MEDICARE SUPPLEMENT

SHOPPER'S GUIDE

KANSAS INSURANCE DEPARTMENT

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insurance.kansas.gov

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SECTION 1: MEDICARE SUPPLEMENT AND MEDICARE SELECT INSURANCE

What is Medicare Supplement insurance?

Medicare Supplement insurance can help cover the expenses that come with the gaps in original Medicare. This supplemental insurance is also often called “Medigap” because it helps pay for these gaps. Medicare Supplement policies cannot be purchased with a Medicare Advantage plan. The Kansas Insurance Department is responsible for regulating Medicare Supplement insurance in the state of Kansas. Medicare and Medicare Advantage plans are regulated by the federal government.

Costs that you must pay, like coinsurance, copayments and deductibles, are examples of some of the gaps in original Medicare coverage. Some Medicare Supplement policies also cover benefits that the Medicare plan does not cover, such as emergency health care while traveling outside the United States. A Medicare Supplement policy may help you save on out-of-pocket costs.

How does Medicare Supplement work?

Medicare Supplement insurance is broken down into plans identified by letters - A, B, C, D, F, G, K, L, M & N. These plans are standardized and must follow federal and state laws, which have been created to protect you, the consumer. All companies in the state of Kansas that wish to sell Medicare Supplement insurance must make Plan A available to their customers. In addition they must offer Medicare Supplement Plan C or Plan F for those eligible for Medicare prior to 01/01/2020, or Plan D or Plan G for those eligible for Medicare on or after 01/01/2020. Plan A features the core benefits of a Medicare Supplement policy. All other plans build on those benefits.

Medicare Supplement Open Enrollment

It is recommended that you buy a Medicare Supplement policy during your six-month Medicare Supplement open enrollment period. During this time you can buy any Medicare Supplement policy sold in Kansas, even if you have health problems. This period automatically starts the month you turn 65 or older, or if under age 65 and eligible for medicare due to disability, and enrolled in Medicare Part B.

If you apply for Medicare Supplement coverage after your open enrollment period, there is no guarantee that an insurance company will sell you a Medicare Supplement policy if you do not meet the medical underwriting requirements, unless you are eligible due to a special situation.

If you have Parts A & B (original Medicare) and a Medicare Supplement policy, you should weigh your decisions very carefully before switching to a Medicare Advantage plan. You may have difficulty getting a Medicare Supplement plan again in the future if you decide to switch back.

Be aware that if you did not sign up for Medicare when you were first eligible and did not have other insurance, you may face a penalty for late enrollment.

Enrollment Periods for Medicare Supplements

Medicare Supplement enrollment periods differ from other Medicare enrollment periods. Insurers must offer a six-month open enrollment period to all Medicare beneficiaries.

This six-month open enrollment period begins with the first month in which the beneficiary first enrolls for benefits under Medicare Part B (for some this is age 65; for others it begins when you lose employer-or group-sponsored health care, or if under age 65 and eligible for Medicare due to disability). During this period, insurers are:

- Required to offer a Medicare Supplement policy to all enrollees, regardless of their health status;
- Required to charge healthy individuals and those with medical conditions the same rate.

After this six-month period ends, insurers are allowed to use medical underwriting to determine:

- Acceptance into the plan; and
- How much you will be charged.

It is important to evaluate your options carefully during your first enrollment period. Should you decide to switch to a different Medicare Supplement policy after this open enrollment period, you may be subject to medical underwriting.

The six-month open enrollment period for Medicare Supplement insurance starts on the same day your Part B Medicare starts. This date is shown on your Medicare card.

Medicare Select Insurance

Medicare Select is another option available to some Kansas Medicare beneficiaries. Medicare Select policies are just like standardized Medicare Supplement policies. However, each Medicare Select policy has specific hospitals and, in some cases, doctors that you must use in order to be eligible for full benefits (except in the case of medical emergencies).

Because the insurers negotiate directly with specific providers, sometimes called “preferred providers,” premium costs for Medicare Select plans are generally lower than a standard Medicare Supplement policy. When you choose to use a preferred provider, Medicare pays its share of the approved charges and the Medicare Select policy pays for the full supplemental benefits provided for in the policy.

If you do not want to use the preferred provider, Medicare will still pay its share of approved charges. However, the Medicare Select policy would not be required to pay any benefits.

MEDICARE SELECT POLICIES: A type of Medicare Supplement policy with a network; To get full benefits (except in emergency), one must use specific hospitals and may have to see specific providers; Can be any of the standardized policies; Generally cost less than non-network policies; Can switch to plan with equal or lesser value at any time with the same company.

BENEFICIARIES WITH DISABILITIES

Disabled Medicare beneficiaries under age 65 have equal access to all Medicare Supplement policies sold in Kansas.

Upon enrolling in Medicare Part B, a disabled beneficiary has a six-month open enrollment period to buy supplemental coverage. That period begins the day Part B coverage becomes effective. Medicare Supplement policies must be sold at the same premium as for seniors who turn 65 and are eligible for Medicare.

Disabled Medicare beneficiaries cannot be turned down for any Medicare Supplement plan being sold in Kansas during the initial six-month open-enrollment period.

Coverage will be guaranteed issue, but the same preexisting condition limitation that applies to age 65 beneficiaries may apply. A second open-enrollment period will apply when the disabled Medicare beneficiary turns 65.

Services Provided Under Medicare Supplement Policies

The following services are provided under Medicare. Medicare Supplement plans help pay for portions of these services not covered by Medicare. For further information check www.medicare.gov.

Hospitalization - Medicare covers:

- Semiprivate room;
- Meals;
- General nursing;
- Other hospital services and supplies:
    - Care in critical access hospitals; and
    - Inpatient mental health care.

This does not include private duty nursing or a television or telephone in your room. It does not include a private room.

Benefit period — Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you are admitted as an inpatient in a hospital or SNF. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after a benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Skilled Nursing Facility Care — Medicare covers a semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related three-day hospital stay). You must have been admitted to the Medicare-approved nursing facility within 30 days of leaving the hospital. Medicare does NOT cover coinsurance or coverage after 100 days per benefit period.

