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Let Us Guide You

Why you may want coverage beyond Medicare

Original Medicare—Parts A and B—aren't enough to cover all the health care needs of most retirees. You've probably read and heard a lot about Medicare insurance and may not be sure which type of plan is right for you. We'll help you decide.

In this section, we'll explain the different parts of Medicare in a simple way, as well as what Original Medicare does and doesn't cover. We'll make sense of the choices you have to get the additional coverage. Then we'll help you find the right plan for your needs and budget.

[Continue to Original Medicare—Parts A and B ▶](#)

Having someone on your side



Selecting additional Medicare insurance may seem a bit intimidating, but it doesn't have to be. With Aon Hewitt Navigators™, you'll have a licensed professional dedicated to helping you. Our services are free of charge. All you pay for is the coverage you choose.

We offer insurance products from more than 70 companies. We give you access to an easy-to-use online plan selection tool. Our certified and licensed benefits advisors are also on hand to help you choose a plan and enroll.

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Original Medicare— Parts A and B

Understanding Original Medicare coverage

Original Medicare (Parts A and B) is the Medicare that most people apply for when they turn 65. For many, Original Medicare alone does not provide a comprehensive safety net for health care expenses. While Medicare Parts A and B help to provide coverage for some hospital and medical costs, the fact remains: for many people it's not enough.

Because of potential gaps in coverage, many people purchase additional health care coverage to help build complete coverage and provide a more comprehensive safety net for their health and financial well-being.

Aon Hewitt Navigators™ will help you pick the right additional coverage to help fill in the entire medical care picture.

The whole coverage picture

Original Medicare
[Details](#)

Additional health care coverage

What does Original Medicare usually cover?

Coverage	Medical Services	Prescription Drugs	Financial Protection
Part A Details	<ul style="list-style-type: none"> Inpatient care in hospitals Limited skilled-nursing care Hospice care services Home health services 	Limited	Limited
Part B Details	<ul style="list-style-type: none"> Doctor's fees Outpatient hospital care Medical equipment and supplies 	None*	Limited

*With a few exceptions, most prescriptions are not covered.

What's NOT covered by Original Medicare?

- Most outpatient prescription drugs
- Dentures
- Routine vision care
- Hearing aids (exams and fittings)
- Long-term care
- Routine foot care
- Routine dental care

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Building Complete Coverage

Completing your health care coverage

As we've said, most retirees buy additional insurance to cover the things Original Medicare (Parts A and B) doesn't cover. Here's why:

- To get complete medical and prescription drug coverage. (Parts A and B only cover inpatient and basic outpatient services, not prescriptions)
- To control their out-of-pocket medical spending. (Without additional coverage, retirees pay the full cost of anything not covered by Medicare Parts A and B)
- To have the peace of mind knowing all their medical needs are covered

When it comes to covering all your medical care needs, you have two main options:



1.

Medicare Advantage Plans

Medicare Part C

Covers medical and prescription drugs

[Details](#)

- Takes over coverage of services provided by Parts A and B
- Plans usually have lower premiums than supplemental coverage, but higher out-of-pocket costs
- Often covers services that Original Medicare doesn't cover like preventive, dental, vision, etc.

2.

Medicare Supplemental Coverage

Medigap

Covers medical and prescriptions when combined with Medicare Part D.

[Details for Medigap](#) [Details for Medicare Part D](#)

- Plans usually have higher monthly premiums than Medicare Advantage, but much lower out-of-pocket costs
- Can cover copayments, coinsurance and deductibles
- Pays its share of medical expenses after Parts A and B pay their shares
- Offers the most flexibility in choosing doctors

