Plan Change Enrollment Kit

Washington

Enrollment is for January 1, 2020 – March 1, 2020 plan effective dates.
Rate structures enclosed differ, based on original plan effective date.

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

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

BA25485ST

Keep health care coverage to fit your life: a Medicare supplement insurance plan

Greetings!

I want to remind you that with an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), you'll receive supplemental coverage that may serve your needs with:

Choice. Freedom in the health system is important – that's why Medicare supplement insurance may work for you. Like any Medicare supplement plan, you will have the ability to see any provider who accepts Medicare patients. In fact, 96% of our plan holders surveyed nationwide are satisfied with that ability.[1]

Stability. With more than 40 years of experience and an "A" rating by A.M. Best,[2] UnitedHealthcare covers more people with Medicare supplement plans nationwide than any other individual insurance carrier.[3]

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

As with any standardized Medicare supplement plan, you'll receive important supplemental coverage that helps pay for some of the out-of-pocket costs not paid by Medicare. With this enrollment kit, you can review benefits and rates for each available plan. You'll also learn about discounts and our unique value-added services[4] that may be available to you.

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

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

Warm regards,

Susan Morisato

AARP® | Medicare Supplement from UnitedHealthcare

Susan Morisato
President, Medicare Supplemental Health Insurance Program
UnitedHealthcare

P.S. Did you know that UnitedHealthcare's mission is *to help people live healthier lives and make the health system work better for everyone*? We're proud to be endorsed by AARP, whose mission is to *empower people to choose how they live as they age*.

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

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

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

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

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

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

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

Insured by UnitedHealthcare Insurance Company, Horsham, PA. Policy form No. GRP 79171 GPS-1 (G-36000-4).

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

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

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

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

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.

AARP® | Medicare Supplement Plans insured by UnitedHealthcare Insurance Company

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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.

Renew Active™ by UnitedHealthcare	Access to an extensive network of participating gyms and fitness locations at no additional cost, and online brain health tools.
AARP® Staying Sharp	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.
Hearing Care Program by HearUSA	A discount on hearing aids and access to screenings by certified HearUSA hearing care providers. The Hearing Care Program by HearUSA includes: • The AARP member rate plus an additional $100 discount on hearing devices in the top 5 tiers of technology and features, ranging from standard to premium. • Extended warranties on many of HearUSA's digital hearing aids. • Your very own hearing health support team.
AARP® Vision Discounts provided by EyeMed:	Save on eyewear purchases and routine eye exams. AARP Vision Discounts provided by EyeMed includes: • 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*.
24/7 Nurse line	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. • 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.
Wellness coaching	Trained wellness coaches are available over the phone to provide personalized programs and support that may help you reach your specific wellness goals.

^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

AARP® | Medicare Supplement Plans insured by UnitedHealthcare Insurance Company

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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.

Overview of Available Plans

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

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

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%	✔	✔ copays apply[3]	✔	✔
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 2019[2]					$5560[2]	$2780[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2300 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.

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

[3] Plan 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.

Cover Page - Rates

Monthly Plan Rates for Washington

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants									Medicare first eligible before 2020 only[2]	
Age[1]	Plan A	Plan B	Plan G	Select G[3]	Plan K	Plan L	Plan N	Select N[3]	Plan C[2]	Plan F[2]
	Standard Rates									
65+	$134.50	$196.50	$192.00	$182.50	$61.75	$135.50	$157.25	$149.50	$231.50	$232.25

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

1 Your age as of your plan effective date.

2 **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.

3 You must use a network hospital with Select Plans G and N.

Your Guide
To AARP Medicare Select and Medicare Supplement Insurance Plans

To help you choose the AARP Medicare Select or 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. Please use the documents that show the specific benefits and rates of each plan which allow you to compare the AARP Medicare Select and AARP Medicare Supplement Plans with other Medicare supplement plans. **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 or, if available in your area, Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• 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 or, if available in your area, Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• 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 or, if available in your area, Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• 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.

Continued...

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 or, if available in your area, Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• 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.
5. Applicant dropped Medicare supplement coverage to enroll for the first time in an MA, other Medicare managed care, PACE, or Select plan, and dropped that plan within two years.	- If the previous plan you had was an AARP Medicare Supplement Plan, then you may apply for Plans A, B, C, F, K, L, N or, if available in your area, Medicare Select N. Also, you can apply for Plan G or, if available in your area, Medicare Select G without having to answer health questions only if Plan G or Medicare Select 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 or, if available in your area, Medicare Select N.	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• See information at the top of this chart.
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.	A, B, C, F, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• See information at the top of this chart.
7. Applicants replace any Medicare Supplement plan, or other more comprehensive coverage (not including Medicaid).	A, B, C, F, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N	• Answer questions on the Application Form in the "Is your acceptance guaranteed" section and the "Your past and current coverage" section.

