

# Medigap Insurance

## Overview

A summary of the insurance policies to supplement and fill gaps in Medicare coverage.

- How to be a smart shopper for Medigap insurance
- Medigap policies
- Medigap and Medicare prescription drug plans
- Comparing Medigap plans
- Original Medicare vs. Medicare Advantage Plans (managed care)
- What's the right choice for you?
- Other kinds of coverage
- Additional resources

Medicare is the basic federal health insurance for older persons and for younger people with disabilities. Because Medicare has gaps in coverage, many people also buy a Medigap policy to supplement their Medicare coverage.

This article describes the various Medigap plans and benefits, and offers advice on how to choose among them. It includes information of special interest to those with low incomes, with disabilities, and with coverage through their former employers. It also includes information about how the new Medicare prescription drug plans may affect your Medigap policy, if it included prescription drug coverage.

## How to be a smart shopper for Medigap insurance

Premiums for Medigap insurance to supplement your Medicare coverage rise as health care costs rise, so it is important to select a policy that best fits your particular financial and health care needs. Besides a careful reading of insurance brochures, we recommend that you research companies' financial ratings, using rating guides available at local libraries. Then, before signing up, consider the following:

- *Price.* It is very important to compare premiums when shopping for Medigap insurance. There are great variations in the premiums that different companies charge for exactly the same coverage. When evaluating premiums, be sure you are comparing identical plans -- it's not hard to do now that all Medigap plans have been standardized. A key to price shopping is understanding that companies use three different methods to calculate annual premiums:
  - Issue age. The premium is set when you buy the policy. As the years go by, you continue to pay the premium of a person of the same age you were when the policy was issued. For example, if you buy the policy at age 65, you will always pay the rate that the company charges people who are 65, regardless of your advancing age.
  - Attained age. The premium is based on your current age and increases automatically as you grow older. Typically, these plans will appear to be less expensive at younger ages, but they may cost considerably more in later years.
  - No age rating. A few companies charge one premium for all policyholders. For people over age 75, this type of policy may be less costly.

Consider what one policy is likely to cost you over the next five or 10 years compared to premiums for other policies. Be alert for discounts that some policies make available to couples or nonsmokers.

- *Open enrollment period.* During Medicare's open enrollment period, or upon an individual's retirement after age 65, companies are prohibited from denying Medigap coverage to Medicare beneficiaries. This window is usually available only during a one-time open enrollment period following one's 65th birthday or on the first day of enrollment in Medicare Part B.
- *Medigap protections.* In many states, insurance companies can refuse to issue a Medigap policy based on applicants' health conditions (except during the open enrollment period). There are other exceptions, in which Medicare gives a "guaranteed issue right" to those in special situations -- for example, to HMO members whose plan stops serving Medicare beneficiaries. If you bought your Medigap policy after 1990, it is guaranteed renewable unless you stop paying your premium, the company goes bankrupt, or you were not truthful on the application.
- *Waiting period.* Insurance companies can refuse to pay claims for preexisting health conditions for up to six months after you buy a policy. Not all companies have this restriction, and some have a shorter waiting period. If you have had health insurance coverage or a Medigap policy for more than six months before applying, this restriction will not apply to you.

### **Medigap policies**

A Medigap policy is a type of insurance sold by private companies to fill gaps in original Medicare plan coverage. It can only be sold in 12 standardized plans, labeled A through L. Plans K and L are new policies that help limit high out-of-pocket costs for doctor's services and hospital care. These two plans are not available in all states. Here are some guidelines to help you make your choice:

- *Basic benefits.* All plans must include coverage of these costs: the \$238/day co-payment for hospital days 61-90 per benefit period; \$476/day for days 91-150; and 100 percent of up to 365 additional days per lifetime; the 20 percent co-payment for medical expenses; and the payment for the first three pints of blood yearly.
- *Part A: In-patient hospital deductible (included in plans B through J).* This benefit pays the deductible (\$952) for hospital stays. Because the deductible must be met for each new benefit period, this coverage could prove especially valuable should you have one or more return visits to the hospital within the year.
- *Part A: Skilled nursing home co-insurance (included in plans C through J).* This benefit pays the co-payment (\$119) for days 21-100 of daily skilled care in a nursing home per benefit period. Only a small number of Medicare beneficiaries

### 3 • Medigap Insurance

require daily skilled care in a nursing home. Because Medigap policies only pay for services covered by Medicare, the Medigap coverage is also limited.

