AARP® | Medicare Supplement
from UnitedHealthcare®

Enrollment Kit

Minnesota

Enrollment is for January 1, 2021 – December 1, 2021 plan effective dates.

AARP® Medicare Supplement Insurance Plans,
insured by UnitedHealthcare Insurance Company

BC10023ST

Meet the Medicare supplement insurance plans built to support you at every step.

Greetings!

Like many on Medicare, you may be looking for additional benefits to help pay for some of the out-of-pocket medical expenses not covered. That's why you may want to consider an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare). You'll have:

Control. Freedom in the health system is important – get the control you want with Medicare supplement insurance. You can see any provider that accepts Medicare patients without network restrictions, and you can see a specialist without first getting a referral. In fact, 95% of plan holders surveyed are satisfied with that ability.[1]

Longevity. Predictability and stability can help you better manage your health care expenses. With more than 40 years of experience and an "A" rating by A.M. Best,[2] UnitedHealthcare is a longstanding health insurance leader, covering more people with Medicare supplement plans nationwide than any other individual insurance carrier.[3]

Service. UnitedHealthcare is committed to service that works, and our member satisfaction surveys can testify. 95% of surveyed members are satisfied with their AARP Medicare Supplement Insurance Plan[1] – and 9 out of 10 of those surveyed would recommend their plans to a friend or family member.[1]

With this enrollment kit, you can review benefits and rates for each available plan. You'll also learn about discounts and our unique value-added services[4] that may be available to you.

Your licensed insurance agent will review the enclosed information with you, and answer your questions.

All of us at UnitedHealthcare would be honored to serve your health insurance needs – now, and for years to come.

Warm regards,

Joseph A. Hafermann
President, Medicare Supplemental Health Insurance Program
UnitedHealthcare

AARP | Medicare Supplement
from UnitedHealthcare

P.S. Did you know that UnitedHealthcare's mission is *to help people live healthier lives and make the health system work better for everyone*? AARP Medicare Supplement Insurance Plans are endorsed by AARP, whose mission is to *empower people to choose how they live as they age*. Join AARP online, by phone, or use the enclosed form.

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.

[1] From a report prepared for UnitedHealthcare Insurance Company by Gongos, Inc., "Medicare Supplement Plan Satisfaction Posted Questionnaire," March 2019, www.uhcmedsupstats.com or call 1-800-523-5800 to request a copy of the full report.

[2] From A.M. Best Company, Inc., data retrieved in March 2019 from ambest.com. In 2019, UnitedHealthcare Insurance Company is rated "A" by A.M. Best, an independent organization that evaluates insurance company financial performance. The rating only refers to the overall financial status of the company and is not a recommendation of the specific policy provisions, rates or practices of the insurance company. www.ambest.com.

[3] From a report prepared for UnitedHealthcare Insurance Company by Mark Farrah Associates, "December 2018 Medigap Enrollment & Market Share," April 2019, www.uhcmedsupstats.com or call 1-800-523-5800 to request a copy of the full report.

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

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.

Questions? Contact your licensed insurance agent or call UnitedHealthcare toll-free: 1-866-387-7550 Monday – Friday, 7 a.m. to 11 p.m. and Saturday 9 a.m. to 5 p.m., Eastern Time.

Exclusive Services & Discounts

Exclusive Services & Discounts

AARP | Medicare Supplement from UnitedHealthcare

AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company

Gym Membership, Discounts, and More

Once you're enrolled in an AARP® Medicare Supplement Insurance Plan, from **UnitedHealthcare Insurance Company (UnitedHealthcare)**, you'll get these insured member discounts and services in 2021.

Gym Membership

Renew Active™ by UnitedHealthcare:

- A gym membership at a location near you, at no additional cost.
- Access to an extensive network of gyms and fitness locations near you.
- A personal fitness plan, plus access to a wide variety of fitness classes.
- Connecting with others at local health and wellness events, and through the Fitbit® Community for Renew Active members.

Brain Health

AARP Staying Sharp:
Online brain health program that helps support a healthy brain lifestyle. AARP® Staying Sharp includes: a brain health assessment, articles, brain exercises, activities, recipes, and brain games.

Dental Discount

Receive discounts for dental services from in-network dentists through Dentegra:

- In-network discounts generally average 30-40%† off of contracted rates nationally for a range of dental services, including cleanings, exams, fillings and crowns.
- Access to 30K in-network general dentists and specialists at 90K locations nationwide.
- No waiting periods, deductibles, or annual maximums.

The Dentegra dental discount is not insurance.

Vision Discount

Save on eyewear purchases and routine eye exams. AARP® Vision Discounts provided by EyeMed includes:

- $50 eye exams at participant providers.*
- At LensCrafters, take an additional $50 off the AARP Vision Discount or best in-store offer on no-line progressive lenses with frame purchase.**

Hearing Discount

A discount on hearing aids and access to screenings by certified HearUSA hearing care providers.

The Hearing Care Program by HearUSA includes:

- The AARP member rate plus an additional $100 discount on hearing devices in the top 5 tiers of technology and features, ranging from standard to premium.
- Extended warranties on many of HearUSA's digital hearing aids.
- Your very own hearing health support team.

24/7 Nurse line

A registered nurse is available to discuss your concerns and answer questions over the phone anytime, day or night. Interpretation services are available in Spanish, as well as in 140+ languages.

- Nurses are also available to help guide you to community resources. These resources may help provide assistance on transportation services, understanding medication cost options, and availability of meal delivery services.

Driver Safety

Refresh your driving skills with the **AARP Smart Driver**™ course. The course helps participants brush up on rules of the road and reduce driver distractions.

The course is available online or in-person, and is offered at no additional cost to AARP Medicare Supplement Plan holders.[1] When you take the AARP Smart Driver™ course, you could be eligible for a discount on your auto insurance.[2]

These offers are only available to insured members covered under an AARP Medicare Supplement Plan from UnitedHealthcare. These are additional insured member services apart from the AARP Medicare Supplement Plan benefits, are not insurance programs, are subject to geographical availability and may be discontinued at any time. None of these services should be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. Note that certain services are provided by Affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare.

AARP | Medicare Supplement from UnitedHealthcare

Renew Active by UnitedHealthcare

Participation in the Renew Active™ program is voluntary. Renew Active includes standard fitness membership. Equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Certain services, classes and events are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Participation in the Fitbit® Community for Renew Active is subject to your acceptance of their respective terms and policies.

The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan. Renew Active premium gym and fitness location network only available with certain plans. The Renew Active premium network of gyms and fitness locations is not available to AARP Medicare Supplement Plan holders.

AARP Staying Sharp

UnitedHealthcare will receive, from AARP Staying Sharp, program confirmation code information together with data regarding your usage of AARP Staying Sharp (for example, the number of times you visited their website each month).

Access to this service is subject to your acceptance of Staying Sharp's Terms of Use and AARP's Privacy Policy. Existing Users who have already accepted AARP's Terms of Use and Privacy Policy will not be required to create a new AARP Online Account, but should refer to the additional Terms of Use regarding AARP Staying Sharp. AARP Staying Sharp is the registered trademark of AARP.

Participation in the brain health assessment is voluntary. Your health assessment responses will be kept confidential in accordance with applicable law and will only be used to provide health and wellness recommendations within the AARP Staying Sharp program.

Dentegra Dental Discount

†Dentegra Fee Schedules vs. Fair Health Mean Data

THIS IS NOT INSURANCE and not intended to replace insurance. All decisions about medications and dental care are between you and your dentist or health care provider. The Dentegra dental discount is not a Qualified Health Plan under the Affordable Care Act. Products or services that are reimbursable by federal programs including Medicare and Medicaid are not available on a discounted or complimentary basis. The Dentegra dental discount provides discounts at certain health care providers for dental services. The range of discounts will vary depending on the type of provider, geographic region and service. The Dentegra dental discount does not make payments to the providers of dental services. Individuals who utilize the Dentegra dental discount are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with Dentegra Insurance Company. Dentegra Insurance Company, 560 Mission Street, San Francisco, CA 94105, is the Discount Plan Organization.

AARP Vision Discounts provided by EyeMed

EyeMed Vision Care LLC (EyeMed) is the network administrator of AARP Vision provided by EyeMed. These discounts cannot be combined with any other discounts, promotions, coupons, or vision care plans unless noted herein. All decisions about medications and vision care are between you and your health care provider. Products or services that are reimbursable by federal programs including Medicare and Medicaid are not available on a discounted or complimentary basis. EyeMed pays a royalty fee to AARP for use of the AARP intellectual property. Amounts paid are used for the general purposes of AARP and its members.

*Offer valid at participating providers. 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.

**Present offer to receive a bonus $50 off your AARP Vision Discount or best in-store offer when you purchase a frame and progressive lenses. Complete pair required. Frame and lens purchase cannot be combined with any other offers, discounts, past purchases, readers or non-prescription sunglasses. Valid doctor's prescription required and the cost of an eye exam is not included. Eyeglasses priced from $218.29 to $2,423.33. Discounts are off tag price. Select brands excluded including: Varilux lenses, and Cartier frames. Void where prohibited. See associate for details. Offer expires 12/31/2021. Code 755453.

Hearing program by HearUSA

HearUSA makes available a network of hearing care providers through which AARP members may access AARP Hearing Program Discounts. All decisions about medications, medical care and hearing care are between you and your health care provider. Products or services that are reimbursable by federal programs including Medicare and Medicaid are not available on a discounted or complimentary basis. HearUSA pays a royalty fee to AARP for use of the AARP intellectual property. Amounts paid are used for the general purposes of AARP and its members. HearUSA is not affiliated with AARP or UnitedHealthcare. AARP and UnitedHealthcare do not endorse and are not responsible for the services, products or information provided by this program. You are strongly encouraged to evaluate your own needs.

Hearing aid discount from HearUSA is $100 off already discounted AARP Member pricing for HearUSA hearing aids. Discount only applies to hearing aids in HearUSA pricing levels 1-5 (minimum purchase of $1300 hearing aid required to receive discount.) One complimentary hearing screening and other hearing discounts, services or offerings contingent upon purchase of qualifying hearing aids. Complimentary hearing screening only available from HearUSA Network providers.

