Arizona Enrollment Materials
For plan effective dates:
January 1 – December 1, 2018.

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Keep cruising. Don't slow down.

Consider a Medicare Supplement Plan to help with some of the out-of-pocket costs not paid by Medicare.

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Discover the health care coverage that fits your life:

A Medicare Supplement Insurance Plan

Hello,

With an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), you get supplemental coverage that may serve your needs with:

- ✓ **Competitive group rates.** These rates are available exclusively to insured AARP members.
- ✓ **High customer satisfaction.** 9 out of 10 plan holders surveyed would recommend their AARP Medicare Supplement Plan to a friend or family member.*
- ✓ **A plan that lets you choose.** 95% of plan holders surveyed were satisfied with the ability to choose their own doctor who accepts Medicare patients.*

As with any standardized Medicare supplement plans, you get important supplemental coverage that helps to pay some of the costs Medicare doesn't pay.

In the following pages you will find rates as well as detailed descriptions of the benefits included in each plan. Your Representative, who is a licensed insurance agent/producer contracted with UnitedHealthcare to offer AARP Medicare Supplement Plans, can review the information with you and answer any questions you may have. Once you've chosen the plan that's best for your needs and budget, your Representative can help you complete and submit the Application Form, along with the first month's premium.

All of us at UnitedHealthcare look forward to serving your health insurance needs now and for many years to come.

Sincerely,

Susan Morisato

Susan Morisato
President, Insurance Solutions
UnitedHealthcare Insurance Company

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P.S. If you're not currently an AARP member, you must join to be eligible to enroll for these plans. You can join AARP online, by phone or by including the form and separate check for the annual membership dues with your application.

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Important disclosures on back

Important Notice: You are entitled to receive a "Guide to Health Insurance for People with Medicare." This guide is free, and briefly describes the Medicare program and the health insurance available to those on Medicare. If you are interested in receiving this free guide, please call 1-800-272-2146, toll-free, or find it on the web at www.medsupeducation.com.

Questions? Contact your licensed insurance agent/producer or call toll-free: **1-866-387-7550** Monday – Friday, 7 a.m. – 11 p.m. and Saturday, 9 a.m. – 5 p.m., ET.

* From a report prepared for UnitedHealthcare Insurance Company by GfK Custom Research NA, "Medicare Supplement Plan Satisfaction Posted Questionnaire," March 2017, www.uhcmedsupstats.com or call 1-800-523-5800 to request a copy of the full report.

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Insured by UnitedHealthcare Insurance Company, Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy form No. GRP 79171 GPS-1 (G-36000-4).

In some states, plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.

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See the enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

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Your Exclusive Member Services.

Get answers. **Save** money. **Live** healthy.

SILVERSNEAKERS® FITNESS PROGRAM

Live healthier with free access to fitness centers and classes.

Use 13,000+ participating fitness locations, with access to exercise equipment, group fitness classes, social activities and more.

Take signature group exercise classes designed just for you and led by certified instructors.

SilverSneakers FLEX™ Community Classes offer additional options such as Latin dance, tai chi and yoga. Self-directed physical activity programs are offered for members who want to work out at home or for those who can't get to a fitness location.

Visit **silversneakers.com** to find a fitness center location near you or to get more information.

AARP® VISION DISCOUNTS provided by EyeMed Vision Care

Save on every eyewear purchase and on routine eye exams.

Save 30% on eyewear, including bifocals, lenses, and frames.* Contact lens wearers save 10% on disposables and 20% on all other contact lenses. Plus, receive a 90-day guarantee on every eyewear purchase. Only at LensCrafters, take an additional $50 off your AARP Vision Discount or best in-store offer on no-line multifocal lenses with frame purchase.

Pay only $50 for routine eye exams** including an Eye Health Exam Report that details your results, and receive $10 off contact lens exams.

Simply show your AARP® Medicare Supplement card when you visit any participating LensCrafters®, Pearle Vision®, Sears Optical®, Target Optical®, and JCPenney Optical® location, or one of many private practice locations.**

NURSE HEALTHLINE

Get your health issues assessed, then get the help you need to make the right choices.

Speak directly with registered nurses, toll-free, 24 hours a day, 365 days a year.

Make informed decisions on how to get proper care. Nurses will review your symptoms, recommend treatment options, and refer you to providers that meet high standards of quality and efficiency.

Identify local resources such as transportation services or community centers.

Spanish is available, as well as translation assistance in 140+ languages.

These are additional insured member services apart from the AARP Medicare Supplement Insurance Plan benefits, are not insurance programs, are subject to geographical availability, and may be discontinued at any time.

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*30% discount only available when a complete pair of glasses (frames, lenses, and lens options) is purchased in the same transaction. Items purchased separately will be discounted at 15% off the retail price.

**Eye exams available by Independent Doctors of Optometry at or next to LensCrafters, Pearle Vision, Sears Optical and Target Optical in most states. Doctors in some states are employed by the location. In California, optometrists are not employed by LensCrafters, Sears Optical and Target Optical, which do not provide eye exams. For LensCrafters, eye exams are available from optometrists employed by EYEXAM of California, a licensed vision health care service plan. For Sears Optical and Target Optical, eye exams are available from self-employed doctors who lease space inside the store. Eye exam discount applies only to comprehensive eye exams and does not include contact lens exams or fitting. Contact lens purchase requires valid contact lens prescription. At LensCrafters locations, contact lenses are available by participating Independent Doctors of Optometry or at LensCrafters locations.

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See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

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Plans & Rates

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Overview of Available Plans

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, B, C, F, G, K, L, N and Medicare Select Plans C and F are currently being offered by UnitedHealthcare Insurance Company.

Basic Benefits:

- **Hospitalization:** Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B co-insurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance

♦Medicare Select Plans C and F contain the same benefits as standardized Medicare Supplement Plans C and F, except for restrictions on your use of hospitals.

Plan A	Plan B	Plan C♦	Plan D	Plan F*♦	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible					
				Part B excess (100%)	Part B excess (100%)				
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
						Out-of-pocket limit $5240; paid at 100% after limit reached	Out-of-pocket limit $2620; paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This option is not currently offered by UnitedHealthcare Insurance Company. This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

Bright Ways To Save

Questions? Contact your licensed insurance agent/producer.

When you choose an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company, you may be able to take advantage of the discounts shown below.

SAVE up to 36% with the Enrollment Discount

See the Enrollment Discount page in this booklet to determine your eligibility and discount.

TAKE $24 OFF with Electronic Funds Transfer

You'll save $2.00 off your total monthly household premium when you use the convenient and easy payment option, Electronic Funds Transfer (EFT). Your monthly payments are automatically forwarded by your bank, which means no checks to write and no postage to pay. Simply complete the EFT form located in this booklet.

LOCK In Your Premium with the Rate Guarantee

Your rate is guaranteed for 12 months from your initial plan effective date. Insured members will not receive an additional rate guarantee when changing from one AARP Medicare Supplement Plan to another.

SAVE 5% with the Multi-Insured Discount

You may be eligible to each take 5% off your monthly premiums if two members are enrolled under the same AARP membership number and each is insured under an eligible AARP-branded supplemental insurance policy with UnitedHealthcare Insurance Company.

SAVE $24 per year with the Annual Payer Discount

Take $24 off your total household premium when you pay your entire calendar year premium in January.

Note: Electronic Funds Transfer (EFT) discount and Annual Payer discount cannot be combined

AARP® | **Medicare Supplement Plans**
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Your Plans and Rates

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

1 Review plan

Look over the Overview of Available Plans in this booklet to find the plans that include the benefits you need. You'll find all of the AARP Medicare Supplement Plans listed here.

For more detailed plan information, please see the *Outlines of Coverage* included in this booklet.

2 Find your rate

The rate you will pay is based on several factors including: the plan you select, your age at the time your coverage will begin and the amount of time since you've enrolled in Medicare Part B.

Applicants Age 65 and older

- First – determine what your age will be as of the date you expect your coverage to begin and be sure to know your Part B effective date.
- Then – go to the rate pages in this booklet to find your rate Group. There are descriptions for each Group to help guide you.
- Use the following chart to help you figure out which rate Group on that rate page applies to you:

If the time period between your coverage start date and your 65th birthday, or your Medicare Part B effective date if later, is:	
Number of years:	**You are in:**
Less than 10	Group 1
10 or more	Group 2

There are separate rate pages for **(Non-Tobacco User or Tobacco User)** depending on whether or not you use tobacco products. You are eligible for the **Non-Tobacco User** rates if you have not used tobacco products within the past 12 months.

If you are in Group 1 and under age 77, you may be eligible for the Standard rates with Enrollment Discount. You can find information about the Enrollment Discount on the next page. Your answers to the medical questions on the application will also affect your rate as described on the rate page.

3 Enroll

Once you've chosen a plan and found your rate, simply fill out the application and any additional required forms included in this booklet and mail them in using the postage-paid reply envelope included in your kit. See the *Enrollment Checklist* in this booklet for the list of items to complete and send in.

Enrollment Discount

Who is eligible?

You may be eligible for the enrollment discount if your age on your insurance plan effective date is:

- 65 to 74 and you do not have any of the medical conditions listed on the application.
- 75 to 76 and your plan effective date is within 10 years of your Medicare Part B effective date AND you do not have any of the medical conditions listed on the application.

Note: Medical questions do not apply to you if you are within 6 months of your Medicare Part B effective date or you meet a guaranteed issue situation.

How it works

The Enrollment Discount is applied to the current Standard Rate. The Standard Rate usually changes each year. The discount you receive in your first year of coverage depends on your age on your plan effective date. The discount percentage decreases 3% each year on the anniversary date of your plan until the discount runs out. Please note that as the discount decreases on the anniversary date of your coverage, the amount you pay for your monthly premium will increase. For example, when the discount drops from 36% to 33%, the premium you pay each month will increase. This increase may happen at a time other than the Plan's annual rate change. Please keep this in mind when budgeting for your health insurance expenses.

Example #1: MEET JANE*...

- Jane's Plan Effective Date is: June 1st
- Jane's Age When Her Plan Becomes Effective: 66 years and 4 months
- Time since Jane enrolled in Medicare Part B: 1 year
- Jane does not have any of the medical conditions listed on the application
- **Jane is eligible for the enrollment discount**

Jane's discount will begin at age 66

- Starting discount will be 33%
- Discount will change to 30% beginning on Jane's anniversary date (June 1st of the next year)

Example #2: MEET JOE*...

- Joe's Plan Effective Date is: June 1st
- Joe's Age When His Plan Becomes Effective: 70
- Time since Joe enrolled in Medicare Part B: 3 years
- Joe does not have any of the medical conditions listed on the application
- **Joe is eligible for the enrollment discount**

Joe's discount will begin at age 70

- Starting discount will be 21%
- Discount will change to 18% beginning on Joe's anniversary date (June 1st of the next year)

	Age on Plan Effective Date	Starting Discount
	65	36%
JANE	**66**	**33%**
	67	30%
	68	27%
	69	24%
JOE	**70**	**21%**
	71	18%
	72	15%
	73	12%
	74	9%
	75	6%
	76	3%
	77	0%

***The people and situations shown above are fictitious and for illustration purposes only.**

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Cover Page - Rates Non-Tobacco Monthly Plan Rates for Arizona

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.									
Age[1]	**Plan A**	**Plan B**	**Plan C**	**Select C[2]**	**Plan F**	**Select F[2]**	**Plan G**	**Plan K**	**Plan L**	**Plan N**
	Standard Rates with Enrollment Discount[3] for individuals ages 65-76 whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
65	$90.56	$126.88	$144.00	$124.32	$145.12	$126.08	$123.20	$42.72	$76.96	$96.80
66	$94.80	$132.82	$150.75	$130.14	$151.92	$131.99	$128.97	$44.72	$80.56	$101.33
67	$99.05	$138.77	$157.50	$135.97	$158.72	$137.90	$134.75	$46.72	$84.17	$105.87
68	$103.29	$144.72	$164.25	$141.80	$165.52	$143.81	$140.52	$48.72	$87.78	$110.41
69	$107.54	$150.67	$171.00	$147.63	$172.33	$149.72	$146.30	$50.73	$91.39	$114.95
70	$111.78	$156.61	$177.75	$153.45	$179.13	$155.63	$152.07	$52.73	$94.99	$119.48
71	$116.03	$162.56	$184.50	$159.28	$185.93	$161.54	$157.85	$54.73	$98.60	$124.02
72	$120.27	$168.51	$191.25	$165.11	$192.73	$167.45	$163.62	$56.73	$102.21	$128.56
73	$124.52	$174.46	$198.00	$170.94	$199.54	$173.36	$169.40	$58.74	$105.82	$133.10
74	$128.76	$180.40	$204.75	$176.76	$206.34	$179.27	$175.17	$60.74	$109.42	$137.63
75	$133.01	$186.35	$211.50	$182.59	$213.14	$185.18	$180.95	$62.74	$113.03	$142.17
76	$137.25	$192.30	$218.25	$188.42	$219.94	$191.09	$186.72	$64.74	$116.64	$146.71
	Standard Rates for ages 77 and older whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
77+	$141.50	$198.25	$225.00	$194.25	$226.75	$197.00	$192.50	$66.75	$120.25	$151.25
	Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed and who have one or more of the medical conditions on the application[4].									
65+	$212.25	$297.37	$337.50	$291.37	$340.12	$295.50	$327.25	$100.12	$180.37	$245.02

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.									
Age[1]	**Plan A**	**Plan B**	**Plan C**	**Select C[2]**	**Plan F**	**Select F[2]**	**Plan G**	**Plan K**	**Plan L**	**Plan N**
	Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
75+	$155.65	$218.07	$247.50	$213.67	$249.42	$216.70	$211.75	$73.42	$132.27	$166.37
	Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed and who have one or more of the medical conditions on the application[4].									
75+	$212.25	$297.37	$337.50	$291.37	$340.12	$295.50	$327.25	$100.12	$180.37	$245.02

The rates above are for plan effective dates from January - December 2018 and may change.

