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"900" Numbers: New Rule Helps Consumers

Facts for Consumers from the Federal Trade Commission
Before dialing a 900 number, there are a few things you should know. For example, how much will the call cost? What will you get for your money? What happens if you have a billing dispute? Under a new Federal Trade Commission (FTC) rule, it will be easier for consumers to get answers to these questions. This brochure explains what protection you have under the Telephone Disclosure and Dispute Resolution Act and the FTC 900-Number Rule. The rule applies to interstate pay-per-call services, or 900 numbers. The brochure also tells what to watch for in 900 numbers and what to do if you are caught in a 900-number scam.

The Advertisement: What it Should Say About Costs

The following information must be included in print, radio, and television advertisements for 900-number services.

The total cost of the call if there is a flat fee.

The per-minute rate if the call is charged by the minute, as well as any minimum charge. If the length of the program is known in advance, the ad also must state the total cost of the complete program.

The range of fees if there are different rates for different options. The ad also must state the initial cost of the call and any minimum charges.

The cost of any other 900 number to which the caller may be transferred.

Any other fees that the service might charge.

This information cannot be hidden in small print. The cost of the 900-number call must be at least half the size of the telephone number.

The Call: What You Should Hear First

When you dial a 900 number that costs more than $2, the first thing you should hear is an introductory message, or "preamble." The preamble must describe the service briefly, give the name of the company providing the service, and tell the cost of the call. Also, it must say that anyone under age 18 needs parental permission to complete the call. Once all this information is provided, you must be given three seconds to hang up without being charged.

The Exceptions to the Rule

The 900-Number Rule does not apply if you have a pre-existing contractual agreement with an information service. Be very careful about entering such an arrangement. If you do, your calls to the service and resulting bills will not be subject to the rule's requirements.

The rule also excludes calls charged to a credit card. However, the bills for such calls would be covered by the dispute resolution procedures of the Fair Credit Billing Act.

Billing Errors: What You Can Do

To help protect consumers, the new rule establishes procedures for resolving billing disputes. When your telephone bill arrives, check it for any 900-number charges. For each pay-per-call charge, the billing statement should include the date, time, and for services that have per-minute rates the length of the call. These charges must appear separately from local and long distance charges on your telephone bill. The billing statement must include a local or toll-free number that you can call with questions about your pay-per-call charges.

If you discover an error, the instructions given with your billing statement will tell you who to call or write. In most cases, this will be your local or long-distance telephone company, but it could be the 900-number company or an independent firm that provides billing services for that company.

You must notify the company listed on your bill within 60 days after the first statement containing the error was sent. The company must acknowledge your notice in writing within 40 days unless it has resolved the

dispute by that time. Within two billing cycles, but no longer than 90 days, the company must:

correct the billing error and notify you of the correction,

or

investigate the matter and either correct the error or explain to you the reason for not doing so.

No one can charge you for having to investigate or respond to a billing dispute. In addition, no one can try to collect the disputed charge from you or report it to a credit bureau until the company handling the dispute has either corrected the error or explained its reason for not doing so. Companies that do not comply with these rules lose the right to collect up to $50 of each disputed charge.

You should be aware that even if the 900- number charge is removed from your phone bill, the service provider might continue to pursue the charge by other means, such as referring the matter to a collection agency. If that happens, you have additional rights under the Fair Debt Collection Practices Act. (See pages 6-7, Complaints: How to Handle Them.)

The FTC Rule: What It Says About Children, Sweepstakes, and More

The Rule also covers other 900-number sales practices. These include services that:

Target children.

Some companies have promoted 900-numbers to children, encouraging them to pick up the phone to talk to a cartoon character. Under the FTC rule, companies cannot advertise or direct pay-per-call services to children under 12 unless they are educational services dedicated to areas of school study.

If the ad is directed to consumers under the age of 18, it must state that parental permission is required to make the call.

Promote sweepstakes.

Some services offer the opportunity to enter a sweepstakes,and win a prize,simply by dialing a 900 number and, in some cases, entering some type of code. The FTC Rule requires ads for sweepstakes to state the odds of winning (or how odds will be calculated).

Also, the ad or the preamble must tell you that there is a free alternative way to enter the sweepstakes. You must be instructed on how to enter free of charge or where to get that information.You do not have to call and incur a charge to enter. This does not apply to contests where you have to demonstrate a skill, such as answering a question correctly.

Offer information on government programs.

Some 900 numbers may provide information about federal programs although they are not affiliated with any government agency. This could mislead some consumers. Under the new rule, the ad and the preamble must state that such services are not authorized, endorsed, or approved by a federal agency.

Use 800 numbers.

The new rule generally prohibits:

using 800 numbers for pay-per-call services.

connecting 800-number callers to 900 numbers.

placing collect return calls to 800-number callers.

FCC Rules on collect calls

Under new Federal Communications Commission regulations, pay-per-call services cannot make collect calls to you if the charge would be more than,or in addition to, the regular long distance charge for the call. Services that do not impose this additional charge could call collect. However, you cannot be charged for the call unless you have clearly indicated that you accept the charge.

Your Best Protection: How to Avoid 900-Number Problems

Scams involving 900 numbers are constantly changing. In general, you can protect yourself if you:

Deal only with reputable companies.

Some companies or organizations sponsor 900-number services for opinion surveys, sports information, or other topics that may interest you. Before you call a 900 number, be sure you understand the cost of the call and the nature of the information or service you will receive.

Think twice before calling a 900 number for a "free" gift.

Television ads, postcards or telemarketers may urge you to call 900 numbers for "free" prizes. Know that you pay for those "free" gifts when you make the 900-number call.

Don't confuse 900 numbers with toll-free 800 numbers.

You pay for the 900-number call. The company pays for the 800-number call.

Talk to your children.

Make sure they understand they shouldn't call 900 numbers without your permission. You can have the phone company block 900-number calls from your phone. Under the new Federal Communications Commission rule, local phone companies must make blocking available (where technically feasible) at no charge through December 31, 1993. After that, telephone companies may charge a "reasonable" fee. However, any subscriber with a new number can request free blocking within 60 days after service begins.

Complaints: How to Handle Them

Under the Federal Communications Commission rule, the phone company can't disconnect your regular local or long-distance telephone service because of failure to pay a 900-number charge. However, you could be blocked from making future calls to 900 numbers for failure to pay legitimate pay-per-call charges. If you want to dispute a 900-number charge, follow the instructions given with your billing statement. It will tell whether you can dispute a charge by phone or whether you need to write a letter. The billing statement should list a local or toll-free telephone number you can call to learn more about your rights and responsibilities. You also can call to get the name and address of the 900-number service provider.

When disputing a charge, include the following information: your name and telephone number, the date and amount of the disputed charge, and the reason you believe the charge is in error. Even if your dispute is resolved by the billing agent,and the charge is removed from your phone bill, you still could be contacted by the pay-per-call service or by a debt collector.

If you are contacted by a debt collector, you have certain rights under federal law. For example, if you do not wish to be contacted again concerning the charge, you can write to the collection agency telling it not to contact you. Under the law, once the collection agency receives your letter, it cannot contact you again except to say there will be no further contact or that some specific action will be taken (if the debt collector or creditor intends to take such action).

Because the debt,if not resolved, can remain on your credit record, you also are legally entitled to dispute the report. Even if you are unsuccessful in having the disputed item removed by the credit bureau, you can have your account of the incident included in your credit report.

If you are having problems with a 900-number service, you may want to file a complaint with the FTC. Write: Correspondence Branch, Federal Trade Commission, Washington, D.C. 20580. While the Commission does not resolve individual disputes, complaints about 900-number scams help the FTC in its law enforcement efforts against companies.

Buying a Used Car

Consumer Information from the Federal Trade Commission

This year, more than 16 million Americans will buy a used car. If that's what you are planning, this brochure from the Federal Trade Commission (FTC) may help you. It explains your protections under the FTC's Used Car Rule and offers some shopping suggestions, even if you are not buying from a used car dealer.

Before you begin looking at used cars, think about what car models and options you want and how much you are able or willing to spend. You can learn about car models, options, and prices by reading newspaper ads, both display and classified. Also, your local library and book stores have magazines that discuss and compare car models, options, and costs, as well as provide information about frequency-of-repair records, safety tests, and mileage. The U.S. Department of Transportation Auto Safety Hotline (800-424-9393) will tell you if a car model has ever been recalled and send you information about that recall.

Before You Look For a Used Car, Consider

Costs. Remember, the real cost of a car includes more than the purchase price: it includes loan terms, such as interest rates and the length of the loan. If you plan to finance the car, you need to know how much money you can put down and how much you can pay monthly. Dealers and lending institutions offer a variety of interest rates and payment schedules, so you will want to shop for terms. If, for example, you need low monthly payments, consider making a large down payment or getting financing that will stretch your payments over five years, rather than the usual three. Of course, this longer payment period means paying more interest and a higher total cost.

Reliability. You can learn how reliable a model is by checking in publications for the frequency-of-repair records. Find out what models have repair facilities in a location convenient to you and if parts are readily available at the repair facility.

Dealer Reputation. Find out from experienced people whose opinions you respect which dealers in your area have good reputations for sales and service. You may wish to call your local consumer protection office and the Better Business Bureau to find out if they have any complaints against particular dealers.

If You Buy a Used Car From a Dealer

If you go to a dealer for a used car, look for a "Buyers Guide" sticker on the window of each car. The Buyers Guide, required by the Federal Trade Commission's Used Car Rule, gives you important information and suggestions to consider. The Buyers Guide tells you:

- Whether the vehicle comes with a warranty and, if so, what specific protection the dealer will provide;
- Whether the vehicle comes with no warranty ("as is") or with implied warranties only;
- That you should ask to have the car inspected by an independent mechanic before you buy;
- That you should get all promises in writing; and
- What some of the major problems are that may occur in any car.

The Used Car Rule requires dealers to post the Buyers Guide on all used vehicles, including automobiles, light-duty vans, and light-duty trucks. "Demonstrator" cars also must have Buyers Guides. But Buyers Guides do not have to be posted on motorcycles and most recreational vehicles. Individuals selling fewer than six cars a year are not required to post Buyers Guides.

Whenever you purchase a used car from a dealer, you should receive the original or an identical copy of the Buyers Guide that appeared in the window of the vehicle you bought. The Buyers Guide must reflect any changes in warranty coverage that you may have negotiated with the dealer. It also becomes a part of your sales contract and overrides any contrary provisions that may be in that contract.

As you read this brochure, you can refer to the Buyers Guide, shown on pages 6 through 8.

"As Is--No Warranty"

About one-half of all used cars sold by dealers come "as is," which means there is no express or implied warranty. If you buy a car "as is" and have problems with it, you must pay for any repairs yourself.

When the dealer offers a vehicle for sale "as is," the box next to the "As Is--No Warranty" disclosure on the Buyers Guide will be checked. If this box is checked but the dealer makes oral promises to repair the vehicle, have the dealer put those promises in writing on the Buyers Guide.

Some states (Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New York, Rhode Island, Vermont, West Virginia and the District of Columbia) do not permit "as is" sales for most or all used motor vehicles.

"Implied Warranties Only"

Implied warranties exist under all state laws and come with almost every purchase from a used car dealer, unless the dealer tells you in writing that implied warranties do not apply. Usually, dealers use the words "as is" or "with all faults" to disclaim implied warranties. Most states require the use of specific words.

"If the dealer makes oral promises, have the dealer put those promises in writing."

The "warranty of merchantability" is the most common type of implied warranty. This means that the seller promises that the product will do what it is supposed to do. For example, a car will run, a toaster will toast.

Another type of implied warranty is the "warranty of fitness for a particular purpose." This applies when you buy a vehicle on the dealer's advice that it is suitable for a particular use. For example, a dealer who suggests that you buy a specific vehicle for hauling a trailer warrants, in effect, that the vehicle will be suitable for hauling a trailer.

If you buy a vehicle with a written warranty, but problems arise that the warranty does not cover, you may still be protected by implied warranties. Any limitation on the duration of implied warranties must appear on the written warranty.

In those states that do not permit "as is" sales by dealers, or if the dealer offers a vehicle with only implied warranties, a disclosure entitled "Implied Warranties Only" will be printed on the Buyers Guide in place of the "As Is" disclosure. The box next to this disclosure would be checked if the dealer chooses to sell the car with implied warranties and no written warranty. A copy of the Buyers Guide with the "Implied Warranties Only" disclosure is shown on page 7.

Dealer Warranties

When dealers offer a written warranty on a used vehicle, they must fill in the warranty portion of the Buyers Guide. Because the terms and conditions of written warranties can vary widely, you may find it useful to compare warranty terms on cars or negotiate warranty coverage.

Dealers may offer a full or limited warranty on all or some of the systems or components of the vehicle. A "full" warranty provides the following terms and conditions:

- Warranty service will be provided to anyone who owns the vehicle during the warranty period when a problem is reported.
- Warranty service will be provided free of charge, including such costs as returning the vehicle or removing and reinstalling a system covered by the warranty, when necessary.
- At your choice, the dealer will provide either a replacement or a full refund if the dealer is unable, after a reasonable number of tries, to repair the vehicle or a system covered by the warranty.
- Warranty service is provided without requiring you to perform any reasonable duty as a precondition for receiving service, except notifying the dealer that service is needed.
- No limit is placed on the duration of implied warranties.

If any one of the above statements is not true, then the warranty is "limited." A "full" or "limited" warranty need not cover the entire vehicle. The dealer may specify only certain systems for coverage under a warranty. Most used car warranties are "limited," which usually means you will have to pay some of the repair costs. By giving a "limited" warranty, the dealer is telling you that there are some costs or responsibilities that the dealer will not assume for systems covered by the warranty.

If the dealer offers a full or limited warranty, the dealer must provide the following information in the "Warranty" section of the Buyers Guide:

- The percentage of the repair cost that the dealer will pay. For example, "the dealer will pay 100% of the labor and 100% of the parts";
- The specific parts and systems, such as the frame, body, or brake system that are covered by the warranty. The back of the Buyers Guide contains a list of descriptive names for the major systems of an automobile where problems may occur;
- The duration of the warranty for each covered system. For example, "30 days or 1,000 miles, whichever occurs first"; and
- Whether a deductible applies.

Under another federal law, the Magnuson-Moss Warranty Act, you have a right to see a copy of the dealer's warranty before a purchase. Examine the warranty carefully before you buy to see what is covered and what is not. It contains more detailed information than the Buyers Guide, such as a step-by-step explanation of hoax to obtain repairs if a covered system or component malfunctions. Also check who is legally responsible for fulfilling the terms of the warranty. If a third party is responsible, the best

way to avoid potential problems is to make sure that the third party is reputable and insured. You can do this by asking the company for the name of their insurer and then checking its performance record with your local Better Business Bureau.

Unexpired Manufacturer's Warranties

If the used vehicle is still covered by the manufacturer's original warranty, the dealer may include it in the "systems covered/duration" section of the Buyers Guide. This does not necessarily mean that the. dealer offers a warranty in addition to the manufacturer's. In some cases, a manufacturer's original warranty can be transferred to a second owner only upon payment of a fee. If you have any questions, ask the dealer to let you examine any unexpired warranty on the vehicle.

Service Contracts

When you buy a car, you may be offered a service contract, which you can buy for an extra cost. In deciding whether you want a service contract, consider:

- Whether the warranty that comes with your car already covers the same repairs that you would get under the service contract or whether the service contract protection begins after the warranty runs out. Does the service contract extend longer than the time you expect to own the car? If so, is the service contract transferable or is a shorter contract available?
- Whether the vehicle is likely to need repairs and their potential costs. The value of a service contract is determined by whether the cost of repairs is likely to be greater than the price you pay for the service contract protection.
- Whether the service contract covers all parts and systems of the car. Check out all claims carefully. Claims that coverage is "bumper to bumper" may not be entirely accurate.
- Whether there is a deductible required, and, if so, consider the amount and terms of the deductible.
- Whether the contract covers incidental expenses, such as towing and the costs of a rental car while your car is being serviced.
- Whether repairs and routine maintenance, such as oil changes, can be performed at locations other than the dealership from which you purchased the contract.
- Whether there is a cancellation and refund policy for the service contract, and what the costs are if you cancel.
- Whether the dealer or company offering the service contract is reputable. Read the contract carefully to determine who is legally responsible for fulfilling the terms of the contract. Some dealers sell service contracts that are backed by a third party. If a third party is responsible, you may wish to ask if the company is insured and to check the company's performance with your local Better Business Bureau.

If a service contract is offered, the dealer must mark the box provided on the Buyers Guide, except in those states that regulate service contracts under their insurance laws. If the Buyers Guide does not include a reference to a service contract, and you are interested, ask the salesperson whether one is available.

When you purchase a service contract from the dealer within 90 days of buying the vehicle, federal law prohibits the dealer from disclaiming implied warranties on the systems covered in that service contract. For example, if you buy a car "as is," the car normally will not be covered by implied warranties.

But if you buy a service contract covering the engine, you automatically get implied warranties on the engine, which may give you protection beyond the scope of the service contract. Make sure you receive a written confirmation that your service contract is in effect.

Spoken Promises

The Buyers Guide warns consumers not to rely on spoken promises. Oral promises are difficult, if not impossible, to enforce. Make sure all promises you want are written into the Buyers Guide and keep it.

Pre-Purchase Independent Inspection

The Buyers Guide also suggests you ask the dealer whether you may have the vehicle inspected by your own mechanic. Some dealers will let you take the car off the lot to get an independent inspection. Others may have reasons, such as insurance restrictions, for denying this request. In such a case, the dealer may permit you to bring an independent mechanic to the used car on the lot. A dealer who refuses to allow any independent inspection may be telling you something about the condition of the car. Remember, a good-looking car, or a car that comes with a warranty, does not necessarily run well. An independent inspection lets you find out about the mechanical condition of the vehicle before you buy it. Although an inspection fee by a mechanic may seem high, when you compare it to the price of the car, it can be worth the cost.

Vehicle Systems

The Buyers Guide includes a list of the 14 major systems of an automobile and some of the major problems that may occur in these systems. You may find this list helpful to evaluate the mechanical condition of the vehicle. The list also may be useful when comparing warranties offered on different cars or by different dealers.

Dealer Identification and Consumer Complaint Information

On the back of the Buyers Guide, you will find the name and address of the dealership. In the space below that, you will find the name and telephone number of the person at the dealership to contact if you have any complaints after the sale.

Spanish Language Sales

If you buy a used car and the sales talk is conducted in Spanish, you are entitled to see and keep a Spanish-language version of the Buyers Guide.

If You Buy a Used Car From a Private Party

Many cars are available privately, such as through classified ads in a newspaper. If you are shopping for a car from an individual, you should understand several differences between sales made by individuals and by dealers.

- Private sellers generally are not covered by the Used Car Rule and therefore, do not have to use the Buyers Guide. However, you still can follow the Guide's suggestions. For example, you can refer to the list of potential problems displayed on the back of the Buyers Guide shown in this brochure. In addition, ask the seller whether you may have the vehicle inspected by your own mechanic and whether you may take it on a test drive.
- Private sales usually are not covered by the "implied warranties" of state law. So, a private sale probably will be on an "as is" basis, unless your contract with the seller specifically provides otherwise. If you have a written contract, the seller must live up to the promises stated in the contract.

"An independent inspection lets you find out about the mechanical condition of the vehicle before you buy it."

Depending on its age, the car also may be covered by a manufacturer's warranty or a separately purchased service contract. However, warranties and service contracts may not be transferable, or there may be limitations or costs for a transfer. Before you purchase the car, ask the seller to let you examine any warranty or service contract on the vehicle.

Many states require that dealers, but not individuals, insure that their vehicles will pass state inspection or carry a minimum warranty before they offer them for sale. Ask your state's attorney general's office or a local consumer protection office about the requirements on individuals and on dealers in your state.

Before You Buy Any Used Car

If you are interested in a particular car, ask the dealer or owner if you can take it on a test drive. Try to drive the car under many different conditions, such as on hills, highways, and in stop-and-go traffic.

You also may want to ask the dealer or owner whether the car has ever been in an accident. Find out as much as you can about the car's prior history and maintenance record. Getting an independent inspection by an experienced mechanic is a good idea before purchasing any used car.

Be prepared to negotiate. Many dealers and individuals are willing to bargain on price and/or on warranty coverage.

If You Have Problems

If something goes wrong with your car and you think that it is covered by a warranty (either express or implied) or a service contract, refer to the terms of the warranty or contract for instructions on how to get service. If a dispute arises concerning the problem, there are several steps you can take.

Try To Work It Out With The Dealer

First, try to resolve the problem with the salesperson or, if necessary, speak with the owner of the dealership. Many problems can be resolved at this level. However, if you believe that you are entitled to service, but the dealer disagrees, you can take other steps.

If your warranty is backed by a car manufacturer and you have a dispute about either service or coverage, contact the local representative of the manufacturer. This local or "zone" representative has the authority to adjust and make decisions about warranty service and repairs to satisfy customers.

Some manufacturers also are willing to repair certain problems in specific models free of charge, even if the manufacturer's warranty does not cover the problem. Ask the manufacturer's zone representative or the service department of a franchised dealership that sells your car model whether there is such a policy.

Other Approaches You Can Try

If you cannot get satisfaction from the dealer or from a manufacturer's zone representative, contact the Better Business Bureau or a state agency, such as the office of the attorney general, the department of motor vehicles, or a consumer protection office. Many states also have county and city offices that intervene or mediate on behalf of individual consumers to resolve complaints.

You also might consider using a dispute resolution organization to arbitrate your disagreement if you and the dealer are willing. Under the terms of many warranties, this may be a required first step before you can sue the dealer or manufacturer. Check your warranty to see if this is the case. If you bought your car from a franchised dealer, you may be able to seek mediation through the Automotive Consumer Action Program
(AUTOCAP), a dispute resolution program coordinated nationally by the National Automobile Dealers Association and sponsored through state and local dealer associations in many cities. Check with the dealer association in your area to see if they operate a mediation program.

If none of these steps is successful, you can consider going to small claims court, where you can resolve disputes involving small amounts of money for a low cost, often without an attorney. The clerk of your local small claims court can tell you how to file a suit and what the dollar limit is in your state.

The Magnuson-Moss Warranty Act also may be helpful. Under this federal law, you can sue based on breach of express warranties, implied warranties, or a service contract. If successful, consumers can recover reasonable attorney's fees and other court costs. A lawyer can advise you if this law applies to your situation.

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(202) 326-2222
TDD: (202) 326-2502

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Atlanta, Georgia 30367
(404) 347-4836

10 Causeway Street
Boston, Massachusetts 02222
(617) 565-7240

55 East Monroe Street
Chicago, Illinois 60603
(312) 353-4423

668 Euclid Avenue
Cleveland, Ohio 44114
(216) 522-4207

100 N. Central Expressway
Dallas, Texas 75201
(214) 767-5501

1405 Curtis Street
Denver, Colorado 80202
(303) 844-2271

11000 Wilshire Boulevard
Los Angeles, California 90024
(213) 209-7575

150 William Street
New York, New York 10038
(212) 264-1207

901 Market Street
San Francisco, California 94103
(415) 744-7920

915 Second Avenue
Seattle, Washington 98174
(206) 553-4656

Auto Service Contracts

Facts for Consumers from the Federal Trade Commission

Buying a car? You also may be encouraged to buy an auto service contract to help protect against unexpected, costly repairs.

While that may sound like a good idea, do not answer "yes" until you fully understand both the terms of the contract and, just as important, who is responsible for providing the coverage.

This fact sheet explains what an auto service contract is, and suggests some important questions to ask before buying one. It also discusses warranty protection that may come with both new and used cars.

The Auto Service Contract: Not a Warranty

Although a service contract is sometimes called an "extended warranty," it is not a warranty as defined by federal law. Like a warranty, a service contract is a promise to perform (or pay for) certain repairs or services.

However, a warranty comes with a new car and is included in the original price, whereas a service contract may be arranged at any time and always costs extra. It is the separate and additional cost that primarily distinguishes a service contract from a warranty.

The Terms: Questions to Ask

To help decide whether to buy an auto service contract, you might consider asking the service contract provider the following questions.

Does the service contract duplicate any warranty coverage?

Do not buy a service contract until you compare it with the manufacturer's warranty or you could be paying for coverage you already have. Most new cars come with a manufacturer's warranty, which usually offers coverage for at least one year or 12,000 miles. Today some warranties last much longer. Even used cars may come with some type of coverage (see pages 6-7). You may decide to buy a "demonstrator"--a car that has never been sold to a retail customer but has been driven for purposes other than test drives. If so, be sure to ask when warranty coverage begins and ends. It could start when you purchase the car, or it might have begun earlier, when the dealer put the car into service. Again, it is important to know how much coverage you have before you consider buying a service contract.

Who backs the service contract?

Make sure you understand who is liable either to perform or pay for repairs under the contract's terms. It may be the manufacturer, the dealership, or an independent company.

Many service contracts sold by dealers are actually handled by independent companies, called administrators. These administrators act as claims adjusters, authorizing the payment of claims to any dealers under the contract. Therefore, if you have a dispute over whether a claim should be paid, you should deal with the administrator. If the administrator goes out of business, the dealership still may be obligated to perform under the contract. The reverse also may be true. If the dealer goes out of business, the administrator may be required to fulfill the terms of the contract. Whether you have recourse depends on your contract's terms and/or your state's laws.

It is important to learn about the reputation of the dealer and/or administrator. Ask for references and check them. You also can contact your local or state consumer protection office, state Department of Motor Vehicles, local Better Business Bureau, or local automobile dealers association to find out if they have public information on the firms. Look for the phone numbers and addresses in your telephone directory.

Be sure to find out how long the dealer or administrator has been in business, and try to determine whether they have the financial resources to meet their contractual obligations. Individual car dealers or dealer associations may set aside funds or buy insurance to cover future claims. Some independent companies are insured against a sudden rush of claims. You also should find out if the auto service

contract is underwritten by an insurance company. In some states, this is required. If the contract is backed by an insurance company, contact your State Insurance Commission to ask about the solvency of the company and whether any complaints have been filed against it. How much does the auto service contract cost?

Usually, the price of the service contract is based on the car make, model, condition (new or used), what is covered, and the length of the contract. The upfront cost can range anywhere from several hundred dollars to more than $1000. In addition to this initial charge, you may need to pay another fee, called a deductible, each time your car is serviced or repaired. Under some service contracts, you pay one charge per visit for all repairs--no matter how many. Other contracts, however, require you to pay a deductible for each unrelated repair.

You also may need to pay transfer or cancellation fees if you sell your car or wish to end the contract. Often, contracts limit the amount paid for towing or related rental car expenses.

What is covered and not covered?

Few auto service contracts cover all repairs. Common repairs for such parts as brakes and clutches generally are not included in service contracts. If the service contract does not list an item, assume it is not covered. For example, if the contract covers the "drive train" only, it will not cover the alternator (a part of the electrical system).

Watch out for absolute exclusions that deny coverage for any reason. For example:

If a covered part is damaged by a non-covered component, the claim may be denied.

If the contract specifies that only "mechanical breakdowns" will be covered, problems caused by "normal wear and tear" may be excluded.

If the engine must be taken apart to diagnose a problem and it is discovered that non- covered parts need to be repaired or replaced, you may have to pay for the labor involved in the teardown and re-assembling of the engine. Even for parts that are covered in the contract, you may not have full protection. Some companies use a "depreciation factor" in calculating coverage. This means the company may pay only partial repair or replacement costs if, for example, they take into account your car's mileage.

How are claims handled?

When your car needs to be repaired or serviced, you may be able to choose among several service dealers or authorized repair centers. Or, you may be required to return the vehicle to the purchasing dealer for service, which could be inconvenient if you bought the car from a dealership in another town.

Find out if your car will be covered if it breaks down while you are using it on a trip or if you take it when you move out of town.

Some auto service contract companies and dealers offer service only in a specific geographical area.

For any repair work or towing services, you may need prior authorization from the contract provider. If so, be sure to ask: how long it takes to get such authorization, whether you can get authorization outside of normal business hours if, for example, your car breaks down on a weekend. whether the company has a toll-free number or if you must call long-distance for authorization. (You may want to test the toll-free number before you buy the contract to see if you can get through easily.)

You may be required to pay for covered repairs and then wait for the service company to reimburse you. If the auto service contract does not specify how long reimbursement usually takes, be sure to ask. You also should find out who arbitrates or settles claims in case you ever have a dispute with the service contract provider and need to use a dispute resolution program.

Are new or reconditioned ("like") parts authorized for use in covered repairs?

If this concerns you, ask. Some consumers are disappointed when they find out "reconditioned" engines are being used as replacement parts under some service contracts. Also ask whether the authorized repair facility maintains an adequate stock of parts. Repair delays may occur if authorized parts are not readily available and must be ordered.

What are your responsibilities?

Under the contract, you may have to follow all of the manufacturer's recommendations for routine maintenance, such as getting oil and spark plug changes periodically. Failure to do so could void the contract. To prove you have maintained the car properly, you may have to keep detailed records, including sales receipts.

Find out if the contract prohibits either taking the car to an independent station for routine maintenance, or performing the work yourself. The contract may specify that the selling dealer is the only authorized facility for servicing the car.

What is the length of the service contract?

If the service contract lasts longer than you expect to own the car, find out if it can be transferred when you sell the car, or if a shorter contract is available. Remember, there may be a fee for transferring the contract to another owner.

Used Cars: Warranty Protection

When shopping for a used car, look for a Buyers Guide sticker posted on the car's side window. This sticker is required by the FTC on all used cars sold by dealers. It tells whether a service contract is available. It also indicates whether the vehicle is being sold with a warranty, with implied warranties, or "as is." Warranty. If the manufacturer's warranty is still in effect on the used car, you may have to pay a fee to obtain coverage, making it a service contract. However, if the dealer absorbs the cost of the manufacturer's fee, the coverage is considered to be a warranty.

Implied warranties only. There are two common types of implied warranties. Both are unspoken and unwritten and based on the principle that the seller stands behind the product. Under a "warranty of merchantability," the seller promises the product will do what it is supposed to do. For example, a toaster will toast, a car will run. If the car doesn't run, implied- warranties law says that the dealer must fix it (unless it was sold "as is") so that the buyer gets a working car. A "warranty of fitness for a particular purpose"; applies when you buy a vehicle on a dealer's advice that it is suitable for a certain use, for example, hauling a trailer.

Used cars usually are covered by implied warranties under state law.

As Is - No Warranty. If you buy a car "as is," you must pay for all repairs, even if the car breaks down on the way home from the dealership. However, if you buy a dealer-service contract within 90 days of buying the used car, state law "implied warranties" may give you additional rights.

Some states prohibit "as is"; sales on most or all used cars. Other states require the use of specific words to disclaim implied warranties. To find out about your state laws, check with your local or state consumer protection office or attorney general.

Other Tips: Problems to Avoid

If you are told you must purchase an auto service contract to qualify for financing, contact the lender yourself to find out if this is true. Some consumers have had difficulty canceling their service contract after discovering the lender did not require one.

If you decide to buy a service contract through a car dealership--and the contract is backed by an administrator and/or a third party--make sure the dealer forwards your payment and gives you written confirmation. Some consumers have discovered too late that the dealership failed to forward their payment, leaving them with no coverage months after they signed a contract.

Contact your local or state consumer protection office if you have reason to believe that your contract was not put into effect as agreed.

In some states, service contract providers are subject to insurance regulations. Find out if this is true in your state. Insurance regulations generally require companies to:

maintain an adequate financial reserve to pay claims.

base their contract fees on expected claims. (Some service providers have been known to realize huge

profits because the cost of their contracts far exceed the cost of repairs or services they provide.)

seek approval from the state insurance office for their premium amounts, or contract fees.

Complaints: How to Handle Them

To report contract problems with a service provider, contact your local and state consumer protection agencies, including the state insurance commissioner and state attorney general. You also can contact the FTC. Write: Correspondence Branch, Federal Trade Commission, Washington, DC 20580. Although the FTC generally does not intervene in individual disputes, the information you provide may indicate a pattern of possible law violations requiring action by the Commission.

Car Ads: Low Interest Loans and Other Offers

Facts for Consumers from the Federal Trade Commission

Car Ads: Low Interest Loans; Other Offers

Many new car dealers have been advertising unusually low interest rates and other special promotions such as high trade-in allowances and free or low-cost options. While these advertisements may help you shop, finding the best deal requires careful comparison.

There are many factors that determine whether a special offer provides genuine savings. The interest rate, for example, is only part of the car dealer's financing package. Other terms, such as the size of the downpayment, also affect the total financing cost. Be sure to consider all aspects of a financing plan before you sign a contract.

When considering an advertised special, read the ad carefully and all or visit the dealer to find out about all the terms and conditions of the offer. Then compare the specials advertised by other dealers.

Questions About Low Interest Loans

Listed below are some financing questions you should consider when talking to dealers.

Will you be charged a higher price for the car to qualify for the low-rate financing? Would the price be lower if you paid cash, or supplied your own financing from your bank or credit union?

Does the financing require a larger-than-usual downpayment? Perhaps 25 or 30 percent?

Are there limits on the length of the loan? In other words, are you required to repay the loan in a shorter period of time, such as 24 or 36 months?

Do you have to buy special or extra merchandise or services such as rustproofing, an extended warranty, or a service contract to qualify for a low interest loan?

Is the financing available for a limited time only? Some merchants limit special deals to a few days or require that you take delivery by a specified date.

Does the low rate apply to all cars in stock or only to certain models?

Are you required to give the dealer the manufacturer's rebate (if one is offered) to qualify for financing?

Questions About Other Promotions

Other special promotions include high trade-in allowances and free or low-cost options. Some dealers also promise to sell you a car for a stated amount over the dealer's invoice. The following questions can help you determine if such special promotions offer genuine value.

Does the advertised trade-in allowance apply to all cars, regardless of their condition? Are there any deductions for high mileage, dents, or rust?

Does the larger trade-in allowance make the cost of the new car higher than it would be without the trade-in? You might be giving back the big trade-in allowance by paying more for your new car.

Is the dealer who offers high trade-in allowance and free or low-cost options actually giving you a better price on the car than another dealer who does not offer such promotions?

Does the "dealer's invoice" reflect the actual amount that the dealer pays the manufacturer? You can consult consumer or automotive publications for information about what the dealer pays.

Does the "dealer's invoice" include the cost of options, such as rustproofing or waterproofing, that already have been added to your car? Is the dealer charging more for these options than other dealers?

Does the dealer have cars in stock without expensive added options? If not, will the dealer order one for you?

Are the special offers available if you order a car instead of buying one off the lot?

Can you take advantage of all special offers simultaneously?

Remember, you are not limited to financing offered by the dealer. You may wish to see what type of loan you can arrange with your bank or credit union.

Once you decide which dealer offers the car and financing you want, read the invoice and the installment contract carefully. Check to see that all the terms of the contract reflect the agreement you made with the dealer. If they differ, get a written explanation before you sign. Careful shopping will help you decide what financing, car, and options are best for you.