Blood — If the hospital gets blood from a blood bank at no charge, you will not have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first three units of blood you get in a calendar year or have blood donated by you or someone else.

Hospice Care — Medicare covers medical and support services from Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief. You must have a doctors certification of a terminal illness. Medicare does NOT cover the copayment or coinsurance.

Medical Expenses — Medicare covers doctor services, outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). It also covers second surgical options, outpatient mental health care, outpatient physical and occupational therapies, including speech-language therapy. Medicare does NOT cover the Part B deductible or coinsurance.

Durable medical equipment, when ordered by a doctor, is paid separately by Medicare. This equipment must meet certain criteria to be covered. Medicare usually pays 80 percent of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If your home health agency does not supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Clinical Laboratory Services — Medicare covers blood tests, urinalysis and other tests for diagnostic services.

Home Health Care — Medicare covers part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aid services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers) and medical supplies, and other services. Medicare does NOT cover the Part B deductible.

Part B Excess charges — “Excess charges” are not covered under Medicare. If doctors decide not to accept the reimbursement rate they receive from Medicare for providing certain services, they are allowed to charge up to 15 percent more for those covered services. If the doctor you visit is one of these, you will be responsible for paying that 15 percent above what Medicare covers. The Medicare Supplement policy may cover some or all of your expenses above the Medicare approved amount.

Foreign Travel — Some Medicare Supplement policies will cover some of your expenses related to emergency care while traveling outside the United States.

GAPS IN MEDICARE

Medicare was never intended to pay 100 percent of medical bills. It forms the foundation for beneficiaries' protection against most medical expenses. There are gaps in Medicare coverage where the beneficiary must pay a portion of expenses. Medicare Supplement insurance can help cover some of these expenses. The Kansas Insurance Department regulates Medicare Supplement insurance.

Items and services not covered under Medicare include:

Acupuncture; Deductibles, coinsurance or copayments when you obtain certain health care services; Dental care and dentures; Cosmetic surgery; Long-term care, like custodial care (help with bathing, dressing, using the bathroom and eating) at home or in a nursing home; Eye care (routine exam), eye refractions; Hearing aids and hearing exams; Orthopedic shoes*; Outpatient prescription drugs*; Routine foot care*; Diabetic supplies (like syringes or insulin, unless the insulin is used with a pump or it may be covered by Medicare Part D); Chiropractic services except to correct a subluxation (when bones in your spine move out of position) using manipulation of the spine. You are responsible for coinsurance, and the Part B deductible applies; Concierge care

* Some exceptions

DO'S AND DON'TS OF BUYING MEDICARE SUPPLEMENT

DO:	DO NOT:
Ask questions of friends and family.	Do not feel pressured to buy now, you have a six-month open enrollment period.
Know what you are buying and insist on an outline of coverage.	Do not drop a current insurance policy until you have new coverage.
Choose the benefits you want and need: benefits are standardized in Medicare Supplement policies.	Do not buy more than one Medicare Supplement policy.
Compare benefits for different policies before buying and considering family and medical history.	Never pay cash. Always use a check made out to the insurance company, not the agent
Keep proof of prior creditable coverage.	Do not buy from agents who claim to be from the government. The government does not sell insurance.
Keep the agent's name and information for later reference.	Do not buy a Medicare Supplement policy if you have a Medicare Advantage plan; they do not work together.

Carefully read the policy. You have a 30-day "free look" period. If you are unsatisfied and cancel, you can receive a full refund.

OVERVIEW OF MEDICARE PARTS A & B

A

IN-PATIENT HOSPITAL

First 60 days	$1,600 deductible
Days 61 - 90	$400 per day coinsurance
Days 91 and on per Lifetime reserve	$800 per day coinsurance

SKILLED NURSING FACILITY

First 20 days	100% (no copay)
Days 21 - 100	$200 per day coinsurance

HOME HEALTH HOSPICE
100% Services

Benefit period ends when patient is out of the hospital or skilled nursing facility for 60 consecutive days.

B

$226 DEDUCTIBLE
(The amount you must pay before any coverage from the insurer)

20% coinsurance

80% OF COSTS
(After deductible is met)

Provider's charges (in or out of hospital)

Durable medical equipment

Ambulance

Outpatient hospital charges

EXCESS CHARGES
If providers do not accept Medicare's reimbursement rate, they are allowed to charge up to 15 percent more for covered services. If the doctor you visit is one of these, you will be responsible for paying that 15 percent above what Medicare covers.

Amount You Pay

Amount Medicare Pays

YOUR MEDICARE COVERAGE CHOICES AT A GLANCE

There are two main ways to get your Medicare coverage: Original Medicare (Parts A and B) or a Medicare Advantage Plan (Part C). Use these steps to help you decide which way to get your coverage.

START

STEP 1: DECIDE HOW YOU WANT TO GET YOUR COVERAGE

ORIGINAL MEDICARE

PART A
Hospital Insurance

+

PART B
Medical Insurance

MEDICARE ADVANTAGE PLAN
(HMO or PPO)

PART C
Combines Part A, Part B and usually Part D

STEP 2: DECIDE IF YOU NEED TO ADD DRUG COVERAGE

PART D
Prescription Drug Coverage (If not already included)

END

NOTE: If you join a Medicare Advantage Plan, you do not need a Medicare Supplement policy. If you already have a Medicare Supplement policy, you cannot use it to pay for out-of-pocket costs you have under a Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you cannot be sold a Medicare Supplement policy.

ORIGINAL MEDICARE

PART A
Hospital Insurance

PART B
Medical Insurance

STEP 2: DECIDE IF YOU NEED TO ADD DRUG COVERAGE

PART D
Prescription Drug Coverage

STEP 3: DECIDE IF YOU NEED TO ADD SUPPLEMENTAL COVERAGE

MEDICARE SUPPLEMENT
Medicare Supplement Insurance

END

For more information on Original Medicare and Medicare Advantage plans, see Section 3.

