Aon Retiree Health Exchange
help you can count on

Recommended by National Council on Aging

2014–2015 Medicare Insurance Guide
Why You Need More Coverage

I already have coverage. Aren’t Medicare Parts A and B enough?
For many people, 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 often not enough.

Because of potential gaps in coverage, many people purchase additional Medicare insurance to help build more complete coverage and provide a more comprehensive safety net.

Building more complete coverage

Medicare Insurance

Medicare Advantage (most plans include prescription drug coverage)

Medicare Part D Prescription Drug

More complete, comprehensive coverage and better financial protection

Medicare Parts A and B

OR

Supplement (Medigap) + Medicare Part D Prescription Drug

**Important notice**

This guide is not intended to replace information available to all Medicare recipients in the Medicare & You handbook available through Medicare. We encourage you to review this and all information available at [www.medicare.gov](http://www.medicare.gov), which will provide you with complete details about Medicare plans, including beneficiary rights, coordination of care, preventive services, how to change plans, state assistance options, definitions, and more.
Your Coverage Checklist

☐ Review this Medicare Insurance Guide.

☐ Verify your coverage in Medicare Parts A and B. You must have both in order to enroll in a medical plan with us. Contact the Social Security Administration at www.ssa.gov or by calling 1-800-772-1213 (TTY 1-800-325-0778) if you have not yet enrolled in Medicare Part B.

☐ Go online to the Aon Retiree Health Exchange website and activate your personal account.

☐ Complete any action items you see in your online account, including providing the prescriptions you take.

☐ Confirm your personal information, including whether you have a Power of Attorney who will assist you through the process.

☐ If you need personal assistance beyond our website, schedule or confirm your appointment with your Benefits Advisor.

☐ To prepare for your appointment:
  ✓ Make sure you have your Medicare insurance cards and ID cards for your other current health and drug plans.
  ✓ Collect your prescription details, including drug names, dosages, and frequency.
  ✓ Write down the names of your preferred doctors, clinics, and hospitals, including their phone numbers and addresses.
  ✓ Determine how much you want to pay each month for a premium. What do you pay today?
  ✓ Write down any features you like or dislike about the plan you have today to share with your Benefits Advisor.
  ✓ Compile a list of questions as you review your materials and other communications.
  ✓ If a Power of Attorney will be signing any enrollment forms on your behalf, be sure to have all legal documentation ready to submit to the insurance company—and alert us when you call to confirm your appointment.
  ✓ Have your checkbook available for payment information (if required).

☐ Compare plans and choose:
  1. Medicare Advantage Plan, or
  2. Supplement (Medigap) and Prescription Drug Plan

☐ Enroll in your selected plan:
  ✓ Enroll online or over the phone with your Benefits Advisor. If any forms are required, review, sign, date, and return forms promptly.
  ✓ Choose automatic payment options available from the insurance company to ensure efficient payments of your premiums each month.

☐ Your new insurance company will contact you to verify your enrollment (a Medicare requirement intended to protect you). Please take requested action promptly. Neglecting to do so could delay your coverage.

☐ Receive and carefully review your insurance cards and plan information from your new insurance company.

☐ Begin making premium payments each month. Consider using automated payment methods when available.

☐ Carefully review information that you receive from your insurance company throughout the year. Plan prices and coverage levels can change.

Now, let’s get started →
As a reminder, to enroll in a medical plan through the Aon Retiree Health Exchange, you must have coverage in BOTH Medicare Parts A and B. If you currently have this level of coverage, you can begin to learn more about Medicare, explore available medical and prescription drug coverage options, and enroll—either with the help of a Benefits Advisor or on your own online by following the steps below.

To access the website, you will need your individual account logon information, which was included with this guide.

1. Beginning October 1, 2014, you can use “Find Plans” to see the details and prices of the medical and prescription drug coverage options available in your area for 2015. Use the sorting tools to focus on coverage features that are important to you.

2. Choose your coverage and add to your cart.

3. Be sure to complete all required fields on the online application (some information will be prefilled for your convenience) and then move on to checkout.

4. Once you complete your application, you will be instructed to call and confirm your enrollment by providing verification over the phone. This “voice signature” is required by the Centers for Medicare & Medicaid Services (CMS) and is designed to protect you from unauthorized enrollments. You can actually complete this step during your scheduled appointment—or whenever you’re ready.

5. To learn more about individual dental and vision options, be sure to review the information provided in “additional products” available online.

