

MEDICARE SUPPLEMENT INSURANCE

PREMIUM COMPARISON GUIDE



State of Nevada

Department of Business & Industry

**Division of Insurance
2017**

Barbara Richardson, Commissioner of Insurance

Brian Sandoval, Governor

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To be used with the Guide to Health Insurance for People with Medicare as developed by the National Association of Insurance Commissioners (NAIC) and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services (CMS) (see page 15 for a link to the guide).

LETTER FROM THE COMMISSIONER

Dear Fellow Nevadan:

The decisions of whether or not to purchase Medicare supplement insurance, and which kind of insurance to buy, are important ones. However, shopping for this insurance requires time and effort and can be confusing. That is why we are pleased to provide you with Nevada's Medicare Supplement Insurance Premium Comparison Guide. This Guide provides valuable information that will assist you in comparing many of the Medicare supplement policies, Medicare Advantage, and Medicare drug plans currently being offered in Nevada.

You may wish to seek the advice of a licensed agent, broker, producer or consultant to assist you in selecting appropriate Medicare supplement insurance coverage. Another source of information is the Nevada Department of Health and Human Services, Division for Aging Services, which administers the Nevada State Health Insurance Assistance Program (SHIP). The program director and volunteer counselors are available to provide you with individual counseling concerning your questions on Medicare or Medicare supplement products.

Your insurance concerns are very important to us at the Division of Insurance. We are here to assist you with any insurance questions or problems you may have.

Our offices in Northern Nevada are located in Carson City. For information, please call our consumer services section at (775) 687-0700. In Southern Nevada, our offices are located in Las Vegas, and you may reach a consumer services officer at (702) 486-4009. The toll-free number for use in Nevada is 1-888-872-3234. The Nevada SHIP advisers may be reached at (702) 486-3478 in Las Vegas or toll free in Nevada at 1-800-307-4444.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Barbara Richardson', with a long, sweeping horizontal line extending to the right.

Barbara Richardson

Commissioner of Insurance

Introduction

Throughout this guide you will find information regarding the following items:

- ❖ The basics of Medicare supplement insurance;
- ❖ Information on all the ten versions of Medicare supplement plans, A through N;
- ❖ Tips for purchasing a plan;
- ❖ Various carriers providing Medicare supplement insurance;
- ❖ Premiums for each plan;
- ❖ Medicare Options, Medicare PPOs, High-Deductible plans, and the Medicare SHIP Program; and
- ❖ Common definitions related to Medicare supplement.

Each year, the Nevada Division of Insurance (DOI) provides a voluntary survey to the companies who provide Medicare supplement coverage in Nevada to collect information on the policy premiums for the New Year. The results of this survey are summarized in the section titled 2017 Annual Premium Comparisons (pages 32 - 45). The comparisons shown in the Guide will give you a start in shopping for Medicare supplement coverage by offering a means for comparing premium costs on policies.

This Comparison Guide is for the purpose of helping you understand the options available for Medicare supplement insurance.

This guide will not cover information on Medicare itself. If you are seeking more information on Medicare, the Centers for Medicare and Medicaid Services publishes a guide titled, Medicare and You. This guide summarizes Medicare benefits, rights and obligations, and provides answers to the most frequently asked questions regarding Medicare. A digital version of Medicare and You can be downloaded at: <https://www.medicare.gov/Pubs/pdf/10050.pdf>. If a paper version of this guide is preferable, printed copies may be found at the Nevada State Health Insurance Assistance Program (SHIP) or your local Social Security office. Please see pages 60 through 65 of this Guide for contact information.

The Basics of Medicare Supplement Insurance

Recent Medicare Enrollment

According to the Centers for Medicare and Medicaid Services, 413,534 Nevadans (14.8% of the population), were eligible to receive benefits through the federal Medicare program in 2013¹. Of these, 130,424 individuals received their benefits through Medicare Advantage and other Health Plans. Medicare Supplement enrollment for 2014 was 72,899 Nevadans, as reported by the NAIC².

This shows that many Nevadans enrolled in Medicare may not be receiving the full amount of coverage they need to keep medical costs down. This guide will provide you with the tools to understand Medicare Supplement and decide whether or not it is necessary to cover your medical costs in 2017.

Medicare Supplement Fills the Gaps

Medicare supplement insurance, also known as a “Medigap policy”, is a distinct type of insurance policy which is sold by private companies to “fill the gaps” in original Medicare plan coverage.

While Medicare supplement policies cover many of the medical expenses Medicare does not cover (such as additional hospitalization

¹ Centers for Medicare and Medicaid Services. Medicare Enrollment Section. Retrieved September 22, 2016, from Medicare Enrollment Section, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2013/Enrollment.html>

² National Association of Insurance Commissioners. (2015). 2014 Medicare Supplement Loss Ratios. Retrieved September 22, 2016, from [www.naic.org, http://www.naic.org/documents/prod_serv_statistical_med_bb.pdf](http://www.naic.org/documents/prod_serv_statistical_med_bb.pdf)

expenses, blood drawing expenses, and additional Medical expenses) Medicare supplement policies purchased after 2006 cannot include coverage for prescription drugs. Prescription drug coverage can be provided through Medicare Part D insurance (see page 51).

Medicare supplement policies are guaranteed renewable if they are purchased after 1990. Unless you are not truthful about information on your application, cease to pay your monthly premium, or the company goes bankrupt, your insurance company cannot drop you from the policy you choose to purchase.

Medicare Supplement Eligibility

In order to be eligible for Medicare supplement, you must be enrolled in Medicare Part A and Part B. If you are currently in your Medigap open enrollment, you are guaranteed the right to buy a Medicare supplement policy. You may not be eligible for Medigap if you: already are enrolled in a Medigap policy, have Medicaid, are enrolled in a Medicare Advantage Plan, or are under the age of 65.

Why Should You Buy Medicare Supplement Insurance?

Medicare supplement insurance is necessary because Medicare does not pay for every medical expense. A Medigap policy will cover the medical expenses which Medicare does not pay such as the Medicare Part B yearly deductible, Medicare Part B covered services, blood, hospital stays, and skilled nursing facilities.

10 Medicare Supplement Plans: A Through N

You can choose from 10 different Medicare supplement policies. Each plan, A, B, C, D, F, G, K, L, M and N, has different benefits and premiums. Each lettered plan is required to have certain benefits, no matter which company you choose to purchase from; however, some plans provide extra benefits.

An insurer may not offer all plans. The plans are described on the chart on pages 28-29, which show the minimum benefits in each plan – this chart will also be included in every company’s sales material. In addition to the 10 plans, insurers may offer one high-deductible version of Plan F. This plan includes the same coverage as Plan F, except you will be responsible for the deductible (adjusted annually) each year and the premium is significantly less than the premium for regular plans A through N.

Each plan, A through N, varies with the established benefits offered. Plans K and L cover 50% and 75%, respectively, of the co-insurance for **basic benefits***, skilled nursing and the Part A deductible. Once you reach the annual out-of-pocket limit, K and L pay 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does **not** include charges from your provider that exceed

***See chart on pages 28-29 for list of basic benefits.**

Medicare-approved amounts, called “excess charges.” You are responsible for paying excess charges for all of the Medicare supplement plans unless you have Medicare supplement policies F, G, or high-deductible Plan F, which cover 100% of the Medicare Part B excess charges.

Medicare Parts A, B, C, and D

Medicare Part A typically pays for your inpatient hospital expenses, hospice services, home health care, and care in a skilled nursing facility.

Remember: a benefit is a health care service or supply that is paid for in part or in full by Medicare.

Medicare Part B typically covers your outpatient health care expenses including doctor fees.

TIP: You may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1 (877) 486-2048.

Medicare Part C (Medicare Advantage plans) must cover at least the same benefits covered under Medicare Part A and Part B; however, your costs may be different, and you may have extra benefits, such as coverage for prescription drugs or extra days in the hospital. If you are already enrolled in Medicare Part C, contact your Medicare Advantage plan administrator for specific plan information.