MEDICARE SUPPLEMENT INSURANCE AT A GLANCE

If "Yes" appears in the chart, Medicare plus the Medicare Supplement policy covers a total of 100 percent of the described benefit. If a row lists a percentage, the policy covers that percentage of the described benefit. If "No" appears, the policy does not cover that benefit. NOTE: The Medicare Supplement policy covers coinsurance only after you have paid the deductible (unless the supplement policy also covers the deductible).

BENEFITS	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first three pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A Hospice Care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled Nursing Facility Care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Medicare Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charges	No	No	No	No	Yes	Yes	No	No	No	No
Foreign Travel Emergency Care (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-Pocket Limit**							$6,940	$3,470		

*Plan F and G also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare covered costs up to the deductible amount of $2,700 in 2023 before your Medicare Supplement plan pays anything.
**After you meet your out-of-pocket yearly limit and your yearly Part B deductible ($226 in 2023), Medicare plus the Medicare Supplement plan pays 100 percent of covered services for the rest of the calendar year.
***Plan N pays 100 percent of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.
Note: Plans C and F only available to those eligible for Medicare before 01/01/2020. See page 12.

GUARANTEED ISSUE RIGHTS FOR MEDICARE SUPPLEMENT POLICIES

YOU HAVE A MEDICARE SUPPLEMENT GUARANTEED ISSUE RIGHT IF...	YOU HAVE THE RIGHT TO BUY...	YOU CAN/MUST APPLY FOR A MEDICARE SUPPLEMENT POLICY...
1. YOU LOSE EMPLOYER GROUP HEALTH PLAN BENEFITS		
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) OR union coverage. The employer group or you are terminating coverage.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company. If you have COBRA coverage, you can either immediately buy a Medicare Supplement policy or wait until COBRA coverage ends.	No later than 63 calendar days after the latest of these dates: • Date coverage ends • Date on notice telling you coverage is ending (if you get one). • Date on a claim denial, if this is the only way you were informed.
2. YOU LOSE YOUR MEDICARE ADVANTAGE COVERAGE		
You have a Medicare Advantage plan and: • Your plan is leaving Medicare. • Your plan stops giving care in your area. • You move out of the plan's service area. **Note**: If you immediately join another Medicare Advantage plan, you can stay in that plan for up to one year and still have the rights described in situations 4 and 5 on page 11.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage plan.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. Note: Medicare Supplement coverage cannot begin until your Medicare Advantage plan coverage has ended.
3. YOU MOVE OUT OF A MEDICARE SELECT POLICY'S SERVICE AREA		
You have Original Medicare and a Medicare Select policy. You move out of the Medicare Select policy's service area. You can keep your Medicare Supplement policy, however the hospitals in your new area may not be a network provider, or you may want to switch to another Medicare Supplement policy.	Medicare Supplement policy A, B, C, F, K or L sold by any insurance company in the state to which you are moving.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends.

Effective January 1, 2020, references to plans C & F in the above scenarios were replaced with plans D & G for those that become eligible for Medicare on or after 01/01/2020.

YOU HAVE A MEDICARE SUPPLEMENT GUARANTEED ISSUE RIGHT IF...	YOU HAVE THE RIGHT TO BUY...	YOU CAN/MUST APPLY FOR A MEDICARE SUPPLEMENT POLICY...
4. YOU WANT TO SWITCH FROM AN ADVANTAGE PLAN TO ORIGINAL MEDICARE		
You joined a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) when first eligible for Medicare Part A at age 65, and within the first year of joining you decide to switch to Original Medicare.	Any Medicare Supplement policy sold in Kansas by any insurance company.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. Note: Medicare Supplement coverage cannot begin until your Advantage plan coverage has ended.
5. YOU MOVE TO A MEDICARE ADVANTAGE PLAN AND WANT TO SWITCH BACK		
You dropped a Medicare Supplement policy to join a Medicare Advantage plan or switch to a Medicare Select policy for the first time; you have been in the plan for less than a year and want to switch back.	The Medicare Supplement policy you had before you obtained the Advantage plan or Select policy, if the same company you had before still sells it. (Drug coverage will not be included.) If it is not available, you can buy Medicare supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	As early as 60 calendar days before your health care coverage ends, but no later than 63 calendar days after it ends. Note: Your rights may last for an extra 12 months under certain circumstances.
6. YOU LOSE MEDICARE SUPPLEMENT COVERAGE THROUGH NO FAULT OF YOUR OWN		
Your Medicare Supplement policy ends through no fault of your own, such as bankruptcy by your insurance company.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	No later than 63 calendar days after coverage ends.
7. YOUR INSURANCE COMPANY COMMITS FRAUD		
You leave a Medicare Advantage plan or drop a Medicare Supplement policy because your company has not followed the rules or has misled you.	Medicare Supplement policy A, B, C, F, K or L sold in Kansas by any insurance company.	No later than 63 calendar days after coverage ends.
8. YOU LOSE YOUR MEDICAID ELIGIBILITY		
You lose your eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).	Any Medicare Supplement policy or Medicare Select policy offered by any company in Kansas.	No later than 63 calendar days from the date your coverage ends.

Effective January 1, 2020, references to plans C & F in the above scenarios were replaced with plans D & G for those that become eligible for Medicare on or after 01/01/2020.

PLAN AVAILABILITY CHANGES DUE TO MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

As a result of the passage of the federal law, MACRA in 2015, Medicare eligibles saw changes to plan offerings as of January 1, 2020. While the benefits under the current Medicare Supplement plans do not change, **plan availability does change**.

There has been a lot of misunderstanding about the impact of MACRA. Please read the following carefully so you know your options and rights.

Only those eligible for Medicare on or after January 1, 2020, are impacted by the changes to plan availability.

Those eligible for Medicare prior to January 1, 2020, are not impacted and can keep their current plans. MACRA prohibits coverage of the Part B deductible under Medicare Supplement plans as of January 1, 2020.

Impacts of MACRA on those eligible for Medicare prior to January 1, 2020:

- All Medicare Supplement plan options are available to you.
- If you are enrolled in Plans C or F, you can keep your plan. These plans remain available to you.
- You may purchase Plans C and F after January 1, 2020.
- You may purchase the new Plan G High Deductible Plan in 2020.