Cover Page - Rates Tobacco Monthly Plan Rates for Arizona

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.									
Age[1]	**Plan A**	**Plan B**	**Plan C**	**Select C[2]**	**Plan F**	**Select F[2]**	**Plan G**	**Plan K**	**Plan L**	**Plan N**
	Standard Rates with Enrollment Discount[3] for individuals ages 65-76 whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
65	$99.61	$139.56	$158.40	$136.74	$159.62	$138.68	$135.52	$46.98	$84.65	$106.47
66	$104.28	$146.10	$165.82	$143.15	$167.11	$145.18	$141.87	$49.19	$88.62	$111.46
67	$108.95	$152.64	$173.25	$149.56	$174.59	$151.69	$148.22	$51.39	$92.58	$116.45
68	$113.62	$159.19	$180.67	$155.97	$182.07	$158.19	$154.57	$53.59	$96.55	$121.45
69	$118.29	$165.73	$188.10	$162.38	$189.55	$164.69	$160.93	$55.79	$100.52	$126.44
70	$122.96	$172.27	$195.52	$168.79	$197.04	$171.19	$167.28	$58.00	$104.49	$131.43
71	$127.63	$178.81	$202.95	$175.20	$204.52	$177.69	$173.63	$60.20	$108.46	$136.42
72	$132.30	$185.35	$210.37	$181.61	$212.00	$184.19	$179.98	$62.40	$112.42	$141.41
73	$136.97	$191.90	$217.80	$188.02	$219.48	$190.69	$186.34	$64.60	$116.39	$146.40
74	$141.64	$198.44	$225.22	$194.43	$226.97	$197.19	$192.69	$66.81	$120.36	$151.39
75	$146.31	$204.98	$232.65	$200.84	$234.45	$203.69	$199.04	$69.01	$124.33	$156.38
76	$150.98	$211.52	$240.07	$207.25	$241.93	$210.19	$205.39	$71.21	$128.30	$161.37
	Standard Rates for ages 77 and older whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
77+	$155.65	$218.07	$247.50	$213.67	$249.42	$216.70	$211.75	$73.42	$132.27	$166.37
	Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed and who have one or more of the medical conditions on the application[4].									
65+	$233.47	$327.10	$371.25	$320.50	$374.13	$325.05	$359.97	$110.13	$198.40	$269.51

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.									
Age[1]	**Plan A**	**Plan B**	**Plan C**	**Select C[2]**	**Plan F**	**Select F[2]**	**Plan G**	**Plan K**	**Plan L**	**Plan N**
	Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed or who do not have any of the medical conditions on the application[4].									
75+	$171.21	$239.87	$272.25	$235.03	$274.36	$238.37	$232.92	$80.76	$145.49	$183.00
	Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed and who have one or more of the medical conditions on the application[4].									
75+	$233.47	$327.10	$371.25	$320.50	$374.13	$325.05	$359.97	$110.13	$198.40	$269.51

The rates above are for plan effective dates from January - December 2018 and may change.

1 Your age as of your plan effective date.

2 You must use a network hospital with Select Plans C and F.

3 **The Enrollment Discount i**s available to applicants age 65 to 76. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date.

The Enrollment Discount is applied to the current Standard Rate. The Standard Rates usually change each year. The discount you receive in your first year of coverage depends on your age on your plan effective date. The discount percentage reduces 3% each year on the anniversary date of your plan until the discount runs out.

4 Refer to Section 6 of the application.

Eligibility & Benefits

SA25579ST

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

You must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan.

Insured by UnitedHealthcare Insurance Company, Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy Form No. GRP 79171 GPS-1 (G-36000-4).

In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage renal disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

SA25579ST

Your Guide
To AARP Medicare Select and Medicare Supplement Insurance Plans

This Guide contains detailed information about AARP Medicare Select and AARP Medicare Supplement Insurance Plans.

AARP Medicare Select and Medicare Supplement Insurance Portfolio of Plans, insured by UnitedHealthcare Insurance Company, provides a choice of benefits to AARP members, so you may choose the plan that best fits your individual supplemental health insurance needs.

To help you choose the AARP Medicare Select or AARP Medicare Supplement Plan to meet your needs and budget, be sure to look at the documents that show the specific benefits of each plan, the expenses that Medicare pays, the benefits the plan pays, the specific costs you would have to pay yourself, and any specific provisions that may apply in your state. Also be sure to review the Monthly Premium information. Benefits and cost vary depending upon the plan selected.

Eligibility to Apply

To be eligible to apply, you must be an AARP member or spouse of a member, age 65 or older, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage.

Guaranteed Acceptance

- Your acceptance in any plan is guaranteed during your Medicare supplement open enrollment period which lasts for 6 months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.
- A person becomes eligible for Guaranteed Issue of a Medicare Supplement plan when he or she loses or terminates health coverage under certain circumstances. Guaranteed Issue means a Medicare Supplement plan will be issued with no pre-existing condition exclusions and no underwriting. In order to become eligible for Guaranteed Issue, your application must be received no later than 63 days after the termination date of your prior health plan. You must also provide a copy of the termination notice you received from your prior plan or employer along with your application. This notice must verify the circumstances of your prior plan's termination and also describe your right to guaranteed issue of Medicare supplement insurance. Here is a summary of these situations:

  1. You have lost or are replacing a plan that was provided by your current or former employer.
  2. You are replacing a Medicare Advantage (MA) plan (sometimes called Medicare Part C) or a Program of All-Inclusive Care for the Elderly (PACE) or a Medicare Select plan, under these circumstances:
     - This was your first time in this type of plan; and
     - You switched to this plan from a Medicare Supplement plan; and
     - You've had it for no longer than 2 years.
  3. You are replacing a Medicare Advantage (MA) plan or a Program of All-Inclusive Care for the Elderly (PACE), under these circumstances:
     - You enrolled in the MA plan when you started Medicare Part A at age 65; and
     - You've had it for no longer than 2 years.
  4. You are replacing a Medicare Advantage plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Medicare Select plan for any of the following reasons:
     - The plan stopped coverage in your area,
     - The plan notified you it will be stopping coverage in your area; or
     - You moved out of the plan's service area.
  5. You are replacing a Medicare Advantage plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Medicare Select or Medicare Supplement plan for any of the following reasons:
     - The plan violated the insurance contract (for example, by failing to provide necessary medical care), or
     - The plan was misrepresented in marketing to you.
  6. You are replacing a Medicare Supplement or Medicare Select plan that was ended by the company (for example, due to bankruptcy).

  If you have any questions on your guaranteed right to insurance, you may wish to contact the administrator of your prior health insurance plan or your local state department on aging.

Continued...

Glossary of Terms

- **Medicare Eligible Expenses** are the health care expenses of the kinds covered under Medicare Parts A and B that Medicare recognizes as reasonable and medically necessary. Physicians under Medicare may agree to accept Medicare's eligible expenses as their fee amount. Your physician or surgeon may charge you more.
- **Hospital or Skilled Nursing Facility** – A hospital is an institution that provides care for which Medicare pays hospital benefits. A skilled nursing facility is a facility that provides skilled nursing care and is approved for payment by Medicare. The skilled nursing facility stay must begin within 30 days after a hospital stay of 3 or more days in a row or a prior covered skilled nursing facility stay. Both the hospital stay and the skilled nursing facility stay must start while you are covered under this plan. Custodial care does not qualify as an eligible expense.
- **Excess Charge** is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- **Select Hospital** is a hospital that has entered into a written agreement to provide services under a UnitedHealthcare Insurance Company Medicare Select Plan.
- **Medical Emergency** is the sudden and unexpected onset of symptoms, illness, injury, or condition; that if care or services are withheld, would be deemed, under appropriate medical standards, to carry substantial risk of serious medical complication or permanent damage to you.
- **Service Area** is the geographic area within which an issuer is authorized to offer Medicare Select coverage.
- **Lifetime Reserve Days** are limited by Medicare to 60 days during your lifetime. Once these are used, Medicare provides no hospital coverage after 90 days of a benefit period.
- **Hospice Care** means care for those who are terminally ill. Hospice Care focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

Additional Information

Exclusions

- Benefits provided under Medicare.
- Care not meeting Medicare's standards.
- Stays beginning, or care or supplies received, before your plan's effective date.
- Injury or sickness payable by Workers' Compensation or similar laws.
- Stays or treatment provided by a government-owned or -operated hospital or facility unless payment of charges is required by law.
- Stays, care, or visits for which no charge would be made to you in the absence of insurance.
- Care or services provided by a non-participating hospital, except in the event of a medical emergency, or if the services are not available from any participating hospital in the service area.
- Any stay which begins, or medical expenses you incur, during the first 3 months after your effective date will not be considered if due to a pre-existing condition. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within 3 months prior to your plan's effective date.

The following individuals are entitled to a waiver of this pre-existing condition exclusion:

1. Individuals who are replacing prior creditable coverage within 63 days after termination; or
2. Individuals who are turning age 65 and whose application form is received within six (6) months after they turn 65 AND are enrolled in Medicare Part B; or
3. Individuals who are entitled to Guaranteed Issue; or
4. Individuals who have been covered under other health insurance coverage within the last 63 days and have enrolled in Medicare Part B within the last 6 months.

Other exclusions may apply; however, in no event will your plan contain coverage limitations or exclusions for the Medicare Eligible Expenses that are more restrictive than those of Medicare. Benefits and exclusions paid by your plan will automatically change when Medicare's requirements change.

Medicare Select Disclosure Statement

Please read this form carefully. The following information is provided in order to make a full and fair disclosure to you of the provisions, restrictions, and limitations of the AARP Medicare Select Plan. Please use the documents that show the specific benefits and rates of each plan which allow you to compare the AARP Medicare Select and AARP Medicare Supplement Plans with other Medicare supplement plans.

Medicare Select Provider Restrictions

In order for benefits to be payable under this insurance plan, you must use one of the select hospitals located throughout the United States, unless:

(1) there is a Medical Emergency; (2) covered services are not available from any select hospital in the Service Area; or (3) covered services are received from a Medicare-approved non-select hospital more than 100 miles from your Primary Residence.

In the case of (3) above, the following benefits may be payable subject to the terms and conditions of this plan:

- 75% of the Part A Medicare Inpatient Hospital Deductible amount per Benefit Period;

- 75% of the Part A Medicare Eligible Expenses not paid by Medicare; and

- 75% of the Part B Medicare Eligible Expenses for outpatient hospital services not paid by Medicare.

Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the Network Hospital. If he or she does not, you may be required to use another physician at the time of hospitalization or you will be required to pay for all expenses.

Right to Replace Your Medicare Select Plan

You have the right to replace your AARP Medicare Select Plan with any other AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company, that has the same or lesser benefits as your current insurance and which does not require the use of participating providers, without providing evidence of insurability.

Quality Assurance

Participating providers are required to maintain a quality assurance program conforming with nationally recognized quality of care standards.

For Your Protection, Please Be Aware of the Following:

You Cannot Be Singled Out for Cancellation

Your coverage cannot be canceled because of your age, your health, or the number of claims you make. Your Medicare supplement plan may be canceled due to nonpayment of premium or material misrepresentation. If your group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Select Plan or AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company. Of course, you may cancel your AARP Medicare Select Plan or AARP Medicare Supplement Plan any time you wish. All transactions go into effect on the first of the month following receipt of the request.

The AARP Insurance Trust

AARP established the AARP Insurance Plan, a trust, to hold the master group insurance policies. The AARP Medicare Supplement Insurance Plan is insured by UnitedHealthcare Insurance Company, not by AARP or its affiliates. Please contact UnitedHealthcare Insurance Company if you have questions about your policy, including any limitations and exclusions.

Premiums are collected from you by the Trust. These premiums are paid to the insurance company for your insurance coverage, a percentage is used to pay expenses, benefitting the insureds, and incurred by the Trust in connection with the insurance programs. At the direction of UnitedHealthcare Insurance Company, a portion of the premium is paid as a royalty to AARP and used for the general purposes of AARP. Income earned from the investment of premiums while on deposit with the Trust is paid to AARP and used for the general purposes of AARP.

Participants are issued certificates of insurance by UnitedHealthcare Insurance Company under the master group insurance policy. The benefits of participating in an insurance program carrying the AARP name are solely the right to receive the insurance coverage and ancillary services provided by the program.

General Information

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers.

These materials describe the AARP Medicare Select and AARP Medicare Supplement Plans available in your state, but is not a contract, policy, or insurance certificate. Please read your Certificate of Insurance, upon receipt, for plan benefits, definitions, exclusions, and limitations. AARP Medicare Select and AARP Medicare Supplement Plans have been developed in line with federal standards. **However, these plans are not connected with, or endorsed by, the U.S. Government or the federal Medicare program.** The Policy Form No. GRP79171 GPS-1 (G-36000-4) is issued in the District of Columbia to the Trustees of the AARP Insurance Plan. By enrolling, you are agreeing to the release of Medicare claim information to UnitedHealthcare Insurance Company so your AARP Medicare Select or AARP Medicare Supplement Plan claims may be processed automatically.