Car Financing Scams

Facts for Consumers from the Federal Trade Commission

Car Financing Scams

When buying a car, don't be misled by cost comparisons between financing and paying cash.

Many car dealers now use fancy computer printouts to show that financing a car is a better deal than paying cash for it. Beware. The numbers may look good, but the bottom line isn't. Although there may be good reasons to finance a car or other expensive items, it's not usually because it saves money. Be skeptical, then, if an auto dealer claims that financing costs you less than paying cash. Information telling the whole story may be missing.

How Much Will It Cost?

The Federal Trade Commission (FTC) has taken action against a company that distributed computer software used to misrepresent the "savings" of financing versus paying cash for a car. Many auto dealerships across the country may be using similar software.

The computerized cost comparison seems to "prove" you can save money by financing at one rate and investing the cash not spent in a certificate of deposit (CD) at a lower rate. But can you really come out ahead by borrowing at one rate and investing at a lower rate?

No! This comparison leaves out a crucial point.

When you pay cash, you have no monthly payments to make. If each month you invest an amount equal to the car payment, the total you accumulate will be more than the value of the CD described above. In the end, paying interest on a loan always costs you more - unless you can invest your cash at an interest rate higher than the loan rate.

Why Finance Your Car or Other Purchases?

You may, however, find it advantageous to finance your car. Many car buyers prefer taking out loans to paying cash for any of the following reasons.

You may need your cash for other purposes, such as paying for other products or services, maintaining a better cash flow, or building a "cash cushion" for such things as emergencies or college tuition.

You may be able to buy a more expensive car by using financing.

Under some circumstances, if you finance a car that develops serious problems, you may not have to continue making payments.

Be aware, however, that car salesmen may be earning commissions when they convince you to finance a car through their dealership. Think carefully, then, about any claims that financing a car can save you money.

If you have questions or problems about the way auto dealers present cost comparisons between financing and paying cash, you may want to contact your local or state consumer protection agency or your state attorney general. You also can contact the National Fraud Information Center at 1-800-876-7060 (9:00 a.m. - 5:30 p.m., EST, Monday - Friday). NFIC will forward all appropriate information to the FTC.

Truth in Leasing

Facts for Consumers from the Federal Trade Commission

Are you wondering whether leasing your next car would be a good idea?

OR

Would you rather lease than buy furniture for an apartment you'll use for only a year?

When leasing looks like a good option, there's a federal law that will help you shop for the best deal. The Consumer Leasing Act requires leasing companies to tell you the facts about the cost and terms of their contracts. You can use the information to compare one lease with another or to compare the cost of leasing with the cost of buying the same property. The law also limits any extra payment you may have to make at the end of a lease and regulates lease advertising. This brochure describes the Consumer Leasing Act and the regulation issued by the Federal Reserve Board to carry it out.

What leases are covered?

The law applies to personal property leased by an individual for a period of more than four months for personal, family, or household use. It covers long-term rentals of cars, furniture, appliances, and other personal property.

The law does not cover:

daily car rentals or month-to-month rentals that you can cancel without penalty at the end of the month; leases for apartments or houses -- or furniture that comes with a rented apartment; property leased to companies or to individuals for business use.

What about costs?

Before you agree to a lease, the law requires that you get a written statement of its costs, including: the amount of any advance payment, such as a security deposit; the number, the amount, and the dates your regular payments are due, as well as the total amount of those payments; and the amount you must pay for license, registration and taxes, and for any other fees, such as maintenance.

What about terms of the lease?

You must also be told certain terms of the lease, including:

what kind of insurance you need;

any express warranty on the property;

who is responsible for maintaining and servicing the property, and any standards for wear and tear (which must be reasonable) set by the leasing company;

any penalty for default or late payment;

how you or the leasing company may cancel the lease and the charges for doing so; and

whether or not you can buy the property and, if you can, when and at what price.

What are open end leases and balloon payments?

One decision that will affect leasing costs and terms is whether you choose an "open end"; (or "finance") or "closed end" lease. In an open end lease, you run the risk of owing extra money depending on the value of the property when you return it. This payment is often called a "balloon payment." For example, when you sign a three-year open end car lease, the leasing company may estimate that the car will be worth $4,000 after three years of normal use. If the car is worth only $3,300 when you return it, you may have to pay a $700 balloon payment.

In a closed end lease, you are not responsible for the value of the property when you return it and will not have to make a balloon payment. As a result, closed end leases usually have higher monthly payments than open end leases.

You should know that in an open end lease:

The leasing company must tell you that you may have a balloon payment and how it is calculated. At the end of the lease you have the right to obtain an estimate of the property's worth from an independent appraiser. Both parties must abide by the estimate.

Limits on Balloon Payments. You should also know that the law limits a balloon payment in an open end lease to no more than three times the average monthly payment -- unless you agree to make a higher payment or you have used the property more than average (for example, if you put more than average mileage on a car). The leasing company may also seek a larger payment by going to court. If it goes to court, the company has the burden of proving that its original estimate of the value of the property, although wrong, was reasonable and made in good faith. The company must pay your attorney's fees in such a lawsuit, whether or not it wins.

How do I shop for a lease?

First, decide whether you want to buy with cash, buy on credit, or lease. When making your decision, be sure to take into account such expenses as the cost of insurance, maintenance, and special fees.

To help you compare the cost of buying on credit with the cost of open end leasing, you must be told the total amount you are responsible for under the lease, the value of the property at the beginning of the lease, and the difference between the two. For example, a three-year open end car lease might show:

36 monthly payments of $225 $ 8,100 + Estimated value of car at end of lease 4,000 Amount you are responsible for under lease 12,100 - Value of car at beginning of lease 10,700 Difference $ 1,400

You could compare this "difference" of $1,400 with the finance charge you would pay if you bought the car on credit.

If you decide to lease, shop around for the best price and terms. Your overall costs will be lower if you bargain for the lowest lease price, just as you would to purchase the car for cash or credit. If you don't bargain, you won't get the lowest price, which affects other lease costs. Compare the costs and advantages of open end and closed end leases, and look at such options as whether the leasing company will pay for repairs and maintenance.

What about advertising?

The law also regulates the advertising of leases. If a leasing company advertises the amount or number of payments or that any or no downpayment is required, it must also mention several other important terms, including the total of regular payments, your responsibilities at the end of the lease, and whether or not you may purchase the property. This is to make sure you receive enough information from the advertisement to understand the offer and to compare it with others.

What are the penalties?

You as an individual may sue a leasing company if it fails to give you the required information or does so improperly. You may sue for 25 percent of the total of the monthly payments (but not less than $100 or more than $1000) plus any actual damages. If an advertisement violates the law, you may sue the leasing company for your actual damages. In any successful lawsuit, you are also entitled to court costs and reasonable attorney's fees. You must file your suit within one year of the termination of the lease agreement. The law also provides criminal penalties for intentional violators.

For More Information

A number of Federal agencies are responsible for enforcing the Consumer Leasing Act. The Federal Trade Commission (FTC) enforces the law for almost all leasing companies other than banks. Questions or complaints can be sent to the nearest FTC Regional Office (listed below), or, if they concern national companies, to: Correspondence Branch, Federal Trade Commission, Washington, D.C. 20580. The Commission does not represent individual consumers in private disputes, but information from consumers as to their experiences and concerns is vital to its enforcement of the Consumer Leasing Act.

FTC Regional Offices

1718 Peachtree Street N.W., Suite 1000 Atlanta Georgia 30367 (404) 347-4836

10 Causeway Street, Suite 1184 Boston, Massachusetts 02222-1073 (617) 565-7240

55 East Monroe Street, Suite 1437 Chicago, Illinois 60603 (312) 353-4423

668 Euclid Avenue, Suite 520-A Cleveland, Ohio 44114 (216) 522-4207 100 N. Central Expressway, Suite 500 Dallas, Texas 75201 (214) 767-5501

1405 Curtis Street, Suite 2900 Denver, Colorado 80202-2393 (303) 844-2271

11000 Wilshire Boulevard, Suite 13209 Los Angeles, California 90024 (310) 575-7575

150 William Street, Suite 1300 New York, New York 10038 (212) 264-1207

901 Market Street, Suite 570 San Francisco, California 94103 (415) 744-7920

2806 Federal Building 915 Second Avenue Seattle, Washington 98174 (206) 220-6363

If you wish to file a complaint about a financial institution, contact the appropriate Federal agency listed below. National Banks

Comptroller of the Currency Compliance Management Mail Stop 7-5 Washington, D.C. 20219

State Member Banks of the Federal Reserve System Board of Governors of the Federal Reserve System Consumer and

Community Affairs 20th & C Sts., N.W. Washington, D.C. 20551 Non-Member Federally Insured Banks Federal Deposit

Insurance Corporation Office of Consumer Programs 550 Seventeenth St., N.W. Washington, D.C. 20429

Federally Insured Savings and Loans, and Federally Chartered State Banks Office of Thrift Supervision Consumer Affairs Program 1700 G St., N.W. Washington, D.C. 20552

Federal Credit Unions National Credit Union Administration 1776 G St., N.W. Washington, D.C. 20456

Car Rental Guide

Facts for Consumers from the Federal Trade Commission

When you go to rent a car, you may be puzzled by some terms car-rental agents use, such as collision damage waivers and drop-off fees. This fact sheet explains such industry terms, and also provides a checklist and worksheet to help you choose the rental car best suited for your needs. (We apologize that the worksheet is not available on-line. To obtain a copy of the worksheet, please request a free copy of the brochure by contacting: Public Reference, Federal Trade Commission, Washington, D.C. 20580; (202) 326-2222. TDD call (202) 326-2502.)

Choosing a Car-Rental Company Before you reserve a car, know what model and options you want or need and how much you are willing to spend. In that way, you are less likely to feel pressured into making a hasty or expensive decision that you may regret later. Before you choose, you may want to take the following steps.

Call several car-rental companies and get price estimates. Many companies have toll-free numbers, and many offer weekly and weekend specials. Watch the newspaper ads and ask about advertised specials. If your business or vacation plans permit flexibility, you may be able to save money by renting a car when you can get a price break. Be sure to ask about any restrictions on special offers, including blackout dates, when an advertised special price is unavailable.

Decide on what model and size car you want, but realize that each car-rental company has its own vehicle classification system. The terms "compact," "mid-size," and "luxury" sometimes differ among companies.

Know that there may be additional fees that could substantially increase an advertised base rate. These costs might include: collision damage waiver fees, in states that allow them; a refundable charge; airport surcharges and drop-off fees; fuel charges; mileage fees; taxes; additional-driver fees; under-age driver fees; out-of-state charges; and equipment-rental fees, for items such as ski racks and car seats. To understand the meaning of these charges, check the definitions given below. To help you compare the cost of these additional fees, refer to the worksheet on pages 6-7.

Learning the Terms

The glossary listed here defines charges that are frequently added to the quoted base rental rate. Asking about these charges before you sign your rental agreement may help you save money on your trip and avoid disputes when it is time to pay the bill.

Collision Damage Waiver (CDW), in states that allow it, is an option charge of $9 to $13 a day. Car-rental agents may use hard-sell tactics to convince you to buy it. Although they call it "collision damage" coverage, technically it is not collision insurance. Rather, it is a "guarantee" that you buy from the car-rental company that it will pay for damages to your rented car. However, under CDW, the rental company will not pay for bodily injuries or damages to your personal property. If you do not buy CDW coverage or are not covered by your own auto insurance policy, you could be liable for the full value of the car. Other companies will hold you liable for the first $1,000 to $2,000.

Some CDWs exclude coverage under certain circumstances. For example, coverage may be revoked if you damage the car when driving in a negligent manner, on unpaved roads, or out of the state in which you rented the vehicle. Some companies void their CDW coverage if a driver drinks alcoholic beverages or if someone is driving other than the one authorized on the rental contract. The coverage offered by car-rental companies may duplicate what is already provided by your auto and homeowners's insurance policies. If you are concerned about bodily injuries, coverage under your medical plan would offer protection that CDW coverage lacks. Check your policies and medical plan. If you are traveling on business, your employer may have insurance that covers you. Also, some credit-card companies and motor clubs provide their members free rental protection when they use the card to pay for the rental.

In addition to CDW coverage, a car-rental company also may offer:

Personal-accident insurance (PAI), at a daily cost of between $1.50 and $4.00, insures against death and

at least part of your medical expenses if you are involved in an accident.

Personal-effects coverage (PEC), also known as personal-effects protection (PEP), safeguards your luggage against damage at an average daily cost of $1.25. You may not need this protection if your homeowner's policy already covers your luggage and other belongings when you are traveling.

A Refundable Charge may be required when you pick up your car. The charge varies, but may cost hundreds of dollars. Most companies make the charge to your credit card but do not process the amount against your account unless you do not return the car, as specified in your rental contract. What you need to remember is that, until you return the car, the spending limit on your card may be reduced by the amount of the deposit. This may be important if you are on vacation, intend to place large charges for hotels and other items on your credit-card account, and are approaching your credit limit on your card. If you do not have a major credit card, or do not wish to charge the deposit to your account, companies may ask for the amount in cash.

Airport Surcharges and Drop-off Fees can add considerably to a base rental rate. Surcharges apply when airport authorities impose fees for airport use even when car-rental companies shuttle you to an off-airport site. Drop-off charges refer to fees that some companies charge to allow you to drop the car at a location different from your pick-up point.

A Fuel Charge is the amount many rental companies add to your bill for gasoline. Some companies give you a half-tank at a charge of $10 to $15 and tell you to return the car empty; others initially fill the tank and charge for the amount of gas you use. Companies that do not charge you for the initial tank of gas may ask you to return the car with a full tank. If you do not refuel the car, you will be charged the rental company's price for gasoline, which is often much higher than you would find at a local station.

Mileage Fees are usually assessed on a cents-per-mile basis or a flat fee when you exceed the allotted free mileage cap. Knowing approximately how far you will drive will help you select the company that offers you the most favorable mileage terms. Taxes, of course, are levied by states and some local municipalities. But you might save some costs if, for example, you pick up your rental car at a suburban location, so as not to be subject to a higher tax rate of an urban pick-up site.

Additional-Driver Fees and Under-Age Driver Fees, costs that a company assesses when you share the driving with a companion or when the driver is under a certain age (often 25), can add a daily charge to your base rental rate.

Out-of-State Charges, as the name suggests, are fees a company adds when you drive the car out of the state where you rented it. Equipment-Rental Fees are costs that a company assesses when you order such extras as ski racks and car seats. If these items are important to you, be sure to request them in advance.

Checklist for Renting a Car

As mentioned earlier, you are likely to negotiate a better deal if you know what kind of car you want and what you want to spend. Here are some other check points that may save you money.

Determine where you will pick up and drop off the car and if these locations are without special fees.

Find out about any blackout dates that could affect an advertised special.

Ask about the weekly rate if you are considering a rental for more than four days. The daily rate for rentals of more than four days, but less than seven, is often higher than renting a car at the weekly rate.

Ask about mandatory additions to the quoted price, such as mileage rates and caps, airport surcharges, and taxes.

Ask about charges for optional CDW, PAI, and PEC coverage. Find out if your own auto insurance policy covers rental cars and the conditions of the coverage.

Ask about other optional charges, such as additional-driver fees, under-age driver fees, out-of-state charges, and equipment-rental fees.

Caskets and Burial Vaults

Facts for Consumers from the Federal Trade Commission

When a loved one dies, difficult and sometimes costly decisions about a funeral have to be made quickly, often under great emotional stress. Your emotional state may dictate decisions not in your best interest. You may want to consult with a disinterested person, perhaps a clergyman or an experienced friend, if you feel unable to objectively evaluate a funeral provider's products and services.

For example, sometimes manufacturers of caskets and burial vaults give to the funeral providers promotional materials that may appeal to the desire to protect the physical remains of the deceased. They may do this by making false or exaggerated claims about the durability of their products. They may make insupportable claims that their products are "waterproof" or impermeable to the elements. The Federal Trade Commission (FTC) has issued orders against some manufacturers, prohibiting them from making such false or deceptive durability claims.

This brochure discusses caskets and burial vaults, their use, and their protective claims. It also briefly discusses the option of funeral pre-planning, and lists organizations you may contact for further information.

Caskets

A casket, also called a coffin, is frequently the single most expensive funeral item you may have to buy if you are planning a traditional funeral. A casket is not required for a direct cremation or an immediate burial. With the latter, the body is generally buried without viewing or embalming and is generally placed in an alternative container made of unfinished wood, pressboard, cardboard, or canvas.

Caskets vary widely in style and price and typically are sold for their visual appeal. They generally are made of metal or wood, although some are constructed of fiberglass or plastic. Most metal caskets are made from rolled steel in different gauges -- the lower the gauge, the thicker the steel. Wooden caskets come in hardwood, softwood and plywood.

The terms "gasketed," "protective," and "sealer" are frequently used to describe a metal casket. These terms mean that the casket has a rubber gasket or other features that delay the penetration of water and prevent rust. Some metal caskets come with a warranty for longevity. Protective features in caskets add to their cost.

Unlike metal caskets, wooden caskets generally are not gasketed and do not carry a warranty for longevity. However, manufacturers of both wooden and metal caskets usually warrant workmanship and materials.

Burial Vaults or Grave Liners

Often, cemeteries require a burial vault or a grave liner to enclose the casket in a grave. The casket is placed into either a vault or a liner to prevent the ground from caving in as the casket deteriorates. A grave liner, also called a "rough box," is made of reinforced concrete and lowered into the grave prior to burial. A burial vault is more substantial and expensive than a grave liner, is typically sold for its visual appeal, and is usually gasketed. Most vaults are constructed of steel-reinforced concrete and lined with other materials, including plastic. Like some caskets, the vault may be sold with a warranty of protective strength.

Preservative and Protective Claims

Under the FTC's Funeral Rule, funeral providers are prohibited from making claims that funeral goods, such as caskets or vaults, will keep out water, dirt, and other gravesite substances when that is not true. The Rule also prohibits funeral providers from telling you a particular funeral item or service can indefinitely preserve a body in the grave. Such claims are untrue.

Pre-planning Funerals

Decisions about purchasing funeral goods and services are often made when people are grieving and under time constraints. For this reason, some people choose to prearrange a funeral. If you are

considering prearranging a funeral for yourself or for a loved one, ask funeral directors about the different types of dispositions and ceremonies available. At the same time, scrutinize claims made by the manufacturers of such products as caskets and burial vaults.

The FTC's Funeral Rule requires funeral directors to itemize prices and provide consumers with price lists, and price information over the phone, which are essential for comparing costs.

If you are considering pre-paying for funeral goods and services, there are a number of issues to consider and questions to ask before pre-paying for funeral arrangements.

Be sure you know what you are paying for. Are you buying only merchandise, such as a casket and vault, or are you purchasing funeral services as well?

What happens to money you have pre-paid? Some states have different requirements concerning the handling of funds paid for pre-arranged funeral services.

What happens to the interest income on money that is pre-paid and put into a trust account?

Are you protected if the firm with which you are doing business should go out of business?

Can you cancel the contract and get back any money you have pre-paid if you should change your mind about the pre-planned funeral?

What if you should move to a different area or death occurs away from home? Some pre-paid funeral plans can be transferred, but often there is an added cost in doing so.

In addition, it is important to keep copies of any documents that you sign or that are given to you at the time pre-arrangements are made. It also is especially important to inform family members about such plans and arrangements and the whereabouts of these documents.

For More Information

Most states have a licensing board that regulates the funeral industry. You may contact the licensing board in your state for information or help. You also may contact the Conference of Funeral Service Examining Boards, 15 Northeast 3rd Street, P.O. Box 497, Washington, Indiana 47501, (812) 254-7887. The Conference, which represents licensing boards in 47 states, provides information on laws in various states and responds to consumer inquiries or complaints about funeral providers. You also may contact the Funeral Service Consumer Assistance Program (FSCAP). This is a program designed to assist consumers and funeral directors in resolving disagreements about funeral service contracts. FSCAP is a service of the National Research and Information Center, an independent, nonprofit organization that researches and provides consumer information on death, grief, and funeral service. You may contact FSCAP at 2250 E. Devon Avenue, Suite 250, Des Plaines, Illinois 60018, 1-800-662-7666.

The American Association of Retired Persons (AARP) is another source of information. AARP is a nonprofit, nonpartisan organization dedicated to helping older Americans achieve lives of independence, dignity and purpose. AARP publishes Funeral Goods and Services and Pre-Paying Your Funeral? These publications are available free by writing: AARP Fulfillment, 601 E Street, N.W., Washington, D.C. 20049.

To learn more about the FTC's Funeral Rule, write: Funerals: A Consumer Guide, Public Reference, Federal Trade Commission, Washington, D.C. 20580. You also may write to this address to receive a free copy of Best Sellers, a listing of all the FTC's consumer publications.

For Further Help

If you have a problem concerning funeral matters, first try to resolve it with your funeral director. If you are dissatisfied, contact your state or local consumer protection agencies listed in your telephone book, or the Conference of Funeral Service Examining Boards or FSCAP, at the numbers listed above. Although the FTC does not resolve individual disputes, information about your experience with a funeral provider may show a pattern of conduct or practice that the Commission may investigate to determine if any action is warranted. Write: Correspondence Branch, Federal Trade Commission, Washington, D.C. 20580.

FTC Consumer Alert - Beloved...Bejeweled...Be Careful (Jewelry)

Consumer Alert

Washington, D.C.

-- Planning a gift of jewelry? Whether it's for sweetheart or yourself, build in time to compare prices and quality. A gift of jewelry can be expensive. If you're not familiar with any jewelers in your area, ask family members, friends or co-workers for recommendations. When you're shopping, ask your salesperson to write down any information you might rely on to make your purchase. And before you buy, ask for the store's refund and return policy.

The Federal Trade Commission has a few additional pointers for jewelry shoppers who are in the market for gold, watches, gemstones, pearls or diamonds:

There's a big difference between 14 karat gold and gold-plated jewelry. Fourteen karat (14K) jewelry contains 14 parts of gold, mixed in throughout with 10 parts of base metal. Gold-plated describes jewelry with a layer of at least 10K gold bonded to a base metal. Gold plating eventually wears away, depending on how often the item is worn and how thick the plating is.

If you're buying a watch, determine whether you want one that runs on a battery or one that must be wound daily. Ask if a warranty or guarantee is included, how long it lasts, and what parts and repair problems it covers. Also ask how and where you can get the watch serviced and repaired.

Know the difference between laboratory-created gemstones and naturally mined stones. Stones created in the lab are visually identical to stones mined from the earth. The big difference is in the cost: laboratory-created stones are less expensive than naturally mined stones. But because they look just like stones mined from the earth, they must be identified as lab-created. If you want a naturally mined stone, ask if it has been treated. Gemstone treatments -- such as heating, dyeing or bleaching -- can improve a stone's appearance or durability. Some treatments are permanent; some may create special care requirements. Treatments also may affect the stone's value.

Ask whether pearls are imitation or real. Real pearls are made by oysters or other mollusks; imitation pearls are man-made. Cultured pearls are made by mollusks with human intervention; an irritant introduced into their shells causes a pearl to grow. Real pearls that are not cultured are fairly rare and expensive. The cost depends on the size, usually stated in millimeters, and the coating or "nacre" on a real pearl, which gives it its iridescence.

When you're buying a diamond, consider four criteria: cut, color, clarity and weight , usually stated as carats. Each factor affects the price. Color is sometimes "graded" on a scale. However, scales are not uniform: a "D" may be the best color for one scale, but not for another. Make sure you know how a particular scale and grade represents the color of the diamond you're considering. A diamond can be described as "flawless" only if it has no visible surface cracks or other imperfections when viewed under 10-power magnification by a skilled diamond grader.

Look Before You Lease

FTC Consumer Alert!

To lease or to buy? That's the choice you face when mulling over makes and models and deciding which car deal best meets your needs. Leasing a car is not the same as buying one. When you buy, you own the car. When you lease, you pay to drive someone else's vehicle. Although leasing can involve lower monthly payments than a loan, at lease end, you will have no ownership or equity in the car.

The number of new car leases is skyrocketing. Before you decide whether to lease or buy, the Federal Trade Commission reminds you: don't be dazzled by so-called deals. Ask questions, nail down the details, read the fine print, and shop around.

If you're thinking of leasing, the FTC offers these shopping tips:

1. Shop as if you're buying a car. Negotiate all the lease terms, including the price of the vehicle. Lowering the lease price will help reduce your monthly payments. Get all the terms in writing.

2. Learn the language of leasing:

In a closed-end lease, you return the car at the end of the lease and "walk away" but you're still usually responsible for certain end-of-lease charges, such as excess mileage, wear and tear, and disposition.

In an open-end lease, you pay the difference between the value stated in your contract and the lessor's appraised value at the end of the lease.

Lease inception fees are payments you must make when the lease starts, and may include a down payment, security deposit, acquisition fee, first month's payment, taxes and title fees.

Ask for a list of all charges due at lease inception. You may be able to negotiate some or all of the terms.

The capitalized cost is the price of the car for leasing purposes plus taxes and extra charges like service contracts and registration fees.

The capitalized cost reduction is similar to a down payment. If you're trading in a car, make sure the dealer applies the trade-in value to the price your lease is based on. The trade-in credit may reduce your down payment or monthly payments.

3. Ask whether extra charges will be assessed for excessive mileage, wear and tear, disposition and early termination, and find out the amount of these charges. Most leases allow you to drive 12,000 to 15,000 a year; if you put on more miles, expect a charge of 10 to 25 cents for each additional mile. You may think the ding in the door is normal wear and tear; to the lessor it may be significant damage. Check out penalties for an early return; expect to pay a substantial charge if you give the car up before the end of your lease.

4. Make sure the manufacturer's warranty covers the entire lease term and the number of miles you're likely to drive.

5. Consider "gap insurance" to cover the difference -- sometimes thousands of dollars -- between what you owe on the lease and what the car is worth if it's stolen or totaled in an accident.

6. Before you sign the deal, take a copy of the contract home and review it carefully away from any dealer pressure. Be alert for any charges that were not disclosed at the dealership, like conveyance, disposition, and preparation fees.

7. Federal law requires lessors to provide lease cost information before you sign the lease. Take a copy of the attached form to the dealer and ask them to complete it. Although these specific disclosures are not mandatory until October 1997, dealers may be willing to provide the information now. If the dealer declines, consider shopping elsewhere.

Guide To Choosing A Nursing Home

INTRODUCTION

Selecting a nursing home is one of the most important and difficult decisions that you may be asked to make either for yourself or for a member of your family. So it's important that you base your decision on the most complete and timely information available.

Ideally, you would have ample time to plan ahead: to examine facilities; to talk to residents of nursing homes and their families; and to find out about the costs of care and make some financial plans to cover the cost of your nursing home care.

Planning ahead is one of the best ways to ease the stress that accompanies choosing a nursing home, and it helps assure a good choice of facility and location when the decision is made.

Unfortunately, such a decision often must be made during a time of crisis -- frequently when a person is ready to leave the hospital after a serious illness or operation.

When an individual can no longer live independently or requires short-term care after a hospital stay, a decision must he made about providing the best alternative arrangement to meet the person's needs for care. Understandably, this can be a bewildering task.

The task of finding the right kind of services in a desirable, nurturing atmosphere is not easy. It is a time-consuming effort to gather the many facts needed to help in the decision-making process.

This booklet is designed as a first step to help you choose a nursing home. We at the Health Care Financing Administration (HCFA) want you to know some of the key resources that are available to you now as you begin your search. This booklet is a guide to some of the places to go, people to speak with, and some of the questions you should ask when considering whether a particular nursing home is right for you or someone in your family.

Finding the right facility is all-important to you or your loved one's well-being. The facility selected will be the home and community for the duration of any stay often for the remainder of a person's life.

Consequently, if you are helping a relative find a nursing home, involve them as much as possible in the decision-making process. If he or she is mentally alert, it is essential that the person's wishes be considered and that the individual be involved in the process of selecting the home every step of the way.

Many people know very little and don't like to think about life in nursing homes. Therefore, if you or a family member is likely to need nursing home care in the future, discuss the subject well in advance of such a move and educate the family about the realities of nursing home care.

By planning ahead, you will have more control of your life. Even if others must make decisions for you, you will have participated in making your preferences and needs known ahead of time. There are people who can help you, however, as you begin your search.

See:

FIRST CONSIDERATIONS

BEGINNING THE SEARCH

VISITING A NURSING HOME

MAKING THE SELECTION

NURSING HOME CHECKLIST

FIRST CONSIDERATIONS

DO YOU NEED NURSING HOME CARE?

Nursing homes are only one of a range of long-term, comprehensive medical, personal, and social services designed to meet the needs of chronically ill and disabled persons. Before considering placement in a nursing home, therefore, you should explore the possibility of using home- and community-based care. What's important is that you discuss your needs and plans with your physician or caregiver and your family to decide on the most appropriate place in which you receive care. Your financial ability to pay will also affect your decision (see "Payment Considerations").

When a less intensive and less restrictive form of care is called for, a mix of services and/or programs popularly called "alternatives to institutional care" may be most appropriate.

While most long-term care is still provided at home by relatives and friends, an increasing number and variety of community based health and supportive services and specialized living arrangements are now being created in communities throughout the nation. Among the home- and community-based services availaidual needs 24-hour nursing care and supervision, however, a nursing home may be the best answer.

Once you decide that nursing home care is needed, you may become overwhelmed. It is normal to be anxious, angry, guilty, depressed, or scared at the thought of making such a big decision for yourself or a family member. This book can help ease those emotions by assisting you to make informed choices. By planning ahead, you will be better prepared to make the appropriate choice for care. By using this book, you will already be familiar with the individuals and organizations to whom you can turn if you need help.

WHY DO PEOPLE LIVE IN NURSING HOMES?

The great majority of nursing home residents are elderly. Some are frail and unable to take care of themselves and live safely on their own. Other residents, regardless of age, suffer from chronic illnesses and need some medical attention, but do not require hospital care. Still others have been transferred to the nursing home from a hospital to convalesce after a serious illness, accident or operation.

Forty percent to 45 percent of everyone turning age 65 in 1990 will stay in a nursing home at least once in their lifetime. About one-half of those admitted to nursing homes stay less than six months. However, one in five will stay a year or more, and one in ten will stay three or more years.

Some nursing home residents have no families to care for them at home. In other cases, the families are not able to supply the kind of care the individual needs there may be no one home during the day, or the care needed may be too specialized or too expensive to provide at home. In still other cases, families may decide that keeping the person at home would be too difficult.

FACTS ABOUT LONG-TERM CARE AND NURSING HOMES

During the past two decades, the number of people over age 65 has grown dramatically, more than 55 percent. While people are living longer, the number of people with chronic illnesses or disabilities that will require long-term care services is also increasing. By the year 2000, almost 9 million older Americans will need long-term care services, up from almost 7 million in 1988. Many of these people will require nursing home services. Typically, these people are older women without spouses.

Almost 20,000 nursing homes in the United States now provide care for about 5 percent of older Americans.

QUALITY-OF-LIFE ISSUES

When people enter nursing homes, they don't leave their personalities at the door. Nor do they lose their basic human rights and needs for respect, encouragement, and friendliness. All individuals need to retain as much control over the events in their daily lives as possible.

Consequently, nursing home residents should have the freedom and privacy to attend to their personal needs. That means several things: from managing their own financial affairs, if they are able, to

decorating their rooms with personal belongings. It also means being able to participate in the planning of their treatment and being assured of the confidentiality of their medical records.

In the 1980s, several studies identified some problems with the quality of care that the nation's nursing homes provided to Medicare and Medicaid residents and recommended the implementation of new and higher standards of care in nursing facilities. In 1987, Congress enacted legislation to raise these standards. In October of 1990, these important new nursing home reforms took effect and are designed to strengthen both the quality of life and quality of care for residents. The reforms call for the provision and enforcement of certain rights of residents to dignity, choice, self-determination, and quality services and activities.

Knowing some of the key details of the law can help you make a better decision about selecting a nursing home. It can also better prepare you to be a resident, to know what to expect, and what to ask for if you are not receiving the care and services to which you are entitled. You will need to ask questions and observe how a nursing home is performing.

Under the law, nursing homes must train their nurse aides. Facilities must also conduct a comprehensive assessment of resident needs within two weeks of admission. The law also requires that nursing home residents have the right to choose activities, schedules and health home, they should be able to share a room, if possible. All residents should have freedom and opportunity to make friends and to socialize.

Residents and their relatives must be able to talk to administrators and staff about questions, problems and complaints without fear of reprisal. Administrators should be courteous, helpful and frank. They should treat residents and their requests with respect. Staff members should respond quickly to calls for assistance and treat residents with courtesy, respect and affection. A long-term care facility may meet every known standard, but that's not enough. Warm, professional relationships between staff and residents are an essential ingredient to quality care.

Residents should not be transferred or discharged arbitrarily and should be given reasonable advance notice if they must be moved.

Many of the specific items you should keep an eye out for are part of the regulations concerning residents' rights a set of rules that nursing homes certified by Medicaid and Medicare must follow. The law applies to referrals, admissions, accommodations, room assignments and transfers, policies regarding financial matters, care services, physical facilities, residents' privileges, and the assignments of medical staff and volunteers. In addition, a civil rights law ensures equal access regardless of race, color or national origin in all nursing homes.

BEGINNING THE SEARCH

SEEK REFERRALS

Before visiting nursing homes, get information about available options from a variety of different people: professionals in the long-term care field (such as the local ombudsman, see below) to friends or acquaintances who have been in a situation similar to yours. They can help focus your search for a nursing home. In that way, you can save some time and avoid needless frustration.

Once again, it is important to remember that choosing a nursing home will require you to use critical judgment at a variety of levels. That final judgment should also include your intuitive "gut feeling." In addition, you should seek information from a broad base of sources and not rely on any one source in making your decision.

LONG-TERM CARE OMBUDSMAN PROGRAM

The Ombudsman program is a significant part of the nursing home system. Federal law requires each State Agency on Aging to have an Office of the Long-Term Care Ombudsman, and more than 500 local ombudsman programs now exist nationwide. These offices provide help and information to older Americans, their families and friends regarding long-term care facilities.

Ombudsmen visit nursing homes on a regular basis, and they often have knowledge of what goes on in facilities in their communities. In addition, they receive and investigate complaints made by or on behalf of nursing home residents and work to resolve the problems. If they are unable to resolve problems or if they find serious violations of standards in the facility, ombudsmen refer complaints to State Health Departments for action.

Ombudsmen can also provide information on licensed long-term care facilities in the state or local area, usually including some descriptive information. They cannot advise you on any one particular nursing home, but they will supply current information regarding nursing homes near you. Ask the local ombudsman about:

* Information from the latest survey report on the facility;

* Any complaints against the nursing homes you plan to visit;

* The number and nature of complaints for the past year against the facility;

* The results and conclusions of the investigation into these complaints; and

* What to look for as tell-tale signs of good care in facilities.