Impacts of MACRA on those eligible for Medicare on or after January 1, 2020:

- You cannot purchase Plans C and F.
- Creates a new Plan G High Deductible.
- Re-designates the guaranteed issued plans from Plans C and F to Plans D and G.
- Makes Plan G High Deductible available to all eligible.

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible G.

SECTION 2: MEDICARE SUPPLEMENT & MEDICARE SELECT PREMIUM RATES

How are Premium Rates Determined?

Premium rates for Medicare Supplement policies are determined in one of two ways. Be sure you know which type of policy you are purchasing.

Issue age — The company will not raise your premium just because you are getting older. Your premium will always be based on the age you were when you purchased the policy, but it will be adjusted for other factors. If you buy a plan at age 65, you will always pay the current premiums charged to 65-year-old customers. Issue-age policies are typically more costly up front, but also can save money in the long run.

Attained age — Premium will increase as you get older. If you buy a plan at age 65, you may have a premium increase each year.

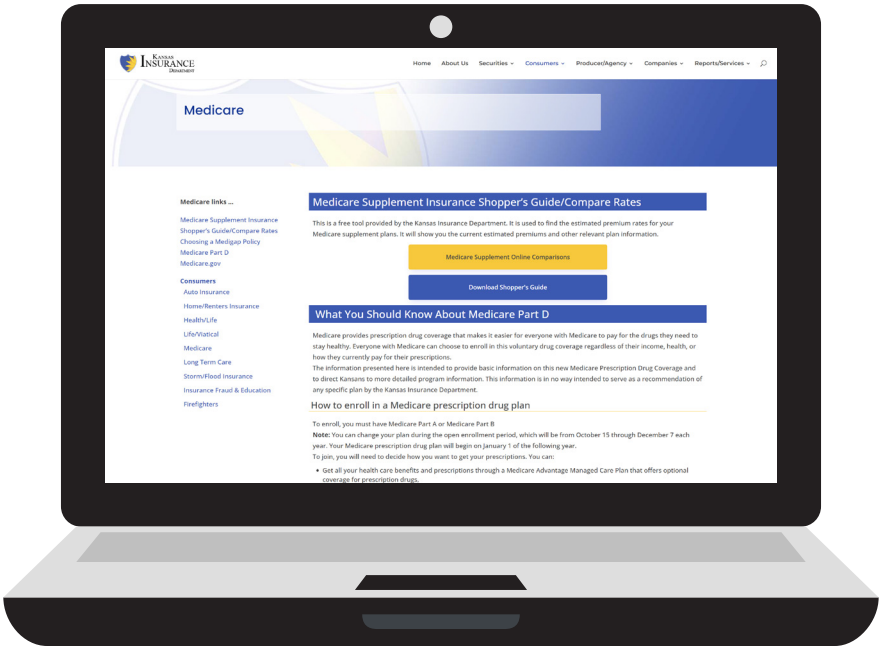
How to Find the Rates?

Plan rates are always changing. The Kansas Insurance Department offers a free online tool for you to find the estimated premium rates for your Medicare supplement plans. It will show you the current estimated premiums and other relevant plan information. You can find this tool by visiting our website at insurance.kansas.gov/medicare/

*If you do not have access to the internet you may call our office at 785-296-3071 and a hard copy can be mailed to you.

TO COMPARE RATES, VISIT

INSURANCE.KANSAS.GOV/MEDICARE



SECTION 3: ABOUT MEDICARE AND MEDICARE ADVANTAGE PLANS

What is Medicare?

Medicare is a federally-run health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). In order to be eligible to receive Medicare, you must meet at least one of the following criteria:

- Be age 65 or older
- Have permanent kidney failure
- Have a Medicare-qualified disability

How does Medicare Work?

There are four separate parts to Medicare:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part C (Medicare Advantage plans) and
- Part D (Prescription Drug Coverage)

Medicare Enrollment

Enrollment periods for Parts A, B, C and D vary. The following are guidelines to help you figure out when your enrollment period is. There are several different enrollment periods that you should be aware of when signing up for Medicare.

Without prior creditible coverage your initial enrollment period is the only time that you can enroll in all Parts of Medicare penalty-free. Make sure to weigh your options carefully during this time so you do not have to pay late enrollment fees for Part B or Part D later on.

MEDICARE PART A (HOSPITAL INSURANCE)

- Helps cover inpatient care in hospitals (includes critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
- Helps cover skilled nursing facility (not custodial or long-term care), hospice, and home health care services

MEDICARE PART B (MEDICAL INSURANCE)

- Helps cover doctor services and outpatient care
- Helps cover some preventive services to help maintain a person's health and to keep certain illnesses from getting worse
- Helps cover durable medical equipment

MEDICARE PART C (MEDICARE ADVANTAGE PLANS)

- A way to get Medicare benefits through private insurance companies approved by and under contract with Medicare
- Includes Part A, Part B, and usually other benefits Medicare does not cover. Some plans also provide prescription drug coverage for an additional cost
- Part C takes the place of Parts A and B

MEDICARE PART D (PRESCRIPTION COVERAGE)

- Run by private companies approved by Medicare
- Helps cover the cost of prescription drugs
- Each plan can vary in cost and drugs covered

NEW TO MEDICARE CHECKLIST

4-6 Months Before Your Month of Eligibility:

- Confirm your eligibility for Medicare benefits.
- Review your current health insurance to see what happens after you become eligible for Medicare.
- Contact you HR department or current insurer; and
- Find out what Medicare covers and the different options for coverage.

3 Months Before Your Month of Eligibility:

- Decide which Medicare option is best for you;
- Check with your doctor(s) and hospitals to see if they accept the different types of supplemental coverage.