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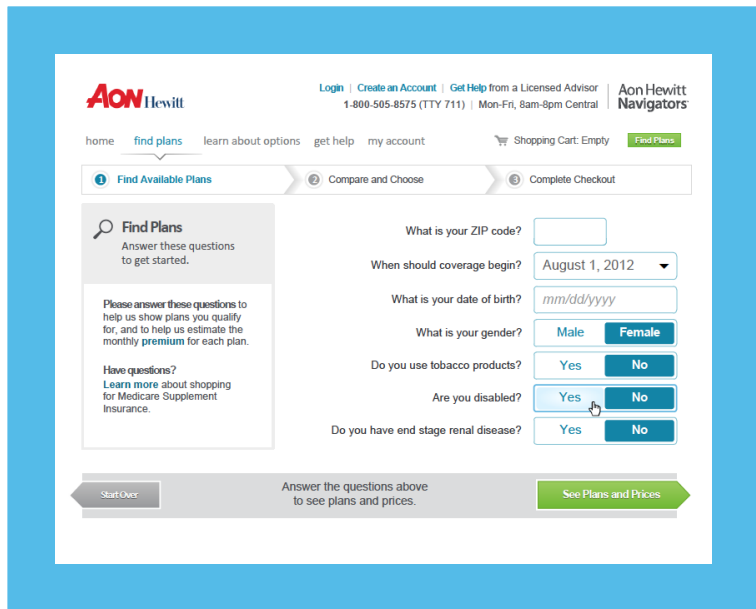


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We'll Help You Choose

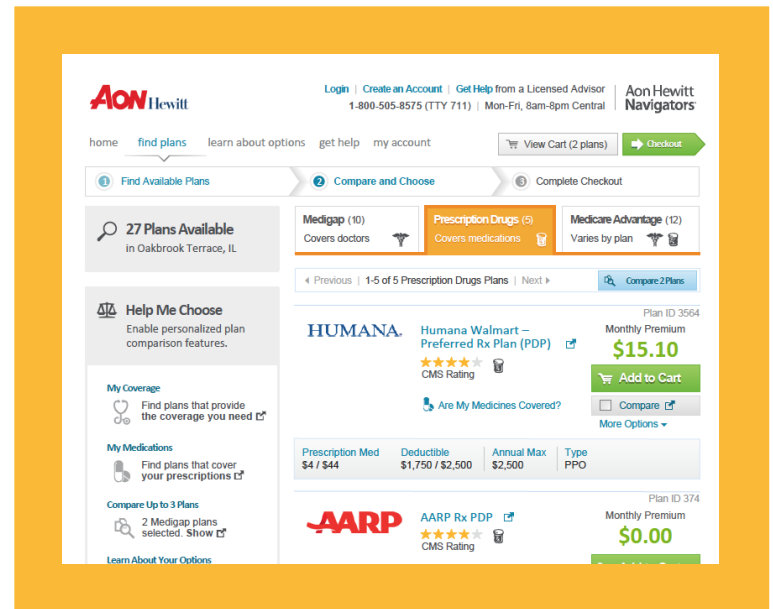
Aon Hewitt Navigators™ will make choosing the right coverage much easier with personalized, professional assistance. Here's how:

Step 1.



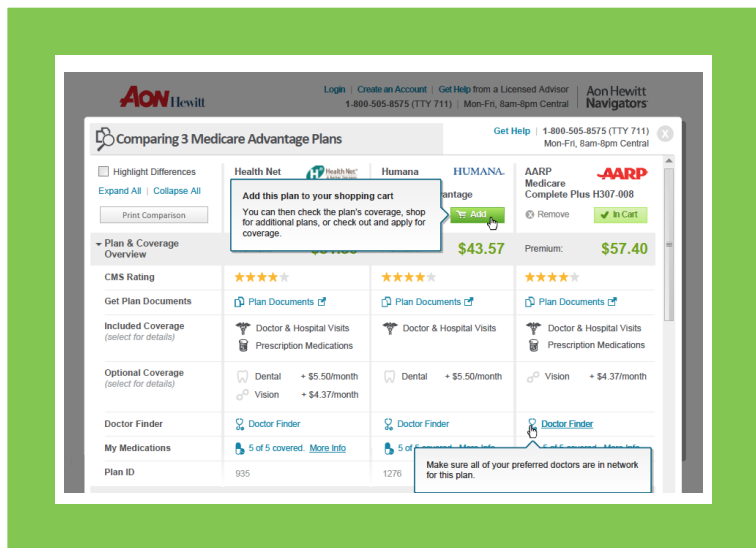
We learn more about you and assess your needs.

