

2009 Guide To Health Insurance For Medicare Beneficiaries



What you need to know
to make informed decisions about
Medicare, Medigap insurance,
Medicare Advantage,
Medicare prescription
drug plans and
long-term care insurance



Karen Weldin Stewart, CIR-ML

Delaware's Insurance Commissioner
1-800-282-8611

www.delawareinsurance.gov

ELDERinfo 1-800-336-9500

A Message From Delaware's Insurance Commissioner Karen Weldin Stewart

At the Department of Insurance, our annual Health Insurance Guide is one of the most asked for and most used publications. Each year, we revise the guide to make it more informative and easier to read.

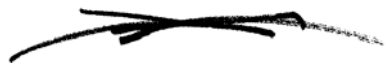
As of January 12, 2009, state law requires all insurance companies offering Medicare supplement policies in Delaware to make available Medicare supplement coverage to any applicant under the age of 65 who is eligible for Medicare due to end stage renal disease. If you have questions or would like to find out more, please give the office a call.

This guide provides you with our annual price comparisons for Medigap insurance, which is private insurance designed to supplement Medicare. When reviewing the rates, keep in mind that changes can be made in the premiums based on your gender and whether or not you smoke, and that rates may change over the course of the year. The toll-free telephone numbers for all companies offering Medigap are included in the guide.

Finally, we have provided some helpful information on long-term care insurance and the companies that offer it in Delaware. Remember that long-term care policies are not standardized like Medigap policies.

I hope you find the 2009 Health Insurance Guide useful in helping to decide what is right for you and your loved ones. If I or my staff can be of help to you, please call 1-800-336-9500 or visit us on the Web at www.delawareinsurance.gov.

Sincerely,



Karen Weldin Stewart, CIR-ML
Insurance Commissioner



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ELDERinfo Counseling Sites

Following, is a listing of participating ELDERinfo counseling sites throughout Delaware. For the name of the counselor and counseling hours at the site nearest you, please call 1-800-336-9500. If you are not able to visit the site, a counselor will call you to answer your questions.

[New Castle County](#)

St. Anthony's Senior Center
1703 W. 10th St., Wilmington

Newark Senior Center
200 White Chapel Rd., Newark

M.O.T. Senior Center
300 S. Scott St., Middletown

Shipleigh Manor
2723 Shipleigh Rd., Wilmington

Claymore Senior Center
504 South Clayton St., Wilmington

[Kent County](#)

Milford Senior Center
111 Park Ave., Milford

Harrington Senior Center
102 Fleming St., Harrington

Frederica Senior Center
216 S. Market St., Frederica

[Sussex County](#)

Harbour Lights CHEER Center
34211 Woods Edge Dr., Lewes

Coastal Leisure Center
36380 Cedar Neck Rd., Ocean View

About Original Medicare, Medigap, And Other Health Insurance Options

Original Medicare

Medicare is a federal health insurance program for people 65 years of age or older, people of any age with permanent kidney failure, and certain disabled people under age 65. The Centers for Medicare & Medicaid Services, part of the U.S. Department of Health and Human Services, manages Medicare. The Original Medicare program has two parts – Hospital Insurance, known as Part A, and Medical Insurance, known as Part B.

Part A: Part A helps pay for inpatient hospital care and certain follow-up care, such as skilled nursing and home health. For most people, Part A is premium-free because you or your spouse paid Medicare taxes for at least 10 years while you were working. If you have less than 10 working years' credit, you may be eligible to purchase coverage and should contact the Social Security Administration for information.

Part B: Part B helps pay for doctors, outpatient hospital care, x-rays, laboratory tests and certain types of medical equipment, such as wheelchairs. If you are eligible for premium-free Part A, you are automatically eligible to purchase Part B, which is voluntary.

The Medicare Part B premium is based on your income. Most people will pay the standard monthly Part B premium of \$96.40. However, some people will pay a higher premium based on their modified adjusted gross income. Your monthly premium will be higher if you file an individual tax return and your annual income is more than \$85,000, or if you are married filing a joint tax return and your annual income is more than \$170,000. These amounts may change each year.

If you have group insurance, check with your employer to see if you are required to select Part B. Your group benefits may be reduced if you do not enroll in Part B when you are eligible.

Part B General Enrollment Period: If you didn't take Part B when you were first eligible for Medicare, you may only sign up during the General Enrollment Period, which runs from January 1 through March 31 of each year. Your Part B coverage then becomes effective July 1 and the monthly Part B premium may be higher. The Part B premium increases 10 percent for each full 12-month period that you could have had Part B but did not take it. You will have to pay this extra amount as long as you have Medicare Part B.

Part B Special Enrollment Period: If you didn't take Part B because you or your spouse currently works and has group health coverage through your current employer or union, you can sign up for Part B during the Special Enrollment Period. You can sign up at any time while you are covered under the group plan, or within 8 months of the date your employer or union group coverage ends or when the employment ends (whichever is first). Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums.

Out-of-Pocket Costs: Medicare does not cover all of your health care costs. Your "out-of-pocket" costs will include your monthly Part B premium, as well as deductibles and the Original Medicare plan coinsurance and outpatient co-payment amounts. Additionally, Medicare does not cover routine eye care, hearing aids, most dental care, dentures, routine foot care or care received in a foreign country. Prescription drugs are now covered by separate Medicare drug plans (see below).

Medicare Prescription Drug Plans (Part D)

Medicare offers prescription drug coverage for everyone with Medicare. This is called "Part D." You can join a Medicare drug plan three months before, the month of or three months after you turn 65. This is called your initial enrollment period.

If you are disabled, you can generally join Part D three months before and three months after your 25th month of disability. The plan will notify you when your coverage begins.

If you don't join a Medicare drug plan during your initial enrollment period, and there is a period of 63 continuous days or more during which you don't have creditable prescription drug coverage, you will only be able to join between November 15 and December 31 and will probably have to pay a late enrollment penalty when you do join. This amount changes every year. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

If you were eligible to join a drug plan when the plans first began in 2006 and did not, you also will only be able to join a plan from November 15 to December 31 each year and will likely pay a penalty.

Once you are enrolled in a prescription drug plan, you may change plans each year between November 15 and December 31 .

For more information about Medicare Part D prescription drug plans, see pages 18 to 21 in this guide.

Medigap

“Medigap” is health insurance sold by insurance companies to help fill the “gaps” in the Original Medicare plan. Medigap insurance policies pay most, if not all, of the Original Medicare plan coinsurance and/or co-payment amounts. Medigap policies may also provide coverage for the Original Medicare plan deductibles.