*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.

Additional Information

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.
- Care or services provided by a non-participating hospital, except in the event of a medical emergency, or if the services are not available from any participating hospital in the service area.

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

Medicare Select Disclosure Statement

Please read this information carefully. The following information is provided in order to make a full and fair disclosure to you of the provisions, restrictions, and limitations of the AARP Medicare Select Plan.

Medicare Select Provider Restrictions

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

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

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

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

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

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

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

Right to Replace Your Medicare Select Plan

You have the right to replace your AARP Medicare Select Plan with any other AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company, that has the same or lesser benefits as your current insurance and which does not require the use of participating providers, without providing evidence of insurability. Under Washington law, you may also be able to replace your AARP Medicare Select Plan with a plan offered by another carrier.

Quality Assurance

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

For Your Protection, Please Be Aware of the Following:

You Cannot Be Singled Out for Cancellation

Your AARP Medicare Select or Medicare Supplement Plan can never be canceled because of your age, your health, or the number of claims you make. Your AARP Medicare Select or Medicare Supplement Plan may be canceled due to nonpayment of premium or material misrepresentation. If your group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Select Plan or AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company or other coverage from an insurance carrier named by the Trustees of the AARP Insurance Plan. Under Washington law, you may also be able to replace your AARP Medicare Select Plan with a plan offered by another carrier. Of course, you may cancel your AARP Medicare Select Plan or AARP Medicare Supplement Plan any time you wish. All transactions go into effect on the first of the month following receipt of the request.

The AARP Insurance Trust

AARP established the AARP Insurance Plan, a trust, to hold the master group insurance policies. The AARP Medicare Select and AARP Medicare Supplement Plans are 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 Select or 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 Select or 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 Select and 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. A producer may contact you.

These materials describe the AARP Medicare Select and AARP Medicare Supplement Plans available in your state, but is not a contract, policy, or insurance certificate. Please read your Certificate of Insurance, upon receipt, for plan benefits, definitions, exclusions, and limitations.

Plan A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$0	$1,364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	$0	Up to $170.50 a day
101st day and after	$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

**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 A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES - 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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
▪ Remainder of Medicare Approved amounts	80%	20%	$0

Plan B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	$0	Up to $170.50 a day
101st day and after	$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

** 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 B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES - 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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
▪ Remainder of Medicare Approved amounts	80%	20%	$0

Plan C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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	All approved amounts	$0	$0
First 20 days			
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

**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 C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES - 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 $185 of Medicare Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES– Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
▪ Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

Plan F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

**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 F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – 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 $185 of Medicare Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
▪ Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

Plan G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

**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 G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – 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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
▪ Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5560 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of the 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.**

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$682 (50% of Part A Deductible)	$682 (50% of Part A Deductible)♦
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** 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
21st thru 100th day	All but $170.50 a day	Up to $85.25 a day (50% of Part A coinsurance)	$85.25 a day♦ (50% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD –			
First 3 Pints	$0	50%	50%♦
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♦

*** 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 K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – 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 $185 of Medicare Approved Amounts****	$0	$0	$185 (Part B Deductible)****♦
Preventive Benefits for Medicare Covered Services	Generally 80% or more of Medicare Approved amounts	Remainder of Medicare Approved amounts	All costs above Medicare Approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $5560)*
BLOOD			
First 3 Pints	$0	50%	50%♦
Next $185 of Medicare Approved Amounts****	$0	$0	$185 (Part B Deductible)****♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5560 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.**

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment:			
▪ First $185 of Medicare Approved Amounts*****	$0	$0	$185 (Part B Deductible)♦
▪ Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

Plan L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2780 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. 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.**

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,023 (75% of Part A Deductible)	$341 (25% of Part A Deductible)♦
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** 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
21st thru 100th day	All but $170.50 a day	Up to $127.87 a day (75% of Part A coinsurance)	$42.63 a day♦ (25% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD –			
First 3 Pints	$0	75%	25%♦
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 Medicare copayment/ coinsurance♦

*** 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 L

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
MEDICAL EXPENSES – 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 $185 of Medicare Approved Amounts****	$0	$0	$185 (Part B Deductible)****♦
Preventive Benefits for Medicare Covered Services	Generally 80% or more of Medicare Approved amounts	Remainder of Medicare Approved amounts	All costs above Medicare Approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2780)*
BLOOD			
First 3 Pints	$0	75%	25%♦
Next $185 of Medicare Approved Amounts****	$0	$0	$185 (Part B Deductible)****♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2780 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.**

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment:			
▪ First $185 of Medicare Approved Amounts*****	$0	$0	$185 (Part B Deductible)♦
▪ Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

Plan N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

**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 N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	Generally 80%	Balance other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (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

Medicare Select - Plan G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** Provider restrictions apply.

