.**	**Generally 100% of approved amount.**	**Nothing for services.**
HOME HEALTH CARE **Medically necessary skilled care, home health aide services, medical supplies, and other services. (Home health care covered under Part B only if you do not have Part A.)**	**For as long as you meet Medicare requirements for home health care benefits.**	**100% of approved amount; 80% of approved amount for durable medical equipment.**	**Nothing for services; 20% of approved amount for durable medical equipment.**
OUTPATIENT HOSPITAL TREATMENT **Medically necessary skilled care, home health aide services, medical supplies, etc.**	**Unlimited if medically necessary.**	**Medicare payment to hospital based on hospital costs.**	**20% of billed amount (after $140 deductible).***
BLOOD	**Unlimited if medically necessary.**	**80% of approved amount (after $140 deductible) and starting with 4th pint.**	**First 3 pints plus 20% of approved amount for additional pints (after $140 deductible).*** **

***** **Once you have had $140 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.**

****** **Federal law limits charges for physician services.**

******* **To the extent any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.**

2012 Rates and Plans for Persons Age 65
Effective 10/2011

Company	A	B	C	D	F	F*	G	K	L	M	N
AARP (United Healthcare)	91.50	143.00	169.75		170.50			64.75	93.50		109.00
American Continental	78.64	89.29			115.15	45.28	100.83				80.07
Blue Cross Blue Shield of WY	80.70		121.00		121.80	48.40		58.80			94.90
Colonial Penn Life	114.80	143.72			162.47	39.75	146.26	62.36	101.79	124.55	91.94
Equitable Life & Casualty	128.00				181.42						127.67
Family Life Ins. Co.	98.17	119.33	135.58	125.08	141.25		125.75			112.50	99.75
Gerber Life Ins. Co.	97.58				140.00		117.86				
Gov't Personnel Life	98.59		130.80		134.09		105.13				92.83
Guarantee Trust Life	103.89		149.48								103.26
Heartland National Life	84.37			106.17	122.95		107.91			99.30	85.57
Humana Ins. Co.	103.75	112.92	130.19		132.85	49.82		60.84	86.49		
Humana/Reader's Digest Plan	118.72				143.98	64.86		75.28			110.25
Liberty National Life	131.00	182.54			205.95	46.90					162.43
Loyal American Life	113.00				163.54		141.85				114.45
Medico Ins. Co.	93.19			125.15	136.72					115.21	103.79
Mutual of Omaha	91.67		133.99	126.92	142.73		108.94				

Companies may have Preferred or Non-Tobacco rates. Standard and Tobacco rates are higher. Some rates differ by gender. Rates are subject to change, and may require policy or monthly service fees. For informational use only. Your rate may be higher or lower.

2012 Rates and Plans for Persons Age 65
Effective 10/2011

Company	A	B	C	D	F	F*	G	K	L	M	N
Order of United Commercial Travelers	120.22	155.73	170.76	151.65	175.91		146.60				123.14
Physicians Life Ins. Co.	118.48	140.71			198.37		154.58				
Physicians Mutual Ins. Co.	108.97				174.69	57.79	135.10				118.53
Reserve National	112.20		166.60		150.25	47.20					114.95
Royal Neighbors Of America	89.74	112.77	131.43	105.30	131.85		105.64				
Sentinel Security Life	81.67	90.03	111.09	91.45	113.77						
Standard Life	197.66	225.05	255.86	154.17	210.41	30.59	155.35				101.48
State Farm Mutual	100.67		151.80		153.29						
Sterling Investors Life	74.47	86.98	104.15	91.15	108.16	42.59	91.64			82.00	75.70
Thrivent Financial for Lutherans	90.19	106.61	138.08	118.68	138.59	45.35	122.17		85.25	107.92	
United American	118.28	171.24	193.84	179.78	194.91	44.41	180.85				153.35
USAA Life	106.59				117.13						
United World Life	99.03	119.09			150.16		123.81			117.25	
World Corp Insurance	103.57				140.08	58.54					

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2012 Rates and Plans for Persons Age 75
Effective 10/2011

Company	A	B	C	D	F	F*	G	K	L	M	N
AARP (United Healthcare)	91.50	143.00	169.75		170.50			64.75	93.50		109.00
American Continental	104.06	131.20			148.59	58.40	133.37				105.93
Blue Cross Blue Shield of WY	111.30		166.70		167.80	66.70		81.00			130.70
Colonial Penn Life	170.50	211.25			238.43	57.98	234.07	94.45	147.92	193.00	152.27
Equitable Life & Casualty	150.08				214.92						151.33
Family Life Ins. Co.	138.50	168.50	194.58	176.75	198.66		177.58			159.00	140.33
Gerber Life Ins. Co.	128.00				187.21		158.01				
Gov't Personnel Life	131.07		177.53		182.00		143.02				126.75
Guarantee Trust Life	138.03		200.52								143.17
Heartland National Life	117.61			154.67	172.11		157.29			144.43	124.37
Humana Ins. Co.	143.17	154.73	178.40		182.04	68.26		83.37	118.51		
Humana/Reader's Digest Plan	159.18				193.80	85.39		99.65			147.57
Liberty National Life	168.21	247.51			290.14	76.81					237.72
Loyal American Life	152.22				220.30		191.04				154.20
Medico Ins. Co.	122.69			172.63	184.57					159.37	146.35
Mutual of Omaha	126.42		184.80	175.03	196.86		150.24				

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2012 Rates and Plans for Persons Age 75
Effective 10/2011

Company	A	B	C	D	F	F*	G	K	L	M	N
Order of United Commercial Travelers	175.77	227.41	244.72	221.44	246.49	214.37					172.54
Physicians Life Ins. Co.	137.81	167.55			249.82		194.43				
Physicians Mutual Ins. Co.	135.77				245.07	93.59	189.53				189.35
Reserve National	156.75		232.75		209.90	65.90					160.60
Royal Neighbors Of America	117.33	147.34	171.74	137.59	172.36		138.14				
Sentinel Security Life	108.21	120.56	149.98	123.73	153.58						
Standard Life	217.02	247.10	280.93	169.28	231.02	33.59	170.57				111.42
State Farm Mutual	146.95		221.59		223.83						
Sterling Investors Life	105.21	122.79	148.95	128.67	152.14	59.92	129.49				115.84
Thrivent Financial for Lutherans	117.59	139.10	180.09	154.80	180.67	59.08	159.16		111.12	140.63	
United American	151.66	231.94	272.96	259.35	273.94	72.54	260.34				224.19
USAA Life	144.50				164.05						
United World Life	130.97	157.50			198.58		163.72			155.05	
World Corp Insurance	138.05				186.73	78.04					

Companies may have Preferred or Non-Tobacco rates. Standard and Tobacco rates are higher. Some rates differ by gender. Rates are subject to change, and may require policy or monthly service fees. For informational use only. Your rate may be higher or lower.