Step 2.



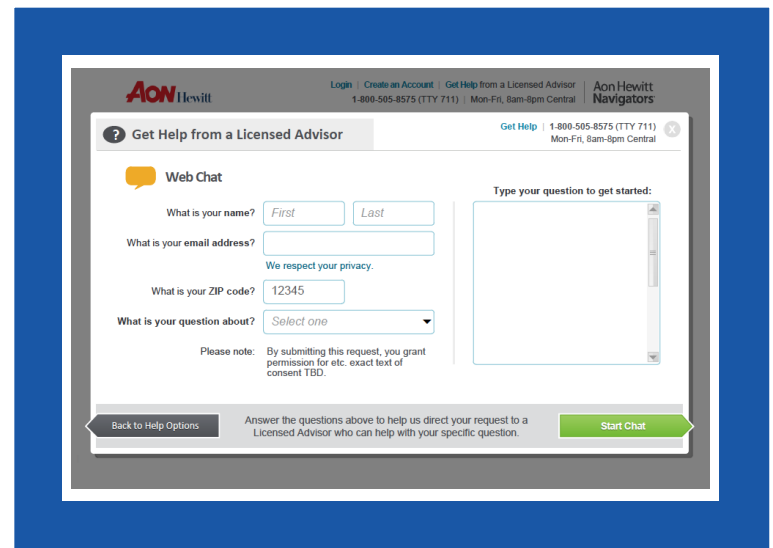
We show the plans available to you.

Step 3.



We help you compare plans and find the one that best fits your needs.

Step 4.



We help you apply for the plan you choose.

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Deciding Which Coverage Is Right for You

Aon Hewitt Navigators™ makes it easier to select and enroll in a supplemental Medicare insurance plan

Before you get started, check out this overview of the differences between Medicare Advantage (Medicare Part C) plans and Supplemental (Medigap) plans to get a feel for which plan may be best for you.

A breakdown of differences between Medicare Part C/Medicare Advantage and Medigap plans:

	1. Medicare Advantage Plans Medicare Part C Covers medical and prescription drugs 	2. Medicare Supplemental Coverage Medigap Covers medical and prescriptions when combined with Medicare Part D. 
THINGS TO CONSIDER		
Typical monthly premium	About \$50 on average	\$150–\$300
Copayments/coinsurance	Varies by plan	Varies by plan
Annual maximum out-of-pocket expense	\$3,000–\$5,000	Varies by plan
Choice of health care providers	Varies by plan (some restrictions or discounts to see certain providers may apply)	You can see any Medicare provider
Prescription drug coverage	YES (often provides its own form of prescription drug coverage)	YES (via enrollment in Medicare Part D Prescription Drug Plan)
Additional thoughts	<ul style="list-style-type: none"> • A good value for many retirees, since Medicare Advantage plans are less expensive than Medigap plans • Plans can change every year • Some plans have extra benefits available 	<ul style="list-style-type: none"> • A good value if you have chronic medical conditions • Plans are standardized • Covers Medicare services only
This plan might make sense if you:	<ul style="list-style-type: none"> • Are willing to change to an in-network doctor if required • Visit doctors infrequently and don't mind paying per-visit copayments and coinsurance • Prefer all your benefits from a single plan and premium 	<ul style="list-style-type: none"> • Want flexibility in choosing your doctors • Visit your doctors frequently • Travel extensively

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PICK A PLAN AND ENROLL—WITH OUR HELP



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Medicare Part A (In-patient Care)

Part A covers hospital stays, including your room, food, bedding and tests, as well as skilled nursing care, hospice care and home health services

Coverage	Medical Services	Prescription Drugs	Financial Protection
Part A	<ul style="list-style-type: none"> • Inpatient care in hospitals • Limited skilled-nursing care • Hospice care services • Home health services 	Limited	Limited

Since most people pay Medicare taxes while they're working, they won't have to pay a premium for Medicare Part A. (However, those who didn't pay Medicare taxes can enroll, but will pay a \$451 monthly premium.)