Note: Not all doctors accept Medicare Advantage plans, so be sure to check first!

Under **Medicare Part D**, all enrollees receive a subsidy for prescription drug insurance – an additional low-income subsidy (LIS) is available to enrollees with sufficiently low income and assets. There are two types of Medicare plans that may help lower prescription drug costs and help to protect against higher costs in the future: Medicare Advantage plans (see Part C) and other Medicare health plans, and Medicare Part D. Medicare Part D is prescription drug coverage that provides additional coverage to the original Medicare plan, some Medicare cost plans, and Medicare private fee-for-service plans. These plans are offered by insurance companies and other private companies approved by Medicare.

Note: Different plans cover different prescriptions, so you will want to review each carefully. You choose the drug plan and pay a monthly premium. If you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later.

Medicare Supplement Insurance Shopping Tips

You May Not Need Medicare Supplement Insurance

If your income is low, you may qualify for a government program that will fill the gaps in your Medicare coverage. To find out if you are eligible for **Medicaid** or if you are a **Qualified Medicare Beneficiary (QMB)**, **Specified Low-Income Medicare Beneficiary (SLMB)** or a **Qualified Individual (QI)** contact the State Department of Health and Human Services, Division of Welfare and Supportive Services (DWSS) in Reno at (775) 684-7200, (702) 486-1646 in Las Vegas/Henderson, or toll free: (800) 992-0900. For a complete list of local phone numbers you may visit <https://dwss.nv.gov/>.

One Policy is Enough

You do not need more than one policy. If you already have a policy and want better benefits, you may be able to **replace** the policy with a new one. Once you receive the new policy you should drop the old one.

Caution: Premiums paid in advance are sometimes non-refundable. For example, if you paid for a one-year policy period and decide to cancel in the middle of the policy term, the premium may be earned by the company when paid by you and there may be no provision for a refund of premium at any time during that policy period.

Right to Coverage

The best time to buy a Medigap policy is during your Medigap open enrollment period. This period lasts for 6 months and begins on the first day of the month in which you are 65 or older **and** enrolled in Medicare Part B. If you joined Medicare because of a disability before you turned 65, federal law now requires that you be given another open enrollment opportunity when you turn 65.

Note: If you apply for a policy after that six-month period, some companies will reject your application if your health is not good.

Shop for Benefits, Service and Price

Check the chart of the 10 plans on pages 28 - 29 to see the benefits that are included in each plan. Every company must use the same letters (A through N) to label its policies. Plan A will always be a company's lowest-priced Medicare supplement policy. It covers valuable basic benefits and must be sold by every company. Plans B through N add other benefits to fill different gaps in your Medicare coverage.

Use the Medicare Guide

The **Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare** ("Guide"), written by the federal government and the National Association of Insurance Commissioners (NAIC), has excellent information about Medicare, as well as health insurance. Any agent or company that offers to sell you Medicare supplement insurance must give you a copy. Upon request, a

copy of the Guide is also available from the Division of Insurance, the Division for Aging Services or the State Health Insurance Assistance Program (“SHIP”).

Note: Download a copy of ***Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*** at:

<http://www.medicare.gov/publications/pubs/pdf/02110.pdf>

Read the Outline of Coverage

The outline of coverage is useful to understand the policy in general terms – the outline of coverage for Medicare supplement insurance includes more details about each of the benefits listed in the plan’s policy.

Evaluate Your New or Existing Policy

In order to understand the details of your coverage, you must read the actual policy. When reviewing the policy, spend extra time studying the provisions about pre-existing conditions. Don’t change policies just to get a lower price. Premiums can change, and a new policy may not remain less expensive than the old one. Ask yourself, “**Would a new policy really improve my health coverage?**” Perhaps your old policy can be updated to provide the additional coverage you want.

Note: before buying any new insurance, read your existing policy.

Purchasing a Plan

Conduct Research on Medicare Supplement Plans

1. **Contact The Insurance Division at 775-687-0700 to confirm that the company is licensed.**
2. **Ask** how an insurance company prices Medigap policies. The manner in which they set the price affects how much you pay now and in the future.

Tip: A good question to ask is if there are factors other than age that may affect the cost of your Medigap policy. Policies may have discounts based on your sex, whether you smoke, whether you are married and/or if you have automatic bank withdrawal.

3. **Before you shop** for plans, make sure you really need Medicare supplement insurance before you buy.
4. **Find out** if you are eligible for group coverage. Group coverage is marketed through employers, labor unions and various private associations. If you have group insurance, ask before retirement if you can continue your employee health insurance or convert it to suitable group Medicare supplement coverage after you turn 65. Group insurance often costs less and is more comprehensive than individually purchased coverage. Also, if your spouse is included in your group health plan, be sure to check on his or her eligibility.
5. **Ask** the reference section of your local public library for financial rating publications that summarize an insurance company's financial position.

Some publications rate companies by letter grades, which can be informative. Four organizations are commonly relied upon to rate insurance companies: A.M. Best, Standard & Poor's (S&P), Moody's Investor Service, and Fitch Ratings. The role of these agencies is to assess the debt and financial strength of companies by providing a neutral analysis. In rating debt and financial strength, these agencies assist in judging an insurer's ability to meet their claims paying obligations. If an

Tip: Consider factors other than price when selecting a policy, including claims handling and a company's reputation for service.

insurance company cannot pay future claims or benefits, all other considerations, such as coverage and pricing, become relatively unimportant.

Pick your Plan

1. **When you find a plan you like**, compare before you buy. Shop around and talk to several agents and companies before making a decision. When shopping for a Medigap policy, be sure you are comparing the same policy. Do not be embarrassed to ask questions. Do not buy a policy until you are satisfied with the answers you receive.
2. **Carefully read** the plan's membership materials and enrollment forms to learn your rights and the nature and extent of your coverage. Remember, PPO plans will likely require extra out-of-pocket expenses from non-network providers.

3. **Get** a copy of the policy.
4. **Discuss the policy** with a relative, friend, Division of Insurance, or someone else whom you trust before buying. When buying by mail, check whether the company has a local agent or a toll-free number that you can call for answers to your questions and for help filing claims. Ask friends and family members about their experience with various companies.
5. **Take full advantage** of your “free look” period by carefully reviewing your new policy. You have 30 days from the date you receive the policy to return and cancel it for a full refund. Read the policy when it arrives; don’t wait until the last minute. The Division of Insurance Consumer Services section can help you understand what your policy covers. You can reach the Consumer Services section by calling (775) 687-0700 to reach the Carson City office, (705) 486-4009 to reach the Las Vegas office, and (888) 872-3234 to reach the Division of Insurance toll-free. Also, some senior citizen organizations have volunteer insurance advisors. See pages 58 through 61 for information regarding senior resources and Nevada’s State Health Insurance Program (SHIP).

Avoiding Fraud

- **Buying locally** from a licensed agent with a good reputation is safer than buying from someone you do not know. A traveling agent may never return to your area.

- **Be careful** to answer all questions accurately. Don't let the agent fill out the application for you. If an agent helps you to complete the application, do not sign it until you are sure that all questions have been completely answered and all requested medical information is included and correct.

Note: The omission of information may cause the company to deny your claims or cancel your policy.

- **Do not pay cash or make a check out to the agent or in the agent's name.** Get a receipt for all payments. Checks should be made payable only to the insurance company.
- **Don't be misled** into believing that a Medicare supplement policy is endorsed by or sold by the state or federal government. Although the Division of Insurance reviews Medicare supplement policy forms to make sure they meet Nevada requirements, the Division does not endorse particular companies or policies.

Note: It is a violation of federal and state law for insurance companies or agents to suggest they are acting on behalf of the government when selling Medicare supplement insurance.

- **Don't be pressured** to buy insurance on the agent's first visit. If you can, invite a trusted friend or relative to be present during the agent's visit. An agent who objects to this may not be the right agent for you.

- **Don't be stampeded** by statements that a certain policy or premium rate will be available only for a limited time. Such statements are seldom true.