Please note: Each eligible individual will need to take these steps to enroll in medical and prescription drug coverage online.

Learn About Medicare Parts A and B

Medicare is the nation’s largest health insurance program. It’s designed to provide coverage for people age 65 and older, people under age 65 who have permanent disabilities, and people of any age with end-stage renal disease—permanent kidney failure requiring dialysis.

What are the primary elements of Medicare Parts A and B coverage?

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Medical Services</th>
<th>Prescription Drugs</th>
<th>Financial Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>• Inpatient care in hospitals</td>
<td>None</td>
<td>Limited</td>
</tr>
<tr>
<td></td>
<td>• Limited skilled nursing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hospice care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B</td>
<td>• Doctors’ fees</td>
<td>Limited*</td>
<td>Limited</td>
</tr>
<tr>
<td></td>
<td>• Outpatient hospital care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical equipment and supplies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*With a few exceptions, most prescriptions are not covered. Please refer to the complete Medicare & You handbook, available at www.medicare.gov, for a full review of Medicare Parts A and B coverage.

What’s not covered by Medicare Parts A and B?
The simple truth is that Medicare Parts A and B do not cover everything. Even if Medicare Part A or Part B covers a service or item, you’ll still generally have to pay deductibles, coinsurance, and copayments without any annual limit on those costs.

Generally, services and items not covered by Medicare Parts A and B include:
- Most outpatient prescription drugs
- Routine vision care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids

Visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048) 24 hours a day/7 days a week or contact the Aon Retiree Health Exchange for more information about Medicare.
Before you can purchase Medicare insurance that includes medical coverage, you must enroll in Medicare Parts A and B. To find out if something specific is covered under Part A and/or Part B, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Ways to sign up for Medicare Parts A and B
- Visit your local Social Security office
- Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
- If you worked for a railroad, call your local Railroad Retirement Board office or 1-877-772-5772

Medicare Part A

What is Part A?
Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, and hospice, along with home health care.

What does Part A cover?
In general, Part A covers:
- Inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Home health care services
- Inpatient care in a religious nonmedical health care institution

How much does Part A cost?
Most people don’t have to pay a premium for Medicare Part A because they or their spouse paid Medicare taxes while working. This is referred to as “premium-free Medicare Part A.” If you are not eligible and need to purchase Medicare Part A, you can expect to pay a premium of up to $426 (in 2014) per month based on your work history. In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both.

Medicare Part B

What is Part B?
Part B is medical insurance that helps cover medically necessary services like doctors’ services, outpatient care, durable medical equipment, home health services, and other medical services. Part B also covers some preventive services. Check your Medicare card to find out if you have Part B.

What does Part B cover?
Part B covers two types of services:
- Medically necessary—Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- Preventive—Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

How much does Part B cost?
If you have Part B, you will pay a premium each month. Most people will pay the standard premium amount, which is $104.90 in 2014. Social Security will contact those individuals who have to pay more based on their income. If you don’t sign up for Part B when you’re first eligible, you may have to pay a late enrollment penalty.
Your Medicare Insurance Options

While Medicare Parts A and B cover a range of hospital and medical costs, there may still be some gaps in coverage. For more complete coverage, many people purchase additional Medicare insurance. The Aon Retiree Health Exchange is here to help you find an insurance plan that provides the safety net you need to control out-of-pocket expenses.

Options to consider:

Medicare Advantage Plans provide medical benefits as good as those covered by Medicare Parts A and B, with greater financial protection. Most Medicare Advantage Plans also include Medicare Part D Prescription Drug coverage, although there are many plans available without that coverage (if desired).

Medicare Cost Plans (available in Minnesota, North Dakota, South Dakota, and Wisconsin) are a type of Health Maintenance Organization (HMO). These plans may work in much the same way as Medicare Advantage Plans and have some of the same rules. In a Medicare Cost (MC) Plan, if you go to a non-network provider, the services are covered under Original Medicare. You would pay the Medicare Part A and Part B coinsurance and deductibles. For further details related to MC Plans, please ask your Benefits Advisor.

Special Needs Plans (SNPs) are plans specifically designed for those who are eligible for both Medicare and Medicaid, or who have been diagnosed with chronic conditions such as diabetes or cardiovascular disease. Contact a Benefits Advisor to better understand these plans and the options available in your area.