Medigap insurance consists of 12 standardized plans, A-L. Please review pages 10 and 11 to learn about Medigap plans.

Some of the Medigap plans pay for services not covered by Medicare, including preventive care not covered by Original Medicare or emergency care while traveling in a foreign country. When describing the benefits of each of the Medigap plans, insurance companies must use the

same format, language, and definitions. They are also required to use a uniform chart and outline of coverage to summarize the benefits in each plan. These requirements make it easier for you to compare policies. As you shop for a Medigap policy, keep in mind that each company's products are alike, so they are competing on service, reliability and price.

All standard Medigap policies are guaranteed renewable. This means that the insurance company must allow you to renew your Medigap policy, unless you do not pay the premiums.

A list of the companies licensed to sell Medigap insurance in Delaware, the plans each company offers, the approximate yearly premium for each plan, and the telephone number for each insurance company can be found on pages 12 to 16.

Medigap and Open Enrollment Guarantees:

During the first six months you are age 65 and enrolled in Part B, you can buy the policy of your choice regardless of whether you had enrolled in Part B before you were 65. During these six months, you cannot be refused a policy because of your disability or for other health reasons, and you cannot be charged more than other applicants. Once you turn 65 and enroll in Part B, the six-month Medigap open enrollment period starts and cannot be extended or repeated.

A waiting period of up to six months may be imposed for coverage of a pre-existing condition. However, if you buy a Medigap policy during your open enrollment period and you had previous health coverage that qualifies as “creditable coverage,” the insurance company must reduce the waiting period for pre-existing conditions by the number of months of creditable coverage you had.

Medicare Savings Program

For certain low-income individuals entitled to Medicare Part A, the Medicare Savings Program may pay some or all of Medicare's premiums, deductibles and coinsurance. The programs that help pay Medicare's premiums are called the Qualified Medicare Beneficiary (QMB) program, the

Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualifying Individual (QI-1) program. For eligibility requirements, please contact *ELDERinfo* at 1-800-336-9500.

Military Retirees

To serve the medical needs of military retirees, their family members, and their survivors who are age 65 and older, there is TRICARE for Life. For eligibility requirements, please contact the Defense Enrollment Eligibility Reporting System (DEERS) at 1-800-538-9552 or TRICARE for Life at 1-888-363-5433. You may also obtain information about TRICARE on the web at www.tricare.osd.mil.

Veterans Benefits and Medicare

Veterans may receive services through the Veterans Administration health care system *and* Medicare. If you are receiving some of your care through the Medicare program, you can still obtain other services through the VA. You do not have to drop your Medicare coverage to receive VA health care benefits. For some veterans, the health care they receive is free. Other veterans may be responsible for making co-payments for services and supplies they obtain, including medications. These co-payments are not reimbursable by Medicare.

When you receive care through the VA, it is important for you to give information about any health care coverage you may have, including coverage provided through your spouse. The VA will submit claims to insurance carriers to recover the costs of providing care for medical conditions that are not “service connected” by the VA. Although the VA cannot currently bill Medicare for your services, any Medicare supplemental insurance you may have can be billed for that portion of the costs that the supplemental policy covers.

For more information about your specific out-of-pocket costs, contact any VA health care facility. Questions regarding whether the VA or Medicare should pay for your doctor or other services covered under Medicare Part B, contact your Medicare carrier. If you have questions about

whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, ask the provider of services to check with the Medicare Intermediary. You may contact the VA Regional Office at 1-800-827-1000 or the VA Medical Center, Eligibility Department at 1-800-461-8262 ext. 5212.

Employer Group Health Insurance

Group Health Coverage for the Currently Employed: When you reach age 65, you may still have private insurance through your or your spouse’s current employer or union membership. If you have this kind of coverage, find out if it can be continued after you retire. Check the price and the benefits, including benefits for your spouse. Group health coverage provided by employers and unions is subject to rules issued by both the Department of Labor and the Internal Revenue Service.

Group Health Coverage for Retired Employees: Group health coverage continued after retirement usually has the advantage of having no waiting period or exclusions for pre-existing conditions. Coverage is usually based on group premium rates, which may be lower than the premium rates for policies you buy yourself. Retiree insurance that is not a Medigap policy does not have to follow the rules for Medigap policies, but under some circumstances must follow the rules of the Department of Labor. These plans have their own rules and might not fill the gaps in Medicare. While retiree insurance may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retirement coverage provided by the employer or union may have caps or limits on benefits. If you are not sure how your plan works with Medicare, call the plan’s benefit office and ask how the plan pays when you have Medicare.

A word of caution: If you give up your employer-based health coverage, you probably won’t be able to get it back. Contact your employee benefits office for more information.

Retirement Health Plans and Medigap

You may buy a Medigap policy even if it duplicates your retiree group insurance benefits. In that case, Medicare would be your primary policy, your group plan would be secondary and your Medigap policy would be third. While your group policy might cover services not covered by a Medigap policy, the Medigap policy might provide a higher reimbursement for a service your group plan does cover, thus lessening or eliminating any out-of-pocket cost to you.

Other Insurance Options

There are several types of “limited” or “supplemental” insurance plans available that are sold to Medicare beneficiaries. These include policies that pay a certain amount only for a specific occurrence, such as a particular disease, hospitalization, accidental injury, surgical expense, etc. Because the benefits provided by these plans are limited, this type of insurance should not be purchased in lieu of Medigap insurance, Medicare managed care plans or comprehensive health coverage. Therefore, when considering the purchase of a limited insurance plan, be aware that the plan may pay benefits in addition to those already provided to you by Medicare, Medigap or a Medicare Managed Care Plan.

Prescription Assistance Program

The Delaware Prescription Assistance Program, (DPAP) is funded by tobacco settlement money and provides a \$3,000 prescription benefit per year for low-income seniors or low-income disabled persons. To determine if you are eligible for assistance, please contact DPAP at 1-800-996-9969.

Consumer Protections

If you lose your health plan coverage under certain circumstances, you will have a right to purchase a Medigap policy (Plan A, B, C, F, K or L) as long as you apply within 63 days of losing your coverage. Special protections apply with regard to pre-existing conditions and for the disabled. The circumstances include:

- Your Medicare Managed Care Plan or Private Fee-for-Service Plan terminates or stops providing care in your area.
- You move outside the plan’s service area.
- You leave the plan because it failed to meet its obligations to you.
- You were in an employer health plan that terminated coverage.
- You drop your Medigap policy to join a Medicare Advantage plan for the first time and you leave within one year of joining.
- You join a Medicare Advantage plan when you first become eligible for Medicare at age 65 and you leave the plan within one year.