- *Part B: Deductible (included in plans C, F, and J).* This benefit pays for the first \$124 of Medicare-covered medical services in each calendar year. Although this benefit is very popular, it is likely to cost as much as or more than the maximum benefit you can receive.
- *Foreign travel emergency (included in plans C through J).* This benefit covers medically necessary emergency care beginning in the first two months of each trip outside the U.S. and within the scope of Medicare-eligible expenses if provided in the U.S. After you pay the \$250 deductible for the calendar year, the plan will pay 80 percent of actual billed charges for covered care, up to a lifetime maximum of \$50,000.
- *At-home recovery (included in plans D, G, I, and J).* This benefit, which covers personal care services, such as bathing, eating, and dressing, is provided only in conjunction with Medicare-covered skilled home health care visits following an illness, an injury, or surgery. Your doctor must order such visits. The benefit pays up to \$40 per visit for no more than seven visits per week and can be used for up to eight weeks after the Medicare visits stop. The maximum annual benefit is \$1,600. The plan does not pay for long-term care.
- *Part B: Excess doctor charges (100 percent coverage in plans F, I, and J; 80 percent coverage in plan G).* This benefit pays the difference between the doctor's actual charges and the Medicare-approved amount. Under federal law, physicians who do not accept assignment -- that is, do not take as full payment the amount approved by Medicare -- cannot charge you more than 15 percent above the amount. This benefit pays all or part of the excess charges, depending on which plan you choose. If most or all of your doctors accept Medicare assignment, you probably do not need this benefit.
- *Preventive medical care (included in plans E and J).* This benefit pays actual charges up to 100 percent for health care screening and some other preventive health services not covered by Medicare as long as your physician orders them. However, the maximum amount it will pay per year is \$120, which is about equal to the amount added to the cost of a policy.
- *Out-patient prescription drugs (basic coverage in plans H and I; extended coverage in plan J).* This benefit provides limited coverage for prescription drugs. It requires that you keep good records of your prescription drug expenses because you have to file the claims yourself.
  - Basic coverage. After you pay a \$250 calendar-year deductible, the plan pays 50 percent of out-patient prescription drug charges up to a maximum of \$1,250 in each calendar year. Your prescriptions would have to cost \$2,750 per year for you to receive the maximum benefit.

#### 4 • Medigap Insurance

- Extended coverage. After you pay a yearly deductible of \$250, the plan pays 50 percent of charges up to a maximum of \$3,000 in each calendar year. Your prescription costs would need to exceed \$6,250 for you to receive the maximum benefit.

Medigap plans H, I, and J offer some coverage for prescription drugs but it is not as good as that offered by a Medicare plan. You must decide whether to keep your Medigap plan (H, I, or J) or drop it for a Medicare plan. Many people will decide to keep a Medigap plan without drug coverage and join a separate Medicare prescription drug plan before May 15, 2006.

Note: Starting January 1, 2006, *you will not be able to buy a new Medigap policy with prescription drug coverage* because private companies approved by Medicare will offer this coverage.

If you now have a Medigap plan with prescription drug coverage, that insurer should have sent you a letter telling you how the policy you have compares with Medicare's new prescription drug coverage. If you have not received such a letter, call your Medigap insurer to get that information. Be aware that if your present coverage is not as good as Medicare's and you later decide to enroll in a Medicare prescription drug plan, you will pay a penalty for each month you were eligible but did not join a new plan.