1-3 Months Before Your Month of Eligibility:

- Enroll in Medicare A and B:
- Visit: socialsecurity.gov
- Call: (800) 772-1213
- TTY: (312) 751-4701
- Enroll in a Medicare Supplement Plan or a Medicare Advantage Plan

SIGNING UP FOR MEDICARE PART A & B AUTOMATIC ENROLLMENT

If you are already getting benefits from Social Security or the Railroad Retirement Board (RRB) you will:

- Automatically get part A and Part B starting the first day of the month you turn 65.
- If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.
- Social Security: Call: 1-800-772-1213
- Railroad Retirement Board: Call: 1-800-808-0772

If you are under 65 and disabled, you will:

- Automatically get Part A and Part B after you receive disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you will:

- Receive Part A and Part B automatically the month your social security disability benefits begin.

If you are automatically enrolled, you will receive your red, white, and blue Medicare card in the mail three months before your 65th birthday or 25th month of disability benefits. If you do nothing, you will keep Part B and will pay Part B premiums. You can choose not to keep Part B, but if you decide you want Part B later, you may have to wait to enroll and pay a penalty for as long as you have Part B.

What is Part C (Medicare Advantage Plans)?

Private insurance companies manage Medicare coverage for their members, and may also provide extra benefits not included in Original Medicare, such as dental, vision or hearing coverage. These plans include all benefits from Part A and Part B, and some plans also include Part D prescription drug coverage.

Remember, in most cases, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services.

Medicare Advantage plans are offered in some areas of the state by Medicare-approved private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.

Medicare Advantage Plans Cover All Medicare Part A and Part B Services

In all types of Medicare Advantage Plans, you are always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the benefits and services that Original Medicare covers. However, if you are in a Medicare Advantage Plan, Original Medicare will still cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

How do Medicare Advantage Plans Work?

- Provides Medicare-covered benefits;
- You still have Medicare rights and protections;
- You may have to use in-network doctors/hospitals;
- Your plan may differ from Original Medicare in cost-sharing or deductibles; and
- If the plan leaves Medicare, you can:
- Join another Medicare Advantage Plan, or
- Return to Original Medicare.

Medicare Advantage Plans Must Follow Medicare's Rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare.

However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year. Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare.

Read the Information You Get from Your Plan

If you are in a Medicare Advantage Plan, review the “Evidence of Coverage” (EOC) and “Annual Notice of Change” (ANOC) your plan sends you each year. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, provider networks, service area, and more that will be effective in January. If you do not get these important documents before the start of Open Enrollment, contact your plan.

What else should I know about Medicare Advantage Plans?

- You have Medicare rights and protections, including the right to appeal.
- You can check with the plan before you get a service to find out if it is covered and what your costs may be.
- You must follow plan rules. It is important to check with the plan for information about your rights and responsibilities.
- If you go to a doctor, other health care provider, facility, or supplier that does not belong to the plan’s network for non-emergency or non-urgent care services, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan’s provider network anytime during the year. Your plan can also change the providers in the network anytime during the year. If this happens, you may need to choose a new provider. You generally cannot change plans during the year if this happens.
- Plans may include fitness and wellness benefits.
- Medicare Advantage Plans cannot charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you will pay nothing for covered services. Each plan can have a different limit, and the limit can change each year. You should consider this when choosing a plan.

TYPES OF MEDICARE ADVANTAGE PLANS

MEDICARE PRIVATE FEE-FOR SERVICE (PFFS) PLAN

Can you get your health care from any doctor or hospital?	Are prescription drugs covered?
You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more. Check with the plan for more information.	Sometimes. If you want Medicare drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.
Do you need to choose a primary care doctor?	Do you need a referral to see a specialist?
No.	No.

MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

Can you get your health care from any doctor or hospital?	Are prescription drugs covered?
In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.	In most cases, yes. If you want Medicare drug coverage, you must join a PPO plan that offers prescription drug coverage. You may contact individual plans to find out if they offer prescription drug coverage.
Do you need to choose a primary care doctor?	Do you need a referral to see a specialist?
No.	In most cases, yes. Certain services, like yearly screening mammograms, do not require a referral.

What else do you need to know about this type of plan?

PPO plans are not the same as Original Medicare or Medicare Supplement.

Medicare PPO plans may offer extra benefits (like dental or vision services) than Original Medicare, but you may have to pay extra for these benefits.

MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

Can you get your health care from any doctor or hospital? No. Generally, you must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option in certain geographic areas.	Are prescription drugs covered? In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.
Do you need to choose a primary care doctor? In most cases, yes.	Do you need a referral to see a specialist? In most cases, yes. Certain services, like yearly screening mammograms, do not require a referral.

What else do you need to know about this type of plan?

- If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor.
- If you get health care outside the plan's network, you may have to pay the full cost.
- It is important that you follow the plan rules. For example, the plan may require prior approval for certain services.

THINGS TO CONSIDER WHEN LOOKING AT A MEDICARE ADVANTAGE PLAN:

1. Is your doctor included in the provider network? If not, you may want to either consider a different plan or find a new doctor who is included in the plan's network.
2. Are the hospitals in the network convenient for you? Make sure you have easy access to hospitals in case of an emergency.
3. Are your prescriptions covered under the plan? This is especially important if you have a chronic condition that requires medication.
4. What will your out-of-pocket costs be?
5. Do you trust the insurance company selling the policy? You should always buy from experienced companies who come well-recommended.

Medicare Advantage Plans are regulated by the Centers for Medicare and Medicaid Services (CMS)

WHAT IS PART D?

Medicare provides prescription drug coverage to help enrollees pay for the drugs they need to stay healthy. Everyone with Original Medicare or a Medicare Advantage Plan can choose to enroll in this voluntary drug coverage regardless of their income, health, or how they currently pay for their prescriptions.

Part D prescription drug coverage is run by private companies approved by Medicare. Part D can be added to either Original Medicare or a Medicare Advantage Plan (check to make sure your Advantage Plan does not already include Part D). You must have Part A or Part B to receive Part D coverage - it cannot stand alone.

Enrollment in Part D

You have the option to enroll in Part D during your initial enrollment period. You must pay a monthly premium for this coverage. The cost for each Part D plan varies based on the company selling the policy.

Like Part B, if you choose not to enroll in Part D during your initial enrollment period, and then change your mind, you may be charged a late enrollment fee, so it is important to evaluate your coverage needs during your initial enrollment period.