The terminating plan is required to provide you with written proof of coverage as evidence of continuous insurance for enrolling in another plan. Do not destroy or lose this notification.

Tips From The Commissioner

Help From **ELDERinfo**

The issues involved in Medicare, Medigap and other health insurance issues can be complex and confusing. For Delawareans with Medicare, the Insurance Commissioner’s **ELDERinfo** program provides Medicare beneficiaries with information and counseling related to all types of health insurance. To contact **ELDERinfo**, call 1-800-336-9500 or go to www.delawareinsurance.gov and click on “**ELDERinfo**.” See back cover for more information.

Medicare Advantage Plans

Medicare Advantage Plans provide more coverage choices and different benefits than Original Medicare or the old Medicare+Choice Plans.

Medicare Advantage Plans are offered by private companies that sign a contract with Medicare. Medicare Advantage Plans provide Medicare-covered benefits to Medicare members through the plan, and may offer prescription drug benefits as well as extra benefits that Medicare doesn't cover, such as vision or dental services. If you join one of these plans, you generally get all your Medicare-covered health care through that plan and will use the health care card that you receive from your Medicare Advantage Plan. If you're in a Medicare Advantage Plan, you generally don't need a Medigap policy because they cover many of the same benefits.

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of \$96.40 in 2009 to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan. The plan may have special rules.

Types of Medicare Advantage Plans currently available in Delaware are listed below. Details about these plans are available by calling the companies listed or online at www.medicare.gov.

- **HMOs** — With a Health Maintenance Organization (HMO), you generally must see a primary care doctor to get a referral before you see any other provider. There is one Medicare Advantage HMO available in 2009, but in New Castle County only: Aetna Medicare (1-800-455-1560).
- **Private Fee-For-Service Plans** — You can see any doctor that accepts the plan's payment terms. The private company, not Medicare, negotiates with providers to decide how much it will pay and what you pay for the services you receive. No referrals are necessary. The Private Fee-For-Service Plans available in Delaware are: Advantra Freedom (1-800-711-1607); Bravo Health (1-888-326-2827); Secure Horizons MedicareDirect (1-800-555-5757); Sterling Life Insurance (1-888-858-8572); Unicare Life & Health Insurance (1-888-949-5384); and WellCare (1-866-238-9898). Coverage is also offered through Mennonite Mutual Aid Association (1-800-348-7468), you must be a member of this religious or fraternal organization to enroll in this plan
- **PPOs** — Medicare Preferred Provider Organization (PPO) Plans allow you to see any doctor, but it costs less to see doctors in the plan's network. Some plans don't require a referral to see a specialist. In 2009, the PPO plans available in Delaware are from Aetna Medicare (1-800-455-1560).
- **Medicare Special Needs Plans** — These plans are specially designed for people with certain chronic diseases and other specialized health needs. Medicare Special Needs Plans must provide all Medicare Part A and Part B health care and services and must provide Medicare prescription drug coverage (Part D). Generally they offer extra benefits and have lower co-payments than the Original Medicare Plan. The Special Needs Plans available in Delaware in 2009 are: Aetna Medicare (1-800-455-1560) and Evercare Health Plans (1-888-834-3721).
- **Medical Savings Plans** — Medicare Medical Savings Account Plans (MSAs) began in 2007. MSAs are similar to Health Savings Account plans available outside of Medicare, and they have two parts. The first part is a Medicare Advantage Plan with a high deductible. This health plan won't begin to pay covered costs until you have met the yearly deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs. In 2009, Medical Savings Plans are from Advantra Savings (1-800-474-5993).

Joining Or Switching Plans

Sometimes, people with Medicare decide to join a plan or switch to another plan. For example, a person who has the Original Medicare Plan might decide to switch to a Medicare PPO. Or, a person might decide to switch from a Medicare PPO to a Private Fee-For-Service.

Compare Original Medicare and the Medicare Advantage Plans available in Delaware. Once you have decided which plan you want, contact the plan you are interested in for enrollment information. For example, some plans will send you an enrollment form. Fill out the form and mail it to the plan, or give it to the plan representative. You can get help filling out this form. You will get a letter from the plan telling you when your coverage begins.

You can't call a Medicare Advantage Plan or other Medicare Health Plan to join over the telephone, unless you are switching to another plan offered by the same company, and the company offers that option.

You can keep a Medigap policy if you join a Medicare Advantage Plan. However, you will have to keep paying your premiums and you may get little or no benefit from it while you are in a Medicare Advantage Plan. If you join a Medicare Advantage Plan, you will have to pay co-payments and deductibles. You can call *ELDERinfo* at 1-800-336-9500 if you need help deciding whether to keep your Medigap policy. If you drop your Medigap policy, you may not be able to get it back, except in certain situations.

If you join a Medicare Advantage Plan or other Medicare Health Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your plan coverage. Talk to your employer or union benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to rejoin it later.

Generally, if you join a Medicare Advantage Plan, you can only change plans under certain

circumstances. You can choose to join, switch or drop a plan during a period from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can switch your plan at other times. After you request to switch, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

You can also make changes in your plan from January 1 to March 31 each year, however you cannot add or change to a plan with prescription drug coverage during this time unless you already have Medicare Part D prescription drug coverage.

You can switch your Medicare plan in one of three ways:

- Join another Medicare plan
- Write or call your plan
- Call 1-800-MEDICARE (1-800-633-4227)

If you want to switch from a Medicare Advantage Plan to Original Medicare and buy a Medigap policy, you need to contact your current plan or call 1-800-MEDICARE (1-800-633-4227). Simply signing up for the Medigap policy won't end your Medicare Advantage Plan coverage.

The Standard Medigap Plans Offered By Insurance Companies

Plan A

Consists of these basic benefits:

- Coverage for the Part A coinsurance amount (\$267 per day in 2009) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount (\$534 per day in 2009) for each of Medicare's 60 non-renewable lifetime hospital in-patient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional in-patient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS. Beneficiaries may be responsible for payment when Medigap hospital benefits are exhausted.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year, unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health service after \$135 deductible is met).

Plan B

Includes the basic benefits under Plan A plus:

- Coverage for the Medicare Part A in-patient hospital deductible (\$1,068 per benefit period in 2009).

Plan C

Includes the benefits under Plan A and Plan B plus:

- Coverage for the Medicare Part B deductible (\$135 per calendar year in 2009).
- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

Plan D

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery, with 100% coverage for Medicare-approved home health services but no coverage for services not covered or approved by Medicare .

Plan E

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for things such as a physical examination, serum cholesterol screening, thyroid function testing, etc.