Nurse line

The information provided through these services is for informational purposes only. Your health information is kept confidential in accordance with applicable law. This is not a substitute for your doctor's care. Nurses and other representatives from these services cannot diagnose problems or recommend treatment. All decisions about medications, vision care, hearing care, health and wellness care or other care is between you and your health care provider. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

AARP Driver Safety

1 Some facilities charge an administrative fee. When registering, check local course listings for administrative fee information.

2 Upon completion, you may be eligible to receive an auto insurance discount. Other restrictions may apply. Consult your agent for details.

This offer is non-transferrable and void where prohibited.

Your participation in the **AARP Smart Driver**™ course is completely voluntary, and participation will not impact your health coverage. Participation in this offering is subject to your acceptance of the AARP® Smart Driver™ Terms of Use and Privacy Policy.

AARP Medicare Supplement Insurance Plans

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.

AARP Medicare Supplement Insurance Plans 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 agent/producer may contact you.

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

Discover the Real Possibilities of AARP Membership

Membership with AARP means:

- ✓ being part of a community of nearly 38 million members.[1]
- ✓ benefiting from a nonprofit, nonpartisan social-welfare organization that has been advocating for the rights of people age 50 and over for over 60 years.[1]
- ✓ enjoying a range of exclusive discounts and offers such as the examples listed below, plus much more!

Health & Wellness
Discounts on hearing exams, hearing aids, eyeglasses, and prescription drugs, as well as health and wellness tools.

Insurance[2] & Finances
Access to multiple insurance programs, as well as other financial services such as financial planning and free tax preparation for those who qualify.

Home & Auto
Get help with housing and mobility, caregiving, driving, and other resources. Save on home security systems and car maintenance.

Retail & Dining
Discounts on clothing, gifts, and groceries, in addition to restaurants.

Travel & Entertainment
Get help with travel planning and save on car rental, hotel, airline tickets, and more. Get discounts on movie tickets and concessions as well as access to free online games.

Magazine, Advocacy & Community
Join AARP's advocacy efforts or a local AARP chapter in your area. Access to community events and volunteering opportunities.

There's always more to discover with your AARP membership.

Explore these benefits and more by visiting **aarp.org/benefits**

[1] 2018 AARP Annual Report. Retrieved April 9, 2020, from https://www.aarp.org/about-aarp/company/annual-reports/

[2] The AARP benefits described are not a benefit of an insurance program.

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Bright Ways To Save

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.

TAKE $24 OFF with Electronic Funds Transfer

You'll save $2.00 off your total monthly household premium, or $24 per year, 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

Questions? Contact your licensed insurance agent/producer.

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

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

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Plans & Rates

Plans & Rates

AARP | Medicare Supplement from UnitedHealthcare

AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company

Overview of Available Plans

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

The Minnesota Commissioner of Insurance has established two types of Medicare Supplement plans and minimum standards for each. The Extended Basic Medicare Supplement is the most comprehensive and the Basic Medicare Supplement is the least comprehensive. The Extended Basic Plan is a qualified Medicare supplement plan; the Basic plan is not qualified.

Minnesota law also permits the purchase of additional riders with the Basic Plan.

Basic Benefits:

- **Hospitalization:** Part A co-insurance
- **Medical Expenses:** Part B co-insurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance

See Plan Benefit Tables for details about both Plans and available Riders

Extended Basic Plan	Basic Plan	Rider 1: Part A Deductible, Preventive Care, Part B Excess Charges	Rider 2: Part B Deductible[2]	Rider 3: Part A Deductible	Rider 4: Part B Excess Charges	Rider 5: Preventive Care
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance					
Skilled nursing facility coinsurance	Skilled nursing facility coinsurance					
Home Health Care Services and Medical Supplies	Home Health Care Services and Medical Supplies					
Part A Deductible		Part A Deductible		Part A Deductible		
Part B Deductible[1]			Part B Deductible[2]			
Preventive Care		Preventive Care				Preventive Care
Care received outside the U.S.						
	Foreign Travel Emergency					
Part B Excess Charges		Part B Excess Charges			Part B Excess Charges	

[1] **IMPORTANT!** Coverage for the Part B Deductible is **not** available to persons "newly eligible" for Medicare on or after 1/1/2020.

[2] **IMPORTANT!** Rider 2 (Part B Deductible) is **not** available to persons "newly eligible" for Medicare on or after 1/1/2020.

Important Information about the Rates in This Package

The plan rates shown in this package are **2021** rates.

If Medicare decides to make a change for 2021, your AARP® Medicare Supplement Plan benefits will automatically change to match any increase in the deductibles and co-payments.

If you have any questions, please contact your licensed insurance agent/producer.

Cover Page - Rates for Minnesota
Monthly Plan Rates[1]
AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Extended Basic Plan (UW)[2]	Extended Basic Plan (RW)[3]
Standard Rates	
$256.50	$238.75
Standard Rates for Tobacco Users	
$282.15	$262.62

Basic Plan (TW)
Standard Rates
$192.00
Standard Rates for Tobacco Users
$211.20

Rider 1 (XW)[4] Part A Deductible and Part B Excess Charges and Preventive Care	Rider 2 (YW)[5] Part B Annual Deductible
Standard Rates	
$41.00	$17.75
Standard Rates for Tobacco Users	
$45.10	$17.75

Rider 3 (VW)[4] Part A Deductible	Rider 4 (WW)[4] Part B Excess Charges	Rider 5 (ZW)[4] Preventive Care
Standard Rates		
$35.00	$6.25	$5.25
Standard Rates for Tobacco Users		
$38.50	$6.87	$5.77

1 These rates are for plan effective dates from January - December 2021 and may change.

2 This Extended Basic Medicare Supplement Plan is only available to persons eligible for Medicare prior to January 1, 2020.

3 This Extended Basic Medicare Supplement Plan does not include coverage for the Medicare Part B Deductible.

4 The Riders are only available with the Basic Plan.
If you want all the benefits of Riders 3, 4 and 5 select Rider 1.

5 This Rider is only available with the Basic Plan and only available to persons eligible for Medicare prior to January 1, 2020.

Eligibility & Benefits

Eligibility & Benefits

AARP | Medicare Supplement
from UnitedHealthcare

AARP Medicare Supplement Insurance Plans,
insured by UnitedHealthcare Insurance Company

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2021

Medicare Supplement Plans insured by UnitedHealthcare Insurance Company

Your Guide to AARP Medicare Supplement Plans

To help you choose the AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company, to best meet your needs and budget, be sure to look at the information shown in this Guide and the other documents that show the expenses that Medicare pays, the benefits each Plan pays and the costs you will have to pay yourself. 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 50 or over, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage. (If you are age 50-64 and eligible for Medicare by reason of disability or End-Stage Renal Disease, you are only eligible if you enrolled in Medicare Part B within the last 6 months, unless you are entitled to Guaranteed Issue as shown in the following "Guaranteed Issue" section.)

Guaranteed Issue

- Your acceptance in any plan for which you're eligible to enroll 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.
- Also, you may be eligible for Guaranteed Issue of a Medicare supplement plan if you lost or terminated other health coverage under one of the following circumstances. You must provide a copy of the termination notice or letter you received from your prior plan or employer and your Application Form must be received no more than 63 days after the termination date of your prior coverage.

Plans Available Without Underwriting For Applicants Entitled to Guaranteed Issue

MN Guaranteed Issue Situations:	For Applicants Age 50-64 who are eligible for Medicare by reason of disability or End-Stage Renal Disease with:		Documentation Must Include:
	A Medicare Part A Effective Date PRIOR to 1/1/2020.	A Medicare Part A Effective Date on or AFTER 1/1/2020.	
	For Applicants Age 65 and over with:		
	• A 65th birthday PRIOR to 1/1/2020. OR • A Medicare Part A Effective Date PRIOR to 1/1/2020.	A 65th birthday AND Medicare Part A Effective Date on or AFTER 1/1/2020.	
1. Applicant loses, learns they have lost, or drops employer coverage.	Basic Plan (TW) and any of these additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	Basic Plan (TW) and any of these additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	• Applicant's name. • Plan Type – confirmation that it's employer coverage being lost. • Coverage termination date. • Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section about "any other type of health insurance coverage." Note: If your employer coverage was a Medicare Advantage plan, also complete the "Medicare Advantage plans" section.
2. Applicant is enrolled in a Medicare Advantage (MA), other Medicare managed care, Program of All-Inclusive Care for the Elderly (PACE) or Medicare Select plan and: • The plan stops coverage in the area, or • The plan sends notice it will stop coverage, or • Applicant moves out of the service area	Basic Plan (TW) and any of the additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	Basic Plan (TW) and any of the additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	• Applicant's name. • Plan Type – confirmation that it's a Medicare Advantage, other Medicare managed care, Program of All-Inclusive Care for the Elderly (PACE) or Medicare Select plan being lost. • Coverage termination date and one of the termination reasons shown in the first column. • Answer the questions on the Application Form in the "Is your acceptance guaranteed" section and the applicable questions in the "Your past and current coverage" section about "Medicare Advantage plans," "Medicare supplement plans" or "any other type of health insurance coverage."

Continued ...