AARP does not employ or endorse agents, brokers or producers.

This is a solicitation of insurance. An agent may contact you.

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$0	$1,340 (Part A deductible)
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	$0	Up to $167.50 per day
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan A Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan B

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	$0	Up to $167.50 per day
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan B (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan B Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All Costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan B Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan C Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan C Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE— Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan F Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE— Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan G

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan G Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan G (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan G Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan G Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan K Pays	You Pay[3]
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$670 (50% of Part A deductible)	$670 (50% of Part A deductible)♦
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $83.75 per day	Up to $83.75 per day♦
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	50%	50%♦
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	50% of co-payment/ co-insurance	50% of Medicare co-payment/ co-insurance♦

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

3 You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5240 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan Benefit Tables: Plan K (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay[4]
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deductible)[5]♦
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $5240)[4]
Blood	First 3 pints	$0	50%	50%♦
	Next $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deductible)[5]♦
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay[4]
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

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Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5240 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

5 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K (continued)

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay[4]
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[6]	$0	$0	$183 (Part B deductible)♦
	Remainder of Medicare-approved amounts	80%	10%	10%♦

Notes

6 Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Plan Benefit Tables: Plan L

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan L Pays	You Pay[3]
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,005 (75% of Part A deductible)	$335 (25% of Part A deductible)♦
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $125.63 per day	Up to $41.87 per day♦
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	75%	25%♦
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	75% of co-payment/ co-insurance	25% of Medicare co-payment/ co-insurance♦

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

3 You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2620 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan Benefit Tables: Plan L (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan L Pays	You Pay[4]
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deductible)[5]♦
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $2620)[4]
Blood	First 3 pints	$0	75%	25%♦
	Next $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deductible)[5]♦
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay[4]
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

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Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2620 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

5 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan L (continued)

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay[4]
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[6]	$0	$0	$183 (Part B deductible)♦
	Remainder of Medicare-approved amounts	80%	15%	5%♦

Notes

6 Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Plan Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

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Notes

3 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Parts A and B, continued				
Service		**Medicare Pays**	**Plan N Pays**	**You Pay**
Durable Medical Equipment Medicare-approved services	First $183 of Medicare-approved amounts[3]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits not covered by Medicare				
Foreign Travel NOT COVERED BY MEDICARE - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan Benefit Tables: Medicare Select – Plan C

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 You must use a network hospital.

3 **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Medicare Select – Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE— Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

2 You must use a network hospital.

4 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Medicare Select – Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,340	$1,340 (Part A deductible)	$0
	Days 61–90	All but $335 per day	$335 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $670 per day	$670 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21–100	All but $167.50 per day	Up to $167.50 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 You must use a network hospital.

3 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Medicare Select – Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[4]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE— Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

2 You must use a network hospital.

4 Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Rules and Disclosures about this Insurance

This page explains important rules governing your Medicare Select coverage. These rules affect you. Please read them carefully and make sure you understand them before you buy or change any Medicare supplement or Medicare Select insurance.

Premium information

You may keep your plan in force by paying the required monthly premium when due. Monthly rates shown reflect current premium levels and all rates are subject to change. Any change will apply to all members of the same class insured under your plan who reside in your state. Your premium can only be changed with the approval of AARP and after we file rates with your state insurance department.

Disclosures

Use the *Overview of Available Plans*, the *Plan Benefit Tables* and *Cover Page - Rates* to compare benefits and premiums among plans.

Read your certificate very carefully

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your insurance company.

Your right to return the certificate

If you find that you are not satisfied with your coverage, you may return the certificate to:

UnitedHealthcare
PO BOX 30607
Salt Lake City, UT 84130-0607

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your premium payments. However, UnitedHealthcare has the right to recover any claims paid during that period. Any premium refund otherwise due to you will be reduced by the amount of any claims paid during this period. If you have received claims payment in excess of the amount of your premium, no refund of premium will be made.

Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new certificate and are sure you want to keep it.

Notice

The certificate may not fully cover all of your medical costs. Neither UnitedHealthcare Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Centers for Medicare & Medicaid Services (CMS) publication *Medicare & You* for more details.

Complete answers are very important

When you fill out the enrollment application for the new certificate, be sure to answer all questions about your medical and health history truthfully and completely. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information. Review the enrollment application carefully before you sign it. Be certain that all information has been properly recorded.

Grievance Procedure

Complaint and Grievance Procedure - UnitedHealthcare has established a formal procedure to respond to customer complaints and grievances. UnitedHealthcare desires to provide a fair, accessible and responsive method of evaluating and resolving complaints and grievances. If UnitedHealthcare determines that any prior action that it has taken was incorrect, corrective action will be taken. You may, at any time, submit a written complaint to the Department of Insurance in your state.

Complaints - If you have a complaint, you may call us at 1-800-523-5880 or write to us at UnitedHealthcare, PO BOX 740807, Atlanta, GA 30374-0807. We will acknowledge all complaints within 15 days and will respond to all complaints within a reasonable period of time.

Grievances - If you are dissatisfied with our handling of a complaint or a claim denial, or are dissatisfied for any other reason, you may submit a formal grievance. Grievances must be in writing and contain the words "this is a grievance" to ensure that we understand the purpose of the communication. You must clearly state the nature of the grievance and send it to: UnitedHealthcare, PO BOX 740807, Atlanta, GA 30374-0807. We will acknowledge in writing all grievances within 15 days and respond to all grievances within a reasonable period of time. All grievances must be filed within 60 days or as soon as reasonably possible from the date of denial of benefits or other action giving rise to the grievance.

Arizona Resident Directory

Participating Hospitals - Effective July 2018
For AARP® Medicare Select Plans C and F Only

Arizona

Apache County

Sage Memorial Hospital*
US-191 & AZ-264
Ganado, AZ 86505
(928) 755-4500

Cochise County

Benson Hospital
450 South Ocotillo Street
Benson, AZ 85602
(520) 586-2261

Copper Queen Community Hospital*
101 Cole Avenue
Bisbee, AZ 85603
(520) 432-5383

Graham County

Northern Cochise Community Hospital
901 West Rex Allen Drive
Willcox, AZ 85643
(520) 384-3541

Maricopa County

HealthSouth East Valley Rehabilitation Hospital
5652 East Baseline Road
Mesa, AZ 85206
(480) 567-0350

Maricopa County *(Continued)*

HealthSouth Scottsdale Rehabilitation Hospital
9630 East Shea Boulevard
Scottsdale, AZ 85260
(480) 551-5400

HealthSouth Valley of the Sun Rehabilitation Hospital
13460 North 67th Avenue
Glendale, AZ 85304
(623) 878-8800

Western Regional Medical Center*
14200 West Celebrate Life Way
Goodyear, AZ 85338
(623) 207-3000

Pima County

Carondelet St. Joseph's Hospital*
350 North Wilmot Road
Tucson, AZ 85711
(520) 296-3211

Carondelet St. Mary's Hospital*
1601 West Saint Mary's Road
Tucson, AZ 85745
(520) 872-3000

HealthSouth Rehabilitation Hospital of Southern Arizona
1921 West Hospital Drive
Tucson, AZ 85704
(520) 742-2800

Pima County *(Continued)*

HealthSouth Rehabilitation Institute of Tucson
2650 North Wyatt Drive
Tucson, AZ 85712
(520) 325-1300

Northwest Medical Center
6200 North La Cholla Boulevard
Tucson, AZ 85741
(520) 742-9000

Oro Valley Hospital
1551 East Tangerine Road
Oro Valley, AZ 85755
(520) 901-3500

Tucson Medical Center
5301 East Grant Road
Tucson, AZ 85712
(520) 327-5461

Yuma County

Yuma Rehabilitation Hospital
901 West 24th Street
Yuma, AZ 85364
(928) 726-5000

* This hospital was contracted by USA Managed Care Organization and leased by UnitedHealthcare for inclusion in the AARP Medicare Select Network.

Utah

Kane County

Kane County Hospital
355 North Main Street
Kanab, UT 84741
(435) 644-5811

Washington County

Dixie Regional Medical Center -
400 East Campus
544 South 400 East
Saint George, UT 84770
(435) 251-1000

Dixie Regional Medical Center -
River Road Campus
1380 East Medical Center Drive
Saint George, UT 84790
(435) 251-1000

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Participating Hospitals listed in this directory are subject to change. For health systems with multiple hospitals, all locations may not participate. Check with your doctor to make sure he or she has admitting privileges at a network hospital. Prior to scheduling any inpatient or outpatient hospital service it is recommended you contact Customer Service at 1-800-523-5800 (any weekday between 7 a.m. and 11 p.m., and on Saturdays between 9 a.m. and 5 p.m., Eastern Time) for a current listing of participating hospitals in your area. You may also call this number to obtain a directory of participating hospitals for other areas when you will be traveling.

All participating hospitals are open 24 hours a day, 7 days a week.

Your Medicare Select policy will only pay full supplemental benefits if covered services are obtained through specified participating hospitals. Medicare Select policies deny payment or pay less than the full benefit if you use a non-participating hospital for non-emergency services.

For AARP® Medicare Select Plans Only

Arizona - Effective April 2018

Medicare Select C and Select F are available to individuals in the following zip code areas:

85123	85614	85653	85725	85775
85128	85615	85654	85726	86021
85131	85616	85655	85728	86022
85132	85617	85658	85730	86031
85135	85618	85670	85731	86034
85137	85619	85671	85732	86036
85141	85620	85701	85733	86432
85145	85622	85702	85734	86502
85191	85623	85703	85735	86503
85192	85624	85704	85736	86504
85194	85625	85705	85737	86505
85531	85626	85706	85738	86506
85535	85627	85707	85739	86507
85536	85629	85708	85740	86508
85543	85630	85709	85741	86511
85546	85631	85710	85742	86512
85548	85632	85711	85743	86515
85551	85635	85712	85744	86520
85552	85636	85713	85745	86538
85601	85637	85714	85746	86540
85602	85638	85715	85747	86556
85603	85640	85716	85748	
85605	85641	85717	85749	
85606	85643	85718	85750	
85607	85644	85719	85751	
85608	85645	85720	85752	
85609	85646	85721	85754	
85610	85648	85722	85755	
85611	85650	85723	85756	
85613	85652	85724	85757	

Enrollment Forms

SA25580ST

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

You must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan.

Insured by UnitedHealthcare Insurance Company, Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy Form No. GRP 79171 GPS-1 (G-36000-4).

In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage renal disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

SA25580ST

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Enrollment Checklist

In the following section, you will find the forms you need to complete when applying for coverage. Please be sure to complete and submit all the necessary forms to ensure your enrollment is processed quickly and accurately.

Here is an overview of the different forms and some helpful tips:

✔ **Application Form**

- Be sure to review and complete each applicable section.
- Please only write comments where indicated on the application.
- Be sure to sign and date the application in all the places indicated.

✔ **AARP Membership Form**

AARP membership is required to enroll in an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company. If you are not currently an AARP member or are unsure, you may enroll, renew or verify in one of three ways:

- Log on to AGNTU.aarpenrollment.com;
- Call toll-free 1-866-331-1964; or
- Complete the membership form and submit it with the plan application, along with a separate check for $16.00 payable to AARP. Note: One membership covers both the member and another individual living in the same household. Therefore, only one membership application is required if two individuals of a household are applying for AARP membership.

✔ **Electronic Funds Transfer (EFT) Authorization Form**

Automatic payments are available by submitting the completed form (signed and dated). If requesting automatic payments, you may deduct $2 from the first month's household premium check.

✔ **Notice to Applicants Regarding Replacement of Coverage**

If you are replacing or losing current coverage as indicated on the form, complete both copies of the form, submit one copy with the enrollment application, and keep the other copy for your records. The licensed insurance agent must also sign and date both copies of the form.

✔ **If Reply Envelope Is Missing**

Please mail completed application to: UnitedHealthcare Insurance Company
P.O. Box 105331
Atlanta, GA 30348-5331

(Over Please)

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers.

AARP does not employ or endorse agents, brokers or producers.

Insured by UnitedHealthcare Insurance Company, Horsham, PA. Policy form No. GRP 79171 GPS-1 (G-36000-4). In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See the following materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company, Horsham, PA 19044

Plans and rates described in this package are good only for residents of Arizona.

Instructions

1. Fill in all requested information on this form and sign in the 2 places where a signature is needed.
2. Print clearly. Use CAPITAL letters.
3. Mark your answers with black or blue ink – not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure
4. Initial any changes or corrections you make while completing this application.

TEAR HERE

AARP Membership Number (If you are already a member) _____

If you are not already an AARP Member, please include your AARP Membership Application and a check or money order for your annual Membership dues and mail with this application.

Applicant First Name	MI	Last Name

Permanent Home Address	City	State	Zip

Mailing Address (if different from above)	City	State	Zip

1 Tell us about yourself

Please provide your Medicare insurance information.

TEAR HERE

NAME OF BENEFICIARY
1A. _____

MEDICARE NUMBER (Include all numbers and letters.)
1B. _____ **1C.** Sex ☐ M ☐ F

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A): **1D.** /01/
MEDICAL (PART B): **1E.** /01/

1F. Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

1G. Birthdate ____/____/____
Month Day Year

1H. Phone Number ( ) -

1I. Email address (optional) _____

By providing your email address, you are agreeing to receive important account information and product offers. Be sure to write all necessary periods (.) and symbols (@).

