EMPOWERMENT KIT

for a worry-free retirement.

See what's included:

- How to choose the right insurance agent
- Health insurance for retirement – buyer's worksheet
- Preventive care checklist
- Federal and state resources
- Glossary

Physicians Mutual®

Insurance for all of us.®

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EMPOWERMENT KIT

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How to choose the right insurance agent

Finding an insurance agent can be easy. But finding a professional you can trust to help you make confident decisions about your coverage options for retirement takes a little more effort. Use this checklist to help you make the best choice.

Health insurance for retirement — buyer's worksheet

Insurance can help fill out-of-pocket health care expenses you may have in retirement. To help you compare your options, use this worksheet with nine important questions to ask when you're shopping for insurance.

Preventive care checklist

Bring this checklist to your doctor and ask which services may be right for you. Getting the preventive care you need today can help you enjoy a healthier retirement.

Federal and state resources

Keep this list of contacts handy for help with Medicare, Social Security and more.

Glossary

Use this reference to find the meaning of common terms used with Medicare and Medicare Supplement insurance.

Questions? Give us a call at
1-800-325-7500

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HOW TO CHOOSE THE RIGHT INSURANCE AGENT

7 tips to help you make the best decision.

Finding an insurance agent can be easy. But finding the right agent — a professional you can trust to help you make confident decisions about your coverage — takes a little more effort. You can ask family and friends for referrals, or find one on your own. Here are seven key things to look for when choosing an agent.

- **Personality:** You want to make sure you feel comfortable with your agent, and that he or she is friendly and approachable.
- **Integrity:** You should never feel rushed into signing a contract or handing over a check. An agent with your best interest in mind will take time to listen and fully understand your specific needs, address your concerns and give you straightforward answers to all of your questions.
- **Industry knowledge:** You'll be relying on your agent to find the best fit for your insurance needs, so you want someone who knows the ins and outs of the industry.
- **Product understanding:** A good agent will help you understand the details of the products they sell.
- **Customer service:** This can be something small, like promptly returning phone calls, or something bigger like helping you handle a complex claim. An agent should be responsive whenever you need help or have questions.
- **Value:** An agent should be proactive in making sure you have the right coverage at a price you can afford. Also find out if the agent does annual reviews to ensure the coverage continues to meet your changing needs.
- **Financial strength of the company they represent:** This is important since an insurer's promise is only as good as the financial strength backing it. Financial rating information, and what it means, should be readily available online, often in the "About Us" section of the company's website.

HEALTH INSURANCE FOR RETIREMENT

Buyer's Worksheet

Insurance can help cover out-of-pocket health care expenses you may have in retirement. The decision of which insurance company to go with can come down to the company's **reliability, financial strength** and **customer service**.

To help you compare your options, here are some important questions to ask when shopping around for insurance.

	Company Name:	**Company Name:**	**Company Name:**
What are the company's financial strength ratings according to leading insurance analysts?	A. M. Best: Weiss Ratings:	A. M. Best: Weiss Ratings:	A. M. Best: Weiss Ratings:
How long has the company been selling insurance?			
How is the premium determined?			
Does the company offer any discounts?			
Does the company offer any rate guarantees?			
How much is the monthly premium?			
On average, how long does the company take to pay a claim?			
Does the company offer a personal, dedicated agent who can answer your questions, or an 800 number?			
Does the company offer insurance options to help fill any other retirement gaps you may have?			

PREVENTIVE CARE CHECKLIST

Take care of yourself today – so you can enjoy a healthier retirement.

Bring this checklist to your doctor and ask which services are right for you.

- ❍ One-Time "Welcome to Medicare" Preventive Visit
- ❍ Yearly "Wellness" Visit
- ❍ Abdominal Aortic Aneurysm Screening
- ❍ Alcohol Misuse Screening and Counseling
- ❍ Bone Mass Measurement (bone density)
- ❍ Breast Cancer Screening (mammogram)
- ❍ Cardiovascular Disease (behavioral therapy)
- ❍ Cardiovascular Disease Screening
- ❍ Cervical and Vaginal Cancer Screening
- ❍ Colorectal Cancer Screenings
  - ❑ Multi-Target Stool DNA Test
  - ❑ Fecal Occult Blood Test
  - ❑ Flexible Sigmoidoscopy
  - ❑ Colonoscopy
  - ❑ Barium Enema
- ❍ Depression Screening
- ❍ Diabetes Screening
- ❍ Diabetes Self-Management Training
- ❍ Flu Shots
- ❍ Glaucoma Tests
- ❍ Hepatitis B Shots
- ❍ Hepatitis C Screening Test
- ❍ HIV Screening
- ❍ Lung Cancer Screening
- ❍ Medical Nutrition Therapy Services
- ❍ Obesity Screening and Counseling
- ❍ Pneumococcal Shot
- ❍ Prostate Cancer Screening
- ❍ Sexually Transmitted Infections Screening and Counseling
- ❍ Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)

These are additional preventive services Medicare Part B does not pay for. If interested, work with your doctor or dentist to personalize your own preventive health care plan.

- ❍ Physical Exams
- ❍ Hearing Exams
- ❍ Regular Dental Exams
- ❍ Refractive Eye Exams
- ❍ Shingles (Zoster) Vaccine*
- ❍ TDAP Vaccine*
- ❍ Any preventive services performed more frequently than Medicare Part B's requirements

*Medicare Part D may offer some coverage

To learn more about these services that may be available to you at no cost, visit www.medicare.gov. You can also call 1-800-MEDICARE (1-800-633-4227).