3. Applicant is enrolled in an MA, other Medicare managed care, PACE or Medicare supplement (including Select) and the plan: • Violates the insurance contract (for example, by failing to provide necessary medical care), or • Was misrepresented in marketing to the individual	Basic Plan (TW) and any of these additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	Basic Plan (TW) and any of these additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	• Applicant's name. • Plan Type – confirmation that it's a Medicare Advantage, other Medicare managed care, Program of All-Inclusive Care for the Elderly (PACE) or Medicare Supplement (including Select) being replaced. • Coverage termination date. • Termination reason. • Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section about "Medicare Advantage plans" or "Medicare supplement plans."
4. Applicant is enrolled in a Medicare supplement plan (including Select) that is involuntarily terminated (for example, company bankruptcy).	Basic Plan (TW) and any of these additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	Basic Plan (TW) and any of these additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	• Applicant's name. • Plan Type – confirmation that it's a Medicare supplement plan being lost. • Insurer name. • Reason for involuntary termination. • If available, documentation of bankruptcy of insurer. • Coverage termination date. • Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section about "Medicare supplement plans."
5. Applicant dropped Medicare supplement coverage to enroll for the first time in an MA, other Medicare managed care, PACE, or Select plan, and dropped that plan within two years.	- If the previous Plan/Rider(s) you had were AARP Medicare Supplement Plan/Rider(s), you may apply for the same Plan/Rider(s) if still available from UnitedHealthcare Insurance Company. If not available: Basic Plan (TW) and any of these additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges - If the previous Medicare Supplement Plan/Rider(s) you had were with another insurer, you may apply for: Basic Plan (TW) and any of these additional optional Riders: Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	- If the previous Plan/Rider(s) you had were AARP Medicare Supplement Plan/Rider(s), you may apply for the same Plan/Rider(s) if still available from UnitedHealthcare Insurance Company. If not available: Basic Plan (TW) and any of these additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges - If the previous Medicare Supplement Plan/Rider(s) you had were with another insurer, you may apply for: Basic Plan (TW) and any of these additional optional Riders: Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges	• Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section about "Medicare Advantage plans."
6. On first enrolling in Medicare Part B**, applicant enrolled in an MA or PACE plan at the same time, and dropped that plan within two years. ****NOTE:** The MA or PACE plan effective date must be equal to the Medicare Part B effective date for this qualifying event to apply.	Extended Basic Plan (UW) **OR** Extended Basic 2020 Plan (RW) **OR** Basic Plan (TW) and any of the additional optional Riders: Rider 1 (XW) Part A Deductible, Part B Excess Charges, Preventive Care Rider 2 (YW) – Part B Annual Deductible Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges Rider 5 (ZW) – Preventive Care	Extended Basic 2020 Plan (RW) **OR** Basic Plan (TW) and any of the optional Riders: Rider 1 (XW) Part A Deductible, Part B Excess Charges, Preventive Care Rider 3 (VW) – Part A Deductible Rider 4 (WW) – Part B Excess Charges Rider 5 (ZW) – Preventive Care	• Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section about "Medicare Advantage plans."

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.

Exclusions

- Benefits provided under Medicare.
- Benefits provided under a Medicare Advantage plan.
- Care not meeting Medicare's standards.
- Stays, care or services for which you would not be charged if you did not have insurance.
- Stays or care which is covered under a prior Medicare supplement plan.
- Charges that are greater than the Medicare Eligible Expenses.
- Cosmetic surgery performed mainly to change a person's appearance. (This exclusion does not apply when coverage is provided for reconstructive surgery.) Eyeglasses or exams, hearing aids or the adjustment of hearing aids. Physician's dental services, x-rays and exams involving the teeth, the tissue or structure around them, the alveolar process, or gums.
- Charges that are more than the usual and customary charge.
- Services or supplies that are not medically necessary for medical care or treatment of a diagnosed sickness or injury.
- Any stay that starts or medical care received for a Pre-existing Condition during the first 3 months after the Plan Effective Date. A Pre-existing Condition means a condition for which medical advice was given or treatment was recommended or received from a physician during the 90 days before the Plan 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.

You Cannot Be Singled Out for Cancellation

Your AARP Medicare Supplement Plan can never be canceled because of your age, your health, or the number of claims you make. Your AARP Medicare Supplement Plan may be canceled due to nonpayment of premium or material misrepresentation. If the group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company. Of course, you may cancel your 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

The Minnesota Commissioner of Insurance has established two types of Medicare supplement insurance and minimum standards for each, with Extended Basic Medicare Supplement being the most comprehensive and Basic Medicare Supplement being the least comprehensive. **Plans RW and UW are qualified Medicare supplement plans. Plan TW is a non-qualified Medicare supplement plan.**

By enrolling, you are agreeing to the release of Medicare claim information to UnitedHealthcare Insurance Company so your AARP Medicare Supplement Plan claims may be processed automatically.

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.

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.

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.**

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

These materials describe the 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.

Plan Benefit Tables: Basic Plan

UnitedHealthcare is required to disclose the following information to you. The Minnesota Commissioner of Insurance has established two types of Medicare Supplement insurance and minimum standards for each. The Extended Basic Medicare Supplement is the most comprehensive and the Basic Medicare Supplement is the least comprehensive. This Basic Plan is approved for use in Minnesota. This is a Non-Qualified Medicare Supplement Plan.

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

Service		Medicare Pays	Basic Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,408	$0	$1,408 (Part A deductible)[2]
	Days 61–90	All but $352 per day	$352 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $704 per day	$704 per day	$0
	After lifetime reserve days are used	$0	100% of Medicare eligible expenses	$0
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 $176.00 per day	$176.00 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 Rider 1 and Rider 3 are optional riders that cover the Part A deductible. Rider 1 covers the Part A deductible as well as Preventive Medical Care and Part B Excess Charges. Rider 3 covers the Part A deductible only. You may purchase Rider 1 or Rider 3 for an additional premium.

Plan Benefit Tables: Basic Plan (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Basic Plan 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 $198 of Medicare-approved amounts[3]	$0	$0	$198 (Part B deductible)[4]
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs[5]
Blood	First 3 pints	$0	All costs	$0
	Next $198 of Medicare-approved amounts[3]	$0	$0	$198 (Part B deductible)[4]
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0
Most Outpatient Mental Health Services (Medicare-approved amount)		80%	20%	$0
Independent Outpatient Therapy (Physical, occupational, speech) - Subject to calendar year maximum of $2040		80%	20%	Amounts over $2040 per year

Parts A and B

Service		Medicare Pays	Basic Plan 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 $198 of Medicare-approved amounts[3]	$0	$0	$198 (Part B deductible)[4]
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

3 Once you have been billed $198 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

4 Rider 2 is an optional rider that covers the Part B deductible. You may purchase Rider 2 for an additional premium.

5 Rider 1 and Rider 4 are optional riders that cover Part B excess charges. Rider 1 covers Part B excess charges as well as the Part A deductible and Preventive Medical Care not covered by Medicare. Rider 4 covers Part B excess charges only. You may purchase Rider 1 or Rider 4 for an additional premium.

Plan Benefit Tables: Basic Plan (continued)

Other Benefits not covered by Medicare

Service	Medicare Pays	Basic Plan 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.	$0	80% of the usual and prevailing charge	20% and amounts over the usual and prevailing charge
Preventive Medical Care NOT COVERED BY MEDICARE	$0	$0	All costs[6]
Immunizations and Cancer Screening Routine immunizations and cancer screening tests including mammograms, surveillance tests for women who are at risk for ovarian cancer, pap smears, colorectal screening tests, and prostate cancer screening.	$0	100% of the costs	$0
Diabetic Equipment and Supplies	$0	80% of the usual and prevailing charge up to the maximum charge allowed by law	20% and amounts over the usual and prevailing charge
Scalp Hair Prosthesis	$0	80% of the usual and prevailing charge (limited to one each calendar year)	20% and amounts over the usual and prevailing charge
Additional Benefits Reconstructive surgery, surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders, and care provided in an ambulatory surgical center.	$0	The usual and prevailing charge	Any charge above the usual and prevailing charge

6 Rider 1 and Rider 5 are optional riders that cover Preventive Medical Care not covered by Medicare. Rider 1 covers Preventive Medical Care not covered by Medicare as well as the Part A deductible and Part B excess charges. Rider 5 covers Preventive Medical Care not covered by Medicare only. You may purchase Rider 1 or Rider 5 for an additional premium.

Plan Benefit Tables: Extended Basic Plan

UnitedHealthcare is required to disclose the following information to you. The Minnesota Commissioner of Insurance has established two types of Medicare Supplement insurance and minimum standards for each. The Extended Basic Medicare Supplement is the most comprehensive and the Basic Medicare Supplement is the least comprehensive. This Extended Basic Plan is approved for use in Minnesota. This is a Qualified Medicare Supplement Plan.

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

Service		Medicare Pays	Extended Basic Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
	Days 61–90	All but $352 per day	$352 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $704 per day	$704 per day	$0
	After lifetime reserve days are used	$0	100% of Medicare eligible expenses	$0
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 $176.00 per day	$176.00 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.

Plan Benefit Tables: Extended Basic Plan (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Extended Basic Plan 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 $198 of Medicare-approved amounts[2]	$0	$198 (Part B deductible) or $0[3]	$0 or $198 (Part B deductible)[3]
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100% of Part B Excess Charges*	Any costs not paid by Medicare or this Plan*
Blood	First 3 pints	$0	All costs	$0
	Next $198 of Medicare-approved amounts[2]	$0	$198 (Part B deductible) or $0[3]	$0 or $198 (Part B deductible)[3]
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0
Most Outpatient Mental Health Services (Medicare-approved amount)		80%	20%	$0
Independent Outpatient Therapy (Physical, occupational, speech) - Subject to calendar year maximum of $2040		80%	20%	Amounts over $2040 per year

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Notes
2 Once you have been billed $198 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
3 Coverage for the Part B Deductible is only available to persons eligible for Medicare prior to January 1, 2020.
*Billing for excess charges is prohibited in Minnesota except for Ambulance Services and Durable Medical Equipment. For these charges, the maximum benefit is 80% of Usual and Customary charges before the $1,000 out of pocket limit is met; the maximum benefit is 100% of Usual and Customary charges after the limit is met.

Plan Benefit Tables: Extended Basic Plan (continued)

Parts A and B

Service		Medicare Pays	Extended Basic Plan 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 $198 of Medicare-approved amounts[2]	$0	$198 (Part B deductible) or $0[3]	$0 or $198 (Part B deductible)[3]
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

2 Once you have been billed $198 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

3 Coverage for the Part B Deductible is <u>only</u> available to persons eligible for Medicare prior to January 1, 2020.

DESCRIPTION OF BENEFITS FOR EXPENSES NOT COVERED BY MEDICARE

These benefits are for expenses that are not covered by Medicare. These benefits are payable only if the charge for the stay, care, service or supply is not a Medicare Eligible Expense.