Completing the Application

- **Never sign** a blank application form.
- **All questions** must be filled out accurately and completely.

Note: An agent may assist you, but you should never let an agent fill out the application for you. **Always double check the information for correctness before signing the application to avoid fraud.**

Note: You may also verify an insurance company on the Division's Web site at www.doi.nv.gov (see the Verify a License link on the left) or by contacting the Division at 1-888-872-3234.

- **Be sure** you have the agent's name and address and the address of the company from which you are purchasing the policy. Know how to contact your agent or the company if you need help. **Always check the license status of the agent and the insurance company with the Division of Insurance.**
- **Read** what you are being asked to sign. If the agent tries to rush you, be suspicious.

Remember, if you are replacing policies, you should have full coverage for all pre-existing conditions when you have been covered for six months under the old policy, the new policy or both. This should be explained to you in a Replacement Notice provided by the new insurance company or its agent. If you return the policy to the company, be sure to send it by certified mail with a return receipt requested. This will give you a record of the date it was returned in case there is a dispute.

Special Information for Military Retirees

You or your spouse may be eligible for TRICARE For Life if either has retired from the United States military service. The benefits covered by TRICARE For Life supplement Medicare coverage and eliminate the need for a Medicare supplement policy. In addition, TRICARE For Life benefits include coverage for outpatient prescription drugs not covered by Medicare. Unlike Medicare supplement policies; there is no enrollment fee to belong to TRICARE For Life. If you believe that you are eligible for this program you can contact TRICARE For Life at (866) 773-0404 or TDD at (866) 773-0405.

More Information is Available

The Division of Insurance Consumer Services section is happy to answer any additional questions you might have. If you have more questions about Medicare supplement insurance, contact us at:

**State of Nevada
Department of Business & Industry
Division of Insurance**

**Carson City Office (775) 687-0700; csc@doi.nv.gov
Las Vegas Office (702) 486-4009**

**Refer to pages 58 - 62 of this guide for free counseling and other
resources.**

Cost Comparison and Guide to Premium Chart

This section of the booklet has a graph outlining the 10 standard plans, a section which outlines who sells Medigap in Nevada and offers a comparison of premiums by insurance company and plan type. Premiums are listed by alphabetical order according to the insurance company's name.

NOTICE:

The policy comparison section summarizes material submitted by the insurers. The figures are theirs, not those of the Division of Insurance. Some information may not be current at the time you read this publication. The policy itself becomes the contract between the insurance company and you, and will be the basis of final determinations. Only policies that meet the requirements of Nevada laws and regulations at time of publication are included.

Publication of this comparison is for informational purposes only. Inclusion of information about a policy in this brochure does not in any way constitute endorsement of a policy or company by the Division of Insurance.

GUIDE TO THE PREMIUM COMPARISON CHART

Annual Premiums

The premiums shown are only a sampling of January 2017, annual rates. For consistency among the carriers they were asked to provide the premiums for 65 and 70 year old female, non-smokers, in downtown Las Vegas (zip 89102), Clark County, Southern Nevada. Rates specific to whether or not you smoke, your age, and your gender can be obtained from the insurance company. Keep in mind, the rate may change as companies file new rates with the Division of Insurance. While rates may change because of increased age and/or an insurance company's increased claims for all similar policyholders, your premiums cannot increase based on your individual claims.

Note: Some companies expect you to pay annually, while others bill every month, and some bill every two to three months.

Age Groups

Premiums for Medicare supplement insurance will be based on your age when you purchase the policy. Although companies may have different premiums for each age, this comparison shows premiums only for ages 65 and 70.

Premium Type

Companies have two different methods of pricing policies which are both based upon your age. These are shown in the **Premium Type** column, in the **2017 Annual Premiums** chart.

- **Issue Age:** These policies are priced at your age when you initially purchase the policy. Your future rates will **not** increase because of age as you become older. If you buy the policy at age 65 you will always pay the premium that the company charges 65-year-old customers; however, your premiums can increase because of an insurance company's overall claims experience. While the initial rate for an **Issue Age** policy may be greater than a similar **Attained Age** policy, it could be less expensive over the life of the policy.
- **Attained Age:** In addition to the annual rate increases for changes in Medicare and overall claims experience, the premium will increase as you become older. If you buy a policy at 65, when you are 70 you will pay whatever the company is then charging individuals who are 70 years old.
- **Community Age Rating:** The premium is the same for all customers who buy this policy, regardless of age.

Remember: Premiums will most likely increase every year in order to keep up with changes in Medicare. Premiums may also increase if overall claim expenses are higher than anticipated.

Area

Some companies charge different premiums based on where you live.

Smoker

Some companies may charge different premiums for non-smokers and smokers. If this column has a **Yes**, the company has two or more sets of prices. You should check with the company to find out if your premium would be higher or lower.

Sex

In the **2017 Annual Premiums** chart, premiums shown are for women. A company with a **No** in this column uses the same rates for both males and females. A company with a **Yes** in this column has a different premium for men. Premiums for men are generally higher than those for women.

Health Screening / Underwriting

Although most companies **underwrite***, some companies offer policies regardless of any health problems you may now have. A company must sell you any Medigap policy they sell, regardless of your health, at the price of a healthy person if you apply during your Medigap open enrollment.

***See pages 65 – 73 for word definitions.**

Innovative Benefits

Each plan, A through N, no matter what company you buy from, is required to have certain benefits; however, some plans provide extra benefits that are termed innovative. Some examples of innovative benefits are: decreasing deductibles, hearing and vision coverage, gym memberships, and preferred rates based on underwriting. While the standard benefits are guaranteed to remain with the policy, the innovative benefits may not be permanently a part of the policy. They may instead only be provided at the company's discretion. Please read the policy carefully to see if the innovative benefits are guaranteed.

Note: To find out which companies provide innovative benefits please visit our website:

http://doi.nv.gov/Health_Insurance_Rates/Medicare_Supplement_Rates/

For specific information about the benefits you may have to contact the companies – contact information is also provided on the website for most companies.

2017 POLICY BENEFIT CHART

Medicare supplement insurance can be sold in only ten standard plans and one high-deductible plan. The chart on the next page shows the benefits for each plan. Every company must make available Plan A. Some plans may not be available in Nevada.

Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20 % of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B co-insurance or co-payments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A co-insurance.

	A	B	C	D	F	F High Deductible*	G	K	L	M	N
Page #	<u>32 - 33</u>	<u>34</u>	<u>35</u>	<u>36</u>	<u>37 - 38</u>	<u>39</u>	<u>40</u>	<u>41</u>	<u>42</u>	<u>43</u>	<u>44</u>
for Rates	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	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 75%	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance, except for co-insurance for office visit, and co-payment for ER
			Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
		Part A Deductible	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 Deductible					
					Part B Excess 100%	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			Foreign Travel Emergency	Foreign Travel Emergency
								Out-of-pocket limit; paid at 100% after limit reached	Out-of-pocket limit; paid at 100% after limit reached		