Summary Of Medigap Plans A—J

	A	B	C	D	E	F/F*	G	H	I	J/J*
Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Deductible			✓			✓				✓
Part B Excess (%)						100%	80%		100%	100%
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Preventive Care Not Covered By Medicare					✓					✓

*Plans F and J also have a high deductible option plan. The high deductible plans offer the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits will not begin until out-of-pocket expenses exceed \$2,000. The out-of-pocket expenses include Medicare deductibles for Part A and Part B but do not include separate prescription drug deductible or foreign travel emergency deductible.

Plan F

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- Coverage for the Medicare Part B deductible (\$135 per calendar year in 2009).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

Plan G

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- Coverage for 80% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery, with 100% coverage for Medicare-approved home health services but no coverage for services not covered or approved by Medicare .

Plan H

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.

Plan I

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery, with 100% coverage for Medicare-approved home health services but no coverage for services not covered or approved by Medicare .

Plan J

Includes the benefits under Plan A and Plan B plus:

- Coverage for the skilled nursing facility care coinsurance amount (\$133.50 per day for days 21 through 100 per benefit period in 2009).
- Coverage for the Medicare Part B deductible (\$135 per calendar year in 2009).
- Coverage for 100% of Medicare Part B excess charges.
- 80% coverage for medically necessary emergency care in a foreign country, after a \$250 deductible.
- Coverage for at-home recovery, with 100% coverage for Medicare-approved home health services but no coverage for services not covered or approved by Medicare .
- Coverage for preventive medical care. The preventive medical care benefit pays up to \$120 per year for things

such as a physical examination, serum cholesterol screening, and thyroid function testing.

Plans K & L

With Different

Cost-sharing For Items And Services Than

Plans A-J

Plan K

- 50% Part A deductible.
- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end.
- 50% Part B coinsurance
- 100% preventative care coinsurance
- 50% of Medicare-eligible expenses for the first three pints of blood.
- 50% skilled nursing facility coinsurance.
- 50% hospice cost-sharing for all Medicare Part A eligible expenses and respite care.
- Plan pays 100% of Medicare co-payments, coinsurance and deductibles for the rest of the calendar year after a \$4,620 out-of-pocket annual limit is reached. The limit does not include expenses that exceed Medicare-approved amounts.

Plan L

- 75% Part A deductible.
- 100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end.
- 75% of Medicare-eligible expenses for the first three pints of blood.
- 75% Part B co-insurance
- 100% coinsurance for Part B preventive service.
- 75% skilled nursing facility co-insurance.
- 75% hospice cost-sharing for all Medicare Part A eligible expenses and respite care.
- Plan pays 100% of Medicare co-payments, coinsurance and deductibles for the rest of the calendar year after a \$2,310 out-of-pocket limit is reached. The limit does not include expenses that exceed Medicare-approved amounts.

2009 Rates For Medigap Insurance Plans

This chart shows the annual premiums, based on age, offered by private insurance companies providing Medigap insurance in Delaware. Premiums are accurate as of April 2009, but may change over the course of the year—contact companies for latest premiums. “Rating” is an evaluation of the company by A.M. Best, an independent rating and information agency. Rating key on page 17. For companies that offer coverage to disabled persons under age 65, rates are in the “<65 DIS” column. Not all companies offer all plans. See page 17 for explanation of column titled “I, C, A.”

Medigap Plan ▶		Plan A							Plan B							Plan C							Plan D							Plan E						
▼COMPANY	Best Rate	I, C, A	65	70	75	80	65/Dis	<65 ESRD	65	70	75	80	65/DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD				
American Progressive Life and Health Insurance Co of New York**1-800-332-3377	B++	A	1498	1767	2055	2252		14592	2076	2467	2097	3237		17041	2501	2928	3413	3785		22667	2163	2574	3042	3399		21180	2184	2599	3073	3432		21551				
Bankers Fidelity Life Ins. Co. 1-866-458-7499	B++	I	866	969	1055	1107		24,000	1396	1566	1773	1868		30000	1758	1934	2207	2363		33000	1434	1608	1815	1970		33000	1320	1425	1638	1765		33000				
Bankers Life and Casualty Co. 1-800-621-3724	B	A	1509	1714	2002	2372		15958	1746	2061	2491	3045		19725	2987	3580	4407	5510		22907	1647	1974	2430	3038		22772	1608	1912	2324	2867		22772				
Blue Cross Blue Shield of Delaware 1-800-633-2563		A	936	1260	1572	1812	2244	14112	1080	1464	1812	2088	2604	16104	1512	2052	2544	2940	3648	21108	1332	1800	2244	2580	3216	21108										
Central Reserve Life Insurance Co.** 1-800-734-3942	B+	A	1860	2081	2400	2627			1959	2193	2527	2769		2575	2886	3321	3640			1851	2072	2387	2617			1723	1925	2213	2423							
Combined Insurance Co. of America** 1-800-544-5531	A	I	1681	1802	2142	2420		*****	1845	1934	2299	2599		*****	2510	2631	3127	3535		*****	2026	2141	2556	2882		*****										
Conseco Health Insurance Co. 1-800-541-2254	B	A	2070	2412	2686	2773	2919	20271	1998	2366	2706	2874	3058	25055	2617	3026	28926	3893	4141	29098	2199	2638	3105	29200	3684	28926	1967	2357	2772	3088	3684	28926				
Continental General Insurance Co. 1-877-291-5434	B+	A	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****				
Continental Life Insurance 800-264-4000	A-	A	1295	1466	1713	1886		18435	1631	1847	2158	2376		23229	1836	2070	2388	2610		25136	1647	1865	2180	2400		23459										
Genworth Life Insurance Company 877-825-9337	A+	A	1678	1978	2302	2521		25079	2018	2398	2826	3147		31418	2430	2846	3319	3679		36327	2024	2407	2846	3179		31763										
Genworth Life and Annuity Assur Co. 1-877-825-9337	A+	A	1594	1736	1913	2098		19339	1595	1775	1984	2190		19874	3284	3600	3958	4324		38679	2208	2446	2690	2934		26213										
Globe Life and Accident Ins. Co. 1-800-801-6831	A+	A	867	1160	1236	1241		7427	1272	1602	1827	1845		8619	1457	1787	2104	2211		9298																
Guarantee Trust Life Insurance Co. 1-800-338-7452	B+	A	1479	1742	2002	2239		*****	2030	2381	2727	3051		*****	2717	3190	3567	4086		*****	1739	2042	2342	2619		*****										
Humana 1-800-872-7294	A-	A	1447	1708	1970	2179		1313	1526	1801	2077	2298		1378	1769	2088	2408	2664		1597																
Lincoln Heritage Life Insurance Co. 800-438-7180	A-	A	1265	1428	1661	1821	16443	16443	1646	1867	2201	2449	22214	22214	1973	2215	2582	2863	25669	25669	1700	1931	2284	2550	23146	23146										
Standard Life and Accident Co. 1-888-350-1488	A	A	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****				
State Farm New Castle 1-302-731-9242 Kent-Sussex 1-302-674-1158	A++	A	1198	1509	1749	1965		2695	1590	2003	2321	2608		3578	1807		2963		4085																	
Sterling Life Insurance Co. 1-800-688-0010	A-	A	1669	1906	2077	2189	2968	*****	1928	2247	2510	2768		*****	2207	2581	2894	3212		*****	2211	2585	2898	3216		*****										
United American Insurance Co. 1-800-331-2512	A+	I,A	1808	1993	1993	1993		8765	2071	2744	2976	3006		10175	2399	3168	3478	3654		10980	2274	3033	3343	3520		10646										
United Healthcare Ins. Co (AARP)+ 1-800-523-5800 (AARP)	A+	C	1332	1332	1332	1332		16215	1761	1761	1761	1761		19062	2049	2049	2049	2049		21243	1920	1920	1920	1920		21063	1920	1920	1920	1920		21063				
USAA Life Insurance Company 1-800-531-8000	A++	A	1233	1364	1473	1562		*****	1897	2097	2248	2380		*****	1995	2332	2783	3228			1966	2176	2340	2484		*****										