Services	Medicare Pays	Medicare Select Plan G Pays	You Pay
HOSPITALIZATION* in a Participating Hospital** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0***
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for atleast 3 days and entered a Medicare Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

***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.

Medicare Select - Plan G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an Asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Medicare Select Plan G Pays	You Pay
MEDICAL EXPENSES – 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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B deductible)
▪ Remainder of Medicare Approved amounts	80%	20%	$0

Medicare Select - Plan G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Medicare Select 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 Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Medicare Select - Plan N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** Provider restrictions apply.

Services	Medicare Pays	Medicare Select Plan N Pays	You Pay
HOSPITALIZATION* in a Participating Hospital** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	$0	100% of Medicare eligible expenses	$0***
▪ Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$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

***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.

Medicare Select - Plan N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an Asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Medicare Select Plan N Pays	You Pay
MEDICAL EXPENSES – 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	$0	$0

Medicare Select - Plan N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 of Medicare Approved amounts for covered services (which are noted with an Asterisk), your Part B Deductible will have been met for the calendar year.

PARTS A & B

Services	Medicare Pays	Medicare Select Plan N Pays	You Pay
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment:			
▪ First $185 of Medicare Approved amounts*	$0	$0	$185 (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

Rules and Disclosures about this Insurance

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

Premium information
UnitedHealthcare can only raise your premium if we raise the premium for all plans like yours in this State.

Disclosures
Use this outline to compare benefits and premiums among plans.

This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2020.

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.

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 *Medicare & You* for more details.

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

Grievance Procedure
Complaint and Grievance Procedure -
UnitedHealthcare has established a formal procedure to respond to customer complaints and grievances. UnitedHealthcare desires to provide a fair, accessible and responsive method of evaluating and resolving complaints and grievances. If UnitedHealthcare determines that any prior action that it has taken was incorrect, corrective action will be taken. You may, at any time, submit a written complaint to the Department of Insurance in your state.
Complaints - If you have a complaint, you may call us at 1-800-523-5880 or write to us at UnitedHealthcare, PO BOX 740807, Atlanta, GA 30374-0807. We will acknowledge all complaints within 15 days and will respond to all complaints within a reasonable period of time.
Grievances - If you are dissatisfied with our handling of a complaint or a claim denial, or are dissatisfied for any other reason, you may submit a formal grievance. Grievances must be in writing and contain the words "this is a grievance" to ensure that we understand the purpose of the communication. You must clearly state the nature of the grievance and send it to: UnitedHealthcare, PO BOX 740807, Atlanta, GA 30374-0807. We will acknowledge in writing all grievances within 15 days and respond to all grievances within a reasonable period of time. All grievances must be filed within 60 days or as soon as reasonably possible from the date of denial of benefits or other action giving rise to the grievance.

Washington Resident Directory

Participating Hospitals - Effective October 2019
For AARP® Medicare Select Plans

Washington

Benton County

Trios Women's and Children's Hospital
900 South Auburn Street
Kennewick, WA 99336
(509) 586-6111

Prosser Memorial Hospital
723 Memorial Street
Prosser, WA 99350
(509) 786-2222

Chelan County

Cascade Medical Center
817 Commercial Street
Leavenworth, WA 98826
(509) 548-5815

Clark County

Legacy Salmon Creek Hospital
2211 NE 139th Street
Vancouver, WA 98686
(360) 487-1000

PeaceHealth Southwest Medical Center*
400 NE Mother Joseph Place
Vancouver, WA 98664
(360) 256-2000

Cowlitz County

PeaceHealth St. John Medical Center*
1615 Delaware Street
Longview, WA 98632
(360) 414-2000

Franklin County

Lourdes Medical Center**
520 North Fourth Avenue
Pasco, WA 99301
(509) 547-7704

Grant County

Columbia Basin Hospital
200 Nat Washington Way
Ephrata, WA 98823
(509) 754-4631

Quincy Valley Medical Center
908 Tenth Avenue SW
Quincy, WA 98848
(509) 787-3531

Samaritan Healthcare
801 East Wheeler Road
Moses Lake, WA 98837
(509) 765-5606

Grays Harbor County

Summit Pacific Medical Center
600 East Main Street
Elma, WA 98541
(360) 346-2222

Jefferson County

Jefferson General Hospital
834 Sheridan Street
Port Townsend, WA 98368
(360) 385-2200