2460720307

First Name Last Name

2 Choose your plan and start date

Plan Choice

2A. Choose only 1 plan from the right-hand column.

☐ Plan A ☐ Plan B
☐ Plan C
☐ Plan F ☐ Plan G
☐ Plan K ☐ Plan L
☐ Plan N
☐ Medicare Select Plan C
☐ Medicare Select Plan F

Plan Start Date

2B. Your plan will start on the first day of the month following receipt and approval of this application and receipt of your first month's payment. If you would like your plan to start on a later date (the first day of a future month), please indicate the date:

/01/
Month Day Year

3 Is your acceptance guaranteed?

3A. Will your AARP Medicare Supplement Plan start date be within 6 months after you turn age 65 **or** enroll in Medicare Part B? ☐Yes ☐No

- If **YES**, your acceptance is guaranteed. Go directly to **Section 7**. (You do not have to answer the questions in **Sections 4, 5 and 6**.)
- If **NO**, you must answer **Question 3B**.

3B. Do you have guaranteed issue rights, as listed in the Guaranteed Acceptance section of "Your Guide" enclosed with this application? **If so, include a copy of the termination notice from your prior insurer or employer.** ☐Yes ☐No

- If **YES**, go directly to **Section 7**. (You do not have to answer the questions in **Sections 4, 5 and 6**.)
- If you answered **NO** to both questions in **Section 3**, continue to **Section 4**.

4 Answer these health questions only if your acceptance is not guaranteed as defined in Section 3.

4A. Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys? ☐Yes ☐No ☐Not Sure

4B. Within the past 2 years, did a medical professional tell you that you may need any of the following? ☐Yes ☐No ☐Not Sure

- hospital admittance as an inpatient
- joint replacement
- organ transplant
- surgery for cancer
- back or spine surgery
- heart or vascular surgery

If you answered YES or NOT SURE to any question in Section 4, we will contact you for further information.

TEAR HERE

TEAR HERE

First Name Last Name

5 Answer these eligibility health questions only if your acceptance is not guaranteed as defined in Section 3.

5A. Within the past 90 days, were you hospitalized as an inpatient (not including overnight outpatient observation)?	☐Yes	☐No	☐Not Sure
5B. Are you currently being treated or living in any type of nursing facility other than an assisted living facility?	☐Yes	☐No	☐Not Sure
5C. Has a medical professional told you that you have End-Stage Renal (Kidney) Disease or that you require dialysis?	☐Yes	☐No	☐Not Sure

Answering YES to any question in Section 5 will result in a denial of coverage. If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit a new application at that time.

If you answered NOT SURE to any question in Section 5, we will contact you for further information.

TEAR HERE

6 Answer these health questions to determine your rate only if your acceptance is not guaranteed as defined in Section 3.

6A. Within the past 2 years, were you diagnosed, treated, given medical advice or prescribed medications/refills by a medical professional for any of the following conditions?			
• Artery or Vein Blockage	☐Yes	☐No	☐Not Sure
• Peripheral Vascular Disease (PVD)	☐Yes	☐No	☐Not Sure
• Cardiomyopathy	☐Yes	☐No	☐Not Sure
• Congestive Heart Failure (CHF)	☐Yes	☐No	☐Not Sure
• Coronary Artery Disease (CAD)	☐Yes	☐No	☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐Yes	☐No	☐Not Sure
• Chronic Kidney Disease	☐Yes	☐No	☐Not Sure
• Diabetes, but only if you have circulation problems or Retinopathy	☐Yes	☐No	☐Not Sure
• Cancer including Melanoma (but not other skin cancers), Leukemia and Lymphoma	☐Yes	☐No	☐Not Sure
• Cirrhosis of the Liver	☐Yes	☐No	☐Not Sure
6B. Within the past 2 years, did you have (as determined by a medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or Mini-Stroke?	☐Yes	☐No	☐Not Sure

If you answered YES to any question in Section 6, your rate will be the Level 2 rate. See the enclosed "Cover Page – Rates."

If you answered NOT SURE to any question, we may need to contact you for additional information.

TEAR HERE

First Name Last Name

7 Tell us about your tobacco usage

7A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product?	☐Yes ☐No

If you answered YES to Question 7A, your rate will be the tobacco rate.
See the enclosed "Cover Page - Rates."

TEAR HERE

8 Tell us about your past and current coverage

Review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge,	
8A. Did you turn age 65 in the last 6 months?	☐Yes ☐No
8B. Did you enroll in Medicare Part B in the last 6 months?	☐Yes ☐No
8C. If YES, what is the effective date?	/01/ (Month Day Year)
Answer these questions about Medicaid	
8D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 8E and 8F.**	☐Yes ☐No
8E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
8F. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Answer these questions about Medicare Advantage plans (sometimes called Medicare Part C)	
8G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 8H through 8K.**	☐Yes ☐No

First Name Last Name

8 Tell us about your past and current coverage (continued)

8H. Fill in the start and end dates of your Medicare plan. If you are still covered under this plan, leave the end date blank.	**Start Date** /01/ (Month Day Year) **End Date** / / (Month Day Year)
8I. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare Supplement plan has been issued, you will need to cancel your Medicare Advantage Plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
8J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
8K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Answer these questions about Medicare supplement plans	
8L. Do you have another Medicare supplement policy in force? If so, what company and what plan do you have? Company: _____ Policy: _____ **If YES, you must answer Question 8M.**	☐Yes ☐No
8M. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
Answer these questions about any other type of health insurance coverage	
8N. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 8O through 8Q.**	☐Yes ☐No
8O. If so, with what company and what kind of policy? **Company:**_____	**Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other_____
8P. What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.	**Start Date** / / (Month Day Year) **End Date** / / (Month Day Year)
8Q. Are you replacing this health insurance?	☐Yes ☐No

TEAR HERE

TEAR HERE

✗ _____ / / **Your Signature – 1** (required) **Today's Date** (required) (Month Day Year)

First Name Last Name

9 Authorization and Verification of Application Information

Read carefully, and sign and date in the signature box below.

- My signature indicates I have read and understand the contents of this application form.
- I declare that the answers on this application are complete and true and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if I have made any fraudulent and material misrepresentation, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.
- I understand the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company. This person may be compensated based on my enrollment in a plan.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.

TEAR HERE

Authorization for the Release of Medical Information

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, or insurance company to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. If not revoked, this authorization is valid for 24 months from the date of my signature. I understand that I or my authorized representative may obtain a copy of this form.

TEAR HERE

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.

I have read all information and have answered all questions to the best of my ability.

X _____ **Your Signature – 2** (required)

_____ / _____ / _____ **Today's Date** (required)
Month Day Year

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

First Name Last Name

10 For Agent Use Only

Agent must complete the following information and include the notice of replacement coverage, if appropriate, with this application. All information must be complete or the application will be returned.

1. List any other health insurance policies issued to the applicant:

   _____

   _____

2. List policies issued which are still in force:

   _____

   _____

3. List policies issued in the past 5 years which are no longer in force:

   _____

   _____

Agent Name (PLEASE PRINT) _____ ___ _____
First Name MI Last Name

X _____ _____ ____/____/____
Agent Signature (required) Agent ID (required) Today's Date (required)
Month Day Year

_____ _____
Agent Email Address Agent Phone Number

TEAR HERE

TEAR HERE

TEAR HERE

AARP membership offers so much for so little.

AARP® Real Possibilities

What Each Member Receives:		Price
Membership	- For individual member (12 months)	**$16**
Membership	- For member's spouse or partner (at any age)	**Included**
Discounts (nationwide)	- Vision: exams, frames, lenses - Pharmacy: prescriptions and over-the-counter items - Plus, look to AARPdiscounts.com for easy access to savings on trusted brands, all in one place. Enjoy one-stop deals from shopping and dining to rental cars, hotels and cruises – and so much more!	**Included**
Trusted Information	- *AARP The Magazine*: the largest magazine circulation in the world - *AARP Bulletin Newspaper* (10 issues per year)	**Included**
Access to Health Products	- AARP-endorsed supplemental insurance - AARP-endorsed dental insurance	**Included**
Advocacy	- Representation of your interests in Washington and your state - Confronting age discrimination by employers - Strengthening Social Security - Protecting pension and retirement benefits - Fighting predatory home loan lending	**Included**
Access to Financial Programs	- AARP-endorsed auto, homeowners, life, mobile home and motorcycle insurance - Earn rewards with a no-annual-fee AARP-endorsed credit card	**Included**
Local Opportunities	- Safe driving courses (also available online) - Over 2,200 local AARP chapters - Social activities, volunteer opportunities, classes and workshops	**Included**

BA25233 (07-14)

TEAR HERE

Yes, I'd like to join AARP today!

It's simple ... just follow these instructions.
If you're already a member, give this to someone you know or complete it to renew your membership.

_____
My Name (please print: Mr./Mrs./Ms./Dr./First, Middle Initial, Last)

_____
Address Apt.

_____
City State Zip

_____ /_____ /_____
Date of Birth: Month / Day / Year

_____
Spouse's/Partner's Name (for **FREE** membership – at any age)

Choose from 3 easy ways to join:

1.) Log on to www.AGNTU.aarpenrollment.com
2.) Call toll-free: 1-866-331-1964
3.) Send completed form in the envelope provided

I agree to pay for the term I select:

☐ **1 year/$16** ☐ **3 years/$43** ☐ **5 years/$63**

☐ Check or money order enclosed, payable to AARP. **Do not send cash.**

☐ Please keep in touch by e-mail about AARP activities, events and member benefits:

_____
E-mail Address V7FYUHG

Please allow up to six weeks for delivery of your Membership Kit. Dues are not deductible for income tax purposes. One membership includes spouse/partner or 2nd household member. Annual dues include $4.03 for a subscription to *AARP The Magazine* and $3.09 for the *AARP Bulletin*. We may steward your resources by converting your check into an electronic deposit. When you join or rejoin, AARP shares your membership information with the companies we have selected to provide AARP member benefits, companies that support AARP operations, and select non-profit organizations. If you do not want us to share your information with providers of AARP member benefits or non-profit organizations, please let us know by calling 1-800-516-1993 or e-mailing us at AARPmember@aarp.org. AARP member benefits are provided by third parties, not by AARP or its affiliates. Providers pay a royalty fee to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. Some provider offers are subject to change and may have restrictions. Please contact the provider directly for details.

AA25001 (07-14) AGT

Explore the possibilities of AARP membership with:

Travel Discounts
Using AARP's exclusive travel savings just once could pay for your membership several times over!

- Savings on hotels, motels and resorts worldwide
- Discounted rates on airfares, cruises and auto rentals
- Special pricing on vacation packages

Health-Related Benefits
With today's high health care costs, AARP membership is more valuable than ever.

- Supplemental health plans and dental insurance for AARP members
- Vision, hearing and prescription discounts nationwide

Local Opportunities
AARP offers many ways to get active in your community.

- Over 2,200 local AARP chapters
- Social activities
- Volunteer opportunities
- Safe driving courses
- Classes and workshops

Protection of Your Rights
Your job. Your health. Your future. AARP will stand up for you by ...

- Representing your interests in Washington and your state
- Confronting age discrimination by employers
- Strengthening Social Security
- Protecting pension and retirement benefits
- Fighting predatory home loan lending

Dependable Financial Programs
Designed specifically for AARP members. With the high level of service you expect.

- Earn rewards with a no-annual-fee credit card
- Auto, homeowners and life insurance

Valuable Information
Accurate and authoritative, direct from your reliable source – AARP.

- *AARP The Magazine*
- *AARP Bulletin*
- FREE financial and health guides
- Our web site, www.aarp.org

Specially Priced Products & Services
AARP helps you save in ways and places you never imagined.

- Discounts on groceries, home security, restaurants and more!
- Reduced-fee legal services*
- Roadside assistance and emergency towing

NOTE: The benefits listed are only a partial list. Your Membership Kit will supply you with a full list of approved service providers that offer exclusive services and discounts to AARP members only.

* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

Value our members appreciate.

Members often tell us their AARP membership paid for itself with the first service they used. They're surprised at how many ways and places their membership proves valuable. And it's an even better value because **your spouse/partner is included free (at any age)!**

TEAR HERE

TEAR HERE

Save $24 a year with the Electronic Funds Transfer (EFT) service

The Easiest Way to Pay

More than 2.5 million AARP® members nationwide enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 off the total monthly premium for your household.

In addition to saving up to $24 a year:

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. You do not need to include a voided check.

Your EFT Effective Date

If you are submitting this EFT form with your enrollment application, your automatic payment start date will be the same as your plan effective date. A letter will be sent to confirm this and will include the amount of your withdrawal. Please note that if your coverage is effective in the future or your account is paid in advance, EFT withdrawals will begin for the next payment due. If your account is effective in the past or is past due, a letter will be sent that explains how to make the payment that is due.

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents), hereafter named UnitedHealthcare, to take monthly withdrawals for the then-current monthly rate from the account named on this form. I also allow the named banking facility (BANK) to charge such withdrawals to this account.

Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name _____ AARP Member Number _____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

Account Type: ☐ Checking ☐ Savings (statement savings only)

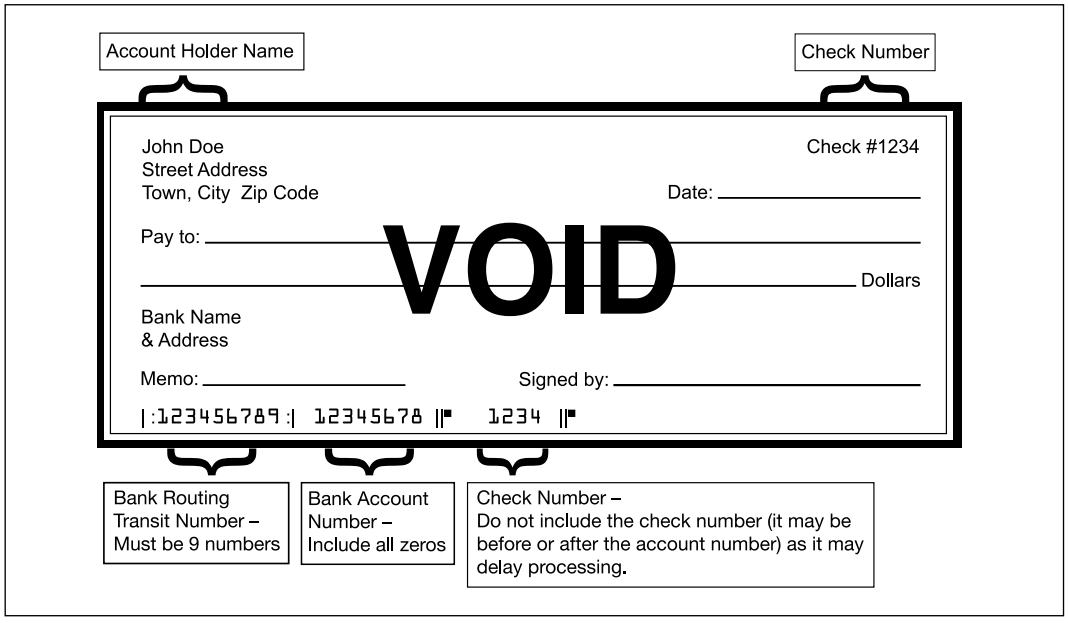
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below to obtain your bank routing information.



We look forward to continuing to serve you.

TEAR HERE

TEAR HERE

Save $24 a year with the Electronic Funds Transfer (EFT) service

The Easiest Way to Pay

More than 2.5 million AARP® members nationwide enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save $2.00 off the total monthly premium for your household.

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- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
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Your EFT Effective Date

If you are submitting this EFT form with your enrollment application, your automatic payment start date will be the same as your plan effective date. A letter will be sent to confirm this and will include the amount of your withdrawal. Please note that if your coverage is effective in the future or your account is paid in advance, EFT withdrawals will begin for the next payment due. If your account is effective in the past or is past due, a letter will be sent that explains how to make the payment that is due.

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents), hereafter named UnitedHealthcare, to take monthly withdrawals for the then-current monthly rate from the account named on this form. I also allow the named banking facility (BANK) to charge such withdrawals to this account.

Monthly withdrawal amounts will be for the total household payment due each month. This will include premiums for a spouse or other member(s) of the household on the same membership account. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name _____ AARP Member Number _____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____
(9 digit number)

Account Type: ☐ Checking ☐ Savings (statement savings only)

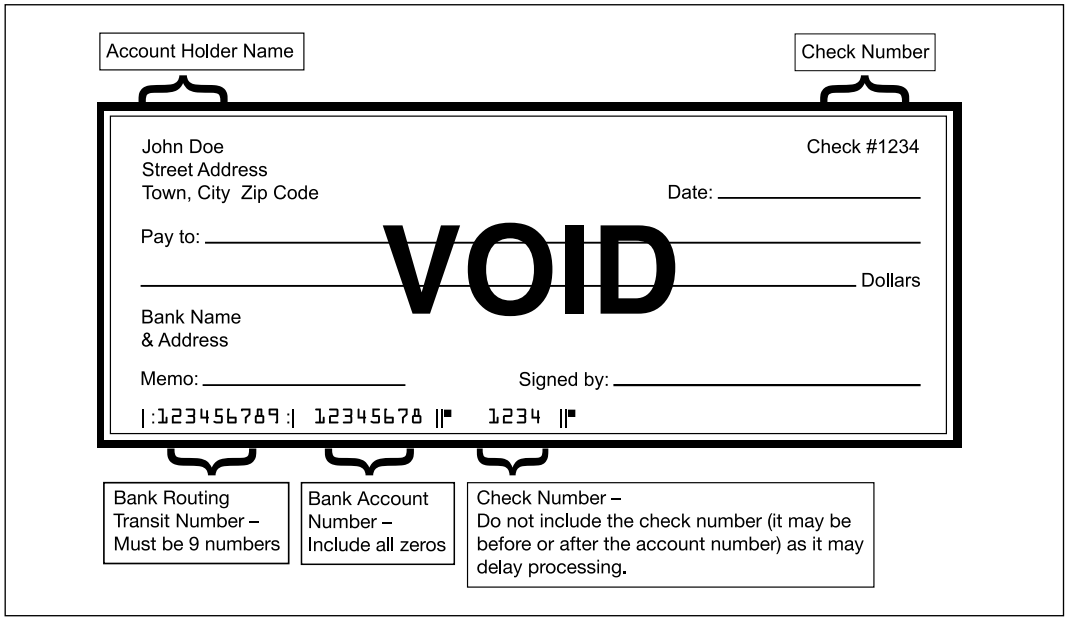
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below to obtain your bank routing information.



We look forward to continuing to serve you.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE UNITEDHEALTHCARE INSURANCE COMPANY

Horsham, Pennsylvania

Save this notice! It may be important to you in the future

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

TEAR HERE

Statement To Applicant By Issuer, Agent, Broker Or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

TEAR HERE

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

TEAR HERE

TEAR HERE

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Horsham, Pennsylvania

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_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.

_____ Other (Please Specify) _____

_____

_____

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative) (Date)

_____

(Applicant's Signature) (Date)

_____

(Applicant's Printed Name & Address)

Thank You for Applying for an AARP® Medicare Supplement Insurance Plan

Insured by UnitedHealthcare Insurance Company

For your records:

You selected Plan _____.

The effective date you requested is (1st day of a future month): _____ / _____.
Month Year

Based on the information you provided, your monthly premium for the plan you selected is $_____.

You will be notified when review of your application has been completed.

Please Note: Your final monthly premium will be determined once your application is approved.

What's next

Once Your Application Is Approved, You Will Receive:

Your insured member identification card.

A Welcome Kit, including your certificate of insurance and coverage details.

Ongoing educational materials about how to make the most of your health plan benefits.

Help and answers to any questions you may have from courteous Customer Service Representatives.

Access to the member website: **www.myaarpmedicare.com**.

A friendly customer service call to review the items listed above.

A continuing relationship with your agent/producer.

Important Notice: You are entitled to receive a "Guide to Health Insurance for People with Medicare." This guide is free, and briefly describes the Medicare program and the health insurance available to those on Medicare. If you are interested in receiving this free guide, please call 1-800-272-2146, toll-free, or find it on the web at www.medsupeducation.com.

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

You must be an AARP member to enroll in an AARP Medicare Supplement Plan.

Insured by UnitedHealthcare Insurance Company, Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy form No. GRP 79171 GPS-1 (G-36000-4).

In some states, plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

See the enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

SA25641ST

UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) does not treat members differently because of sex, age, race, color, disability, or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call 1-800-523-5800, TTY 711, Monday through Friday, 7 a.m. to 11 p.m., and Saturday, 9 a.m. to 5 p.m. EST.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building, Washington, DC 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-800-523-5800, TTY 711, Monday through Friday, 7 a.m. to 11 p.m., and Saturday, 9 a.m. to 5 p.m. EST.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-800-523-5800.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-523-5800.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請致電： 1-800-523-5800.

XIN LƯU Ý: Nếu quý vị nói **tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-523-5800.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-523-5800 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-523-5800.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по номеру 1-800-523-5800.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-800-523-5800.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-523-5800.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-523-5800.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-523-5800.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-523-5800.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-523-5800.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-523-5800 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-800-523-5800 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-800-523-5800 تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया 1-800-523-5800. **पर कॉल करें।**

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-523-5800.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-523-5800។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-523-5800.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-800-523-5800 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-523-5800.

CENTERS FOR MEDICARE & MEDICAID SERVICES

2018

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

- Medicare Supplement Insurance (Medigap) policies
- What Medigap policies cover
- Your rights to buy a Medigap policy
- How to buy a Medigap policy

Developed jointly by the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC)

Who should read this guide?

This guide can help if you're thinking about buying a Medigap policy or already have one. It'll help you understand Medicare Supplement Insurance policies (also called Medigap policies). A Medigap policy is a type of private insurance that helps you pay for some of the costs that Original Medicare doesn't cover.

Important information about this guide

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

The "2018 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

New Medicare cards are in the mail!

You asked, and we listened. You're getting a new Medicare card! Your new card will have a new Medicare number instead of your Social Security Number. This will help keep your information more secure and help protect your identity.

The new card won't change your coverage or benefits. You'll get more information from Medicare when your new card is mailed.

Paid for by the Department of Health & Human Services.

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SECTION 1

Medicare Basics

A brief look at Medicare

A Medicare Supplement Insurance (Medigap) policy is health insurance sold by private insurance companies which can help pay some of the health care costs that Original Medicare doesn't cover, like coinsurance, copayments, or deductibles. Some Medigap policies also cover certain benefits Original Medicare doesn't cover, like emergency foreign travel expenses. Medigap policies don't cover your share of the costs under other types of health coverage, including Medicare Advantage Plans (like HMOs or PPOs), stand-alone Medicare Prescription Drug Plans, employer/union group health coverage, Medicaid, or TRICARE. Insurance companies generally can't sell you a Medigap policy if you have coverage through Medicaid or a Medicare Advantage Plan.

Before you learn more about Medigap policies, the next few pages provide a brief look at Medicare. If you already know the basics about Medicare and only want to learn about Medigap, skip to page 9.

Words in blue are defined on pages 49–50.

What's Medicare?

Medicare is health insurance for:

- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

The different parts of Medicare

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance) helps cover

- Inpatient care in hospitals
- Skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance) helps cover

- Services from doctors and other health care providers, hospital outpatient care, durable medical equipment, and home health care
- Preventive services to help maintain your health and to keep certain illnesses from getting worse

Medicare Part C (Medicare Advantage)

- Includes all benefits and services covered under Part A and Part B
- Run by Medicare-approved private insurance companies
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of outpatient prescription drugs
- Run by Medicare-approved private insurance companies
- May help lower your prescription drug costs and help protect against higher costs in the future

Your Medicare coverage choices at a glance

There are 2 main ways to get your Medicare coverage — Original Medicare or a Medicare Advantage Plan. Use these steps to help you decide. See page 35 for information about Medicare Advantage Plans and Medigap policies.

Option1: Original Medicare

This includes Part A and B

Part A
Hospital Insurance

Part B
Medical Insurance

You can add:

Part D
Medicare Prescription Drug Coverage

You can also add:

Medigap
Medicare Supplement Insurance
(Medigap policies help pay your out-of-pocket costs in Original Medicare.)

Option2: Medicare Advantage (Part C)

These plans are like HMOs or PPOs, and include Part A, B, and typically D.

Part A
Hospital Insurance

Part B
Medical Insurance

Part D
Medicare Prescription Drug Coverage
(most plans cover prescription drugs.)

Medicare and the Health Insurance Marketplace

If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare. You should do this during your Initial Enrollment Period to avoid a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. Once you're considered eligible for premium-free Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you might have to pay back some or all of the help you got when you file your taxes. Visit HealthCare.gov to connect to the Marketplace in your state and learn more. Be sure not to end your Marketplace plan before your Medicare coverage begins. Otherwise, you may have a gap in coverage.

Note: Medicare isn't part of the Marketplace. The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies, Medicare Advantage Plans, or Medicare drug plans (Part D).

For more information

Remember, this guide is about Medigap policies. To learn more about Medicare, visit Medicare.gov, look at your "Medicare & You" handbook, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION 2

Medigap Basics

What's a Medigap policy?

A Medigap policy is private health insurance that helps supplement Original Medicare. This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). These are "gaps" in Medicare coverage.

If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share. A Medigap policy is different from a Medicare Advantage Plan (like an HMO or PPO) because those plans are ways to get Medicare benefits, while a Medigap policy only supplements the costs of your Original Medicare benefits.

Note: Medicare doesn't pay any of your costs for a Medigap policy.

All Medigap policies must follow federal and state laws designed to protect you, and policies must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies in most states can only sell you a "standardized" Medigap policy identified by letters A through N. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. **Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies.**

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. See pages 42–44. In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. Medicare SELECT plans are standardized plans that may require you to see certain providers and may cost less than other plans. See page 20.

What Medigap policies cover

The chart on page 11 gives you a quick look at the standardized Medigap Plans available. You'll need more details than this chart provides to compare and choose a policy. Call your State Health Insurance Assistance Program (SHIP) for help. See pages 47–48 for your state's phone number.

Notes:

- Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Plan C or Plan F. Not all types of Medigap policies may be available in your state. See pages 42–44 if you live in **Massachusetts**, **Minnesota**, or **Wisconsin**.
- Plans D and G effective on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- Plans E, H, I, and J are **no longer sold**, but, if you already have one, you can generally keep it.
- Starting January 1, 2020, Medigap plans sold to new people with Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare starting on January 1, 2020. If you already have either of these two plans (or the high deductible version of Plan F) or are covered by one of these plans prior to January 1, 2020, you will be able to keep your plan. If you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy one of these plans.