#### **Medigap and Medicare prescription drug plans**

It is important to know that *you may not receive benefits under two different prescription drug plans*, so if you already have some form of drug coverage, you must decide whether to keep it or drop it for a Medicare prescription drug plan instead.

#### **Medicare prescription drug plan**

Under the new Medicare prescription drug plan, private companies now offer insurance to protect individuals with Medicare against very high costs of prescription drugs. Both generic and brand-name drugs are covered, although each company may cover a different set of drugs -- that is, each will have its own "formulary." If you sign up for a plan, you will receive its prescription drug card, which you must use at a pharmacy that participates in your company's plan. There is a monthly premium in addition to the Part B premium usually deducted from your Social Security payment, and in addition to the premium for a Medigap or an HMO Medicare Advantage plan. In 2006, the annual deductible will be no higher than \$250; after this amount, the plan will cover 75 percent of the next \$2,000 of your costs for drugs on your company's formulary.

After you have reached this \$2,000 level -- over and above the \$250 deductible amount -- the Medicare prescription drug plan stops paying for drugs unless you reach a \$5,100 threshold. At this point, your Medicare prescription drug plan

kicks back in and will pay for 95 percent of your drug costs. This is known as the Coverage Gap.

Thus, while all individual company plans must offer, at a minimum, the Medicare standard coverage, there are several variables for the purchaser to study. First, which plan formularies cover the drugs you use most; second, which ones include your preferred pharmacy; and, finally, what is the price difference between plans. All companies offering a Medicare prescription drug plan must accept any Medicare beneficiary in its service area.

### **Comparing Medigap plans**

Some consumers may have a choice of 12 standard plans. Others will not because many insurance companies do not offer all 12 plans. It is common for a company to offer only three or four. Some Medicare beneficiaries may have a choice of a Medigap plan, called a Medicare SELECT policy, sold by some companies in some states. A Medicare SELECT policy allows you to reduce the cost of your coverage by agreeing to use specific hospitals and, in some cases, specific doctors to get your full insurance benefit.

To decide which plan is most appropriate for you, consider your health needs and economic circumstances. People who are very sick or who already have high medical expenses will only be able to get certain plans when they are eligible for open enrollment. If you already have a Medigap plan and decide to make a switch, don't cancel the first policy until the new one has become effective.

### **Standard Medigap benefit plans**

**Plan A** offers the least expensive and least comprehensive coverage. It is only appropriate for people who can afford some out-of-pocket medical costs or for people who are covered by an employer plan and who have to pay deductibles and co-insurance that this Medigap plan might not cover.

**Plan B** offers the same coverage as Plan A except that Plan B also covers the \$952 deductible charge for the first day you are in a hospital. If your income is limited and you are concerned about this cost, Plan B may be your best choice.

**Plan C** is appropriate if you want more coverage than Plans A or B offer and if most of your doctors accept Medicare assignment. This option is likely to cost about the same as Plans D, E, and G.

**Plan D** makes sense for people who anticipate a need for the at-home recovery benefit and who see doctors who accept Medicare assignment.

**Plan E** is appropriate for people who are basically healthy and who want preventive health services on a regular basis. Remember that if you buy this

policy, you will be paying for \$120 worth of health screening and preventive health services, regardless of whether you use them.

**Plan F** makes the most sense for people who see doctors who do not accept Medicare assignment. Keep in mind that doctors are prohibited from charging more than 15 percent above the Medicare-approved amount. If your costs for these charges are relatively small or most of your doctors take assignment, you may be better off with a different plan.

**Plan G** is appropriate for consumers whose doctors don't accept Medicare assignment and who also want the at-home recovery benefit. Only 80 percent of the excess doctor charges are covered under this plan, and the Part B deductible (\$124) isn't covered either. The cost of this plan is comparable to Plans C, D, and E.