Medicare Part A Details

Hospital inpatient care coverage: for up to 90 days, including bed, meals and nursing services. Coverage starts when you're admitted and ends when you have either been out of the hospital for 60 days or haven't received medical care in a hospital or skilled nursing facility.

Your hospital inpatient care costs under Medicare Part A

- \$1,156 deductible per benefit period
- \$0 for the first 60 days of each benefit period
- \$2289 per day for days 61–90 of each benefit period
- \$578 per "lifetime reserve day" after 90 days of each benefit period

Stay at skilled nursing facility (SNF): for up to 100 days during each treatment period. A treatment period starts on the first day of treatment and ends when you have spent 60 consecutive days outside the facility or if you remain but do not receive Medicare-coverable care for 60 consecutive days.

Your costs under Medicare Part A

- \$0 for the first 20 days of each benefit period
- \$144.50 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of each benefit period

In-home care coverage: for eligible home health services needed after leaving the hospital, including physical therapy, speech-language pathology and periodic skilled nursing care.

Your in-home care costs under Medicare Part A:

- Funds for home health care services
- 20% of the Medicare-approved amount for durable medical equipment

Hospice care coverage: ensuring that you or your loved ones are as comfortable as possible and that their physical, mental and emotional needs are attended to when nearing the end of life.

Your hospice care costs under Medicare Part A are limited to:

- \$0 for hospice care
- \$5 maximum co-payment per prescription for outpatient prescription drugs for pain and symptom management
- 5% of the Medicare-approved amount for inpatient respite care (care given by another caregiver so that the usual caregiver can rest)

Medicare Part A Enrollment Information

Enrollment dates:

October 15–December 7, 2013

Initial enrollment

You can enroll in Medicare Part A any time within the three months leading up to your 65th birthday, or any time within the three months immediately after your 65th birthday.

Annual enrollment

If you don't enroll within your initial enrollment period, you can sign up during the annual enrollment period between January 1 and March 31 each year. If you sign up during the annual enrollment period, your coverage will begin that same year on July 1. Those with qualifying disabilities can enroll three months before until three months after their 25th consecutive month of disability.

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Medicare Part B

Part B is insurance that covers doctor visits, outpatient treatment and certain kinds of preventive care

Coverage	Medical Services	Prescription Drugs	Financial Protection
Part B	<ul style="list-style-type: none"> • Doctor's fees • Outpatient hospital care • Medical equipment and supplies 	None*	Limited

*With a few exceptions, most prescriptions are not covered.

You will typically pay a monthly premium of around \$100 for Medicare Part B. You will pay for services out-of-pocket until you reach the amount of your annual deductible—\$147.00 for 2013. After that, Medicare will cover your expenses. During this period, you are responsible for 20% of the services as part of your coinsurance share with Medicare.

What Medicare Part B Covers

- Outpatient care at a hospital or other care facility
- Medically necessary services, including lab tests, X-rays, physical therapy or rehabilitation services
- Ambulance services
- Some at-home health care, including intermittent skilled-nursing care, physical therapy and speech-language pathology

Preventive care services covered by Medicare Part B:

- Annual routine physical exams
- Glaucoma tests
- Smoking cessation
- Diabetes screenings
- HIV screening
- Cardiovascular screenings
- Flu and hepatitis B shots
- Cancer screenings
- Diabetes self-management training

Medicare Part B Enrollment Information

Initial enrollment

You can enroll in Medicare Part B any time within the three months leading up to your 65th birthday, or you can enroll anytime within the three months immediately after your 65th birthday.

Annual enrollment

If you don't enroll within your initial enrollment period, you can sign up during the annual enrollment period between January 1 and March 31 each year. If you sign up during the annual enrollment period, your coverage will begin that same year on July 1. Those with qualifying disabilities can enroll three months before until three months after the 25th consecutive month of disability.

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Medicare Part C (Medicare Advantage)

Medicare Part C (or Medicare Advantage) is offered by private insurers that work with Medicare to provide you with the same basic coverage as Parts A and B — plus extra coverage like vision, hearing, dental and prescription drug benefits

Typical Part C/Medicare Advantage plans have a low to no monthly premium. However, your costs may include copayments, deductibles and coinsurance when you use the plan.