This chart shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Medicare Part B coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%** ***
Blood (first 3 pints)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A hospice care coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Skilled nursing facility care coinsurance			**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A deductible		**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	50%	**100%**
Part B deductible			**100%**		**100%**					
Part B excess charges					**100%**	**100%**				
Foreign travel emergency (up to plan limits)			**80%**	**80%**	**80%**	**80%**			**80%**	**80%**
							Out-of-pocket limit in 2018**			
							$5,240	$2,620		

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,240 in 2018 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2018), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

What Medigap policies don't cover

Generally, Medigap policies don't cover long-term care (like care in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Types of coverage that are NOT Medigap policies

- Medicare Advantage Plans (Part C), like an HMO or PPO
- Medicare Prescription Drug Plans (Part D)
- Medicaid
- Employer or union plans, including the Federal Employees Health Benefits Program (FEHBP)
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans
- Qualified Health Plans sold in the Health Insurance Marketplace

What types of Medigap policies can insurance companies sell?

In most cases, Medigap insurance companies can sell you only a "standardized" Medigap policy. All Medigap policies must have specific benefits, so you can compare them easily. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

Insurance companies that sell Medigap policies don't have to offer every Medigap plan. However, they must offer Plan A if they offer any Medigap policy. If they offer any plan in addition to Plan A, they must also offer Plan C or Plan F. Each insurance company decides which Medigap plan it wants to sell, although state laws might affect which ones they offer.

Words in blue are defined on pages 49–50.

In some cases, an insurance company must sell you a Medigap policy, even if you have health problems. Here are certain times that you're guaranteed the right to buy a Medigap policy:

- When you're in your Medigap Open Enrollment Period. See pages 14–15.
- If you have a guaranteed issue right. See pages 21–23.

You may be able to buy a Medigap policy at other times, but the insurance company can deny you a Medigap policy based on your health. Also, in some cases it may be illegal for the insurance company to sell you a Medigap policy (like if you already have Medicaid or a Medicare Advantage Plan).

What do I need to know if I want to buy a Medigap policy?

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to buy a Medigap policy.
- If you have a Medicare Advantage Plan (like an HMO or PPO) but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the Plan. Ask that the new Medigap policy start when your Medicare Advantage Plan enrollment ends, so you'll have continuous coverage.
- You pay the private insurance company a premium for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, **you each will have to buy separate Medigap policies**.
- When you have your Medigap Open Enrollment Period, you can buy a Medigap policy from any insurance company that's licensed in your state.
- If you want to buy a Medigap policy, see page 11 for an overview of the basic benefits covered by different Medigap policies to review the benefit choices. Then, follow the "**Steps to Buying a Medigap Policy**" on pages 25–30.
- If you want to drop your Medigap policy, write your insurance company to cancel the policy and confirm it's cancelled. Your agent can't cancel the policy for you.
- Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you stay enrolled and pay the premium.
- Different insurance companies may charge different premiums for the same exact policy. As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).
- Some states may have laws that may give you additional protections.

What do I need to know if I want to buy a Medigap policy? (continued)

- Although some Medigap policies sold in the past covered prescription drugs, Medigap policies sold after January 1, 2006, aren't allowed to include prescription drug coverage.
- If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D) offered by private companies approved by Medicare. See pages 6–7.

To learn about Medicare prescription drug coverage, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

When's the best time to buy a Medigap policy?

The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods including those for people under 65. During this period, an insurance company can't use medical underwriting. This means the insurance company can't do any of these because of your health problems:

- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except as explained below)

Words in blue are defined on pages 49–50.

While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition. A pre-existing condition is a health problem you have before the date a new insurance policy starts. In some cases, the Medigap insurance company can refuse to cover your out-of-pocket costs for these pre-existing health problems for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

When's the best time to buy a Medigap policy? (continued)

Coverage for a pre-existing condition can only be excluded if the condition was treated or diagnosed within 6 months before the coverage starts under the Medigap policy. This is called the "look-back period." Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't, but you're responsible for the Medicare coinsurance or copayment.

Creditable coverage

If you have a pre-existing condition, you buy a Medigap policy during your Medigap Open Enrollment Period, and you're replacing certain kinds of health coverage that count as "creditable coverage," it's possible to avoid or shorten waiting periods for pre-existing conditions. Prior creditable coverage is generally any other health coverage you recently had before applying for a Medigap policy. If you've had at least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing conditions.

There are many types of health care coverage that may count as creditable coverage for Medigap policies, but they'll only count if you didn't have a break in coverage for more than 63 days.

Your Medigap insurance company can tell you if your previous coverage will count as creditable coverage for this purpose. You can also call your State Health Insurance Assistance Program. See pages 47–48.

If you buy a Medigap policy when you have a guaranteed issue right (also called "Medigap protection"), the insurance company can't use a pre-existing condition waiting period. See pages 21–23 for more information about guaranteed issue rights.

Note: If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65. See page 39 for more information.

Why is it important to buy a Medigap policy when I'm first eligible?

When you're first eligible, you have the right to buy any Medigap policy offered in your state. In addition, you generally will get better prices and more choices among policies. It's very important to understand your Medigap Open Enrollment Period. Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the Medigap policy. However, if you apply during your Medigap Open Enrollment Period, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health. If you apply for Medigap coverage **after** your Open Enrollment Period, there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements, **unless** you're eligible for guaranteed issue rights (Medigap protections) because of one of the limited situations listed on pages 22–23.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap Open Enrollment Period begins when you enroll in Part B and can't be changed or repeated. In most cases, it makes sense to enroll in Part B and purchase a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty and might miss your Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Employer coverage

Words in blue are defined on pages 49–50.

If you have group health coverage through an employer or union, because either you or your spouse is currently working, you may want to wait to enroll in Part B. This is because benefits based on current employment often provide coverage similar to Part B, so you would be paying for Part B before you need it, and your Medigap Open Enrollment Period might expire before a Medigap policy would be useful. When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty which means your Medigap Open Enrollment Period will start when you're ready to take advantage of it. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare. See page 24 for more information.

How do insurance companies set prices for Medigap policies?

Each insurance company decides how it'll set the price, or premium, for its Medigap policies. The way they set the price affects how much you pay now and in the future. Medigap policies can be priced or "rated" in 3 ways:

1. Community-rated (also called "no-age-rated")
2. Issue-age-rated (also called "entry-age-rated")
3. Attained-age-rated

Each of these ways of pricing Medigap policies is described in the chart on the next page. The examples show how your age affects your premiums, and why it's important to look at how much the Medigap policy will cost you now and in the future. The amounts in the examples aren't actual costs. Other factors like where you live, medical underwriting, and discounts can also affect the amount of your premium.

How do insurance companies set prices for Medigap policies? (continued)

Type of pricing	How it's priced	What this pricing may mean for you	Examples
Community-rated (also called "no-age-rated")	Generally the same premium is charged to everyone who has the Medigap policy, regardless of age or gender.	Your premium isn't based on your age. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Smith is 65. He buys a Medigap policy and pays a $165 monthly premium. Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a $165 monthly premium.
Issue-age-rated (also called "entry age-rated")	The premium is based on the age you are when you buy (are "issued") the Medigap policy.	Premiums are lower for people who buy at a younger age and won't change as you get older. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is 72. She buys the same Medigap policy as Mr. Han. Since she is older when she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you've "attained"), so your premium goes up as you get older.	Premiums are low for younger buyers but go up as you get older. They may be the least expensive at first, but they can eventually become the most expensive. Premiums may also go up because of inflation and other factors.	Mrs. Anderson is 65. She buys a Medigap policy and pays a $120 monthly premium. Her premium will go up each year: • At 66, her premium goes up to $126. • At 67, her premium goes up to $132. • At 72, her premium goes up to $165. Mr. Dodd is 72. He buys the same Medigap policy as Mrs. Anderson. He pays a $165 monthly premium. His premium is higher than Mrs. Anderson's because it's based on his current age. Mr. Dodd's premium will go up each year: • At 73, his premium goes up to $171. • At 74, his premium goes up to $177.

Comparing Medigap costs

As discussed on the previous pages, the cost of Medigap policies can vary widely. **There can be big differences in the premiums that different insurance companies charge for exactly the same coverage**. As you shop for a Medigap policy, be sure to compare the same type of Medigap policy, and consider the type of pricing used. See pages 17–18. For example, compare a Plan C from one insurance company with a Plan C from another insurance company. Although this guide **can't** give actual costs of Medigap policies, you can get this information by calling insurance companies or your State Health Insurance Assistance Program. See pages 47–48.

You can also find out which insurance companies sell Medigap policies in your area by visiting Medicare.gov.

The cost of your Medigap policy may also depend on whether the insurance company:

- Offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses medical underwriting, or applies a different premium when you don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. See page 20.
- Offers a "high-deductible option" for Plan F. If you buy Plan F with a high-deductible option, you must pay the first $2,240 of deductibles, copayments, and coinsurance (in 2018) for covered services not paid by Medicare before the Medigap policy pays anything. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

If you bought Medigap Plan J before January 1, 2006, and it still covers prescription drugs, you would also pay a separate deductible ($250 per year) for prescription drugs covered by the Medigap policy. And, if you have a Plan J with a high deductible option, you must also pay a $2,240 deductible (in 2018) before the policy pays anything for medical benefits.

What's Medicare SELECT?

Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be any of the standardized Medigap plans (see page 11). These policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT hospital or doctor for non-emergency services, you'll have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

How does Medigap help pay my Medicare Part B bills?

In most Medigap policies, when you sign the Medigap insurance contract you agree to have the Medigap insurance company get your Medicare Part B claim information directly from Medicare, and then they pay the doctor directly whatever amount is owed under your policy. Some Medigap insurance companies also provide this service for Medicare Part A claims.

If your Medigap insurance company **doesn't** provide this service, ask your doctors if they participate in Medicare. Participating providers have signed an arrangement to accept assignment for all Medicare-covered services. If your doctor participates, the Medigap insurance company is required to pay the doctor directly if you request. If your doctor doesn't participate but still accepts Medicare, you may be asked to pay the coinsurance amount at the time of service. In these cases, your Medigap insurance company will pay you directly according to policy limits.

If you have any questions about Medigap claim filing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

Guaranteed issue rights are rights you have in certain situations when insurance companies must offer you certain Medigap policies when you aren't in your Medigap Open Enrollment Period. In these situations, an insurance company must:

- Sell you a Medigap policy
- Cover all your pre-existing health conditions
- Can't charge you more for a Medigap policy regardless of past or present health problems

If you live in Massachusetts, Minnesota, or Wisconsin, you have guaranteed issue rights to buy a Medigap policy, but the Medigap policies are different. See pages 42–44 for your Medigap policy choices.

When do I have guaranteed issue rights?

In most cases, you have a guaranteed issue right when you have certain types of other health care coverage that changes in some way, like when you lose the other health care coverage. In other cases, you have a "trial right" to try a Medicare Advantage Plan and still buy a Medigap policy if you change your mind. For information on trial rights, see page 23.

This chart describes the most common situations, under federal law, that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issue rights.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
You're in a Medicare Advantage Plan (like an HMO or PPO), and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. **Note:** In this situation, you may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. Call the Medicare SELECT insurer for more information about your options.	Medigap Plan A, B, C, F, K, or L that's sold by any insurance company in your state or the state you're moving to.	As early as 60 calendar days before the date your Medicare SELECT coverage will end, but no later than 63 calendar days after your Medicare SELECT coverage ends.

This chart describes the most common situations, under federal law, that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issue rights. (continued)

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
(**Trial right**) You joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	Any Medigap policy that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
(**Trial right**) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medigap policy **isn't** available, you can buy Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.
You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.

Can I buy a Medigap policy if I lose my health care coverage?

Yes, you may be able to buy a Medigap policy. Because you may have a guaranteed issue right to buy a Medigap policy, make sure you keep these:

- A copy of any letters, notices, emails, and/or claim denials that have your name on them as proof of your coverage being terminated.
- The postmarked envelope these papers come in as proof of when it was mailed.

You may need to send a copy of some or all of these papers with your Medigap application to prove you have a guaranteed issue right.

If you have a Medicare Advantage Plan (like an HMO or PPO) but you're planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the plan. Ask that the new policy take effect when your Medicare Advantage enrollment ends, so you'll have continuous coverage.

For more information

If you have any questions or want to learn about any additional Medigap rights in your state, you can:

- Call your State Health Insurance Assistance Program to make sure that you qualify for these guaranteed issue rights. See pages 47–48.
- Call your State Insurance Department if you're denied Medigap coverage in any of these situations. See pages 47–48.

Important: The guaranteed issue rights in this section are from federal law. These rights are for both Medigap and Medicare SELECT policies. Many states provide additional Medigap rights.

There may be times when more than one of the situations in the chart on pages 22–23 applies to you. When this happens, you can choose the guaranteed issue right that gives you the best choice.

Some of the situations listed include loss of coverage under Programs of All-inclusive Care for the Elderly (PACE). PACE combines medical, social, and long-term care services, and prescription drug coverage for frail people. To be eligible for PACE, you must meet certain conditions. PACE may be available in states that have chosen it as an optional Medicaid benefit. If you have Medicaid, an insurance company can sell you a Medigap policy **only** in certain situations. For more information about PACE, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION

4

Steps to Buying a Medigap Policy

Step-by-step guide to buying a Medigap policy

Buying a **Medigap policy** is an important decision. Only you can decide if a Medigap policy is the way for you to supplement Original Medicare coverage and which Medigap policy to choose. Shop carefully. Compare available Medigap policies to see which one meets your needs. As you shop for a Medigap policy, keep in mind that different insurance companies may charge different amounts for exactly the same Medigap policy, and not all insurance companies offer all of the Medigap policies.