**Plan H** is usually the least expensive plan offering prescription drug coverage. The drug benefit is limited; you will be reimbursed for no more than 50 percent of your prescription drug bills, and the maximum reimbursement is \$1,250.\*

**Plan I** is more expensive than Plan H because it also includes coverage for excess doctor charges and the at-home recovery benefit.\*

**Plan J** is the most comprehensive and expensive plan available and includes all the possible benefits in the plans discussed above. This plan is appropriate only for people who can afford the cost.\*

**Plans K and L** were new in 2005 and are not yet widely available. They are discussed under a separate heading below.

*\* Plans H, I, and J are not available to new purchasers because better drug coverage is available through the new Medicare prescription drug plans. You may keep one of these policies for its other benefits and drop only the prescription drug portion of coverage. You will then want to enroll in one of the Medicare prescription drug plans.*

Medigap benefits by plan

Medigap benefits	A	B	C	D	E	F	G	H	I	J	K	L
Basic benefits	•	•	•	•	•	•	•	•	•	•	•	•
Part A: In-patient hospital deductible		•	•	•	•	•	•	•	•	50%	75%	•
Part A: Skilled nursing home co-payment			•	•	•	•	•	•	•	50%	75%	•
Part B: Deductible			•			•						
Foreign travel emergency			•	•	•	•	•	•	•	•		
At-home recovery				•			•		•	•		
Part B: Excess doctor charges						100%	80%		100%	100%		
Preventive screening					•						•	
Out-patient prescription drugs	Not available to new purchasers											

Notes:

- States may allow only some of the 12 benefit plans to be sold.
- States may approve innovative additional benefit plans under certain circumstances.
- These standard benefit plans do not apply to policies sold in Massachusetts, Minnesota, and Wisconsin.
- Availability of plans will vary from company to company.
- Plans F and J now offer a \$1,500 deductible option.

Explanation of chart

As you look at the chart and read about the benefits offered, these observations may prove helpful:

- *Plan A* is the least expensive and least comprehensive.
- *Plan J* is the most expensive and most comprehensive.
- *Plans F, G, I, and J* may be attractive to people whose doctors do not accept assignment. These plans pay the difference between the doctor’s “limiting” charges that can be up to 15 percent over Medicare’s approved payment amount.
- *Plans H, I, and J* offer some protection against high prescription costs, but the coverage is not as good as a Medicare drug plan. They are not available to new purchasers.

- *Only when you first enroll in Part B can you select any plan and be guaranteed coverage, with a few exceptions, such as if your Medicare Advantage plan is discontinued. Not all consumers have a choice of all 12 plans for two reasons:*
  - Some companies offer only two or three of these plans. You will be restricted to purchasing from a company whose policies have been approved for sale in your state. Check with your state insurance department for a current list.
  - Some companies allow you to switch among Plans A through G at any time without being rejected. For example, if you originally buy Plan C but later find that Plan G better suits your needs, some companies let you make this change.
- *Prescription coverage has significant restrictions. The most any plan will pay is 50 percent after a yearly deductible and with an annual limit. Even under Plan J, your prescription costs would need to exceed \$6,250 each year for you to get the maximum benefits. Since January 1, 2006, prescription drug coverage has not been available to new purchasers of Medigaps. You may keep it if you already have it, but you will have to pay a penalty if you later decide to enroll in a Medicare prescription drug plan.*
- *The hospital deductible is applied per benefit period and could occur several times a year. There may be no savings in having the cost of the \$124 Part B deductible and preventive screening coverage -- the typical cost may be the same as the benefit.*
- *The at-home recovery benefit may provide limited help to those who were receiving the home health benefit and live alone or do not have a family support system to provide care. Extensive and comprehensive custodial care can be covered only under a separate private long-term-care insurance policy.*
- *The need to insure for excess doctor charges can be reduced in two ways:*
  - Select doctors who accept assignment. This means that they accept Medicare-approved charges as payment in full.
  - Ask a doctor to accept assignment. Some will do so, particularly a specialist whom you would see on a limited basis or for a specific procedure. Federal law prohibits doctors in the Medicare program from charging more than 115 percent of the Medicare-approved amount. Some states reduce or prohibit the amount a doctor charges Medicare patients in excess of the approved amount. You should check with your state's insurance department.
- *Medicare limits how many days of nursing home care it will pay for. Although Medicare can help to pay for up to 100 days in a skilled nursing home facility, Medicare only pays for an average of 28 days in a nursing home because of the strict eligibility requirements for skilled nursing care. If approved, Medicare will pay 100 percent for days 1-20 and all but \$119 per day for days 21-100 for this skilled care.*
- *An option to Plans F and J adds a \$1,500 annual deductible to these policies before the benefits of Plans F or J are paid. Plans with this high-deductible option will have*