Your exact costs will vary depending on the plan you choose, and your Aon Hewitt Navigators™ Benefits Advisor will guide you through the decision-making process to pick the right Part C (Medicare Advantage) plan for your needs.



The Four Types of Medicare Part C (Medicare Advantage) Plans Include:

- HMO (Health Maintenance Organization plan): a defined network of doctors and hospitals from which you select a primary care physician
- PPO (Preferred Provider Organization plan): a network of doctors and hospitals that allows you to choose providers outside of the network
- PFFS (Private Fee-For-Service plan): a plan that pays a specific amount for health care services, provided the treating health care provider accepts that amount (it may be less than his or her usual fee)
- MC (Medicare Cost plan): provides access to a network of doctors and hospitals approved by Medicare. If policy holders opt for coverage outside of the network, Medicare-covered services are paid for through Medicare Parts A and B.

Medicare Part C (Medicare Advantage) Enrollment Information

Initial enrollment

You can enroll in Medicare Part C anytime within the three months leading up to your 65th birthday, or you can enroll anytime within the three months immediately after your 65th birthday.

Annual enrollment

If you don't enroll within your initial enrollment period, you can sign up during the annual enrollment period between January 1 and March 31 each year. If you sign up during the annual enrollment period, your coverage will begin that same year on July 1.

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Medicare Part D Prescription Drug Plan

Original Medicare doesn't include coverage for most prescription drugs, but Medicare Part D Prescription Drug Plan exists to help provide coverage for both generic and brand-name drugs

Medicare Part D Prescription Drug Plan coverage helps cover most commonly prescribed drugs. Part D is provided by private insurers.

Each plan has its own list of covered drugs, called a formulary. Be sure to check your plan's formulary every year, as it may change from year to year. Prescription drug plans separate different drugs into "tiers," each with a different cost.

Many tier systems look like this:

Tier	Pay Level	What Is Covered	Payment Amount
Tier 1	Lowest copay	Most generic prescription drugs	\$5
Tier 2	Medium copay	Preferred brand-name prescription drugs	\$30
Tier 3	Highest copay	Non-preferred brand-name prescription drugs	\$60

Medicare Part D Prescription Drug Plan Costs

- Monthly premium: varies by plan, but you may ask your drug insurer to automatically deduct your Part D premium from your Social Security check
- Yearly deductible: not all Medicare drug insurance plans will have deductibles, but for those that do, it will not be greater than \$320

More Important Medicare Part D Information

The "donut hole"

There is sometimes a coverage gap, known as the donut hole, within Medicare Part D. This means that there's a chance that if your total retail drug costs reach a certain amount, you may be responsible for paying up to 100% of those costs up to the yearly limit.

Your Aon Hewitt Navigators™ Benefits Advisor will help you explore options for closing the donut hole in your plan, should you have one.

Medicare Extra Help

If you're a single person with a yearly income of less than \$16,755 or if you're married with a yearly income of under \$22,695, you may qualify for Medicare Extra Help with your Part D plan. Medicare Extra Help will cover 100% of prescription costs, as well as part or all of your entire Part D premium. To apply, contact the Social Security Administration at socialsecurity.gov/extrahelp or call 1-800-772-1213.

Catastrophic coverage

You will be out of the coverage gap once you spend over \$4,700 out-of-pocket in a given year. After that, you will begin receiving catastrophic coverage, which will ensure that you pay only a small copayment or coinsurance for prescription drugs the rest of that year.

Your Medicare Part D coverage depends on the insurance plan you choose. Aon Hewitt Navigators Benefits Advisors are here to make sure you have all the information you need to make the decision that's right for you.

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2.

Medicare Supplemental Coverage

Medigap

Covers medical and prescriptions when combined with Medicare Part D.

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Medigap Plans Close Gaps in Your Medicare Coverage

If you enroll in Original Medicare, it's possible that there will still be gaps in your coverage. Medigap Plans (also known as Supplemental Medicare Plans) cover the services that Medicare Parts A and B do not.

