

Nevada

Enrollment is for January 1, 2020 – December 1, 2020 plan effective dates.
Rates are for January 1, 2020 – December 1, 2020 plan effective dates.

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

AARP® | Medicare Supplement Plans
insured by **UnitedHealthcare
Insurance Company**



Enrollment Kit

BA25479ST



IMPORTANT MESSAGE ABOUT PLAN C & PLAN F

For 1/1/2020 new plan effective dates and later

Due to new Medicare rules, you may only apply for **Plan C** or **Plan F** for a 1/1/2020 or later plan effective date if:

You will be age 65
PRIOR
to 1/1/2020

OR

You will be age 65
ON or AFTER
1/1/2020

AND

have a Medicare
Part A Effective Date
PRIOR to 1/1/2020



Questions?

Contact your licensed insurance agent/producer.



Introducing At Your Best by UnitedHealthcare™



WELLNESS



DISCOUNTS



SUPPORT

At Your Best by UnitedHealthcare™ — available at no additional cost to you starting January 1, 2020 — gives you more than you expected as an insured member of an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare). The offering includes health and wellness resources, discount programs and support services to help you live better.

With the newly expanded services, insured members will have access to an extensive network of participating gyms and fitness locations^ at no additional cost, a hearing program, 24/7 Nurse line, and more.

<p>Renew Active™ by UnitedHealthcare</p> <p>AARP® Staying Sharp</p>	<p>Access to an extensive network of participating gyms and fitness locations at no additional cost, and online brain health tools.</p> <p>Online brain health program that helps support a healthy brain lifestyle. For insured members of the AARP Medicare Supplement Plan, AARP Staying Sharp includes: a brain health assessment, articles, brain exercises, activities, recipes, and brain games.</p>
<p>Hearing Care Program by HearUSA</p>	<p>A discount on hearing aids and access to screenings by certified HearUSA hearing care providers. The Hearing Care Program by HearUSA includes:</p> <ul style="list-style-type: none"> • 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.
<p>AARP® Vision Discounts provided by EyeMed:</p>	<p>Save on eyewear purchases and routine eye exams. AARP Vision Discounts provided by EyeMed includes:</p> <ul style="list-style-type: none"> • At LensCrafters, take an additional \$50 off the AARP® Vision Discount provided by EyeMed or best in-store offer on no-line progressive lenses with frame purchase**. • \$50 eye exams at participant providers*.
<p>24/7 Nurse line</p>	<p>A registered nurse is available to discuss your concerns and answer questions over the phone anytime, day or night. Spanish is available, as well as translation assistance in 140+ languages.</p> <ul style="list-style-type: none"> • 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.
<p>Wellness coaching</p>	<p>Trained wellness coaches are available over the phone to provide personalized programs and support that may help you reach your specific wellness goals.</p>

^Availability of fitness program may vary by area. Fitness program network only includes participating facilities and locations.

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.

Call UnitedHealthcare now to request information about AARP Medicare Supplement Insurance Plans and to learn more about At Your Best by UnitedHealthcare.

atyourbestbyuhc.com

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AARP® | Medicare Supplement Plans
insured by **UnitedHealthcare Insurance Company**

ITC

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.

Renew Active™ by UnitedHealthcare

You can only receive the Renew Active special membership rate if you are an insured member covered under an AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company.

Renew Active includes standard fitness membership. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Equipment and classes may vary by location.

AARP® Staying Sharp

AARP® will share only non-identifiable, aggregate information with UnitedHealthcare that is collected through the use of the AARP Staying Sharp Platform. This information may be used by UnitedHealthcare to potentially help develop future programs and services for its insured members.

This program offering is not an insurance program, is only offered in certain jurisdictions and may be discontinued at any time. Links are made available so that you will have an opportunity to obtain information from the third party on its website. Links are provided solely as a convenience and not as an endorsement of the content of the third-party site or any products or services offered on that site. UnitedHealthcare Insurance Company is not responsible for the content on any linked site or any link contained in a linked site. UnitedHealthcare does not make any representations regarding the content or accuracy of the materials on such sites.

Participation in the brain health assessment is voluntary. 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. 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.

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.

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 12/31/2020. Code 755453.

24/7 Nurse line & Wellness coaching

The information provided through these services is for informational purposes only. Your health information is kept confidential in accordance with applicable law. None of these programs are a substitute for your doctor's care. Nurses, wellness coaches, 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 are between you and your health care provider. Consult your physician before beginning an exercise program or making major changes in your diet or health care regimen.

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*. It means benefiting from a nonprofit, nonpartisan social-welfare organization that has been advocating for the rights of people age 50 and over for over 50 years*. Members of AARP also enjoy exclusive discounts and offers such as the programs and examples listed below, plus much more!



Health & Wellness

Discounts on hearing exams, hearing aids and eyeglasses as well as health and wellness tools



Insurance** & Finances

Access to insurance programs as well as other financial services such as free tax preparation for those who qualify



Entertainment, Shopping & Restaurants

Discounts on movie tickets and concessions as well as shopping and restaurants



Travel & Auto

Save on car rental, hotel, airline tickets and other travel bookings as well as car care & maintenance



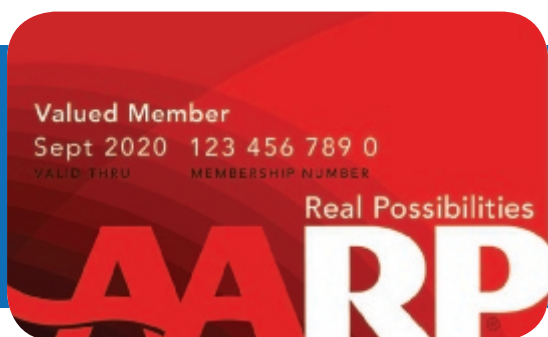
Home & Family

Get help with caregiving and other resources



Magazine, Advocacy & Community

Join AARP's advocacy efforts or a local AARP chapter in your area



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

Explore all your benefits by visiting aarp.org/benefits

*2016 AARP Annual Report (July 7, 2017). Retrieved November 21, 2017, from www.aarp.org/content/dam/aarp/about_aarp/about_us/2017/2016-annual-report-aarp.pdf

**The AARP benefits described are not a benefit of an insurance program.

Bright Ways To Save



Questions? Contact your
licensed insurance agent/producer.

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

SAVE up to 39%* with the Enrollment Discount

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

TAKE \$24 OFF with Electronic Funds Transfer

You'll save \$2.00 off your total monthly household premium, 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

AARP | Medicare Supplement
from **UnitedHealthcare**

* The rate discount is 39% at ages 65-68, 36% at age 69, 33% at age 70, and so on, decreasing by 3% on the Plan anniversary date, through age 80. The discount then decreases to 0% after age 80. The discount is available to new applicants who are accepted to enroll in an AARP Medicare Supplement Plan for January 1, 2020 and after Plan Effective Dates.

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

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

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Overview of Available Plans

Medicare Supplement Plans A, B, C, F, G, K, L and N are currently being offered by UnitedHealthcare Insurance Company.

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of this benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020 ²					\$5880 ²	\$2940 ²				

¹Plans F and G also have a high deductible option which require first paying a plan deductible of \$2340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

1 Review plans

You'll find all of the AARP Medicare Supplement Insurance Plans listed on the page titled "Overview of Available Plans" in this section. Please see the Plan Benefit Tables, also in this section, for the coverage details for each plan. Eligibility for certain plans depends on your age and/or your Medicare Part A effective date.