lower premiums. However, this option may not be approved in all states. It is important to remember that if Medicare does not pay for a service, your Medigap policy will not pay either. Medigap pays only after Medicare has paid the approved amount of the charge. Retiree plans may be significantly different than a Medigap policy. Check with your plan administrator for more information.

### **Medigap Plans K and L**

Both plans include the basic benefits: \$238/day co-payment for hospital days 61-90; \$476/day for days 91-150; and 100 percent of up to 365 additional days per lifetime; the 20 percent co-payment for medical expenses; and the payment for the first three pints of blood yearly. In addition:

#### **Plan K**

- Pays 50 percent of the in-patient hospital deductible (per benefit period); in 2006, this deductible is \$952.
- Pays 50 percent of co-payment for skilled nursing facility care for days 21 through 100; the co-payment is \$119 per day in 2006.
- Pays 100 percent co-insurance for Part B preventive medical care.
- Pays 50 percent of hospice cost-sharing for all Part A Medicare covered expenses and respite care.
- Once you meet the annual Part B deductible of \$124 and reach \$4,000 in annual out-of-pocket co-insurance charges, the plan pays 100 percent of Medicare Part A and Part B co-insurance and deductibles for the rest of the calendar year.

#### **Plan L**

- Pays 75 percent of the in-patient hospital deductible (per benefit period); in 2006, this deductible is \$952.
- Pays 75 percent of co-payment for skilled nursing facility care for days 21 through 100; the co-payment is \$119 per day in 2006.
- Pays 100 percent co-insurance for Part B preventive medical care.
- Pays 75 percent of hospice cost-sharing for all Part A Medicare covered expenses and respite care.
- Once you meet the annual Part B deductible of \$124 and reach \$2,000 in annual out-of-pocket co-insurance charges, the plans pays 100% of Medicare Part A and Part B co-insurance and deductibles for the rest of the calendar year.

*Plans K and L are meant to help people in covering catastrophic costs but at a lower premium by having higher deductibles and co-payments.*

### **Original Medicare vs. Medicare Advantage plans (managed care)**

While most seniors continue to receive their health care under the original Medicare plan, many older people have chosen to join health maintenance organizations (HMOs), the most popular form of managed care plans. A managed care plan combines health insurance and health care services in one organization. Members receive their care in one of two ways: either from doctors who work in a clinic setting and are employed directly by the plan or from independent physicians who work under contract to the plan, called Preferred Provider Organizations (PPOs).

As Medicare beneficiaries, seniors who join an HMO continue to have their Part B premiums deducted from their Social Security checks each month, and are usually charged a monthly premium by the HMO. Otherwise, there are few additional out-of-pocket costs. You may have a co-payment for a doctor visit, usually \$10 to \$35. HMO members are guaranteed all the benefits covered by original Medicare, and, in addition, may receive many benefits not covered, including hearing and eye exams, and regular physical checkups.