We will not pay benefits under this Plan that duplicate benefits provided by Medicare. We will not pay benefits for stays, care or services for which Medicare would have paid benefits if a claim had been submitted. There is no benefit for any item or service eligible for Part D coverage, whether or not you have such coverage. Payment of benefits will not exceed any charge limitation established by the Medicare program or state law.

1. Hospital Stays

This Plan will pay 80% of the Usual and Customary Charge if you are confined for inpatient care in a Hospital and the stay is not covered by Medicare. This Plan will pay for Hospital room and board, and other services and supplies furnished by the Hospital for medical care.

This benefit has these added requirements

Benefits will be paid up to the maximum charge amount allowed by law.

This Plan will not pay benefits for a private room if the charge is more than the Hospital's charge for its most common semi-private room, unless a private room is prescribed as Medically Necessary by your Physician.

2. Medical Care

This Plan will pay 80% of the Usual and Customary Charge for the following Covered Expenses when the charges are not paid by Medicare or otherwise covered under this Plan.

This benefit has these added requirements

Benefits will be paid up to the maximum charge amount allowed by law.

Payment of benefits will not duplicate benefits payable under Medicare or any other coverage provided by this Plan.

These Covered Expenses include the following:

A. **Physician Services** – Physician services for the diagnosis and treatment of Sickness or Injury. This includes a second opinion from a Physician on any surgical procedure expected to cost at least $500 in Physician, laboratory and Hospital fees.
B. **Nursing Home Services** – Nursing Home services for the following:
   a. Nursing Home room and board for regular daily services and supplies furnished by the Nursing Home. This Plan will not pay benefits for a private room if the charge is more than the Nursing Home's charge for its most common semi-private room, unless a private room is prescribed as Medically Necessary by your Physician. If the Nursing Home does not have semi-private rooms, its most common semi-private room charge will be 90% of its lowest private room charge.
   b. All other services and supplies furnished by the Nursing Home for medical care.
   Benefits will not be paid for more than 120 days in a calendar year. Your Nursing Home stay must start within 30 days after you are Hospital confined for at least three days in a row for the same or

related Sickness or Injury. You must need nursing care 24 hours a day to treat your Sickness or Injury.

C. **Therapy** – Treatment by a physical therapist or occupational therapist at the direction of your Physician.

D. **Oral Surgery** – Oral surgery for partially or completely unerupted impacted teeth, a tooth root without extraction of the entire tooth, or the gums and tissue of your mouth. Benefits will not be paid for oral surgery performed in connection with the extraction or repair of teeth. Benefits will not be paid for root canal, gingivitis or periodontal disease.

E. **Ambulance** – Ambulance transportation provided by a licensed ambulance service to the nearest facility qualified to treat your Sickness or Injury. This includes a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

F. **Other Services and Supplies** – The following other services and supplies:
   - Use of radium or other radioactive materials
   - Oxygen
   - Anesthetics and their administration
   - Artificial limbs, eyes, larynx, and other prosthetic devices (other than dental, but including scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata;
     see the “Additional State Mandated Benefits” section for scalp hair prosthesis benefit limitations)
   - Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids
   - Diagnostic x-ray exam and laboratory tests

G. **Home Health Agency** – Home Health Agency services for the following:
   a. Part-time or intermittent home nursing care by or under the supervision of a Registered Nurse.
   b. Part-time or intermittent home health aide services, primarily for your care.

   You must receive services in your home by a member of a Home Health Agency. Services must be for the care and treatment of your Sickness or Injury. If you could not receive these services in your home, confinement in a Hospital or nursing facility would be needed for you to receive the required care. Each visit by a member of a Home Health Agency shall be considered as one visit. Benefits will not be paid for prescription drugs included in the home care plan of treatment. For care received outside the United States, you must receive home health services outside a hospital or nursing home facility.

H. **Emergency Services** – Emergency services 24 hours a day and seven days a week for the treatment of an Emergency Medical Condition.

3. Care received outside the United States

Medicare usually does not cover care you receive outside the United States. In most cases, you are responsible for the full cost of care you receive outside the United States.

This Plan covers certain care while you are on a Trip outside the United States.

This Plan will pay 80% of the Usual and Customary Charge for the services described above as Hospital Stays and Medical Care under the “Description of Benefits for Expenses Not Covered by Medicare.” This Plan will pay these benefits if the services you received while in a foreign country would have qualified as Medicare Eligible Expenses if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid for a stay or care only if these three things are true:

1. The service is not covered by Medicare, but would have been covered by Medicare if it had been received in the United States.
2. The service is received on or after your Effective Date while you are in a foreign country.
3. The person providing medical care cannot be you or your spouse; your or your spouse's child, brother, sister or parent.

The following exclusions apply to this benefit:

1. Benefits are not payable for charges in excess of any charge limitation established by Medicare or Minnesota law.
2. If you establish residency outside the United States, we will not pay benefits for any service or supply rendered in the foreign country.

You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

Payment of benefits will not duplicate benefits payable under Medicare or any other coverage provided by this Plan.

4. Preventive Medical Care

This Plan will pay benefits for the the actual charges up to 100% of the Medicare-approved amount for the following preventive health services:

a. An annual clinical preventive medical history and physical examination. This examination may include tests and services from paragraph b. below and patient education to address preventive health care measures.
b. Preventive screening tests and preventive services. The selection and frequency of these tests and services must be medically appropriate as determined by your Physician.

This Plan will pay benefits for these preventive health services, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes. The preventive health service must be received on or after the Effective Date. This benefit has a limit of $120 each calendar year for all preventive health services combined.

This benefit will not be paid for any preventive health service that is:

- covered by Medicare.
- performed for the treatment of a Sickness or Injury.
- used to diagnose or treat a condition that has already manifested itself.

5. Additional State-Mandated Benefits

This Plan will pay benefits for the following care and services only if these two things are true:

a. The procedure must be deemed appropriate by your Physician.
b. The procedure must be received on or after your Effective Date.

Payment of benefits will not duplicate benefits payable under Medicare or any other coverage provided by this Plan.

A. Alcoholism, Chemical Dependency, Drug Addiction

This Plan will pay 80% of the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as coverage for any other condition when treatment is provided for: (1) outpatient chemical dependency and alcoholism services that must not place a greater financial burden on the Insured or be more restrictive than those requirements and limitations for outpatient medical services; (2) inpatient hospital and residential chemical dependency and alcoholism services that must not place a greater financial burden on the Insured or be more restrictive than those requirements and limitations for inpatient hospital medical services.

B. Ambulatory Surgical Center Services

This Plan will pay 80% of the Usual and Customary Charge for care provided in an Ambulatory Surgical Center

C. Court-ordered Mental Health Services

This Plan will pay 80% of the Usual and Customary Charge, when ordered by a court of competent jurisdiction, for mental health services issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist which includes the diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Coverage is contingent on the evaluation and court-ordered treatment plan being performed by a participating provider or another provider as required by law.

D. Diabetes Equipment and Supplies; Diabetes Outpatient Self-Management Training and Education

This Plan will pay 80% for all Physician-prescribed, Medically Necessary diabetic equipment and supplies (includes oral and injectable insulin) for diabetes self-management training and self-education classes, medical nutrition therapy, and treatment of diabetes not otherwise covered under Part D of the Medicare program. The Plan coverage for diabetes outpatient self-management training and education, including medical nutrition therapy, is covered when provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage includes persons with gestational, Type I, or Type II diabetes, subject to the Medicare Part B Deductible.

E. Immunizations

This Plan will pay 100% of the cost of routine immunizations that are not covered under Medicare.

Immunizations include any medically recognized vaccine intended to produce immunity against a specified disease or condition.

F. Lyme Disease Benefit

This Plan will pay for treatment of Lyme Disease to the same extent that we pay for treatment of any other Sickness.

G. Mental Health Services Benefit

This Plan will pay 80% of the Usual and Customary Charge for outpatient mental health covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition if they are Medically Necessary.

H. Phenylketonuria Treatment

This Plan will pay 80% of Covered Expenses for special dietary treatment for phenylketonuria when recommended by a Physician.

I. Reconstructive Surgery

This Plan will pay 80% of the Usual and Customary Charge for the following types of care:

- Reconstructive surgery. The surgery must be incidental to or following surgery for Injury, Sickness, or other diseases of the involved part.
- Reconstructive breast surgery following mastectomies if mastectomy is Medically Necessary. This includes all stages of reconstruction of the breast on which the mastectomy has been performed, surgery, and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas.

J. Routine Cancer Screening

This Plan will pay 100% of the cost of routine cancer screening procedures that are not covered under Medicare. Cancer screening procedures include:

- Mammograms. Coverage for preventive mammogram screening that includes digital breast tomosynthesis (3D) for women who are at risk for breast cancer.
- Surveillance tests for ovarian cancer for women who are at risk for ovarian cancer (annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination, or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute).
  - "At risk for ovarian cancer" means (1) having a family history with one or more first or second degree relatives with ovarian cancer, of clusters of women relatives with breast cancer, or of nonpolyposis colorectal cancer, or (2) testing positive for BRCA1 or BRCA2 mutations.
- Papanicolaou tests (pap smears)
- Colorectal screening tests
- Prostate cancer screening consisting at a minimum of a prostate-specific antigen blood test and a digital rectal examination

K. Scalp Hair Prosthesis
This Plan will pay 80% of the Usual and Customary Charge for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, This Plan has a limit of one (1) scalp hair prosthesis per calendar year.

L. Temporomandibular Joint Disorder and Craniomandibular Disorder
This Plan will pay 80% of the Usual and Customary Charge for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a Physician or dentist.

M. Ventilator Dependent Benefit
This Plan will pay 80% of the Usual and Customary Charge for services by a private-duty nurse or personal care assistant to a ventilator-dependent person in the person's home. The Plan pay the Usual and Customary Charge for services provided by a private-duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a licensed hospital, not to exceed 120 hours. The personal care assistant or private-duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the ventilator-dependent patient.

6. **Out-of-pocket expenses** – After total out-of-pocket Covered Expenses of $1,000 are paid in any calendar year by you, all benefits not subject to an annual limit will be paid at 100% of the Usual and Customary Charge for the rest of the calendar year.