2 Find your rate

Your rate for the plan you select will be based on several factors, including your age on the plan effective date, your gender, tobacco usage, and your Medicare Part B effective date.

For Applicants Age 65 and Older:

- Determine your age as of the date you expect your coverage to begin.
- Use the chart below to determine which rate Group applies to you.
- Go to the rate pages (in this section) to locate your rate, based on your gender, non-tobacco or tobacco usage,* and the rate Group that applies to you.

If the time period between your plan effective date and your 65th birthday (or your Medicare Part B effective date – whichever is later) is:	
Number of years:	You are in:
Less than 10	Group 1
10 or more	Group 2

If you are in Group 1 and under age 81, you may be eligible for the current Standard Rate with the Enrollment Discount. You can find information about the Enrollment Discount and the eligibility requirements on the back of this page. Your answers to the medical questions on the application will also affect your monthly premium as the rate page indicates.

3 Enroll

After you choose a plan and find your rate, simply fill out the application and any additional required forms in this booklet and send them in using the enclosed postage-paid reply envelope. Or, you can conveniently enroll online with the guidance of your licensed insurance agent. See the *Enrollment Checklist* enclosed in the "Forms" section of this booklet for the list of items to complete and submit with your application.

*You are eligible for a **non-tobacco rate** if you have not smoked tobacco cigarettes or used other tobacco products within the past 12 months.

Enrollment Discount



Who is eligible?

You may be eligible for the Enrollment Discount if your age on your plan effective date is:

- 65 to 74 and you do not have any of the medical conditions listed on the application.
- 75 to 80 and your plan effective date is within 10 years of your Medicare Part B effective date and you do not have any of the medical conditions listed on the application.

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

How it works

The Enrollment Discount is applied to the current Standard Rate, which usually changes each year. The discount you receive in your first year of coverage depends on your age on your coverage effective date and decreases 3% each year, after age 68, on the anniversary date of your coverage. Please note that as the discount decreases on your plan's anniversary date, your monthly premium will increase; this may happen at a time other than the Plan's annual rate change. Please keep this in mind when budgeting for your health insurance expenses.

Example 1: Meet Jill*

- Plan Effective Date: January 1st
- Jill's age on her Plan Effective Date: 66
- Time since her Medicare Part B enrollment: 1 year
- No medical conditions listed on the application

Jill is eligible for the Enrollment Discount

Discount will begin at age 66

- Starting discount will be 39%
- Discount will change to 36% on her plan anniversary date of January 1 of the year Jill is age 69

Example 2: Meet Harry*

- Plan Effective Date: April 1st
- Harry's age on his Plan Effective Date: 70
- Time since his Medicare Part B enrollment: 3 years
- No medical conditions listed on the application

Harry is eligible for the Enrollment Discount

Discount will begin at age 70

- Starting discount will be 33%
- Discount will change to 30% on April 1 of the next year

Example 3: Meet Maria*

- Plan Effective Date: June 1st
- Maria's age on her Plan Effective Date: 69
- Time since her Medicare Part B enrollment: 11 years
- No medical conditions listed on the application

Maria is *not* eligible for the Enrollment Discount

Although Maria does not have a medical condition listed on the application, it has been more than 10 years since she enrolled in Medicare Part B.

	Age on Plan Effective Date	Starting Discount
	65	39%
Jill	66	39%
	67	39%
	68	39%
	69	36%
Harry	70	33%
	71	30%
	72	27%
	73	24%
	74	21%
	75	18%
	76	15%
	77	12%
	78	9%
	79	6%
	80	3%
	81	0%

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

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You must be an AARP member to enroll in an AARP Medicare Supplement Insurance 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 agent/producer may contact you.

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

Cover Page - Rates

Female Non-Tobacco Monthly Plan Rates for Nevada - Area 1

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$102.32	\$147.62	\$133.43	\$52.46	\$90.73	\$114.83	\$169.73	\$170.49
66	\$102.32	\$147.62	\$133.43	\$52.46	\$90.73	\$114.83	\$169.73	\$170.49
67	\$102.32	\$147.62	\$133.43	\$52.46	\$90.73	\$114.83	\$169.73	\$170.49
68	\$102.32	\$147.62	\$133.43	\$52.46	\$90.73	\$114.83	\$169.73	\$170.49
69	\$107.36	\$154.88	\$140.00	\$55.04	\$95.20	\$120.48	\$178.08	\$178.88
70	\$112.39	\$162.14	\$146.56	\$57.62	\$99.66	\$126.12	\$186.42	\$187.26
71	\$117.42	\$169.40	\$153.12	\$60.20	\$104.12	\$131.77	\$194.77	\$195.65
72	\$122.45	\$176.66	\$159.68	\$62.78	\$108.58	\$137.42	\$203.12	\$204.03
73	\$127.49	\$183.92	\$166.25	\$65.36	\$113.05	\$143.07	\$211.47	\$212.42
74	\$132.52	\$191.18	\$172.81	\$67.94	\$117.51	\$148.71	\$219.81	\$220.80
75	\$137.55	\$198.44	\$179.37	\$70.52	\$121.97	\$154.36	\$228.16	\$229.19
76	\$142.58	\$205.70	\$185.93	\$73.10	\$126.43	\$160.01	\$236.51	\$237.57
77	\$147.62	\$212.96	\$192.50	\$75.68	\$130.90	\$165.66	\$244.86	\$245.96
78	\$152.65	\$220.22	\$199.06	\$78.26	\$135.36	\$171.30	\$253.20	\$254.34
79	\$157.68	\$227.48	\$205.62	\$80.84	\$139.82	\$176.95	\$261.55	\$262.73
80	\$162.71	\$234.74	\$212.18	\$83.42	\$144.28	\$182.60	\$269.90	\$271.11
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$167.75	\$242.00	\$218.75	\$86.00	\$148.75	\$188.25	\$278.25	\$279.50
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$251.62	\$363.00	\$406.87	\$129.00	\$223.12	\$357.67	\$417.37	\$419.25
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$184.52	\$266.20	\$240.62	\$94.60	\$163.62	\$207.07	\$306.07	\$307.45
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$251.62	\$363.00	\$406.87	\$129.00	\$223.12	\$357.67	\$417.37	\$419.25

The rates above are for plan effective dates from January - December 2020 and may change.