A quick comparison:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Medical Services</th>
<th>Prescription Drugs</th>
<th>Financial Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>Covers at least the same services as Medicare Parts A and B and may cover additional services or supplies</td>
<td>More complete coverage (many plans)</td>
<td>More complete coverage (many plans)</td>
</tr>
<tr>
<td>Supplement (Medigap)</td>
<td>Helps pay for services and supplies not fully paid by Medicare Parts A and B and may cover other items</td>
<td>No coverage</td>
<td>No prescription coverage</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>None</td>
<td>More complete coverage</td>
<td>More complete coverage</td>
</tr>
</tbody>
</table>

Medicare Cost Plans (available in Minnesota, North Dakota, South Dakota, and Wisconsin) are a type of Health Maintenance Organization (HMO). These plans may work in much the same way as Medicare Advantage Plans and have some of the same rules. In a Medicare Cost (MC) Plan, if you go to a non-network provider, the services are covered under Original Medicare. You would pay the Medicare Part A and Part B coinsurance and deductibles. For further details related to MC Plans, please ask your Benefits Advisor.

Special Needs Plans (SNPs) are plans specifically designed for those who are eligible for both Medicare and Medicaid, or who have been diagnosed with chronic conditions such as diabetes or cardiovascular disease. Contact a Benefits Advisor to better understand these plans and the options available in your area.
Option 1: Medicare Advantage

Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private insurance companies and are approved by Medicare. If you join a Medicare Advantage Plan, you still have Original Medicare. You will always have your Medicare Part A and Part B, but the insurance company is responsible for coordinating your care and paying claims.

In all types of Medicare Advantage Plans, you’re always covered for emergency and urgent care. Medicare Advantage Plans must cover all the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you’re in a Medicare Advantage Plan. Medicare Advantage Plans aren’t supplemental coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare Prescription Drug coverage (Part D).

How much does a Medicare Advantage Plan cost?

In addition to your Medicare Part B premium, you will usually pay a monthly premium for your Medicare Advantage Plan. This premium may vary, depending on the services covered. Note that there may be plans available that have no monthly plan premium. In most cases there are no deductibles, and for most medical services you will pay a copayment instead of coinsurance. Each plan is different, so you need to understand the specifics before enrolling in any plan.

Medicare Advantage Plans have an out-of-pocket maximum, which provides you with financial protection by setting a yearly cap on how much you’ll have to pay for health services. This protection does not mean less coverage, however; Medicare Advantage Plans must cover all the services that Medicare Parts A and B cover, with the exception of hospice care (which remains covered under Medicare Part A).

Be aware

Need prescription drug coverage? Be sure it’s included!

If you choose a Medicare Advantage HMO, Point-of-Service (POS), or Preferred Provider Organization (PPO) Plan, you will not be able to enroll in a stand-alone Medicare Part D Prescription Drug Plan. Be sure that your approach to Medicare insurance coverage includes prescription drug coverage before you enroll.

Important considerations for plans

- To enroll in a Medicare Advantage Plan, you must be enrolled in Medicare Parts A and B.
- To receive maximum benefits from a Medicare Advantage Plan, you will generally need to receive care from the doctors, health care providers, facilities, or suppliers who participate in the plan’s network (if the plan includes network limitations).
- Before traveling, you should always check with your provider to understand benefits available to you.
- The design and specifications of Medicare Advantage Plans—including premiums, copayments, deductibles, and covered services—may change each year. To ensure that your needs are met, review available plans online or set up an appointment with your Benefits Advisor to evaluate your options.
### Medicare Advantage Plan comparison chart