Below is a step-by-step guide to help you buy a Medigap policy. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44.

STEP 1: Decide which benefits you want, then decide which of the standardized Medigap policies meet your needs.

STEP 2: Find out which insurance companies sell Medigap policies in your state.

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs.

STEP 4: Buy the Medigap policy.

STEP 1: Decide which benefits you want, then decide which of the Medigap policy meets your needs.

Think about your current and future health care needs when deciding which benefits you want because you might not be able to switch Medigap policies later. Decide which benefits you need, and select the Medigap policy that will work best for you. The chart on page 11 provides an overview of Medigap benefits.

STEP 2: Find out which insurance companies sell Medigap policies in your state.

To find out which insurance companies sell Medigap policies in your state:

- Call your State Health Insurance Assistance Program. See pages 47–48. Ask if they have a "Medigap rate comparison shopping guide" for your state. This guide usually lists companies that sell Medigap policies in your state and their costs.
- Call your State Insurance Department. See pages 47–48.
- Visit Medicare.gov/find-a-plan:

  This website will help you find information on your health plan options, including the Medigap policies in your area. You can also get information on:

  ✔ How to contact the insurance companies that sell Medigap policies in your state.

  ✔ What each Medigap policy covers.

  ✔ How insurance companies decide what to charge you for a Medigap policy premium.

  If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227). A customer service representative will help you get information on all your health plan options including the Medigap policies in your area. TTY users can call 1-877-486-2048.

Words in blue are defined on pages 49–50.

STEP 2: (continued)

Since costs can vary between companies, plan to call more than one insurance company that sells Medigap policies in your state. Before you call, check the companies to be sure they're honest and reliable by using one of these resources:

- Call your State Insurance Department. Ask if they keep a record of complaints against insurance companies that can be shared with you. When deciding which Medigap policy is right for you, consider these complaints, if any.
- Call your State Health Insurance Assistance Program. These programs can give you help at no cost to you with choosing a Medigap policy.
- Go to your local public library for help with:
  - Getting information on an insurance company's financial strength from independent rating services like weissratings.com, A.M. Best, and Standard & Poor's.
  - Looking at information about the insurance company online.
- Talk to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy from the same Medigap insurance company.

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs.

Before you call any insurance companies, figure out if you're in your Medigap Open Enrollment Period or if you have a guaranteed issue right. Read pages 14–15 and 22–23 carefully. If you have questions, call your State Health Insurance Assistance Program. See pages 47–48. This chart can help you keep track of the information you get.

Ask each insurance company…	Company 1	Company 2
"Are you licensed in ___?" (Say the name of your state.) **Note:** If the answer is NO, STOP here, and try another company.		
"Do you sell Medigap Plan ___?" (Say the letter of the Medigap Plan you're interested in.) **Note:** Insurance companies usually offer some, but not all, Medigap policies. Make sure the company sells the plan you want. Also, if you're interested in a Medicare SELECT or high-deductible Medigap policy, tell them.		
"Do you use medical underwriting for this Medigap policy?" **Note:** If the answer is NO, go to step 4 on page 30. If the answer is YES, but you know you're in your Medigap Open Enrollment Period or have a guaranteed issue right to buy that Medigap policy, go to step 4. Otherwise, you can ask, "Can you tell me whether I'm likely to qualify for the Medigap policy?"		
"Do you have a waiting period for pre-existing conditions?" **Note:** If the answer is YES, ask how long the waiting period is and write it in the box.		
"Do you price this Medigap policy by using community-rating, issue-age-rating, or attained-age-rating?" See page 18. **Note:** Circle the one that applies for that insurance company.	Community Issue-age Attained-age	Community Issue-age Attained-age
"I'm ___ years old. What would my premium be under this Medigap policy?" **Note:** If it's attained-age, ask, "How frequently does the premium increase due to my age?"		
"Has the premium for this Medigap policy increased in the last 3 years due to inflation or other reasons?" **Note:** If the answer is YES, ask how much it has increased, and write it in the box.		
"Do you offer any discounts or additional benefits?" See page 19.		

STEP 3: (continued)

Watch out for illegal practices.

It's illegal for anyone to:

- Pressure you into buying a Medigap policy, or lie to or mislead you to switch from one company or policy to another.
- Sell you a second Medigap policy when they know that you already have one, unless you tell the insurance company in writing that you plan to cancel your existing Medigap policy.
- Sell you a Medigap policy if they know you have Medicaid, except in certain situations.
- Sell you a Medigap policy if they know you're in a Medicare Advantage Plan (like an HMO or PPO) unless your coverage under the Medicare Advantage Plan will end before the effective date of the Medigap policy.
- Claim that a Medigap policy is a part of Medicare or any other federal program. Medigap is private health insurance.
- Claim that a Medicare Advantage Plan is a Medigap policy.
- Sell you a Medigap policy that can't legally be sold in your state. Check with your State Insurance Department (see pages 47–48) to make sure that the Medigap policy you're interested in can be sold in your state.
- Misuse the names, letters, or symbols of the U.S. Department of Health & Human Services (HHS), Social Security Administration (SSA), Centers for Medicare & Medicaid Services (CMS), or any of their various programs like Medicare. (For example, they can't suggest the Medigap policy has been approved or recommended by the federal government.)
- Claim to be a Medicare representative if they work for a Medigap insurance company.
- Sell you a Medicare Advantage Plan when you say you want to stay in Original Medicare and buy a Medigap policy. A Medicare Advantage Plan isn't the same as Original Medicare. See page 5. If you enroll in a Medicare Advantage Plan, you can't use a Medigap policy.

If you believe that a federal law has been broken, call the Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477). TTY users can call 1-800-377-4950. Your State Insurance Department can help you with other insurance-related problems.

STEP 4: Buy the Medigap policy.

Once you decide on the insurance company and the Medigap policy you want, apply. The insurance company must give you a clearly worded summary of your Medigap policy. Read it carefully. If you don't understand it, ask questions. Remember these when you buy your Medigap policy:

- **Filling out your application.** Fill out the application carefully and completely, including medical questions. The answers you give will determine your eligibility for an Open Enrollment Period or guaranteed issue rights. If the insurance agent fills out the application, make sure it's correct. If you buy a Medigap policy during your Medigap Open Enrollment Period or provide evidence that you're entitled to a guaranteed issue right, the insurance company can't use any medical answers you give to deny you a Medigap policy or change the price. The insurance company can't ask you any questions about your family history or require you to take a genetic test.
- **Paying for your Medigap policy.** You can pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. If buying from an agent, get a receipt with the insurance company's name, address, and phone number for your records. Some companies may offer electronic funds transfer.
- **Starting your Medigap policy.** Ask for your Medigap policy to become effective when you want coverage to start. Generally, Medigap policies begin the first of the month after you apply. If, for any reason, the insurance company won't give you the effective date for the month you want, call your State Insurance Department. See pages 47–48.

  Note: If you already have a Medigap policy, ask for your new Medigap policy to become effective when your old Medigap policy coverage ends.
- **Getting your Medigap policy.** If you don't get your Medigap policy in 30 days, call your insurance company. If you don't get your Medigap policy in 60 days, call your State Insurance Department.

SECTION 5

If You Already Have a Medigap Policy

Read this section to see if any of these situations apply to you:

- You're thinking about switching to a different Medigap policy. See pages 32–35.
- You're losing your Medigap coverage. See page 36.
- You have a Medigap policy with Medicare prescription drug coverage. See pages 36–38.

If you just want a refresher about Medigap insurance, turn to page 11.

Switching Medigap policies

If you're thinking about switching to a new Medigap policy, see below and pages 33–35 to answer some common questions.

Can I switch to a different Medigap policy?

In most cases, you won't have a right under federal law to switch Medigap policies, unless you're within your 6-month Medigap Open Enrollment Period or are eligible under a specific circumstance for guaranteed issue rights. But, if your state has more generous requirements, or the insurance company is willing to sell you a Medigap policy, make sure you compare benefits and premiums before switching. If you bought your Medigap policy before 2010, it may offer coverage that isn't available in a newer Medigap policy. On the other hand, Medigap policies bought before 1992 might not be guaranteed renewable and might have bigger premium increases than newer, standardized Medigap policies currently being sold.

If you decide to switch, don't cancel your first Medigap policy until you've decided to keep the second Medigap policy. On the application for the new Medigap policy, you'll have to promise that you'll cancel your first Medigap policy. You have 30 days to decide if you want to keep the new Medigap policy. This is called your "free look period." The 30-day free look period starts when you get your new Medigap policy. You'll need to pay both premiums for one month.

Words in blue are defined on pages 49–50.

Switching Medigap policies (continued)

Do I have to switch Medigap policies if I have a Medigap policy that's no longer sold?

No. But you can't have more than one Medigap policy, so if you buy a new Medigap policy, you have to give up your old policy (except for your 30-day "free look period," described on page 32). Once you cancel the old policy, you can't get it back.

Do I have to wait a certain length of time after I buy my first Medigap policy before I can switch to a different Medigap policy?

No. If you've had your old Medigap policy for less than 6 months, the Medigap insurance company may be able to make you wait up to 6 months for coverage of a pre-existing condition. However, if your old Medigap policy had the same benefits, and you had it for 6 months or more, the new insurance company can't exclude your pre-existing condition. If you've had your Medigap policy less than 6 months, the number of months you've had your current Medigap policy must be subtracted from the time you must wait before your new Medigap policy covers your pre-existing condition.

If the new Medigap policy has a benefit that isn't in your current Medigap policy, you may still have to wait up to 6 months before that benefit will be covered, regardless of how long you've had your current Medigap policy.

If you've had your current Medigap policy longer than 6 months and want to replace it with a new one with the same benefits and the insurance company agrees to issue the new policy, they can't write pre-existing conditions, waiting periods, elimination periods, or probationary periods into the replacement policy.

Switching Medigap policies (continued)

Why would I want to switch to a different Medigap policy?

Some reasons for switching may include:

- You're paying for benefits you don't need.
- You need more benefits than you needed before.
- Your current Medigap policy has the right benefits, but you want to change your insurance company.
- Your current Medigap policy has the right benefits, but you want to find a policy that's less expensive.

It's important to compare the benefits in your current Medigap policy to the benefits listed on page 11. If you live in Massachusetts, Minnesota, or Wisconsin, see pages 42–44. To help you compare benefits and decide which Medigap policy you want, follow the "**Steps to Buying a Medigap Policy**" in Section 4. If you decide to change insurance companies, you can call the new insurance company and arrange to apply for your new Medigap policy. If your application is accepted, call your current insurance company, and ask to have your coverage end. The insurance company can tell you how to submit a request to end your coverage.

As discussed on page 32, you should have your old Medigap policy coverage end **after** you have the new Medigap policy for 30 days. Remember, this is your 30-day free look period. You'll need to pay both premiums for one month.

Switching Medigap policies (continued)

Can I keep my current Medigap policy (or Medicare SELECT policy) or switch to a different Medigap policy if I move out-of-state?

In general, you can keep your current Medigap policy regardless of where you live as long as you still have Original Medicare. If you want to switch to a different Medigap policy, you'll have to check with your current or the new insurance company to see if they'll offer you a different Medigap policy.

You may have to pay more for your new Medigap policy and answer some medical questions if you're buying a Medigap policy outside of your Medigap Open Enrollment Period. See pages 14–16.

If you have a Medicare SELECT policy and you move out of the policy's area, you can:

- Buy a standardized Medigap policy from your current Medigap policy insurance company that offers the same or fewer benefits than your current Medicare SELECT policy. If you've had your Medicare SELECT policy for more than 6 months, you won't have to answer any medical questions.
- Use your guaranteed issue right to buy any Plan A, B, C, F, K, or L that's sold in most states by any insurance company.

Your state may provide additional Medigap rights. Call your State Health Insurance Assistance Program or State Department of Insurance for more information. See pages 47–78 for their phone numbers.

What happens to my Medigap policy if I join a Medicare Advantage Plan?

Words in blue are defined on pages 49–50.

Medigap policies can't work with Medicare Advantage Plans. If you decide to keep your Medigap policy, you'll have to pay your Medigap policy premium, but the Medigap policy can't pay any deductibles, copayments, coinsurance, or premiums under a Medicare Advantage Plan. So, if you join a Medicare Advantage Plan, you may want to drop your Medigap policy. Contact your Medigap insurance company to find out how to disenroll. However, if you leave the Medicare Advantage Plan you might not be able to get the same Medigap policy back, or in some cases, any Medigap policy unless you have a "trial right." See page 23. Your rights to buy a Medigap policy may vary by state. You always have a legal right to keep the Medigap policy after you join a Medicare Advantage Plan. However, because you have a Medicare Advantage Plan, the Medigap policy would no longer provide benefits that supplement Medicare.

Losing Medigap coverage

Can my Medigap insurance company drop me?

If you bought your Medigap policy **after 1992**, in most cases the Medigap insurance company can't drop you because the Medigap policy is guaranteed renewable. This means your insurance company can't drop you unless one of these happens:

- You stop paying your premium.
- You weren't truthful on the Medigap policy application.
- The insurance company becomes bankrupt or insolvent.

If you bought your Medigap policy **before 1992**, it might not be guaranteed renewable. This means the Medigap insurance company can refuse to renew the Medigap policy, as long as it gets the state's approval to cancel your Medigap policy. However, if this does happen, you have the right to buy another Medigap policy. See the guaranteed issue right on page 23.