Cover Page - Rates

Female Tobacco Monthly Plan Rates for Nevada - Area 1

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$112.55	\$162.38	\$146.77	\$57.70	\$99.80	\$126.31	\$186.70	\$187.54
66	\$112.55	\$162.38	\$146.77	\$57.70	\$99.80	\$126.31	\$186.70	\$187.54
67	\$112.55	\$162.38	\$146.77	\$57.70	\$99.80	\$126.31	\$186.70	\$187.54
68	\$112.55	\$162.38	\$146.77	\$57.70	\$99.80	\$126.31	\$186.70	\$187.54
69	\$118.09	\$170.36	\$153.99	\$60.54	\$104.71	\$132.52	\$195.88	\$196.76
70	\$123.62	\$178.35	\$161.21	\$63.38	\$109.62	\$138.73	\$205.06	\$205.99
71	\$129.16	\$186.34	\$168.43	\$66.22	\$114.53	\$144.94	\$214.24	\$215.21
72	\$134.69	\$194.32	\$175.65	\$69.05	\$119.44	\$151.16	\$223.43	\$224.43
73	\$140.23	\$202.31	\$182.87	\$71.89	\$124.35	\$157.37	\$232.61	\$233.66
74	\$145.77	\$210.29	\$190.08	\$74.73	\$129.25	\$163.58	\$241.79	\$242.88
75	\$151.30	\$218.28	\$197.30	\$77.57	\$134.16	\$169.79	\$250.97	\$252.10
76	\$156.84	\$226.27	\$204.52	\$80.41	\$139.07	\$176.00	\$260.15	\$261.33
77	\$162.37	\$234.25	\$211.74	\$83.24	\$143.98	\$182.22	\$269.34	\$270.55
78	\$167.91	\$242.24	\$218.96	\$86.08	\$148.89	\$188.43	\$278.52	\$279.77
79	\$173.44	\$250.22	\$226.18	\$88.92	\$153.80	\$194.64	\$287.70	\$289.00
80	\$178.98	\$258.21	\$233.40	\$91.76	\$158.71	\$200.85	\$296.88	\$298.22
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$184.52	\$266.20	\$240.62	\$94.60	\$163.62	\$207.07	\$306.07	\$307.45
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$276.78	\$399.30	\$447.55	\$141.90	\$245.43	\$393.43	\$459.10	\$461.17
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$202.97	\$292.82	\$264.68	\$104.06	\$179.98	\$227.77	\$336.67	\$338.19
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$276.78	\$399.30	\$447.55	\$141.90	\$245.43	\$393.43	\$459.10	\$461.17

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Cover Page - Rates

Male Non-Tobacco Monthly Plan Rates for Nevada - Area 1

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$115.44	\$166.53	\$150.51	\$59.17	\$102.32	\$129.47	\$191.38	\$192.15
66	\$115.44	\$166.53	\$150.51	\$59.17	\$102.32	\$129.47	\$191.38	\$192.15
67	\$115.44	\$166.53	\$150.51	\$59.17	\$102.32	\$129.47	\$191.38	\$192.15
68	\$115.44	\$166.53	\$150.51	\$59.17	\$102.32	\$129.47	\$191.38	\$192.15
69	\$121.12	\$174.72	\$157.92	\$62.08	\$107.36	\$135.84	\$200.80	\$201.60
70	\$126.79	\$182.91	\$165.32	\$64.99	\$112.39	\$142.20	\$210.21	\$211.05
71	\$132.47	\$191.10	\$172.72	\$67.90	\$117.42	\$148.57	\$219.62	\$220.50
72	\$138.15	\$199.29	\$180.12	\$70.81	\$122.45	\$154.94	\$229.03	\$229.95
73	\$143.83	\$207.48	\$187.53	\$73.72	\$127.49	\$161.31	\$238.45	\$239.40
74	\$149.50	\$215.67	\$194.93	\$76.63	\$132.52	\$167.67	\$247.86	\$248.85
75	\$155.18	\$223.86	\$202.33	\$79.54	\$137.55	\$174.04	\$257.27	\$258.30
76	\$160.86	\$232.05	\$209.73	\$82.45	\$142.58	\$180.41	\$266.68	\$267.75
77	\$166.54	\$240.24	\$217.14	\$85.36	\$147.62	\$186.78	\$276.10	\$277.20
78	\$172.21	\$248.43	\$224.54	\$88.27	\$152.65	\$193.14	\$285.51	\$286.65
79	\$177.89	\$256.62	\$231.94	\$91.18	\$157.68	\$199.51	\$294.92	\$296.10
80	\$183.57	\$264.81	\$239.34	\$94.09	\$162.71	\$205.88	\$304.33	\$305.55
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$189.25	\$273.00	\$246.75	\$97.00	\$167.75	\$212.25	\$313.75	\$315.00
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$283.87	\$409.50	\$458.95	\$145.50	\$251.62	\$403.27	\$470.62	\$472.50
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$208.17	\$300.30	\$271.42	\$106.70	\$184.52	\$233.47	\$345.12	\$346.50
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$283.87	\$409.50	\$458.95	\$145.50	\$251.62	\$403.27	\$470.62	\$472.50

The rates above are for plan effective dates from January - December 2020 and may change.

Cover Page - Rates

Male Tobacco Monthly Plan Rates for Nevada - Area 1

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$126.98	\$183.18	\$165.56	\$65.08	\$112.55	\$142.41	\$210.52	\$211.36
66	\$126.98	\$183.18	\$165.56	\$65.08	\$112.55	\$142.41	\$210.52	\$211.36
67	\$126.98	\$183.18	\$165.56	\$65.08	\$112.55	\$142.41	\$210.52	\$211.36
68	\$126.98	\$183.18	\$165.56	\$65.08	\$112.55	\$142.41	\$210.52	\$211.36
69	\$133.22	\$192.19	\$173.70	\$68.28	\$118.09	\$149.42	\$220.87	\$221.76
70	\$139.47	\$201.20	\$181.85	\$71.48	\$123.62	\$156.42	\$231.23	\$232.15
71	\$145.71	\$210.21	\$189.99	\$74.69	\$129.16	\$163.42	\$241.58	\$242.55
72	\$151.96	\$219.21	\$198.13	\$77.89	\$134.69	\$170.43	\$251.93	\$252.94
73	\$158.20	\$228.22	\$206.27	\$81.09	\$140.23	\$177.43	\$262.29	\$263.34
74	\$164.45	\$237.23	\$214.42	\$84.29	\$145.77	\$184.44	\$272.64	\$273.73
75	\$170.69	\$246.24	\$222.56	\$87.49	\$151.30	\$191.44	\$282.99	\$284.13
76	\$176.94	\$255.25	\$230.70	\$90.69	\$156.84	\$198.44	\$293.35	\$294.52
77	\$183.18	\$264.26	\$238.84	\$93.89	\$162.37	\$205.45	\$303.70	\$304.92
78	\$189.43	\$273.27	\$246.99	\$97.09	\$167.91	\$212.45	\$314.05	\$315.31
79	\$195.67	\$282.28	\$255.13	\$100.29	\$173.44	\$219.46	\$324.41	\$325.71
80	\$201.92	\$291.29	\$263.27	\$103.49	\$178.98	\$226.46	\$334.76	\$336.10
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$208.17	\$300.30	\$271.42	\$106.70	\$184.52	\$233.47	\$345.12	\$346.50
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$312.25	\$450.45	\$504.84	\$160.05	\$276.78	\$443.59	\$517.68	\$519.75
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$228.98	\$330.33	\$298.56	\$117.37	\$202.97	\$256.81	\$379.63	\$381.15
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$312.25	\$450.45	\$504.84	\$160.05	\$276.78	\$443.59	\$517.68	\$519.75

The rates above are for plan effective dates from January - December 2020 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 80. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible

You are eligible for the enrollment discount if you are between the ages of 65 and 80 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date, if later, and you do not have any medical conditions on the application that would qualify you for the Level 2 rate.

The Level 2 rates do not apply to individuals who meet Medigap Open Enrollment or Guaranteed Issue.