<table>
<thead>
<tr>
<th>Type</th>
<th>Doctors and Hospitals</th>
<th>Referrals</th>
<th>Prescription Drugs</th>
<th>Notes</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization (HMO) Plans</td>
<td>In most HMOs, you can only go to doctors, other health care providers, or hospitals on the plan’s list except in an emergency. You may also need to get a referral from your Primary Care Physician (PCP).</td>
<td>Your PCP may need to provide referrals for hospital and specialized care.</td>
<td>HMO members cannot enroll in a stand-alone Medicare Part D Prescription Drug Plan. Be sure the HMO Plan you select includes prescription drug coverage before you enroll.</td>
<td>These plans are often the least expensive and can provide excellent value and well-coordinated care in areas where there are strong HMO Plans with an extensive network of providers.</td>
<td>$</td>
</tr>
<tr>
<td>Medical Savings Account (MSA) Plans</td>
<td>MSA Plans combine a high-deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year.</td>
<td>Typically, no referrals are needed for hospital or specialized care.</td>
<td>You must enroll in a stand-alone Medicare Part D Prescription Drug Plan if you want drug coverage.</td>
<td>Your MSA will be funded up to a preset dollar amount each year. You use these funds to pay for services (excluding prescriptions) until you reach the out-of-pocket maximum, after which your insurer pays 100%. Any money remaining in your account at the end of the year carries over into subsequent years.</td>
<td>$</td>
</tr>
<tr>
<td>Point-of-Service (POS) Plans</td>
<td>POS Plans may allow you to visit doctors and hospitals outside their network for some covered services, usually for a higher copayment or coinsurance.</td>
<td>Some POS Plans do not require referrals for specialty services.</td>
<td>In most cases, yes, but ask the plan. If you want Medicare drug coverage, you must join an HMO Plan that offers prescription drug coverage.</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Preferred Provider Organization (PPO) Plans</td>
<td>In a PPO, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. You pay more if you use doctors, hospitals, and providers outside of the network.</td>
<td>Typically, you don’t need a referral. However, you may need plan approval for certain services. Check with your plan provider for full details.</td>
<td>PPO members cannot enroll in a stand-alone Medicare Part D Prescription Drug Plan. Be sure the PPO Plan you select includes prescription drug coverage before you enroll.</td>
<td>PPO Plans offer flexibility to choose from a wide range of health care providers, often for an affordable price.</td>
<td>$</td>
</tr>
<tr>
<td>Private Fee-for-Service (PFFS) Plans</td>
<td>PFFS Plans are similar to Original Medicare in that you can generally go to any doctor, other health care provider, or hospital as long as they agree to treat you. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.</td>
<td>No referrals are needed for hospital or specialized care.</td>
<td>You can elect a PFFS Plan that has prescription drug coverage, or enroll in a stand-alone Medicare Part D Prescription Drug Plan.</td>
<td>Some health care providers do not accept PFFS Plans. Check with your doctors to make sure they accept PFFS Plans before enrolling.</td>
<td>$</td>
</tr>
<tr>
<td>Special Needs Plans (SNPs)</td>
<td>SNPs are specifically designed for those eligible for both Medicare and Medicaid—and anyone who has been diagnosed with certain chronic conditions such as diabetes or cardiovascular disease. You generally get care and services from doctors, other health care providers, or hospitals in the plan’s network (except emergency care, out-of-area urgent care, or out-of-area dialysis).</td>
<td>In most cases, yes. Certain services, like yearly screening mammograms, don’t require a referral.</td>
<td>Yes. All SNPs must provide Medicare Part D Prescription Drug coverage.</td>
<td>Plans should coordinate the services and providers you need to help you stay healthy and follow doctors’ or other health care providers’ orders. If you have Medicare and Medicaid, your plan should make sure that all the plan doctors or other health care providers you use accept Medicaid. If you live in an institution, make sure that plan providers serve people where you live.</td>
<td>$</td>
</tr>
<tr>
<td>Other Types of Medicare Health Plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Cost (MC) Plans</td>
<td>MC Plans are a type of Medicare Health Plan available in certain areas of the country.</td>
<td>No referrals are needed for hospital or specialized care.</td>
<td>You can elect an MC Plan that has prescription drug coverage, or enroll in a stand-alone Medicare Part D Prescription Drug Plan.</td>
<td>Available in Minnesota, North Dakota, South Dakota, and Wisconsin.</td>
<td>$</td>
</tr>
</tbody>
</table>
Option 2: Supplement (Medigap) + Medicare Part D Prescription Drug

Supplement (Medigap)

As the name suggests, Supplement (Medigap) insurance is designed to fill gaps in Medicare Parts A and B coverage by assuming responsibility for various costs not covered by Original Medicare.

While there are a number of different Supplement (Medigap) Plans, their benefits are standardized in each state. This means that within your state, the coverage of each plan offered by one insurance company will be the same as the coverage for the same plan offered by any other insurance company. The difference among the Supplement (Medigap) Plans within your state lies in the details of how much coverage they offer and which gaps they fill.

How much does a Supplement (Medigap) Plan cost?

You will pay a monthly premium for your Supplement (Medigap) policy in addition to your monthly Medicare Part B premium. Premiums vary based on the plan you choose. Insurance companies may charge different premiums for exactly the same coverage.