While the additional services offered by an HMO, plus the savings in out-of-pocket costs, make them an attractive choice, the limitations they impose discourage many seniors from enrolling. Regardless of whether you've had the same doctor for years under original Medicare, for instance, you may have to transfer to a new doctor once you join an HMO, as members are required to see only doctors belonging to that plan's network. There are also restrictions on which hospital you can go to for surgery, which surgeon can perform an operation, and the use of an emergency room before receiving prior approval. Despite these drawbacks, many older people belonging to HMOs express continued satisfaction with their choice.

HMO plans offered to Medicare beneficiaries are now called Medicare Advantage plans. They may be offered by HMOs, PPOs, or Physician Fee-for-Service plans. Some of these Medicare Advantage plans will offer prescription drug coverage.

If you are already receiving health care from an HMO through a Medicare Advantage plan, you should have received a letter stating whether the HMO will offer prescription drug coverage under a Medicare plan. If that drug coverage is offered, you do not need to do anything except pay the monthly premium. If drug coverage is not offered, you may switch to another HMO that offers a plan with Medicare drug coverage, or keep your current plan and sign up for a separate Medicare prescription drug plan. In this case, you will pay a monthly premium to the HMO and to the prescription drug plan. Be aware that if your present Medicare Advantage plan offers Medicare-approved drug coverage and you elect to join a freestanding prescription drug plan, you will be automatically

disenrolled from your present HMO. You are allowed to participate in only one Medicare prescription drug plan at a time.

### **What's the right choice for you?**

Pros and cons are evident in both original Medicare and HMOs, so it's important to compare plans based on your own individual needs. What works well for one person may not work for the next person. Consider the following questions when deciding what's best for you:

- *Is it important for you to have a wide choice of doctors?* Under original Medicare, you have unlimited choice of doctors; under a traditional HMO you'll be limited to the plan network. A PPO allows you greater choice of physicians.
- *Have you had a long-term relationship with your doctors?* If so, how would you feel about replacing them? This is a special consideration for elderly people whose medical histories are well known to their current physicians.
- *Is it necessary for you to have access to medical specialists?* If you have a serious or chronic illness and want to be examined by a particular medical specialist, membership in an HMO could present a problem. Under most circumstances, you may only see a specialist who participates in the HMO network.
- *Do you travel a lot or spend part of the year away from home?* HMOs generally pay only for care provided within the plan's local service area. If you want to visit a doctor when traveling or living in another area, your HMO won't cover the charge, except for emergency care.
- *Is the cost of health care a major concern for you?* HMOs usually charge a small premium to belong, but they cover almost the entire cost of any service, so you won't need to buy a Medigap policy. You'll also save money on some other health care expenses not covered by original Medicare. If health care costs are a burden, an HMO may be the right choice for you.

### **Low-income Medicare beneficiaries**

Here are some ways to get help paying for Medicare premiums.

#### **Medicare savings programs**

These are programs offered by states to help people with limited income and resources pay for Medicare premiums and sometimes also Medicare deductibles and co-payments. To be eligible, an individual usually must have a monthly income of less than \$1,097, or \$1,464 for a married couple. Resources, such as savings accounts, stocks, bonds, and money in a checking account, are limited to \$4,000 for an individual and \$6,000 for a couple. Income limits are slightly higher for residents of Alaska and Hawaii, and some states may have more generous limits. If you think you may qualify, call your State Medical Assistance Office by calling 800-MEDICARE (800-633-4227).

### **Medicaid**

Medicaid is a joint federal and state program that helps pay medical costs for some people with limited income and resources. While programs vary from state to state, most of your health care costs are covered if you have Medicare and Medicaid. Call 800-MEDICARE (800-633-4227) to get the number for your State Medical Assistance Office.