Medigap policies and Medicare prescription drug coverage

If you bought a Medigap policy before January 1, 2006, and it has coverage for prescription drugs, see below and page 37.

Medicare offers prescription drug coverage (Part D) for everyone with Medicare. If you have a Medigap policy with prescription drug coverage, that means you chose not to join a Medicare Prescription Drug Plan when you were first eligible. However, you can still join a Medicare drug plan. Your situation may have changed in ways that make a Medicare Prescription Drug Plan fit your needs better than the prescription drug coverage in your Medigap policy. It's a good idea to review your coverage each fall, because you can join a Medicare Prescription Drug Plan between October 15–December 7. Your new coverage will begin on January 1.

Medigap policies and Medicare prescription drug coverage (continued)

Why would I change my mind and join a Medicare Prescription Drug Plan?

In a Medicare Prescription Drug Plan, you may have to pay a monthly premium, but Medicare pays a large part of the cost. There's no maximum yearly amount as with Medigap prescription drug benefits in old Plans H, I, and J (these plans are no longer sold). However, a Medicare Prescription Drug Plan might only cover certain prescription drugs (on its "formulary" or "drug list"). It's important that you check whether your current prescription drugs are on the Medicare drug plan's list of covered prescription drugs before you join.

If your Medigap premium or your prescription drug needs were very low when you had your first chance to join a Medicare Prescription Drug Plan, your Medigap prescription drug coverage may have met your needs. However, if your Medigap premium or the amount of prescription drugs you use has increased recently, a Medicare Prescription Drug Plan might now be a better choice for you.

Will I have to pay a late enrollment penalty if I join a Medicare Prescription Drug Plan now?

If you qualify for Extra Help, you won't pay a late enrollment penalty. If you don't qualify for Extra Help, it will depend on whether your Medigap policy includes "creditable prescription drug coverage." This means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard prescription drug coverage.

If your Medigap policy's drug coverage **isn't** creditable coverage, and you join a Medicare Prescription Drug Plan now, you'll probably pay a higher premium (a penalty added to your monthly premium) than if you had joined when you were first eligible. Each month that you wait to join a Medicare Prescription Drug Plan will make your late enrollment penalty higher. Your Medigap carrier must send you a notice each year telling you if the prescription drug coverage in your Medigap policy is creditable. Keep these notices in case you decide later to join a Medicare Prescription Drug Plan. Also consider that your prescription drug needs could increase as you get older.

Will I have to pay a late enrollment penalty if I join a Medicare Prescription Drug Plan now? (continued)

If your Medigap policy includes creditable prescription drug coverage and you decide to join a Medicare Prescription Drug Plan, you won't have to pay a late enrollment penalty as long as you don't go 63 or more days in a row without creditable prescription drug coverage. So, don't drop your Medigap policy **before** you join the Medicare drug plan and the coverage starts. In general, you can only join a Medicare drug plan between October 15 –December 7. However, if you lose your Medigap policy (for example, if it isn't guaranteed renewable, and your company cancels it), you may be able to join a Medicare drug plan at the time you lose your Medigap policy.

Can I join a Medicare Prescription Drug Plan and have a Medigap policy with prescription drug coverage?

No. If your Medigap policy covers prescription drugs, you must tell your Medigap insurance company if you join a Medicare drug plan so it can remove the prescription drug coverage from your Medigap policy and adjust your premium. Once the drug coverage is removed, you can't get that coverage back even though you didn't change Medigap policies.

What if I decide to drop my entire Medigap policy (not just the Medigap prescription drug coverage) and join a Medicare Advantage Plan that offers prescription drug coverage?

You need to be careful about the timing because in general, you can only join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) during the Medicare Open Enrollment Period between October 15 –December 7. If you join during Medicare Open Enrollment Period, your coverage will begin on January 1 as long as the plan gets your enrollment request by December 7.

SECTION

6

Medigap Policies for People with a Disability or ESRD

Information for people under 65

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD)

You may have Medicare before turning 65 due to a disability or ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

If you're under 65 and have Medicare because of a disability or ESRD, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65. These states are listed on the next page.

Important: This section provides information on the minimum federal standards. For your state requirements, call your State Health Insurance Assistance Program. See pages 47–48.

Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD) (continued)

At the time of printing this guide, these states required insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65:

- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Idaho
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Vermont
- Wisconsin

Note: Some states provide these rights to all people with Medicare under 65, while others only extend them to people eligible for Medicare because of disability or only to people with ESRD. Check with your State Insurance Department about what rights you might have under state law.

Even if your state isn't on the list above, some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can probably use medical underwriting. Also, some of the federal guaranteed rights are available to people with Medicare under 65, see pages 21–24. Check with your State Insurance Department about what additional rights you might have under state law.

Words in blue are defined on pages 49–50.

Remember, if you're already enrolled in Medicare Part B, you'll get a Medigap Open Enrollment Period when you turn 65. You'll probably have a wider choice of Medigap policies and be able to get a lower premium at that time. During the Medigap Open Enrollment Period, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare (Part A and/or Part B) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period imposed for coverage bought during the Medigap Open Enrollment Period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, see pages 16–17. If you have questions, call your State Health Insurance Assistance Program. See pages 47–48.

SECTION 7

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Massachusetts benefits 42

Minnesota benefits 43

Wisconsin benefits 44

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

- **Inpatient hospital care:** covers the Medicare Part A coinsurance plus coverage for 365 additional days after Medicare coverage ends
- **Medical costs:** covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice coinsurance or copayment

The check marks in this chart mean the benefit is covered.

Medigap benefits	Core plan	Supplement 1 Plan
Basic benefits	✓	✓
Part A: inpatient hospital deductible		✓
Part A: skilled nursing facility (SNF) coinsurance		✓
Part B: deductible		✓
Foreign travel emergency		✓
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year
State-mandated benefits (annual Pap tests and mammograms—check your plan for other state-mandated benefits)	✓	✓

For more information on these Medigap policies, visit Medicare.gov/find-a-plan, or call your State Insurance Department. See pages 47–48.

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

- **Inpatient hospital care:** covers the Part A coinsurance
- **Medical costs:** covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice and respite cost sharing
- Parts A and B home health services and supplies cost sharing

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan	Extended basic plan
Basic benefits	✓	✓
Part A: inpatient hospital deductible		✓
Part A: skilled nursing facility (SNF) coinsurance	✓ (Provides 100 days of SNF care)	✓ (Provides 120 days of SNF care)
Part B: deductible		✓
Foreign travel emergency	80%	80%*
Outpatient mental health	20%	20%
Usual and customary fees		80%*
Medicare-covered preventive care	✓	✓
Physical therapy	20%	20%
Coverage while in a foreign country		80%*
State-mandated benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations)	✓	✓

Mandatory riders

Insurance companies can offer 4 additional riders that can be added to a basic plan. You may choose any one or all of these riders to design a Medigap policy that meets your needs:

1. Part A: inpatient hospital deductible
2. Part B: deductible
3. Usual and customary fees
4. Non-Medicare preventive care

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

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

Important: The basic and extended basic benefits are available when you enroll in Part B, regardless of age or health problems. If you are under 65, return to work and drop Part B to elect your employer's health plan, you'll get a 6-month Medigap Open Enrollment Period after you turn 65 and retire from that employer when you can join Part B again.

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

- **Inpatient hospital care:** covers the Part A coinsurance
- **Medical costs:** covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- **Blood:** covers the first 3 pints of blood each year
- Part A hospice coinsurance or copayment

The check marks in this chart mean the benefit is covered.

Medigap benefits	Basic plan
Basic benefits	✓
Part A: skilled nursing facility (SNF) coinsurance	✓
Inpatient mental health coverage	175 days per lifetime in addition to Medicare's benefit
Home health care	40 visits per year in addition to those paid by Medicare
State-mandated benefits	✓

Optional riders

Insurance companies are allowed to offer these 7 additional riders to a Medigap policy:

1. Part A deductible
2. Additional home health care (365 visits including those paid by Medicare)
3. Part B deductible
4. Part B excess charges
5. Foreign travel emergency
6. 50% Part A deductible
7. Part B copayment or coinsurance

For more information on these Medigap policies, visit Medicare.gov/find-a-plan or call your State Insurance Department. See pages 47–48.

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan ($2,240 deductible for 2018) is also available.

SECTION

8

For More Information

Where to get more information

On pages 47–48, you'll find phone numbers for your State Health Insurance Assistance Program (SHIP) and State Insurance Department.

- Call your SHIP for help with:
  - Buying a Medigap policy or long-term care insurance.
  - Dealing with payment denials or appeals.
  - Medicare rights and protections.
  - Choosing a Medicare plan.
  - Deciding whether to suspend your Medigap policy.
  - Questions about Medicare bills.
- Call your State Insurance Department if you have questions about the Medigap policies sold in your area or any insurance-related problems.

How to get help with Medicare and Medigap questions

If you have questions about Medicare, Medigap, or need updated phone numbers for the contacts listed on pages 47– 48:

Visit Medicare.gov:

- For Medigap policies in your area, visit Medicare.gov/find-a-plan.
- For updated phone numbers, visit Medicare.gov/contacts.

Call 1-800-MEDICARE (1-800-633-4227):

Customer service representatives are available 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048. If you need help in a language other than English or Spanish, let the customer service representative know the language.

State Health Insurance Assistance Program and State Insurance Department

State	State Health Insurance Assistance Program	State Insurance Department
Alabama	1-800-243-5463	1-800-433-3966
Alaska	1-800-478-6065	1-800-467-8725
American Samoa	Not available	1-684-633-4116
Arizona	1-800-432-4040	1-800-325-2548
Arkansas	1-800-224-6330	1-800-224-6330
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7415	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-3272
Illinois	1-800-252-8966	1-888-473-4858
Indiana	1-800-452-4800	1-800-622-4461
Iowa	1-800-351-4664	1-877-955-1212
Kansas	1-800-860-5260	1-800-432-2484
Kentucky	1-877-293-7447	1-800-595-6053
Louisiana	1-800-259-5300	1-800-259-5301
Maine	1-800-262-2232	1-800-300-5000
Maryland	1-800-243-3425	1-800-735-2258
Massachusetts	1-800-243-4636	1-877-563-4467
Michigan	1-800-803-7174	1-877-999-6442
Minnesota	1-800-333-2433	1-800-657-3602
Mississippi	1-601-359-4577	1-800-562-2957
Missouri	1-800-390-3330	1-800-726-7390
Montana	1-800-551-3191	1-800-332-6148
Nebraska	1-800-234-7119	1-800-234-7119

State	State Health Insurance Assistance Program	State Insurance Department
Nevada	1-800-307-4444	1-800-992-0900
New Hampshire	1-866-634-9412	1-800-852-3416
New Jersey	1-800-792-8820	1-800-446-7467
New Mexico	1-800-432-2080	1-888-727-5772
New York	1-800-701-0501	1-800-342-3736
North Carolina	1-855-408-1212	1-800-546-5664
North Dakota	1-888-575-6611	1-800-247-0560
Northern Mariana Islands	Not available	1-670-664-3064
Ohio	1-800-686-1578	1-800-686-1526
Oklahoma	1-800-763-2828	1-800-522-0071
Oregon	1-800-722-4134	1-888-877-4894
Pennsylvania	1-800-783-7067	1-877-881-6388
Puerto Rico	1-877-725-4300	1-888-722-8686
Rhode Island	1-888-884-8721	1-401-462-9500
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 1-340-714-4354 (St. Thomas)	1-340-774-7166
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-994-6272	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION 9

Definitions

Where words in BLUE are defined

Assignment—An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance—An amount you may be required to pay as your share of the costs for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Excess charge—If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

Guaranteed issue rights—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a Medigap policy because of a past or present health problem.

Guaranteed renewable policy—An insurance policy that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud, or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Medicaid—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical underwriting—The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare prescription drug plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare SELECT—A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medigap Open Enrollment Period—A one-time-only, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Medicare Part B, **and** you're 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional Open Enrollment rights under state law.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Insurance Department—A state agency that regulates insurance and can provide information about Medigap policies and other private health insurance.

Notice of Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides auxiliary aids and services, like publications, documents and communications, in Braille, large print, data/audio CD, relay services and TTY communications.
CMS provides free auxiliary aids and services to help us better communicate with people with disabilities. Auxiliary aids include materials in Braille, audio/data CD or other accessible formats.

Note: You can get the Choosing a Medigap Policy electronically in standard print, large print, or as an eBook.

For Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents, you can contact our Customer Accessibility Resource Staff:

Call 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.

Send a fax to 1-844-530-3676.

Send an email to altformatrequest@cms.hhs.gov.

Send a letter to:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

You can also contact the Customer Accessibility Resource staff:

- To follow up on a previous accessibility request
- If you have questions about the quality or timeliness of your previous request

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

Nondiscrimination Notice

CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

How to file a complaint

If you believe you've been subjected to discrimination in a CMS program or activity, there are 3 ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online at hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. By phone: Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. In writing: Send information about your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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To get this publication in Braille, Spanish, or large print (English), visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

¿Necesita una copia en español? Visite Medicare.gov en el sitio Web. Para saber si esta publicación esta impresa y disponible (en español), llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

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Get answers here.

Contact your licensed insurance agent/producer contracted with UnitedHealthcare Insurance Company.

Name:

Email:

Phone:

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In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage renal disease.

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See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.

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