FEDERAL AND STATE RESOURCES

Important contacts for help with Medicare, Social Security and more.

Medicare

For questions about Medicare or for personal help in choosing the coverage that is right for you:

- Call 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.
- Visit Medicare.gov, the official Medicare website.
- Login to MyMedicare.gov, a free, secure online service for accessing personalized information regarding your Medicare benefits and services.
- Read "Medicare & You," the official Medicare handbook that includes information on Parts A, B, C and D.

Social Security Administration

If you have questions about eligibility and enrollment in Medicare, Social Security retirement benefits, and/or low-income assistance for a Part D plan, call 1-800-772-1213 or TTY 1-800-325-0778.

Your State's Medical Assistance or Medicaid office (in California, Medi-Cal office)

If you have questions about your state's Medicaid program, call Medicare and ask for the phone number for your state's Medical Assistance or Medicaid (in California, Medi-Cal) office.

Your State's Health Insurance Assistance Program (SHIP)

For help with questions about buying insurance, choosing a health plan, and your rights and protections under Medicare, visit shiptacenter.org or call Medicare and ask for the phone number for your state's Health Insurance Assistance Program's office.

Your health plan's customer service center

For help with your existing health coverage, call the phone number on your identification card.

Information from: Medicare.gov and the *Medicare & You* handbook, 2017

GLOSSARY

Common terms used with Medicare and Medicare Supplement insurance.

Affordable Care Act: The Patient Protection and Affordable Care Act (PPACA/ACA) is a federal law passed in 2010. The ACA aims to reform the United States' health care industry and make health insurance more widely available.

Beneficiary: A person who has health care insurance through the Medicare or Medicaid programs.

Carrier: A private company that has a contract with Medicare to pay your Part B bills.

Centers for Medicare & Medicaid Services (CMS): The Federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS works to make sure the beneficiaries in these programs are able to get high-quality health care.

Coinsurance: The percentage of the plan charge for services you may have to pay after you pay any plan deductibles. Usually, the payment is a percentage of the cost of the service (like 20%).

Co-payment (co-pay): The cost for medical care you pay yourself. Usually, the co-payment is a pre-determined dollar amount you pay each time you utilize a particular service (like $10 each time you fill a prescription or $20 each time you visit your doctor).

Creditable drug coverage: Prescription drug coverage (like from an employer or union) that is, on average, at least as good as the Part D standard prescription drug coverage.

Deductible: The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B and Part D. These amounts can change every year.

Disenroll: Ending your coverage with a health plan.

Durable Medical Equipment (DME): Reusable medical equipment, such as walkers, wheelchairs or hospital beds, that is ordered by a doctor for use in the home. DME is paid for under both Part A and Part B for home health services.

Gaps: Costs or services that are not covered under Medicare Parts A and B.

Group health plan: Insurance that provides health coverage to employees and their families, and is supported by an employer or employee organization.

Guaranteed issue rights: Rights you have in certain situations when insurance companies are required by law to sell or offer you coverage. The company can't deny you coverage or place conditions on an insurance policy, must cover you for all old health problems, and can't charge you more because of past or present health problems.

Health Maintenance Organization (HMO): A type of Medicare Advantage plan in which a group of providers agrees to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually get your care from the providers in the plan.

Intermediary: A private company that has a contract with Medicare to pay Part A and some Part B bills.

Managed care plan: A health plan that contracts with health care providers to offer care at lower costs. Plans must cover all Part A and Part B health care. Some also cover extra benefits, like additional days in the hospital. Your costs may be lower than in Medicare Parts A and B.

Medicaid (in California, **Medi-Cal**): A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Programs vary by state, but most medical costs are covered if you qualify for both Medicare and Medicaid.

GLOSSARY (CONTINUED)

Common terms used with Medicare and Medicare Supplement insurance.

Medically necessary: Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are provided for the diagnosis, direct care and treatment of your medical condition; meet the standards of good medical practice in the local area; and aren't mainly for the convenience of you or your doctor.

Medicare: The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant).

Medicare Advantage Plan (MA): A Medicare Part C program that allows you to choose private health plans to help provide your health care. Everyone who has Part A and Part B is eligible, except those with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-approved amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "approved charge."

Medicare Supplement insurance: A Medigap insurance policy sold by private insurance companies to supplement some of the "gaps" in Medicare coverage. There are 10 standardized plans (except in Minnesota, Massachusetts and Wisconsin). Medigap policies only work with Medicare Parts A and B.

Network: A group of doctors, hospitals, pharmacies and other health care experts contracted or hired by a health plan to take care of its members.

Out-of-pocket costs: Health care costs you must pay on your own because they are not covered by Medicare or other insurance.

Preferred Provider Organization (PPO): A type of Medicare Advantage plan in which you use providers that belong to the network. You can use providers outside of the network for an additional cost.

Preventive services: Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, mammograms and other screenings).

Private Fee-for-Service Plan (PFFS): A type of Medicare Advantage plan in which you use providers that belong to the network (unless certain exceptions apply). The health plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits Medicare Parts A and B don't include.

Provider: A doctor, hospital, health care professional or health care facility.

Referral: A written okay from your primary care doctor for you to see a specialist or get certain services. In many Managed Care plans, you need a referral before you can get care from anyone except your primary care doctor. If you don't get a referral, the plan may not pay for your care.

Service area: The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. A plan may disenroll you if you move out of its service area.

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Information from: Medicare.gov and the *Medicare & You* handbook, 2017