Part B Excess Charges

An important gap in Medicare Part B is medical charges that are in excess of approved amounts. Plans F and G pay 100% of allowed excess charges. Excess physician charges have limits. Excess charges equal the difference between the Medicare-approved amount and the limiting charge. The maximum limiting physician charge for Medicare Part B eligible services is 15% over the Medicare-approved amount.

Some doctors are participating physicians, which means they accept assignment (they accept Medicare's approved amount—80% in most cases). If most of your doctors are participating physicians, you may prefer to self-insure for the excess charges instead of paying additional insurance premiums for this benefit. One way to control your medical costs is to use doctors who accept assignment.

Medigap Plans K & L

Medigap Plans K and L provide different cost-sharing for items and services than Medigap Plans A through G. You will have to pay some out-of-pocket costs for some covered services until you meet the yearly limit. Once you meet the yearly limit, the Medigap policy pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. Refer to the chart for the 10 standard plans for out-of-pocket costs.

Medigap Plans M & N

Medigap Plans M and N are new choices. Please see the chart on page 8 for more details.

Medicare SELECT—Another Option

Medicare supplement policies generally pay the same benefits regardless of your choice of health care provider. If Medicare pays for a service, the standard Medicare supplement policy must pay its regular share of benefits. One exception is Medicare SELECT.

- Another type of Medicare supplement insurance. Medicare SELECT is the same as standard Medicare supplement insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard plans identified by letters A through G.
- Restricted provider network. With Medicare SELECT you must use specific hospitals and, in some cases, specific doctors to receive full benefits. Hospitals or doctors specified by a Medicare SELECT policy are called "participating or preferred providers." When you go to the preferred provider, Medicare pays its share of the approved charges. The Medicare SELECT policy then pays the full supplemental benefits described in the policy.
- Medicare is not restricted. You can go to a provider outside the network for non-emergency care, and Medicare still pays its share of approved charges. However, the Medicare SELECT policy is not required to pay under these circumstances, although some companies may have a provision that allows a limited payment.
- Emergencies outside the network. Generally Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider. The only exception is in the case of an emergency.
- Designated service area. Medicare SELECT requires that you live in a designated service area to be eligible for enrollment.
- Lower Premiums. Medicare SELECT policies generally have lower premiums because service areas and providers are limited. If you live in a designated area and agree to receive your care from the preferred providers for your plan, a Medicare SELECT plan may save you money.
- Replacing a Medicare SELECT policy. You can replace a Medicare SELECT policy with a regular Medicare supplement insurance policy if you move out of the service area. You also may choose to change after a Medicare SELECT policy has been in effect for six months. The insurance company must allow you to purchase a regular Medicare supplement policy with equal or lesser benefits, regardless of your health condition.