How it works

The Enrollment Discount is applied to the current Standard Rate. The Standard Rates usually change each year. The discount you receive in your first year of coverage depends on your age on your plan effective date. After age 68, the discount percentage reduces 3% each year on the anniversary date of your plan until the discount runs out.

3 Refer to Section 6 of the application.

4 **IMPORTANT:** Plans C and F are only available to eligible Applicants (a) with a 65th birthday prior to 1/1/2020 or (b) with a Medicare Part A effective date prior to 1/1/2020.

NEVADA Area 1 ZIP Codes

The ZIP Codes Below Apply to Rates Included on the Page Headed "Cover Page – Rates"

88901	89025	89053	89107	89124	89141	89158	89185
88905	89026	89054	89108	89125	89142	89159	89191
89002	89027	89067	89109	89126	89143	89160	89193
89004	89028	89070	89110	89127	89144	89161	89195
89005	89029	89074	89111	89128	89145	89162	89199
89006	89030	89077	89112	89129	89146	89163	
89007	89031	89081	89113	89130	89147	89164	
89009	89032	89084	89114	89131	89148	89165	
89011	89033	89085	89115	89132	89149	89166	
89012	89034	89086	89116	89133	89150	89169	
89014	89036	89087	89117	89134	89151	89170	
89015	89037	89101	89118	89135	89152	89173	
89016	89039	89102	89119	89136	89153	89177	
89018	89040	89103	89120	89137	89154	89178	
89019	89044	89104	89121	89138	89155	89179	
89021	89046	89105	89122	89139	89156	89180	
89024	89052	89106	89123	89140	89157	89183	

Cover Page - Rates

Female Non-Tobacco Monthly Plan Rates for Nevada - Area 2

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$82.80	\$119.40	\$107.97	\$42.39	\$73.35	\$92.87	\$137.40	\$137.86
66	\$82.80	\$119.40	\$107.97	\$42.39	\$73.35	\$92.87	\$137.40	\$137.86
67	\$82.80	\$119.40	\$107.97	\$42.39	\$73.35	\$92.87	\$137.40	\$137.86
68	\$82.80	\$119.40	\$107.97	\$42.39	\$73.35	\$92.87	\$137.40	\$137.86
69	\$86.88	\$125.28	\$113.28	\$44.48	\$76.96	\$97.44	\$144.16	\$144.64
70	\$90.95	\$131.15	\$118.59	\$46.56	\$80.56	\$102.00	\$150.91	\$151.42
71	\$95.02	\$137.02	\$123.90	\$48.65	\$84.17	\$106.57	\$157.67	\$158.20
72	\$99.09	\$142.89	\$129.21	\$50.73	\$87.78	\$111.14	\$164.43	\$164.98
73	\$103.17	\$148.77	\$134.52	\$52.82	\$91.39	\$115.71	\$171.19	\$171.76
74	\$107.24	\$154.64	\$139.83	\$54.90	\$94.99	\$120.27	\$177.94	\$178.54
75	\$111.31	\$160.51	\$145.14	\$56.99	\$98.60	\$124.84	\$184.70	\$185.32
76	\$115.38	\$166.38	\$150.45	\$59.07	\$102.21	\$129.41	\$191.46	\$192.10
77	\$119.46	\$172.26	\$155.76	\$61.16	\$105.82	\$133.98	\$198.22	\$198.88
78	\$123.53	\$178.13	\$161.07	\$63.24	\$109.42	\$138.54	\$204.97	\$205.66
79	\$127.60	\$184.00	\$166.38	\$65.33	\$113.03	\$143.11	\$211.73	\$212.44
80	\$131.67	\$189.87	\$171.69	\$67.41	\$116.64	\$147.68	\$218.49	\$219.22
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$135.75	\$195.75	\$177.00	\$69.50	\$120.25	\$152.25	\$225.25	\$226.00
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$203.62	\$293.62	\$329.22	\$104.25	\$180.37	\$289.27	\$337.87	\$339.00
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$149.32	\$215.32	\$194.70	\$76.45	\$132.27	\$167.47	\$247.77	\$248.60
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$203.62	\$293.62	\$329.22	\$104.25	\$180.37	\$289.27	\$337.87	\$339.00

The rates above are for plan effective dates from January - December 2020 and may change.

Cover Page - Rates

Female Tobacco Monthly Plan Rates for Nevada - Area 2

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$91.08	\$131.34	\$118.76	\$46.63	\$80.68	\$102.15	\$151.13	\$151.64
66	\$91.08	\$131.34	\$118.76	\$46.63	\$80.68	\$102.15	\$151.13	\$151.64
67	\$91.08	\$131.34	\$118.76	\$46.63	\$80.68	\$102.15	\$151.13	\$151.64
68	\$91.08	\$131.34	\$118.76	\$46.63	\$80.68	\$102.15	\$151.13	\$151.64
69	\$95.56	\$137.80	\$124.60	\$48.92	\$84.65	\$107.18	\$158.57	\$159.10
70	\$100.04	\$144.26	\$130.44	\$51.22	\$88.62	\$112.20	\$166.00	\$166.56
71	\$104.52	\$150.72	\$136.29	\$53.51	\$92.58	\$117.22	\$173.43	\$174.02
72	\$109.00	\$157.18	\$142.13	\$55.80	\$96.55	\$122.25	\$180.87	\$181.47
73	\$113.48	\$163.64	\$147.97	\$58.10	\$100.52	\$127.27	\$188.30	\$188.93
74	\$117.96	\$170.10	\$153.81	\$60.39	\$104.49	\$132.30	\$195.73	\$196.39
75	\$122.44	\$176.56	\$159.65	\$62.68	\$108.46	\$137.32	\$203.17	\$203.85
76	\$126.92	\$183.02	\$165.49	\$64.98	\$112.42	\$142.34	\$210.60	\$211.31
77	\$131.40	\$189.48	\$171.33	\$67.27	\$116.39	\$147.37	\$218.03	\$218.76
78	\$135.88	\$195.94	\$177.17	\$69.56	\$120.36	\$152.39	\$225.47	\$226.22
79	\$140.36	\$202.40	\$183.01	\$71.86	\$124.33	\$157.42	\$232.90	\$233.68
80	\$144.84	\$208.86	\$188.85	\$74.15	\$128.30	\$162.44	\$240.33	\$241.14
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$149.32	\$215.32	\$194.70	\$76.45	\$132.27	\$167.47	\$247.77	\$248.60
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$223.98	\$322.98	\$362.14	\$114.67	\$198.40	\$318.19	\$371.65	\$372.90
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$164.25	\$236.85	\$214.17	\$84.09	\$145.49	\$184.21	\$272.54	\$273.46
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$223.98	\$322.98	\$362.14	\$114.67	\$198.40	\$318.19	\$371.65	\$372.90

The rates above are for plan effective dates from January - December 2020 and may change.