Be aware

Supplement (Medigap) Plans do not cover prescription drugs. If you choose a Supplement (Medigap) Plan, consider enrolling in a Medicare Part D Prescription Drug Plan as well.

Supplement (Medigap) Plans and their benefits:

All states except Massachusetts, Minnesota, and Wisconsin

The table below is a summary of what each standardized Supplement (Medigap) Plan (A to N) covers.

Most people consider Plan F the “gold standard.” With Plan F, you only pay the monthly premium and pay nothing additional for a Medicare-covered procedure when you see a doctor or go to a hospital that accepts Medicare.

(A check mark [✓] indicates areas where the plan pays 100% of the benefit cost.)

### 2014 Supplement (Medigap) Plans

<table>
<thead>
<tr>
<th>Supplement (Medigap) Benefits</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
<th>G</th>
<th>K²</th>
<th>L²</th>
<th>M</th>
<th>N¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A Coinsurance and Hospital Costs (up to 365 days after Medicare benefits are used up)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part A Hospital Deductible</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50%</td>
<td>75%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care Copay/Coinsurance</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50%</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part A Hospice Care Coinsurance or Copayments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B Deductible</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B Coinsurance (generally 20%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50%</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part B Excess Charges</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Blood (first three pints)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50%</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergencies (up to plan limits)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

¹ Some insurance companies offer a high-deductible version of Plan F, which requires you to pay a deductible of $2,140 before these costs are covered (in 2014).


³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don’t result in an inpatient admission (in 2014).
Option 2 (continued)

**Supplement (Medigap) Plans and their benefits:**
**Massachusetts, Minnesota, and Wisconsin only**

In these three states, standard Supplement (Medigap) benefits work a bit differently. If you live in Massachusetts, Minnesota, or Wisconsin, please refer to the following information:

**Massachusetts benefits**
- **Inpatient Hospital Care:** Covers the Medicare Part A (hospital insurance) coinsurance plus coverage for 365 additional days after Medicare coverage ends
- **Medical Costs:** Covers the Medicare Part B (medical insurance) coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** Covers the first three pints of blood each year
- **Part A hospice coinsurance or copayment**

**Massachusetts: Chart of standardized Supplement (Medigap) policies**

(A check mark [✓] indicates that the benefit is covered.)

<table>
<thead>
<tr>
<th>Massachusetts Supplement (Medigap) Benefits</th>
<th>Core Plan</th>
<th>Supplement (Medigap) 1 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part A: Inpatient Hospital Deductible</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part A: Skilled Nursing Facility Coinsurance</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B: Deductible</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Inpatient Days in Mental Health Hospitals</td>
<td>60 days per calendar year</td>
<td>120 days per benefit year</td>
</tr>
<tr>
<td>State-Mandated Benefits (annual Pap tests and mammograms; check your plan for other state-mandated benefits)</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Minnesota benefits**
- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** Covers the first three pints of blood each year
- **Part A hospice and respite cost sharing**
- **Parts A and B home health services and supplies cost sharing**

**Minnesota: Chart of standardized Supplement (Medigap) policies**

(A check mark [✓] indicates that the benefit is covered.)

<table>
<thead>
<tr>
<th>Minnesota Supplement (Medigap) Benefits</th>
<th>Basic Plan</th>
<th>Extended Basic Plan</th>
<th>Mandatory Riders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part A: Inpatient Hospital Deductible</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medicare Part A: Skilled Nursing Facility (SNF) Coinsurance</td>
<td>✓ Provides 100 days of SNF care</td>
<td>✓ Provides 120 days of SNF care</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B Deductible</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td>80%</td>
<td>80%*</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Usual and Customary Fees</td>
<td>80%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare-Covered Preventive Care</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Coverage While in a Foreign Country</td>
<td>80%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-Mandated Benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

*Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.

Minnesota versions of Supplement (Medigap) Plans K, L, M, N, and high-deductible F are available.

Important: The Basic and Extended Basic benefits are available when you enroll in Part B, regardless of age or health problems. If you return to work and drop Part B to elect your employer’s health plan, you will get another 6-month Supplement (Medigap) Open Enrollment Period after you retire from that employer, when you can elect Part B again.
Wisconsin benefits
- **Inpatient Hospital Care**: Covers the Part A coinsurance
- **Medical Costs**: Covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood**: Covers the first three pints of blood each year
- Part A hospice coinsurance or copayment

Wisconsin: Chart of standardized Supplement (Medigap) policies
(A check mark [✓] indicates that the benefit is covered.)