Rules and Disclosures about this Insurance

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

Renewability and Premium information

This plan is Guaranteed Renewable. You may keep your Medicare supplement 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 following approval by the Minnesota Commissioner of Commerce. Any change will apply to all members of the same class insured under your plan who reside in your state.

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
P.O. 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 within 10 days. 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.

THESE PLANS DO NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THESE PLANS DO NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DO NOT COVER ALL CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR CERTIFICATE CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR CERTIFICATE.

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.

Exclusions

These plans do not provide coverage for the following:

- Benefits provided under Medicare
- Benefits provided under a Medicare Advantage Plan
- Care not meeting Medicare's standards
- Care for which you have no obligation to pay
- Charges greater than Medicare eligible expenses
- Cosmetic surgery, except that this exclusion does not apply when coverage is provided for Reconstructive surgery
- Dental charges, except that this exclusion does not apply to treatment of a malignant tumor (or its removal), craniomandibular disorder, temporomandibular joint disorders or malocclusion
- Eyeglasses and hearing aids
- Charges for more than the usual and customary charge
- Unnecessary charges

Loss Ratio

These plans provide an anticipated average loss ratio of at least 75%. This means that, on average, certificateholders may expect that at least $75 of every $100 in premium will be returned as benefits to certificateholders.

Forms

Forms

AARP | Medicare Supplement
from UnitedHealthcare

AARP Medicare Supplement Insurance Plans,
insured by UnitedHealthcare Insurance Company

AARP | Medicare Supplement
from UnitedHealthcare

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; if requesting, you may deduct $2 from the first month's household premium check.

- ❑ Submit the completed form (signed and dated).

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.

TEAR HERE

Application Form

AARP® Medicare Supplement Insurance Plans

Insured by
UnitedHealthcare Insurance Company (UnitedHealthcare),
Horsham, PA 19044

Instructions

1. Fill in all requested information on this Application Form and sign in all places a signature is needed.
2. Print clearly, using CAPITAL letters AND black or blue ink - not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure
3. Initial any changes or corrections you make while completing this Application Form.

Note: Plans and rates are only good for residents of the state of Minnesota. The information you provide on this Application Form will be used to determine your acceptance and rate.

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

Applicant First Name MI Last Name

Permanent Home Address Line 1 (P.O. Box/PMB is not allowed)

Permanent Home Address Line 2 City State Zip

Mailing Address Line 1 (if different from permanent address)

Mailing Address Line 2 City State Zip

TEAR HERE

1 Provide additional information about yourself and your Medicare Insurance.

( ) -

1A. Phone Number **1B.** Email address (optional). Include periods (.) and symbols (@).

By providing your address, phone number and/or email address, you are agreeing to receive information and be contacted by UnitedHealthcare Insurance Company.

1C. Birthdate ____/____/____ (Month Day Year) **1D.** Gender ☐ Male ☐ Female

1E. Medicare Number______________________ (From your Medicare card.)

1F. Medicare Start: Hospital (Part A) ____ / 01 / ____ (Month Year) Medical (Part B) ____ / 01 / ____ (Month Year)

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

2460720307 _AGT

TEAR HERE

First Name Last Name

2 Choose your Plan and start date.

Plan Choice

2A. You are eligible to apply if all of these are true:

- you are an AARP member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A and B,
- you are not enrolled in more than one Medicare supplement plan at the same time,
- if you are not yet age 65, you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are an "Eligible Person" entitled to guaranteed acceptance as shown in "Your Guide."

Please choose a Plan or Plan/Rider(s) combo from the right-hand column. Important: The *Extended Basic Plan (UW) and Part B Annual Deductible Rider 2 (YW) are only available to eligible Applicants with a 65th birthday prior to 1/1/2020 or a Medicare Part A Effective Date prior to 1/1/2020 due to first becoming eligible for Medicare by reason of age or disability. Please call if you have questions.

☐ Extended Basic Plan (UW)*
☐ Extended Basic 2020 Plan (RW)
☐ Basic Plan (TW)

If you are enrolling in Basic Plan (TW), you can add additional option riders for which you're eligible to enroll:

☐ Rider 1 (XW) – Part A Deductible ***and*** Part B Excess Charges ***and*** Preventive Care
☐ Rider 2 (YW) – Part B Annual Deductible*
☐ Rider 3 (VW) – Part A Deductible
☐ Rider 4 (WW) – Part B Excess Charges
☐ Rider 5 (ZW) – Preventive Care

Plan Start Date

2B. Your Plan will start on the first day of the month following receipt and approval of this Application Form 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"? **If YES, see Your Guide for the documentation you will need to provide from your prior insurer or employer.** ☐Yes ☐No

- If **YES**, and you are applying for a Plan that is eligible for guaranteed acceptance as defined in the Guaranteed Acceptance Section in "Your Guide", skip directly to **Section 7**.

If **YES** and you are applying for a Plan that is **NOT** eligible for guaranteed acceptance as defined in the Guaranteed Acceptance Section in "Your Guide", continue to **Section 4**.

Note: Applicants age 50-64 who answer **YES** and are eligible for Medicare by reason of disability or ESRD may only apply for the Plans shown in the Guaranteed Acceptance Section in "Your Guide".

- If you answered **NO** to both questions in **Section 3** and you are:
  - **age 65 or over,** continue to **Section 4**.
  - **age 50-64 and eligible for Medicare by reason of disability or ESRD, you are NOT eligible to apply for these Plans**.

TEAR HERE

TEAR HERE

First Name Last Name

4 Answer this health question 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

If you answered YES or NOT SURE to question 4A, we may follow up for additional information.

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. Within the past 2 years, did a medical professional tell you that you may need any of the following that **has NOT been completed**? • hospital admittance as an inpatient • joint replacement • organ transplant • surgery for cancer • back or spine surgery • heart or vascular surgery	☐Yes ☐No ☐Not Sure
5D. 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
5E. Within the past 2 years, did you have (as determined by a medical professional) or were you diagnosed, treated, given medical advice or prescribed medications/refills for any of the following conditions?	
• Atrial Fibrillation or Flutter	☐Yes ☐No ☐Not Sure
• 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
• End-Stage Renal (Kidney) Disease or Require Dialysis	☐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
• Macular Degeneration, but only if you have the wet form	☐Yes ☐No ☐Not Sure
• Multiple Sclerosis	☐Yes ☐No ☐Not Sure
• Rheumatoid Arthritis	☐Yes ☐No ☐Not Sure
• Systemic Lupus Erythematosus (SLE)	☐Yes ☐No ☐Not Sure

TEAR HERE

First Name Last Name

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

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 may follow up for additional information.

TEAR HERE

6 Tell us about your medical providers.

Provide the following information for all physicians that you have seen within the past two years. We may follow up with your physicians for additional information. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it. ☐

( ) -

Primary Physician Phone #

Address

City State ZIP Code

Specialist Name Specialty

Diagnosis/Condition

Specialist Name Specialty

Diagnosis/Condition

TEAR HERE

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 "Cover Page - Rates."

8 Your past and current coverage

Review the statements.

- Loss Ratio: These plans provide an anticipated loss ratio of 75%. This means that, on average, plan holders may expect that $75 of every $100 in premiums will be returned as benefits to plan holders.
- 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.

TEAR HERE

First Name Last Name

8 Your past and current coverage (continued)

• You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

• If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, 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 your employer or union-based group health plan.

• 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).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your Application Form.

PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge, **8A.** Did you turn age 65 <u>in the last 6 months</u>?	☐Yes ☐No
8B. Did you enroll in Medicare Part B <u>within the last 6 months</u>?	☐Yes ☐No
8C. If YES, what is the effective date?	___/___/___ Month Day Year
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
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

TEAR HERE

TEAR HERE

First Name Last Name

8 Your past and current coverage (continued)

8H. Provide the start and end dates of your Medicare plan other than original Medicare. If you are still covered under this plan, leave the end date blank.	**Start Date** ___/___/___ Month Day Year **End Date** ___/___/___ Month Day Year
8I. If you are still covered under the Medicare plan other than original Medicare, 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.)	☐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
Questions about Medicare supplement plans	
8L. Do you have another Medicare supplement policy in force? If so, what insurance company and what plan do you have? Insurance 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?	☐Yes ☐No
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 insurance company and what kind of policy? **Insurance 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

✗ ______________________ **Your Signature** (required)

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

TEAR HERE

TEAR HERE

First Name Last Name

9 Authorization and Verification of Application Information

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

- I represent the answers on this Application Form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this Application Form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premiums or reduce my benefits, subject to the certificate provision, Effects of Statements You Made to Us.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.
- I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.

If the Application Form is being completed through an Agent or Broker:

- I understand an agent or broker discussing Plan options with me is appointed by UnitedHealthcare Insurance Company, and may be compensated based on my enrollment in a Plan.
- I understand that an agent or broker cannot change or waive any terms or requirements related to this Application Form and its contents, underwriting, premium or coverage and cannot grant approval.

Authorization for the Release of Medical Information

I authorize UnitedHealthcare Insurance Company and its affiliates ("The Company") to obtain from any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution or person, or The Company's own information, any data or records about me or 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. 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 only as permitted under applicable federal or state law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand that I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, I understand that I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage. I understand that I or my authorized representative may obtain a copy of this form. This authorization excludes the release of information about the results of tests performed to determine the presence of bloodborne pathogens which include, but are not limited to, the Hepatitis B virus (HBV), the Hepatitis C virus (HCV) and the Human Immunodeficiency virus (HIV), which were administered: 1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota Security Hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law.

TEAR HERE

First Name Last Name

9 Authorization and Verification of Application Information (continued)

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 90 days prior to the insurance effective date.

My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.

✗ ______________________________ **Your Signature** (required)

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

Note: If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐

10 For Agent/Broker Use Only

Agent/Broker must complete the following information and include the notice of replacement coverage, if appropriate, with this Application Form. All information must be complete or the Application Form 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

✗ ______ Agent Signature (required) ______ Agent ID (required) ___ / ___ / ___ Today's Date (required) Month Day Year

______ Agent Email Address ( ) - Agent Phone Number

✗ ______ Broker Name ______ Broker ID

TEAR HERE

TEAR HERE

AARP BENEFITS are worth far more than the cost of membership.