King County

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104
(206) 744-3000

St. Elizabeth Hospital
1455 Battersby Avenue
Enumclaw, WA 98022
(360) 802-8800

St. Francis Hospital
34515 9th Avenue South
Federal Way, WA 98003
(253) 944-8100

Kittitas County

Kittitas Valley Hospital*
603 S. Chestnut Street
Ellensburg, WA 98926
(509) 962-9841

Klickitat County

Skyline Hospital
211 NE Skyline Drive
White Salmon, WA 98672
(509) 493-1101

Lewis County

Morton General Hospital
521 Adams Avenue
Morton, WA 98356
(360) 496-5112

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

**This hospital was contracted by AmeriPlus and leased by UnitedHealthcare for inclusion in the AARP Medicare Select Network.

Washington (Continued)

Pacific County

Willapa Harbor Hospital
800 Alder Street
South Bend, WA 98586
(360) 875-5526

Pierce County

CHI Franciscan Rehabilitation Hospital
815 South Vassault Street
Tacoma, WA 98465
(253) 444-3320

St. Anthony Hospital
11567 Canterwood Blvd. NW
Gig Harbor, WA 98332
(253) 530-2000

St. Clare Hospital
11315 Bridgeport Way SW
Lakewood, WA 98499
(253) 985-1711

St. Joseph Medical Center
1717 South J Street
Tacoma, WA 98405
(253) 426-4101

Snohomish County

Swedish Edmonds Hospital
21601 76th Avenue West
Edmonds, WA 98026
(425) 640-4000

Spokane County

Multicare Deaconess Hospital
800 West 5th Avenue
Spokane, WA 99204
(509) 458-5800

Multicare Valley Hospital
12606 East Mission Avenue
Spokane, WA 99216
(509) 924-6650

Providence Holy Family Hospital**
5633 North Lidgerwood Street
Spokane, WA 99208
(509) 482-0111

Providence Sacred Heart Medical Center**
101 West Eighth Street
Spokane, WA 99204
(509) 474-3131

Walla Walla County

Providence St Mary Medical Center*
401 W Poplar Street
Walla Walla, WA 99362
(509) 525-3320

Whitman County

Pullman Regional
835 SE Bishop Blvd.
Pullman, WA 99163
(509) 332-2541

Yakima County

Sunnyside Community Hospital
1016 Tacoma Avenue
Sunnyside, WA 98944
(509) 837-1500

Toppenish Community Hospital
502 West Fourth Avenue
Toppenish, WA 98948
(509) 865-3105

Idaho

Kootenai County

Kootenai Health
2003 Kootenai Health Way
Coeur d'Alene, ID 83814
(208) 625-4000

Kootenai County *(Continued)*

Northern Idaho Advanced Care Hospital
600 North Cecil Road
Post Falls, ID 83854
(208) 262-2800

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

**This hospital was contracted by AmeriPlus and leased by UnitedHealthcare for inclusion in the AARP Medicare Select Network.

Oregon

Multnomah County

Legacy Emanuel Medical Center
2801 North Gantenbein Avenue
Portland, OR 97227
(503) 413-2200

Legacy Good Samaritan
Medical Center
1015 NW 22nd Avenue
Portland, OR 97210
(503) 413-7711

Multnomah County
(Continued)

Legacy Mount Hood
Medical Center
24800 SE Stark Street
Gresham, OR 97030
(503) 667-1122

Umatilla County

Good Shepherd Medical Center
610 NW 11th Street
Hermiston, OR 97838
(541) 667-3400

Washington County

Legacy Meridian Park Hospital
19300 SW 65th Avenue
Tualatin, OR 97062
(503) 692-1212

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

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

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

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

For AARP® Medicare Select Plans Only

Washington - Effective July 2019

Medicare Select Plans are available to individuals in the following zip code areas:

98001	98031	98063	98111	98154	98207	98253	98292	98338	98370	98402	98446
98002	98032	98064	98112	98155	98208	98255	98293	98339	98371	98403	98447
98003	98033	98065	98113	98158	98213	98256	98294	98340	98372	98404	98448
98004	98034	98068	98114	98160	98220	98257	98296	98342	98373	98405	98464
98005	98035	98070	98115	98161	98221	98258	98297	98343	98374	98406	98465
98006	98036	98071	98116	98164	98222	98259	98303	98344	98375	98407	98466
98007	98037	98072	98117	98165	98223	98260	98304	98345	98376	98408	98467
98008	98038	98073	98118	98166	98224	98261	98310	98346	98377	98409	98471
98009	98039	98074	98119	98168	98225	98262	98311	98348	98378	98411	98481
98010	98040	98075	98121	98170	98226	98263	98312	98349	98380	98412	98490
98011	98041	98077	98122	98174	98227	98270	98314	98351	98382	98413	98493
98012	98042	98082	98124	98175	98228	98271	98315	98352	98383	98415	98496
98013	98043	98083	98125	98177	98229	98272	98320	98353	98384	98416	98497
98014	98045	98087	98126	98178	98232	98273	98321	98354	98385	98417	98498
98015	98046	98089	98127	98181	98233	98274	98322	98355	98386	98418	98499
98019	98047	98092	98129	98185	98235	98275	98323	98356	98387	98419	98501
98020	98050	98093	98131	98188	98236	98277	98324	98358	98388	98421	98502
98021	98051	98101	98133	98190	98238	98278	98325	98359	98390	98422	98503
98022	98052	98102	98134	98191	98239	98279	98327	98360	98391	98424	98504
98023	98053	98103	98136	98194	98241	98280	98328	98361	98392	98430	98505
98024	98055	98104	98138	98195	98243	98282	98329	98362	98393	98431	98506
98025	98056	98105	98139	98198	98245	98284	98330	98363	98394	98433	98507
98026	98057	98106	98141	98199	98248	98286	98332	98364	98395	98438	98508
98027	98058	98107	98144	98201	98249	98287	98333	98365	98396	98439	98509
98028	98059	98108	98145	98203	98250	98288	98335	98366	98397	98443	98511
98029	98061	98109	98146	98204	98251	98290	98336	98367	98398	98444	98512
98030	98062	98110	98148	98206	98252	98291	98337	98368	98401	98445	98513

CONTINUED ON REVERSE ▶

CONTINUED

98516	98561	98599	98640	98802	98901	98952	99039	99158	99218	99347
98520	98562	98601	98641	98807	98902	98953	99040	99159	99219	99348
98522	98563	98602	98642	98811	98903	99001	99101	99161	99220	99349
98524	98564	98603	98643	98813	98904	99003	99102	99163	99223	99350
98526	98565	98604	98644	98814	98907	99004	99103	99164	99224	99352
98527	98566	98605	98645	98815	98908	99005	99104	99169	99228	99353
98528	98568	98606	98647	98816	98909	99006	99105	99170	99251	99354
98530	98569	98607	98648	98817	98920	99008	99109	99171	99252	99356
98531	98570	98609	98649	98821	98921	99009	99110	99173	99256	99357
98532	98571	98610	98650	98822	98922	99011	99111	99174	99258	99359
98533	98572	98611	98651	98823	98923	99012	99113	99176	99260	99360
98535	98575	98612	98660	98824	98925	99013	99115	99179	99301	99361
98536	98576	98613	98661	98826	98926	99014	99117	99180	99302	99362
98537	98577	98614	98662	98828	98930	99016	99119	99181	99320	99363
98538	98579	98616	98663	98830	98932	99017	99122	99185	99321	99371
98539	98580	98617	98664	98831	98933	99018	99123	99201	99322	99401
98540	98581	98619	98665	98832	98934	99019	99125	99202	99323	99402
98541	98582	98620	98666	98834	98935	99020	99128	99203	99324	99403
98542	98583	98621	98668	98836	98936	99021	99129	99204	99326	
98544	98584	98622	98670	98837	98937	99022	99130	99205	99328	
98546	98585	98623	98671	98843	98938	99023	99131	99206	99329	
98547	98586	98624	98672	98845	98939	99025	99134	99207	99330	
98548	98587	98625	98673	98846	98940	99026	99135	99208	99333	
98550	98588	98626	98674	98847	98941	99027	99136	99209	99335	
98552	98589	98628	98675	98848	98942	99029	99137	99210	99336	
98554	98590	98629	98682	98850	98943	99030	99143	99211	99337	
98555	98591	98631	98683	98851	98944	99031	99144	99212	99338	
98556	98592	98632	98684	98852	98946	99032	99147	99213	99341	
98557	98593	98635	98685	98853	98947	99033	99148	99214	99343	
98558	98595	98637	98686	98857	98948	99034	99149	99215	99344	
98559	98596	98638	98687	98858	98950	99036	99154	99216	99345	
98560	98597	98639	98801	98860	98951	99037	99156	99217	99346	