Cover Page - Rates

Male Non-Tobacco Monthly Plan Rates for Nevada - Area 2

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$93.48	\$134.65	\$121.69	\$47.88	\$82.80	\$104.76	\$154.78	\$155.55
66	\$93.48	\$134.65	\$121.69	\$47.88	\$82.80	\$104.76	\$154.78	\$155.55
67	\$93.48	\$134.65	\$121.69	\$47.88	\$82.80	\$104.76	\$154.78	\$155.55
68	\$93.48	\$134.65	\$121.69	\$47.88	\$82.80	\$104.76	\$154.78	\$155.55
69	\$98.08	\$141.28	\$127.68	\$50.24	\$86.88	\$109.92	\$162.40	\$163.20
70	\$102.67	\$147.90	\$133.66	\$52.59	\$90.95	\$115.07	\$170.01	\$170.85
71	\$107.27	\$154.52	\$139.65	\$54.95	\$95.02	\$120.22	\$177.62	\$178.50
72	\$111.87	\$161.14	\$145.63	\$57.30	\$99.09	\$125.37	\$185.23	\$186.15
73	\$116.47	\$167.77	\$151.62	\$59.66	\$103.17	\$130.53	\$192.85	\$193.80
74	\$121.06	\$174.39	\$157.60	\$62.01	\$107.24	\$135.68	\$200.46	\$201.45
75	\$125.66	\$181.01	\$163.59	\$64.37	\$111.31	\$140.83	\$208.07	\$209.10
76	\$130.26	\$187.63	\$169.57	\$66.72	\$115.38	\$145.98	\$215.68	\$216.75
77	\$134.86	\$194.26	\$175.56	\$69.08	\$119.46	\$151.14	\$223.30	\$224.40
78	\$139.45	\$200.88	\$181.54	\$71.43	\$123.53	\$156.29	\$230.91	\$232.05
79	\$144.05	\$207.50	\$187.53	\$73.79	\$127.60	\$161.44	\$238.52	\$239.70
80	\$148.65	\$214.12	\$193.51	\$76.14	\$131.67	\$166.59	\$246.13	\$247.35
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$153.25	\$220.75	\$199.50	\$78.50	\$135.75	\$171.75	\$253.75	\$255.00
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$229.87	\$331.12	\$371.07	\$117.75	\$203.62	\$326.32	\$380.62	\$382.50
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$168.57	\$242.82	\$219.45	\$86.35	\$149.32	\$188.92	\$279.12	\$280.50
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$229.87	\$331.12	\$371.07	\$117.75	\$203.62	\$326.32	\$380.62	\$382.50

The rates above are for plan effective dates from January - December 2020 and may change.

Cover Page - Rates

Male Tobacco Monthly Plan Rates for Nevada - Area 2

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

Plans Available to All Applicants							Medicare first eligible before 2020 only ⁴	
Group 1		Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Standard Rates with Enrollment Discount² for individuals ages 65-80 whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
65	\$102.82	\$148.12	\$133.86	\$52.67	\$91.08	\$115.24	\$170.26	\$171.10
66	\$102.82	\$148.12	\$133.86	\$52.67	\$91.08	\$115.24	\$170.26	\$171.10
67	\$102.82	\$148.12	\$133.86	\$52.67	\$91.08	\$115.24	\$170.26	\$171.10
68	\$102.82	\$148.12	\$133.86	\$52.67	\$91.08	\$115.24	\$170.26	\$171.10
69	\$107.88	\$155.40	\$140.44	\$55.26	\$95.56	\$120.90	\$178.63	\$179.52
70	\$112.94	\$162.68	\$147.03	\$57.85	\$100.04	\$126.57	\$187.01	\$187.93
71	\$117.99	\$169.97	\$153.61	\$60.44	\$104.52	\$132.24	\$195.38	\$196.35
72	\$123.05	\$177.25	\$160.19	\$63.03	\$109.00	\$137.91	\$203.75	\$204.76
73	\$128.11	\$184.54	\$166.78	\$65.62	\$113.48	\$143.57	\$212.13	\$213.18
74	\$133.17	\$191.82	\$173.36	\$68.21	\$117.96	\$149.24	\$220.50	\$221.59
75	\$138.22	\$199.11	\$179.94	\$70.80	\$122.44	\$154.91	\$228.87	\$230.01
76	\$143.28	\$206.39	\$186.53	\$73.39	\$126.92	\$160.58	\$237.25	\$238.42
77	\$148.34	\$213.68	\$193.11	\$75.98	\$131.40	\$166.24	\$245.62	\$246.84
78	\$153.39	\$220.96	\$199.69	\$78.57	\$135.88	\$171.91	\$253.99	\$255.25
79	\$158.45	\$228.25	\$206.28	\$81.16	\$140.36	\$177.58	\$262.37	\$263.67
80	\$163.51	\$235.53	\$212.86	\$83.75	\$144.84	\$183.25	\$270.74	\$272.08
Standard Rates for individuals ages 81 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
81+	\$168.57	\$242.82	\$219.45	\$86.35	\$149.32	\$188.92	\$279.12	\$280.50
Level 2 Rates for individuals ages 65 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
65+	\$252.85	\$364.23	\$408.17	\$129.52	\$223.98	\$358.94	\$418.68	\$420.75
Group 2		Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.						
Age ¹	Plan A	Plan B	Plan G	Plan K	Plan L	Plan N	Plan C ⁴	Plan F ⁴
Level 1 Rates for individuals ages 75 and older whose acceptance is guaranteed <u>or</u> who do not have any of the medical conditions on the application³.								
75+	\$185.42	\$267.10	\$241.39	\$94.98	\$164.25	\$207.81	\$307.03	\$308.55
Level 2 Rates for individuals ages 75 and older whose acceptance is not guaranteed <u>and</u> who have one or more of the medical conditions on the application³.								
75+	\$252.85	\$364.23	\$408.17	\$129.52	\$223.98	\$358.94	\$418.68	\$420.75

The rates above are for plan effective dates from January - December 2020 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 80. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible

You are eligible for the enrollment discount if you are between the ages of 65 and 80 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date, if later, and you do not have any medical conditions on the application that would qualify you for the Level 2 rate.

The Level 2 rates do not apply to individuals who meet Medigap Open Enrollment or Guaranteed Issue.

How it works

The Enrollment Discount is applied to the current Standard Rate. The Standard Rates usually change each year. The discount you receive in your first year of coverage depends on your age on your plan effective date. After age 68, the discount percentage reduces 3% each year on the anniversary date of your plan until the discount runs out.

3 Refer to Section 6 of the application.

4 **IMPORTANT:** Plans C and F are only available to eligible Applicants (a) with a 65th birthday prior to 1/1/2020 or (b) with a Medicare Part A effective date prior to 1/1/2020.

NEVADA Area 2 ZIP Codes

The ZIP Codes Below Apply to Rates Included on the Page Headed "Cover Page – Rates"

89001	89311	89415	89438	89505	89701	89826
89003	89314	89418	89439	89506	89702	89828
89008	89315	89419	89440	89507	89703	89830
89010	89316	89420	89441	89508	89704	89831
89013	89317	89421	89442	89509	89705	89832
89017	89318	89422	89444	89510	89706	89833
89020	89319	89423	89445	89511	89711	89834
89022	89402	89424	89446	89512	89712	89835
89023	89403	89425	89447	89513	89713	89883
89041	89404	89426	89448	89515	89714	
89042	89405	89427	89449	89519	89721	
89043	89406	89428	89450	89520	89801	
89045	89407	89429	89451	89521	89802	
89047	89408	89430	89452	89523	89803	
89048	89409	89431	89460	89533	89815	
89049	89410	89432	89496	89555	89820	
89060	89411	89433	89501	89557	89821	
89061	89412	89434	89502	89570	89822	
89301	89413	89435	89503	89595	89823	
89310	89414	89436	89504	89599	89825	

Your Guide to AARP Medicare Supplement Insurance 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 65 or older, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage.