If there are local advocacy groups or support groups for the aged and their families, they will also be good sources for recommendations.

OTHER COMMUNITY RESOURCES

While the ombudsman program is a good place to begin your search for a nursing home, there are many other valuable community resources that you should consult before deciding which nursing homes to visit. Among these resources:

* Hospital discharge planners or social workers; * Your family physician; * Religious organizations; * Volunteer organizations such as Pets on Wheels; * State nursing home associations; and * Close friends or relatives.

In meeting with these resources, ask about the facility's reputation in the community. Does the facility have a list of references especially family members of current residents?

OTHER KEY FACTORS TO CONSIDER

As you set about deciding on a nursing home, it is also homes provide different types of care; yet all must provide certain basic services. The key is to match the home to the resident to ensure the nursing home provides the person the kind of care and services needed.

Some people may want a safe and comfortable place to live among pleasant companions. You may want a home that places special emphasis on ethnic factors, such as special food or foreign languages, while others may prefer similarity in religious background.

On the other hand, other residents may require help with grooming and occasional medical treatment. Still others may require constant medical attention, therapy, and other skilled nursing care.

Once you identify what you want and need in a home, simply telephoning some of the nursing homes on your list may eliminate the need to visit them. Some of the key questions that you may ask over the phone to facilities are:

* Is the nursing home certified for participation in the Medicare or Medicaid programs?

* What are the facility's admissions requirements for residents?

* What is the "typical profile" of a resident in the facility? For example, if you require temporary rehabilitation services and the nursing home specializes in Alzheimer's disease care, it's probably not a good match.

* Does the nursing home require that a resident sign over personal property or real estate in exchange for care?

* Does the facility have vacancies, or is there a waiting list?

LOCATION

As you develop your list of potential nursing homes to visit, you should also consider the location of the facility. For example, how close is it to family members and friends? How easy is it for people to visit? How near is it to other community contacts and resources that you hope to continue to see and use?

ENROLLMENT IN A MANAGED CARE PLAN

If you or your family member is enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP), ask a representative of the plan about coordination of health care services between the HMO/CMP and the nursing home. Ask which nursing homes the HMO or health plan works with in the area. If you are interested in a nursing home outside of the area served by the HMO, discuss this with the plan representatives.

PUBLIC INFORMATION

Your State Health Department produces a yearly report on the performance of each nursing home that is certified for Medicare or Medicaid. You should review the latest report. It is required to be posted at the nursing home and is also available through your state health department or from the local ombudsman program. You should talk to the nursing home administrator and long-term care ombudsman about the results of the survey report. What did the nursing home do to correct problems, if any, that were identified in the report? The Health Care Financing Administration, which administers the Medicare and Medicaid programs, also produces an annual report on nursing home information that allows consumers to compare performance of different nursing homes on a variety of measures.

VISITING A NURSING HOME

TALK TO RESIDENTS AND STAFF

It is very important for you or a family member to visit a nursing home before becoming a resident. A visit provides you an opportunity to talk not only with people who work at the facility, but more importantly, with the people who live and receive care at the nursing home and their families.

Ask residents what they like about the home and what they do when they need something to be different. Ask them what they like about the staff. Ask visitors or volunteers the same questions. If you see no volunteers, ask why none work in the home.

Take advantage of this opportunity. You can gain valuable insight into the quality of life in the facility.

WHEN AND HOW OFTEN SHOULD YOU VISIT A HOME?

Ideally, you should visit a nursing home more than once and during different times of the day. One visit should be during late morning or midday so you can observe whether people are out of bed, and, if possible, whether the noon meal is being served. You should also plan to visit during the afternoon to observe activities as well as during and after the evening meal and evening hours.

The first time you visit a nursing home, make an appointment to see the administrator or admissions director so that you can fully explain the purpose of your visit. Mention that you would like to watch the daily routine at the nursing home, including staff preparing and serving a meal in the dining room and to residents in their own rooms, and observe as many different resident achts. You may ask for a copy of the statement, which you can then review carefully at home. You may also ask to see the posted results of the nursing home's most recent Medicare and/or Medicaid survey of the facility and the resulting plan of correction, if there were problems.

The administrator or admissions director can also arrange for you to speak with any of the staff, including the nursing home social worker. In fact, when you visit a nursing home, you should carefully observe staff members at work. Once again, the interactions among staff and between staff and residents should be warm, but professional. You should also note the physical condition of the nursing home.

Is the building clean, free from overwhelming odors, and well-maintained?

Evaluate the quality of the care and concern for residents you see. For example, do nursing assistants speak slowly and clearly so the resident can hear and see them? How does the staff react when a resident's behavior is inappropriate? How does the staff respond to residents with Alzheimer's disease or residents who seem to have some impairments in expressing themselves? Overall, does the staff show an active interest in and affection for individual residents? In addition, ask residents if there is enough staff to meet their needs.

FORM YOUR OWN IMPRESSIONS

Although a formal tour is useful, it is important that you talk to residents and observe conditions in the nursing home by yourself, without facility staff assisting you. Make an unscheduled visit.

Ask residents their opinion of the nursing home, and if they will show you around the facility. In either case, be observant. Notice whether the residents are dressed neatly and appropriately for the time of day. Ask how often residents get a full bath or shower. Do they appear to be contented and enjoying the activities, and do residents interact with one another?

Remember, although some residents may prefer to watch rather than participate in activities at the nursing home, if most residents are passive, it may be a sign that the home has no activity program or that residents are kept on medications.

Are residents eager to discuss their feelings about the nursing home with you, or do they appear apathetic about their surroundings? Ask residents whether the facility has a resident council a committee of residents that helps advise the facility about resident concerns, needs, wants, likes, and dislikes. The law does not require nursing homes to have such councils.

And, if possible, meet with members of the family council at the nursing home. Family councils, which are similar to resident councils, are composed of family members of the facility's residents. Even if the nursing home does not have a family council, ask to speak with family members of residents of the facility. Also note whether visiting hours are generous and set for the convenience of residents and visitors.

In making these kinds of observations, trust your instincts and perceptions. Be certain to bring a note pad and pen with you to make notes about your impressions soon after you leave the facility. Impressions become blurred with time.

MEDICAL SERVICES

Medical and nursing care are crucial to you or your relative's welfare as a resident of the nursing home. Therefore, you need to spend extra time to ensure your needs will be met in this important area. In most cases, you can choose your own physician, even for emergency care.

Nursing homes also have their own physician. You should understand how often the physician visits the facility and reviews medical records of the residents. Does the physician and nursing staff meet with residents and their families to develop plans for treatment? On average, how many residents is each nurse aide or direct care nurse assigned to care for? Are licensed nurses on duty around the clock? If not, is there 24-hour access by telephone? In addition, will the confidentiality of your medical records be assured? The importance of understanding the answers to these questions in part depends on the needs of the individual resident. Still, you need to know the answers in case you need medical trehomes are making progress in finding other, safe ways to care for residents without restraining them. If you see residents with restraints, you should carefully question the staff about the nursing home's philosophy on the use of restraints. Ask what kind of activities and rehabilitation are used to keep residents restraint free.

When a medication is used, facility staff must check the resident to make sure there are no adverse side-effects. When a physical restraint is used, the resident should be monitored frequently to see that all is well, and to take care of any physical needs such as toileting.

Remember that federal law states that nursing home residents have the right to be free from any restraints administered for purposes of discipline or convenience, and not required to treat medical conditions.

In addition, the law says you will have the right to be free from any type of abuse-verbal, sexual, physical, and mental. That includes corporal punishment and involuntary seclusion.

FOOD SERVICES

The preparation and serving of meals is one of the most important services provided to nursing home residents each day. On your visit to the nursing homes, take the time to watch servers in action. Ask to sample the food. Are hot foods served hot?

Ask the dietitian at the facility for a list of menus for the month, and ask how special diets are handled. Among the questions you should get answers to from both the dietitian and residents are:

* How much time is allowed for eating each meal?

* Is food delivered to residents who are unable or unwilling to eat in the dining room?

* Are snacks available?

* Are those residents in need of special equipment or assistance at meal time provided with such equipment or assistance?

As you watch residents eat their meal, note whether they seem to be enjoying the food. Talk to residents about the quality and variety of their meals.

FIRE SAFETY

Although nursing home fires causing multiple deaths do not occur often, fire safety is very important. It is often difficult to evacuate residents quickly enough should a major fire erupt. Therefore, review the facility's fire safety training program. Do all staff know what to do? Are residents provided a supervised place in which to smoke?

FOLLOW-UP OBSERVATIONS

When deciding on which nursing home to enter, one visit is not enough. Ideally, you should plan on a second and, if time permits, a third visit to a facility after reviewing your written notes from the initial visit. Once again, you should make unannounced visits to the nursing home.

On your follow-up visit, go back at a different time of the day, preferably during the evening and/or weekend. There are usually fewer staff on duty at that time, and the visit will give you an indication of the types of evening or weekend activities, if any, that are available for the residents. These visits will also give you a way to compare the level of attention that staff give to residents and whether the attitude of staff is the same during the night and day and during weekdays and weekends.

MAKING THE SELECTION

PAYMENT CONSIDERATIONS

For most people, finding ways to finance nursing home care is a major concern. There are four basic ways in which nursing home costs may be financed:

* Personal Resources -- About one-half of all nursing facility residents pay for costs out of personal resources. When many people enter a nursing home, they first pay for their care out of their own income and savings. Because of the high cost of such care, however, some people deplete their resources and apply for Medicaid.

* Private Insurance -- Some Medicare supplementary insurance policies, often referred to as "Medigap" insurance, also can provide a source of payment for nursing homes. There is also private, long-term care insurance available.

* Medicaid -- State and federal coverage is available to eligible low income individuals who need care at least above the level of room and board. The nursing home must be Medicaid-certified.

* Medicare -- Under some limited circumstances, Medicare hospital insurance (Part A) will pay for a fixed period of skilled nursing home care. The nursing home must be Medicare-certified.

Many health maintenance organizations (HMOs) and other coordinated care plans participate in the Medicare and Medicaid programs. These health care plans often cover certain benefits in addition to those required by Medicare and Medicaid and are experienced in "coordinating" a member's health care. Some HMOs may also offer more medical or supportive services; others mayme costs for up to 100 days per benefit period for those who meet coverage requirements and require care in a skilled nursing facility (SNF). The first through the 20th day carry no deductible or coinsurance amounts for the resident; however, the 21st through the 100th days carry a coinsurance amount. This amount is calculated each year and is equal to one-eighth of the annual hospital deductible. For example, in 1993 the coinsurance amount is $84.50 per day.

Medicare only pays for care in SNFs following a hospital stay of at least three days and when individuals require daily skilled nursing or skilled rehabilitation (physical therapy, speech therapy or occupational therapy) services that must be performed or supervised by professionals. Many nursing homes have both Medicare and non- Medicare parts. Medicare law does not permit payment for residents in non- Medicare parts of the facility, even if the care needed meets the medical standards for coverage. Therefore, in order for Medicare to pay, the resident must be placed in the section of the nursing home that is certified under Medicare.

To help you avoid such problems, however, SNFs generally work closely with hospital discharge planners and social workers to ensure that only individuals requiring skilled services are admitted to skilled parts of the nursing home. If the SNF determines that the person does not meet skilled standards and then admits the resident to a skilled part, it must provide the individual with a Notice of Non Coverage. Nursing homes are required to give residents the Notice of Non Coverage at time of admission, or any time after admission, when skilled services are no longer required.

You may appeal the nursing home's decision for non- coverage. You should not be charged for services until you receive a formal decision on your appeal from Medicare. However, if as a result of the appeal, it is determined that Medicare will not cover your stay, you are liable for the cost of care since the start of your nursing home stay.

When you visit a nursing home, if you are eligible for Medicare coverage, ask to see a copy of the facility's Notice of Non-Coverage. Ask some of the residents in the facility if they have had difficulties or misunderstandings with the facility over payments and whether problems were satisfactorily and quickly resolved.

MEDICAID ELIGIBILITY

Medicaid pays nursing home expenses for individuals who meet income and resource eligibility

requirements. Medicaid can pay for nursing facility care that ranges from skilled nursing care to care that is above the level of room and board, but less intensive than "skilled" care.

It is important to contact the local State Medicaid Agency for eligibility and program information as early in the placement process as possible. Financial guidelines vary from State to State and can be somewhat restrictive, but remember that eligibility is retroactive to the date of application.

Moreover, if either spouse transfers resources, such as real estate or bank accounts, for less than fair market value within 30 months before a spouse goes into a nursing home, this could affect the extent to which the Medicaid program would pay for the cost of care for the spouse in the nursing home and for certain community services.

Recent changes in Medicaid law the "spousal impoverishment" provisions provide some protection for a certain amount of income and resources for a spouse still living at home when the other partner needs nursing home placement.

LONG-TERM CARE FINANCING AND INSURANCE

Given the increasing likelihood of older Americans having to use long-term care services at some point in their lives, an important part of planning ahead is preparing for your financial future. This is important because most home care and about half of nursing home costs are paid directly by consumers and their families.

There are a variety of financing mechanisms for long-term care services, including continuing care retirement communities and private long-term care insurance.

Medicare supplemental insurance (Medigap) policies generally cover very little long-term care at home or in a nursing home, usually covering only deductibles, coinsurance, and long hospital stays. Medicaid covers nursing home care and some community care benefits such as home health care or adult day care. Coverage varies by State and is generally limited to people with low income and assets.

One option that you might wish to consider is purchasing long-term care insurance. This type of insurance policy covers nursing home care and increasingly includes home services may help you select a policy most appropriate to your needs.

People purchase long-term care insurance for several reasons. If you are deciding whether and when to buy long-term care insurance, you should consider the following questions:

* Will your income cover long-term care expenses, along with other ongoing expenses?

* If you purchase such insurance, can you pay for the deductible period and coinsurance?

* Can you pay the premiums now? Can you pay if the premiums rise?

* Will you be able to pay the premiums if your spouse dies?

* Will you be able to pay for upgrading benefits to meet inflation?

* Would you become eligible for Medicaid if you had large medical bills, or entered a nursing home where average yearly costs run almost $30,000? Before signing a long-term care insurance policy, you should also ask if you have a period during which to cancel the policy and receive a refund for the first premium. As you shop around:

* Be sure that the policy does not base coverage on medical necessity, or require prior hospitalization before entering a nursing home, or prior nursing home stays for home health care.

* Be sure that the insurer can cancel your policy only for reason of nonpayment of premiums.

* Make certain you have realistic inflation protection.

* Check the length of time that preexisting conditions are excluded.

* Check for permanent exclusions on certain conditions, such as Alzheimer's disease.

Finally, if you decide to purchase long-term care insurance, do some checking into the reputation and financial stability of the company offering the insurance. Your state health insurance commissioner and

consumer affairs offices should be helpful in identifying reliable companies.

REVIEWING THE CONTRACT

Before an individual is admitted to a nursing home, the resident, or the person sponsoring the resident, will have to sign a contract. Before you sign any contract with a nursing home, stop, and carefully review the document. Remember: the admissions contract is a legally binding document that spells out the conditions under which the resident is accepted.

A comprehensive contract should:

* State your rights and obligations as a resident of the facility, including safe guards for residents' rights and grievance procedures;

* Specify how much money you must pay each day or month to live in the nursing home;

* Detail the prices for items not included in the basic monthly or daily charge;

* State the facility's policy on holding a bed if you temporarily leave the home for reasons such as hospitalization or vacation; and

* State whether the facility is Medicaid and/or Medicare certified. If so, and if you desire, the facility must accept Medicaid payments when your own funds run out, or accept Medicare repayments if you qualify for Medicare coverage. Private pay admissions contracts are illegal and cannot be enforced.

Remember: discrimination against Medicaid recipients is illegal.

ADDITIONAL TIPS BEFORE SIGNING A CONTRACT

* Ask the nursing home for a copy of a contract. In this way, you will he able to review the document at your own pace, get additional advice from a variety of outside sources, and compile a list of questions that you might have about provisions in the contract.

* Have the nursing home administrator, the home's social worker, or the local ombudsman answer your questions.

* Because the admissions contract is a legally binding document, you should talk to a lawyer, if possible, on terms of the contract.

* Remember that you can change terms of the contract. But if you make changes, each of them must be initialed by both you and the nursing home representative.

* Be sure that the contract is complete and correct before you sign it. There should be no blank spaces.

NURSING HOME CHECKLIST

When you visit a nursing home, you should carry this checklist with you It will help you to compare one facility with another, but remember to compare facilities certified in the same category; for example, a skilled nursing facility with another skilled nursing home Because nursing homes may be licensed in more than one category, always compare similar types of service among facilities.

LOOK AT DAILY LIFE	Y	N	Y	N
1. Do residents seem to enjoy being with staff?	[]	[]	[]	[]
2. Are most residents dressed for the season and time of day?	[]	[]	[]	[]
3. Does staff know the residents by name?	[]	[]	[]	[]
4. Does staff respond quickly to resident calls for assistance?	[]	[]	[]	[]
5. Are activities tailored appropriate in a variety of activities?	[]	[]	[]	[]
7. Does the home serve food attractively?	[]	[]	[]	[]
8. Does the home consider personal food likes and dislikes in planning meals?	[]	[]	[]	[]
9. Does the home use care in selecting roommates?	[]	[]	[]	[]
10. Does the nursing home have a resident's council? If it does, does the council influence decisions about resident life?	[]	[]	[]	[]
11. Does the nursing home have a family council? If it does, does the council influence decisions about resident life?	[]	[]	[]	[]
12 Does the facility have contact with community groups, such as pet therapy programs and Scouts?	[]	[]	[]	[]
LOOK AT CARE RESIDENTS RECEIVE				
1. Do various staff and professional experts participate in evaluating each resident's needs and interests?	[]	[]	[]	[]
2. Does the resident or his or her family participate in developing the resident's care plan?	[]	[]	[]	[]
3. Does the home offer programs to restore lost physical functioning (for example, physical therapy, occupational therapy, speech and language therapy)?	[]	[]	[]	[]
4. Does the home have any special services that meet your needs? For example, special care units for residents with dementia or with respiratory problems?	[]	[]	[]	[]
5. Does the nursing home have a program to restrict the use of physical restraints?	[]	[]	[]	[]
6. Is a registered nurse available for nursing staff?	[]	[]	[]	[]
7. Does the nursing home have an arrangement with a nearby hospital?	[]	[]	[]	[]
LOOK AT HOW THE NURSING HOME HANDLES PAYMENT				
1. Is the facility certified for Medicare?	[]	[]	[]	[]
2. Is the facility certified for Medicaid?	[]	[]	[]	[]

3. Is the resident or the resident's family informed when charges are increased?	[]	[]	[]	[]
LOOK AT THE ENVIRONMENT				
1. Is the outside of the nursing home clean and in good repair?	[]	[]	[]	[]
2. Are there outdoor areas accessible for residents to use?	[]	[]	[]	[]
3. Is the inside of the nursing home clean and in good repair?	[]	[]	[]	[]
4. Does the nursing home have handrails in hallways and grab bars in bathrooms?	[]	[]	[]	[]
5. When floors are being cleaned, are warning signs displayed, or are areas blocked off to prevent accidents?	[]	[]	[]	[]
6. Is the nursing home free from unpleasant odors?	[]	[]	[]	[]
7. Are toilets convenient to bedrooms?	[]	[]	[]	[]
8. Do noise levels fit the activities that are going on?	[]	[]	[]	[]
9. Is it easy for residents in wheelchairs to move around the home?	[]	[]	[]	[]
10 Is the lighting appropriate for what residents are doing?	[]	[]	[]	[]
11 Are there private areas for residents to visit with family, visitors, or physicians?	[]	[]	[]	[]
12 Are residents' bedrooms furnished in a pleasant manner?	[]	[]	[]	[]
13 Do the residents have some personal items in their bedrooms (for example, family pictures, souvenirs, a chair)?	[]	[]	[]	[]
14 Do the residents' rooms have accessible storage areas for residents' personal items?	[]	[]	[]	[]
OTHER THINGS TO LOOK FOR				
1. Does the nursing home have a good reputation in the community?	[]	[]	[]	[]
2. Does the nursing home have a list of references?	[]	[]	[]	[]
3. Is the nursing home convenient for family or friends to visit?	[]	[]	[]	[]
4. Does the local ombudsman visit the facility regularly?	[]	[]	[]	[]

Telemarketing: Reloading and Double-Scamming Frauds Facts for Consumers from the Federal Trade Commission

Prepared in cooperation with Call For Action, Inc., a Washington, D.C.-based international network of radio and television consumer hotlines

If you've taken the bait and lost money to a telemarketer, expect that the same or another telemarketer will try to hook you again. Consumers who have been victimized often are placed on what is known in the trade as "sucker lists" and then victimized again. "Sucker lists" contain the names, addresses, phone numbers, and sometimes other information of people who have responded to bogus telephone solicitations. These lists, which are created, bought, and sold by some telemarketers, are invaluable because unscrupulous promoters know that consumers who have been tricked once are vulnerable to additional scams. These telemarketers hope that consumers believe that "this time" they will win the "grand prize." Most often, however, these consumers simply lose more money.

The Federal Trade Commission (FTC) is investigating complaints about some telemarketing firms that take your money, not just once, but repeatedly. Such activity is known as "reloading" or "double-scamming."

This brochure explains how reloading scams work, what precautions you can take to avoid becoming a victim, and where to go if you have a complaint about a telemarketer.

How the Scam Works

"Reloaders" or "double-scammers" use a variety of approaches to retarget consumers. For example, if you have lost money to a telemarketer you may be contacted by an individual claiming to represent a government agency, private company, or consumer organization that works, for a fee, to recover lost money or a product or prize. The problem is that the second caller may be just as bogus as the first. And, if you've paid the recovery fee -- you guessed it -- you've been double-scammed. In some instances, the second caller works for the firm that took your money in the first place.

Understand that some local government agencies and consumer organizations do provide assistance to consumers who have lost money. But they will not guarantee to get back your money and they will not charge a fee.

In another approach, a telemarketer may use prize incentives to persuade you to purchase merchandise. If you buy, you may get a call back saying that you now qualify for a more valuable prize. They lead you to believe that making an additional purchase could increase your chances of winning. If you buy a second time, the telemarketer may contact you yet a third time, repeating the same salespitch. The only change is that you are now a "grand prize" finalist and, by buying more merchandise you could win the "grand prize."

Of course the telemarketer wants payment when you agree to the purchase usually by a credit card phone order or the delivery of a check by courier service. However, it may be several weeks or more before you get your products and prizes. When your merchandise or prizes do arrive, you may discover that you paid too much for inferior products and that you did not win the "grand prize" after all. By that time your credit card account has been charged and your checks cashed.

How to Protect Yourself

To avoid being victimized by a reloading operation, consider the following precautions.

Beware of individuals claiming to represent companies, consumer organizations, or government agencies that will recover your lost money for a fee. National, state, and local consumer enforcement agencies, such as your Attorney General and consumer protection offices and non-profit organizations, such as Call For Action, or the National Fraud Information Center, do not charge for their services.

Before you make a purchase by phone from a company you do not know, ask the company to send you written materials about its operation. You may be on a "sucker list." Even if you don't get information, you can still check out the organization with your state or local consumer protection office before you send any money.

Be skeptical of promoters who repeatedly contact you, stating that if you purchase more of their merchandise, you have a better chance of winning valuable prizes.

Make sure you receive and inspect your original purchase or prize before making additional purchases.

If You Have a Complaint

Always try to resolve complaints with the company first, but be careful. Don't let the company representative persuade you to accept a substitute product or award if this truly isn't what you want. If you want your money back, say so and don't accept less.

If that does not work and you believe you have been defrauded, contact the National Fraud Information Center at 1-800-876-7060, 9 a.m. - 5:30 p.m. EST, Monday - Friday; Call For Action (CFA) at (202) 537-0585; TDD (202) 537-1551; your state Attorney General; local consumer protection office; and Better Business Bureau, to report the company.

The National Fraud Information Center is a private, non-profit organization that operates a consumer

assistance hotline to provide services and assistance in filing complaints. Call For Action (CFA) is a Washington, D.C.-based international network of radio and television consumer hotlines. The CFA Network of 800 volunteers helps consumers retrieve money or services.

In addition, you may wish to file a complaint with the FTC by writing to: Correspondence Branch, Federal Trade Commission, Washington, D.C. 20580. Although the FTC generally does not intervene in individual disputes, the information you provide may help to indicate a pattern of possible law violations requiring action by the Commission.

Questions and Answers about Homeowners Insurance

Homeowners insurance

1). I AM CONFUSED ABOUT THE AMOUNT OF HOMEOWNERS INSURANCE COVERAGE I SHOULD BUY FOR MY HOME. HOW MUCH IS ENOUGH?

"Enough" depends on what you want to have happen after a loss and if you have any requirements for liability limits because you also have an umbrella liability policy. Let's talk about the building itself. If you want to have just enough to pay off any mortgage and walk away, you might be tempted to buy just that amount. However, not all losses are total and losses that are partial will usually be paid with a look to "did the insured underinsure?" Explaining coinsurance penalties on a tape like this is not practical. Your company agent should be able to give you examples.

Also as a practical matter, most people find that "enough" means enough to rebuild the home. When you calculate it, be sure to eliminate the cost of the foundation and the land and don't use the sales price, the tax assessment value, or the value the mortgage lending company used as its worth. All these can vary greatly from the construction costs. Also, if you have a home that is non-standard, for example, a home built in the 1880's with lots of hand plastering, fancy woodwork and hand-made stainglass windows, discuss this with your agent. If your home is in a historic district where you are required to rebuild it, virtually as it was, again ask your agent. Regular homeowners policies are not designed for this and at the time of a claim you will probably be unhappy and underinsured. You also need to decide what amounts you need for your personal property and for your liability. These will vary on exactly what you do have and again what you want to have happen at the time of the loss.

2). WHAT IS THE DIFFERENCE BETWEEN ACTUAL CASH VALUE AND REPLACEMENT COST?

Replacement cost is the amount to repair or replace the damaged property using materials of like kind and quality, without deduction for depreciation. Depreciation is the loss in value that develops as an item ages, wears out, or becomes obsolete. Actual Cash Value is the replacement cost of an item, less the amount for depreciation.

3). I AM BUYING A HOUSE AND THE BANK SAYS I MUST HAVE INSURANCE TO COVER THE MORTGAGE. THE MORTGAGE IS ABOUT $20,000 MORE THAN THE REPLACEMENT COST OF THE HOUSE. NOW WHAT DO I DO?

First, talk to the bank. Your agent should be able to help you get documentation for the bank to show the maximum amount that the carrier will allow you to buy. By the way, you should also ask the agent to find out if the building is on a flood plain and, if so, if Federal Flood Insurance is available. This is relatively inexpensive and while some banks don't require it, it can be really useful to the homeowner. Your agent might also suggest earthquake coverage. Again, the bank or lending institution might not require it, but depending on where the house is located and how it is constructed, you might want to consider it.

4). I HAVE COVERAGE ON MY HOMEOWNERS POLICY FOR SPECIFIC JEWELRY ITEMS. I HAD A RECENT LOSS AND MY INSURANCE COMPANY WANTS ME TO USE THEIR JEWELER TO REPLACE THE ITEMS. WHAT HAPPENS IF I DECIDE NOT TO REPLACE THE ITEMS THROUGH THEIR JEWELER?

Generally, insurance companies will replace the items if possible through their jeweler because they receive a better price than if they used your jeweler. If you decide not to replace the jewelry, your company will pay you only the amount of money that they could replace it for through their jeweler.

5). SEVERAL ITEMS THAT I USE FOR MY BUSINESS WERE STOLEN FROM MY HOME. WHY DID MY INSURANCE COMPANY ONLY PAY A PART OF MY CLAIM FOR MY LOSS?

Most homeowners policies will cover business items up to $2,500 in your home or $250.00 away from your home, subject to your deductible. There are some exceptions to this limitation on business items, but it is so important that you check your policy in each case. You should also be aware that there are other policies available that specifically cover business equipment. You should contact your agent to determine the cost of the coverage for these items.

6). MY INSURANCE COMPANY JUST NOTIFIED ME THAT THEY ARE NOT RENEWING MY POLICY. CAN THEY DO THIS AND ARE THEY REQUIRED TO SEND ME A NON-RENEWAL NOTICE BY CERTIFIED MAIL?

Under Massachusetts law, your company must notify you of their decision not to renew your policy, at least 45 days prior to its expiration date. Your insurance company does not have to send you a notice by certified mail. They are only required to use first-class mail to the address listed on your policy.

7). I LIVE NEAR THE OCEAN AND MY INSURANCE COMPANY IS NOT RENEWING MY POLICY. WHERE ELSE COULD I PURCHASE INSURANCE IF THIS HAPPENS?

Your company has the right to renew or not renew your policy. Recent severe storm losses incurred by many insurance companies have caused them not to renew policies in coastal areas. You have several options if your insurance is not renewed. First, you can check with your company agent to see if they have companies writing business in the area other than the one that is not renewing you. Second, you can ask about purchasing insurance through the FAIR PLAN, technically, the Massachusetts Property Insurance Underwriting Association. It was formed by the Massachusetts legislature in 1968 to make available insurance protection to individuals who were having problems getting insurance for their home. Third, you could also contact the FAIR PLAN directly. Their phone number is (617) 723-3800 or 1-800-392-6108. And don't forget to ask your agent about the Federal Flood Insurance Plan, especially if you are in a coastal area. It is a good companion to a homeowners policy.

8). MY HOME SUFFERED A WATER LOSS LAST WINTER DUE TO ICE DAMS ON THE ROOF. WITH THE MELTING OF ICE AND SNOW, BOTH THE ROOF AND THE INSIDE OF MY HOUSE SUFFERED WATER DAMAGE. WHAT WOULD BE COVERED UNDER MY HOMEOWNERS POLICY?

Generally, damage to both the exterior and interior of a home resulting from weight of ice and snow or ice dams is covered under the homeowners policy. However, when a claim is evaluated, the insurance company adjuster will look at the damage to the roof and will pay only for the area damaged in the loss. If further damage to the roof has occurred due to wear and tear, that part of the claim will not be covered.

9). MY HOME WAS RECENTLY BROKEN INTO AND I DO NOT HAVE SALES RECEIPTS FOR THE STOLEN ITEMS? WHAT WILL THE INSURANCE COMPANY ACCEPT FOR PROOF OF OWNERSHIP? . If the actual receipts are not available, insurance companies generally will accept photos, warranties, owners manuals, canceled checks, credit receipts, bills, servicing agreements, even video tapes, as proof of ownership. We suggest that you consider video taping your home before a loss.

10). WHEN CAN AN INSURANCE COMPANY CANCEL MY HOMEOWNERS COVERAGE DURING THE POLICY TERM?

According to Massachusetts General Laws Chapter 175, Section 99 (12), your policy can be canceled for these reasons:

a). Non-payment of premium;

b). Material Misrepresentation/Fraud. That means that they honestly believed you planned on committing a fraud;

c). Conviction of a crime arising out of acts increasing the hazard insured against. (For example, conviction for illegal storage of fireworks);

d). Discovery of willful or reckless acts or omissions by the insured increasing the hazard insured against. (An example of this would be not getting a gas leak fixed);

e). Physical changes in the property insured which result in the property becoming uninsurable (For example, should the home become vacant for more than 60 consecutive days, there is automatically assumed to be a greater exposure to vandalism and damage); and

f). A determination by the Commissioner of Insurance that continuation of the policy would place the insurance company in violation of the law.

11). I HAVE SPECIFICALLY INSURED ANTIQUE ITEMS LISTED ON MY HOMEOWNERS POLICY. IF I HAVE A TOTAL LOSS, WOULD THE INSURANCE COMPANY PAY ME THE THEIR INSURED VALUE?

Your insurance company would first confirm the value of the items with one or more independent antique dealers. You should then be paid a dollar value based on the dealer(s) estimate of the worth of the antique items. If you disagree with the settlement offered by your company, then you can follow the dispute resolution process outlined in your policy. There is a simpler way. Get appraisals and have your company agent establish what the values are specifically in the policy. You should also keep your appraisals up to date.

12). DURING A STORM, A TREE FROM MY NEIGHBOR'S YARD FELL AND DESTROYED MY FENCE. DOES MY HOMEOWNER'S POLICY PAY FOR THE DAMAGE OR DOES MY NEIGHBOR'S POLICY?

Generally, your own policy should cover such a loss. Your insurance company may be able to recover the amount it pays you for the loss and your deductible from the homeowner's insurance that your neighbor may have, in the event that the loss occurred as a result of your neighbor's negligence.

13). SEVERAL RECENT RAINSTORMS HAVE FLOODED AND DAMAGED MY BASEMENT. IS THERE ANY COVERAGE UNDER MY HOMEOWNERS POLICY?

Flood coverage is generally excluded on the basic homeowners policy. However, some homeowners policies provide coverage for backup of sewers and drains that cause flooding in your basement. This coverage can be purchased for a nominal premium. You should check with your company agent to see if this coverage is provided and how much it costs.

However, if you live in a flood-prone area, you should consider purchasing a flood insurance policy. Flood policies have certain provisions that may limit recovery at the time of a claim. For example, unless two or more acres are flooded, or your neighbor's home as well as yours is damaged, the National Flood Insurance Plan will not cover your loss. It also is limited as to what it will cover in basements. Generally, it is the washer and dryer. Your agent should be able to inform you about the advisability of purchasing flood insurance depending on the area in which you live and on coverage other than for official floods.

14). THE FOOD IN MY FREEZER WENT BAD BECAUSE I LOST POWER IN MY HOME. DOES MY HOMEOWNER'S POLICY PROVIDE COVERAGE FOR THIS?

The basic homeowners policy usually does not. But, this is a popular coverage for insurance companies to offer and you may be able to buy it for a nominal additional premium. There is also the issue of where the power was lost. Some policies are limited to coverage for electricity lost in the home or where the electricity enters the home. Others will limit it to within so many yards from the home. Your agent should be able to tell you about the availability of coverage and how much it would cost.

What You Need to Know About Federal Disaster Assistance and Federal Flood Insurance

When you think about buying a flood insurance policy, do you have these kinds of reactions:

Disaster assistance will be available if my home (or business) is flooded. I don't need to buy flood insurance!

It's too expensive!

My home isn't going to be flooded--we've never been flooded before!

Here are the facts you need to know before you decide.

Disaster assistance will be available if my home (or business) is flooded. I don't need to buy flood insurance!

Did you know that, before most forms of Federal disaster assistance are offered, the President must declare a major disaster?

Did you know that the Federal Emergency Management Agency's Individual and Family Grant Program (for Personal Property) and Temporary Housing Program (for Home Repair and Rental Assistance) are available only if the President declares a major disaster and makes that assistance available?

Did you know that more than 90 percent of all disasters are not Presidentially declared?