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Enrollment Checklist

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

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

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

✔ **AARP Membership Form**
AARP membership is required to enroll in an AARP Medicare Supplement Plan, insured by UnitedHealthcare Insurance Company. If you are not currently an AARP member or are unsure, you may enroll, renew or verify in one of three ways:
- Log on to AGNTU.aarpenrollment.com;
- Call toll-free 1-866-331-1964; or
- Complete the membership form and submit it with the plan application, along with a separate check for $16.00 payable to AARP. Note: One membership covers both the member and another individual living in the same household. Therefore, only one membership application is required if two individuals of a household are applying for AARP membership.

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

✔ **Notice to Applicants Regarding Replacement of Coverage**
If you are replacing or losing current coverage as indicated on the form, complete both copies of the form, submit one copy with the enrollment application, and keep the other copy for your records. The licensed insurance producer must also sign and date both copies of the form.

✔ **If Reply Envelope Is Missing**
Please mail completed application to: UnitedHealthcare Insurance Company
P.O. Box 105331
Atlanta, GA 30348-5331

(Over Please)

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

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

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

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

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

Application Form

AARP® Medicare Supplement Insurance Plans

Insured by
UnitedHealthcare Insurance Company (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 Washington. The information you provide on this Application Form will be used to determine your acceptance and rate.

TEAR HERE

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

1 Provide additional information about yourself and your Medicare Insurance.

( ) -

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

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

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

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

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

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

2460720307 _AGT

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
☐Medicare Select Plan G
☐Medicare Select 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 7**. You do not have to answer the questions in **Sections 4, 5 and 6**.
- If **NO**, you must answer **Question 3B**.

3B. Do you intend to replace your current standardized Medicare supplement plan A through N or your more comprehensive coverage? (For example, employer-sponsored HMO, major medical, pre-standardized Medicare supplement, etc.) ☐Yes ☐No

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

3C. Do you have guaranteed issue rights, as listed in the Guaranteed Acceptance section of "Your Guide"? **If YES, see Your Guide for the documentation you will need to provide from your prior insurer or employer.** ☐Yes ☐No

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

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

- If you answered **NO** to all questions in **Section 3**, continue to **Section 4**.

TEAR HERE

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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.

TEAR HERE

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

5A. Within the past 90 days, were you hospitalized as an inpatient (not including overnight outpatient observation)?	☐Yes ☐No ☐Not Sure
5B. Are you currently being treated or living in any type of nursing facility other than an assisted living facility?	☐Yes ☐No ☐Not Sure
5C. Within the past 2 years, did a medical professional tell you that you may need any of the following that **has NOT been completed**? • hospital admittance as an inpatient • joint replacement • organ transplant • surgery for cancer • back or spine surgery • heart or vascular surgery	☐Yes ☐No ☐Not Sure
5D. Within the past 2 years, did you have (as determined by a medical professional) a Heart Attack, Stroke, Transient Ischemic Attack (TIA) or mini-stroke?	☐Yes ☐No ☐Not Sure
5E. Within the past 2 years, did you have (as determined by a medical professional) or were you diagnosed, treated, given medical advice or prescribed medication/refills for any of the following conditions?	
• Atrial Fibrillation or Flutter	☐Yes ☐No ☐Not Sure
• Artery or Vein Blockage	☐Yes ☐No ☐Not Sure
• Peripheral Vascular Disease (PVD)	☐Yes ☐No ☐Not Sure
• Cardiomyopathy	☐Yes ☐No ☐Not Sure
• Congestive Heart Failure (CHF)	☐Yes ☐No ☐Not Sure
• Coronary Artery Disease (CAD)	☐Yes ☐No ☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐Yes ☐No ☐Not Sure
• End-Stage Renal (Kidney) Disease or Require Dialysis	☐Yes ☐No ☐Not Sure
• Chronic Kidney Disease	☐Yes ☐No ☐Not Sure
• Diabetes, but only if you have circulation problems or Retinopathy	☐Yes ☐No ☐Not Sure

TEAR HERE

First Name Last Name

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

• Cancer including Melanoma (but not other skin cancers), Leukemia or Lymphoma	☐Yes	☐No	☐Not Sure
• Cirrhosis of the Liver	☐Yes	☐No	☐Not Sure
• Macular Degeneration, but only if you have the wet form	☐Yes	☐No	☐Not Sure
• Multiple Sclerosis	☐Yes	☐No	☐Not Sure
• Rheumatoid Arthritis	☐Yes	☐No	☐Not Sure
• Systemic Lupus Erythematosus (SLE)	☐Yes	☐No	☐Not Sure