*****Call for Rates

2009 Rates For Medigap Insurance Plans (Continued)

Please see chart explanation and beginning of chart on pages 10 and 11.

Medigap Plan ▶	Plan F						Plan HIGH DED F						Plan G				Plan G Con't.		Plan H					Plan I					Plan J					Plan HIGH DED J							
	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80	65/ DIS	65	70	75	80	65/ DIS	<65 ESRD	65	70	75	80		65/ DIS	<65 ESRD					
▼COMPANY																																									
Amer. Progr.	2578	3018	3518	3899		22679	887	1039	1212	1342		20492																													
Bankers Fid.	1981	2132	2377	2510		36000	595	640	640	753		34000	1401	1512	1738	1873		36000						1401	1512	1738	1873		36000												
Bankers Life.	1762	2112	2599	3249		22987	404	482	577	692		9193	1687	2023	2490	3113		22852												1738	2144	2648	3302		22994						
Blue Cross.	1548	2100	2604	3000	3732	22236																																			
Central Res.	2408	2696	3104	3400			666	746	860	942			1867	2089	2405	2636																									
Combined	2516	2637	3134	3543		*****																																			
Conseco	2171	2525	2955	3246	3454	29300							2147	2589	3058	3398	3615	29028																							
Continental	*****	*****	*****	*****	*****	*****																																			
Continental Life	1895	2126	2445	2643		25440																								1905	2137	2457	2656		25564						
Genworth Life Ins.	2507	2932	3419	3790		37429	987	1154	1345	1491		14718																													
Genworth Life & Ann.	3303	3638	4078	4294		40216																								3273	3543	3838	4076		37075	None Offered in Delaware					
Globe Life	1466	1797	2117	2227		9326																																			
Guarantee	2858	3365	3866	4329		*****							1665	1956	2239	2505		*****																							
Humana	1781	2103	2425	2683		1611	704	831	958	1060		643																													
Lincoln	2034	2282	2661	2951	26465	26465																																			
Standard	*****	*****	*****	*****	*****	*****																																			
State Farm	1825	2299	2664	2993																																					
Sterling	2579	3040	3419	3803		*****							2287	2710	3067	3449																									
United Amer.	3156	3465	3603	3697		11012	749	983	1093	1158		5417	3023	3328	3467	3560		1062																							
United Health	2061	2061	2061	2061		21276							1932	1932	1932	1932		21090	1809	1809	1809	1809		1821	1821	1821	1821		21090	2088	2088	2088	2088		21291						
USAA	2095	2308	2481	2642		*****																																			

*****Call for Rates

2009 Rates For Medigap Insurance Plans (Continued)

Please see chart explanation and beginning of chart on pages 12 and 13.

Medigap Plan ▶	Plan K						Plan L					
	65	70	75	80	65/DIS	<65 ESRD	65	70	75	80	65/ DIS	<65 ESRD
▼COMPANY												
Amer. Progr.												
Bankers Fid.												
Bankers Life.	701	865	1069	1333		9280	1010	1246	1539	1919		13361
Blue Cross.												
Central Res.												
Combined												
Conseco												
Continental												
Continental Life												
Genworth Life Ins.												
Genworth Life & Ann.												
Globe Life												
Guarantee												
Humana	850	1004	1157	1280		781	1234	1457	1680	1859		1124
Lincoln												
Standard												
State Farm												
Sterling	1043	1239	1406	1589								
United Amer.	1108	1477	1646	1732		5902	1558	2079	2312	2438		8288
United Health	993	993	993	993		14871	1422	1422	1422	1422		17952
USAA												

Rating Key

See chart column on page 12

A++ and A+ = Superior
A and A- = Excellent
B++ and B+ = Very Good
B and B- = Fair
C = Weak
NR = No Rating Available
u = Under review

Ratings by A.M. Best, an independent rating and information agency, are accurate as of March 2009. For the most current rating information, please visit www.ambest.com.

I, C, A Key

See chart column on page 12

I = Issue Age premium, based on the age at which you purchased your policy and will not increase simply because you age. Premiums may increase due to inflation.

C = Community Rated premiums, meaning all policyholders pay the same premium regardless of age.

A = Attained Age premiums, meaning the price of the policy will increase as you get older. Most companies that use attained age pricing raise the price every year.

Tips From The Commissioner

- You only need one Medigap policy.
- The lowest price is not always the best deal. If the policy is priced too low, you could be hit with a big price hike in the future.
- Don't be fooled by sales hype. All plans are identical from one insurance company to another - and must be labeled with the letters A, B, C, D, E, F, G, H, I, J, K or L.
- Your premiums are not guaranteed for life. They may (and probably will) go up.
- Medical conditions you had before purchasing the policy can be excluded, but not for longer than six months.
- All policies have a 30-day free look period. During this time, you may review the policy, cancel, and get a full refund.
- Pay by check. Make the check out to the insurance company, not the agent. Never pay with cash.
- If you are switching policies, do not cancel your current plan until you have received your new policy.

Medicare Prescription Drug Plans

In 2006, new Medicare prescription drug plans, known as Medicare Part D, became available to people with Medicare. Insurance companies and other private companies offer these drug plans. All people with Medicare are eligible to enroll in plans that cover prescription drugs.