* Plan F also has an option called a high-deductible Plan F. This high-deductible plan pays the same benefits as Plan F after a calendar-year deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses equal to the annual deductible have been satisfied. Out-of-pocket expenses for this deductible are expenses that would ordinarily have been paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Who Sells Medigap in Nevada?		
Company	Telephone Number	Website
AARP/UnitedHealthcare	1-866-465-0088	www.aarpmedicaresupplement.com
Aetna Life Insurance Company	1-888-624-6290	www.aetnaseniorproducts.com
American Continental	1-800-264-4000	www.aetnaseniorproducts.com
American Republic Corp Insurance	1-888-755-3065	www.americanenterprise.com
American Republic Insurance	1-888-755-3065	www.americanenterprise.com
American Retirement Life Insurance Company	1-877-229-0293	www.cignasupplementalbenefits.com
Americo Financial Life and Annuity Insurance Company	1-800-231-0801	http://www.americo.com/
Bankers Fidelity Life Insurance Company	1-866-458-7504	http://bflic.com
Central States Indemnity Company Of Omaha	1-866-644-3988	www.csi-omaha.com
Colonial Penn Life Insurance Company	1-800-800-2254	https://www.bankerslife.com/products/medicare-supplement-insurance/
Combined Insurance Company of America	1-800-544-5531	www.combinedinsurance.com
Equitable Life And Casualty Ins Company	1-877-358-4060	equilife.com
Gerber Life Insurance Company	1-877-778-0839	
Globe Life and Accident Insurance Company	1-888-534-3257	www.globecaremedsupp.com
Guarantee Trust Life Insurance Company		www.gtlic.com
Heartland National Life Insurance Company	1-877-358-4060	heartlandnational.net
Humana Insurance Company	1-888-310-8482	www.humana.com
Humana Insurance Company (Healthy Living)	1-888-310-8482	www.humana.com
Liberty National Life Insurance Company	1-800-331-2512	http://www.LibertyNational.com
Medico Insurance Company	1-800-228-6080	www.gomedico.com
Mutual of Omaha Insurance Company	1-800-667-2937	www.mutualofomaha.com
Oxford Life Insurance Company	1-866-641-9999	oxfordlife.com
Standard Life & Accident Insurance Co.	1-888-350-1488	www.slaico.com
State Farm Mutual Automobile Ins Co	See Local Agent	www.statefarm.com
Transamerica Life Insurance Company	1-855-288-4181	https://www.transamerica.com/individual/products/insurance/medicare-solutions/medicare-supplement/
Thrivent Financial for Lutherans	1-800-847-4836	www.thrivent.com
United American Insurance Company	1-800-331-2512	www.unitedamerican.com
USAA Life Insurance Company	1-800-531-8722	www.usaa.com
WMI Mutual Insurance Company	801-748-5340 x127	www.wmimutual.com/medigap

Please See Our Website For Rates by Age, Zip Codes, etc.

http://doi.nv.gov/Health_Insurance_Rates/Medicare_Supplement_Rates/

2017 Annual Premium Comparisons

Legend:

Pre-X Months - if pre-existing conditions are considered - The months of wait the

Definitions of Premium Type:

Attained Age - The monthly premiums for these policies will be based on your current

Issue Age - The monthly premiums for these policies will be based on when you buy

Community - The monthly premiums for these policies will be based on geographical

Please check out the rates for all ages and zip codes on Nevada Division of Insurance's website, along with company contact information:

http://doi.nv.gov/Health_Insurance_Rates/Medicare_Supplement_Rates/

Plan A Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	Plan A	1001	1334	Attained Age	2
USAA LIFE INSURANCE COMPANY	Plan A	1053	1232	Attained Age	
TRANSAMERICA LIFE INSURANCE COMPANY	Plan A	1168	1469	Issue Age	6
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY	Plan A	1208	1510	Attained Age	0
WMI MUTUAL INSURANCE COMPANY	Plan A	1248	1416	Attained Age	6
AMERICAN REPUBLIC INSURANCE COMPANY	Plan A	1309	1365	Attained Age	0
UNITEDHEALTHCARE INSURANCE COMPANY	Plan A	1329	1614	Community Rated	3
THRIVENT FINANCIAL FOR LUTHERANS	Plan A	1353	1607	Attained Age	0
UNITED AMERICAN INSURANCE COMPANY	Plan A	1368	1881	Attained Age	2
MEDICO INSURANCE COMPANY	Plan A	1395	1574	Attained Age	0
AMERICAN RETIREMENT LIFE INSURANCE COMPANY	Plan A	1462	1719	Attained Age	6
AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY	Plan A	1490	1676	Attained Age	12
CENTRAL STATES INDEMNITY COMPANY OF OMAHA	Plan A	1531	1714	Attained Age	12
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan A	1544	1748	Attained Age	12
GUARANTEE TRUST LIFE INSURANCE COMPANY	Plan A	1586	1683	Attained Age	6
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	Plan A	1588	1941	Attained Age	6

Plan A Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
LIBERTY NATIONAL LIFE INSURANCE COMPANY	Plan A	1629	2242	Attained Age	2
AMERICAN REPUBLIC CORP INSURANCE COMPANY	Plan A	1630	1826	Attained Age	0
COMBINED INSURANCE COMPANY OF AMERICA	Plan A	1652	2159	Attained Age	0
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan A	1740	1932	Attained Age	12
MUTUAL OF OMAHA INSURANCE COMPANY	Plan A	1746	1891	Attained Age	0
OXFORD LIFE INSURANCE COMPANY	Plan A	1794	2133	Attained Age	12
EQUITABLE LIFE AND CASUALTY INS COMPANY	Plan A	1849	2244	Attained Age	6
AETNA LIFE INSURANCE COMPANY	Plan A	1854	2233	Attained Age	0
HUMANA INSURANCE COMPANY	Plan A	1889	2229	Attained Age	12
GERBER LIFE INSURANCE COMPANY	Plan A	2012	2380	Attained Age	0
HUMANA INSURANCE COMPANY- MORE PLANS	Plan A	2118	2470	Attained Age	12
COLONIAL PENN LIFE INSURANCE COMPANY	Plan A	2395	2926	Attained Age	0
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan A	3248	3330	Attained Age	6

Plan B Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	Plan B	1476	1824	Attained Age	2
THRIVENT FINANCIAL FOR LUTHERANS	Plan B	1516	1821	Attained Age	0
TRANSAMERICA LIFE INSURANCE COMPANY	Plan B	1543	1939	Issue Age	6
CENTRAL STATES INDEMNITY COMPANY OF OMAHA	Plan B	1785	1997	Attained Age	12
UNITEDHEALTHCARE INSURANCE COMPANY	Plan B	1886	2290	Community Rated	3
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan B	1948	2203	Attained Age	12
AETNA LIFE INSURANCE COMPANY	Plan B	2051	2510	Attained Age	0
UNITED AMERICAN INSURANCE COMPANY	Plan B	2054	2853	Attained Age	2
HUMANA INSURANCE COMPANY	Plan B	2054	2424	Attained Age	12
COLONIAL PENN LIFE INSURANCE COMPANY	Plan B	2264	2756	Attained Age	0
LIBERTY NATIONAL LIFE INSURANCE COMPANY	Plan B	2265	3147	Attained Age	2
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan B	3698	3791	Attained Age	6

Plan C Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	Plan C	1650	1996	Attained Age	2
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY	Plan C	1773	2217	Attained Age	0
THRIVENT FINANCIAL FOR LUTHERANS	Plan C	1792	2123	Attained Age	0
TRANSAMERICA LIFE INSURANCE COMPANY	Plan C	1825	2295	Issue Age	6
WMI MUTUAL INSURANCE COMPANY	Plan C	1896	2196	Attained Age	6
CENTRAL STATES INDEMNITY COMPANY OF OMAHA	Plan C	2160	2417	Attained Age	12
UNITEDHEALTHCARE INSURANCE COMPANY	Plan C	2167	2632	Community Rated	3
UNITED AMERICAN INSURANCE COMPANY	Plan C	2338	3237	Attained Age	2
HUMANA INSURANCE COMPANY	Plan C	2431	2869	Attained Age	12
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan C	4205	4310	Attained Age	6

Plan D Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
THRIVENT FINANCIAL FOR LUTHERANS	Plan D	1542	1866	Attained Age	0
TRANSAMERICA LIFE INSURANCE COMPANY	Plan D	1687	2121	Issue Age	6
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	Plan D	1925	2390	Attained Age	6
UNITED AMERICAN INSURANCE COMPANY	Plan D	2156	3059	Attained Age	2
MEDICO INSURANCE COMPANY	Plan D	2284	2611	Attained Age	0
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan D	2534	2597	Attained Age	6