Did you know that the most typical form of Federal disaster assistance is a loan that must be paid back with interest?

Did you know that the average Individual and Family Grant payment is less than $2,500?

Did you know that, to qualify for Home Repair Assistance, your home must have relatively minor damage that can be repaired quickly?

Did you know you cannot qualify for Rental Assistance unless your home has been destroyed or significantly damaged?

It's too expensive!

Did you know that the average duration of a Small Business Administration (SBA) disaster home loan is 18.5 years?

Did you know that the average SBA disaster home loan payment for the average duration is $140 a month?

Did you know that, depending on where you live, you can buy a National Flood Insurance Program (NFIP) flood insurance policy for a $50,000 home for about $135 a year?

Did you know that the payment for the average duration for a $50,000 SBA home damage loan is $320 a month?

Did you know that the average premium for an NFIP flood insurance policy is $300 a year?

My home isn't going to be flooded--we've never been flooded before!

Did you know that floods are the most common natural disaster?

Did you know that more than 80 percent of all Presidentially declared disasters include flooding?

Did you know that because more and more buildings, roads, and parking lots are being built where forests and meadows used to be, floods are becoming more severe?

Buildings in special flood hazard areas have a 26 percent chance of being flooded during a 30-year mortgage.

Did you know that more than 25 percent of all claims paid by the NFIP are for policies outside the special

flood hazard area?

So, what's so great about flood insurance?

Homeowners, business owners, and renters can all purchase flood insurance, as long as their community participates in the NFIP.

Flood insurance puts you in control: you don't have to wait in lines or qualify for disaster assistance that you may have to pay back with interest.

Flood insurance claims are paid even if a disaster is not declared by the President.

You can buy flood insurance no matter where you live, in high-, low-, or moderate-risk areas, as long as your community participates in the NFIP.

Flood insurance claims are handled quickly so flood victims can recover quickly.

When you file a flood insurance claim, you can get a partial payment immediately, so you can start recovering faster.

Flood insurance reimburses you for all covered losses. Homeowners can get up to $250,000 of coverage and businesses up to $500,000.

There is separate contents coverage, so renters can get flood insurance, too.

The average NFIP loss paid from the 1993 Midwest Flood was more than $25,000.

Flood insurance claims are paid by policyholder premiums, not taxpayer dollars.

Maintaining a flood insurance policy is one of the most important things you can do to protect yourself and reduce the cost of flooding disasters.

Myths and Facts About the NFIP

Myths and Facts About the NFIP How the NFIP Works

Who needs flood insurance? Everyone. And everyone in a participating community of the National Flood Insurance Program (NFIP) can buy flood insurance. Nationwide more than 18,000 communities have joined the Program. In some instances people have been told that they can not buy flood insurance because of where they live. To clear up this and other misconceptions about Federal flood insurance the NFIP has compiled the following list of common myths about the Program and the real facts behind them to give you the full story about this valuable protection.

1. You can't buy flood insurance if you are located in a high risk flood area.

You can buy Federal flood insurance no matter where you live if your community belongs to the NFIP except in Coastal Barrier Resources System (CBRS) areas. The Program was created in 1968 to provide affordable flood insurance to people who live in areas with the greatest risk of flooding called Special Flood Hazard Areas (SFHAs). In fact under the National Flood Insurance Act lenders must require borrowers whose property is located within an SFHA to purchase flood insurance as a condition of receiving a Federally-backed mortgage loan. There is an exemption for conventional loans on properties within CBRS areas. Lenders should notify borrowers that their property is located in an SFHA and that affordable Federal flood insurance is available.

2. You can't buy flood insurance immediately before or during a flood.

You can purchase flood coverage at any time. There is a 30-day waiting period after you've applied and paid the premium before the policy is effective with the following exceptions: 1) If the initial purchase of flood insurance is in connection with the making increasing extending or renewing of a loan there is no waiting period. The coverage becomes effective at the time of the loan provided application and presentment of premium is made at or prior to loan closing. 2) If the initial purchase of flood insurance is made during the one-year period following the issuance of a revised flood map for a community there is a one-day waiting period. The policy does not cover a "loss in progress " defined by the NFIP as a loss occurring as of 12:01 a.m. on the first day of the policy term. In addition you cannot increase the amount of insurance coverage you have during a loss in progress.

3. Homeowners insurance policies cover flooding.

Unfortunately many homeowners do not find out until it is too late that their homeowners' policies do not cover flooding. Federal flood insurance protects your most valuable assets your home and belongings.

4. Flood insurance is only available for homeowners.

Flood insurance is available to protect homes condominiums apartments and non-residential buildings including commercial structures. A maximum of $250 000 of building coverage is available for single-family residential buildings; $250 000 per unit for multifamily residences. The limit for contents coverage on all residential buildings is $100,000 which is also available to renters. Commercial structures can be insured to a limit of $500 000 for the building and $500 000 for the contents.

5. You can't buy flood insurance if your property has been flooded.

It doesn't matter how many times your home apartment or business has flooded. You are still eligible to purchase flood insurance provided that your community is participating in the NFIP.

6. Only residents of high risk flood zones need to insure their property.

FACT: Even if you live in an area which is not flood-prone it's advisable to have flood insurance. One-third of the NFIP's claims come from outside high risk flood areas. The NFIP's Preferred Risk Policy available for as little as $80 per year is designed for residential properties located in low-to-moderate flood risk zones.

7. The NFIP does not offer any type of basement coverage.

Yes it does. The NFIP defines a basement as any area of a building with a floor which is subgrade, or

below ground level on all sides. Basement coverage under an NFIP policy includes cleanup expenses and items used to service the building such as elevators furnaces hot water heaters washers and dryers air conditioners freezers utility connections circuit breaker boxes pumps and tanks used in solar energy systems. The policy does not cover the contents of a finished basement and improvements such as finished walls floors and ceilings.

8. Federal disaster assistance will pay for flood damage.

Before a community is eligible for disaster assistance it must be declared a Federal disaster area. Federal disaster assistance declarations are awarded in less than 50 percent of flooding incidents. The annual premium for an NFIP policy averaging about $300 per year is less expensive than interest on Federal disaster loans even though they are always granted on favorable terms.

Furthermore if you are uninsured and receive Federal disaster assistance after a flood you must purchase flood insurance to receive disaster relief in the future.

9. The NFIP encourages coastal development.

One of the NFIP's primary objectives is to guide development away from high flood risk areas. NFIP regulations minimize the impact of structures that are built in Special Flood Hazard Areas (SFHA) by requiring them not to cause obstructions to the natural flow of floodwaters. Also as a condition of community participation in the NFIP those structures built within SFHAs must adhere to strict floodplain management regulations. In addition the Coastal Barrier Resources Act of 1982 relies on the NFIP to discourage building in the fragile coastal areas covered by CBRA by prohibiting the sale of flood insurance in designated CBRA areas. These laws do not prohibit property owners from building along coastal areas; however they do transfer the financial risk of such building from Federal taxpayers to those who choose to live or invest in these areas.

10. Federal flood insurance can only be purchased through the NFIP, directly.

Federal flood insurance is sold and serviced directly through the NFIP or through a Write Your Own (WYO) company. WYO companies write and service policies on a nonrisk-bearing basis through a special arrangement with the Federal Insurance Administration.

11. The NFIP does not cover flooding resulting from hurricanes, or the overflow of rivers or tidal waters.

The NFIP defines covered flooding as a general and temporary condition during which the surface of normally dry land is partially or completely inundated. Two adjacent properties or two or more acres must be affected. Flooding can be caused by any one of the following:

- the overflow of inland or tidal waters
- the unusual and rapid accumulation or runoff of surface waters from any source such as heavy rainfall
- the incidence of mudslides or mudflows. caused by flooding which are comparable to a river of
- liquid and flowing mud
- the collapse or destabilization of land along the shore of a lake or other body of water resulting from erosion or the effect of waves or water currents exceeding normal, cyclical levels

12. Wind-driven rain is considered flooding.

No it isn't. Rain entering through wind-damaged windows doors or a hole in a wall or the roof resulting in standing water or puddles is considered windstorm rather than flood damage. Federal flood insurance only covers damage caused by the general condition of flooding (defined above) typically caused by storm surge wave wash tidal waves or the overflow of any body of water above normal cyclical levels. Buildings which sustain this type of damage usually have a watermark showing how high the water has risen before it subsides. Although the Standard Flood Insurance Policy (SFIP) specifically excludes wind and hail coverage most homeowners' policies provide coverage.

For more information about the NFIP, ask your insurance agent or company, or call the NFIP's toll-free number at 1-800-427-4661.

FEMA: How to File a Flood Insurance Claim

How to File a Flood Insurance Claim

When Your Property Is Damaged By A Flood

If possible, photograph the outside of the premises, showing the flooding and the damage. Also, photograph the inside of the premises, showing the damaged property and the height of the water.If you have flood insurance, start by calling your insurance agent to report your claim. The agent will prepare a Notice of Loss form and an adjuster will be assigned to assist you.Separate the damaged from the undamaged property and put it in the best possible order for the adjuster's examination. If reasonably possible, protect the property from further damage. When the adjuster visits your property, let him or her know if you need an advance or partial payment of loss. Again, good records can assist the NFIP in giving you an advance payment. Use your inventory to work with the adjuster in presenting your claim.Damaged property which presents a health hazard or which may hamper local clean-up operations should be disposed of. Be sure to adequately describe discarded items so that, when the adjuster examines your losses and your records, these article are included in the documentation.Good records speed up settlement of your claim. Compile a room-by-room inventory of missing or damaged goods, and include manufacturer's names, dates and places of purchases, and prices. Try to locate receipts or proofs of purchase, especially for major appliances, and note manufacturers' names, serial numbers, prices, and dates of purchase.

Answers to Questions About The National Flood Insurance Project

FEDERAL EMERGENCY MANAGEMENT AGENCY

FIA-2

Answers to Questions About the National Flood Insurance Program

This pamphlet is intended to acquaint the public with the National Flood Insurance Program (NFIP). Despite the highly technical nature of the Program, there has been a deliberate effort to minimize the use of technical terms, This publication is designed for readers who do not need a detailed history or refined technical or legal explanations, but do need a basic understanding of the program and the answers to some frequently asked questions. Readers who need legal definitions should refer to the Standard Flood Insurance Policy and to Federal regulations.

The information provided is as current as possible, but changes in the NFIP are made periodically. Readers can obtain the most up-to-date insurance information by using the telephone and address directory at the back of the pamphlet.

Use of acronyms and initials has been limited, but some terms are used so often that acronyms and initials are practical and of assistance to the reader. The term will be spelled out at its first use in the text with the acronym or initials following in parentheses. For readers' convenience, following is a listing of acronyms and initials that appear in Answers to Questions About the National Flood Insurance Program:

FEMA - Federal Emergency Management Agency

FHBM - Flood Hazard Boundary Map

FIA - Federal Insurance Administration

FIRM - Flood Insurance Rate Map

LOMA - Letter of Map Amendment

LOMR - Letter of Map Revision

NFIP - National Flood Insurance Program

SFHA - Special Flood Hazard Area

SFIP - Standard Flood Insurance Policy

WYO - Write Your Own

Guide to Answers to Questions About the National Flood Insurance Program

See:

Introduction to the NFIP

1. What is the National Flood Insurance Program (NFIP)?

The NFIP is a federal program enabling property owners to purchase insurance protection against losses from flooding. This insurance is designed to provide an insurance alternative to disaster assistance to meet the escalating costs of repairing damage to buildings and their contents caused by floods. Until recently, such coverage was generally unavailable from private-sector insurance companies.

Participation in the NFIP is based on an agreement between local communities and the federal government which states that if a community will implement and enforce measures to reduce future flood risks to new construction in special flood hazard areas, the federal government will make flood insurance available within the community as a financial protection against flood losses which do occur.

2. Why was the NFIP established by Congress?

For decades, the national response to flood disasters was generally limited to constructing flood control works such as dams, levees, sea walls, and the like and providing disaster relief to flood victims. This approach did not reduce losses or discourage unwise development and, in some instances, may have actually encouraged additional development. To compound the problem, the public could not buy flood coverage from insurance companies, and building techniques to reduce flood damage were often overlooked.

In the face of mounting flood losses and escalating costs to the general taxpayers of disaster relief, Congress created the NFIP. The intent was to mitigate future damage and provide protection for property owners against potential losses through an insurance mechanism that allows a premium to be paid for the protection by those most in need of this protection.

3. How was the NFIP established and who administers it?

Congress established the NFIP with the passage of the National Flood Insurance Act of 1968. The NFIP was broadened and modified with the passage of the Flood Disaster Protection Act of 1973 and other legislative measures. The NFIP is administered by the Federal Insurance Administration (FIA), a component of the Federal Emergency Management Agency (FEMA), an independent agency.

4. What is a flood?

"Flood" is defined in the Standard Flood Insurance Policy (SFIP), in part, as:

A general and temporary condition of partial or complete inundation of normally dry land areas from overflow of inland or tidal waters or from the unusual and rapid accumulation or runoff of surface waters from any source.

5. Do the state insurance regulators have any jurisdiction over the NFIP in their respective slates?

As established by Congress, the NFIP is subject to the rules and regulations of the Federal Insurance Administration. FIA has elected to have state-licensed insurance companies' agents and brokers sell flood insurance to consumers. State regulators hold the insurance companies' agents and brokers accountable for providing NFIP customers with the same standards and level of service that the states require of them in selling their other lines of insurance. Private insurance companies participating in the Write Your Own (WYO) program must be licensed and regulated by states to engage in the business of property insurance in those states in which they wish to sell flood insurance.

6. What is the NFIP's "Write Your Own" (WYO) program?

In 1981, a strong effort was begun by the Federal Insurance Administrator to reinvolve the private-sector insurance companies in the NFIP. Representatives of major insurance companies and insurance trade associations met with FIA officials to determine the best way to achieve this reinvolvement, and the compa.

Over the next several months, FIA, working with insurance company executives, addressed and resolved the financial control issues that prevented the development of a WYO program in the past. The goals of

the WYO program are:

* Increase the NFIP policy base and the geographic distribution of policies

* Improve service to NFIP policyholders through the infusion of insurance industry knowledge

* Provide the insurance industry with direct operating experience with flood insurance.

In August 1983, the Administrator extended an invitation to all licensed property and casualty insurance companies to participate in the WYO, and as of October 1988, over 200 insurance companies had signed arrangements with FIA to sell and service flood insurance under their own names.

7. How does the NFIP benefit properly owners? Taxpayers? Communities?

Through the NFIP, property owners in participating communities are able to insure against flood losses. By employing wise floodplain management, a participating community can protect its citizens against much of the devastating financial loss resulting from future flood disasters. More careful local management of development in the floodplains results in construction practices that can reduce flood loss and the high costs associated with flood disasters to all levels of government.

8. What is the definition of a community?

A "community," as defined for NFIP's purposes, is any state, area, or political subdivision; any Indian tribe, authorized tribal organization, or Alaska native village, or authorized native organization which has the authority to adopt and enforce floodplain management ordinances for the area under its jurisdiction. In most cases, a community is an incorporated city, town, township, borough, or village or an unincorporated area of a county or parish. However, some states have statutory authorizes which vary from this description.

9. Why is participation in the NFIP on a community basis rather than on an individual basis?

The National Flood Insurance Act allows FIA to make flood insurance available only in those areas where the appropriate public body has adopted adequate floodplain management regulators for its flood-prone areas. Individual citizens cannot regulate building or establish construction priorities for communities. Without community oversight of building activities in the floodplain, the best efforts of some to reduce future flood losses could be undermined or nullified by the careless building of others. Unless the community as a whole is practicing adequate flood hazard mitigation, the potential for loss cannot be reduced sufficiently to affect disaster relief costs. Insurance rates also would reflect the probable higher losses that would result without local floodplain management enforcement activities.

10. Is community participation mandatory?

No. Community participation in the NFIP is voluntary (although some states require NFIP participation as part of their state floodplain management program). Each identified flood-prone community must assess its floodhazard and determine whether flood insurance and floodplain management would benefit the community's residents and economy. However, a community that chooses not to participate within one year after the flood hazard has been identified and a flood risk map has been provided is subject to the ramifications explained in the answer to Question #18.

Because a community's participation status can significantly affect current and future owners of property located in Special Flood Hazard Areas (SFHA)and the availability of federal financial assistance in the flood-prone areas of the community, the decision should be made with a full awareness of the consequence of each action.

11. What is the emergency program?

The emergency program is the initial phase of a community's participation in the NFIP and is designed to provide a limited amount of insurance at federally subsidized rates prior to the effective date of the community's initial Flood Insurance Rate Map (FIRM). A community participating in the emergency program is usually provided with a Flood Hazard Boundary Map (FHBM) and is required to adopt limited measures aimed at controlling future use of its floodplains. Relatively few of the 18,000 communities participating in the NFIP remain in the emergency program, and all of them will information on mapping, see Question #61.)

12. What is the regular program?

The regular program is the phase of a community's participation in the NFIP under which more comprehensive floodplain management requirements are imposed and higher amounts of insurance are available based on risk zones and elevations determined in the flood insurance study of the community. A FIRM is used in this phase of NFIP participation.

13. What is probation?

Probation is the formal notification by FEMA to a community that its floodplain management compliance program does not meet NFIP criteria. It is an action authorized under federal regulations.

14. When can a community be placed on probation?

A community can be placed on probation 90 days after FEMA provides written notice to community officials of specific deficiencies. Probation generally is imposed only after FEMA has consulted with the community and has not been able to resolve deficiencies. The FEMA Regional Director has the authority to place communities on probation.

15. How long will probation last?

Probation may be continued for up to one year after the community corrects all program deficiencies and remedies all violations to the maximum extent possible.

16. What penalties are imposed when a community is placed on probation?

An additional $25 charge is added to the premium for each flood insurance policy sold or renewed in the community. The additional charge is effective for at least one year after the community's probation period begins. The surcharge is intended to focus the attention of policyholders on the community's non-compliance to help avoid suspension of the community which has serious adverse impacts on those policyholders. Probation does not affect the availability of flood insurance.

17. What is suspension?

Suspension of a participating community (usually after a period of probation) occurs when the community fails to solve its compliance problems. The community is provided written notice of the impending suspension and granted 30 days in which to show cause why it should not be suspended. Suspension is imposed by the Federal Insurance Administrator. If suspended, the community becomes non-participating and flood insurance policies cannot be written or renewed. Policies in force at the time of suspension continue in force for the policy term. Three-year policies, which are written only by Write Your Own (WYO) companies, remain in force until the next annual anniversary date of the policy.

18. What happens if a community does not participate in the NFIP?

Flood insurance under the NFIP or WYO program is not available within that community. (See Question #27 on mandatory purchase requirements.) If a Presidentially declared disaster due to flooding occurs in a non-participating community, no federal financial assistance can be provided for the permanent repair or reconstruction of insurable buildings in Special Flood Hazard Areas (SFHAs). Eligible applicants may receive those forms of disaster assistance that are not related to permanent repair and reconstruction of buildings.

Flood Insurance Information for Prospective Buyers

19. Who may purchase a flood insurance policy?

NFIP coverage is available to all owners and occupants of insurable property (a building and/or its contents) in a community participating in the NFIP. Owners and renters may insure their personal property against flood loss. Builders of buildings in the course of construction, condominium associations, and owners of residential condominium units in participating communities all may purchase flood insurance.

Condominium associations may purchase a condominium master policy that covers both the common elements of the building and the individual units owned by the members of the association. Residential condominium unit owners may purchase building and contents (personal property) flood insurance to supplement any insurance purchased by the condominium owners' association. Owners of non-residential condominium units may purchase only contents coverage in their own name. The non-residential condominium building must be insured in the name of the association.

20. How can I find out if I am eligible to purchase flood insurance?

NFIP coverage is available only in participating communities.

21. How can a property owner determine if the property is in a Special Flood Hazard Area (SFHA)?

FEMA publishes maps indicating communities' flood hazard areas and the degree of risk in those areas. Flood insurance maps usually are on file in a local repository in the community such as the town hall or county building. A property owner may consult these maps to determine if the property is in a SFHA. A toll-free telephone number and mailing address for the Flood Map Distribution Center are listed in the Flood Insurance Address and Telephone Directory at the back of this publication (Page 33), and may be used to order maps. Delivery is usually within two to four weeks. There is a charge for maps for some users, so it is advisable to call for detailed information.

22. What types of property may be insured against flood loss?

Almost every type of walled and roofed building that is principally above ground and not entirely over water may be insured if it is in a participating community. In most cases, this includes manufactured (i.e., mobile) homes that are anchored to permanent foundations, but does not include travel trailers or converted buses or vans. Contents within insurable walled and roofed buildings also may be insured under separate coverage.

23. What kinds of property are not insurable under the NFIP?

Buildings over water or principally below ground, gas and liquid storage tanks, animals, birds, fish, aircraft, wharves, piers, bulkheads, growing crops, shrubbery, land, livestock, roads, machinery or equipment in the open, and motor vehicles are not insurable. Most contents and finishing materials located in a basement or in enclosures below the lowest elevated floor of an elevated Post-FIRM building are not covered. (See Question #41 for coverage limitations in basements and below lowest elevated floors.) Information on the insurability of any special property may be obtained by contacting a property insurance agent or a Write Your Own company agent.

24. Are there certain buildings that cannot be covered?

Flood insurance is not available for buildings which the Federal Insurance Administrator determines have been declared by a state or local zoning or other authorized authority to be in violation of state or local floodplain management regulations or ordinances. No new policies can be written to cover such buildings, nor can an existing policy be renewed.

Buildings constructed or substantially improved since October 1, 1983, and located in designated undeveloped coastal barrier portions or communities are not eligible for flood insurance. These areas are located in over 100 communities on the Atlantic and Gulf coasts and are delineated on the communities' flood maps.

25. How is flood insurance purchased?

After a community joins the NFIP, a policy may be purchased from any licensed property insurance agent or broker who is in good standing in the state in which the agent is licensed or through any agent representing a Write Your Own company (WYO) (see Question #6), including an employee of the company authorized to issue the coverage. The steps leading to the purchase of a flood insurance policy are:

* A property owner perceives a risk of flooding to an insurable building and elects to purchase flood insurance or a lender making a mortgage informs the builder or potential buyer that the building is in a Special Flood Hazard Area (SFHA) and that flood insurance must be purchased as required by the Flood Disaster Protection Act of 1973. The builder or borrower contacts an insurance agent or broker or Write Your Own (WYO) company.

* The insurance agent completes the necessary forms for the builder or buyer. In the case of a building constructed in a SFHA after the issuance of a Flood Ins through a company that sells property insurance (e.g., homeowners) if that company is participating in the WYO program. In this case, the company's agent goes through the same process as an agent in obtaining coverage directly with the NFIP, except the property owner must submit the full premium to the company, not the NFIP. The policy is then serviced by the company under its customary business practices.

26. How are flood insurance premiums calculated?

A number of factors determine the premium rates for flood insurance coverage. They include the amount of coverage purchased, location, age of the building, building occupancy, the design of the building, and, for buildings in SFHAs, the elevation. The only buildings in Zones B, C, and X which are eligible for preferred risk coverage at a pre-determined, reduced premium rate are single-family and 1-4 family dwellings. For these exceptions, there are certain loss limitations depending on the amount of insurance purchased.

27. Is the purchase of flood insurance mandatory?

The Flood Disaster Protection Act of 1973 as amended mandates the purchase of flood insurance as a condition of receipt of federal or federally related financial assistance for acquisition and/or construction of buildings in SFHAs of any community. The purchase of flood insurance on a voluntary basis is frequently prudent even outside of SFHAs.

The Act prohibits federal agencies, such as FHA, VA and SBA, from making or guaranteeing a loan secured by a building in a SFHA unless flood insurance has been purchased. The prohibition applies in all communities which FEMA has identified as having SFHAs, including those communities that are not participating in the NFIP. Flood insurance cannot be purchased for buildings in non-participating communities.

The prohibition of the Act applies to federal regulatory instrumentalities, such as Office of Comptroller of the Currency, Federal Deposit Insurance Corporation, Federal Savings and Loan Institution, and Federal Home Loan Bank Board Lending institutions regulated, or whose deposits are insured, by a Federal instrumentality, must require the purchase of flood insurance according to the regulations of the federal instrumentality.

The purchase of flood insurance does not apply for conventional loans from federally regulated lenders when the community in which the building is located is not participating in the NFIP. In these cases, the lending institution is required to notify the borrower that, in the event of a flood-related Presidentially declared disaster, Federal disaster assistance will not be available for the permanent repair or restoration of the building. Federally regulated or insured lending institutions are required in all cases to notify the borrower when the building being used to secure a loan is in a SFHA.

The amount of flood insurance required by a lending institution cannot exceed the amount of coverage which the Congress has made available and should not exceed the insurable value of the building, whichever is less. A lending institution is not required by statute to make the borrower purchase flood insurance for more than the amount of the loan or for more than twice the amount of insurance available under the Emergency Program ($35,000 times 2 = $70,000), whichever is less. A lending institution may, however, as part of its lending policy, require the borrower to purchase flood insurance in a greater amount than required by statute, and for buildings outside SFHAs.

28. Why is there a requirement to purchase flood insurance in communities which have not suffered flooding in many years or ever?

A major purpose of the NFIP is to alert communities to the danger of flooding and to assist them in reducing potential property losses before a flood occurs, not when it is too late. Therefore, FEMA determines flood risk through the use of all available information for each community. Historical flood data are only one element used in determining flood risk. More critical conclusions can be made by evaluating the community's rainfall and river-flow data, topography, wind velocity, tidal surge, flood control measures, development (existing and planned), community maps, and other data.

29. How many buildings or locations (and their contents) may be insured on each policy?

Normally, only one building and its contents can be insured on each policy. The Dwelling Form of the Standard Flood Insurance Policy does provide coverage for up to 10 percent of policy amount for appurtenant garages and carports, but not for tool and storage sheds and the like. In addition, up to buildings and/or their contents may be insured on one policy on a scheduled building basis, if the application to schedule buildings under one policy is presented on a form or in a format approved by the Federal Insurance Administrator.

30. What is the flood insurance policy term?

Flood insurance coverage written directly with the NFIP is available only on a one-year, prepaid basis. Write Your Own companies may offer three-year policies at their discretion.

31. Is them a minimum premium for a flood insurance policy?

There is a minimum premium for all flood insurance policies.

32. Is there a waiting period for flood insurance to become effective?

There is normally a five-day waiting period. During the 30-day period following a community's initial entry into the emergency program or following the community's conversion to the regular program, the effective date and time of any new or added amount of flood insurance coverage is 12:01 a.m. of the day following the application date and the presentment of payment of premium. When title to a property is conveyed, any new or added flood insurance coverage on the property is effective when the title is transferred.

33. What is "presentment of payment?"

"Presentment of payment" is the receipt of premium and is considered to be the time that payment is actually received by the NFIP. Delivery to an insurance agent or broker or mailing a premium by ordinary mail with placement of a postmark does not constitute presentment to the NFIP.

A premium mailed in a timely manner by certified mail and received by the NFIP is considered to have been delivered to and received by the NFIP as of the date of the certification by the post office. If time is short and coverage is needed, the certified mail transmittal of payment should be considered.

34. Is there any difference in the waiting period and presentment of payment for policies written with a Write Your Own (WYO) company?

The waiting period for policies written with WYO companies is the same as detailed in Question #32. The presentment of payment is determined from the time the agent or authorized employee of the WYO company received the application and premium, or from the time the application and premium are received in a central office or processing facility. Property owners should check with individual WYO company agents for details about specific companies.

35. Is there a special rating procedure applicable to V zones (coastal high hazard areas)?

In calculating the applicable rates for buildings which were constructed or substantially improved in V zones after October 1, 1981, the actuarial formula takes into account the ability of the building to withstand the impact of wave action. The agent must follow the special instructions in the Flood Insurance Manual in preparing an application for coverage for buildings located in any V zone. (See Question #63 for a further explanation of V zones.)

36. Can flood insurance be cancelled at the request of the insured with a refund of premium?

Yes, but only in certain circumstances, since all of the premium is fully earned on the first day of the policy term. Premium will be refunded on a pro-rata basis when the policyholder no longer owns or has an insurable interest in the insured property, provided that no claim has been paid or is pending. There are other limited cancellation provisions for the refunding of premium. Policyholders wishing to cancel a policy should contact the insurance agent who wrote the policy to discuss cancellation criteria. Additional information on cancellations may be obtained by calling the appropriate toll-free number shown in the "Flood Insurance Address and Telephone Directory" section.

37. Is there a "grace period" for an insured under the NFIP policy conditions?

All policies expire at 12:01 a.m. on the last day of the effective term. (For the ease and convenience of insurance agents and brokers, lenders, and policyholders, NFIP rules allow for "renewal" of expiring policies and no new application is required.) Coverage remains in force for 30 days after the expiration of the policy, and claims for losses that occur in that period will be honored providing that full renewal premium is received by the end of the 30-day period. A coverage "grace period" also remains in force for 30 days after written notice to the mortgagee of the expiration of a policy for any mortgagee named in the policy.

Coverage

38. How much flood insurance coverage is available?

Building Coverage	Emergency Program	Regular Program
Single-family dwelling	*$ 35,000	$185,000
Other residential*	100,000	250,000
Non-residential	100,000	200,000
Small business	100,000	250,000
Contents Coverage (per unit)		
Residential	$ 10,000	$ 60,000

39. Are there limitations on the amount of insurance available for certain types of properly?

General coverage limitations are explained in the answer to Question #38 above. In addition, items such as paintings, etchings, pictures, tapestries, other works of art, jewelry, articles of gold, silver or platinum, and furs are limited to $250 coverage in the aggregate. This limitation does not apply to other items that are personal property or household contents usual or incidental to the occupancy of the building as a residence. For other limitations under the Standard Flood Insurance Policy, see the current policy or contact a property insurance agent or broker.

40. What flood losses are covered?

The Standard Flood Insurance Policy (SFIP) contains a complete definition of the coverage it provides. Direct physical losses by "flood" are covered. Also covered are losses resulting from flood-related erosion caused by waves or currents of water activity exceeding anticipated cyclical levels and accompanied by a severe storm, flash flood, abnormal tidal surge, or the like, which result in flooding, as defined. Damages caused by mudslides (i.e., mudflows), as specifically defined in the policy, are covered.

In certain cases, NFIP will pay claims on insured buildings that are subject to imminent collapse or subsidence as a result of erosion so the building can be demolished or relocated before the damage occurs. Specific requirements must be met for such claims to be paid, and the amounts of payment are defined by statute.

41. What coverage is available in basements and enclosed areas beneath the lowest elevated floor?

Coverage is provided for foundation elements, including posts, pilings, piers, or other support systems for elevated buildings. Coverage also is available for basement and enclosure utility connections, mechanical equipment necessary for the habitability of the building, such as furnaces, hot water heaters, clothes washers and dryers, food freezers, air conditioners, heat pumps, electrical junctions and circuit breaker boxes. Finished structural elements such as paneling and linoleum and contents items such as rugs and furniture are not covered. The SFIP has a complete list of covered elements and equipment.

42. What is a basement?

The NFIP's definition of "basement" includes any part of a building where all sides of the floor are located below ground level. Even though a room may have windows and constitute living quarters, it is still considered to be a basement if the floor is below ground level on all sides.

43. Are losses from water seepage, sewer backup, or hydrostatic pressure covered?

These losses are covered only when they occur in conjunction with a general condition of flooding in which the insured property has been, at the same time, physically damaged by surface floodwaters.

44. Does the NFIP apply a deductible to losses?

A minimum deductible is applied separately to a building and its contents, although both may be damaged in the same flood. Higher deductibles are available, and an insurance agent can detail the range of specific amounts of available deductibles. Optional higher deductibles reduce policy premiums but will

have to be approved by the any lienholder.

45. Are costs of preventive measures covered under the SFIP?

Some are. When an insured building is in imminent danger of being flooded, the reasonable expenses incurred by the insured for removal of insured contents to a safe location and return and the purchase of sandbags, sand to fill them, plastic sheeting and lumber used in connection with them, the cost of pumps, fill for temporary levees, and wood will be reimbursed up to the amount of the minimum standard deductible ($500). No deductible is applied to this coverage.

46. Does insurance under the SFIP provide coverage at replacement cost?

Only for one type of building, and if several criteria are met. Replacement cost coverage is available for a single-family dwelling that is the policyholder's principal residence and is insured for at least 80 percent of the building's replacement cost at the time of the loss up to the maximum amount of insurance available at the inception of the policy term (see #38 and #39 for coverage lto condominium units not contiguous to the ground.

Contents losses are always adjusted on an actual cash value basis. If the replacement cost conditions are not met, the building loss also is adjusted on an actual cash value basis.

Filing a Flood Insurance Claim

47. How does a policyholder file a claim for flood loss?

A flood insurance policyholder should immediately report any flood loss to the insurance agent who wrote the policy. A claims adjuster will be assigned the loss, and the policyholder must file a "proof of loss" within 60 days of the date of loss. A policyholder whose policy is with a Write Your Own (WYO) company must follow the company's claim procedures. The 60-day time limit for filing a proof of loss remains the same. When the anticipated number of claims exceeds a predetermined number after widespread flooding, an Integrated Flood Insurance Claims Office is established at the site to assist insurance agents and adjusters in providing prompt service to policyholders.

48. What is a "proof of loss?"

A proof of loss -- the policyholder's valuation of claimed damages -- is a sworn statement made by the policyholder that substantiates the insurance claim and is required to be submitted to the NFIP or WYO company within 60 days of the loss. A printed form usually is available from the adjuster assigned to the claim.

49. What is a "loss in progress?"

A loss in progress occurs when actual flood damage to a building or its contents started before the inception of the policy.

50. Is a loss in progress covered?

The Standard Flood Insurance Policy does not cover damage caused by a loss in progress.

51. What is the maximum that can be collected for a loss under the NFIP policy?

An insured will never be paid more than the value of the covered loss, less deductible, up to the amounts of insurance purchased, so purchasing insurance to value is an important consideration. The amount of insurance a property owner needs should be discussed with an insurance agent or broker.

The Community's Role in Floodplain Management

52. What is the role of the community in NFIP participation?

When the community chooses to join the NFIP, it then must adopt and enforce minimum floodplain management standards for participation. FEMA works closely with states and local communities to identify flood hazard areas and flooding risks. The floodplain management requirements within the SFHA are designed to prevent new development from increasing the flood threat and to protect new and existing buildings from anticipated flood events.

When a community chooses to join the NFIP, it then must require permits for all development in the SFHA and ensure that construction materials and methods used will minimize future flood damage. Permit files must contain documentation to substantiate how buildings were actually constructed. In return, the federal government makes flood insurance available for almost every building and its contents within the community.

Communities must ensure that their adopted floodplain management regulations and enforcement procedures meet program requirements. Local regulations must be updated when additional data are provided by FEMA or when federal or state standards are revised.