<table>
<thead>
<tr>
<th>Wisconsin Supplement (Medigap) Benefits</th>
<th>Basic Plan</th>
<th>Optional Riders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>✓</td>
<td>Insurance companies are allowed to offer the following additional riders to a Supplement (Medigap) policy:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Part A Deductible</td>
</tr>
<tr>
<td>Medicare Part A Skilled Nursing Facility Coinsurance</td>
<td>✓</td>
<td>• Additional Home Health Care (365 visits including those paid by Medicare)</td>
</tr>
<tr>
<td>Inpatient Mental Health Coverage</td>
<td>175 days per lifetime in addition to Medicare’s benefit</td>
<td>• Part B Deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>40 visits in addition to those paid by Medicare</td>
<td>• Part B Excess Charges</td>
</tr>
<tr>
<td>State-Mandated Benefits</td>
<td>✓</td>
<td>• Foreign Travel Emergency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 50% Part A Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Part B Copayment or Coinsurance</td>
</tr>
</tbody>
</table>

**Important considerations for plans in all states**
- To enroll in a Supplement (Medigap) Plan, you must be enrolled in Medicare Parts A and B.
- Although most Supplement (Medigap) Plans cover expenses from any health care provider that accepts Medicare, some Supplement (Medigap) companies also offer a Medigap SELECT Plan. Medigap SELECT Plans provide coverage only within a defined network of providers. Before you purchase a Medigap SELECT Plan, check to make sure that your hospital is included in that particular plan’s network.
- Most Supplement (Medigap) Plans don’t require a copayment or coinsurance for hospital charges.
- If you buy coverage when you first become eligible at age 65, or if your company stops providing a group retiree health plan, you are guaranteed to qualify for a wide variety of Supplement (Medigap) Plans and may not be required to pass any health screening by the Supplement (Medigap) insurer.
Medicare Part D Prescription Drug

Medicare Part D Prescription Drug coverage helps you pay for prescription drugs that are not covered by Medicare Parts A and B. Medicare Part D Prescription Drug coverage is insurance available from an insurance company or other private company that is approved by Medicare.

There are two ways in which you can obtain the prescription drug coverage you need:

- **Medicare Part D Prescription Drug Plans (PDPs)** can be added to Medicare Parts A and B, and while most commonly added to Supplement (Medigap) Plans, they can also be added to other types of Medicare Plans (Medicare Advantage, Cost Plans, etc.).
- **Medicare Advantage Prescription Drug (MAPD) Plans** are Medicare Advantage Plans (see page 10 for details) that include prescription drug coverage. If you enroll in a Medicare Advantage Prescription Drug Plan, you will not need to enroll in a separate PDP. Note that while most Medicare Advantage Plans cover prescription drugs, some plan types allow you to add drug coverage if it’s not already included.

**Important considerations for plans**

- You must be enrolled in Medicare Part A and/or Part B before you can enroll in a Medicare Part D Prescription Drug Plan.
- Unless you have coverage from another source that is considered comparable to Medicare’s (known as “creditable” coverage), you may pay a penalty if you don’t enroll in Medicare Part D Prescription Drug coverage when you are first eligible.
- Each Medicare Part D Prescription Drug Plan has a “formulary,” which is a list of approved drugs. All drugs listed on your plan’s formulary will be covered by the plan. The good news is that all Medicare Part D Prescription Drug Plans must cover medications that treat almost every medical condition.
- If you have limited income and assets, you may be eligible for the Extra Help program to pay your premiums and drug costs. Contact the Social Security Administration at [www.ssa.gov](http://www.ssa.gov) or by calling 1-800-772-1213 (TTY 1-800-325-0778) for more information.
- If you have other prescription drug coverage, such as Veterans Affairs (VA) coverage, you may not need additional Part D drug coverage. Be sure to discuss any other drug coverage you have with your Benefits Advisor.