Guaranteed Acceptance

- Your acceptance in any plan 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

Guaranteed Issue Situations:	Plans for Applicants With: • A 65th birthday PRIOR to 1/1/2020. OR • A Medicare Part A Effective Date PRIOR to 1/1/2020.	Plans for Applicants With: A 65th birthday AND Medicare Part A Effective Date on or AFTER 1/1/2020.	Notice, letter or other documentation from prior insurer must include items below. Also, please answer the questions on the Application Form in the "Is your acceptance guaranteed" and "Your past and current coverage" sections.
1. Applicant loses, learns they have lost, or drops employer coverage.	A, B, C, F, K, L, N	A, B, G, K, L, N	<ul style="list-style-type: none"> Applicant's name. Plan Type – confirmation that it's employer coverage being lost. Coverage termination date.
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	A, B, C, F, K, L, N	A, B, G, K, L, N	<ul style="list-style-type: none"> 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.
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	A, B, C, F, K, L, N	A, B, G, K, L, N	<ul style="list-style-type: none"> 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.
4. Applicant is enrolled in a Medicare supplement plan (including Select) that is involuntarily terminated (for example, company bankruptcy).	A, B, C, F, K, L, N	A, B, G, K, L, N	<ul style="list-style-type: none"> 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.

Continued ...

<p>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.</p>	<p>- If the previous plan you had was an AARP Medicare Supplement Plan, then you may apply for Plans A, B, C, F, K, L, N. Also, you can apply for Plan G without having to answer health questions only if Plan G was the Plan you previously had. - If the previous Medicare Supplement Plan* you had was with another insurer, then you can only apply for Plans A, B, C, F, K, L, N.</p>	<p>A, B, G, K, L, N</p>	<ul style="list-style-type: none"> • See information at the top of this chart.
<p>6. On first enrolling in Medicare Part A at age 65**, 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 A effective date for this qualifying event to apply.</p>	<p>A, B, C, F, G, K, L, N</p>	<p>A, B, G, K, L, N</p>	<ul style="list-style-type: none"> • See information at the top of this chart.

*Prior Plan can also be a Medicare Select or High Deductible version of the Plan being applied for.

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

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

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

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

You Cannot Be Singled Out for Cancellation

Your AARP Medicare Supplement Plan cannot 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

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: Plan A

Medicare Part A: Hospital Services per Benefit Period ¹				
Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	\$0	(Part A Deductible)
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	\$0	Up to ² a day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan A, continued

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan A Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Notes

4 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan B

Medicare Part A: Hospital Services per Benefit Period ¹				
Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	(Part A Deductible)	\$0
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	\$0	Up to ² a day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan B, continued

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan B Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All Costs
Blood	First 3 pints	\$0	All costs	\$0
	Next portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan B Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Notes

4 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	(Part A Deductible)	\$0
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	Up to ² a 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan C, continued

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

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

Notes

4 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

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Plan Benefit Tables: Plan C, continued

Other Benefits not covered by Medicare

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

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	(Part A Deductible)	\$0
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	Up to ² a 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan F, continued

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

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

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Notes

4 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F, continued

Other Benefits not covered by Medicare

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

Plan Benefit Tables: Plan G

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan G Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	(Part A Deductible)	\$0
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	Up to ² a 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan G, continued

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Notes

4 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Continued on next page ►

Plan Benefit Tables: Plan G, continued

Other Benefits not covered by Medicare

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

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Services per Benefit Period²

Service		Medicare Pays	Plan K Pays	You Pay ¹
Hospitalization² Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ³	(50% of Part A Deductible)	(50% of Part A Deductible) ⁵
	Days 61–90	All but ³ a day	³ a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ³ a day	³ a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ⁴
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 ³ a day	Up to 50% of ³ a day	Up to 50% of ³ a day ⁵
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	50%	50% ⁵
	Additional amounts	100%	\$0	\$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance ⁵

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Notes

1 You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit each calendar year.

2 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 consecutive days.

3 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

4 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's

"Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

Plan Benefit Tables: Plan K, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay ⁶
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 portion of Medicare-approved amounts ⁷	\$0	\$0	(Part B Deductible) ^{5,7}
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ⁵
Part B Excess Charges Above Medicare-approved amounts ⁶		\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit) ⁶
Blood	First 3 pints	\$0	50%	50% ⁵
	Next portion of Medicare-approved amounts ⁷	\$0	\$0	(Part B Deductible) ^{5,7}
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ⁵
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

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Notes

3 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the**

amount charged by your provider and the amount paid by Medicare for the item or service.

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

7 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁷), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K, continued

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay ⁶
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First portion of Medicare-approved amounts ⁸	\$0	\$0	(Part B Deductible) ⁵
	Remainder of Medicare-approved amounts	80%	10%	10% ⁵

Notes

3 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

6 This plan limits your annual out-of-pocket payments for Medicare-approved amounts per year. ³**However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

8 Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

Plan Benefit Tables: Plan L

Medicare Part A: Hospital Services per Benefit Period²

Service		Medicare Pays	Plan L Pays	You Pay ¹
Hospitalization² Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ³	(75% of Part A Deductible)	(25% of Part A Deductible) ⁵
	Days 61–90	All but ³ a day	³ a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ³ a day	³ a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ⁴
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 ³ a day	Up to 75% of ³ a day	Up to 25% of ³ a day ⁵
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	75%	25% ⁵
	Additional amounts	100%	\$0	\$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ⁵

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Notes

- You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit each calendar year.
- 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 consecutive days.
- The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.
- NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would

have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

Plan Benefit Tables: Plan L, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan L Pays	You Pay ⁶
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 portion of Medicare-approved amounts ⁷	\$0	\$0	(Part B Deductible) ^{5,7}
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ⁵
Part B Excess Charges Above Medicare-approved amounts ⁶		\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit) ⁶
Blood	First 3 pints	\$0	75%	25% ⁵
	Next portion of Medicare-approved amounts ⁷	\$0	\$0	(Part B Deductible) ^{5,7}
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ⁵
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

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Notes

3 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or**

service.

6 This plan limits your annual out-of-pocket payments for Medicare-approved amounts per year. ³**However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

7 Once you have been billed a portion of Medicare-approved amounts for covered services equal to the Part B Deductible (which are noted with a footnote ⁷), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan L, continued

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay ⁶
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First portion of Medicare-approved amounts ⁸	\$0	\$0	(Part B Deductible) ⁵
	Remainder of Medicare-approved amounts	80%	15%	5% ⁵

Notes

3 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

5 The amounts that count toward your annual limit are noted with a footnote (⁵) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

6 This plan limits your annual out-of-pocket payments for Medicare-approved amounts per year. **3 However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

8 Medicare benefits are subject to change. For the current Medicare benefits, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

Plan Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period ¹				
Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but ²	(Part A Deductible)	\$0
	Days 61–90	All but ² a day	² a day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but ² a day	² a day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ³
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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 ² a day	Up to ² a 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$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 consecutive days.

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

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

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to ² per office visit and up to ² per emergency room visit. The copayment of up to ² is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to ² per office visit and up to ² per emergency room visit. The copayment of up to ² is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

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Notes

2 The amount that Medicare does not pay is subject to change. For the current amount that Medicare does not pay, please consult the most current version of the *Guide to Health Insurance for People with Medicare*, which must be provided by an issuer to an applicant pursuant to NAC 687B.240.