The Medicare drug plans are complex and can be confusing. The decision of whether to sign up for a Medicare drug plan should only be made after considering your individual circumstances and evaluating whether the Medicare drug plan provides benefits that are better, about the same or less than any prescription drug coverage you may already have.

May 15, 2006 was the deadline for the initial enrollment period for the Medicare drug plans. If you were eligible then to sign up for a Medicare prescription drug plan and decided not to, you will likely be charged more if you decide to sign up at some point in the future. And, if you were first eligible for drug plans in 2006 and didn't sign up, you may only sign up during the enrollment period that runs from November 15 and December 31 of each year.

How They Are Supposed To Work

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join you will pay a monthly premium and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose.

Drug plans vary in what prescription drugs are covered, how much you have to pay, and which pharmacies you can use. All drug plans have to provide at least a standard level of coverage set by Medicare. However, some plans offer more coverage and additional drugs for a higher monthly premium. When you join a drug plan, it is important for you to choose one that meets your specific prescription drug needs.

Plans vary, but in general, this is how they work:

- You will choose a prescription drug plan and pay a monthly premium, which is different for different plans. Some plans have no premium.
- You may have to pay a deductible. No plan can have a deductible more than \$295.
- Medicare will pay 75 percent of your drug costs between \$295 and \$2,700 a year in drug spending. You will pay only 25 percent of these costs.
- You will pay 100 percent of the drug costs above \$2,700 until you reach \$4,350 in out-of-pocket spending in a year. (This is referred to as the Part D “donut hole.”)
- Medicare will pay about 95 percent of your drug costs after you have spent \$4,350 in a year.

Some prescription drug plans may have additional options to help you pay the out-of-pocket costs.

Frequently Asked Questions About The Medicare Prescription Drug Plans

When can I join a Medicare prescription drug plan? Medicare beneficiaries who have Medicare Part A and/or Part B can join a Part D drug plan. If you join during the three months before you turn 65, your drug coverage will begin the first day of the month of your birthday. If you join the month you turn 65 or in the three months after, your coverage will begin the first day of the month after the month you join. This period around your 65th birthday is called your initial enrollment period.

If you are disabled, you can generally join a Part D plan three months before and three months after your 25th month of disability. The plan will notify you when your coverage begins.

If you don't join a Medicare drug plan during your initial enrollment period, and there is a period of 63 continuous days or more during which you don't have creditable prescription drug coverage, you

may have to pay a late enrollment penalty when you do join. This amount changes every year. You will have to pay a penalty as long as you have Medicare prescription drug coverage.

Even if you don't use many prescription drugs now, Medicare says that you should consider joining a plan as soon as you are eligible in order to avoid the late enrollment penalty. However, if you have other coverage that is at least as good as Medicare prescription drug coverage, called creditable prescription drug coverage, the penalty will not apply.

In most cases, if you don't have creditable coverage and don't join a drug plan during your initial enrollment period, your premium will go up 1 percent of the national base premium for every full month you waited to enroll. (The national base premium for 2009 is \$30.36.) You will have to pay this penalty in addition to your premium for as long as you have Medicare prescription drug coverage. You may also have to wait until the next annual enrollment period (November 15 to December 31 each year) to enroll. The enrollment will be effective January 1 of the following year.

What if I can't pay for a Medicare prescription drug plan? Some people with an income at or below a set amount and with limited assets (including your savings and stocks, but not counting your home) will qualify for extra help. The income amount in 2009 is \$16,245 for a single person or \$21,855 for a married couple. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions. The level of extra help will be based on your income and assets. Many people who automatically qualified for extra help should have received a letter in 2008. To find out if you qualify for extra assistance, call the federal Social Security Administration at 1-800-772-1213 or go to www.socialsecurity.gov online. There is no risk to call or apply.

Do Medicare prescription drug plans work with all types of Medicare health plans? Yes. There are Medicare prescription drug plans that add coverage to Original Medicare. These plans are

offered by insurance companies and other private companies. Some drug plans are a part of Medicare Advantage Plans in some areas.

What if I already have prescription drug coverage from a Medigap supplemental insurance policy?

If you have a Medigap policy with drug coverage, you should have received a detailed notice from your insurance company telling you whether or not your policy covers as much as or more than a Medicare prescription drug plan. This notice will explain your rights and choices.

What if I have prescription drug coverage from an employer or union?

If you have prescription drug coverage from an employer or union, you should have received a notice from your employer or union that tells you if your plan covers as much as or more than a Medicare prescription drug plan.

If your employer or union plan covers as much as or more than a Medicare prescription drug plan, you can:

- Keep your current drug plan. If you join a Medicare prescription drug plan later your monthly premium won't be higher (no surcharge), *or*
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

If your employer or union plan covers less than a Medicare prescription drug plan, you can:

- Keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage, *or*
- Just keep your current drug plan. But, if you join a Medicare prescription drug plan later, you will have to pay a penalty along with your monthly premium, *or*
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your employer or union drug plan back.

How Do I Decide If I Should Sign Up?

Which Medicare prescription drug plan to sign up for — or whether to sign up at all — is a decision that is based on your individual and specific circumstances. Before you make a decision, you need to find out the following information:

- If you have drug coverage now, does it cover at least as much as Medicare prescription drug coverage? Your current plan can tell you if it does.
- If you have drug coverage now, should you keep it?
- How would Medicare prescription drug coverage affect your out-of-pocket costs?
- Does a Medicare drug plan available in Delaware cover the drugs you need?
- Would you qualify for help paying for your prescription drug costs if you join a Medicare drug plan?
- If you wait to join a Medicare drug plan, will your premium be higher because you have to pay a penalty?
- Do you spend part of each year in another state? This may be important if the drug plan you are considering requires you to use certain pharmacies.

Drug Plans Available In Delaware

Different drug plans are available in different states. There are 48 plans available in Delaware in 2009.

To find the names and details of plans available in Delaware, go to www.medicare.gov on the web or call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or call the Delaware Insurance Commissioner's ELDER*info* office at 1-800-336-9500.

Things To Look For In A Plan

Consider the following tips from the staff of ELDER*info*, a program in the Delaware Insurance Commissioner's Office that has helped thousands of Delaware beneficiaries compare Medicare prescription drug plans and decide whether to join.

Drug list: Also known as a “formulary,” each Medicare drug plan will have a list of prescription drugs that it will cover. Plans may cover both generic and brand-name prescription drugs. These drugs must be approved by the Food and Drug Administration as safe and effective. Make sure your prescription drugs are on the plan's formulary.