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**Option 2 (continued)**

**How much does Medicare Part D Prescription Drug coverage cost?**

The cost of Medicare Part D Prescription Drug coverage varies with the plan you choose. As with most other insurance plans, you must pay a monthly premium for your Medicare Part D Prescription Drug Plan, upon which the coverage works as follows:

<table>
<thead>
<tr>
<th>Expense</th>
<th>Description</th>
<th>Your Cost (varies by plan; 2014 approximate ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>This is the monthly cost of your Medicare Part D Prescription Drug Plan coverage in addition to your Part B premium. Regardless of whether you use your plan to purchase prescription drugs, you will be responsible for paying this premium.</td>
<td>$0–$100 per month</td>
</tr>
<tr>
<td>Deductible</td>
<td>This is the amount you pay out of pocket for your prescriptions each year before your plan begins to pay. Some plans don’t have a deductible.</td>
<td>$0–$310 per year</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Once you’ve satisfied your deductible (if required), you and the Medicare Part D Prescription Drug Plan share the cost of your prescriptions. This is a percentage of the total cost of the prescription. The amount may vary depending on whether you require a brand-name or generic prescription.</td>
<td>Depends on plan</td>
</tr>
<tr>
<td>Copayment</td>
<td>Some plans require that you pay a set dollar amount for each prescription, as opposed to a percentage of its cost (see “Coinsurance” above). This amount may vary depending on whether you require a brand-name or generic prescription. Coinsurance and copayments are often “either/or,” so you’ll rarely have to pay both.</td>
<td>Depends on plan</td>
</tr>
<tr>
<td>Coverage Gap, or Donut Hole</td>
<td>Most Medicare Prescription Drug Plans have a coverage gap, or “donut hole.” This means that after you and your plan have spent a certain amount of money for covered prescriptions, you may have to pay higher costs out of pocket for other prescriptions, up to an annual limit.</td>
<td>Once you enter the coverage gap, you pay 47.5% of the plan’s cost for covered brand-name drugs and pay 72% of the plan’s cost for covered generic drugs until you reach the end of the coverage gap. Some plans provide additional coverage in the donut hole. There will be additional savings in the coverage gap each year through 2020.</td>
</tr>
<tr>
<td>Catastrophic Coverage</td>
<td>If, over the course of a calendar year, your spending on covered prescription drugs exceeds a preset limit, your plan’s catastrophic coverage will begin to provide a safety net for you. Once that happens, the Medicare Part D Prescription Drug Plan will cover about 95% of the cost of your prescriptions. The exact amount you need to spend before catastrophic coverage begins depends on the type of prescriptions you require.</td>
<td>After your out-of-pocket costs (including the rebate for brand-name drugs purchased in the coverage gap) reach $4,550 (in 2014), you will then pay only a small percentage of your prescription costs.</td>
</tr>
</tbody>
</table>
Making the Right Choice: Medicare Advantage or Supplement (Medigap)?

Finding the right Medicare insurance can be challenging, but your Benefits Advisor is ready to help you explore your options, understand the differences between individual plans, and help you enroll—all at no cost to you. In short, we are dedicated to helping you find a plan that fits your needs and protects you against the rising cost of health care services and prescriptions. The result: You have greater peace of mind.

Compare Medicare Advantage and Supplement (Medigap) Plans:

<table>
<thead>
<tr>
<th>Medicare Advantage (with prescription drug coverage)</th>
<th>Supplement (Medigap) + Medicare Part D Prescription Drug Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical Monthly Premium</td>
<td>$150–$300</td>
</tr>
<tr>
<td>Copayments/Coinsurance/Deductibles</td>
<td>Varies by plan</td>
</tr>
<tr>
<td>Average Annual Maximum Out-of-Pocket Expense</td>
<td>Varies by plan</td>
</tr>
<tr>
<td>Health Care Provider</td>
<td>See any Medicare provider</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>Yes (via enrollment in a stand-alone Medicare Part D Prescription Drug Plan)</td>
</tr>
</tbody>
</table>

Other Considerations:
- Can be a good value for many retirees since less expensive than Supplement (Medigap) Plans
- Plans can change every year
- Some plans have extra benefits available
- Medical underwriting not required
- Generally a good value if you need frequent medical care
- Plans are standardized
- Covers Medicare services only
- Medical underwriting may be required

Might Make Sense if You...
- Are open to potentially changing your doctors since the network is defined
- Visit your doctors rarely and don’t mind paying per-visit copayments and coinsurance
- Would prefer to receive your benefits from one plan, have one card, and pay one premium
- Want flexibility in choosing your doctors since Supplement (Medigap) is accepted by all doctors who accept Medicare
- Visit your doctors frequently since copayments and coinsurance for visits are generally covered by your premium, depending on the plan you select
- Travel extensively since Supplement (Medigap) is widely accepted