53. What is the difference between a FHBM and a FIRM?

A FHBM is based on approximate data and identifies, in general, the SFHAs within a community. It is used in the emergency program of the NFIP for conversion to the regular program. If a detailed Flood Insurance Study has been performed, the FIRM will show base flood elevations and insurance risk zones in addition to floodplain boundaries. The FIRM may also show a delineation of the floodway. (See Question #64 for a description of "floodway.") After the effective data of the FIRM, the community's floodplain management ordinances must be in compliance with appropriate regular program requirem At the request of the Federal Insurance Administrator, each governor has designated an agency of state or territorial government to coordinate that state's or territory's NFIP activities. These agencies often assist communities in developing and adopting necessary floodplain management measures. Some states require more stringent measures than those of the NFIP. A list of state coordinating agencies and their telephone numbers is provided starting on page 35 of this booklet.

55. Do federal requirements take precedence over state requirements?

The regulatory requirements set forth by FIA are the minimum measures acceptable for NFIP participation. More stringent requirements adopted by the local community or state would take precedence over the minimum regulatory requirements established for flood insurance availability.

56. What is meant when FEMA uses the phrase, "floodplain management measures"?

The phrase, "floodplain management measures," refers to an overall community program of corrective and preventive measures for reducing future flood damage. These measures take a variety of forms and generally include zoning, subdivision, or building requirements, and special-purpose floodplain ordinances.

57. Do the floodplain management measures required by the NFIP affect existing buildings?

They affect existing buildings only when an existing building is substantially improved.

58. What constitutes "substantial improvement" or "substantial damage?"

"Substantial improvement" means any rehabilitation, addition, or other improvement of a building when the cost of the improvement equals or exceeds 50 percent of the market value of the building before start of construction of the improvement. The term includes buildings which have incurred "substantial damage," or damage of any origin sustained by a building when the cost of restoring the building to its pre-damaged condition would equal or exceed 50 percent of the market value of the building before the damage occurred. Substantial damage is determined regardless of the actual repair work performed.

Substantial improvement or damage does not, however, include any project for improvement of a building to correct existing violations of state or local health, sanitary, or safety code specifications which have

been identified by the local code enforcement official and which are the minimum necessary to assure safe living conditions. Also excluded from the substantial improvement requirement are alterations to historic structures as defined by the NFIP.

59. Do FEMA requirements apply to construction taking place outside the Specific Flood Hazard Areas (SFHA) within the community?

No. The local floodplain management regulations required by the NFIP apply only in the SFHAs.

60. Can modifications be made to the basic floodplain management requirements?

In developing their floodplain management ordinances, participating communities must meet at least the minimum regulatory standards issued by FEMA. NFIP standards and policies are reviewed periodically and revised whenever appropriate.

Mapping

61. What is the role of the local community in its flood hazard assessment?

Before the flood hazard assessment is initiated, FEMA considers all available existing information for use in the study. Public meetings may be conducted at which interested parties may present relevant facts to help ensure accurate results. FEMA also works closely with each community's officials before and during the study to describe the technical procedures and to obtain community input before publication of the Flood Insurance Study (FIS) and Flood Insurance Rate Map (FIRM). Before the FIS is initiated, community officials, FEMA representatives, and the study contractor meet to discuss the areas that need to be studied. This is called the time and cost estimate meeting.

62. How are flood hazard areas and flood levels determined?

Flood hazard areas are determined using statistical analyses of records of river flow, storm tides, and rainfall; information obtained through consultation with the community; floodplain topographic surveys; and hydrologic and hydraulic analysis. The detailed FIS covers those areas that are subject to flooding from rivers and streams, along coastal areas and lake shores,hin the 100-year flood boundary, which are termed "Special Flood Hazard Areas (SFHAs)." A "100-year flood" does not refer to a flood that occurs once every 100 years, but refers to a flood level with a 1 percent or greater chance of being equalled or exceeded in any given year. The SFHAs may be further subdivided into insurance risk rate zones (see below). Areas between the 100-year and 500-year flood boundaries are termed "moderate flood hazard areas." The remaining areas are above the 500-year flood level and are termed "minimal flood hazard areas."

Historically, about one-third of claims paid by the NFIP are for flood damage tin areas identified as having only "moderate" and "minimal" risk of flood. Flooding in these often is the result of inadequate local drainage systems, and such flooding sources with small drainage areas are generally not identified on FIRMS. The SFHAs are subdivided into flood hazard zones (insurance risk rate zones) according to the following criteria:

Zone V: SFHAs along coasts subject to inundation by the 100-year flood with the additional hazards associated with storm waves. Because detailed hydraulic analyses have not been performed, no base flood elevations or depths are shown. Mandatory flood insurance purchase requirements apply.

Zones VE and V1-30: SFHAs along coasts subject to inundation by the 100-year flood with additional hazards due to velocity (wave action). Base flood elevations derived from detailed hydraulic analyses are shown within these zones. Mandatory flood insurance purchase requirements apply. (Zone VE is used on new and revised maps in place of Zones V1-30.)

Zone A: SFHAs subject to inundation by the 100-year flood. Because detailed hydraulic analyses have not been performed, no base flood elevation or depths are shown. Mandatory flood insurance purchase requirements apply.

Zones AE and A1-30: SFHAs subject to inundation by the 100-year flood determined in a Flood Insurance Study by detailed methods. Base flood elevations are shown within these zones. Mandatory flood insurance purchase requirements apply. (Zone AE is used on new and revised maps in place of Zones A1-30.)

Zone AH: SFHAs subject to inundation by 100-year shallow flooding (usually areas of ponding) where average depths are between one and three feet. Base flood elevations derived from detailed hydraulic analyses are shown in this zone. Mandatory flood insurance purchase requirements apply.

Zone AO: SFHAs subject to inundation by 100-year shallow flooding(usually sheet flow on sloping terrain) where average depths are between one and three feet. Average flood depths derived from detailed hydraulic analyses are shown within this zone. Mandatory flood insurance purchase requirements apply.

Zone A99: SFHAs subject to inundation by the 100-year flood which will be protected by a federal flood protection system when construction has reached specified statutory progress toward completion. No base flood elevations or depths are shown. Mandatory flood insurance purchase requirements apply.

Zones B, C, and X: These areas have been identified in the community flood insurance study as areas of moderate or minimal hazard from the principal source of flood in the area. However, buildings in these zones could be flooded by severe, concentrated rainfall coupled with inadequate local creates areas of high flood risk within these rate zones. Flood insurance is available in participating communities but is not required by regulation in these zones. (Zone X is used on new and revised maps in place of Zones B and C.)

Zone D: Unstudied areas where flood hazards are undetermined but flooding is possible. No mandatory flood insurance purchase requirements apply, but coverage is available in participating communities.

64. What is a floodway and who designates it?

The floodway includes the channel of a river and the adjacent floodplain that state standards specify smaller allowable increases. FEMA requires the community to designate a floodway to avoid the possibility of significantly additional rise in base flood elevations.

65. If a FIRM is believed to be incorrect, what can be done to change it?

Three procedures have been established for changing or correcting a flood map. They are: Letter of Map Amendment (LOMAsurance Administrator reviews scientific or technical data submitted by the owner or lessee of property who believes the property has incorrectly been included in a designated SFHA. A LOMA amends the currently effective FEMA map and establishes that a property is not located in a SFHA.

Although FEMA may issue a LOMA, it is the lending institution'$ prerogative to require flood insurance as a condition of its own beyond the provisions of the Flood Disaster Protection Act of 1973 before granting a loan or mortgage. Those seeking a LOMA should first confer with the affected lending institution to determine whether the institution will waive the requirement for flood insurance if a LOMA is issued. If so, the policyholder may cancel flood insurance coverage and obtain a premium refund.

67. What comprises technical or scientific data?

In general, the scientific or technical data needed to effect a map amendment include certified topographic data and/or hydrologic and hydraulic analyses to support the request for amendment or revision.

68. What is a LOMR?

A LOMR is an official revision to the currently effective FEMA map. It is used to change flood zones, floodplain and floodway delineations, flood elevations, and planimetric features. All requests for LOMRs must be made to FEMA through the chief executive officer of the community, since it is the community that must adopt any changes and revisions to the map. A LOMR is usually followed by a physical map revision.

69. What is a conditional map revision?

Communities, developers, and property owners often undertake improvement projects intended to reduce the flood hazard in their communities and usually want FEMA maps to recognize the effects of these projects. Similarly, property owners and developers who intend to place structures in the 100-year floodplain usually must demonstrate to lending institutions and local officials that these structures will be above base flood elevation.

Those who are planning such actions may submit design plans and other engineering data to FEMA and request that FEMA evaluate them. The response to such requests describe the changes that may eventually be made to the effective flood map and are called "conditional letters of map revision."

FIA charges a fee to defray the costs associated with the evaluation of proposed projects. Information on these fees may be obtained from the appropriate FEMA Regional Office (see pp. 35-37).

70. What is a physical map revision?

A physical map revision is an official republication of a map to effect changes to flood insurance zones, floodplain delineations, flood elevations, floodways, and planimetric features. These changes typically occur as a flood insurance risk zones.

The community's chief executive officer can submit scientific and technical data to FEMA to support the request for a map revision. The data will be analyzed, and the map will be revised if warranted. The executive officer is afforded a review period. When base flood elevations are changed, a 90-day appeal period is provided, followed by a period for formal approval.

71. Who should be contacted in FEMA to initiate a LOMA, LOMR, or physical map revision?

Requests for multiple-lot or multiple-building determinations that do not involve changes to base flood elevations or floodways should be addressed to FIA's Office of Risk Assessment at the address given in the Flood Insurance Address and Telephone Directory (Page 33).

All other requests should be sent to the appropriate FEMA Regional Office (see pp. 35-37).

72. How long does it take to obtain a LOMA, LOMR, or physical map revision?

For single-building or single-lot determinations that do not involve changes to base flood elevations or floodways, a LOMA or LOMR generally can be issued within four weeks. LOMAs and LOMRs involving multiple lots or multiple buildings require up to eight weeks to process. Times are specified from the date of receipt of all technical, scientific, or legal documentation. LOMRs involving decreases in Base Flood Elevations (BFEs) or floodways take approximately 90 days for processing. If changes in flooding conditions are extensive or if BFEs increase, a physical map revision will be required, which may take 12 months or longer.

73. If a LOMA or LOM holder must supply a copy of the LOMA or LOMR and a waiver for the flood insurance purchase requirement from the lending institution to the insurance agent or broker who services the policy. A completed a cancellation form with the LOMA or LOMR and the waiver must be submitted by the agent to the NFIP or the appropriate Write Your Own company. When a LOMA or LOMR is issued and cancellation requested, the policyholder may be eligible for a refund of the premium paid for the current policy year only if no claim is pending and no claim has been paid during the current policy year.

74. Why is the burden of proof on the person requesting a map change?

Government agencies and private engineering firms are contracted at considerable cost to perform analyses of flood risks and prepare flood maps for the community. The analysis and Flood Insurance Study findings are then reviewed by FEMA and community officials. FEMA has no justification for changing a study determination without sufficient evidence that a change is appropriate.

75. How can the technical data that is the basis for the flood hazard information shown on the published FEMA maps be obtained?

By writing to the address shown in the Flood Insurance Address and Telephone Directory (page 33) for the EDSP Repository and requesting the technical data. Requesters' letters should give the name of the community for which the data are sought, provide specific information as to the portion of the community and type of data needed, and should give the requester's name and telephone number. Before the request is serviced, the repository staff will call to discuss the request. If a charge will be necessary for the service, the extent of the service and the costs will be discussed during the call.

Flood Insurance Address and Telephone Directory

For general program information or inquiries about the laws, regulations, or administrative policies related to the NFIP, write:

Federal Emergency Management Agency
Federal Insurance Administration
500 C Street, S.W.
Washington, DC 20472

For insurance questions, call local property insurance agents or brokers or call toll-free, 1-(800) 638-6620*.

* In Maryland, call 1-(800) 492-6605. In Alaska, Guam, and Hawaii, call 1-(800) 638-6831.

To order Flood Hazard Boundary Maps, Flood Insurance Rate Maps, and for information on Flood Insurance Studies, call the Flood Map Distribution Center's toll-free number, 1-800-333-1363, or mail a Flood Insurance Map Order Form (obtained by calling the same number), to:

Federal Emergency Management Agency
Flood Map Distribution Center
6930 (A-4) San Tomas Road
Baltimore, MD 21227-6227

For information pertaining to hazard identification mapping and floodplain management, contact the appropriate FEMA Regional Office listed on the following pages or the FEMA/FIA address shown above.

For requests for multiple-lot or multiple-building LOMA, LOMR, or physical map revision determinations, write:

Federal Emergency Management Agency
Federal Insurance Administration
Office of Risk Assessment
Technical Operations Division
Washington, DC 20472

For technical data that is the basis for flood hazard identification write:

EDSP Repository
7500 Greenway Center Drive
Suite 700
Greenbelt, MD 20770

FEMA Regional Offices

REGION I

(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)

J. W. McCormack Post Office and Courthouse Building
Room 462
Boston, MA 02109
(617) 223-9561

REGION II

(New Jersey, New York, Puerto Rico, and Virgin Islands)

26 Federal Plaza
Room 1337
New York, NY 10278
(212) 225-7203

REGION III

(Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)

Liberty Square Building (Second floor)
105 South Seventh Street
Philadelphia, PA 19106
(215) 931-5750

REGION IV

(Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

1371 Peachtree Street, N.E.
Suite 700
Atlanta, GA 30309
(404) 853-4400

REGION V

(Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

175 West Jackson Boulevard (Fourth floor)
Chicago, IL 60604-2698
(312) 408-5500

REGION VI

(Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Federal Regional Center
800 North Loop 288
Denton, TX 76201-3698
(817) 898-5134

REGION VII

(Iowa, Kansas, Missouri, and Nebraska)

Federal Office Building
911 Walnut Street
Room 200
Kansas City, MO 64106
(816) 283-7002

REGION VIII

(Colorado, Montana, North Box 25267
Denver, CO 80225-0267
(303) 235-4830

REGION IX

(Arizona, California, Hawaii, Nevada, Guam, American Samoa, Northern Mariana Isles, Micronesia, Marshall Islands, and Palau)

Presidio of San Francisco
Building 105
San Francisco, CA 94129
(415) 923-7179

REGION X

(Alaska, Idaho, Oregon, and Washington)

Federal Regional Center
130 228th Street, S.W.
Bothell, WA 98021-9796

(206) 481-8800

State Coordinating Agencies for Flood Insurance

ALABAMA

Alabama Department of Economics and Community Affairs
(205) 284-8735
State Planning Division
P.O. Box 2939
3465 Norman Bridge Road
Montgomery, Alabama 36105-0939

ALASKA

Alaska Department of Community and Regional Affairs Municipal and Regional Assistance Division
(907) 561-8586
949 East 36 - Suite 400
Anchorage, Alaska 99508

ARIZONA
Arizona Department of Water Resources
15 South 15th Avenue
Phoenix, Arizona 85004
(602) 542-1560

ARKANSAS
Arkansas Soil and Water Conservation Commission
#1 Capitol Mall - Suite 2D
Little Rock, Arkansas 72201
(501) 628-3969

CALIFORNIA
California Department of Water
Resources
P.O. Box 942836
Sacramento, California 94236-0001

COLORADO
Colorado Water Conservation Board
State Centennial Building, Room 721
1313 Sherman Street
Denver, Colorado 80203
(303) 866-3441

CONNECTICUT
State Department of Environmental Protection
168 Capitol Avenue
Hartford, Connecticut 06106
(203) 566-7244

DELAWARE
Department of Natural Resources and Environmental Control
Division of Soil and Water Conservation
89 Kings Highway P.O. 1401
Dover, Delaware 19903
(302) 736-4411

DISTRICT OF COLUMBIA
Department of Consumer and Regulatory Affairs
Washington, D.C. 20001
(202) 727-7170

FLORIDA
Department of Community Affairs
Division of Emergency Management
Rhyne Building
2741 Centerview
Tallahassee, Florida 32399
(904) 487-4915

GEORGIA
Department of Natural Resources Environmental Protection Division
205 Butler Street S.E.
Floyd Towers East - Suite 1252
Atlanta, Georgia 30334
(404) 656-4713

GUAM
Office of Civil Defense
Post Office Box 2877
Agana, Guam 96910
(011) 671-477-9841

HAWAII
Hawaii Board of Land and Natural Resources
P.O. Box 621
Honolulu, Hawaii 96809
(808) 548-7642

IDAHO
Department of Water Resources
State House
Boise, Idaho 83720
(208) 334-7900

ILLINOIS
Illinois Department of Transportation
Division of Water Resources
2300 South Dirksen Parkway
Springfield, Illinois 62764
(217) 782-3862

INDIANA
Department of Natural Resources
2475 Directors Row
Indianapolis, Indiana 46241
(317) 232-4160

IOWA
Iowa Department of Natural Resources
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5385

KANSAS
Division of Water Resources
Kansas State Board of Agriculture
109 Southwest Ninth Street
Topeka, Kansas 66612-1283
(913) 296-3717

KENTUCKY

Kentucky Department of Natural Resources
Division of Water
18 Reilly Road
Fort Boone Plaza
Frankfort, Kentucky 40601
(502) 564-3410

LOUISIANA
Louisiana Department of Transportation and Development
Office of Public Works
Floodplain Management Section
P.O. Box 94245
Baton Rouge, Louisiana 70804-9245
(504) 379-1432

MAINE
Maine Department of Economic Affairs
Tawes State Office Building D-3
Annapolis, Maryland 21401
(207) 289-3154

MASSACHUSETTS
Massachusetts Division of Water Resources
Salltonstall Building - Room 1304
100 Cambridge Street
Boston, Massachusetts 02202
(617) 727-3267

MICHIGAN Water Management Division
Michigan Department of Natural Resources
P.O. Box 30028
Lansing, Michigan 48909
(517) 335-3182

MINNESOTA
Flood Plains/Shoreline Management Section
Division of Waters
Department of Natural Resources
500 LaFayette Road - Box 32
St. Paul, Minnesota 55515-4032
(612) 296-4800

MISSISSIPPI
Mississippi Emergency Management Agency
P.O. Box 4501
Fondren Station
Jackson, Mississippi 39216
(602) 960-9033

MISSOURI
Department of Natural Resources
101 North Jefferson
P.O. Box 176
Jefferson City, Missouri, 65102
(314) 751-2116

MONTANA
Montana Department of Natural Resources and Conservation
1520 East 6th Avenue
Helena, Montana 59620-2301

(406) 444-6646

NEBRASKA
Nebraska Natural Resources Commission
P.O. Box 94876
Lincoln, Nebraska 68509
(402) 471-2081

NEVADA
Division of Emergency Management State of Nevada
Capitol Complex
2525 South Carson
Carson City, Nevada 89710
(702) 885-4240

NEW HAMPSHIRE
Governors Office of Emergency Management
State Office Park South
107 Pleasant Street
Concord, New Hampshire 03301
(603) 271-2231

NEW JERSEY
New Jersey Department of Environmental Protection
Division of Coastal Resources
P.O. Box 401
501 East State Street
CN 401
Trenton, New Jersey 08625
(609) 292-2296

NEW MEXICO
New Mexico State Engineer's Office
Bataan Memorial Building
Santa Fe, New Mexico 87503
(505) 827-6091

NEW YORK
Flood Protection Bureau
New York Department of Environmental Conservation
50 Wolf Road - Room 330
Albany, New York 12233-3507
(518) 457-3151

NORTH CAROLINA
North Carolina Department of Crime Control and Public Safety
Division of Emergency Management
116 West Jones Street
Raleigh, North Carolina 27603-1335
(919) 733-3867

NORTH DAKOTA
State Water Commission (701) 224-2750
900 East Boulevard
Bismark, North Dakota 58505

OHIO
Ohio Department of Natural Resources

Division of Water
Flood Plain Management
Fountain Square
Columbus, Ohio 43224

OKLAHOMA
Oklahoma Water Resources Board
(405) 271-2555
12th Floor Northeast
1000 Northeast 10th
P.O. Box 53585
Oklahoma City, Oklahoma 73152

OREGON
Department of Land Conservation Development
(503) 378-2332
1175 Court Street N.E.
Salem, Oregon 97310

PENNSYLVANIA
Department of Community Affairs
(717) 787-7400
Forum Building - Room 317
Harrisburg, Pennsylvania 17120

PUERTO RICO
Puerto Rico Planning Board
(809) 726-6000
P.O. Box 41119, Minillas Station
Extension 4494
De Diego Avenue, Stop 22
San Juan, Puerto Rico 00940-90985

RHODE ISLAND
Department of Administration
(401) 277-2656
Statewide Planning Program
265 Melrose Street
Providence, Rhode Island 02907

SOUTH CAROLINA
South Carolina Water Resources Commission
(803) 737-0800
AT&T Capital Center, Suite 1100
1201 Main Street
Columbia, South Carolina 29201

SOUTH DAKOTA
Disaster Assistance Program
(605) 773-3231
Emergency and Disaster Services
500 East Capitol
Pierre, South Dakota 57501

TENNESSEE
Tennessee Department of Economic and Community Development
Division of Community Development
320 Sixth Avenue, North - Sixth floor
Nashville, Tennessee 37219-5408
(615) 741-2211

VERMONT
Division of Water Resources
Agency of Environmental Conservation
10 North Building
103 South Main Street
Waterbury, Vermont 05676
(802) 244-6951

VIRGIN ISLANDS
Department of Planning
179 Alton & Welgunst
St. Thomas, Virgin Islands 00802
(809) 774-3320(809) 774-3320

VIRGINIA
Department of Conservation and Historic Resources
Division on Soil and Water Conservation
203 Governor Street - Suite 206
Richmond, Virginia 23219-2094
(804) 786-2886

WASHINGTON
Department of Ecology
Mail Stop PV11
Olympia, Washington 98504
(206) 459-6169

WEST VIRGINIA
West Virginia Office of Emergency Services
Room EB-80
Capitol Building
Charleston, West Virginia 25305
(304) 348-5380

WISCONSIN
Department of Natural Resources
Flood Plain - Shoreland Management Section
P.O. Box 7921
Madison, Wisconsin 53707
(608) 266-3093

WYOMING
Wyoming Emergency Management Agency
P.O. Box 1709
Cheyenne, Wyoming 82003
(307) 777-7566

Medicare Handbook

This handbook explains the Medicare program, but it is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

Message from the Secretary:

For three decades, Medicare has helped pay medical bills for millions of older Americans, providing them with comprehensive health benefits they can count on. Today, Medicare serves more than 38 million older and disabled Americans. Few programs, public or private, have such a positive impact on so many Americans.

Before the introduction of Medicare in 1966, only 50 percent of the Nation's elderly population had any health insurance. In 1996, 30 years later, only about 1 percent of the elderly are uninsured. Medicare has evolved into one of the world's best health insurance programs, delivering essential services that have improved the quality of life for many of our most vulnerable citizens.

We in the federal government, from President Clinton to the employees of the Department of Health and Human Services, are determined to continue to provide you with the first- rate health care and peace of mind which have always been Medicare's hallmark. If you are a new enrollee, we want to welcome you to Medicare. If you have been part of the Medicare beneficiary "family," we want to reassure you of our commitment to keep Medicare working for you.

Donna E. Shalala, Secretary, Department of Health and Human Services

Message from the Administrator: It is with pride that the Health Care Financing Administration (HCFA) issues the 1996 edition of Your Medicare Handbook during this 30th anniversary year of the Medicare program.

This handbook was created to be a readable, easy to understand reference tool for Medicare beneficiaries. It provides information about benefits and answers the most frequently asked questions about Medicare. You'll find a summary of your Medicare benefits, rights and obligations, and a list of organizations that you can contact if you need assistance with a Medicare-related matter.

At HCFA, serving you is our top priority. That means providing you with world-class service and making sure that you have the information you need to best use your Medicare benefits. As the administrator of HCFA, the federal agency within the Department of Health and Human Services that administers Medicare, I can assure you that we take these commitments seriously. We're proud of Medicare's accomplishments, and want to be sure that you are satisfied with our service.

Bruce C. Vladeck, Administrator, Health Care Financing Administration

Introduction to Medicare

Your Medicare Handbook is intended to provide you with the information you need in order to take full advantage of your Medicare benefits. On the following pages you will learn about who's eligible for Medicare, how to enroll for Medicare and what hospital and medical expenses are covered by Medicare, and how much of the bill you are responsible for paying.

You will also find information about managed care plans and Medicare supplemental (Medigap) insurance. And in the back of the handbook you will find a glossary of Medicare terms and a directory that lists the names and telephone numbers of organizations that can help you with Medicare-related issues.

Medicare is administered by the Health Care Financing Administration (HCFA), a federal agency in the Department of Health and Human Services. The Social Security Administration (SSA) helps HCFA by enrolling people in Medicare and by collecting Medicare premiums. Various commercial insurance companies are under contract with HCFA to process and pay Medicare claims, and groups of doctors and other health care professionals have contracts to monitor the quality of care delivered to Medicare beneficiaries. And, of course, HCFA also forms partnerships with the thousands of providers of health care services - hospitals, nursing homes, and home health agencies; doctors; suppliers of medical

equipment; clinical laboratories; and managed care plans such as health maintenance organizations (HMOs).

HCFA's goal is to provide you with quality services and publications. If after using Your Medicare Handbook, you would like to comment on the contents or design or offer suggestions for improving it, we would like to hear from you. We are particularly interested in knowing whether the handbook provides the information you need as a Medicare beneficiary, and whether it is easy to read and understand. Please send your comments to:

Health Care Financing Administration
Office of Beneficiary Relations
N-1005
7500 Security Boulevard
Baltimore, MD 21244-1850

This handbook is also available on audio tape for the visually impaired and on the Internet. HCFA's WEB site address is: http://www.hcfa.gov

Medicare Handbook- Part I What is Medicare?

HEALTH INSURANCE
Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Both parts will be explained in more detail later, but basically Part A helps pay for care in a hospital and a skilled nursing facility, and for home health and hospice care. Part B helps pay doctor bills, and for outpatient hospital care and various other medical services not covered by Part A.

See:

Who's Eligible for Medicare?

Enrollment

Applying for Medicare:

Your Medicare Card

Fee-for-Service or Managed Care?

Who's Eligible for Medicare?

You are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment, and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with a chronic kidney disease.

Here are some simple guidelines. You can get Part A at age 65 without having to pay premiums if:

* You are already receiving retirement benefits from Social Security or the Railroad Retirement Board.

* You could receive Social Security or Railroad Retirement benefits but have not filed for them.

* You or your spouse had Medicare-covered government employment.

* If you are under 65, you can get Part A without having to pay premiums if:

* You have received Social Security or Railroad Retirement Board disability benefits for 24 months.

* You are a kidney dialysis or kidney transplant patient.

While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. The Part B monthly premium in 1996 is $42.50. It is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement check.

If you have questions about your eligibility for Medicare Part A or Part B or if you want to apply for Medicare, call the Social Security Administration. The toll-free telephone number is: 1-800-772-1213. You can also get information about buying Part A, as well as Part B, if you do not qualify for premium-free Part A.

Enrollment

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works.

Automatic Enrollment:

If you are already getting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about three months before your 65th birthday. If you do not want Part B, follow the instructions that come with the card.

If you are disabled, you will automatically get a Medicare card in the mail after you have received Social Security or Railroad Retirement Board disability benefits for 24 months.

Applying for Medicare:

If you are not receiving Social Security or Railroad Retirement benefits three months before you turn 65, you need to apply for Medicare. You apply by contacting any Social Security Administration office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

Apply three months before you turn 65. That's the beginning of your seven-month initial enrollment period. By applying early you'll avoid a possible delay in the start of your Part B coverage.

If you do not enroll during this seven-month period, you'll have to wait to enroll during the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year and Part B coverage starts the following July.

Don't put off enrolling. If you wait 12 or more months to sign up, your premiums generally will be higher.

Part B premiums go up 10 percent for each 12 months that you could have been enrolled but were not. The increase in the Part A premium (if you have to pay a premium) is 10 percent no matter how late you enroll for coverage.

Under certain circumstances, however, you can delay your Part B enrollment without having to pay higher premiums. If you are age 65 or over and have group health insurance based on your own or your spouse's current employment, or if you are disabled and have group health insurance based on your current employment or the current employment of any family member you have a choice:

* You may enroll at any time while you are covered by the group health plan, or;

* You can enroll during a special eight- month enrollment period that begins the month employment ends or the month you are no longer covered under the employer plan, whichever comes first.

If you do not enroll by the end of the eight-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

Even if you continue to work after you turn 65, you should at least sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B at the same time. You would have to pay the monthly Part B premium and the Part B benefits would be of limited value to you as long as the employer plan was the primary payer of your medical bills. Moreover, you would trigger your six- month Medigap open enrollment period (see Medigap Insurance).

Your Medicare Card

Once enrolled, you'll receive a Medicare card imprinted with your name and Medicare claim number. It shows what coverage you have (Part A, Part B or both) and the date your coverage started.

Show your card whenever you get medical care. This will assure that a claim for payment is sent to Medicare. Make sure to use your exact name and claim number. If you are married, your spouse will have his or her own card and claim number. Never let anyone else use your Medicare card, and keep the number as safe as you would a credit card number.

Take your card with you when you travel and have it handy when you call about a Medicare claim. If you lose your card, contact the Social Security Administration right away.

Fee-for-Service or Managed Care?

One important decision you may have to make is how you will receive your Medicare hospital and medical benefits. If you live in an area served by a managed care plan, you have a choice. You can receive your Medicare benefits either through the fee-for-service system or through a managed care plan such as a health maintenance organization (HMO).

If you choose fee-for-service, you can go to almost any doctor, hospital or other health care provider you want to. Generally, a fee is charged each time a service is used. Medicare pays its share of the bill. You are responsible for paying the balance.

In managed care, you usually must get all of your care from the doctors, hospitals, and other health care providers that are part of the plan, except in emergencies. Depending on the plan, you may have to pay a monthly premium and a copayment each time you go to the doctor or use other services.

Regardless of whether you choose fee-for-service or managed care, you retain all of your Medicare benefits, protections and appeal rights.

Let's look at how the two systems work under Medicare. The following sections describe Medicare's Part A and Part B benefits and how Medicare works if you receive your health care through the fee-for-service system. The explanation of how Medicare works with managed care plans follows.

Medicare Handbook- Medicare and Managed Care

Managed care plans can represent good health care value. They provide all of Medicare's benefits and frequently more, and there is little or no paperwork.

You may have to pay a fixed monthly premium and a copayment each time a service is used. The premiums and copayments vary from plan to plan and can be changed each year. You also must continue to pay the Part B premium to Medicare. You do not pay Medicare's deductibles and coinsurance.

Usually there are no other charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. Your costs are therefore more predictable than under fee-for-service Medicare.

In addition to offering you all your Medicare benefits, many plans promote preventive health care by providing extra benefits such as eye examinations, hearing aids, routine physicals, scheduled inoculations and prescription drugs for little or no extra fee.

Each plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. Depending on how the plan is organized, services are usually provided either at one or more centrally located health facilities or in the private practice offices of the doctors and other health care professionals that are part of the plan. You generally must receive all covered care through the plan or from health care professionals to whom the plan refers you or else the plan will not pay.

Most managed care plans allow you to select a primary care doctor from those that are part of the plan. If you do not make a selection, one will be assigned to you. Your primary care doctor is responsible for managing your medical care, admitting you to a hospital and referring you to specialists. You are allowed to change your primary care doctor as long as you select another primary care doctor affiliated with the plan.

See:

Types of Plans

Enrolling in a Plan

Leaving A Plan

Types of Plans

Before enrolling in a managed care plan, find out whether the plan has a "risk" or a "cost" contract with Medicare. There's an important difference.

See:

Risk Plans:

Cost Plans:

Risk Plans:

These plans have "lock-in" requirements. This means that you generally are locked into receiving all covered care through the plan or through referrals by the plan. In most cases, if you receive services that are not authorized by the plan, neither the plan nor Medicare will pay.

The only exceptions recognized by all Medicare-contracting plans are for emergency services, which you may receive anywhere in the United States, and for services you urgently need when you are temporarily out of the plan's service area.

A third exception offered by a few risk plans is called the "point-of-service" (POS) option. Under the POS option, the plan permits you to receive certain services outside the plan's provider network and the plan will pay a percentage of the charges. In return for this flexibility expect to pay at least 20 percent of the bill.

Cost Plans:

These plans do not have lock-in requirements. If you enroll in a cost plan, you can either go to health care providers affiliated with the plan or go outside the plan. If you go outside the plan, the plan probably will not pay but Medicare will.

Medicare will pay its share of charges it approves. You will be responsible for Medicare's coinsurance, deductibles and other charges, just as if you were receiving care under the fee-for-service system.

Because of this flexibility, a cost plan may be a good choice for you if you travel frequently, live in another state part of the year, or want to use a doctor who is not affiliated with a plan.

Enrolling in a Plan

Most Medicare beneficiaries can enroll in a managed care plan. To enroll:

1. You must have Medicare Part B and continue paying Part B premiums.

2. You must live in the plan's service area.

3. You cannot be receiving care in a Medicare-certified hospice.

4. You cannot have permanent kidney failure at the time of enrollment.

The names of the plans in your area are available by calling your state insurance counseling office. (See state-by-state listing beginning in Medicare Beneficiary Resources Section) Insurance counselors will give you information about the plans in your state to help you decide whether managed care is right for you.

All plans that have contracts with Medicare must have an advertised open enrollment period of at least 30 days once a year. Plans must enroll Medicare beneficiaries in the order of application. You cannot be rejected because of poor health.

If your area is served by more than one plan, compare the doctors' qualifications, facilities, premiums, copayments, and benefits to determine which plan best suits your needs at a price you can afford. Determine whether the plan's providers are in a location convenient to you and whether transportation is available at all hours to get you to them.

Carefully weigh the advantages and disadvantages of plan membership if you travel a lot or live part of the year in another state. Plans must provide coverage for a fixed period of time when you travel.

Also keep in mind that if you enroll in a plan and later move out of the plan's service area, you will have to disenroll and either return to fee-for-service Medicare or enroll in a plan that serves your new location.

Because each plan is different, your benefits and premiums probably will not be exactly the same if you enroll in another plan.

Leaving A Plan

You can stay in a managed care plan as long as it has a Medicare contract or you can leave at any time to join another plan or to return to fee-for-service Medicare.

To end your enrollment, send a signed request to the plan or to your local Social Security Administration office or, if appropriate, the Railroad Retirement Board. You return to fee- for-service Medicare the first day of the next month after the plan receives your request to disenroll.

To change from one managed care plan to another, simply enroll in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

Medigap insurance is another issue that you should consider if you are thinking about enrolling in a plan or if you are already in a plan and are thinking about disenrolling.