HEALTHCARE PRODUCTS & SERVICES
access to health and dental insurance products, as well as vision and prescription discounts

AWARD-WINNING PUBLICATIONS
including *AARP The Magazine*, the *AARP Bulletin*, and free guides on financial planning and health

PROTECTION OF YOUR RIGHTS
in Washington and your state government to strengthen Medicare and Social Security, confront age discrimination and protect pension benefits

TRAVEL DISCOUNTS
on hundreds of hotels, resorts, car rentals, tours, cruises and plane fares worldwide

FINANCIAL SERVICES access to life, auto and homeowners insurance, AARP-endorsed credit card, plus investment program options

COMMUNITY INVOLVEMENT
Local chapters with volunteer opportunities, social activities, Driver Safety Courses, and AARP Foundation Tax-Aide program

Join or renew and save 25% when you sign up for Automatic Renewal!

Save 25% off AARP standard yearly price for your first year when you select Automatic Renewal.

Visit agntu.aarpenrollment.com
Or call 1-866-331-1964

Complete the following Membership Activation Form if you don't already have an AARP membership or if it's coming up for renewal or expired.

TEAR HERE

BA25522ST

AARP® Real Possibilities

MEMBERSHIP ACTIVATION FORM

YES, I want to join AARP or renew by mail!
Check or money order enclosed, payable to AARP.
(Send no cash, please.)

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

Your Name (please print)______________________________

Address______________________________ Apt._______

City ______________________ State _____ Zip_______

Date of Birth _________ / _________ / _________
Month Day Year

For FREE Spouse/Partner Membership

Spouse's/Partner's Name______________________________

Date of Birth _________ / _________ / _________
Month Day Year

VCGFDAUH

AA25002ST

OR

Yes, I want to join or renew with Automatic Renewal and SAVE 25%

Visit agntu.aarpenrollment.com
Or call 1-866-331-1964

Why sign up for Automatic Renewal?

Saves time with fewer mailings. It's safe, secure and you can cancel at any time.

With AARP automatic renewal, you will be charged $12 for your first year. For any subsequent year you remain enrolled, you will be charged the full annual rate (currently $16) on the first day of the month in which your membership expires. You may cancel at any time by calling 1-800-516-1993.

TEAR HERE

AGT

Here are some featured health related benefits of AARP that you'll have access to as a member:

- ✔ Supplemental Health Insurance
- ✔ Dental Coverage
- ✔ Hearing Care Program
- ✔ Vision Care Discounts
- ✔ Prescription Discounts
- ✔ AARP® Staying Sharp
- ✔ Health Tools
- ✔ Online Recipe Database
- ✔ Hearing Center
- ✔ Family Caregiving Resources
- ✔ Housing and Mobility Resources
- ✔ Local Assistance Directory

AARP®
Real Possibilities

Act now and make the most of membership.

Join or renew with Automatic Renewal and save 25% your first year!

SAVE 25%

Visit agntu.aarpenrollment.com

Or call 1-866-331-1964

Return this form in the enclosed envelope.

Please allow 3-4 weeks for delivery of your Membership Kit. Dues are not deductible for income tax purposes. One membership also includes spouse/partner. Some 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 general purposes of AARP. Some provider offers are subject to change and may have restrictions. Please contact the provider directly for details. Annual dues include $4.03 for a subscription to *AARP The Magazine* and $3.09 for the *AARP Bulletin*. Dues outside U.S. domestic mail limits: $17/one year for Canada and Mexico, $28/one year for all other countries. When you join, 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 member@aarp.org. We may steward your resources by converting your check into an electronic deposit.

Stop worrying about payment due dates. Sign up for Electronic Funds Transfer (EFT).

TEAR HERE

With automatic payments through the Electronic Funds Transfer (EFT) service, your monthly premium is automatically deducted from your bank account on or around the fifth of each month. No more looking for stamps or worrying if your payment will arrive on time. And you save $2 every month—up to $24 a year.*

Sign up in 3 easy steps.

1. Fill out the front side of the Authorization Form attached below.
2. Write a check for your next payment. Be sure the check is for the account you want your automatic payments to be withdrawn from.
3. Mail your check, payment coupon, and Authorization Form in the envelope provided. Please don't send a deposit slip or canceled check.

When signing up for EFT, here are a few important details to keep in mind:

- Your EFT start date will be during the first month after your EFT form is processed.
- You'll receive a confirmation letter that includes the amount of the withdrawal. Until then, continue to use your monthly premium coupons to make your payments.
- 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, you'll receive a letter explaining how to make the payment that is due.

*Certain discounts may not be available to Medicare supplement plan holders in certain states.

TEAR HERE

Be sure to keep a copy of this form for your records.

AGT

EFT AUTHORIZATION FORM ***Please read both sides of this form before signing below.***

Insured 1 Name:

Bank Name: ____________________

Bank Routing Number: ____________________ Bank Account Number: ____________________

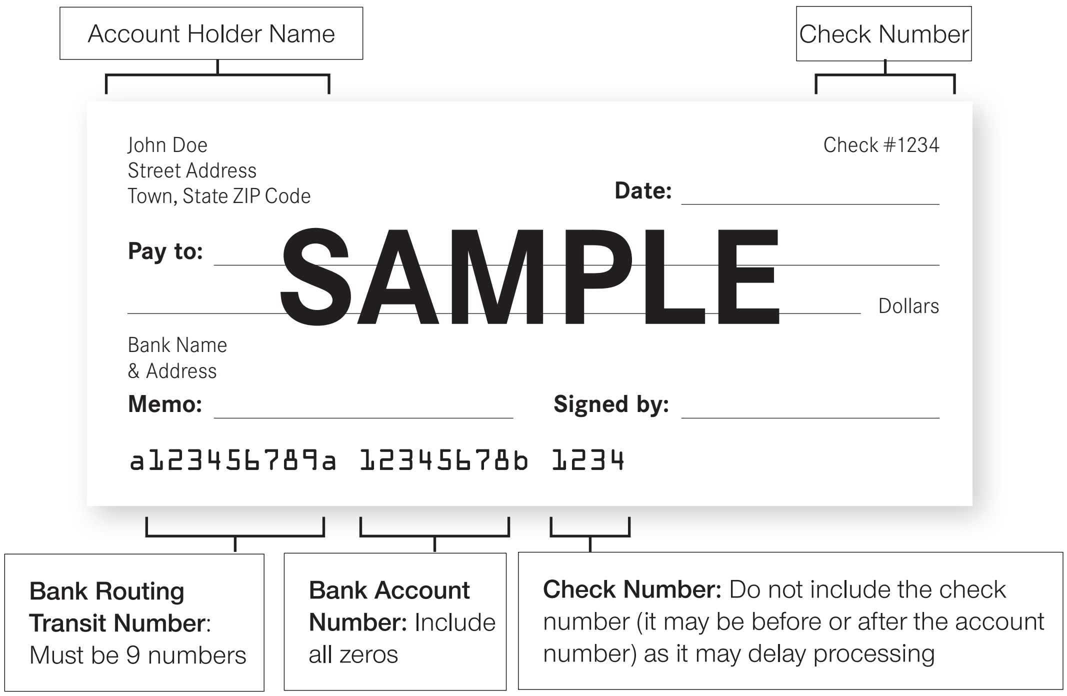
Account Type: ☐ Checking ☐ Savings (statement savings only)

Bank Account Holder's Name (if different from Member): ____________________

Bank Account Holder's Signature: ____________________ Date ____________

MI10098ST (08-20)

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



EFT AUTHORIZATION

I allow UnitedHealthcare Insurance Company and affiliates (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.

TEAR HERE

Stop worrying about payment due dates. Sign up for Electronic Funds Transfer (EFT).

With automatic payments through the Electronic Funds Transfer (EFT) service, your monthly premium is automatically deducted from your bank account on or around the fifth of each month. No more looking for stamps or worrying if your payment will arrive on time. And you save $2 every month—up to $24 a year.*

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1. Fill out the front side of the Authorization Form attached below.
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3. Mail your check, payment coupon, and Authorization Form in the envelope provided. Please don't send a deposit slip or canceled check.

When signing up for EFT, here are a few important details to keep in mind:

- Your EFT start date will be during the first month after your EFT form is processed.
- You'll receive a confirmation letter that includes the amount of the withdrawal. Until then, continue to use your monthly premium coupons to make your payments.
- 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, you'll receive a letter explaining how to make the payment that is due.

*Certain discounts may not be available to Medicare supplement plan holders in certain states.

TEAR HERE

Be sure to keep a copy of this form for your records.

AGT

EFT AUTHORIZATION FORM ***Please read both sides of this form before signing below.***

Insured 1 Name:

Bank Name: __________

Bank Routing Number: __________ Bank Account Number: __________

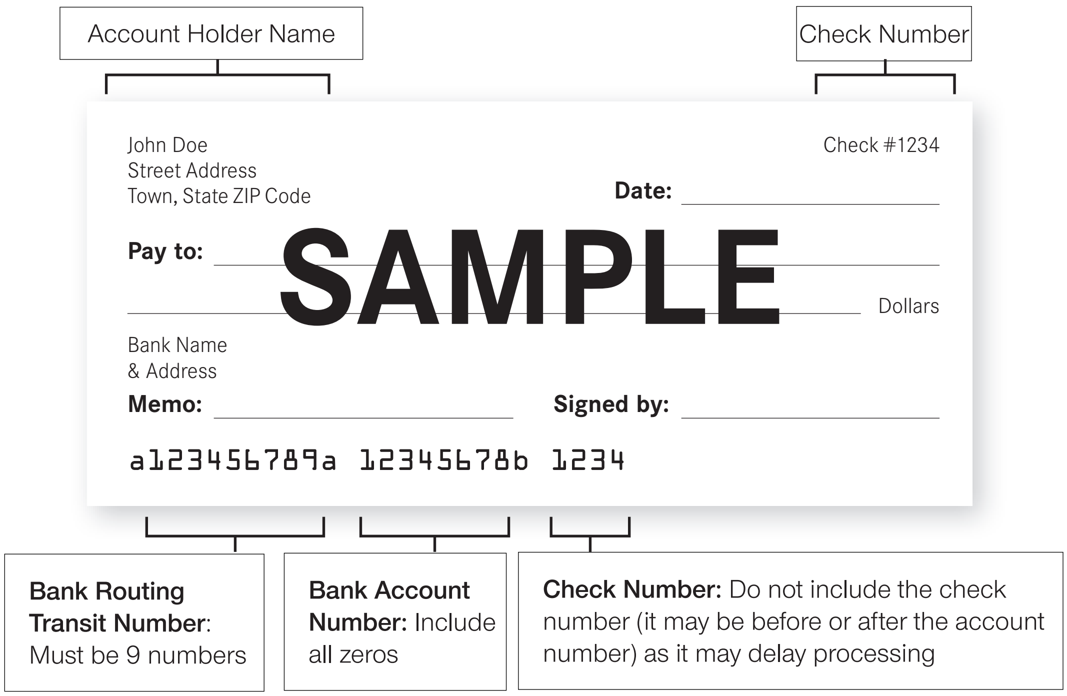
Account Type: ☐ Checking ☐ Savings (statement savings only)

Bank Account Holder's Name (if different from Member): __________

Bank Account Holder's Signature: __________ Date __________

MI10098ST (08-20)

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



EFT AUTHORIZATION

I allow UnitedHealthcare Insurance Company and affiliates (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.