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 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

7 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 reinstituted if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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

PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge, **7A.** Did you turn age 65 in the last 6 months?	☐Yes ☐No
7B. Did you enroll in Medicare Part B within the last 6 months?	☐Yes ☐No
7C. If YES, what is the effective date?	/01/ Month Day Year
Questions about Medicaid	
7D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 7E and 7F.**	☐Yes ☐No
7E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
7F. 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)	
7G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 7H through 7K.**	☐Yes ☐No
7H. 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

TEAR HERE

TEAR HERE

First Name Last Name

7 Your past and current coverage (continued)

7I. 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.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
7J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
7K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No
Questions about Medicare supplement plans	
7L. Do you have another Medicare supplement policy in force? If so, what insurance company and what plan do you have? Insurance Company: _____ Policy: _____ **If YES, you must answer Question 7M.**	☐Yes ☐No
7M. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
Questions about any other type of health insurance coverage	
7N. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 7O through 7Q.**	☐Yes ☐No
7O. If so, with what insurance company and what kind of policy? **Insurance Company:**_____	**Policy:** ☐HMO/PPO ☐Major Medical ☐Employer Plan ☐Union Plan ☐Other_____
7P. 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
7Q. Are you replacing this health insurance?	☐Yes ☐No

TEAR HERE

TEAR HERE

✗ _____
Your Signature (required)

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

First Name Last Name

8 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.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- 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 you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.

If the Application Form is being completed through a Producer:

- I understand the producer 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 a producer 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.

TEAR HERE

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. ☐

First Name Last Name

9 For Producer Use Only

If application is being made through a Producer, he or she must complete the following information and include the notice of replacement coverage, if appropriate, with this application. All information must be complete or the Application Form will be returned.

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

_____

_____

2. List policies issued which are still in force:

_____

_____

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

_____

_____

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

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

_____ (____) ____-_____
Agent Email Address Agent Phone Number

✗ _____ _____
Broker Name Broker ID

TEAR HERE

TEAR HERE

TEAR HERE

TEAR HERE

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

The Easiest Way to Pay

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

In addition to saving up to $24 a year:

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

Signing Up is Easy

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

Your EFT Effective Date

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

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

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

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

Member Name _____ AARP Member Number_____

Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____ Account Type: ☐ Checking
(9 digit number) ☐ Savings (statement savings only)

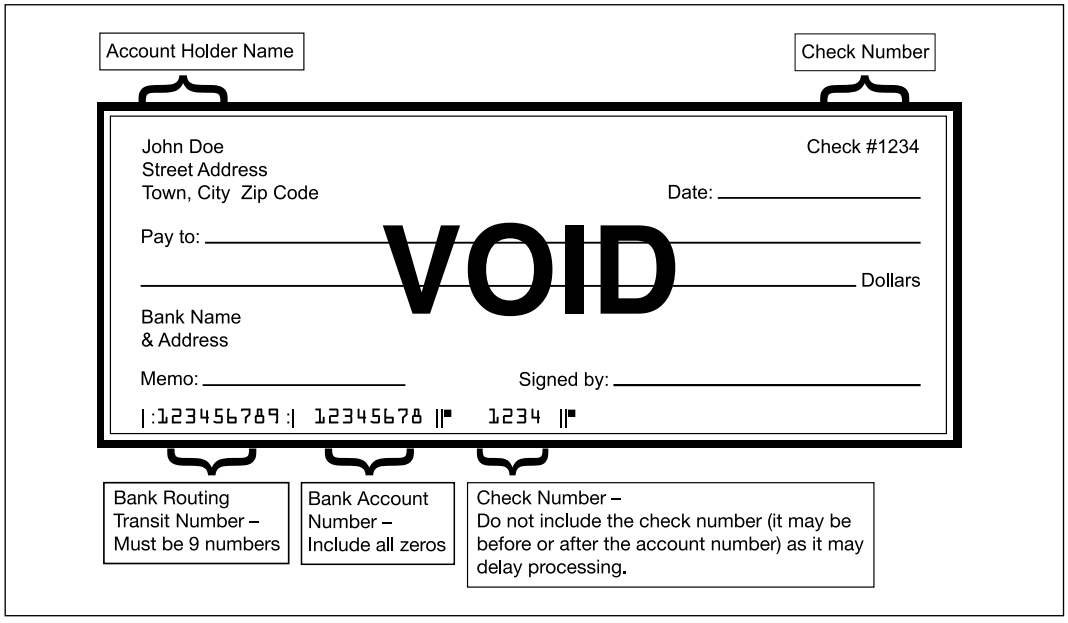
Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

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



We look forward to continuing to serve you.