4 Once you have been billed a portion of Medicare-approved amounts (equal to the Part B Deductible) for covered services (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Parts A and B

Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment Medicare-approved services	First portion of Medicare-approved amounts ⁴	\$0	\$0	(Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits not covered by Medicare

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

⁴ Once you have been billed a portion of Medicare-approved amounts (equal to the Part B Deductible) for covered services (which are noted with a footnote ⁴), your Part B Deductible will have been met for the calendar year.

Rules and Disclosures about this Insurance

This page explains important rules governing your Medicare 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.

Premium information

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

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

Policy replacement

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

Notice

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

Complete answers are very important

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

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 Nevada. The information you provide on this Application Form will be used to determine your acceptance and rate.

TEAR HERE

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 _____ / _____ / _____ **1D.** Gender Male Female
Month Day Year

1E. Medicare Number _____ (From your Medicare card.)

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

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

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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 65 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 entitled to guaranteed acceptance, please look at "Your Guide" to determine which Plans you are eligible for guaranteed acceptance in without having to answer health questions.

Please choose 1 Plan from the right-hand column. Important: Plans C and F are only available to eligible Applicants with a 65th birthday prior to 1/1/2020 or with a Medicare Part A Effective Date prior to 1/1/2020. Please call if you have questions.

- Plan A Plan B
- Plan C
- Plan F Plan G
- Plan K Plan L
- Plan N

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 8**. You do not have to answer the questions in **Sections 4, 5, 6 and 7**.
- 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 8**.
- 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**.
- If you answered **NO** to both questions in **Section 3**, continue to **Section 4**.

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. Has a medical professional told you that you have End-Stage Renal (Kidney) Disease or that you require dialysis?

Yes No Not Sure

5D. Within the past 2 years, did a medical professional tell you that you may need any of the following that **has NOT been completed**?

Yes No Not Sure

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

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.

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

6A. Within the past 2 years, 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

TEAR HERE

TEAR HERE

First Name

Last Name

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

- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure
- Yes No Not Sure

6B. Within the past 2 years, did you have (as determined by a medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or Mini-Stroke? Yes No Not Sure

If you answered YES to any question in Section 6, your rate will be the Level 2 rate. See the enclosed "Cover Page – Rates."
If you answered NOT SURE to any question, we may follow up for additional information.

7 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

TEAR HERE

First Name

Last Name

8 Tell us about your tobacco usage.

8A. 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 8A, your rate will be the tobacco rate. See "Cover Page - Rates."

9 Your past and current coverage

Review the statements.

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.
- 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 reinstated if requested within 90 days of losing your employer or union-based group health plan.
- 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,

9A. Did you turn age 65 in the last 6 months?

Yes No

9B. Did you enroll in Medicare Part B in the last 6 months?

Yes No

9C. If YES, what is the effective date?

_____/01/
Month Day Year

Questions about Medicaid

9D. 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.

Yes No

If YES, you must answer Questions 9E and 9F.

First Name

Last Name

9 Your past and current coverage (continued)

9E. Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

9F. 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)

9G. 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)? Yes No
If YES, you must answer Questions 9H through 9K.

9H. 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

9I. 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
If YES, please enclose a copy of the Replacement Notice.

9J. Was this your first time in this type of Medicare plan? Yes No

9K. Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

Questions about Medicare supplement plans

9L. Do you have another Medicare supplement policy in force? Yes No
If so, what insurance company and what plan do you have?
Insurance Company: _____
Policy: _____
If YES, you must answer Question 9M.

9M. Do you intend to replace your current Medicare supplement policy with this policy? Yes No
If YES, please enclose a copy of the Replacement Notice.

Questions about any other type of health insurance coverage

9N. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? Yes No
If YES, you must answer Questions 9O through 9Q.

9O. If so, with what insurance company and what kind of policy?
Insurance Company: _____

Policy:
 HMO/PPO
 Major Medical
 Employer Plan
 Union Plan
 Other _____

TEAR HERE

TEAR HERE

First Name

Last Name

9 Your past and current coverage (continued)

9P. 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

9Q. Are you replacing this health insurance?

Yes No

X

Your Signature (required)

____ / ____ / ____
Today's Date (required)
Month Day Year

10 Authorization and Verification of Application Information

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

- I declare 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 premium, or reduce my benefits.
- 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 and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. If not revoked, this authorization is valid for 24 months from the date of my signature.

First Name

Last Name

10

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 3 months prior to the insurance effective date.

TEAR HERE

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.

X

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.

11

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself or anyone else actively insured under this account to receive notice of lapse due to nonpayment of premium of this policy or certificate to supplement Medicare.

Check this box if you elect **NOT** to designate a person to receive a notice of lapse. **Also, be sure to sign below.**

1) Name

First Name Middle Initial Last Name

Address

Street Address City

State Zip Code Area Code Phone Number

2) Name

First Name Middle Initial Last Name

Address

Street Address City

State Zip Code Area Code Phone Number

TEAR HERE

X

Your Signature (REQUIRED WHETHER OR NOT YOU ELECT TO DESIGNATE ANOTHER PERSON)

First Name

Last Name

12 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:

TEAR HERE

TEAR HERE

Agent Name (PLEASE PRINT)		
_____	_____	_____
First Name	MI	Last Name
<input checked="" type="checkbox"/>	_____	_____ / ____ / ____
Agent Signature (required)	Agent ID (required)	Today's Date (required) Month Day Year
_____	()	-
Agent Email Address	Agent Phone Number	
<input checked="" type="checkbox"/>	_____	_____
Broker Name	Broker ID	



Plan Document Delivery Preferences

If you are accepted, you have the option to have your plan documents, such as Certificate of Insurance, Outline of Coverage and other important plan information, sent to you via **Online** or **U.S. Mail**.

If you select the Online option, please review and agree to the following Electronic Delivery Terms and Conditions.

Electronic Delivery Terms and Conditions

By choosing “Online,” you will receive your plan documents electronically instead of receiving paper copies through the U.S. Mail. When plan documents are available, you will be notified by email and access to the documents is provided through Member.UHCInfo.com.

The types of communications available electronically are subject to change. If additional types of communications become available for electronic delivery, you will have the opportunity to select your delivery preference at that time. Occasionally, in addition to electronic delivery, you may also receive a hard copy document.

You can request a free paper copy of documents that we are required to provide to you by calling the phone number on your health insurance ID card.

Your consent remains in effect until you withdraw it. You may withdraw your consent at any time and choose to begin receiving paper mailings by calling the phone number on your health insurance ID card or by changing your delivery preference on the Profile and Preference section on Member.UHCInfo.com once you are accepted.

If attempts are made to deliver information to an email address you provide and the message is returned as undeliverable after several attempts and that email address is not updated by you, we will assume that you have withdrawn consent for electronic delivery and will begin sending the information to you in paper format. To ensure that you continue to receive emails from us, add the email “from” address to your email address book or safe list. To update your email address, you can call the phone number on your health insurance ID card, or log onto Member.UHCInfo.com once you are accepted.