Plan F Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	Plan F	1667	2015	Attained Age	2
AMERICAN RETIREMENT LIFE INSURANCE COMPANY	Plan F	1789	2088	Attained Age	6
THRIVENT FINANCIAL FOR LUTHERANS	Plan F	1801	2133	Attained Age	0
USAA LIFE INSURANCE COMPANY	Plan F	1805	2115	Attained Age	
TRANSAMERICA LIFE INSURANCE COMPANY	Plan F	1836	2308	Issue Age	6
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY	Plan F	1840	2300	Attained Age	0
AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY	Plan F	1848	2067	Attained Age	12
WMI MUTUAL INSURANCE COMPANY	Plan F	1968	2280	Attained Age	6
AMERICAN REPUBLIC INSURANCE COMPANY	Plan F	1982	2067	Attained Age	0
GUARANTEE TRUST LIFE INSURANCE COMPANY	Plan F	2011	2135	Attained Age	6
OXFORD LIFE INSURANCE COMPANY	Plan F	2061	2435	Attained Age	12
UNITEDHEALTHCARE INSURANCE COMPANY	Plan F	2176	2642	Community Rated	3
CENTRAL STATES INDEMNITY COMPANY OF OMAHA	Plan F	2203	2466	Attained Age	12
COMBINED INSURANCE COMPANY OF AMERICA	Plan F	2265	2961	Attained Age	0
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan F	2281	2560	Attained Age	12
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	Plan F	2291	2774	Attained Age	6

Plan F Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
AMERICAN REPUBLIC CORP INSURANCE COMPANY	Plan F	2313	2591	Attained Age	0
AETNA LIFE INSURANCE COMPANY	Plan F	2320	2846	Attained Age	0
UNITED AMERICAN INSURANCE COMPANY	Plan F	2376	3283	Attained Age	2
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan F	2412	2664	Attained Age	12
HUMANA INSURANCE COMPANY	Plan F	2480	2927	Attained Age	12
LIBERTY NATIONAL LIFE INSURANCE COMPANY	Plan F	2565	3555	Attained Age	2
MEDICO INSURANCE COMPANY	Plan F	2612	2956	Attained Age	0
EQUITABLE LIFE AND CASUALTY INS COMPANY	Plan F	2627	3206	Attained Age	6
HUMANA INSURANCE COMPANY- MORE PLANS	Plan F	2691	3147	Attained Age	12
COLONIAL PENN LIFE INSURANCE COMPANY	Plan F	2720	3295	Attained Age	0
MUTUAL OF OMAHA INSURANCE COMPANY	Plan F	2771	3002	Attained Age	0
GERBER LIFE INSURANCE COMPANY	Plan F	2887	3421	Attained Age	0
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan F	3458	3544	Attained Age	6

Plan F (High Deductible) Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	Plan F (High Deductible)	330	480	Attained Age	2
UNITED AMERICAN INSURANCE COMPANY	Plan F (High Deductible)	355	516	Attained Age	2
LIBERTY NATIONAL LIFE INSURANCE COMPANY	Plan F (High Deductible)	440	640	Attained Age	2
COLONIAL PENN LIFE INSURANCE COMPANY	Plan F (High Deductible)	498	604	Attained Age	0
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan F (High Deductible)	503	515	Attained Age	6
THRIVENT FINANCIAL FOR LUTHERANS	Plan F (High Deductible)	537	660	Attained Age	0
MUTUAL OF OMAHA INSURANCE COMPANY	Plan F (High Deductible)	605	683	Attained Age	0
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan F (High Deductible)	612	683	Attained Age	12
AMERICAN REPUBLIC CORP INSURANCE COMPANY	Plan F (High Deductible)	659	738	Attained Age	0
AMERICAN REPUBLIC INSURANCE COMPANY	Plan F (High Deductible)	748	780	Attained Age	0
HUMANA INSURANCE COMPANY	Plan F (High Deductible)	769	904	Attained Age	12
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan F (High Deductible)	888	996	Attained Age	12
HUMANA INSURANCE COMPANY- MORE PLANS	Plan F (High Deductible)	983	1130	Attained Age	12

Plan G Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
AMERICAN RETIREMENT LIFE INSURANCE COMPANY	Plan G	1351	1604	Attained Age	6
THRIVENT FINANCIAL FOR LUTHERANS	Plan G	1552	1877	Attained Age	0
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan G	1562	1766	Attained Age	12
GUARANTEE TRUST LIFE INSURANCE COMPANY	Plan G	1664	1769	Attained Age	6
TRANSAMERICA LIFE INSURANCE COMPANY	Plan G	1686	2120	Issue Age	6
EQUITABLE LIFE AND CASUALTY INS COMPANY	Plan G	1762	1994	Attained Age	6
WMI MUTUAL INSURANCE COMPANY	Plan G	1764	2052	Attained Age	6
MUTUAL OF OMAHA INSURANCE COMPANY	Plan G	1997	2164	Attained Age	0
COLONIAL PENN LIFE INSURANCE COMPANY	Plan G	2007	2472	Attained Age	0
UNITED AMERICAN INSURANCE COMPANY	Plan G	2064	2923	Attained Age	2
AETNA LIFE INSURANCE COMPANY	Plan G	2153	2667	Attained Age	0
GERBER LIFE INSURANCE COMPANY	Plan G	2187	2592	Attained Age	0
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan G	2189	2549	Attained Age	12
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan G	2553	2617	Attained Age	6

Plan K Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
UNITEDHEALTHCARE INSURANCE COMPANY	Plan K	731	887	Community Rated	3
COLONIAL PENN LIFE INSURANCE COMPANY	Plan K	836	1019	Attained Age	0
TRANSAMERICA LIFE INSURANCE COMPANY	Plan K	841	1057	Issue Age	6
AMERICAN REPUBLIC CORP INSURANCE COMPANY	Plan K	974	1091	Attained Age	0
HUMANA INSURANCE COMPANY	Plan K	1118	1317	Attained Age	12
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan K	1175	1386	Attained Age	12
UNITED AMERICAN INSURANCE COMPANY	Plan K	1286	1712	Attained Age	2
HUMANA INSURANCE COMPANY- MORE PLANS	Plan K	1347	1559	Attained Age	12

Plan L Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
UNITEDHEALTHCARE INSURANCE COMPANY	Plan L	1172	1423	Community Rated	3
TRANSAMERICA LIFE INSURANCE COMPANY	Plan L	1248	1569	Issue Age	6
AMERICAN REPUBLIC CORP INSURANCE COMPANY	Plan L	1327	1487	Attained Age	0
HUMANA INSURANCE COMPANY	Plan L	1579	1862	Attained Age	12
COLONIAL PENN LIFE INSURANCE COMPANY	Plan L	1704	2042	Attained Age	0
UNITED AMERICAN INSURANCE COMPANY	Plan L	1809	2414	Attained Age	2

Plan M Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
THRIVENT FINANCIAL FOR LUTHERANS	Plan M	1458	1756	Attained Age	0
TRANSAMERICA LIFE INSURANCE COMPANY	Plan M	1536	1932	Issue Age	6
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	Plan M	1799	2237	Attained Age	6
COLONIAL PENN LIFE INSURANCE COMPANY	Plan M	2105	2603	Attained Age	0