TEAR HERE

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.

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.

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

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

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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) ____________________

____

____

TEAR HERE

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)

Glossary: Prescription Drugs

Partial Prescription Drug List

Drug Name	Medical Condition(s)
Abatacept	Rheumatoid arthritis
Abemaciclib	Cancer
Abiraterone Acetate	Cancer
Aclidinium Br-Formoterol Inh Powd	Chronic obstructive pulmonary disease, emphysema
Aclidinium Bromide Aerosol	Chronic obstructive pulmonary disease, emphysema
Actemra	Rheumatoid arthritis
Adalimumab	Rheumatoid arthritis
Afatinib	Cancer
Afinitor	Cancer
Aflibercept	Wet Macular degeneration
Aggrenox	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Aldactone	Congestive heart failure, Cardiomyopathy
Alecensa	Cancer
Alectinib	Cancer
Alemtuzumab	Multiple Sclerosis
Amiloride	Congestive heart failure
Amiodarone	Atrial fibrillation or flutter
Ampyra	Multiple Sclerosis
Anakinra	Rheumatoid arthritis
Anoro Ellipta	Chronic obstructive pulmonary disease, emphysema
Apalutamide	Cancer
Apixaban	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Aprepitant	Cancer
Aranesp	End-stage renal disease
Arava	Rheumatoid arthritis
Arixtra	Artery or vein blockage
Aromasin	Cancer

Drug Name	Medical Condition(s)
Aspirin-Dipyridamole	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Aubagio	Multiple Sclerosis
Avastin	Wet Macular degeneration
Avonex	Multiple Sclerosis
Baricitinib	Rheumatoid arthritis
Belimumab	Systemic lupus erythematosus
Benlysta	Systemic lupus erythematosus
Beovu	Wet Macular degeneration
Betapace	Congestive heart failure, cardiomyopathy, atrial fibrillation or flutter
Betaseron	Multiple Sclerosis
Bevacizumab	Wet Macular degeneration
Bicalutamide	Cancer
Bortezomib	Cancer, lymphoma
Brilinta	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Brolucizumab	Wet Macular degeneration
Calcitriol	Chronic kidney disease
Calcium Acetate	End-stage renal disease
Capecitabine	Cancer
Casodex	Cancer
Certolizumab	Rheumatoid arthritis
Chloroquine	Systemic lupus erythematosus
Cilostazol	Artery or vein blockage, peripheral vascular disease
Cimzia	Rheumatoid arthritis
Cinacalcet	End-stage renal disease
Clopidogrel	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Copaxone	Multiple Sclerosis
Cordarone	Atrial fibrillation or flutter
Corlanor	Congestive heart failure
Coumadin	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Cyclophosphamide	Cancer, leukemia, lymphoma

Drug Name	Medical Condition(s)
Cytoxan	Cancer, leukemia, lymphoma
Dabigatran Etexilate Mesylate	Artery or vein blockage, atrial fibrillation or flutter
Dalfampridine	Multiple Sclerosis
Dalteparin	Artery or vein blockage
Darbepoetin Alfa	End-stage renal disease
Dasatinib	Leukemia
Digitek	Congestive heart failure, atrial fibrillation or flutter
Digoxin	Congestive heart failure, atrial fibrillation or flutter
Dimethyl fumarate	Multiple Sclerosis
Dipyridamole	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Diroximel fumarate	Multiple Sclerosis
Dofetilide	Atrial fibrillation or flutter
Doxercalciferol	End-stage renal disease
Dronedarone	Atrial fibrillation or flutter
Duaklir Pressair	Chronic obstructive pulmonary disease, emphysema
Edoxaban Tosylate	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Effient	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Eliquis	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Emend	Cancer
Enbrel	Rheumatoid arthritis
Enoxaparin	Artery or vein blockage
Entresto	Congestive heart failure
Enulose	Cirrhosis of the liver
Enzalutamide	Cancer
Epoetin Alfa	End-stage renal disease
Erleada	Cancer
Erlotinib	Cancer
Etanercept	Rheumatoid arthritis
Eulexin	Cancer
Everolimus	Cancer

Drug Name	Medical Condition(s)
Evomela	Cancer
Exemestane	Cancer
Extavia	Multiple Sclerosis
Eylea	Wet Macular degeneration
Fingolimod	Multiple Sclerosis
Flecainide	Atrial fibrillation or flutter
Flutamide	Cancer
Fluticasone-Umeclidinium-Vilanterol	Chronic obstructive pulmonary disease, emphysema
Fondaparinux Sodium	Artery or vein blockage
Fragmin	Artery or vein blockage
Generlac	Cirrhosis of the liver
Gilenya	Multiple Sclerosis
Gilotrif	Cancer
Glatiramer	Multiple Sclerosis
Gleevec	Leukemia
Golimumab	Rheumatoid arthritis
Hectorol	End-stage renal disease
Heparin	Artery or vein blockage
Humira	Rheumatoid arthritis
Hydrea	Cancer, leukemia
Hydroxychloroquine	Rheumatoid arthritis, systemic lupus erythematosus
Hydroxyurea	Cancer, leukemia
Ibrance	Cancer
Ibrutinib	Leukemia
Imatinib	Leukemia
Imbruvica	Leukemia
Incruse Ellipta	Chronic obstructive pulmonary disease, emphysema
Infliximab	Rheumatoid arthritis
Interferon beta 1a	Multiple Sclerosis
Interferon beta 1b	Multiple Sclerosis

Drug Name	Medical Condition(s)
Isordil	Artery or vein blockage, coronary artery disease, heart attack
Isosorbide	Artery or vein blockage, coronary artery disease, heart attack
Ivabradine	Congestive heart failure
Jantoven	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Kevzara	Rheumatoid arthritis
Kineret	Rheumatoid arthritis
Kionex	End-stage renal disease
Leflunomide	Rheumatoid arthritis
Lemtrada	Multiple Sclerosis
Lenalidomide	Cancer
Lucentis	Wet Macular degeneration
Macugen	Wet Macular degeneration
Mavenclad	Multiple Sclerosis
Mayzent	Multiple Sclerosis
Mekinist	Cancer
Melphalan	Cancer
Mercaptopurine	Cancer, leukemia
Methotrexate	Rheumatoid arthritis
Metolazone	Chronic kidney disease
Minitran	Artery or vein blockage, coronary artery disease, heart attack
Multaq	Atrial fibrillation or flutter
Natalizumab	Multiple Sclerosis
Nephro Caps	End-stage renal disease
Neratinib	Cancer
Nerlynx	Cancer
Nexavar	Cancer
Nilotinib	Leukemia
Nitro-Dur, Nitro-Stat	Artery or vein blockage, coronary artery disease, heart attack
Nitroglycerin	Artery or vein blockage, coronary artery disease, heart attack
Ocrelizumab	Multiple Sclerosis

Drug Name	Medical Condition(s)
Ocrevus	Multiple Sclerosis
Olumiant	Rheumatoid arthritis
Orencia	Rheumatoid arthritis
Osimertinib	Cancer
Palbociclib	Cancer
Paricalcitol	End-stage renal disease
Pegaptanib	Wet Macular degeneration
Peginterferon beta 1a	Multiple Sclerosis
Pentoxifylline	Artery or vein blockage, peripheral vascular disease
Persantine	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Plaquenil	Rheumatoid arthritis, systemic lupus erythematosus
Plavix	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Plegridy	Multiple Sclerosis
Pletal	Artery or vein blockage, peripheral vascular disease
Pomalidomide	Cancer
Pomalyst	Cancer
Pradaxa	Artery or vein blockage, atrial fibrillation or flutter
Prasugrel	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Procrit	End-stage renal disease
Propafenone	Atrial fibrillation or flutter
Quinidine	Atrial fibrillation or flutter
Ranexa	Artery or vein blockage, coronary artery disease, heart attack
Ranibizumab	Wet Macular degeneration
Ranolazine	Artery or vein blockage, coronary artery disease, heart attack
Rebif	Multiple Sclerosis
Remicade	Rheumatoid arthritis
Renvela	End-stage renal disease
Revlimid	Cancer
Rinvoq	Rheumatoid arthritis
Rivaroxaban	Artery or vein blockage, atrial fibrillation or flutter