Requirements to access and retain information – In order to receive and retain electronic communications, you must have access to a computer or other device which is capable of accessing the Internet and you must have software which permits you to receive and access Portable Document Format or “PDF” files, such as [Adobe Acrobat Reader](#)® version 6.0 or higher. For access to the website, you can use one of the following browsers: Chrome, Firefox, Safari 9+ or Internet Explorer 10+.

We will send your plan documents electronically to the email address you have provided.

TEAR HERE

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

The Easiest Way to Pay

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

In addition to saving up to \$24 a year:

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

Signing Up is Easy

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

Your EFT Effective Date

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

TEAR HERE

Complete Form on Reverse ►

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

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

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

Member Name _____ AARP Member Number _____

Member Address _____

Street Address

Member Address _____

City

State

Zip Code

Bank Name _____

Bank Routing No. _____

(9 digit number)

Account Type: Checking

Savings (statement savings only)

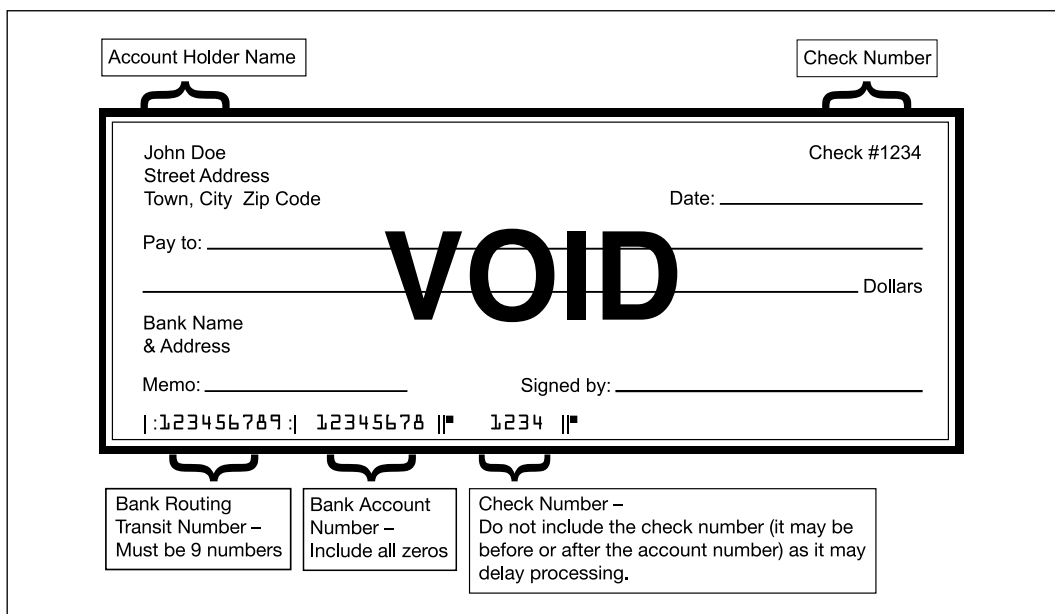
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

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



We look forward to continuing to serve you.

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

Horsham, Pennsylvania

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

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

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

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):

- | | |
|--|---|
| <input type="checkbox"/> Additional benefits. | <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment. |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Other (Please Specify) _____ |
| <input type="checkbox"/> Fewer benefits and lower premiums | _____ |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D. | _____ |

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



Language Assistance Services

We provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **toll-free 1-800-523-5800**, TTY 711. We are available Monday through Friday, 7 a.m. to 11 p.m. ET and Saturday 9 a.m. to 5 p.m. ET.

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ
1-800-523-5800

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-523-5800.

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-523-5800។

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

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

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

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-523-5800.

યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્ય પરચા છે. કૃપા કરી 1-800-523-5800 પર કોલ કરો.

Notice of Non-Discrimination

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call toll-free 1-800-523-5800, TTY 711. We are available Monday through Friday, 7 a.m. to 11 p.m. ET and Saturday 9 a.m. to 5 p.m. ET.

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

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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



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](https://www.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.

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SECTION

Medicare Basics

1

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](https://www.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](https://www.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

Medigap Basics

2

What's a Medigap policy?

A Medigap policy is an insurance policy that helps supplement Original Medicare and is sold by private companies. A Medigap 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.

Benefits	Medicare Supplement Insurance (Medigap) Plans									
	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.

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).

Words in [blue](#) are defined on pages 49–50.

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](https://www.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.

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.

Words in **blue** are defined on pages 49–50.

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.	<p>Mr. Smith is 65. He buys a Medigap policy and pays a \$165 monthly premium.</p> <hr/> <p>Mrs. Perez is 72. She buys the same Medigap policy as Mr. Smith. She also pays a \$165 monthly premium.</p>
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.	<p>Mr. Han is 65. He buys a Medigap policy and pays a \$145 monthly premium.</p> <hr/> <p>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.</p>
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.	<p>Mrs. Anderson is 65. She buys a Medigap policy and pays a \$120 monthly premium. Her premium will go up each year:</p> <ul style="list-style-type: none"> • At 66, her premium goes up to \$126. • At 67, her premium goes up to \$132. <hr/> <p>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:</p> <ul style="list-style-type: none"> • 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](https://www.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...
<p>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.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p> <p>You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.</p>	<p>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.</p>
<p>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.</p> <p>Note: In this situation, you may have additional rights under state law.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p> <p>If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.</p>	<p>No later than 63 calendar days after the latest of these 3 dates:</p> <ol style="list-style-type: none"> 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.
<p>You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area.</p> <p>Call the Medicare SELECT insurer for more information about your options.</p>	<p>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.</p>	<p>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.</p>

***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...
<p>(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.</p>	<p>Any Medigap policy that's sold in your state by any insurance company.*</p>	<p>As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.</p> <p>Note: Your rights may last for an extra 12 months under certain circumstances.</p>
<p>(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.</p>	<p>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.</p> <p>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.</p>	<p>As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.</p> <p>Note: Your rights may last for an extra 12 months under certain circumstances.</p>
<p>Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p>	<p>No later than 63 calendar days from the date your coverage ends.</p>
<p>You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.</p>	<p>Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company.</p>	<p>No later than 63 calendar days from the date your coverage ends.</p>

***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

Steps to Buying a Medigap Policy

4

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](https://www.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
<p>“Are you licensed in ___?” (Say the name of your state.) Note: If the answer is NO, STOP here, and try another company.</p>		
<p>“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.</p>		
<p>“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?”</p>		
<p>“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.</p>		
<p>“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.</p>	Community Issue-age Attained-age	Community Issue-age Attained-age
<p>“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?”</p>		
<p>“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.</p>		
<p>“Do you offer any discounts or additional benefits?” (See page 19.)</p>		

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

If You Already Have a Medigap Policy

5

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

Medigap Policies for People with a Disability or ESRD

6

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.

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.)

Words in [blue](#) are defined on pages 49–50.

SECTION

7 Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

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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](https://www.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	✓

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.

For more information on these Medigap policies, visit [Medicare.gov/find-a-plan](https://www.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.

SECTION

For More Information

8

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](https://www.medicare.gov/medigap-supplemental-insurance-plans).
- For updated phone numbers, visit [Medicare.gov/contacts](https://www.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.

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 can expect your insured Member Identification (ID) Card to arrive. Using the information on the Member ID Card, you can 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**.



Let's talk about your needs

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

Name _____

Email _____

Phone _____



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

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

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

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

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

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

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