Plan N Rates

Company Name	Plan Type	Rate at Age 65	Rate at Age 70	Premium Type	Pre-X Months
AMERICAN RETIREMENT LIFE INSURANCE COMPANY	Plan N	1195	1412	Attained Age	6
BANKERS FIDELITY LIFE INSURANCE COMPANY	Plan N	1202	1356	Attained Age	12
AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY	Plan N	1258	1419	Attained Age	12
COLONIAL PENN LIFE INSURANCE COMPANY	Plan N	1297	1677	Attained Age	0
USAA LIFE INSURANCE COMPANY	Plan N	1336	1563	Attained Age	
GUARANTEE TRUST LIFE INSURANCE COMPANY	Plan N	1367	1452	Attained Age	6
AMERICAN CONTINENTAL INSURANCE COMPANY	Plan N	1435	1622	Attained Age	12
OXFORD LIFE INSURANCE COMPANY	Plan N	1439	1714	Attained Age	12
TRANSAMERICA LIFE INSURANCE COMPANY	Plan N	1445	1816	Issue Age	6
MUTUAL OF OMAHA INSURANCE COMPANY	Plan N	1484	1608	Attained Age	0
CENTRAL STATES INDEMNITY COMPANY OF OMAHA	Plan N	1497	1676	Attained Age	12
UNITEDHEALTHCARE INSURANCE COMPANY	Plan N	1501	1823	Community Rated	3
AETNA LIFE INSURANCE COMPANY	Plan N	1539	1916	Attained Age	0
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	Plan N	1550	1914	Attained Age	6
HUMANA INSURANCE COMPANY	Plan N	1553	1832	Attained Age	12
COMBINED INSURANCE COMPANY OF AMERICA	Plan N	1586	2072	Attained Age	0
STANDARD LIFE & ACCIDENT INSURANCE COMPANY	Plan N	1668	1709	Attained Age	6
UNITED AMERICAN INSURANCE COMPANY	Plan N	1714	2437	Attained Age	2
EQUITABLE LIFE AND CASUALTY INS COMPANY	Plan N	1722	2104	Attained Age	6
HUMANA INSURANCE COMPANY- MORE PLANS	Plan N	1866	2173	Attained Age	12
LIBERTY NATIONAL LIFE INSURANCE COMPANY	Plan N	1956	2782	Attained Age	2

Medicare Options

Original fee-for-service Medicare and original Medicare with a Medicare supplement policy are available to all Nevada beneficiaries who are age 65 or older. Currently there are no insurers who offer Medicare supplement policies to beneficiaries under 65. There are also Medicare Advantage Plans (Part C) offered by private companies that provide Parts A and B (and sometimes Part D drug coverage) services to Medicare beneficiaries through special arrangements including HMOs, PPOs, and Managed Care Companies.

Medicare Advantage

Although Advantage plans are subsidized by the federal government, some companies charge nominal premiums and each company offers differing services. The companies that offer Part C in Nevada are as follows (separated by county):

Carson City

- **Senior Care Plus** (1-888-775-7003)

Churchill County

- **Senior Care Plus** (1-888-775-7003)

Clark County

- **Aetna Medicare** (1-800-642-0013)

- **CareMore Health Plan of Nevada** (1-877-908-6999)
- **Humana** (1-866-945-4481)
- **Senior Dimensions** (1-855-895-6703)
- **UnitedHealthcare** (1-877-517-5276)

Douglas County

- **Senior Care Plus** (1-888-775-7003)
- **Senior Dimensions** (1-855-895-6703)

Esmeralda County

- **Senior Dimensions** (1-855-895-6703)

Lyon County

- **Senior Care Plus** (1-888-775-7003)

Mineral County

- **Senior Dimensions** (1-855-895-6703)

Nye County

- **Humana** (1-866-945-4481)
- **Senior Dimensions** (1-855-895-6703)

Storey County

- **Senior Care Plus** (1-888-775-7003)

Washoe County

- **Humana** (1-866-945-4481)
- **Senior Care Plus** (1-888-775-7003)
- **Senior Dimensions** (1-855-895-6703)

Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties do not have access to Advantage Plans.

Original Medicare is the traditional fee-for-service Medicare and is available to all Medicare beneficiaries. There are two parts of original Medicare: Medicare Part A and Medicare Part B. Medicare Part A (hospital insurance) is available to all eligible Medicare beneficiaries for no monthly premium. Medicare Part B is an optional insurance which you must pay a monthly premium in order to receive the benefits this part covers.

Under traditional Medicare, you can choose any health care provider who accepts Medicare. Medicare will pay the provider each time you incur an expense. While Medicare pays its portion, you are responsible for paying the remaining balance, including deductibles, co-payments, co-insurance and the cost of services not covered by Medicare.

Note: All newly enrolled Medicare beneficiaries are covered for an initial physical examination and numerous preventive care services.

Original Medicare with a Supplement Policy

You can purchase a private Medicare supplement insurance plan (Medigap insurance) to cover some of your obligations after traditional Medicare has paid its portion. You may purchase one of 10 standard Medicare supplemental insurance policies. The benefits provided by these plans are summarized on the policy benefit chart found on pages 28 - 29. Most policies pay Medicare co-insurance amounts while others pay Medicare deductibles. Some beneficiaries may already have supplemental coverage from other sources such as a former employer or Medicaid. There are two different versions of Medigap policies:

- **Medigap:** You can go to any doctor or hospital.
- **Medicare SELECT:** These plans are almost identical to standard Medigap insurance. When you purchase one of Medicare's SELECT policies, you're buying a standard Medigap plan. The only difference is that this type of plan operates like managed care plans. In other words, you **must** use plan hospitals and, in some cases, plan doctors in order to be eligible for full Medigap benefits.

Part D Coverage with Original Medicare

In years past, private insurers were able to provide supplement insurance combined with drug coverage just as some Medicare Advantage (Part C) companies offer; however, now recipients with Original Medicare can choose a Medigap policy and separately shop for

a Part D (prescription drug) policy from a private insurer. Although purchasing a supplement or drug policy is not mandatory, if you wait until coverage is needed, financial penalties will incur. There are many Part D insurers with various plans to choose from.

For more information you may visit the Medicare Plan finder at <https://www.medicare.gov/find-a-plan/questions/home.aspx> or contact Nevada SHIP (pages 58 – 61) for more information.

Managed Care

Under a managed care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) offer comprehensive, coordinated medical services on a pre-paid basis. Payments are made monthly to Medicare and Medicare makes a monthly payment to the managed care plan. Some plans will charge a monthly premium or require a co-payment per visit or service. The monthly premiums and co-payments will vary depending on the plan you choose and the county in which you live.

Note: A supplemental insurance policy is not necessary if you join a managed care plan.

There are several different types of managed care plans:

- **HMO:** In a Health Maintenance Organization, you **must** use the plan's providers (doctors, hospitals, skilled nursing facilities and

ancillary providers). These providers are paid directly by the HMO and you are only required to make small co-payments. These plans sometimes offer services that are not covered by traditional fee-for-service Medicare.

- **HMO with POS option:** Less restrictive than HMOs. When combined with a basic HMO package, the POS (point-of-service) option allows you to use doctors and hospitals outside of the plan for an additional cost.
- **PSO:** In a Provider Sponsored Organization you **must** use the plan's providers. These plans operate like an HMO; however, the plan is sponsored by the providers (doctors and/or hospitals).
- **PPO:** The in-network benefits are provided by the plan's providers (preferred providers). However, you can use doctors and hospitals outside of the plan for an additional cost.

Private Fee-for-Service Plan

In a private fee-for-service plan, you select a private insurance plan which accepts Medicare beneficiaries. You will pay the Medicare premiums, any other monthly premium the private fee-for-service plan charges, and an amount per visit or service. The fee-for-service plan determines how much to allow for the service; however, the provider may charge more than the allowed amount and bill you for the difference. The plan may provide extra benefits that traditional Medicare does not cover.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used to pay for medical and retiree health expenses incurred by individuals and their families. HSAs are open to anyone who enrolls in a high-deductible health insurance plan; however, current tax laws do not allow Medicare beneficiaries to enroll. HSAs fall under the jurisdiction of the United States Department of Treasury. If an individual ceases to be eligible for their HSA or makes an ineligible withdrawal, penalties and taxes may apply.

For assistance with HSAs, please contact your HSA trustee or visit the United States Department of the Treasury's Web site at:

<http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx> or call 1-800-829-1040.

Medicare HMOs

An HMO that has a contract with Medicare must provide or arrange for the full range of Part A and B services if you are covered under both parts of Medicare. HMOs can also provide benefits beyond what Medicare allows, such as: preventive care, prescription drugs (limited amount), dental care, hearing aids, and eyeglasses.

Before joining a plan, be sure to read the plan's membership materials and enrollment forms carefully to learn your rights and the nature and extent of your coverage. If you belong to an HMO plan, the plan will not pay claims for any non-emergency benefits you receive from providers outside of the HMO. Below is a list of Medicare HMO companies in Nevada.