Tier levels: There are different levels of co-payments for drugs in the plans. Tier 1 consists of generic drugs that will cost you the least amount. Tier 2 drugs are preferred brand-name drugs that will cost you more than Tier 1 drugs. And Tier 3 is made up of non-preferred brand-name drugs that will cost you more than Tier 1 and Tier 2 drugs. Make sure you know which tier your drugs fall into.

Step therapy: Step therapy is a type of prior authorization. With step therapy, in most cases you must first try certain less expensive drugs that have been proven effective for most people with your condition before you can get a more expensive brand-name drug covered. However, if you have already tried the similar, less expensive drugs and they didn't work, or if your doctor believes that because of your medical condition it is medically necessary for you to be on a step-therapy drug, he or she can contact the plan to request an exception. If your doctor's request is approved, the step-therapy drug will be covered. When evaluating Medicare drug plans, check to see if any of your drugs fall into this category.

Quantity limits: For safety and cost reasons, some plans may limit the quantity of drugs that they cover over a certain period of time. Check to see if any of your drugs has a limit.

\$0 co-payment for generic drugs: The co-payments for generic drugs may increase from \$0 once your drug costs reach a certain dollar amount. Ask any plan that you are considering

what this drug cost limit is and what the new co-payment for generic drugs will be once that limit is reached.

How Do I Sign Up?

To sign up for a Medicare prescription drug plan, you can:

- Sign up online at www.medicare.gov ;
- Call 1-800-MEDICARE;
- Call the company whose plan you want to choose; or
- Call *ELDERinfo* in Delaware at 1-800-336-9500

Once you join a plan, the company will send you a membership card, member handbook, drug list pharmacy provider directory, and the complaint and appeals procedures.

For Help or More Information

Many Delaware beneficiaries have needed help understanding which Medicare prescription drug plan is best for them, whether they qualify for financial assistance, or whether they should sign up for a plan at all.

Wherever you call for help, you will need to have on hand: the full name of any prescription drug you currently take; whether it is liquid, tablet or capsule; the strength and dosage (for example, 100 mg, two times a day); the number of doses in each prescription; and the cost of the prescription.

Counseling and information are available from:

- **Medicare.gov:** This website maintained by the federal government allows you to input your specific prescriptions and dosages in order to compare the plans that are available in Delaware based on your specific information.
- **1-800-MEDICARE:** Call the federal government's Medicare hotline with your prescription drug information at hand and a representative will go through the plan

comparison process over the phone.

- **Delaware's ELDERinfo Program:** The Insurance Commissioner's service for people with Medicare can provide you with free counseling on whether a Medicare drug plan would save you money and which one may be most suited for you. The statewide toll-free number is 1-800-336-9500.

Preventing Medicare Fraud

People with Medicare should keep their personal information safe. Don't give your information to anyone who comes to your home or calls you uninvited, selling Medicare-related products. They can only give you information about a plan, and can't ask you for your personal information or enroll you in a plan.

Only give personal information when you have made the contact. For example, if you call or visit the websites of plans that are approved by Medicare; if you call or visit people in the community who work with Medicare, like your State Health Insurance Assistance Program or the Social Security Administration; or if you call 1-800-MEDICARE or visit www.medicare.gov on the web.

People who are really working with Medicare won't try to enroll you into a drug plan over the telephone unless you call them, or unless you are already in a Medicare Advantage Plan and they call to ask if you would like to add prescription drug coverage to the coverage you already have.

Call 1-800-MEDICARE if you aren't sure if a plan is approved by Medicare. Plans are allowed to mail information and to call you. They aren't allowed to sell plans door-to-door.

If you think someone is misusing your personal information, you can call:

- 1-800-MEDICARE (TTY users should call 1-877-486-2048) ;
- Fraud Hotline of the HHS Office of the Inspector General at 1-800-447-8477 (TTY 1-800-377-4950) ;
- Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 (TTY 1-866-653-4261) ; or
- Senior Medicare Patrol at 1-800-223-9074.

Insurance Fraud

Many frauds and crimes are committed against senior citizens, including insurance-related fraud. To help protect against insurance fraud, follow these simple rules:

- When buying insurance or obtaining any services, remember, if it seems too good to be true, it probably is.
- When dealing with an agent you do not know, ask for identification and call the Insurance Commissioner's Office at 1-800-282-8611 or go to www.delawareinsurance.gov to verify the agent's status, as well as the agency or insurance company the agent represents.
- If an agent selling you insurance or handling your insurance claim is reluctant to answer your questions, contact the Insurance Commissioner's Office.
- Never sign a blank form or pay in cash.
- Always make your checks or money orders payable to the insurance company.

If you have questions or if you need to report insurance fraud to the Delaware Fraud Prevention Bureau, please call 1-800-632-5154.

About Long-Term Care Insurance

Long-term care is a general term that includes a wide range of services providing assistance with health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders, such as Alzheimer's disease. These services are typically required by the elderly, but may also be used by disabled people of any age.

Types of long-term care include:

- Personal care or custodial care for people who only need help with activities of daily living, such as eating, bathing, dressing or taking medication.
- Skilled care that is generally provided in a nursing home by licensed medical personnel under physician's orders, but may also be provided at home with help from visiting nurses or therapists.

Long-term care can be expensive depending on the amount and type of care needed and where it is received. On average, a year in a nursing home costs approximately \$56,000. Home care, which can include part-time skilled nursing care, speech therapy, physical therapy and other services can easily cost \$19,000 a year, while personal care provided at home by a home health aide costs approximately \$11,000 per year.

Payment methods for long-term care vary and can include:

- Medicare will cover an approved skilled nursing facility on an extremely limited basis. The skilled nursing facility benefit only covers you if a medical professional says you need daily skilled care after you have been in the hospital for at least 3 days. You should not rely on Medicare to pay your long-term care needs.
- Long-term care insurance will pay for some or all of your long-term care. It may consist of an individual policy or group coverage. Benefits can cover a wide range of services.

- Self-funding, which means paying for care with personal or family money, pensions, savings, or investments.
- Medicaid pays for nearly half of all nursing home care. You must meet federal and state guidelines for income and assets to qualify.

Long-term care insurance is not a good buy for everyone. If you have significant assets you wish to protect and income that will allow you to pay premiums without financial difficulty, long-term care insurance may be right for you. However, if you have a limited income or have trouble stretching your income to meet financial obligations, such as paying rent, utilities, food, or medicine, you probably should not buy a policy.

People with very limited income and assets may qualify for Medicaid's Long-Term Care Services Program. The decision to purchase long-term care insurance will depend on your health, age, overall retirement objectives, and your income. You should discuss this purchase with a family member or financial advisor.