You will be charged more for Part D coverage if you enroll after your initial enrollment period.

Penalty for each month enrollment was delayed is one percent of a benchmark premium. For example: 24 months of delay becomes a 24 percent penalty. It continues for a lifetime unless you qualify for “Extra Help.”

How Does Part D Work?

Medicare prescription drug plans vary. In general, when you join, you will pay a monthly premium in addition to any premiums for Medicare Part A and Part B. You may also pay a deductible for your prescriptions. After you pay the yearly deductible, you will pay varying coinsurance amounts.

Medicare prescription drug plans can offer more generous coverage for higher premiums. Joining is your choice.

Things to remember:

- If you want coverage, you must enroll. Enrollment is not automatic.
- Once you are enrolled, you will pay a monthly premium.
- If you have a low income and limited assets, you may qualify for the “Extra Help” program to help with the costs.

Part D "Extra Help"

Some people qualify for government assistance in paying for Part D through a program called "Extra Help." This program can assist with the costs of monthly premiums, annual deductibles, and prescription copayments.

To find out more about the "Extra Help" program, contact your local Social Security office or call 800-772-1213. You can also get more information, and even enroll in the program, by visiting Social Security online at: www.ssa.gov/prescription help/

HOW DOES OTHER INSURANCE WORK WITH PART D?

Employer or Union Health Coverage

If you have prescription drug coverage based on employment, the employer or union will notify you each year to let you know if your drug coverage is creditable. If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage. Call your benefits administrator for more information before making any changes to your coverage.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of COBRA. However, if you take COBRA and it includes creditable prescription drug coverage, you will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends.

Federal Employee Health Benefits Program (FEHBP)

If you join a Medicare drug plan, you can keep your FEHBP plan, and your plan will let you know who pays first. For more information, contact the Office of Personnel Management at 800-332-9798. You can also call your plan if you have questions.

Veterans Benefits

You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if you do, you can not use both types of coverage for the same prescription. For more information, call the VA at 800-827-1000.

TRICARE (Military Health Benefits)

People with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits. If you have TRICARE, you are not required to join a Medicare drug plan. If you do, your Medicare drug plan pays first, and TRICARE pays second. If you join a Medicare Advantage plan with prescription drug coverage, TRICARE will not pay for your prescription drugs. For more information, call the TRICARE pharmacy contractor at 877-363-8779 (TTY call 877-540-6261).

Four ways to lower your costs during the Part D coverage gap

1. Consider switching to generics or other lower-cost drugs.

2. Find a pharmaceutical assistance program. Check www.medicare.gov to find out whether there is an assistance program for the drugs you take.

3. Apply for “Extra Help.” Limited income and resources? Check with your Social Security office.

4. Explore national and community-based charitable programs. Groups like the National Patient Advocate Foundation and the National Organization for Rare Disorders may be able to help you.

SECTION 4: CONSUMER PROTECTIONS AND RESOURCES

Consumer Rights

Free look period — You are entitled to a 30-day "free look" at your Medicare Supplement insurance policy, beginning the day you receive the policy. Be sure to keep track of the date the policy arrived; the postmark date on the envelope can be a good indicator of when this 30-day period begins.

If you are dissatisfied for any reason, you can return the policy within the 30 days and get your money back, no questions asked.

Use this "free look" period to do the following:

- Make sure it provides the benefits you expect and desire;
- Check for limitations, exclusions or waiting periods; and
- Read the application carefully to make sure that it has not been changed in any way and that all medical information is accurate.

Required Disclosures

Your Medicare Supplement policy must clearly disclose the existence of any of the following:

- Limitations or exclusion of payments for pre-existing conditions;
- Rights of the insurance company to change premiums;
- Automatic premium increases based on age at time of renewal if attained age rated

Outline of Coverage

An agent seeking your business must provide an outline of coverage when giving you an application form. This outline of coverage must do the following:

- Summarize the major benefit gaps in Medicare and tell you how much each benefit package offered by the insurance company will pay toward filling each gap;
- Disclose the premium for each benefit package that is offered; and
- Declare your right to a premium refund if you return the policy during the 30-day "free look" period.

Guaranteed Renewable

All Medicare Supplement insurance policies sold today are guaranteed renewable. The insurance company cannot refuse to renew your policy unless you do not pay the premiums or you submit false information on the application.

Medicare Claims Service

All calls regarding Medicare claim payments should be directed to 800-MEDICARE (800-633-4227). This is an automated system that will direct your call based upon your responses to a few automated voice prompts.

Protect Yourself from Identity Theft

Identity theft occurs when someone uses your personal information (like your name, Social Security, Medicare or credit card number) without your consent to commit fraud or other crimes. Keep this information safe. Do not give your information to anyone who comes to your home (or calls you) uninvited selling Medicare-related products.

If you lose your Medicare card or it is stolen, go to www.socialsecurity.gov on the web, or call the Social Security Administration at 800-772-1213. If you think someone is using your personal information, call one of the following:

- 800-MEDICARE (1-800-633-4227) (TTY users should call 877-486-2048)
- The Fraud Hotline of the HHS Office of the Inspector General at 800-447-8477 (TTY users should call 800-377-4950)
- The Federal Trade Commission's ID Theft Hotline at 877-438-4338 to make a report (TTY users should call 866-653-4261). For more information about identity theft, visit: www.consumer.gov/idtheft on the web.

NOTE: Medicare cannot ask for your Social Security number over the telephone. Report any plans that ask for your Social Security Number over the telephone by calling 800-MEDICARE, (800-633-4227).

Insurance fraud

Fraud is not limited to Medicare. People can be victims of fraud when they are buying supplement insurance or other specialty insurance products. Consumers should be wary of agents who fill out medical history and say it is okay not to tell the company certain health information. Also, while it is important to shop around for the best price, if it seems too good to be true, it probably is.

To report suspected insurance fraud, call the Kansas Insurance Department at 800-432-2484.

HOW DOES MY INSURANCE WORK WITH MEDICARE?