Medicare PPO's

A Medicare PPO plan is an option for Medicare Part C. Each PPO plan has a list, known as a “network”, of primary care doctors, specialists, and hospitals that you may choose from. If you have a preferred doctor, specialist or hospital, which are not included in the plan's network, you may still see them for your medical needs; however, they will usually cost more than a choice from the plan's network. Some Medicare PPO plans offer prescription drug coverage and additional benefits, such as written and hearing screenings, disease management, and other services not covered under original Medicare. Monthly premiums and how much you pay for services vary depending on the plan. There is an annual limit on your out-of-pocket that varies depending on the plan.

Note: It is illegal to be sold a Medicare Supplemental Insurance Policy if you have Part C unless you plan to drop Part C and enroll in traditional Medicare.

High-Deductible Plans

High-Deductible Plan F

There is an annual deductible for the High-Deductible Plan F. Other than the deductible amount, this plan has the same coverage as regular Plan F. Benefits under this plan will not begin until the out-of-pocket expenses have reached the deductible. The expenses not paid are the amounts the policy would have paid under regular Plan F, including the Medicare deductibles for Part A and Part B, but not the separate deductible for emergency foreign travel in Plan F. The premium for this plan is significantly less than the regular Plan F. These plans are seen in the 2016 Annual Premiums chart on pages 39 through 41.

Annual Limit Plans

Plans K and L

Plans K and L provide for different cost-sharing for items and services than Plans A – G, M and N. Once you reach the annual limit, the two plans pay 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include charges from your provider that exceed Medicare-approved amounts, called “excess charges.” You are responsible for paying excess charges.

GUARANTEED ISSUE

During the initial six month enrollment window after your 65th birthday, insurers cannot decline to offer you coverage. However, beyond the 6 months companies can decline to insure you. And even during the window, companies can decline to cover pre-existing conditions for up to 6 months after enrollment. The most common conditions for guaranteed issue are seen below.

Note: Certain people will have a right to guaranteed issue of a Medicare supplement plan, without regard to pre-existing conditions, no matter when they enroll, even if it's beyond the 6 month window. In order to be eligible for guaranteed issue under any of the following six circumstances, you must apply within 63 days after losing your other health plan coverage.

1. When an employer terminates a group plan or eliminates substantially all supplemental benefits, an individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**
2. When a group plan is primary to Medicare and either the plan terminates or an individual leaves the plan, the individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**
3. An individual who has a Medicare SELECT supplemental policy or is enrolled in a Medicare Advantage plan under Medicare (managed care or private fee-for-service, see pages 46 - 53), and discontinues the coverage because:

- a. The plan terminates or no longer provides service in the individual's area of residence;
- b. The individual is no longer eligible for the plan due to a change in residence; or
- c. The individual can show that the plan:
 - 1) Violated a material provision of the contract; or
 - 2) The agent for the plan materially misrepresented the plan.

The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

4. An individual who is enrolled in a Medicare supplement plan and the coverage ceases because:
 - a. The insurer becomes insolvent;
 - b. Other involuntary terminations occur;
 - c. The insurer violated a material provision of the contract, or;
 - d. The insurer or agent materially misrepresented the plan.

The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

5. An individual who terminates a Medicare supplement plan in order to sign up for a Medicare SELECT supplemental policy or a plan under Medicare Advantage, and then terminates the new coverage within 12 months, is **eligible for the same plan** the individual had prior to the change.
6. An individual who becomes eligible for the first time and signs up for Medicare Advantage and terminates this coverage within 12 months is **eligible for any plan.**

For more information: please consult the federally published Choosing a Medigap Policy at <http://www.medicare.gov/Pubs/pdf/02110.pdf> and / or contact SHIP (see pages 58- 61 for contact information).

Medicare SHIP Program

The State Health Insurance Assistance Program (SHIP) is funded by a grant from the federal government and administered by the Nevada Department of Health and Human Services, Division for Aging Services.

The Program meets one of the most universal and critical needs of seniors and Medicare beneficiaries today: **free** one-on-one assistance and counseling for questions and problems regarding Medicare and supplemental health insurance. SHIP provides the following services:

- Pre-Medicare counseling;
- Information and eligibility on Medicare entitlements, benefits, limitations, Medicaid (Qualified Medicare Beneficiaries & Specified Low Income Medicare Beneficiaries), and Managed Care Plans through Health Maintenance Organizations (HMOs);
- Assistance with claims, requests for reconsideration and appeals processes under Medicare and supplemental insurance;
- Unbiased information that will assist the consumer in determining supplemental insurance and long-term care insurance needs;
- Outreach information and materials for seniors and families through meetings, seminars, classes, health fairs, senior fairs and the media (**speakers available**); and
- Referrals for coordination with federal and other state and community services.

Arrangements may be made for homebound seniors, as well as other seniors, who need personal counseling assistance. Please call (702)

486-3478 in Las Vegas; and statewide **call toll free 1-800-307-4444**.

The services offered by the Program are **free of charge and confidential**. Senior citizens are assured there will be no selling or soliciting for insurance.

Medicare Counseling Program

The following is a list of Senior Centers and/or local numbers to contact for counseling with the Nevada State Health Insurance Assistance Program (SHIP):

Please call ahead for counseling times & additional information.

<i>Southern Nevada</i>	
SHIP Office 1820 E. Sahara Avenue, Suite 205 Las Vegas, NV 89104 (702) 486-3478	
Boulder City Senior Center (702) 293-3320	E. Las Vegas Community Senior Center (702) 229-1515
East Valley Family Services (702) 631-7098	Heritage Senior Facility (702) 267-2956
Las Vegas Senior Center (702) 229-6454	Mountain View H2U (702) 255-5404
Olive Crest (702) 685-3459	Pahrump Senior Center (775) 537-2323
RAGE, Inc. (702) 333-1038	Spring Valley Hospital (702) 853-3276
Sunrise H2U (702) 853-3000	Valley Hospital (702) 894-5512
Whitney Senior Center (702) 455-7576	

<i>Northern Nevada</i>	
Access to Healthcare Network (775) 385-2345	Aging & Disability Services, Senior Rx (775) 687-0518
Carson City Senior Center (775) 883-0703	Carson Tahoe Cancer Center (775) 883-0703
Dayton Senior Center (775) 246-6210	Douglas Senior Center (775) 783-6455
Elko Aging & Disability Resource Center (775) 753-4085	Elko County Senior Center (775) 738-5911
Fallon Senior Center (775) 423-7096	Fernley Senior Center (775) 575-3370
Incline Village Recreation Center (775) 832-1310	Inter-Tribal Council of Nevada (775) 355-0600
Neil Road Community Center (775) 334-2262	Pershing County Senior Center (775) 273-2291
Reno Senior Center (775) 328-2575	Silver Springs Senior Center (775) 577-5014
Storey County Senior Center (775) 847-0957	Winnemucca Senior Center (775) 423-7096

THE SERVICE OFFERED BY THE MEDICARE SHIP PROGRAM IS PROVIDED BY TRAINED VOLUNTEERS/ADVISORS AND IS **FREE OF CHARGE**

Other Resources

Division of Insurance

(702) 486-4009 or (775) 687-0700 or Toll-Free: (888) 872-3234

www.doi.nv.gov

Centers for Medicare & Medicaid Services (CMS)

Toll-Free: (800) Medicare (633-4227)

www.cms.gov

Social Security Administration (SSA)

(800) 772-1213 TTY (800) 325-0778

www.ssa.gov

National Association of Insurance Commissioners (NAIC)

(816) 842-3600

www.naic.org

Public Employees' Retirement System of Nevada (PERS)

(775) 687-4200 or Toll-Free: (866) 473-7768

www.nvpers.org

Nevada Aging & Disability Services Division

(702) 486-3545 or (775) 687-4210

<http://www.nvaging.net/>

Governor's Office of Consumer Health Assistance (GOVCHA)

(702) 486-3587 or Toll-Free (888) 333-1597

<http://dhhs.nv.gov/cha.htm>

Public Employees' Benefits Program

(775) 684-7000 or Toll-Free (800) 326-5496

www.pebp.state.nv.us

How to File an Inquiry or Complaint

If you have an insurance question or problem, you should first contact your agent or company to get the matter resolved.