The "Shopper's Guide to Long-Term Care Insurance" which includes a policy comparison worksheet, is available from ELDERinfo at 1-800-336-9500.

Coverage: Like most insurance policies, the details of services covered and benefits paid will vary from policy to policy. However, state law requires that certain provisions be included in all long-term care insurance policies. Some of these provisions are:

- Coverage for all levels of nursing home care—skilled, intermediate, and custodial.
- Coverage for 12 months or longer.
- Policies must be guaranteed renewable. This means the company cannot cancel your policy for any reason except non-payment of

premiums or a misrepresentation on your application for coverage.

- No longer than a 6-month pre-existing condition exclusion.
- A 30-day “free look” period. You can return the policy for any reason during this time and receive a full refund.
- Benefits cannot be conditioned on a hospital stay prior to admission to a nursing home.

What Else Must Be Offered:

- The option to purchase inflation protection of at least 5 percent compounded annually. This feature will increase the benefits of your policy over time. Therefore, the younger you are when you buy a policy, the more important it is for you to consider adding inflation protection. Keep in mind that the cost of this additional benefit could add significantly to your premiums. If you decline to purchase inflation protection, you will be asked to sign a statement rejecting the coverage. Be sure you understand what you are signing.
- Third-party notification. To avoid a lapse of the policy for non-payment of premiums, companies must offer to notify a person in addition to yourself whom you designate of the impending lapse.
- The option to purchase a non-forfeiture benefit which will allow you to receive some value for the money you have paid into the policy should you have to drop your coverage. A non-forfeiture benefit can add roughly 10 percent to 100 percent to a policy’s cost. If you decline to purchase this benefit, you will be asked to sign a statement rejecting the offer. If you reject the offer, the company is required to provide a “contingent benefit upon lapse.” This benefit will take effect when your premiums increase to a certain level. You will then be offered the opportunity to accept: (1) a reduction in the benefits provided by the current policy so that premium costs stay the same; or (2) a conversion of the policy to paid-up status with a

shorter benefit period. You may also choose to keep your policy and continue to pay the higher premium.

Federally Tax-Qualified Long-Term Care

Insurance Policies: Under the Health Insurance and Portability Act of 1996 (HIPAA), long-term care insurance policies that met certain requirements became eligible for federal income tax advantages. These policies are now called “tax-qualified” long-term care insurance policies. You may be asked to choose between a “tax-qualified” plan and one that is “non tax-qualified.” If you have a qualified long-term care policy and you itemize your deductions, you may be able to deduct part, or all, of the premium you pay for the policy. You may also be able to add the premium to your other deductible medical expenses. You may then be able to deduct the amount that is more than 7.5% of your adjusted gross income on your federal tax return. It is recommended that you contact your personal tax advisor for complete details before filing your return.

Long-Term Care Insurance Companies

Allianz Life Ins. Co. Of North America	1-800-950-1962	A
American Family Life Assurance Co.	1-800-992-3522	A+
Assurity Life Ins. Co.	1-888-505-3980	A-
Bankers Life & Casualty Ins. Co.	1-800-621-3724	B
Berkshire Life Ins. Co. Of America	1-888-505-8743	A++
Combined Ins. Co. Of America	1-800-544-5531	A
Conseco Health Ins. Co.	1-800-541-2254	B
Conseco Senior Health Ins. Co.	1-800-441-3978	C++
Cuna Mutual Life Ins. Co.	1-800-643-5264	A
Equitable Life & Casualty Ins. Co.	1-800-352-5150	B++
First-Penn Pacific Life Ins. Co.	1-800-323-1746	A+
Genworth	1-800-456-7766	A
Golden Rule Ins. Co.	1-800-261-3361	A
Great American Life Ins. Co.	1-800-921-9338	A
Guarantee Trust Life Ins. Co.	1-800-338-7452	B+
John Hancock Life Ins. Co.	1-800-377-7311	A++
Knights Of Columbus	1-800-214-9825	A++
Loyal American Life Ins. Co.	1-800-633-6752	A
Massachusetts Mutual Life Ins. Co.	1-888-505-8952	A++
Medamerica Ins. Co	1-800-544-0327	B++
Metropolitan Life Ins. Co. (AARP)	1-800-452-1393	A+
Minnesota Life Ins. Co.	1-888-505-9817	A+
Mutual Of Omaha Ins. Co.	1-800-775-6000	A+
New York Life Ins. Co.	1-800-224-4582	A++
Northwestern Long-Term Care Ins. Co.	1-800-890-6704	A++
Physicians Mutual Ins. Co.	1-800-228-9100	A
Provident Life & Accident Ins Co.	1-800-331-1538	A-
Prudential Ins. Co. Of America	1-800-732-0416	A+
State Farm Mutual Automobile Ins Co.	(302) 674-1158	A++
State Life Ins. Co.	1-888-505-8101	A
Teachers Ins. & Annuity Assoc (TIAA)	1-800-223-1200	A++
United American Ins. Co.	1-800-825-6767	A+
United Security Assurance Co. Of Pa.	1-800-872-3044	B+
United Teacher Associates Inc. Co.	1-800-880-8824	A-
Unum Life . Co. Of America	1-800-227-4165	A-
Woodmen Of The World/ Omaha Woodmen Life Ins. Society	1-800-225-3108	A+

Rating Key

A++ and A+ = Superior
A and A- = Excellent

B++ and B+ = Very Good
B and B- = Fair

C = Weak
NR = No Rating Available

u = Under review

Ratings are from A.M. Best Rating, an independent rating and information agency, and are accurate as of April 2009. For the most current rate information, please visit www.ambest.com.

ELDER*info*

1-800-336-9500

Health Insurance Counseling For People With Medicare

The Delaware Insurance Commissioner's **ELDER***info* program helps people with Medicare in Delaware deal with the complex and often confusing health insurance system.

ELDER*info* provides counseling and assistance on questions and problems related to Medicare, Medicaid, Medigap, long-term care insurance and other types of health insurance. There is no charge for this service.

Counselors with **ELDER***info* are volunteers who have completed extensive training on health insurance. Counselors provide one-on-one assistance in an objective and confidential manner.

Call 1-800-336-9500 to schedule an appointment with an **ELDER***info* counselor at a site near you.

To become an **ELDER***info* volunteer and help other Medicare beneficiaries understand their health insurance options, please call 1-800-336-9500.

ELDER*info* is Delaware's State Health Insurance Assistance Program (SHIP) and is funded in part by a grant from the Centers for Medicare and Medicaid Services.