If you have Original Medicare, Parts A and B pay their share of the fee for a treatment first. Then Medigap pays to cover the remaining cost. For example, if you regularly see a doctor for a condition like diabetes, you would need Medicare Plan B with coinsurance and a deductible. Medigap plans could cover the cost of your coinsurance, balancing out the cost with Medicare so that you would only pay out-of-pocket for your deductible.

Medigap plan benefits are standardized by state. Aon Hewitt Navigators™ Benefits Advisors can help you understand your state's Medigap policies. We will answer all your questions and guide you through the Medigap enrollment process to ensure that you will have full coverage.

Below is a summary of Medigap plan benefits, including 2013 out-of-pocket costs where applicable. An asterisk (*) indicates an area where Medigap will cover 100% of your benefit costs. Please be aware that Medigap plans do not cover prescription drug costs, though some will offer a combination of coverage, including Medicare Part D coverage.

Medicare Supplemental (Medigap) Plans and Benefits

Medigap Benefits	A	B	C	D	F**	G	K	L	M	N
Medicare Part A coinsurance and hospital costs	*	*	*	*	*	*	*	*	*	*
Medicare Part A hospital deductible	*	*	*	*	*	*	50%	75%	50%	*
Skilled nursing facility copay/coinsurance			*	*	*	*	50%	75%	*	
Medicare Part B deductible			*		*					
Medicare Part B coinsurance	*	*	*	*	*	*	50%	75%	*	*
Medicare Part B excess charges					*	*				
Blood (first 3 pints)	*	*	*	*	*	*	50%	*	*	*
Foreign travel emergencies			*	*	*	*			*	*
Out-of-pocket limit in 2013							\$4,800	\$2,400		

**Plan F also offers a high-deductible plan in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments and deductibles) up to the deductible amount of \$2,110 in 2013 before your policy pays anything.

The Medigap plans described above are available in all states except Massachusetts, Minnesota and Wisconsin. In these states, Medigap plans are structured differently. Below, we have compared and summarized the different Medigap plans offered in these states and the benefits offered in each plan.

Medigap Benefits	Massachusetts		Minnesota		Wisconsin	
	Core Plan	Supplement 1 Plan	Basic Plan	Extended Basic Plan (or Riders)	Basic Plan	Optional Riders Available
Hospital copays/coinsurance	*	*	*	*	*	*
Medicare Part A hospital deductible		*		*		*
Skilled nursing copay/coinsurance		*	**	**	*	*
Medicare Part B deductible		*		*		*
Medicare Part B coinsurance (typically 20%)	*	*	*	*	*	*
Medicare Part B excess charges				80%		*
Blood (first 3 pints)	*	*	*	*	*	*
Foreign travel emergencies (up to plan limits)		*	* (80%)	* (80%)		*
Inpatient days in mental health hospitals	60 days/calendar year	120 days/benefit year			175 per lifetime days in addition to Medicare benefits	60 days/calendar year
Preventive care and other state benefits	*	*	*	*	*	*

Medigap in Massachusetts

Medigap	Medigap Plans	
	Core Plan	Supplement 1
Basic benefits	Yes	Yes
Part A: inpatient hospital deductible	No	Yes
Part A: skilled nursing facility coinsurance	No	Yes
Part B: deductible	No	Yes
Foreign travel emergency	No	Yes
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year
State-mandated benefits (yearly pap tests and mammograms. Check your plan for other state-mandated benefits.)	No	Yes

Medigap in Minnesota

Medigap	Medigap Plans	
	Basic Plan	Extended Basic Plan
Basic benefits	Yes	Yes
Part A: inpatient hospital deductible	No	Yes
Part A: skilled nursing facility coinsurance	Yes	Yes
Part B: deductible	No	Yes
Foreign travel emergency	80%	80%*
Outpatient mental health	50%	50%
Usual and customary fees	No	80%*
Medicare-covered preventive care	Yes	Yes
Physical therapy	20%	20%
Coverage while in a foreign country	No	80%*
State-mandated benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations.)	Yes	Yes

*The plan pays 100% after you spend \$1,000 in out-of-pocket costs in a calendar year.