If you have a Medigap policy and decide to enroll in a plan, you may either keep the policy or, if after deciding you like the plan, you may cancel it. You generally do not need a Medigap policy if you are in a managed care plan.

A Medigap policy could be of value to you if you leave the plan and return to fee-for- service Medicare. If you previously had a Medigap policy but dropped it while in the plan or never had one before you joined the plan, you might not be able to buy the policy of your choice, especially if you have a health problem.

Medicare Part A Benefits

Medicare Coverage

When all program requirements are met, Medicare Part A helps pay for:

* Care in a hospital.

* Care in a skilled nursing facility following a hospital stay.

* Home health care.

* Hospice care.

* Blood, after the first three pints.

Benefit Periods

Coverage for care in hospitals and skilled nursing facilities is measured in "benefit periods". In each benefit period you are limited as to the number of days Medicare will help pay for inpatient hospital and skilled nursing facility care. Exceed the limit and you are responsible for all charges for each additional day of care.

A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 straight days. It also ends if you are in a skilled nursing facility but have not received skilled care there for 60 straight days.

The next time you are admitted to a hospital, a new benefit period begins and your hospital and skilled nursing facility benefits are renewed. There is no limit to the number of benefit periods you can have.

Inpatient Hospital Care

If you need inpatient hospital care, Medicare Part A helps pay for up to 90 days of medically necessary care in a Medicare-certified hospital in a benefit period.

During the first 60 days Medicare pays all covered costs except for $736. That's the hospital deductible for 1996 and you are responsible for paying it. You only pay the deductible once during a benefit period no matter how many times you go to the hospital.

For the 61st through the 90th day in a benefit period, Medicare pays all covered costs except for coinsurance of $184 per day in 1996. You are responsible for paying the coinsurance.

Reserve Days:

In the unlikely event that you are in the hospital for more than 90 days in a benefit period, you can use your "reserve days" to help pay the bill. When a reserve day is used Medicare pays all covered cost except for coinsurance of $368 in 1996. Again, you are responsible for paying the coinsurance.

You have a supply of 60 reserve days. Once a reserve day is used, it is not renewed. So if you use 10 reserve days, you'll have 50 left to use during the rest of your life.

Covered Hospital Services:

When you are in the hospital, Part A helps pay for a semiprivate room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests and X- rays. Coverage is also provided for use of the operating and recovery rooms, intensive care and coronary care units, and all other medically necessary services and supplies.

Hospital Services Not Covered:

Medicare does not pay for personal convenience items such as a telephone or television in your room, for private duty nurses, or any extra charges for a private room unless it is medically necessary.

Qualifying for Hospital Care:

Medicare helps pay for inpatient hospital care when these four requirements are met:

1. A doctor prescribes inpatient hospital care for an illness or injury.

2. Your illness or injury requires care that can only be provided in a hospital.

3. The hospital participates in Medicare.

4. The hospital's Utilization Review Committee or a Peer Review Organization (PRO) did not disapprove your stay.

Important Message:

When you are admitted to the hospital for covered care, the hospital is required to give you a copy of a document called An Important Message From Medicare. If you don't get a copy be sure to ask for one.

The message explains your rights as a Medicare hospital patient. It also tells you what to do if you think you are being discharged from the hospital too early or are notified that Medicare will no longer pay for your hospital care.

Advance Directive:

Hospitals also must tell you about your right to prepare an advance directive. An advance directive is a written statement that explains what services you want or do not want if you ever become unable to communicate your wishes during a medical emergency.

Involve loved ones and your legal and religious advisers in the preparation of your advance directive. They can help ensure that your wishes are followed should you become incapacitated. Your doctor also should be consulted and asked to include the advance directive in your medical records. An advanced directive is also called a "living will" or "durable power of attorney for health care."

Skilled nursing facilities, hospices, home health agencies and HMOs serving Medicare beneficiaries also must give you information about advance directives.

Psychiatric Hospital Coverage:

In addition to covering care in a general hospital, Part A helps pay for care in a Medicare- participating psychiatric hospital. Coverage is limited to a lifetime maximum of 190 days of care. Psychiatric care provided in a general hospital is not subject to the 190-day limit. If you are a patient in a psychiatric hospital when you first become entitled to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Christian Science Sanatorium:

Part A also helps pay for inpatient hospital and skilled nursing facility services provided by a participating Christian Science sanatorium. It must be operated or listed and certified by the First Church of Christ, Scientist, in Boston, to qualify for Medicare payment. Medicare will not pay for the practitioner.

Skilled Nursing Facility Care

If after being discharged from the hospital, you need to go to a skilled nursing facility, Medicare will help pay for your care for up to 100 days in a benefit period.

Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount of $92 in 1996. You are responsible for paying the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

What happens if you are discharged from a skilled nursing facility and later must be readmitted? If you are still in the same benefit period, Medicare will continue to help pay for your care until you have used up your 100 days of coverage. The care must be for a condition treated during your previous stay.

If you have been out of the skilled nursing facility 60 or more days and the benefit period has ended, another three-day hospital stay will be required before your skilled nursing facility care benefits are renewed.

A skilled nursing facility is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. The care must be either performed by or provided under the supervision of licensed nursing

personnel.

Not all nursing homes are skilled nursing facilities. Most nursing homes primarily offer custodial care such as help in eating, bathing, taking medicine, and toileting. Medicare does not cover custodial care if that is the only care you need.

If you're in doubt about whether your stay in a skilled nursing facility will be covered by Medicare, ask your doctor or someone in the facility's business office. Keep in mind that a skilled nursing facility cannot require you to pay a cash deposit as a condition of admission unless it is clear that your care will not be covered by Medicare.

Qualifying for Skilled Nursing Facility Care:

Medicare pays for care in a skilled nursing facility when these five conditions are met:

1. You require daily skilled nursing or rehabilitation services that can only be provided in a skilled nursing facility.

2. You were in the hospital three days in a row, not counting the day of discharge, before entering the skilled nursing facility.

3. You are admitted to the facility within a short period of time (generally 30 days) after leaving the hospital.

4. The condition for which you are receiving skilled nursing care was treated in the hospital or arose while you were receiving care for a condition treated in the hospital.

5. A medical professional certifies that skilled nursing care is necessary.

Blood Coverage

You may need blood as part of a covered inpatient stay in a hospital or a skilled nursing facility-whole blood, units of packed red blood cells, or blood components. If so, Medicare will help pay the costs, including the cost of processing and administering it.

You must either pay for or replace the first three pints of blood each year-this is the annual blood deductible. You can replace the blood you use yourself or have another person donate on your behalf.

Both Part A and Part B of Medicare cover blood, and to the extent that you meet the three-pint blood deductible under one part you do not have to meet it under the other part.

Home Health Care

If you are confined to your home and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services.

Medicare Part A (or Part B if you do not have Part A) pays the entire bill for covered services for as long as they are medically reasonable and necessary. Coverage is provided for the services of skilled nurses, home health aides, medical social workers and different kinds of therapists. The services may be provided either on a part-time or intermittent basis, not full-time.

Besides paying for health care services, the home health benefit also covers the full cost of some medical supplies and 80 percent of the approved amount for durable medical equipment, such as wheelchairs, hospital beds, oxygen supplies and walkers.

Qualifying for Home Health Care:

Medicare pays for home health care when these four conditions are met:

1. You require intermittent skilled nursing care, physical therapy, or speech language pathology.

2. You are confined to your home.

3. Your doctor determines that you need home health care and sets up a plan for you to receive care at home.

4. The home health agency providing the care participates in Medicare.

You can find a Medicare-approved home health agency by asking your doctor, your hospital discharge planner, or by looking in the Yellow Pages under "home health care."

Hospice Care

Another benefit available under Part A is hospice care if you are terminally ill. You can elect to receive hospice care rather than regular Medicare benefits for the management of your illness.

Hospice care may be provided by either a private organization or a public agency for up to 210 days, or even longer in some cases. Emphasis is on providing comfort and relief from pain. While the Medicare hospice benefit primarily provides for care at home, it can help pay for inpatient care as well as for a variety of services not usually covered by Medicare, including homemaker services, counseling, and certain prescription drugs.

Medicare pays nearly the entire bill for hospice care. There can be a copayment of up to $5 for each drug prescription and about $5 per day for inpatient respite care. Respite care is intended to give temporary relief to the person or persons who regularly assist with home care.

Qualifying for Hospice Care:

Medicare pays for hospice care when these three conditions are met:

1. Your doctor certifies that you are terminally ill.
2. You choose to receive hospice care instead of the standard Medicare benefits for the illness.
3. The care is provided by a Medicare-participating hospice program.

If you elect hospice care and later require treatment for a condition other than the terminal illness, you can use Medicare's standard benefits. When standard benefits are used, you must pay any required deductibles and coinsurance.

Part A Claims

When you receive services covered by Part A, you do not file a claim for payment. In fact, you seldom if ever have to get involved in the processing of a Part A claim.

The hospital, skilled nursing facility or other provider from whom you received services files the claim for you. It is sent to a private insurance organization called a "Medicare intermediary." The intermediary has a contract with the Federal Government to handle Part A claims.

The intermediary will send you a Benefits Notice showing what was billed, Medicare's portion of the bill, and what you are responsible for paying. All questions about charges and payments should be directed to the intermediary. The intermediary's address and telephone number appear on the notice.

Medicare Part A Chart: 1996

	Services	Benefit	Medicare Pays	You Pay (1)
Hospitalization:	Semiprivate room and board, general nursing and other hospitalization services and supplies. (Medicare payments based on benefit periods, see Medicare Part A Benefits section)	First 60 days	All but $736	$736
		61st to 90th day	All but $184 a day	$184 a day
		91st to 150th day (2)	All but $368 a day	$368 a day
		Beyond 150 days	Nothing	All costs
Skilled Nursing Facility Care:	Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. (Medicare payments based on benefit periods, see Medicare Part A Benefits section)	First 20 days	100% of approved amount	Nothing
		Additional 80 days	All but $92 a day	Up to $92 a day
		Beyond 100 days	Nothing	All costs
Home Health Care:	Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare conditions	100% of approved amt.; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Hospice Care:	Pain relief, symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs and inpatient respite care.
Blood:	When furnished by a hospital or skilled nursing	Unlimited if medically necessary	All but first 3 pints per calendar years	For first 3 pints. (3)

	facility during a covered stay

1996 Part A Monthly premium: $289 with fewer than 30 quarters of Medicare-covered employment; $188 with more than 30 quarters but fewer than 40 quarters of covered employment. Most beneficiaries do not have to pay a premium for Part A.

(1) Either you or your insurance company are responsible for paying the amounts listed in the "You Pay" column.

(2) This 60-reserve-days benefit may be used only once in a lifetime (see Medicare Part A Benefits section)

(3) Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

Medicare Handbook- Medicare Part B Benefits

Medicare Coverage

Medicare Part B picks up where Part A leaves off. It pays for a wide range of medical services and supplies, but perhaps most important, it helps pay doctor bills.

The medically necessary services of a doctor are covered no matter where you receive them--at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital.

Part B also helps pay for:

* Outpatient hospital services.

* X-rays and laboratory tests.

* Ambulance transportation.

* Breast prostheses following a mastectomy.

* Services of certain specially qualified practitioners who are not doctors.

* Physical and occupational therapy.

* Speech language pathology services.

* Home health care, if you do not have Part A of Medicare.

* Blood, after the first three pints.

* Flu, pneumonia and hepatitis B shots.

* Pap smears for the detection of cervical cancer.

* Mammograms to screen for breast cancer.

* Outpatient mental health services.

* Artificial limbs and eyes.

* Arm, leg, back and neck braces.

* Durable medical equipment, including wheelchairs, walkers, hospital beds and oxygen equipment prescribed by a doctor for home use.

* Kidney dialysis and kidney transplants. Under limited circumstances, heart and liver transplants in a Medicare-approved facility.

* Medical supplies and items such as ostomy bags, surgical dressings, splints and casts.

Benefit Limits

Some Part B benefits have special requirements and some are more strictly limited than others. Pap smears, for example, are generally covered once every three years, mammograms every 24 months, and therapeutic shoes once a year.

Durable Medical Equipment:

Wheelchairs and other durable medical equipment are covered only when prescribed by a doctor for use at home and are provided by a supplier approved by Medicare. You can find out what equipment is covered and whether a supplier is approved by calling Medicare's durable medical equipment (DME) regional carrier for your area.

Ambulance Services:

The ambulance benefit is also strictly limited. Medicare will help pay for the service only if:

1. The ambulance, equipment and personnel meet Medicare requirements, and;

2. Transportation in any other vehicle could endanger your health.

Coverage is generally restricted to transportation between your home and a hospital, your home and a skilled nursing facility, or a hospital and a skilled nursing home.

What's Not Covered:

Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids and most prescription drugs. Eyeglasses are only covered if you need corrective lenses after a cataract operation.

What You Pay

When you use your Part B benefits, you are responsible for paying the first $100 each year of the charges approved by Medicare. This is called the Part B annual deductible.

After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are responsible for the remaining 20 percent. This is called coinsurance. Sometimes your share of the bill is more than 20 percent of the Medicare- approved amount. If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare- approved amount. If you receive outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides having to pay Medicare's deductibles and coinsurance, you are responsible for all charges for services and supplies you receive that are not covered by Medicare.

What Is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment of Medicare. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the 20 percent coinsurance. That can mean savings for you.

Here's how. Let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare- approved amount for the service you receive is $100.

Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115, which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge.

Medicare would pay 80 percent of $100, or $80 and you would be responsible for the remaining $35. But because Medicare pays its share of the bill to you and not the doctor when a claim is unassigned, the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

Limiting Charge:

Be aware that Federal law prohibits a doctor who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded. In some states, the limit is even stricter.

Other Charge Limits:

Doctors who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery performed.

Additionally, any doctor who does not participate in Medicare and who provides you with a service that he or she knows or has reason to believe Medicare will determine to be medically unnecessary, and thus will not pay for, must tell you that in writing before performing the service. If written notice is not given, and

you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

To avoid excess charges go to doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others sign agreements to accept assignment of all Medicare claims. They are called participating doctors and suppliers. You can get the names, addresses and telephone numbers of participating doctors and suppliers by calling your Medicare carrier.

Part B Claims

Carriers are private insurance companies that contract with the Federal Government to process Medicare claims and make payments for services and supplies covered by Part B.

Every time you go to the doctor for a service covered by Medicare, the doctor is required by law to send the claim for payment to the carrier for the area where the service was provided. After processing your claim, the carrier usually will send you a statement called an Explanation of Medicare Benefits (EOMB). It shows what was billed, the amount Medicare approved, and what you owe. It also tells you how to file an appeal if you disagree with a payment decision. Contact the carrier with any questions about a Part B claim. The carrier's name and telephone number are printed on the benefit notice. A state-by-state listing of Medicare carriers can be found in the section, "Medicare Beneficiary Resource Directory."

If you get Medicare under the Railroad Retirement system, your claims are processed by the MetraHealth office that serves your region. You can get the telephone number from any Railroad Retirement Board office.

Getting A Second Opinion

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

Medicare pays the same way for a second opinion as it pays for other doctor services as long as you are seeking advice for the treatment of a medical condition covered by Medicare. If the first two opinions contradict each other, Medicare will help pay for a third opinion.

You can ask your own doctor to refer you to another doctor for a second opinion. Or you can call your Medicare carrier and ask for the names and phone numbers of doctors in your area who provide second opinions.

Does Medicare Cover the Services of All Kinds of Medical Professionals?

Most of the doctor services covered by Medicare must be provided by either a doctor of medicine or a doctor of osteopathy. Under very limited circumstances, Medicare can help pay for the services of chiropractors, podiatrists, dentists, and optometrists.

As an example of how restrictive the coverage is, there is only one chiropractic service covered by Medicare. That's manipulation of the spine to correct a dislocation that can be shown by an X-ray. Medicare does not pay for an X-ray performed by a chiropractor.

When in doubt about whether a service is covered by Medicare call your Medicare carrier.

The carrier can also tell you whether Medicare will pay for services provided by a medical professional who is not a doctor. In some cases Medicare covers the services of certified registered nurse anesthetists, certified midwives, nurse practitioners, physician assistants, clinical social workers and clinical psychologists. The coverage is limited, so call your Medicare carrier to find out whether Medicare will pay for the kind of service you need.

Special Health Care Facilities

Besides helping to pay for care in a hospital or skilled nursing facility, Medicare covers a variety of services provided at special types of health care facilities.

Ambulatory Surgical Center:

For example, Part B helps pay for certain types of surgery performed at a Medicare- approved ambulatory surgical center. This type of surgery does not require a hospital stay.

Rural Health Clinics:

Various services provided at rural health clinics are also covered. These clinics serve areas where few people live. Medicare pays for services provided by the doctors, nurse practitioners, doctor assistants, nurse midwives, clinical psychologists and social workers that are part of the clinic.

Comprehensive Outpatient Rehabilitation Facility (CORF):

Part B pays for services provided at a comprehensive outpatient rehabilitation facility if they were prescribed by a doctor and the facility participates in Medicare.

Community Mental Health Centers:

Under certain conditions, Part B helps pay for outpatient mental health care provided by community mental health centers or hospital outpatient departments. These are specially qualified programs that provide partial hospitalization for mental health care. Check with the program you have chosen to see if it meets the conditions for Medicare payment.

Federally Qualified Health Centers:

A full range of services can be obtained at federally qualified health centers. These facilities are mainly community health centers, Indian health clinics, migrant worker health centers and health centers for the homeless. They are generally located in inner-city and rural areas, and they are open to all Medicare beneficiaries.

Certified Medical Laboratory:

Laboratory clinical diagnostic tests are covered when provided by a certified medical laboratory that participates in Medicare. The laboratory must accept assignment of your Medicare claim and cannot bill you. Part B pays all charges. (In Maryland only, you can be billed for 20 percent coinsurance for hospital outpatient tests.)

Programs That Help Low-Income Beneficiaries

If you are a Medicare beneficiary with a very low-income and few assets, you might qualify for state assistance in paying your health care costs. There are two programs that can help.

One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

The QMB program pays Medicare's premiums, deductibles and coinsurance for certain elderly and disabled persons who are entitled to Medicare Part A. Your income must be at or below the national poverty level and your savings and other assets cannot exceed $4,000 for one person or $6,000 for a couple.

The monthly income limits for the QMB program in 1996 for all states except Alaska and Hawaii are $665 for an individual and $884 for a couple. In Alaska the monthly income limits are $825 for an individual and $1,099 for a couple while in Hawaii they are $763 for an individual and $1,014 for a couple.

The SLMB program is for persons entitled to Medicare Part A whose incomes are slightly higher than the national poverty level. The program pays only your Medicare Part B premium. The monthly income limits for the SLMB program in 1996 for all states except Alaska and Hawaii are $794 for an individual and $1,057 for a couple.

In Alaska the monthly income limits are $986 for an individual and $1,314 for a couple while in Hawaii they are $912 for an individual and $1,213 for a couple.

For more information contact your state or local Medicaid, public welfare or social services office. You can find the number in the telephone directory under "State Government."

Medicare Part B Chart: 1996

	Services	Benefit	Medicare Pays	You Pay (1)
Medical Expenses	Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary	80% of approved amount (after $100 deductible). Reduced to 50% for most outpatient mental health services.	$100 deductible, plus 20% of approved amount and limited charges above approved amount.
Clinical Laboratory Services	Blood tests, urinalyses, and more	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
Home Health Care	Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
Outpatient Hospital Treatment	Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	20% of whatever the hospital charges (after $100 deductible).
Blood		Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint.)	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible). (2)
Ambulatory Surgical Services		Unlimited if medically necessary.	80% of pre-determined amount (after $100 deductible).	$100 deductible, plus 20% of pre-determined amount.

1996 Part B monthly premium: $42.50 (premium may be higher if you enroll late.

(1) Either you or your insurance company are responsible for paying the amounts in the "Your Pay" column.

(2) Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid or replaced
under Part B.

Medicare beneficiary resource directory

This directory provides a state-by-state listing of Medicare carriers, Peer Review Organizations (PROs), Medicare durable medical equipment regional carriers and state insurance counseling offices. The telephone numbers for the Health Care Financing Administration's 10 regional offices are also provided. An explanation of the assistance available from each of these organizations follows.

MEDICARE CARRIERS can answer questions about Medicare coverage and Medicare Part B claims. The toll-free 800 numbers listed, in many cases, can be used only in the states where the carriers are located. Out-of-state callers may use a carrier's commercial number, if one is listed.

PEER REVIEW ORGANIZATIONS (PROs) are groups of practicing doctors and other health care professionals paid by the Federal Government to monitor the quality of care provided to Medicare patients by hospitals, skilled nursing facilities, home health agencies, managed care plans and ambulatory surgical centers. If the quality of care you received from one of these facilities was unsatisfactory, you may file a written complaint with the PRO. If you need help in preparing the complaint, the PRO will take the information from you over the telephone and write the complaint for you.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS can tell you what durable medical equipment (wheelchairs, hospital beds, etc.) is covered by Medicare and what the Medicare-approved amount is for a particular piece of equipment. The regional carrier can also identify durable medical equipment suppliers in your area who are approved by Medicare. If you have a complaint about a supplier or suspect that you have been improperly billed for durable medical equipment or otherwise defrauded, contact your durable medical equipment regional carrier.

STATE INSURANCE COUNSELING AND ASSISTANCE PROGRAM offices can provide you with general information about Medicare, Medicaid, managed care plans and the various types of health insurance available to supplement Medicare, including Medigap and long-term care insurance. Counselors can also help you with questions about your medical bills, insurance claims and Medicare benefit explanation forms. The services are free.

THE SOCIAL SECURITY ADMINISTRATION can answer questions about Medicare enrollment, entitlement and premiums, and help you replace a lost Medicare card. Call 1-800-772-1213.

HEALTH CARE FINANCING ADMINISTRATION REGIONAL OFFICES can answer questions about Medicare policy and help resolve Medicare-related problems involving a Medicare carrier, PRO or other organization that is under contract to the Federal Government to serve Medicare beneficiaries. These offices can also give you the names of managed care plans that serve your area. For general information about Medicare or for help with a specific issue, you should first contact the organization listed above that provides the services you need or handles the type of issues or problems that you want help with. If you still are not satisfied, call the HCFA regional office that serves your state.

ALABAMA --INSURANCE COUNSELING GENERAL INFORMATION--
1-800-243-5463

--MEDICARE CARRIERS--:
Blue Cross/Blue Shield of Alabama
1-800-292-8855 or 205-988-2244

--PEER REVIEW ORGANIZATIONS (PROs)--
Alabama Quality Assurance Foundation
1-800-760-3540

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS--Palmetto Government Benefits Administrators

1-800-213-5452 (Spanish @ 1-800-213-5446)

ALASKA --INSURANCE COUNSELING GENERAL INFORMATION--
1-800-478-6065
907-562-7249

--MEDICARE CARRIERS--:
Aetna Life Insurance Co
1-800-452-0125 or 503-222-6831

--PEER REVIEW ORGANIZATIONS (PROs)--
PRO-WEST
1-800-445-6941

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS--
CIGNA Medicare
1-800-899-7095

ARIZONA --INSURANCE COUNSELING GENERAL INFORMATION--
1-800-432-4040
602-542-6595

--MEDICARE CARRIERS--:
Aetna Life Insurance Co.
1-800-352-0411 or 602-861-1968

--PEER REVIEW ORGANIZATIONS (PROs)--
Health Services Advisory Group, Inc.
1-800-359-9909

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS--
CIGNA Medicare
1-800-899-7095

ARKANSAS --INSURANCE COUNSELING GENERAL INFORMATION--
1-800-852-5494
501-371-2780

--MEDICARE CARRIERS--:
Blue Cross/Blue Shield
1-800-482-5525 or 501-378-2320

--PEER REVIEW ORGANIZATIONS (PROs)--
Arkansas Foundation for Medical Care, Inc.
1-800-824-7586

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS--
Palmetto Government Benefits Administrators
1-800-213-5452

CALIFORNIA --INSURANCE COUNSELING GENERAL INFORMATION--
1-800-434-0222
916-323-7315

--MEDICARE CARRIERS--:
Transamerica Occidental Life Ins. Co.

Counties of Los Angeles, Orange, San Diego,Ventura, Imperial, San Luis Obispo, and Santa Barbara

1-800-675-2266 or 213-748-2311 Rest of State: Blue Shield of California 1-800-952-8627 or 916-743-1583

--PEER REVIEW ORGANIZATIONS (PROs)-- California Medical Review, Inc.

1-800-841-1602 or 415-882-5800 (PRO will accept collect calls out of state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

COLORADO --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-544-9181 303-894-7499 ext. 356

--MEDICARE CARRIERS--: Blue Shield of North Dakota 1-800-332-6681 or 303-831-2661

--PEER REVIEW ORGANIZATIONS (PROs)-- Colorado Foundation for Medical Care 1-800-727-7086 or 303-695-3333

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

CONNECTICUT --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-994-9422

--MEDICARE CARRIERS--: MetraHealth 1-800-982-6819 or 203-728-6783 Meridan 203-237-8592

--PEER REVIEW ORGANIZATIONS (PROs)-- Connecticut Peer Review Organization, Inc. 1-800-553-7590 or 203-632-2008

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

DELAWARE --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-336-9500

--MEDICARE CARRIERS--: Xact Medicare Services 1-800-851-3535

--PEER REVIEW ORGANIZATIONS (PROs)-- Health Care Excel 1-800-642-8686 ext 266

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

DISTRICT OF COLUMBIA --INSURANCE COUNSELING GENERAL INFORMATION-- 202-676-3900

--MEDICARE CARRIERS--: Xact Medicare Services 1-800-233-1124

--PEER REVIEW ORGANIZATIONS (PROs)-- Delmarva Foundation for Medical Care, Inc. 1-800-645-0011 D.C./1-800-492-5811 MD.

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

FLORIDA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-963-5337

--MEDICARE CARRIERS-- Blue Cross/ Blue Shield of FLA.

Copies of Benefits notices, requests for MEDPARD directories, address changes and brief claims inquiries (status or verification of receipt)

800-666-7586 or 904-355-8899 For all your other Medicare needs: 800-333-7586 or 904-355-3680

--PEER REVIEW ORGANIZATIONS (PROs)-- Florida Medical Quality Assurance, Inc. 1-800-844-0795 or 813-281-9024

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

GEORGIA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-669-8387

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-727-0827 or 912-920-2412

--PEER REVIEW ORGANIZATIONS (PROs)-- Georgia Medical Care Foundation 1-800-982-0411 or 404-982-0411

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

HAWAII --INSURANCE COUNSELING GENERAL INFORMATION-- 808-586-0100

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-272-5242 or 808-524-1240

--PEER REVIEW ORGANIZATIONS (PROs)-- Hawaii Medical Service Association

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

IDAHO --INSURANCE COUNSELING GENERAL INFORMATION-- S.W. 1-800-247-4422 1-800-488-5725

--MEDICARE CARRIERS-- CIGNA Medicare 1-800-627-2782 or 208-342-7763

--PEER REVIEW ORGANIZATIONS (PROs)-- PRO-WEST 1-800-445-6941 or 208-343-4617

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

ILLINOIS --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-548-9034

--MEDICARE CARRIERS-- Claims/Health Care Service Corp. 1-800-642-6930 or 312-938-8000 TDD 1-800-535-6152

--PEER REVIEW ORGANIZATIONS (PROs)-- Crescent Counties Foundation for Medical Care 1-800-647-8089 or 708-769-9600

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

INDIANA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-452-4800

--MEDICARE CARRIERS-- AdminaStar Federal 1-800-622-4792 or 317-842-4151

--PEER REVIEW ORGANIZATIONS (PROs)-- Indiana Medical Review Organization 1-800-288-1499

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

IOWA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-351-4664

--MEDICARE CARRIERS-- IASD Health Services Corporation Blue Cross & Blue Shield of Iowa 1-800-532-1285 or 515-245-4785

--PEER REVIEW ORGANIZATIONS (PROs)-- Iowa Foundation for Medical Care 1-800-752-7014 or 515-223-2900

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

KANSAS --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-432-3535

--MEDICARE CARRIERS-- Blue Cross/Blue Shield of Kansas Counties of: Johnson and Wyandotte 1-800-892-5900 or 816-561-0900 Rest of state: 1-800-432-3531or 913-232-3773

--PEER REVIEW ORGANIZATIONS (PROs)-- The Kansas Foundation for Medical Care 1-800-432-0407 or 913-273-2552

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

KENTUCKY --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-372-2973 502-564-7372

--MEDICARE CARRIERS-- AdminaStar of Kentucky 1-800-999-7608 or 502-425-6759

--PEER REVIEW ORGANIZATIONS (PROs)-- Kentucky Medical Review Organization 1-800-288-1499

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

LOUISIANA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-259-5301 504-342-0828

--MEDICARE CARRIERS-- Blue Cross & Blue Shield, Inc. 1-800-462-9666 or 504-529-1494 Baton Rouge: 504-927-3490

--PEER REVIEW ORGANIZATIONS (PROs)-- Louisiana Health Care Review, Inc. 1-800-433-4958 or 504-926-6353

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

MAINE --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-750-5353

--MEDICARE CARRIERS-- C and S Administrative Services 1-800-492-0919 or 207-828-4300 Outside of Maine 207-945-0244

--PEER REVIEW ORGANIZATIONS (PROs)-- Health Care Review, Inc. 1-800-541-9888 or 1-800-528-0700

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

MARYLAND --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-243-3425 410-225-1074

--MEDICARE CARRIERS-- Xact Medicare Services Counties of: Montgomery & Prince George's 1-800-233-1124/Other areas Trail Blazer Enterprises 1-800-492-4795

--PEER REVIEW ORGANIZATIONS (PROs)-- Delmarva Foundation for Medical Care 1-800-492-5811 Outside Maryland 1-800-645-0011

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

MASSACHUSETTS 1-800-882-2003 617-727-7750

--MEDICARE CARRIERS-- C and S Administrative Services 1-800-882-1228 or 617-741-3300

--PEER REVIEW ORGANIZATIONS (PROs)-- Massachusetts Peer Review Organization 1-800-252-5533 or 617-890-0011

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

MICHIGAN --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-803-7174

--MEDICARE CARRIERS-- Michigan Medicare Claims 1-800-482-4045 or 313-225-8200

--PEER REVIEW ORGANIZATIONS (PROs)-- Michigan Peer Review Organization 1-800-365-5899

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

MINNESOTA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-882-6262

--MEDICARE CARRIERS--: MetraHealth 1-800-352-2762 or 612-884-7171

--PEER REVIEW ORGANIZATIONS (PROs)-- Foundation for Health Care Evaluation 1-800-444-3423

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

MISSISSIPPI --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-948-3090

--MEDICARE CARRIERS-- MetraHealth 1-800-682-5417 or 601-956-0372

--PEER REVIEW ORGANIZATIONS (PROs)-- Mississippi Foundation for Medical Care 1-800-844-0600 or 601-948-8894

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

MISSOURI 1-800-390-3330

--MEDICARE CARRIERS-- Blue Cross/Blue Shield of Kansas Counties of:

Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Claire, Saline, Vernon and Worth 1-800-892-5900 or 816-561-0900

Rest of state: Medicare General American Life Insurance Company 1-800-392-3070 or 314-843-8880

--PEER REVIEW ORGANIZATIONS (PROs)-- Missouri Patient Care Review Foundation 1-800-347-1016

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

MONTANA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-332-2272

--MEDICARE CARRIERS-- Blue Cross/Blue Shield of Montana 1-800-332-6146 or 406-444-8350

--PEER REVIEW ORGANIZATIONS (PROs)-- Montana-Wyoming Foundation Medical Care 1-800-497-8232 or 406-443-4020

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

NEBRASKA --INSURANCE COUNSELING GENERAL INFORMATION-- 402-471-2201

--MEDICARE CARRIERS-- Blue Cross /Blue Shield of Kansas 1-800-633-1113

--PEER REVIEW ORGANIZATIONS (PROs)-- Iowa Foundation For Medical Care 1-800-247-3004 or 1-800-422-4812

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

NEVADA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-307-4444 702-367-1218

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-528-0311 or 602-861-1968

--PEER REVIEW ORGANIZATIONS (PROs)-- HealthInsight *703-385-9933

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

NEW HAMPSHIRE --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-852-3388 603-271-4642

--MEDICARE CARRIERS-- C and S Administrative Services 1-800-447-1142 or 207-828-4300

--PEER REVIEW ORGANIZATIONS (PROs)-- Northeast Health Care Quality Foundation 1-800-772-0151or 603-749-1641

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

NEW JERSEY --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-792-8820

--MEDICARE CARRIERS-- Xact Medicare Services 1-800-462-9306

--PEER REVIEW ORGANIZATIONS (PROs)-- The PRO of New Jersey Inc.

1-800-624-4557 or 908-238-5570 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

NEW MEXICO --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-432-2080

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-423-2925 or 505-821-3350

--PEER REVIEW ORGANIZATIONS (PROs)-- New Mexico Medical Review Association 1-800-279-6824 or 505-842-6236

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

NEW YORK --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-333-4114 In New York City: 212-869-3850

--MEDICARE CARRIERS-- Empire Blue Cross and Blue Shield

Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster & Westchester

1-800-442-8430 or 516-244-5100 Queens County: 212-721-1770 Rest of state: BC/BS of Western N.Y. 1-800-252-6550

--PEER REVIEW ORGANIZATIONS (PROs)-- Island Peer Review Organization, Inc.

1-800-331-7767 or 516-326-7767 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

NORTH CAROLINA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-443-9354

--MEDICARE CARRIERS-- CIGNA 1-800-672-3071 or 919-665-0341

--PEER REVIEW ORGANIZATIONS (PROs)-- Medical Review of North Carolina 1-800-7220468 or 919-851-2955

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

NORTH DAKOTA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-247-0560

--MEDICARE CARRIERS-- Blue Shield of North Dakota 1-800-247-2267 or 701-277-2363

--PEER REVIEW ORGANIZATIONS (PROs)-- North Dakota Health Care Review, Inc.

1-800-472-2902 or 701-852-4231 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

OHIO --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-686-1578

--MEDICARE CARRIERS-- Nationwide Mutual Insurance Co. 1-800-282-0530 or 614-249-7157

--PEER REVIEW ORGANIZATIONS (PROs)-- Peer Review Systems, Inc. 1-800-837-0664 or 1-800-589-7337

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

OKLAHOMA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-763-2828 405-521-6628

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-522-9079 or 405-848-7711

--PEER REVIEW ORGANIZATIONS (PROs)-- Oklahoma Foundation for Peer Review 1-800-522-3414 or 405-840-2891

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

OREGON --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-722-4134

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-452-0125 or 503-222-6831

--PEER REVIEW ORGANIZATIONS (PROs)-- Oregon Medical Professional Review Org. 1-800-344-4354

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

PENNSYLVANIA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-783-7067

--MEDICARE CARRIERS-- Xact Medicare Services 1-800-382-1274

--PEER REVIEW ORGANIZATIONS (PROs)-- Keystone Peer Review Organization, Inc. 1-800-322-1914 or 717-564-8288

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

RHODE ISLAND --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-322-2880

--MEDICARE CARRIERS-- Blue Cross / Blue Shield of RI 1-800-662-5170 or 401-861-2273

--PEER REVIEW ORGANIZATIONS (PROs)-- Health Care Review, Inc.