If you cannot get the matter resolved, contact the **Nevada Division of Insurance** for assistance. Inquiries or questions may be directed to the Consumer Services section at either of the Insurance Division offices.

Las Vegas
3300 West Sahara Ave #275, Las Vegas 89102
(702) 486-4009

or

Carson City
1818 E. College Pkwy, Suite 103, Carson City 89706
(775) 687-0700

Or, call **toll-free** anywhere in Nevada at

1-888-872-3234

Or email: csc@doi.nv.gov

www.doi.nv.gov

The Division of Insurance cannot recommend an insurance company or tell you which policy to buy; however, our staff can explain the insurance terminology in your policy to you. The Division of Insurance will also contact the company on your behalf in an attempt to help resolve problems you may be having.

POLICY CHECKLIST

You may find this checklist useful in assessing the benefits provided by a Medicare supplement policy or in comparing policies.

	Policy 1		Policy 2		Policy 3	
	Yes	No	Yes	No	Yes	No
DOES THE POLICY COVER:						
Medicare Part A hospital deductible?						
Medicare Part A hospital daily coinsurance?						
Hospital care beyond Medicare's 150-day limit?						
Skilled nursing facility daily coinsurance?						
Skilled nursing beyond Medicare's limits?						
Medicare Part B annual deductible?						
Medicare Part B coinsurance?						
Physician and supplier charges in excess of Medicare's approved amounts?						
OTHER POLICY CONSIDERATIONS:						
Can the company cancel or refuse to renew the policy?						
What are the policy limits for covered services?						
How much is the annual premium?						
Non-smoking, sex, area, or other discounts?						
How long before existing health problems are covered?						

DEFINITIONS

The following terms are commonly used in Medicare supplement and long-term care insurance policies. Definitions differ from policy to policy, so it is important to understand the definition used in a specific insurance policy before you purchase it.

Allowed, approved, or eligible charges: The basis by which Medicare pays for health care costs. The approved charge paid by Medicare may be only 60 to 80% of the actual charge.

Assignment: In the original Medicare plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts assignment. If your doctor doesn't accept assignment, you may still be able to see the doctor but you will need to pay the excess charges above what Medicare would pay.

Advance directives: Legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself.

Attained Age: Adjective referring to a type of policy that bases its premium on the insured's current age.

Benefit: A benefit is a health care service or supply that is paid for in part or in full by Medicare.

Benefit period: A specified number of days, months or years for which benefits will be payable during any one confinement or spell of illness, or for successive confinements for the same condition.

Body mass index (BMI): A measure of body fat based on height and weight that applies to both adult men and women.

Chronic: A chronic condition is one lasting three months or more.

Co-insurance or co-payment: The portion of a charge for a covered medical service that you must pay out of your own pocket. For example, Part B of Medicare generally requires a co-payment of 20%.

Custodial care: The level of care required to assist an individual in the activities of daily living. This care helps meet personal needs and

can be provided by persons without professional licenses or extensive training.

Deductible: The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.

Effective date: The date on which insurance coverage goes into effect. It is not always the same as the date the application is completed.

Enrollment period: A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Excess charges: The portion of the Medicare provider's charges which exceed Medicare's approved payment amount.

Exclusion or limitation: A specific service, expense, condition or situation not covered by an insurance plan.

Fee for service: In health care, a payment mechanism in which a provider is paid for each individual service rendered to a patient.

Group Policies: Group policies are defined by an employer, organization or association being the policyholder, instead of the individual. In other words, it will be defined by who the individual members are paying. If the individual members are paying an organization other than an Insurance Carrier, then the policy will be deemed to Group policy.

Guaranteed issue: A policy of insurance that will be issued regardless of health condition.

Guaranteed renewable: The policy must be renewed by the company except for non-payment of premiums and / or material misrepresentations. Additionally, premiums for policies may only be increased if premiums for all like policies are increased by the same amount.

Health maintenance organization (HMO): A type of Medicare Advantage plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists or hospitals on the plan's list, except in an emergency. Your costs may be lower than in the original Medicare plan.

Health Savings Account (HSA): Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families. They are available to anyone who enrolls in a high-deductible health insurance plan. However, current tax laws do not allow Medicare beneficiaries to either contribute to their existing account or enroll.

Home health care: A wide variety of skilled nursing care and supportive services for individuals who do not need institutional care. The services are available through intermittent visits and may include nursing care, physical therapy, speech and hearing therapy, occupational therapy, social services, and other support services.

Individual Policies: Individual policies are defined by the individual being the policyholder. If the individual members pay the Insurance Carrier directly, then the policy will be deemed to Individual policy.

Intermediate care: Less intensive care than skilled nursing care. It usually includes assistance with activities of daily living with the availability of any on-duty registered nurse.

Issue Age: These policies are priced at your age when you initially purchase the policy. Increases in age alone will not affect future premiums.

Lapse: Termination of a policy due to failure by the policyholder to pay the required premium within the time specified in the policy.

Limiting charge: The highest dollar amount you can be charged for a covered service by doctors and other health care providers who do not accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to some supplies or equipment. (See Approved Amount; Assignment.)

Long-term care: A wide range of routine and complex services designed to provide maintenance, preventive, rehabilitative and supportive services to those individuals who have conditions that impair their ability to function independently.

Managed care: A system of health care where the goal is a system that delivers quality, cost-effective health care through monitoring, utilization review, and preventive services.

Medically necessary: Reasonable and necessary services for diagnosis or treatment as generally accepted by health care professionals that are clinically appropriate with regard to type, frequency, extent, location and duration; not primarily provided for the convenience of the patient, physician or other provider of healthcare; required to improve a specific health condition of an insured or to preserve his existing state of health; and the most clinically appropriate level of health care that may be safely provided to the insured.

Medicare Advantage plan: A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare.

Medicare managed care plans: These are health care choices (such as HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists or hospitals on the plan's list. Plans must

cover all Medicare Part A and Part B health care. Some plans cover extras, such as preventive care not covered by Medicare. Your costs may be lower than in the original Medicare plan.

Network: A list of primary care doctors, specialists and hospitals that members of a managed care organization can go to. Doctors, hospitals and other health care providers who have contracted with the health insurer or a third-party administrator provide health care at a reduced rate to members within the network.

Open enrollment: A period when new beneficiaries may elect to enroll in a policy of insurance regardless of health. For a Medicare supplement policy this period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B.

Out-of-pocket costs: Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Point of service (POS): A managed care plan that allows you to use doctors and hospitals outside the plan for an additional cost. (See Medicare managed care plan.)

Pre-existing condition: A medical condition for which medical advice was given or treatment was recommended or received from a doctor within a specified period before the effective date of coverage.

Preferred provider organization (PPO): Health service organization plan with a network of physicians and suppliers who contract to provide services to a health insurance plan on a discounted fee-for-service basis.

Skilled nursing care: Medically necessary care that can only be provided by, or under the supervision of, skilled, licensed, medical professionals such as registered nurses or professional therapists. All skilled services require a physician's order. Medicare's definition of "skilled nursing care" is often different from the definitions used in long-term care insurance policies.

State Health Insurance Assistance Program ("SHIP"): SHIP refers to a group of federal and state funded programs. These programs work together to provide assistance with public and private health insurance issues as well as options for Medicare beneficiaries or those soon to be Medicare beneficiaries, their families and caregivers. SHIP has a centralized component of statewide

assistance and a local component of county- and tribal-based benefit counselors.

TRICARE: TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide.

Underwrite: The process by which an insurer determines whether or not, and on what basis, it will accept an application for insurance.

Usual and customary or reasonable charges: The fee most commonly charged by physicians or providers for a particular service, treatment or supply. This fee may vary from area to area throughout the state.

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