Medigap in Wisconsin

Wisconsin offers plans known as "50% and 25% cost-sharing plans," which are similar to regular Medigap Plans K (50%) and L (25%). A \$2,000 high-deductible plan is also available.

Additionally, insurance companies in Wisconsin are allowed to offer the following additional benefits to a Medigap policy:

- Part A deductible
- Additional home health care (365 visits, including those paid by Medicare)
- Part B deductible
- Part B excess charges
- Foreign travel emergency
- 50% Part A deductible
- Part B copayment or coinsurance

Medigap Terms and Regulations for All States

- You must already be enrolled in Medicare Parts A and B in order to enroll in a Medigap plan
- Within most Medigap plans, you will not be required to make a copayment or have coinsurance for hospital charges
- To receive Medigap insurance, you will not be required to pass a health screening provided that you buy coverage when you first become eligible at age 65 or your company stops providing a group retiree health plan. In all other situations, however, you will very likely need to pass a health screening in order to receive coverage.

Medigap premiums

There are three different ways in which an insurance company can determine your Medigap premium rate.

- No-age rated: Your premium will be the same, regardless of your age
- Policy-age rated: Your premium will be based on your age at the time that you first buy your policy. The sooner you enroll, the lower your premium will be.
- Attained-age rated: Your premium will be based on your current age; this means that your premium will increase over time as you grow older.

Original Medicare vision coverage

Original Medicare (Parts A and B) does not provide comprehensive coverage for vision treatment; however, in many cases, it can provide coverage for some vision needs, provided that certain conditions are met.

Vision benefits differ according to which parts of Medicare you purchase

- Medicare Part A (hospital insurance): Because Medicare Part A covers treatment in a hospital or rehabilitation facility, it covers vision treatment that requires emergency room attention, but not routine eye exams.
- Medicare Part B (Medical Insurance): Although routine eye exams are not covered under Part B, eye doctor visits related to eye diseases often are covered.
- Medicare Part C (Medicare Advantage): Because these plans are purchased through a private insurer, the vision benefits they contain will vary from plan to plan. However, you can probably expect them to cover routine eye exams, contact lenses and eyeglasses and frames.
- Medicare Part D (Prescription Drug Coverage): Medicare Part D helps pay the cost of prescription drugs, including medicines for eye diseases such as glaucoma.

Medicare Vision Costs

The costs and conditions pertaining to your individual plan will vary by state, and you will pay an annual Plan B deductible of \$1,147. In addition, Medicare beneficiaries have a coinsurance obligation (the amount you are required to pay as your share of the costs for services after you pay any deductibles). If you choose to participate in Medicare Parts A and B, you will likely be eligible for the types of Medicare vision coverage listed below.

- Cataract surgery: Medicare covers many costs associated with cataract surgery, including intraocular lenses (IOLs).
- Eyewear following cataract surgery: Medicare will cover the cost of one pair of eyeglasses or contact lenses following cataract surgery. Only standard frames are covered.
- Glaucoma screenings: Medicare helps pay the cost of an annual glaucoma screening for individuals at high risk for glaucoma, including people with diabetes or a family history of glaucoma. Glaucoma screenings consist of a comprehensive eye exam, including dilation and intraocular pressure (IOP) measurement.
- Ocular prostheses: Medicare will pay costs associated with obtaining and maintaining an artificial eye.

When choosing Medicare insurance plans like Part C/Medicare Advantage or Medigap, it's easy to overlook the importance of covering your vision needs. Although Medicare cannot provide full coverage for all of your eye needs, there are several areas where it can help, especially in cases of injury. If you have serious vision problems, your Aon Hewitt Navigators™ Benefits Advisor will work with you to find the plan that best meets your needs.

Original Medicare dental coverage

As with vision coverage, Original Medicare does not provide complete coverage for dental services, but can provide help in certain situations. For example, although Medicare does not pay for regularly scheduled dentist appointments, it does provide payment for the dental benefits listed below.

Medicare Dental Benefits:

- Dental services that are a necessary part of a covered procedure (e.g., reconstruction of the jaw following accidental injury).
- Extraction procedures prior to radiation treatment for diseases involving the jaw.
- Oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such examination could be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

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