1-800-662-5028 or 401-331-6661 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

SOUTH CAROLINA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-868-9095 803-737-7500

--MEDICARE CARRIERS-- Palmetto Govt Benefits Administrators 1-800-868-2522 or 803-788-3882

--PEER REVIEW ORGANIZATIONS (PROs)-- Medical Review of North Carolina 1-800-922-5089 or 803-731-8225

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

SOUTH DAKOTA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-822-8804 605-773-3656

--MEDICARE CARRIERS-- Blue Shield of North Dakota 1-800-437-4762

--PEER REVIEW ORGANIZATIONS (PROs)-- South Dakota Foundation for Medical Care 1-800-658-2285

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

TENNESSEE --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-525-2816

--MEDICARE CARRIERS-- CIGNA Medicare 1-800-342-8900 or 615-244-5650

--PEER REVIEW ORGANIZATIONS (PROs)-- Mid-South Foundation for Medical Care 1-800-489-4633

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

TEXAS --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-252-3439

--MEDICARE CARRIERS-- Blue Cross & Blue Shield of Texas 214-235-3433

--PEER REVIEW ORGANIZATIONS (PROs)-- Texas Medical Foundation 1-800-725-8315 or 512-329-6610

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- Palmetto Government Benefits Administrators 1-800-213-5452

UTAH --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-439-3805 801-538-3910

--MEDICARE CARRIERS-- Blue Shield of Utah 1-800-426-3477 or 801-481-6196

--PEER REVIEW ORGANIZATIONS (PROs)-- HealthInsight 1-800-274-2290

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

VERMONT --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-642-5119

--MEDICARE CARRIERS-- C and S Administrative Services 1-800-447-1142 or 207-828-4300

--PEER REVIEW ORGANIZATIONS (PROs)-- Northeast Health Care Quality Foundation 1-800-772-0151 or 603-749-1641

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- MetraHealth 1-800-842-2052

VIRGINIA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-552-3402

--MEDICARE CARRIERS-- Xact Medicare Services Counties of: Arlington, Fairfax 1-800-233-1124 Rest of State: MetraHealth 1-800-552-3423 or 804-330-4786

--PEER REVIEW ORGANIZATIONS (PROs)-- Medical Society of Virginia Review Organization DC, MD, VA 1-800-545-3814 or 804-289-5320 Richmond 804-289-5397

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

WASHINGTON --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-397-4422

--MEDICARE CARRIERS-- Aetna Life Insurance Company 1-800-372-6604 or 206-621-0359

--PEER REVIEW ORGANIZATIONS (PROs)-- PRO-WEST 1-800-445-6941 or 206-368-8272

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

WEST VIRGINA --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-642-9004 304-558-3317

--MEDICARE CARRIERS-- Nationwide Mutual Insurance Co. 1-800-848-0106 or 614-249-7157

--PEER REVIEW ORGANIZATIONS (PROs)-- West Virginia Medical Institute, Inc. 1-800-642-8686, ext. 266 Charleston 346-9864

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

WISCONSIN --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-242-1060

--MEDICARE CARRIERS-- WPS 1-800-944-0051 or 608-221-3330 TDD 1-800-828-2837

--PEER REVIEW ORGANIZATIONS (PROs)-- Wisconsin Peer Review Organization 1-800-362-2320 or 608-274-1940

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- AdminaStar Federal Inc. 1-800-270-2313

WYOMING --INSURANCE COUNSELING GENERAL INFORMATION-- 1-800-856-4398

--MEDICARE CARRIERS-- Blue Cross & Blue Shield of N.D. 1-800-422-2371

--PEER REVIEW ORGANIZATIONS (PROs)-- Mont/Wyo Foundation for Medical Care

1-800-497-8232 or 406-443-4020 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

AMERICAN SAMOA --INSURANCE COUNSELING GENERAL INFORMATION-- None

--MEDICARE CARRIERS-- Hawaii Medical Service Assn. 809-944-2247

--PEER REVIEW ORGANIZATIONS (PROs)-- Hawaii Medical Service Assn./HMSA

808-948-5110 (PRO will accept collect calls from out-of-state on this number)

-DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS-- CIGNA Medicare 1-800-899-7095

GUAM --INSURANCE COUNSELING GENERAL INFORMATION-- 617-475-0262/3

--MEDICARE CARRIERS-- Aetna Life Insurance Company 808-524-1240

--PEER REVIEW ORGANIZATIONS (PROs)-- Hawaii Medical Service Assn./HMSA

808-948-5110 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS CIGNA Medicare 1-800-899-7095

NORTHERN MARIANA ISLANDS --INSURANCE COUNSELING GENERAL INFORMATION-- None

--MEDICARE CARRIERS-- Aetna Life Insurance Company 808-524-1240

--PEER REVIEW ORGANIZATIONS (PROs)-- Hawaii Medical Service Assn./HMSA

808-948-5110 (PRO will accept collect calls from out-of-state on this number)

--DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS CIGNA Medicare 1-800-899-7095

Total Health Insurance for People with Medicare

* WHAT MEDICARE PAYS AND DOESN'T PAY

* 10 STANDARD MEDIGAP INSURANCE PLANS

* YOUR RIGHT TO MEDIGAP INSURANCE

* TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE

Developed jointly by the National Association of Insurance, Commissioners and the Health Care Financing, Administration of the U.S. Department, of Health and Human Services. Publication No. HCFA-02110

- NOTICE -

Listed in the back of this brochure are the addresses and telephone numbers of each of the state agencies on aging and the state insurance departments. They are available to assist you with any questions you may have about private insurance to supplement Medicare.

Suspected violations of the laws governing the marketing of insurance policies should generally be reported to your state insurance department since states are responsible for the regulation of insurance within their boundaries.

There are, however, federal penalties for certain violations concerning Medicare supplement insurance ("Medigap") policies. It is, for example, a federal offense for an insurance agent to indicate that he or she represents the Medicare program or any other federal agency in order to sell a policy. It is also illegal for an insurance company or agent to sell you a policy that duplicates coverage you already have.

The federal toll-free telephone number for filing complaints is: 1-800-638-6833

See:

DEFINITIONS OF SOME MEDICARE TERMS

Actual Charge:

The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount:

The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge. For physician services the approved amount is taken from a national fee schedule that assigns a dollar value to all physician services covered by Medicare.

Assignment:

An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as the total charge for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the provider after the beneficiary meets the annual Part B deductible of $100. The beneficiary pays the other 20%.

Benefit Period:

A benefit period is a way of measuring a beneficiary's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the beneficiary is hospitalized and ends after the beneficiary has been out of the hospital or skilled nursing facility for 60 days in a row. If the beneficiary is hospitalized after 60 days, a new benefit period begins and most Medicare Part A benefits are renewed. There is no limit as to the number of benefit periods a beneficiary can have.

Coinsurance:

The portion or percentage of Medicare's approved amounts for covered services that a beneficiary is responsible for paying.

Deductible:

The amount of expense a beneficiary must first incur before Medicare begins payment for covered service's.

Excess Charge:

The difference between the Medicare-approved amount for a service or supply and the actual charge, if the actual charge is more than the approved amount.

Limiting Charge:

The maximum amount a physician may charge a Medicare beneficiary for a covered physician service if the physician does not accept assignment of the Medicare claim. The limit is 15% more than the fee schedule amount for nonparticipating physicians. Limiting charge information appears on Medicare's Explanation of Medicare Benefits (EOMB) form.

Medicare Carrier:

An insurance organization under contract to the federal government to process Medicare Part B claims from physicians and other health care providers. The names and addresses of the carriers and areas they serve are listed in the back of The Medicare Handbook, available from any Social Security Administration office.

Medicare Hospital Insurance:

This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance:

This is Part B of Medicare. This plan helps pay for medically necessary physician services and many other medical services and supplies not covered by Part A.

Participating Physician and Supplier:

A physician or supplier who agrees to accept assignment on all Medicare claims.

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most older Americans covered by Medicare, there are aspects of the federal health insurance program that you find complex and confusing. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This booklet will give you a better understanding of your Medicare benefits, identify the gaps in your Medicare coverage, and provide tips on shopping for private health insurance to fill those gaps. As a Medicare beneficiary, you probably are already aware that Medicare does not cover all of your potential health care costs. For example, you are responsible for Medicare's deductibles and coinsurance and for charges for services not covered by Medicare.

Few people can afford to pay all of those expenses out of their own funds, so many rely on supplemental insurance to cover some of the costs. As you seek to limit your out-of-pocket costs for health care services, you will find that there are three basic ways of doing so:

1. Through the purchase of Medicare supplement insurance, which is also called "Medigap" or "MedSup" insurance;

2. By enrolling in a managed care plan, such as a health maintenance organization (HMO) that has a contract to serve Medicare beneficiaries; and,

3. By continuing coverage under an employer-provided health insurance policy, if you are eligible for such protection.

In addition, for beneficiaries who qualify, some costs may be covered by state Medicaid programs (see page 17).

Each of these ways will be discussed in subsequent sections. Special attention will be devoted to employer plans and Medigap insurance, which most Medicare beneficiaries purchase. Insurance Counseling

Although the information in this booklet will help you to be a better informed and more careful purchaser, you may wish to obtain additional information before buying health insurance. Information about insurance to supplement Medicare is available from various senior citizen advocacy organizations and governmental agencies.

You first may want to turn to your state government for help, as all states now offer insurance counseling in one-on-one confidential sessions with trained counselors. In these sessions, you will be able to clarify insurance issues that you find confusing and receive assistance in evaluating your insurance needs. These services are provided at no charge to you. The telephone number for your state insurance counseling office is listed in the directory of state insurance departments and agencies on aging beginning on page 27.

WHAT IS MEDICARE?

Before discussing Medigap and the other types of private insurance available to supplement Medicare, it will be helpful to review your Medicare benefits and identify the payment gaps.

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). The Social Security Administration, also a part of HHS, provides information about the program and handles enrollment.

Two Parts of Medicare

Medicare has two parts--Hospital Insurance (Part A) and Medical Insurance (Part B). Part A is financed through part of the Social Security (FICA) tax paid by workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse is entitled to benefits under either the Social Security or Railroad Retirement systems or worked a sufficient period of time in federal, state, or local government employment to be insured.

If you do not qualify for premium-free Part A benefits, you may purchase the coverage if you are at least age 65 and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and you still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. If you do not qualify for premium-free Part A but had at least 30 quarters of covered employment, the Pan A monthly premium in 1994 is $184. If you had fewer than 30 quarters or no quarters of covered employment the premium is $245 per month in 1994.

Part B is optional and is offered to all beneficiaries when they become entitled to Part A. It also may be purchased by most persons age 65 or over who do not qualify for premium-free Part A coverage. The Part B premium, which most Medicare beneficiaries have deducted from their monthly Social Security check, is $41.10 per month in 1994.

You are automatically enrolled in Part B when you become entitled to Part A unless you state that you don't want it. Although you do not have to purchase Part B, it is a good buy because the federal government pays about 75 percent of the program costs.

Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your coverage started. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health care benefit. Benefit Periods

Medicare Part A hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a qualified hospital. It ends when you have been out of a hospital or skilled nursing or rehabilitation facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, all Part A hospital and skilled nursing facility benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits that were used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

See:

Inpatient Hospital Care

Gaps in Medicare Inpatient Hospital Coverage:

Skilled Nursing Facility Care

Gaps in Medicare Skilled Nursing Facility, Coverage:

Home Health Care

Gaps in Medicare Home Health Coverage

Hospice Care

Gaps in Medicare Hospice Coverage:

Psychiatric Hospital Care

Gaps in Medicare Inpatient Psychiatric Hospital Care:

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges for covered hospital services during the first 60 days of a benefit period except for the deductible. The Pan A deductible in 1994 is $696 per benefit period. You are responsible for the deductible. In addition to the deductible, you are responsible for a share of the daily costs if your hospital stay lasts more than 60 days. For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of $174 a day in 1994. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you are in the hospital for more than 90 consecutive days. When a reserve day is used, Part A pays for all covered services except for coinsurance of $348 a day in 1994. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps in Medicare Inpatient Hospital Coverage:

You pay $696 deductible on first admission to hospital in each benefit period.

You pay $174 daily coinsurance for days 61 through 90.

No coverage beyond 90 days in any benefit period unless you have "lifetime reserve" days available and use them.

You pay $348 daily coinsurance for each lifetime reserve day used.

No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part B, it does not have to be met under Part A.

No coverage for a private hospital room, unless medically necessary, or for a private duty nurse.

No coverage for personal convenience items, such as a telephone or television in a hospital room.

No coverage for care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.

No coverage for care received outside the U. S. and its territories, except under limited circumstances in Canada and Mexico.

Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. Medicare benefits are payable only if you require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis, and the care is provided in a facility certified by Medicare. Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

To qualify for Medicare coverage for skilled nursing facility care, you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility. You must be admitted to the facility for the same condition for which you were treated in the hospital and the admission generally must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and receive, skilled nursing or skilled rehabilitation services on a daily basis.

Medicare can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance in 1994 is $87. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Gaps in Medicare Skilled Nursing Facility, Coverage:

You pay $87 daily coinsurance for days 21 through 100 in each benefit period.

No coverage beyond 100 days in a benefit period.

No coverage for care in a nursing home, or in a SNF not certified by Medicare, or for just custodial care in a

Medicare-certified SNF.

No coverage for 3-pint blood deductible (see list of gaps under inpatient hospital care).

Home Health Care

Medicare fully covers medically necessary home health visits if you are homebound, including parttime or intermittent skilled nursing services. A Medicare-certified home health agency can also furnish the services of physical and speech therapists. Should you require speech-language pathology, physical therapy, continuing occupational therapy or intermittent skilled nursing services, are confined to your home, and are under the care of a physician, Medicare can also pay for medical supplies, necessary part-time or intermittent home health aide services, occupational therapy, and medical social services. Coverage is also provided for a portion of the cost of wheelchairs, hospital beds and other durable medical equipment (DME) provided under a plan-of-care set up and periodically reviewed by a physician.

Gaps in Medicare Home Health Coverage

No coverage for full-time nursing care.

No coverage for drugs or for meals delivered to your home

You pay 20% of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.

No coverage for homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare beneficiaries certified as terminally ill may choose to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. If you enroll in a Medicare-certified hospice program, you will receive medical and support services necessary for symptom management and pain relief. When these services which are most often provided in your home- are furnished by a Medicare-certified hospice program, the coverage includes: physician services, nursing care, medical appliances and supplies (including drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, home health aide and homemaker services.

You do not have to pay Medicare's deductibles and coinsurance for services and supplies furnished under the hospice benefit. You must pay only limited charges for outpatient drugs and inpatient respite care. In the event you require medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps in Medicare Hospice Coverage:

You pay limited charges for inpatient respite care and outpatient drugs.

You pay deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Psychiatric Hospital Care

Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days (or have used fewer than 190 days but have exhausted your inpatient hospital coverage), Part A doesn't pay for any more inpatient care in a psychiatric hospital. However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Gaps in Medicare Inpatient Psychiatric Hospital Care:

* No coverage for care after you have received 190 days of such specialized treatment in your lifetime (even if you have not yet exhausted your inpatient hospital coverage).

MEDICARE MEDICAL INSURANCE (PART B) BENEFITS

Part B helps pay for medically necessary physician services no matter where you receive them--at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the use at home of durable medical equipment, such as wheelchairs and hospital beds.

Additionally, Part B covers medically necessary physical therapy, occupational therapy, and speech-language pathology services in a doctor's office, as an outpatient, or in your home. Mental health services are covered as are mammograms and Pap smears. And if you qualify for home health care but do not have Part A, then Part B pays for all covered home health visits.

Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished to hospice enrollees, non-self administrable drugs provided as part of a physician's services, and special drugs, such as drugs furnished during the first year after an organ transplantation, erythropoetin for home dialysis patients, and certain oral cancer drugs.

When you use your Part B benefits, you will be required to pay the first $100 (the annual deductible) each calendar year. The deductible must represent charges for services and supplies covered by Medicare. It also must be based on the Medicare approved amounts, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for covered services you receive the rest of the year. You are responsible for the other 20 percent. If you require home health services, you do not have to pay a deductible or coinsurance. You do, however, have to pay 20 percent of the Medicare-approved amount for any durable medical equipment! supplied under the Medicare home health benefit.

You may also have other out-of-pocket costs under Part B if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge" or "balance billing." You should be aware, however, that there are certain charge limitations mandated by federal law (discussed below) and that some states also limit physician charges. Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on a national fee schedule. The schedule assigns a dollar value to each physician service based on work, practice costs and malpractice insurance costs. Under this payment system, each time you go to a physician for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians and medical suppliers whether they accept assignment of Medicare claims. Accepting Assignment

Those who take assignment on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by Medicare, except for the deductible and coinsurance amounts that you must pay.

For example, for your first annual visit, if you go to a participating physician, or if you go to a nonparticipating physician who accepts assignment, and the Medicare-approved amount for the service you receive is $200, you will be billed $120: $100 for the annual deductible plus 20 percent of the remaining $100, or $20. Medicare would pay the other $80. Having met the deductible for the year, the next time you used Part B services furnished by a physician or medical supplier who accepts assignment, you would be responsible for only 20 percent of the Medicare-approved amount. Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in The Medicare Participating Physician/Supplier Directory, which is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging.

It also is available free by writing or calling the insurance company that processes Medicare Pan B claims for your area. Called a Medicare "carrier," the company's name, address and telephone number are listed in the back of The Medicare Handbook, available from any Social Security office.

Even if your physician or supplier does not participate in Medicare, ask before receiving any services or supplies whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. If your physician or supplier will not accept assignment, you are responsible for paying all permissible charges.

Medicare will then reimburse you its share of the approved amount for the services or supplies you received. Regardless of whether your physician or supplier accepts assignment, they are required to file your Medicare claim for you.

In certain situations nonparticipating providers of services are required by law to accept assignment. For instance, all physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 18).

See:

Physician Charge Limits

More Charge Limits

Gaps in Medicare Coverage for Doctors and Medical Suppliers

Physician Charge Limits

While physicians who do not accept assignment of a Medicare claim can charge more than physicians who do, there is a limit as to the amount they can charge you for services covered by Medicare. Under the law, they are not permitted to charge more than 115 percent of the Medicare-approved amount for the service. Physicians who knowingly, willfully, and repeatedly charge more than the legal limit are subject to sanctions. If you think you have been overcharged, or you want to know what the limiting charge is for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form that you generally receive from the Medicare carrier when you go to a physician for a Medicare-covered service. You do not have to pay charges that exceed the legal limit.

If you think your physician has exceeded the charge limit, you should contact the physician and ask for a reduction in the charge, or a refund, if you have paid more than the charge limit. If you cannot resolve the issue with the physician, you can call your Medicare carrier and ask for assistance.

More Charge Limits

Another federal law requires physicians who do not accept assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If the physician did not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount. Any nonparticipating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary and thus will not pay for, is required to so notify you in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps in Medicare Coverage for Doctors and Medical Suppliers

You pay $100 annual deductible.

Generally, you pay 20% coinsurance.

You pay legally permissible charges in excess of the Medicare-approved amount for unassigned claims (see page 6).

You pay 50% of approved charges for most outpatient mental health treatment.

You pay all charges in excess of Medicare's maximum yearly limit of $900 for independent physical or occupational therapists.

No coverage for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.

No coverage for most self-administerable prescription drugs or immunizations, except for pneumococcal, influenza and hepatitis B vaccinations.

No coverage for routine physicals and other screening services, except for mammograms and Pap smears.

Generally, no coverage for dental care or dentures.

No coverage for acupuncture treatment.

No coverage for hearing aids or routine hearing loss examinations.

No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

No coverage for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.

No coverage for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.

No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

No coverage for routine eye examinations or eyeglasses, except prosthetic lenses, if needed, after cataract surgery.

Medicare Benefit Charts

The charts on pages 8 and 9 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

TYPES OF PRIVATE HEALTH INSURANCE

Whether you need health insurance in addition to Medicare is a decision that only you can make. As you saw from the review of your Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance can help fill many of the gaps. But before buying insurance to supplement your Medicare benefits, make sure you need it. Not everyone does (see page 17). In general it is advisable to buy the additional protection that private health insurance can provide. If you decide to buy supplemental insurance, shop carefully and buy a policy that offers the kind of additional help you think you need most.

A variety of private insurance policies is available to help pay for medical expenses, services and supplies that Medicare covers only partly or not at all. The basic types of policies include:

Medigap, which pays some of the amounts that Medicare does not pay for covered services and may pay for certain services not covered by Medicare.

Managed care plans [these include health maintenance organizations (HMOs) and competitive medical plans (CMPs)], from which you purchase health care services directly for a fixed monthly premium;

Continuation or conversion of an employer-provided or other policy you have when you reach 65;

Nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home or at-home care;

Hospital indemnity policies, which pay only when you need treatment for the insured disease.

Specified disease policies, which pay only when you need treatment for the insured disease.

See:

Medigap

Managed Care Plans That Contract With Medicare

Group Insurance

Long-Term Care Insurance

Hospital Indemnity Insurance

Specified Disease Insurance

Medigap

Medigap insurance is regulated by federal and state law and must be clearly identified as Medicare supplement insurance. Unlike other types of health insurance, it is designed specifically to supplement Medicare's benefits by filling in some of the gaps in Medicare coverage.

To make it easier for consumers to comparison shop for Medigap insurance, nearly all states, U.S. territories, and the District of Columbia have adopted regulations that limit the number of different Medigap policies that can be sold in any of those jurisdictions to no more than 10 standard benefit plans. The plans, which have letter designations ranging from "A" through "J", were developed by the National Association of Insurance Commissioners and incorporated into state and federal laws. See pages 22-24 for descriptions and comparisons of the 10 plans.

Plan A of the 10 standard Medigap plans is the "basic" benefit package. Each of the other nine plans includes the basic package plus a different combination of benefits. The plans cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. Insurers are not permitted to change the combination of benefits in any of the plans or to change the letter designations.

Each state must allow the sale of Plan A, and all Medigap insurers must make Plan A available. Insurers are not required to offer any of the other nine plans, but most offer several plans, and some offer all 10. Insurers can independently decide which of the nine optional plans they will sell as long as the plans they select have been approved for sale in the state in which they are to be offered.

Some states have limited the number of plans available in the state. Delaware does not permit Plans C, F, G and H to be sold in the state. Pennsylvania and Vermont do not permit the sale of Plans F, G and I. (As this guide was being prepared for printing, however, Pennsylvania was considering a proposal that would permit the sale of all 10 plans.)

Residents of Minnesota, Massachusetts and Wisconsin will find that their Medigap plans are different than those sold in other states. This is because those states had alternative Medigap standardization programs in effect before the federal legislation standardizing Medigap was enacted. Therefore, they were not required to change their benefit plans. If you live in Minnesota, Massachusetts or Wisconsin, you should contact the state insurance department to find out what Medigap coverage is available to you.

The only areas where standardization is not in effect are Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Comparing Medigap Plans: To make it easier for consumers to compare plans and premiums, the same format, language, and definitions must be used in describing the benefits of each of the plans. A uniform chart and outline of coverage also must be used by the insurer to summarize those benefits for you.

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. Compare benefits and premiums and be satisfied that the insurer is reputable before buying. And in selecting the benefits that meet your needs, remember that Medicare pays only for services it determines to be medically necessary and only the amount it determines to be reasonable.

Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide coverage for Medicare's deductibles. Some of the 10 standard plans pay for services not covered by Medicare and some pay for charges in excess of Medicare's approved amount. Look for the plan that best meets your needs.

All standard Medigap plans must have a loss ratio of at least 65 percent for individual policies and 75 percent for group policies. This means that on average either 65 cents or 75 cents of each premium dollar goes for benefits.

Unlike some types of health coverage that restrict where and from whom you can receive care, Medigap policies generally pay the same supplemental benefits regardless of your choice of health care provider. If Medicare pays for a service, wherever provided, the standard Medigap policy must pay its regular share of benefits. The only exception is Medicare SELECT insurance, discussed on page 13.

Besides the standardized benefit plans, federal law permits states to allow an insurer to add "new and innovative benefits" to a standardized plan that otherwise complies with applicable standards. Any such new or innovative benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplification. Check with your state insurance department to find out whether such benefits are available in your state.

Your Right To Medigap Coverage: If you are 65 or older, state and federal laws guarantee that for a period of 6 months from the date you first enroll in Medicare Part B, you have a right to buy the Medigap policy of your choice regardless of your health conditions.

During this 6-month open enrollment period, you have the choice of any of the different Medigap policies sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of your medical history, health status, or claims experience. The company can, however, impose the same preexisting condition restrictions (see page 19) that it applies to Medigap policies sold outside the open enrollment period.

Many individuals are enrolled automatically in Pan B as soon as they rum 65, or they sign up during an initial 7-month enrollment period that begins 3 months before they turn 65. If you are in this group, your Part B coverage generally starts in the month you turn 65 or shortly thereafter, depending on when you applied for Part B. Your Medigap open enrollment period starts as soon as your Part B coverage starts.

Others may delay their enrollment in Part B. For example, if after turning 65, you continue to work and choose to be continuously covered by an employer insurance plan, or if you are continuously covered under a spouse's employment related insurance instead of Medicare Part B, you will have a special 7-month enrollment period for Part B. It begins with the month your or your spouse's work ends or when you are no longer covered under the employer plan, whichever comes first. Your 6-month Medigap open enrollment period starts when your Part B coverage begins.

If you are covered under an employer group health plan when you become eligible for Part B at age 65, carefully consider your options. Once you enroll in Part B the 6-month Medigap open enrollment period starts and cannot be extended or repeated.

If you cannot defer Part B enrollment as described above, but are 65 or older and are eligible for Part B but never signed up for it, you may buy Part B during Medicare's annual general enrollment period. It runs from January 1 through March 31. If you sign-up during an open enrollment period, both your Part B coverage and Medigap open enrollment period begin the following July 1.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are not eligible.

If you are under age 65, disabled, and enrolled in Medicare Part B, you are not eligible for Medigap open enrollment unless your state requires open enrollment for persons under 65 who qualify for Medicare because of a disability. Moreover, unless your state requires otherwise, you will not be eligible for the Medigap open enrollment period when you turn 65 because you will not be enrolling in Part B for the first time.

Older Medigap Policies: Current federal requirements generally do not apply to Medigap policies in force in a state before the requirements which took effect in that state in 1992. Depending on which state you live in, you will not have to switch to one of the 10 standard plans if you have an older policy that is guaranteed renewable.

Some states, however, have specific requirements that affect existing non-standard policies. For example, some states require or permit insurers to convert older policies to the standardized plans. Check with your state insurance department to find out what state-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the standardized Medigap plans if it is to your advantage and an insurer is willing to sell you one.

If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some

of the older policies may provide superior coverage, especially for prescription drugs and extended skilled nursing care.

If you had the old Medigap policy at least 6 months and you decide to switch, the new policy is not permitted to impose a waiting period for a preexisting condition if you satisfied a waiting period for a similar benefit under your old policy. If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to 6 months unless prohibited by your state may be applied to that particular benefit.

Because it is unlawful for anyone to sell you insurance that duplicates coverage you already have, and because you do not need more than one Medigap policy, you must sign a statement that you intend to replace your current policy and will not keep both policies. Do not cancel the old policy until the new one is in force and you have decided to keep it (see "Free Look," page 20).

Medigap Insurance Defined: Under state and federal laws, Medigap policies are policies designed to supplement your Medicare benefits. They must provide specific benefits that pay, within limits, some or all of the costs of services either not covered or not fully covered by Medicare. The definition does not include all insurance products that may help you cover out-of-pocket costs. For example, neither a health plan offered by a company for current or former employees, nor by a labor organization for current or former members, is Medigap insurance. Nor are limited benefit plans such as hospital indemnity insurance. They do not qualify because they are not required. to provide the same benefits that the 10 standard Medigap plans must provide.

Similarly, coverage provided to individuals enrolled in managed care plans, such as health maintenance organizations (HMOs) under contracts or agreements with the federal government, does not meet the definition of Medigap insurance even though some of the coverage may be similar. On the other hand, an HMO's supplemental insurance product sold to an individual Medicare beneficiary who is not enrolled under either an employer plan or a federal contract or agreement, does qualify as Medigap insurance.

Medicare SELECT. A Medicare supplement health insurance product called "Medicare SELECT" is permitted to be sold in Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, Noah Dakota, Ohio, Texas, Washington and Wisconsin. Medicare SELECT, which may be offered in the designated states by insurance companies and HMOs, is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard Medigap plans (see page 22).

The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT policies will only pay or provide full supplemental benefits if covered services are obtained through specified health care professionals and facilities. Medicare SELECT policies are expected to have lower premiums because of this limitation. The specified health care professionals and facilities, called "preferred providers," are selected by the insurance company or HMO. Each issuer of a Medicare SELECT policy makes arrangements with its own network of preferred providers.

If you have a Medicare SELECT policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay or provide the full supplemental benefits provided for in the policy. Medicare SELECT insurers must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network. In general, Medicare SELECT policies deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges if the services you receive outside the network are services covered by Medicare.

Medicare SELECT will be evaluated through 1994 to determine if it should be continued and made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the policies are discontinued. If the program is not extended, Medicare SELECT policyholders will have the option to purchase any standard Medigap policy that the insurance company or HMO offers, if in fact it issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similar benefits.

Carrier Filing of Medigap Claims. Under certain circumstances, when you receive medical services covered by both Medicare and your Medigap insurance, you may not have to file a separate claim with

your Medigap insurer in order to have payment made directly to your physician or medical supplier. By law, the Medicare carrier that processes Medicare claims for your area must send your claim to the Medigap insurer for payment when the following three conditions are met for a Medicare Part B claim:

1. Your physician or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries:

2. Your policy must be a Medigap policy: and

3. You must instruct your physician to indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating physician or supplier. Your physician will put your Medigap policy number on the Medicare claim form.

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medigap insurer and generally send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your physician or medical supplier and send you a notice that they have done so. If the insurer refuses to pay the physician directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact the Medicare carrier. Look in The Medicare Handbook for the name and telephone number of the carrier for your area.

Managed Care Plans That Contract With Medicare

Managed care plans, also called coordinated care and prepaid plans, include health maintenance organizations (HMOs) and competitive medical plans (CMPs). They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they arrange for health care.

As a Medicare beneficiary, you can choose how you will receive hospital, doctor, and other health care services covered by Medicare. You can receive them either through the traditional fee-for-service delivery system or through a managed care plan that has a contract with Medicare. If you choose fee-for-service care, you should consider purchasing Medigap insurance.

If you enroll in a Medicare-contracting HMO or CMP, you will not need a Medigap policy. In fact, insurers are prohibited from issuing you one because it would duplicate your HMO or CMP benefits. If you have a Medigap policy and decide to enroll in a plan, you will be asked to provide an assurance that you will give up the Medigap policy.

Should you enroll in a managed care plan and later disenroll and return to fee-for-service care, you likely will be able to buy a Medigap policy, but you may not get the policy; of your choice, especially if you have a health problem. On the other hand, both disabled and aged Medicare beneficiaries generally may enroll in a Medicare-contracting HMO or CMP without regard to any health problems they may have. For this and other reasons, managed care can be an attractive option for many beneficiaries.

A managed care plan generally arranges with a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) to offer comprehensive, coordinated medical services to plan members on a prepaid basis. If you enroll in an HMO or CMP with a Medicare contract; services usually must be obtained from the professionals and facilities that are part of the plan, except in a medical emergency.

The plan must provide or arrange for all Part A and B services (if you are covered under both parts of Medicare). Some plans also provide benefits beyond what Medicare covers, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses.

Medicare makes a monthly payment to the plan to cover Medicare's share of the cost of the services you receive. Additionally, most plans charge enrollees a monthly premium and nominal copayments as services are used. Usually there are no other charges--no matter how many times you visit the doctor, are hospitalized, or use other covered services. Medicare's deductibles and coinsurance do not apply to beneficiaries enrolled in plans with Medicare contracts.

If you enroll in an HMO or a CMP that has a "risk" contract with Medicare, Medicare will not pay for non-emergency services you receive from providers outside of the HMO or CMP. That is, you must receive all your health care benefits (except in an emergency) from the HMO or CMP in order to be covered.

If you enroll in a plan that has a "cost" contract with Medicare, you can receive covered services either through the plan or outside the plan. If you go outside the plan for non-emergency services, Medicare will still pay but the plan will not. You would be responsible for the same charges that you would be liable for if you were only covered by Medicare, but you would no longer have a Medigap policy to cover those charges.

You are eligible to enroll in a managed care plan with a Medicare contract if you live in the plan's service area, are enrolled in Medicare Part B, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. The plan must enroll Medicare beneficiaries in the order of application, without health screening, during at least one open enrollment period each year.

Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. If you live in an area that is served by more than one managed care plan, compare benefits, costs and other features to determine which plan meets your needs. Also, determine which type of contract the plan has with Medicare.

Group Insurance

There are two principal sources of group insurance: employers and voluntary associations.

Employer Group Insurance for Retirees. Many people have private insurance when they reach age 65 that often is purchased through their or their spouse's current employer or union membership. If you have such coverage, find out if it can be continued when you or your spouse retires. Check the price and the benefits, including benefits for your spouse.

Group health insurance that is continued after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions, and the coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance protection.

Furthermore, since employer group insurance policies do not have to comply with the federal minimum benefit standards for Medigap policies, it is important to determine what coverage your specific retirement policy provides. While the policy may not provide the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care.

Special Rules for Working People Age 65 or Over. If you are 65 or over and you or your spouse works, Medicare may be secondary payer to any employer group health plan (EGHP) coverage you have. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer plan.

Employers who have 20 or more employees are required to offer the same health benefits, under the same conditions, to employees age 65 or over and to employees' spouses who are 65 or over, that they offer to younger employees and spouses. EGHP coverage of employers of 20 or more employees is primary to Medicare.

You may accept or reject coverage under the EGHP. If you accept the employer plan, it will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, you can buy supplemental insurance but an employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary for certain people under age 65 who are entitled to Medicare based on disability (other than those with permanent kidney failure) and who have large group health plan (LGHP) coverage. An LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees.

This requirement applies to those who have LGHP coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must not treat any of these people differently because they are disabled and have Medicare.

The term "employee" here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working, but whom the employer treats as employees. Medicare determines whether an individual is considered to be an employee.

Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is secondary payer to EGHPs for 18 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under an EGHP or are covered under an EGHP as dependents. EGHPs are primary payers during this period without regard to the size of the EGHP or the number of employees. The 18-month

period begins with the earlier of:

* The first month in which the person becomes entitled to Medicare Part A or

* The first month in which an individual would have been entitled to Part A if he had filed an application for Medicare benefits.

However, EGHPs may be primary for an additional 3 months, or a total of up to 21 months: the first three months of dialysis (a period during which an individual generally is not eligible for Medicare benefits) plus the first 18 months of Medicare eligibility or entitlement. After the period of up to 21 months expires, Medicare is primary payer for entitled individuals and the EGHP is secondary.

The Health Care Financing Administration pamphlet entitled Medicare Coverage of Kidney Dialysis and Kidney Transplant Services contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or the Consumer Information Center, Department 59, Pueblo, CO 81009.

Association Group Insurance. Many organizations, other than employers, offer group health insurance coverage to their members. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices. Association group Medigap insurance must comply with the same rules that apply to other Medigap policies.

The following types of coverage are generally limited in scope and are not substitutes for Medigap insurance or managed care plans.

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing home. Some of these policies also cover care in the home, and others are available to pay for care in a skilled nursing facility (SNF) after your Medicare benefits run out (see page 3 for an explanation of the Medicare benefit for skilled nursing facility care).

If you are in the market for nursing home or longterm care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any Medigap policy, managed care plan, or other coverage you have.

It is important to remember that custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only care of this nature that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility.

For more information about long-term care insurance, request a copy of A Shopper's Guide to Long-Term Care Insurance from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64 105-1925. You may also obtain a copy of the Guide to Choosing a Nursing Home by writing to Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, MD 21207.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed cash amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount. Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have, but other group health insurance may coordinate benefits with hospital confinement indemnity insurance sold on a group basis.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

DO YOU NEED MORE INSURANCE?

Before buying insurance to supplement Medicare, ask yourself whether you need private health insurance in addition to Medicare. Not everyone does.

See:

Medicaid Recipients

Qualified Medicare Beneficiary Program: Assistance for Low-Income Elderly

Federally Qualified Health Center

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. They also qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you become eligible for Medicaid, and you have Medigap insurance purchased on or after November 5, 1991, you can request that the Medigap benefits and premiums be suspended for up to two years while you are covered by Medicaid. Should you become ineligible for Medicaid benefits during the two years, your Medigap policy will be reinstated if you give proper notice and begin paying premiums again. You do not, however, have to suspend your Medigap policy, and suspension is not always to a Medicaid recipient's advantage. You may want to discuss your options with your state Medicaid representatives.

Qualified Medicare Beneficiary Program: Assistance for Low-Income Elderly

Limited financial assistance is available through Medicaid for paying Medicare premiums, deductibles, and coinsurance amounts for certain low-income elderly and disabled beneficiaries. If your annual income is at or below the national poverty level and your cash and savings are very limited, you may qualify for state assistance in paying Medicare's monthly premiums, deductibles and coinsurance. This is called the "Qualified Medicare Beneficiary" (QMB) program.

To have qualified in 1993, your income could not have been more than $601 per month for one person or $806 per month for a couple, except in Alaska and Hawaii. In Alaska the income limits were $745 per month for one person and $1,002 per month for a couple. In Hawaii they were $690 per month for one person and $925 per month for a couple. The limits for 1994 will be announced in February 1994. Financial resources such as bank accounts, stocks, and bonds cannot exceed $4,000 for one person or $6,000 for a couple.

Financial assistance also is available for Medicare beneficiaries under the "Specified Low-Income Medicare Beneficiary" (SLMB) program. This program is for beneficiaries whose incomes exceed the poverty level by not more than 10 percent and who meet certain resource limitations. To have qualified for this program in 1993, your income could not have been more than $659 a month for one person or $884 a month for a couple, except in Alaska and Hawaii. In Alaska the income limits were $818 per month for one person and $1,100 per month for a couple. In Hawaii they were $758 per month for one person and $1,016 per month for a couple. Individuals in this category are eligible only for Medicaid payment of their Medicare Pan B premium, which is $41.10 per month in 1994. If you think you qualify for state assistance in paying your Medicare expenses under either of these two programs, contact your state or local social service agency. If you cannot find a telephone number for the state agency, call 1-800638-6833 for assistance.

Federally Qualified Health Center

Medicare pays for some health services, including preventive care, when provided by a federally qualified health center (FQHC). These facilities are typically community health centers, migrant health centers and health centers for the homeless. They are generally located in inner-city and rural areas. The services covered by Medicare at FQHCs include routine physical examinations, screenings, and diagnostic tests for the detection of vision and hearing problems and other medical conditions, and the administration of certain vaccines for immunization against influenza and other diseases.

When those services are furnished at a FQHC, the $100 annual Part B deductible does not apply (see page 5). However, if other services are provided, such as X-rays or screening mammograms, the FQHC may bill the Medicare carrier. In that case, you would be responsible for any unmet portion of the Pan B annual deductible of $.100. As for the 20 percent Part B coinsurance, it is applicable for all FQHC services but Public Health Service guidelines allow the FQHC to waive it in some instances. Any Medicare beneficiary may seek services at an FQHC.

To find out whether one of these centers serves your area, call 1-800-638-6833.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop Carefully Before You Buy. Policies differ as to coverage and cost, and companies differ as to service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage is expensive and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. Federal law prohibits issuing duplicative coverage to Medicare beneficiaries even if both policies would pay full benefits. The law generally prohibits the sale of a Medicare supplement policy to a person who has Medicaid or another health insurance policy that provides coverage for any of the same benefits.

Similarly, the sale of any other kind of health insurance policy is generally prohibited if it duplicates coverage you already have. When you buy a replacement Medigap policy, the insurer is required to obtain your written statement that you intend to cancel the first policy after the new policy becomes effective. If you are on Medicaid, insurers may not sell you a Medigap policy unless the state pays the premium. Anyone who sells you a policy in violation of these anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call 1-800-638-6833 to report suspected violations.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other managed care plan; buying a Medigap policy; or buying a longterm care insurance policy.

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the 6 months before the date the policy went into effect.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you immediately for expenses connected with that problem. Medigap policies, however, are required to cover preexisting conditions after the policy has been in effect for 6 months.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another--you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them a long time. If you decide to replace your Medigap policy, you must be given credit for the time spent under the old policy in determining when any preexisting conditions restrictions apply under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy.

Prohibited Marketing Practices. It is unlawful for a company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make fraudulent or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising also is prohibited. This lactic involves mailings to identify individuals who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies (but not Medigap policies) pay less than the Medicare-approved amounts for hospital outpatient medical services and for services provided in a doctor's office. Others do not pay anything toward the cost of those services.

Check Your Right to Renew. States now require that Medigap policies be guaranteed renewable. This means that the company can refuse to renew your policy only if you do not pay the premiums or you made material misrepresentations on the application. Beware of older policies that let the company refuse to renew on an individual basis. These policies provide the least permanent coverage.

Even though your policy may be guaranteed renewable. the company may adjust the premiums from time to time. Some policies have premiums which increase as you grow older.

Be A ware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program.

If anyone tells you that they are from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to claim that a policy has been approved for sale in any state in which it has not received state approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your state. You should check with your state insurance department to make sure that any company you are considering is licensed in your state. This is for your protection. Agents also must be licensed by your state and may be required by the state to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy the Medigap policy of their choice without conditions being imposed (see page 11). Once this open enrollment period elapses, you may be limited as to the Medigap policies available to you, especially if you have a preexisting health condition.

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who tells you that your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

Look For an Outline of Coverage. You must be given a clearly worded summary of the policy... READ IT CAREFULLY.

Do Not Pay Cash. Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address and telephone number for your records.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without a response, contact your state insurance department.

Use the "Free-Look" Provision. Insurance companies must give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

See:

For Your Protection

For Your Protection

As noted above, federal criminal and civil penalties can be imposed against anyone who sells you a policy that duplicates coverage you already have unless you sign a statement declaring that the first policy will be cancelled, or unless you have Medicaid and the state Medicaid agency pays the premium for your Medigap policy. Penalties may also be imposed for claiming that a policy meets legal standards for federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received state approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, or the Health Care Financing Administration. It also is illegal to use the names. letters, symbols or emblems of their various programs.

This law is aimed primarily at mass marketers who use this information on mail solicitations to either imply or claim that the product they are selling whether it be insurance or something else--has either been endorsed or is being sold by the U.S. government. The advertising literature used by these organizations is often designed to look like it came from a government agency.

If you believe you have been the victim of any unlawful sales practices, contact your state insurance department immediately. If you believe that federal law has been violated, you may call 1-800-638-6833. In most cases, however, your state insurance department can offer the most assistance in resolving insurance related problems.

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these basic benefits:

Coverage for the Part A coinsurance amount ($174 per day in 1994) for the 61st through the 90th day of hospitalization in each Medicare benefit period.

Coverage for the Part A coinsurance amount ($348 per day in 1994) for each of Medicare's 60 non-renewable lifetime hospital inpatient 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 inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.

Coverage under Medicare Parts A and B for the reasonable cost of the first three 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 mental health services) after $100 annual deductible is met.

PLAN B includes the basic benefits plus:

* Coverage for the Medicare Part A inpatient hospital deductible ($696 per benefit period in 1994).

PLAN C includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care coinsurance amount ($87 per day for days 21 through 100 per benefit period in 1994).

Coverage for the Medicare Part B deductible ($100 per calendar year in 1994).

80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

PLAN D includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Coverage for at-home recovery. The at-home recovery benefit pays up to $1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

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 such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

PLAN F includes the basic benefits plus:

Coverage for the Medicare Part A deductible. Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for the Medicare Part B deductible. 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible. Coverage for 100% of Medicare Part B excess charges. *

PLAN G includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for 80% of Medicare Plan B excess charges.* 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Coverage for at-home recovery (see Plan D).

PLAN H includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $1,250 after the policyholder meets a $250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for 100% of Medicare Part B excess charges. *

Basic prescription drug coverage (see Plan H for description).

80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Coverage for at-home recovery (see Plan D).

PLAN J includes the basic benefits plus:

Coverage for the Medicare Part A deductible.

Coverage for the skilled nursing facility care daily coinsurance amount.

Coverage for the Medicare Part B deductible.

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 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible (this is called the "extended" drug benefit).

Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

Basic Benefits pay the patient's share of Medicare's approved amount for physician services (generally 20%) after $100 annual deductible, the patient's cost of a long hospital stay ($174/day for days 60-90, $348/day for days 91-150, approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

a "basic" benefit with $250 annual deductible, 50% coinsurance and a $1,250 maximum annual benefit (Plans H and I above),

and

an "extended" benefit (Plan J above) containing a $250 annual deductible, 50% coinsurance and a

$3,000 maximum annual benefit.

Each of the 10 plans has a letter designation ranging from "A" through "J". Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans, they all must make Plan A available if they sell any of the other 9 in a state.

See:

INSURANCE POLICY CHECK-LIST

NOTES

INSURANCE POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

Does the policy cover:	POLICY 1		POLICY 2		POLICY 3	
	YES	NO	YES	NO	YES	NO
Medicare Part A hospital deductible?						
*Medicare Part A hospital daily coinsurance?						
*Hospital care beyond Medicare's 150-day limit?						
Skilled nursing facility (SNF) daily coinsurance?						
SNF care beyond Medicare's limits?						
Medicare Part B annual deductible?						
*Medicare Part B coinsurance?						
Physician and supplier charges in excess of Medicare's approved amounts?						
*Medicare blood deductibles?						
Prescription drugs?						
Other Policy Considerations						
Can the company cancel or non-renew the policy?						
What are the policy limits for covered services?						
How much is the annual premium?						
How often can the company raise the premium?						
How long before existing health problems are covered?						
Does the policy have a waiting period before any benefits will be paid?						

How long?

* Most states now require that these benefits be included in all newly issued Medigap policies.

NOTES

DIRECTORY OF STATE INSURANCE DEPARTMENTS AND AGENCIES ON AGING

Each state has its own laws and regulations governing all types of insurance. The insurance offices listed in the left column of this directory are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. The middle column of the directory lists the telephone number to call for insurance counseling services. Calls to an 800 number listed in this directory are free when made within the respective state.

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Frequently Asked Questions About Social Security

SOCIAL SECURITY ADMINISTRATION

Q: I don't have a Social Security number. What should I do?

A: If you don't have a Social Security number, you must apply for one. There is no charge. Call Social Security's toll-free number, 1-800-772-1213, and ask for an application for a Social Security card. You may also obtain this application at any Social Security office. If you are 18 or older and have never had a Social Security number, you must go to a Social Security office in person to apply.

Q: I lost my Social Security card so I called Social Security's toll-free number, 1-800-772-1213, and asked for an application for a replacement card. When I get the application, do I have to provide documents to prove my identity?

A: Yes. Page two of the application lists examples of the identity documents we will accept. You must supply us with originals or certified copies of these documents. If you were not born in the U.S., you will need to submit evidence showing your U.S. citizenship or lawful alien status.

Q: I carry my Social Security card in my wallet. I wonder if that's a good idea because my wallet could be lost or stolen and my number could be used by someone else.

A: It is important to protect both your Social Security card and your number. You can prevent the loss or misuse of your card by keeping it with other valuable personal documents, such as your insurance papers and birth certificate. However, there are occasions when you will need to have your card with you--when you apply for a new job, for example. If your card is lost or stolen, you can apply for a replacement card. If you have evidence that someone is using your Social Security card or number, call Social Security at 1-800-772-1213.

For more about the uses of Social Security numbers, check our publication, Your Social Security Number.

MISLEADING INFORMATION

Q: I recently married and received a letter from a company offering to take care of changing my name on Social Security records for a fee. The letter and the envelope it came in certainly gave me the impression that they were connected with Social Security. I learned later they weren't and I also learned that Social Security provides this service for free so I would like to report this company to someone. What should I do?

A: To report the company, refer the complete mailing, including the envelope, to:

Social Security Administration Office of Communications Misleading Information Post Office Box 17740 Baltimore, Maryland 21235

If it's more convenient, you can take the entire package to your local postmaster, or send a complaint that includes the package to the:

Chief Postal Inspector United States Postal Service 475 L'Enfant Plaza, SW Washington, DC 20260-2100

Also, advise your State's Attorney General or Consumer Affairs Office and the Better Business Bureau in your area. Remember, ALL SOCIAL SECURITY SERVICES ARE FREE.

800 NUMBER

Q: I can't get to a phone during business hours. Can I call at night to get an application for a Social Security card?

A: Yes. You can apply for an original or replacement Social Security card by calling our toll-free number, 1-800-772-1213, on your touchtone phone 24 hours a day, 7 days a week. Live service is available 7 AM to 7 PM and automated service is available via touchtone phone the rest of the time. Additional services available include:

Application for a Social Security card (SS-5); Request for Earnings and Benefit Estimate Statement (SSA-7004); General information pamphlets; and Verification of benefit amount.

You'll be asked to give your name and address and the application form will be mailed to you within two weeks. Click here to return to CONTENTS.

DIRECT DEPOSIT

Q: What are the advantages of direct deposit?

A: Among other advantages, direct deposit will mean:

You won't need to worry about your checks being lost, stolen, or misplaced;

You won't have to worry about cashing your check if you're hospitalized or in ill health;

You will avoid future possibilities of missing a check; You can be away from home without the worry of a check sitting unprotected in your mailbox; and You won't have to make a special trip to your bank or stand in line to deposit your check.

Q: I'm receiving Social Security. How do I have my retirement check sent to my bank? A: Your first step is to call your bank and say that you want to sign up for direct deposit. When you call, have your Social Security number and your checkbook, bank statement, or any papers that show your bank account number. Direct deposit should take effect with either your next check or the one that follows it.

Your payment will then be deposited in your savings or checking account each month, automatically.

CHANGE OF ADDRESS

Q: How do I change my address on my Social Security records? A: Call Social Security's toll-free number, 1-800-772-1213, and tell them your new address including the ZIP code, your new telephone number, and your Social Security claim number. Our lines are busiest early in the week and early in the month, so it's best to call at other times.

Q: My mother will be moving. What does she need to do to make sure she won't miss any of her Social Security checks?

A: Your mother needs to inform Social Security of her new address and phone number as soon as she knows them. She can report by calling Social Security's toll free number,1-800-772-1213, or she can write or visit the office. Her report should include her Social Security number. Your mother also needs to file a change of address form with the post office.

EARNINGS RECORD

Q: How often should I check my Social Security earnings record? Is there much of a chance that an error may occur?

A: You should check your Social Security earnings record at least once every three years. Errors in your earnings record are more likely to occur if you change jobs frequently or have more than one employer. To check your earnings record, contact your local Social Security office or call our toll-free number: 1-800-772-1213 and ask for the Request For Personal Earnings And Benefit Estimate Statement (Form 7004). The form may also be downloaded from this server.

The form asks a few identifying questions (name, address, date of birth, etc.). Four to six weeks after you send in the form, you'll receive a statement that shows your earnings as reported to Social Security by your employer(s). Check our records against your own files.

If you find an error, contact Social Security right away with proof of your actual earnings (such as a W-2 form).

Our lines are busiest early in the week and early in the month, so it's best to call at other times.

Q: Someone told me that Social Security has a financial planning service. I don't understand the connection between financial planning and Social Security. A: Social Security is not in the financial planning business. However, Social Security can offer you a free Personal Earnings and Benefit Estimate Statement to help you in assessing your financial planning needs. Remember, Social Security was always meant to be a supplement to other pensions and savings.

The statement gives you a breakdown of all the wages reported under your social security number as well

as estimates of what Social Security benefits you and your family would be eligible for. Once you know what to expect from Social Security, you can plan your other financial needs. To get your free Personal Earnings and Benefit Estimate Statement, call our toll-free number, 1-800-772-1213, or contact your nearest Social Security office, or download from this server.

If you're approaching 60, SSA will send you a Personal Earnings and Benefit Estimate Statement by October without a request from you.

PROOF OF BENEFITS

Q: I need proof of what I receive from Social Security. What can I use?

A: Every year Social Security will send you an SSA-1099 form showing how much you received in the past year. You can use this as proof of your benefit amount. We'll also send you a notice when your amount increases because of an annual cost of living raise (The annual cost of living notice--COLA--goes on to individuals with direct deposit, not to those paid by check.). If you don't have these notices or you need a statement of your current benefit, you can have one mailed to you by calling our toll-free number, 1-800-772-1213. You can show this notice as proof of how much you get.

BENEFIT COMPUTATIONS

Q: Why is my neighbor's check more than mine?

A: Benefit computations are based on a person's date of birth and complete work history, so differences are very likely. To protect each person's privacy, we cannot give you information about someone else's Social Security record.

RETIREMENT

Q: Are my benefits figured on my last five years of earnings?

A: No. Retirement benefits are calculated on earnings during a lifetime of work under the Social Security system. Years of high earnings will increase the amount of the benefit.

Q: Will my retirement pension from my job reduce the amount of my Social Security benefit?

A: If your pension is from work where you also paid Social Security taxes, it will not affect your Social Security benefit. Pensions from work that are not covered by Social Security (for example, the federal civil service and some state or local government systems) probably will reduce the amount of your Social Security benefit. For additional information, see Social Security publications "Government Pension Offset" (05-10007) and "A Pension for Work Not Covered" (05-10045).

Q: I will be 62 on August 2 of this year and that's when I plan on retiring. Will my first benefit check be for the month of August or September?

A: Since you were born on the first or second day of the month, you will be eligible the month you were born--August. But, in most cases, Social Security retirement benefits do not begin the month the person reaches 62; benefits usually begin the following month. To receive retirement benefits, you must be at least age 62 for the entire month. But, the law says that you "attain" your age the day before your birthday. Since you were born on August 2, you legally attain your age on August 1; therefore you're eligible for benefits for August because you're considered 62 for the entire month.

Q: My neighbor, who is retired, told me that the income he receives from his part-time job at the local nursery gives him an increase in his Social Security benefits. Is that right?

A: People who return to work after they start receiving benefits may be able to receive a higher benefit based on those earnings. This is because Social Security automatically recomputes the benefit amount after the additional earnings are credited to the individual's earnings record.

Q: If I work after I start receiving Social Security retirement benefits, will I have to pay FICA taxes?

A: Yes, and your extra earnings may increase your benefits. For additional information, call your local Social Security office or Social Security's toll-free number, 1-800-772-1213.

Q: I am 70 years old and still working. Do I have to report my earnings to Social Security?

A: In the year you reach age 70, you are responsible for reporting your earnings for the months before the month you reach 70. You do not have to report your earnings if you are 70 or older all year. You can report your earnings by calling Social Security's toll-free number, 1-800-772-1213 or contacting your local Social Security office. Representatives at the toll-free number can give you the address and telephone number of your nearest Social Security office.

Q: I understand I can retire at age 62 and collect Social Security benefits, but that they will be less than if I wait until 65 to retire. How does that work?

A: Your benefits are reduced five-ninths of one percent for each month you are retired before age 65, up to a maximum of 20 percent for people who retire the month they reach 62. But remember, by taking benefits at 62, you'll receive Social Security checks for a longer period of time.

Q: I think Social Security is a rip off compared to a private retirement plan I have. Can I drop out of Social Security?

A: No. Social Security coverage is mandatory. But consider this: unlike your private plan, Social Security provides disability and survivors coverage in addition to retirement benefits. And Social Security generally offers greater protection for family members than private pensions.

Q: I have two children at home and I plan to retire next fall. Will my children be eligible for monthly Social Security checks after I retire?

A: Monthly Social Security payments may be made to unmarried children under age 18, or age 19 if still in high school, or children age 18 or over who were severely disabled before age 22 and who continue to be disabled.

Q: I'd like to get Social Security retirement benefits and continue working. Is it hard to follow the rules?

A: It's easier than you think. When you apply for your retirement benefits, the Social Security representative will explain how your earnings will affect your benefit checks. You will need to estimate your future earnings and, at the end of each year, file a report of your actual earnings. Your benefits will be paid based on your estimated earnings so your estimate needs to be as accurate as possible. After you report your actual earnings, we will send you an additional check for benefits you are due if your original estimate was too high. If your estimate was too low and you are overpaid, the money will be withheld from your checks in the next year.

SOCIAL SECURITY TAXES

Q: I'm a married woman who works and pays Social Security taxes. A friend of mine told me she'll be eligible for Social Security benefits on her husband's record, even though she's never worked or paid Social Security taxes. That doesn't seem fair. Does that mean that the Social Security taxes I'm paying are wasted, since I could get benefits on my husband's record without ever working?

A: The Social Security taxes you are paying are not wasted. As a married woman who works and pays Social Security taxes, you have advantages by being eligible for your own benefit. You may get a higher benefit when you retire than if your benefit was based solely on your husband's earnings. You can retire before your husband, based on your own earnings, even though your husband continues to work. As a working woman, you earn disability protection for you and your dependent children. Also, in the event of your death, your survivors may be eligible for benefits based on your earnings.

Q: If you hire someone to work in your home, must you pay Social Security taxes on their earnings?

A: It depends on how much the household worker is being paid. Effective with 1994 earnings, no tax is due unless the earnings are at least $1,000 in a year. You report the earnings once a year. You, as the employer, should withhold the employee share of 7.65 percent of wages, add an equal employer share, and send the total to the Internal Revenue Service once a year.

Workers covered include maids, child care providers, gardeners, and others who provide household services. Workers under age 18 are exempt unless household employment, including babysitting, is their main occupation.

If you have questions about reporting household employment and paying the Social Security taxes, call

the Internal Revenue Service's toll-free number, 1-800-829-1040.

Q: I may open a small business. Will I pay more in Social Security taxes than I did when I worked for someone else?

A: Yes and no. Self-employed people pay twice as much in Social Security taxes as employees pay. However, because employers pay a matching share, the combined rate is the same as the self-employment tax. But there are special tax credits you can take when you file your tax return that are intended to lower your overall rate. In 1995, the self-employment tax rate is 15.3 percent of your net profit up to $61,200. But if your net earnings exceed $61,200, you must continue to pay the Medicare portion of the Social Security tax (2.9 percent) on the remainder of your earnings.

For more information about your tax responsibilities as the owner of a small business, call the IRS toll-free number 1-800-829-1040.

Q: I think I could do better if you let me invest the Social Security I pay into an IRA or some other investment plan. What do you think?

A: Maybe you could--but then again, maybe your investments wouldn't work out. Remember these facts:

Your Social Security taxes pay for potential disability and survivors benefits as well as for retirement benefits;

Social Security incorporates social goals--such as giving more protection to families and to low income workers--that are not part of private pension plans; and

Social Security benefits are adjusted yearly for increases in the cost-of-living--a feature not present in many private plans.

Q: Both my husband and I work and pay Social Security taxes. On which record will my benefits be based?

A: You will receive benefits based on your work record if you work long enough under Social Security--usually 10 years--to be entitled to benefits. If your wife's benefit is more that your own Social Security, you will receive an additional amount on your husband's record.

SURVIVOR'S BENEFITS

Q: My ex-wife died a month ago. Are our children, ages 11 and 14, eligible for Social Security benefits?

A: Possibly. It depends on whether she had enough work credits to be insured. If she did, your children may be eligible for benefits. Apply for survivors benefits promptly because benefits are generally retroactive only up to 6 months. You can apply by calling Social Security's toll-free number, 1-800-772-1213, or by calling your local Social Security office.

Q: My two children and I have been receiving survivors benefits since my wife died. Will these benefits continue if I remarry?

A: Your remarriage would have no effect on the benefits being paid to your children. If you get benefits only because you are caring for your children, your benefits would end at the time of your remarriage unless you marry someone who is receiving Social Security benefits.

Q: My mother, a widow, died in late January. Social Security tells me that I must return her January benefit (paid in February) even though she was alive most of the month. Why is this?

A: Social Security benefits are not pro-rated. To be entitled to a Social Security benefit check for a given month, the person must be alive the entire month. No benefit is payable for the month of death.

Q: I'm a 63-year-old widow receiving reduced Social Security benefits. Can I switch to a higher benefit when I turn 65?

A: Ordinarily, you can't change from a reduced benefit to a full benefit when you reach age 65. But if you are a widow or widower who already has earned enough credits to get Social Security on your own record, or you are continuing to work at higher earnings, you may be able to switch to a higher benefit. Contact your Social Security office to ask for a benefit computation.

Q: When a Social Security beneficiary dies, does the funeral home notify Social Security or is notification up to the family?

A: Many funeral directors voluntarily provide death information directly to Social Security. But, family members of a deceased individual still have the legal responsibility to notify Social Security.

Q: My wife, who had worked for about six years, died last month and now I am the sole support for our two young children. Am I eligible for Social Security survivors benefits?

A: Possibly. Depending on your wife's age at death, she may have had enough work credit to be insured. If she was, you and your children may be eligible for benefits. However, if you're working, your earnings may reduce your Social Security benefits.

Q: Our daughter, who had two young children, passed away two years ago. Her husband is planning to remarry and his fiance wants to adopt the children after the marriage. Will the children lose the Social Security survivor's benefits that they currently receive?

A: No. The adoption of a child already entitled to survivor's benefits does not terminate the child's benefits.

MAXIMUM FAMILY BENEFIT

Q: I've heard that there is a maximum family benefit under Social Security. Does this mean that once the maximum is reached, some family members won't get benefits?

A: No. Each family member entitled to a monthly benefit will receive one. The total benefits received by the family, however, cannot exceed the family maximum amount. That amount is divided among all entitled dependents. The more dependents who receive benefits on the worker's Social Security record, the lower the benefit amount will be for each dependent. However, the family maximum does not affect the wage earner's benefit.

SUPPLEMENTAL SECURITY INCOME

Q: What is SSI?

A: SSI is short for Supplemental Security Income. It pays checks to individuals who are 65 or older, or blind, or have a disability and who don't own much or have a lot of income. SSI isn't just for adults. Monthly checks can go to disabled and blind children also.

Q: Is the SSI payment for an eligible couple twice that of an eligible individual? And if it isn't, why not?

A: The SSI program provides a basic Federal payment for an eligible individual and a larger amount for an eligible couple. The payment for a couple is lower than that made to two individuals because married people living together generally share expenses and live more economically than two people living independently.

Q: I have been receiving Supplemental Security Income (SSI) checks for several months and my check has always arrived on the 1st of the month. I cash the check immediately, shop for groceries, and pay my rent that is due on the 1st as well. What happens when the 1st of the month falls on a Saturday? Must my rent be late because I can't cash my check until Monday?

A: For SSI recipients, if the 1st falls on a Saturday, Sunday, or legal holiday, the SSI check should arrive on the previous banking day.

Q: A few days ago I saw a poster that advised individuals 65 or over with limited income and resources to apply for Supplemental Security Income (SSI) at any Social Security office. Next month I'll turn 65 and I thought I'd be eligible for SSI so I planned to apply until my neighbor told me I'd probably be turned down because I have children who could help support me. Is this true?

A: No. Your eligibility for SSI would not be affected by your children's ability to help support you. But, any support they give you would be considered income for SSI purposes and could affect the amount of your payment. For more information, contact your nearest Social Security office or call Social Security's toll-free number, 1-800-772-1213.

Q: When I started receiving Supplemental Security Income (SSI) checks, I received a booklet that told me

what I should report to Social Security. I misplaced the booklet. How can I get a new one?

A: Call your local Social Security office or Social Security's toll-free number, 1-800-772-1213 and ask for the booklet, When You Get SSI, What You Need to Know.

Q: I just got a notice from Social Security that said my Supplemental Security Income (SSI) case is being reviewed. What does this mean?

A: Social Security reviews every Supplemental Security Income case from time to time to make sure the individuals who are receiving checks should continue to get them. The review also determines if the individuals are receiving the correct amounts.

TELECOMMUNICATIONS DEVICE FOR THE DEAF (TDD) SERVICES

Q: Can I use my TDD (Telecommunications Device for the Deaf) to call Social Security on the national Social Security toll-free voice line?

A: TDD use is limited to the special toll-free TDD service line. Voice calls should not be made to the TDD toll-free number and TDD calls should not be made to other Social Security numbers established for voice callers. The Social Security national TDD toll-free number is 1-800-325-0778.

DISABILITY

Q: I understand that to get Social Security disability benefits, your disability must be expected to last at least a year. Does this mean that you must wait a year after being disabled before you can get benefits?

A: You do not have to wait a year after the onset of the disability before you can get benefits. You should file as soon as you can after becoming disabled and benefits begin after a 5-month waiting period. The waiting period begins with the month Social Security decides your disability began.

Q: I have been receiving Social Security disability benefits for the past four years and my condition has not improved. Is there a time limit on Social Security disability benefits?

A: No. You will continue to receive a disability benefit as long as your condition keeps you from working. But, your case will be reviewed periodically to see if there has been any improvement in your condition and whether you are still eligible for benefits. If you are still eligible when you reach 65, your disability benefit will be automatically converted to retirement benefits.

Q: I had a serious back injury four years ago and received disability benefits for about 18 months until I could return to work. Unfortunately, my back problems have recurred and I don't know how much longer I will be able to continue working. When I initially applied for benefits, I waited several months before I received my first check. If I reapply for benefits, will my wait be as long as it was the first time?

A: Maybe not. It depends on what the new medical reports say and whether additional evidence is required. A worker who becomes disabled a second time within five years after benefits stop can have his or her checks start again, beginning with the first full month of disability if the new claim is approved.

Q: My brother had an accident at work last year and is now receiving Social Security disability benefits for himself, his wife, and daughter. Before his accident, he helped support another daughter by a woman to whom he has never been married. Is the second child entitled to some benefits as well?

A: Yes, even though your brother wasn't married to the second child's mother, Social Security pays benefits to all of his children, even if they were born out of wedlock. Each child is entitled to equal benefits.

PROPER DOCUMENTATION

Q: I'm getting ready to sign up for Social Security. I heard I have to show you my birth certificate. I've got a copy of it in my safe deposit box. Is this good enough?

A: It depends on what you mean by a "copy." If it's a copy of your birth record that's been certified by the agency that issued your birth certificate, then it's acceptable. "Certified" means it's been signed by the issuing agency and has a official seal. If all you have is an uncertified photocopy, that's not legally acceptable.

Q: What documents will I need show to my claims representative to prove I'm eligible for Social Security benefits?

A: To show us you're eligible for Social Security and to help us decide how much your benefits should be will depend on the circumstances of your claim. Here is a list of some of the documents you can use:

Your Social Security card (or a record of your number); Your birth certificate; Children's birth certificates (if they are applying); Marriage certificate (if signing up on a spouse's record); Your most recent W-2 form, or your tax return if you're self- employed; Your military discharge papers if you had military service.

You must bring or mail the original documents, or certified copies, to the local Social Security office, where they will be photocopied and returned to you.

REPRESENTATIVE PAYEES

Q: I have an elderly friend who receives Social Security benefits. I'm concerned that she's unable to manage her money to pay her bills on time. Can Social Security help her?

A: Yes. When an individual who gets Social Security or Supplemental Security Income (SSI) checks is unable to manage benefits in his or her own best interest, the Social Security Administration appoints a representative payee to assume these responsibilities. In these cases, the Social Security or SSI benefits are sent directly to the representative payee. The payee takes care of using funds for the personal care and well-being of the beneficiary and agrees to report certain changes in the beneficiary's circumstances that could affect the continuing eligibility to receive benefits. To get more information, call your local Social Security office and ask about "representative payees."

TAXABLE EARNINGS

Q: My 17-year-old daughter has a summer job keeping house for a neighbor. Are her earnings taxable for Social Security?

A: No. Workers under age 18 are exempt unless household employment is their main occupation. Workers 18 and older are also exempt if they earn less than $1,000 a year in cash wages for household work.

If you have questions about reporting household employment and paying the Social Security taxes, call the Internal Revenue Service's toll-free number, 1-800-829-1040.

PERSONAL EARNINGS AND BENEFIT ESTIMATE STATEMENT

Q: I'm in my late '50s, still working, and haven't started drawing Social Security yet. Will Social Security send me a document that will help me determine what my future benefits will be?

A: Yes. If you haven't received in already, you should receive a document in the mail that will give you an estimate of your future benefits. You can use this statement as a part of your planning for retirement. After you've read the statement, you don't need to do anything unless you believe the earnings information is incorrect. If the error involves recent earnings at your current job, contact your employer. If your statement shows incorrect earnings at a former job, report the discrepancy to Social Security's toll-free number, 1-800-772-1213. When you call, be sure to have your records of the correct earnings handy--such as W-2s, pay stubs, and tax returns. You should also call the toll-free number to report an incorrect name or Social Security number on the statement.

Q: I am in my forties. How do I get a benefit estimate statement?

A: Call the toll-free number 1-800-772-1213 anytime--including weekends and holidays--and ask for form SSA-7004 (Request for Personal Earnings and Benefit Estimate Statement. You should receive the statement in four to six weeks.