Important plan information
- The benefit information provided in this guide is a brief summary, not a complete description of benefits. For more information, contact the appropriate plan.
- Limitations, copayments, and restrictions may apply.
- Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year. Be sure to read any information sent to you by your selected insurance company.
- You must continue to pay your Medicare Part B premium to maintain enrollment in a medical plan.
- A Private Fee-for-Service (PFFS) Plan is not a Supplement (Medigap) Plan. Providers who do not contract with the plan are not required to see you except in an emergency.
- Medical Savings Account (MSA) Plans combine a high-deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay out of pocket before your coverage begins. Medicare MSA Plans don’t cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan. There are additional restrictions to join an MSA Plan, and enrollment is generally for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan for additional information.
- Medicare has neither reviewed nor endorsed this information.
Help After You Enroll

Services through the Aon Retiree Health Exchange do not stop after you enroll. If you have questions about your plan or problems resolving an issue with your insurance plan provider, help is just a phone call away. If you enrolled in a Medicare insurance plan through us, our advocacy services are available to you free of charge.

Our advocates are experienced with Medicare insurance plans, billing procedures, claims and appeals, and solving access-to-care problems. Beyond their professional expertise, they also understand how frustrating and stressful any issues you encounter can be. That’s why they’re dedicated to providing expert guidance and the solutions you need, whenever you need them.

What to do if you have questions or issues

1. **First, start by contacting your insurance plan provider.** If you have an issue regarding a bill or have a coverage question, always call your insurance company first to attempt to resolve the issue.

2. **Next, contact your Benefits Advisor.** Your Benefits Advisor will be your primary contact for Medicare insurance-related questions. However, you can also call our team of professional advocates to help resolve your issue—whether that means finding a solution themselves or connecting you with someone who can.

Overview of what advocates can do for you

• Help resolve Medicare insurance claims, billing disputes, and other issues.
• Research and resolve tough health care and benefits issues, including access to care, eligibility, claims, and Medicare questions.
• Apply their comprehensive understanding of your benefits plan to research, identify, and implement solutions to help resolve your challenge.

We are here to help you

Your personalized letter includes a special phone number that will connect you to a licensed Benefits Advisor, as well as logon information for our website. You can also contact us at:

Phone: 1-800-350-1470 (TTY use 711 relay), Monday–Friday, 8 a.m.–8 p.m. Central time. Closed on holidays.

Web: retiree.aon.com

What to expect going forward

Generally, you do not need to enroll each year, provided you continue to like your plan and can continue to pay the premiums if they were to change. However, here are a few things to consider each fall:

• We will send you a reminder that the Medicare Open Enrollment Period is approaching. The Medicare Open Enrollment Period is usually October 15–December 7 each year.
• Your insurance provider is required to send you information about plan or pricing changes as well. Always open, review, and save information provided by your insurance carrier(s).
• If you are comfortable with those changes, no action is required.
• If you wish to consider new options, tools are available to you online that will help you compare your options and apply for new coverage.
• If you need assistance from your Benefits Advisor, please call or go online to schedule an appointment.
Contacts and Resources

Call my Benefits Advisor:

Medicare
✔ Call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), available 24 hours a day/7 days a week
✔ Go online www.medicare.gov

Social Security
✔ Visit your local Social Security office
✔ Call 1-800-772-1213 (TTY 1-800-325-0778)
✔ Go online www.ssa.gov

Railroad Retirement Benefits
✔ Call your local Railroad Retirement Board office or 1-877-772-5772
✔ Go online www.rrb.gov

Other special resources:


Notes
Notes
About Us

Private Aon Retiree Health Exchange services are available through Aon Hewitt Health Market Insurance Solutions Inc, a third-party marketing organization (TMO), retained to sell or promote a plan sponsor’s Medicare products on the plan sponsor’s behalf who holds the contract with the federal government.

Aon Hewitt Health Market Insurance Solutions Inc is an Aon Hewitt company.

Aon Hewitt is the global leader in human capital consulting and outsourcing solutions. The company partners with organizations to solve their most complex benefits, talent, and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates, and administers a wide range of human capital, retirement, investment management, health care, compensation, and talent management strategies. With 30,000 professionals in offices across six continents, Aon Hewitt makes the world a better place to work for clients and their employees. For more information on Aon Hewitt, please visit www.aonhewitt.com.