Drug Name	Medical Condition(s)
Rythmol	Atrial fibrillation or flutter
Sacubitril-Valsartan	Congestive heart failure
Sarilumab	Rheumatoid arthritis
Savaysa	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Sensipar	End-stage renal disease
Sevelamer	End-stage renal disease
Simponi	Rheumatoid arthritis
Siponimod	Multiple Sclerosis
Sorafenib	Cancer
Sorin	Congestive heart failure, cardiomyopathy, atrial fibrillation or flutter
Sotalol	Congestive heart failure, cardiomyopathy, atrial fibrillation or flutter
Spironolactone	Congestive heart failure, Cardiomyopathy
Sprycel	Leukemia
SPS 15 Suspension	End-stage renal disease
Sunitinib	Cancer
Sutent	Cancer
Tagrisso	Cancer
Tarceva	Cancer
Tasigna	Leukemia
Tecfidera	Multiple Sclerosis
Temodar	Cancer
Temozolomide	Cancer
Teriflunomide	Multiple Sclerosis
Ticagrelor	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Ticlid	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Ticlopidine	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA
Tikosyn	Atrial fibrillation or flutter
Tiotropium Br-Olodaterol Inhal Aero Soln	Chronic obstructive pulmonary disease, emphysema
Tocilizumab	Rheumatoid arthritis
Tofacitinib	Rheumatoid arthritis

Drug Name	Medical Condition(s)
Tolmetin	Rheumatoid arthritis
Trametinib	Cancer
Trelegy	Chronic obstructive pulmonary disease, emphysema
Tudorza	Chronic obstructive pulmonary disease, emphysema
Tysabri	Multiple Sclerosis
Umeclidinium Br Aero Powd Breath Act	Chronic obstructive pulmonary disease, emphysema
Umeclidinium-Vilanterol Aero Powd	Chronic obstructive pulmonary disease, emphysema
Upadacitinib	Rheumatoid arthritis
Velcade	Cancer, lymphoma
Verzenio	Cancer
Vumerity	Multiple Sclerosis
Warfarin	Artery or vein blockage, coronary artery disease, peripheral artery disease, heart attack, stroke, mini-stroke, TIA, atrial fibrillation or flutter
Xalkori	Cancer
Xarelto	Artery or vein blockage, atrial fibrillation or flutter
Xeljanz	Rheumatoid arthritis
Xeloda	Cancer
Xtandi	Cancer
Zaroxolyn	Chronic kidney disease
Zemplar	End-stage renal disease
Zytiga	Cancer

CENTERS FOR MEDICARE & MEDICAID SERVICES

2020

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

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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 Medicare Supplement Insurance (Medigap) policy or already have one. It'll help you understand how Medigap policies work.

Important information about this guide

The information in this guide describes the Medicare Program at the time this guide 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 "2020 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.

Paid for by the Department of Health & Human Services.

SECTION 1

Medicare Basics

A brief look at Medicare

A Medicare Supplement Insurance (Medigap) policy is health insurance that can help pay some of the health care costs that Original Medicare doesn't cover, like coinsurance, copayments, or deductibles. Private insurance companies sell Medigap policies. 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.

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, certain people under 65 with disabilities, and 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.

Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)

Part D (Prescription drug coverage)

Helps cover:

- Cost of prescription drugs (including many recommended shots or vaccines)

Part D plans are run by private insurance companies that follow rules set by Medicare.

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare.

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Part D plan.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.
- Can use any doctor or hospital that takes Medicare, anywhere in the U.S.

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**
(Some examples include coverage from a Medicare Supplement Insurance (Medigap) policy, or coverage from a former employer or union.)

Medicare Advantage
(also known as Part C)

- Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Plans may have lower out-of-pocket costs than Original Medicare.
- In most cases, you'll need to use doctors who are in the plan's network.
- Most plans offer extra benefits that Original Medicare doesn't cover— like vision, hearing, dental, and more.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

☑ **Extra benefits**

Some plans also include:

☐ **Lower out-of-pocket-costs**

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 during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. For most people, their Initial Enrollment period is the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.

You can keep your Marketplace plan without penalty until your Medicare coverage starts. 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 may 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, or find out how to terminate your Marketplace financial help or plan to avoid a gap in coverage. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Note: Medicare isn't part of the Marketplace. The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies, Medicare Advantage Plans, or Medicare prescription drug coverage (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 an insurance policy that helps supplement Original Medicare and is sold by private companies. A Medigiap policy can help pay some of the remaining health care costs that Original Medicare doesn't pay for covered services and supplies, like copayments, coinsurance, and deductibles. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. 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.” 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.

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.

- 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 to individuals who are not new to Medicare and either Plan D or Plan G to individuals who are new to Medicare. Not all types of Medigap policies may be available in your state.
- Plans D and G with coverage starting 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 people new to 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 who are new to Medicare on or after 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'll 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.
    - People new to Medicare are those who turn 65 on or after January 1, 2020, and those who get Medicare Part A (Hospital Insurance) on or after January 1, 2020.

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.)

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 2020**			
							$5,880	$2,940		

* Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,340 in 2020 before your policy pays anything. (Plans C and F won't be available to people who are newly eligible for Medicare on or after January 1, 2020.)

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), 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 non-skilled care you get 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 (also known as 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.

Words in blue are defined on pages 49–50.

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.

In some cases, an insurance company must sell you a Medigap policy if you want one, 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).
- 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.
- 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.
- 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 to decide whether to accept your application. 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)

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.

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.

Words in blue are defined on pages 49–50.

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

Creditable coverage

It's possible to avoid or shorten your waiting period for a pre-existing condition if:

- You buy a Medigap policy during your Medicare Open Enrollment Period.
- You're replacing certain kinds of health coverage that counts as "creditable coverage".

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. Outside of Medigap Open Enrollment, 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 it can't be changed or repeated. After your Medigap Open Enrollment Period ends, you may be denied a Medigap policy or charged more for a Medigap policy due to past or present health problems.

In most cases, it makes sense to enroll in Part B and buy 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 6-month Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Words in blue are defined on pages 49–50.

Employer coverage

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. Benefits based on current employment often provide coverage similar to Part B, so you wouldn't want to pay 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. 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 G plan from one insurance company with a Plan G plan 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 Plans F or G. If you buy Plans F or G with a high-deductible option, you must pay the first $2,340 of deductibles, copayments, and coinsurance (in 2020) 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 $2,340 deductible (in 2020) 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 may pay you directly according to policy limits. Check with your Medigap plan for more details.

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.

Medigap guaranteed issue right situations

The chart on this page and the next page 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 offer 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*, D*, F*, G*, 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*, D*, F*, G*, 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*, D*, F*, G*, 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.

***Note:** Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

Medigap guaranteed issue right situations (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*, D*, F*, G*, 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*, D*, F*, G*, 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*, D*, F*, G*, 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.

***Note:** Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

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 plan coverage ends. The Medigap insurer can sell it to you as long as you're leaving the Medicare Advantage Plan. Ask that the new policy take effect when your Medicare Advantage enrollment ends, so you'll have continuous health coverage.

For more information about Medigap rights

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 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/medigap-supplemental-insurance-plans:

  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:

- Calling 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.
- Calling your State Health Insurance Assistance Program. These programs can give you help at no cost to you with choosing a Medigap policy.
- Going 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.
- Talking 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 if 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.** Your insurance company will let you know your payment options for your particular policy. You may be able to 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, which lets you set up a repeating payment to debit automatically from a checking account or credit card.
- **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 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 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 explained on page 32, make sure your old Medigap policy coverage ends **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.

Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F.

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.

Words in blue are defined on pages 49–50.

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

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)

What if I change my mind and join a Medicare Prescription Drug Plan?

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.

In a Medicare Prescription Drug Plan, you may have to pay a monthly premium. There's no yearly maximum coverage amounts 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 Prescription Drug Plan's list of covered prescription drugs before you join.

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 Prescription 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 Prescription 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?

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. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back so pay careful attention to the timing.

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:

- Arkansas
- 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.

Words in blue are defined on pages 49–50.

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.

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—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

Note: Supplement 1 Plan (which includes coverage of the Part B deductible) will no longer be available to people who are new to Medicare on or after January 1, 2020. These people can buy Supplement 1A Plan.

However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Supplement Plan 1.

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

Medigap benefits	Core plan	Supplement 1 Plan	Supplement 1A 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	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.**

Note: Coverage of the Part B deductible will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to get this benefit

Minnesota versions of Medigap Plans K, L, M and N are available. Minnesota versions of high-deductible F are available to people who had or were eligible for Medicare before January 1, 2020. (See page 10 for details on eligibility.)

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	✓

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 ($2,340 deductible for 2020) is also available.

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 ***Note:** Coverage of the Part B deductible will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to get this benefit.

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/medigap-supplemental-insurance-plans.
- 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	1-844-822-4622	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 (St. Croix) 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.	1-202-727-8370	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 cost 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 (also called "Medigap protections")—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, like 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 to take your application for insurance, whether 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. Medicare Advantage Plans provide all of your 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, most 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.

CMS 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 free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**

   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

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare Prescription Drug Plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (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.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare Prescription Drug Plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:**
   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

Official Business
Penalty for Private Use, $300

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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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Thank You for Applying for an AARP® Medicare Supplement Insurance Plan Insured by UnitedHealthcare Insurance Company

For Your Records:

You selected Plan ________________________________ with a requested effective date (1st day of a future month) of ______ / ______ / ______.

Based on the information you provided, your monthly premium for the plan you selected may be $_____________. **Please note that your final monthly premium will be determined once your application is approved.**

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

What's Next:

Once your application is approved, you may expect your insured Member Identification (ID) Card to arrive. Using the information on the Member ID Card, you may register for a secure online account at **www.myaarpmedicare.com** to gain access to tools and resources to help you manage both your plan and your health.

In addition to your insured Member ID Card and website access, you'll also receive:

Your Welcome Kit.

The Welcome Kit will include your Certificate of Insurance and coverage details.

Educational Materials.

UnitedHealthcare's educational materials can help you make the most of your plan benefits.

Dedicated Customer Service.

You'll receive a friendly call from one of our courteous and caring UnitedHealthcare Customer Service Advocates, who will review your new member materials, and help answer questions you may have.

Exclusive AARP Member Benefits.

A full listing of the benefits you receive with your AARP membership — including healthcare-related discounts, access to financial programs, driver safety courses, social activities, and more — can be found when you log into **www.myaarpmedicare.com**.

AARP® | Medicare Supplement from UnitedHealthcare®

Let's talk about your needs

Your licensed insurance agent contracted with UnitedHealthcare Insurance Company is here to help.

Name ______________________________

Email ______________________________

Phone ____________________

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