If you have retiree insurance (insurance from your or your spouse's former employment)...	Medicare pays first
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees...	Your group health plan pays first.
If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees...	Medicare pays first.
If you are under 65 and disabled, have group health plan coverage based on your, a spouse's, or a family member's current employment, and the employer has 100 or more employees...	Your group health plan pays first.
If you are under 65 and disabled, have group health plan coverage based on your, a spouse's, or a family member's current employment, and the employer has fewer than 100 employees...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.

TIPS & WARNINGS

- Shop carefully before you buy. Policies differ as to coverage and cost. Companies differ in services.

- Do not buy more policies than you need. Insurance agents are prohibited from selling a second Medicare Supplement policy to someone who has a Medicare Supplement policy already in force, unless you intend to cancel the first policy after the replacement policy goes into effect.

- Check for preexisting condition exclusions and waiting periods. Medicare Supplement policies are required to cover preexisting conditions after the policy has been in effect for six months. Some policies may cover you sooner.

- Beware of replacing existing coverage. Make sure you have a good reason for switching from one policy to another. You should only switch for different benefits, better service, or a more affordable price. If you decide to replace your policy, you must be given credit for the time spent under the old policy. In other words, insurance companies must take into account the amount of time you were covered under your old policy when applying any preexisting condition exclusions or restrictions.

- Companies can decline you for coverage if you have a preexisting condition and your six-month initial open enrollment period is over.

- You must sign a statement that indicates your intention to terminate the policy to be replaced.

- Do not cancel your policy until you have been accepted into the new plan.

- You should use caution in purchasing other types of insurance that duplicate benefits provided by Medicare and your supplemental coverage.

- NO Medicare Supplement policy covers every medical expense not covered by Medicare.

- Medicare Supplement policies are not sold or endorsed by state or federal government agencies.

- Know about the agent and company with which you are working. Call our Consumer Assistance Hotline, 800-432-2484, to check any agent or company you are considering is licensed in Kansas.

- Take your time. Do not be pressured into buying a policy. Principled sales people will not rush you.

- If you decide to buy, complete the application carefully. It is against the law for an agent to suggest you falsify an application. Do not withhold medical information on the application for insurance. Coverage could be refused for a period of time, a claim could be denied or your policy canceled if you leave out any of the medical information requested. NEVER sign a blank application. Do not let the agent fill it out for you.

- DO NOT pay cash. Pay by check, money order or bank draft made payable to the insurance company. Get a receipt for your records.

GLOSSARY OF TERMS

Assignment — An agreement by your provider or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period — The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or SNF. The benefit period ends when you have not received any inpatient hospital (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods a beneficiary can have.

Coinsurance — An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage. In a Medicare prescription drug plan (Part D) or Medicare health plan, the coinsurance will vary depending on how much you have spent.

Copayment — An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or prescription. A copayment is usually a set amount, rather than a percentage.

Creditable — Creditable coverage is any coverage that is offered through an employer or group sponsored health plan, or some other health plan, that is equal or better than coverage you would receive under Medicare. Providing proof to Medicare that you have creditable coverage at the time you enroll will keep you from having to pay a late penalty fee if you enroll in prescription drug coverage after your initial open enrollment period.

Deductible — The amount you must pay for health care or prescriptions, before Original Medicare, your Medicare drug plan, your Medicare health plan, or your other insurance begins to pay. These amounts can change every year.

Extra Help — A Medicare program to help people with limited income and resources pay Medicare Part D prescription drug program costs, such as premiums, deductibles, and coinsurance.

Guaranteed Issue Rights — Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medicare Supplement policy. In these situations, an insurance company cannot deny you a Medicare Supplement policy, or place conditions on a Medicare Supplement policy, such as exclusions for preexisting conditions, and cannot charge you more for a policy because of past or present health problems.

Health Maintenance Organization (HMO) — A type of Medicare health plan that is available in densely populated areas of the state. Plans must cover all Medicare Part A and Part B services. 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.

High deductible Medicare Supplement policy — A type of Medicare Supplement policy that has a high deductible but a lower monthly premium. You must pay the deductible before the Medicare Supplement policy pays anything. The deductible amount can change each year.

Medical underwriting — Medical underwriting is the process an insurance company uses to

determine whether to accept you as a beneficiary under a policy. The company also uses medical underwriting to determine how much of a monthly premium to charge you. Medical underwriting is based on information you give to the company about your past and present medical conditions.

Medically necessary — Services or supplies that are needed for the diagnosis or treatment of your medical condition and accepted standards of medical practice.

Medicare Advantage Plans — Medicare Advantage Plans (like an HMO or PPO), also called "Part C," are health plans run by Medicare-approved private insurance companies. Medicare Advantage Plans include Part A, Part B, and sometimes other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost.

Medicare Medical Savings Account (MSA) plan — A type of Medicare Advantage Plan. MSA plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.

Medicare-approved amount — In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Supplement — A Medicare Supplement insurance policy.

Open enrollment period (Medicare Supplement insurance) — A one-time only six-month period when federal law allows you to buy any Medicare Supplement policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B. During this period, you cannot be denied a Medicare Supplement policy or be charged more due to a past or present health problem. Kansas regulations allow individuals under age 65 the same open enrollment period whether they receive Medicare because of age or disability.

Out-of-network — Generally, an out-of-network benefit provides you with the option to get plan services out of the plan's contracted network of providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

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

Preexisting condition — A health problem you had before the date that a new insurance policy starts.

Preferred Provider Organization (PPO) — A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium — The periodic payment to Medicare, an insurance company, a health care plan or a drug plan for health care or prescription drug coverage.

Private Fee-for-Service plan — A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that agrees to treat you under the plan and that accepts the plan's payment terms. The plan decides how much you must pay for services.

Referral — A written order from your primary care doctor for you to see a specialist or get certain services. In many HMOs, you need to get a referral before you can get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care.

Service area — The area where a health plan accepts members. For plans that limit which doctors and hospitals you may use, it is generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) — A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitation services and other related health services.