### **Extra help to pay for Medicare prescription drug coverage**

If you have limited income and resources, you may qualify for extra help in paying for your Medicare prescription drug plan's monthly premium, yearly deductible, and prescription co-payments. Individuals whose resources are no more than \$11,500, or \$23,000 for a married couple (including bank accounts, stocks, and bonds, but not your house or car), may qualify for extra help, depending on their income. For individuals with incomes below \$12,920 (\$17,321 for a married couple), there is no premium for a Medicare prescription drug plan, no yearly deductible, and no greater than a \$5 cost for a drug covered by the plan. People with the resource limits described above but with incomes up to \$14,000 for an individual (\$19,245 for a married couple) will also receive some extra help but may have to pay part of the premium, plus a \$50 deductible and 15 percent of each covered prescription.

The Social Security Administration (SSA) has mailed letters to people who automatically qualified for extra help. If you did not receive a letter but think you may qualify, call the SSA at 800-772-1213 or visit Social Security Online at [www.socialsecurity.gov](http://www.socialsecurity.gov). For more information, go to Access to Benefits Coalition at [www.accesstobenefits.org](http://www.accesstobenefits.org).

### **Other kinds of coverage**

#### **Health insurance from a former employer**

If you continue your health care coverage you from a current or former employer after you retire, and this insurance includes prescription drug coverage, your insurance plan should have sent you a letter stating whether this coverage is as good as Medicare's. If it is equivalent, you can choose between the two based on costs. If the employer's plan is not as good, you would likely do better to drop the drug portion of the employer's plan and join a Medicare plan. Discuss this with your former employer's plan administrator.

#### **Insurance through the Department of Defense**

If you are a military service retiree, spouse, or survivor and are age 65, you may be eligible for TRICARE for Life. If eligible, you will get all Medicare-covered benefits under the Original Medicare plan, plus all TRICARE for Life benefits. For more information, call 800-363-5433 or visit [www.tricare.osd.mil](http://www.tricare.osd.mil).

### **People under age 65 with disabilities**

If you are under 65 and eligible for Medicare because of a disability or end-stage renal disease, you may want a Medigap policy. Unfortunately, only a few companies offer Medigap policies to people with disabilities who are younger than 65. Ask your state insurance department for a list of companies that sell Medigap policies to younger Medicare beneficiaries.

Younger Medicare beneficiaries do not have a six-month open enrollment period at the time of eligibility as those 65 and older do. When a disabled person becomes 65, he or she is entitled to an open enrollment period. Some states have more generous requirements.

### **Additional resources**

#### **Centers for Medicare and Medicaid Services (CMS)**

*www.medicare.gov*

CMS administers the federal Medicare and Medicaid programs and offers publications, including: *Guide to Health Insurance for People with Medicare*, *Learning About Medicare Health Plans*, and *Medicare and You*. Also, use the Search tool to locate insurance companies that sell Medigaps in your state.

#### **My Medicare Matters**

*www.mymedicarematters.org*

This Web site is designed to help individuals learn about the new Medicare Prescription Drug coverage. It is sponsored by The National Council on the Aging and the Access to Benefits Coalition.

#### **The National Council on the Aging (NCOA)**

*www.ncoa.org*

The NCOA offers a free, confidential Web-based service called BenefitsCheckUpRx at *www.benefitscheckupRx.org* that is sponsored by the U.S. Department of Health and Human Services and the Administration on Aging. If you have Medicare and are considering whether to sign up for the new Medicare prescription drug coverage, this is a good place to start.

#### **State Health Insurance Assistance Programs (SHIP)**

These local agencies are an excellent resource for answers to questions on choosing a health plan; buying a Medigap policy; understanding the new prescription drug plan; and learning about Medicare rights, protections, and appeals. Call 800-MEDICARE (800-633-4227) for the telephone number of your local SHIP program.

#### **Weiss Ratings**

Weiss Ratings, Inc., is the nation's leading independent provider of ratings and analyses of financial services companies. The *Shopper's Guide to Medicare*

*Supplement Insurance* (\$49 plus shipping and handling) has price comparisons for Medigap insurance based on your age, gender, and zip code. Obtain a copy by visiting [www.WeissRatings.com](http://www.WeissRatings.com) or by calling 800-289-9222.