COMPANY CUSTOMER SERVICE PHONE NUMBERS

COMPANY	PHONE
ACE PROPERTY AND CASUALTY INSURANCE COMPANY	215-640-1000
AETNA HEALTH INSURANCE COMPANY	888-247-1028
AMERICAN BENEFIT LIFE INSURANCE COMPANYv	800-745-4927
AMERICAN HOME LIFE INSURANCE COMPANY (THE)	800-876-0199
ASSURED LIFE ASSOCIATION	800-995-5991
BANKERS FIDELITY ASSURANCE COMPANY	404-266-5600
BANKERS RESERVE LIFE INSURANCE COMPANY OF WISCONSIN	314-445-0086
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.	800-752-6650
CAPITOL LIFE INSURANCE COMPANY	800-525-2115
CENTRAL STATES HEALTH & LIFE COMPANY OF OMAHA	800-790-7055
CHRISTIAN FIDELITY LIFE INSURANCE CO	800-386-5202
CIGNA HEALTH AND LIFE INSURANCE COMPANY	855-226-0519
CIGNA NATIONAL HEALTH INSURANCE COMPANY	866-459-4272
COMPBENEFITS INSURANCE COMPANY	502-580-8965
COVENTRY HEALTH AND LIFE INSURANCE CO	800-990-0345
EVERENCE ASSOCIATION INC.	800-348-7468
FEDERAL LIFE INSURANCE COMPANY	847-520-1900

FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	800-445-1425
GLOBE LIFE & ACCIDENT INSURANCE CO	800-801-6831
GPM HEALTH AND LIFE INSURANCE COMPANY	509-838-4235
GUARANTEE TRUST LIFE INSURANCE COMPANY	847-460-4772
HEARTLAND NATIONAL LIFE INSURANCE COMPANY	816-478-0120
HUMANA BENEFIT PLAN OF ILLINOIS, INC.	502-580-1000
LUMICO LIFE INSURANCE COMPANY	866-440-4047
MANHATTANLIFE ASSURANCE COMPANY OF AMERICA	800-669-9030
MANHATTANLIFE OF AMERICA INSURANCE COMPANY	713-529-0045
MEDICO INSURANCE COMPANY	800-228-6080
MEMBERS HEALTH INSURANCE COMPANY	833-282-5928
MISSOURI VALLEY LIFE AND HEALTH INS CO	800-358-2557
MONITOR LIFE INSURANCE COMPANY OF NEW YORK	601-956-2028
NASSAU LIFE INSURANCE COMPANY OF KANSAS	800-420-5382
NATIONAL GUARDIAN LIFE INSURANCE CO	800-626-7931
NATIONAL HEALTH INSURANCE COMPANY	888-781-0580
NEW ERA LIFE INSURANCE COMPANY	281-368-7200
OLD SURETY LIFE INSURANCE COMPANY	800-272-5466
OMAHA INSURANCE COMPANY	800-667-2937
ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA	800-848-0123

PEKIN LIFE INSURANCE COMPANY	309-346-1161
RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA	800-745-7509
RESOURCE LIFE INSURANCE COMPANY	312-356-2486
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY	Contact Local Agent
STATE MUTUAL INSURANCE COMPANY	855-764-4000
TIER ONE INSURANCE COMPANY	706-596-3208
TRANSAMERICA LIFE INSURANCE COMPANY	319-398-8511
UNIFIED LIFE INSURANCE COMPANY	800-237-4463
UNION SECURITY INSURANCE COMPANY	800-733-7879
UNITED AMERICAN INSURANCE COMPANY	972-529-5085
UNITED INSURANCE COMPANY OF AMERICA	800-791-4357
UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA	800-207-8050
UNITED STATES FIRE INSURANCE COMPANY	973-490-6600
UNITEDHEALTHCARE INSURANCE COMPANY	877-832-7734
UNITEDHEALTHCARE INSURANCE COMPANY OF AMERICA	860-702-5428
USAA LIFE INSURANCE COMPANY	800-531-8000
WASHINGTON NATIONAL INSURANCE COMPANY	800-525-7662

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ADDITIONAL RESOURCES

Senior Health Insurance Counselors of Kansas
Phone: 800-860-5260
www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Area Agencies on Aging / Aging and Disability Resource Centers (AAA / ADRC)
www.agingcare.com/

Wyandotte-Leavenworth AAA/ADRC (Kansas City)
Phone: 888-661-1444

Northwest Kansas AAA/ADRC (Hays)
Phone: 800-432-7422

Southeast Kansas AAA/ADRC (Chanute)
Phone: 800-794-2440

East Central Kansas AAA/ADRC (Ottawa)
Phone: 800-633-5621

Northeast Kansas AAA/ADRC (Hiawatha)
Phone: 800-883-2549

Johnson County AAA/ADRC (Olathe)
Phone: 913-715-8860

Central Plains AAA/ADRC (Wichita)
Phone: 800-367-7298

Jayhawk AAA/ADRC (Topeka)
Phone: 800-798-1366

Southwest Kansas AAA/ADRC (Dodge City)
Phone: 800-742-9531

North Central/Flint Hills AAA/ADRC (Manhattan)
Phone: 800-432-2703

South Central Kansas AAA/ADRC (Arkansas City)
Phone: 800-362-0264

KanCare
Consumer Assistance: 866-305-5147
www.kancare.ks.gov/

Kansas Department of Health and Environment (KDHE) – State Medicaid Agency
www.kdheks.gov/

Kansas Commission on Veterans Affairs
Phone: 785-296-3676
kcva.ks.gov/

Elder Law Hotline
Phone: 888-353-5337
www.kansaslegalservices.org

Kansas Bar Association
Phone: 785-234-5696
www.ksbar.org

Kansas Department for Aging and Disability Services (KDADS)
Phone: 800-432-3535
www.kdads.ks.gov

Long-Term Care Ombudsman
Phone: 877-662-8362
785-296-3017
www.da.state.ks.us/care

Kansas Department for Children and Families (DCF) – Medicaid Eligibility and Enrollment
Customer Service Assistance: 888-369-4777
www.dcf.ks.gov

Kansas Medical Assistance Program
Phone: 800-766-9012
www.kmap-state-ks.us/Public/homepage.asp

KANSAS INSURANCE DEPARTMENT

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