TEAR HERE

TEAR HERE

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Member Address _____
Street Addresss

Member Address _____
City State Zip Code

Bank Name _____

Bank Routing No. _____ Account Type: ☐ Checking
(9 digit number) ☐ Savings (statement savings only)

Bank Account No. _____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

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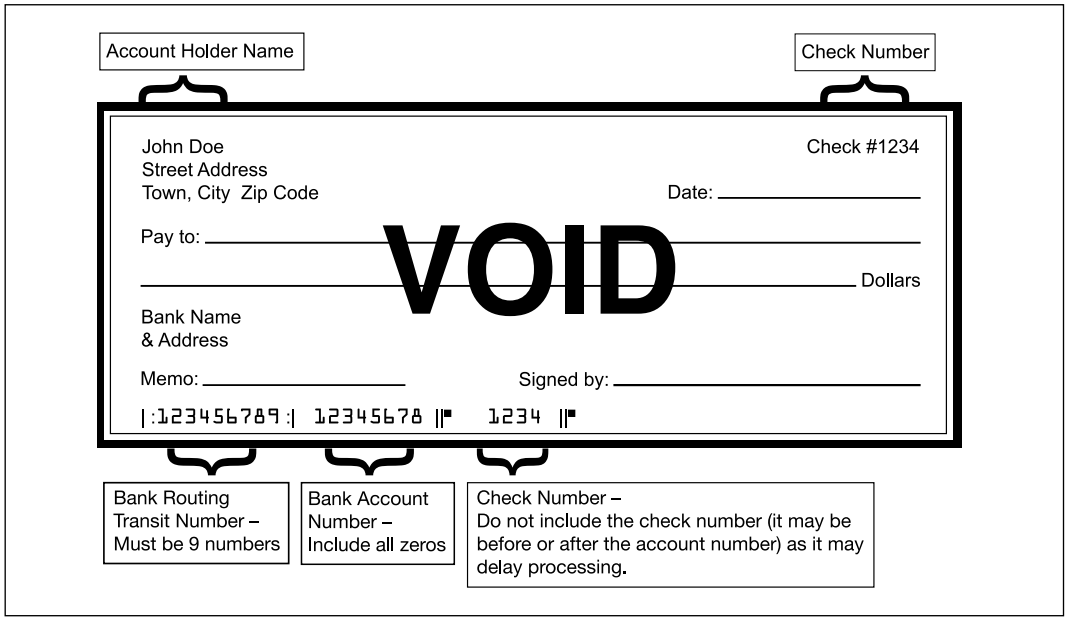

We look forward to continuing to serve you.

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

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-523-5800번으로 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،(Arabic)**فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ

1-800-523-5800

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

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

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

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

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

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

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

تماس بگیرید. 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 नि:शुल्क उपलध 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: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតៃថ្ល គឺមានសំរាប់អ្នក។ សូ មទូរស័ព្ទ 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.

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

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

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

ધ્યાન આપો: જો તમે ગુજરાતી **(Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ પરરાપ 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

2019

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

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

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

Who should read this guide?

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

Important information about this guide

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

The "2019 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 1

Medicare Basics

A brief look at Medicare

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

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

Words in blue are defined on pages 49–50.

What's Medicare?

Medicare is health insurance for:

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

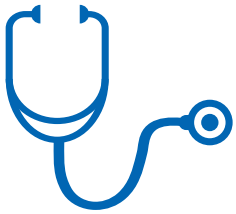
The different parts of Medicare

The different parts of Medicare help cover specific services.

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 and supplies)
- Many preventive services (like screenings, shots, and yearly "Wellness" visits)

Part D (Prescription drug coverage)

Helps cover:

- Cost of prescription drugs

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 deductible and 20% coinsurance), you can also shop for and buy supplemental coverage.

☑ **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.
- Some plans may have lower out-of-pocket costs than Original Medicare.
- Some plans offer extra benefits that Original Medicare doesn't cover — like vision, hearing, or dental.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

Some plans also include:

☐ **Lower out-of-pocket-costs**

☐ **Extra benefits**

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. It's important to terminate your Marketplace coverage in a timely manner to avoid an overlap in coverage. Once you're considered eligible for premium free Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back some or all of the help you got when you file your taxes. Visit HealthCare.gov to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan or Marketplace financial help when your Medicare enrollment begins 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 drug plans (Part D).

For more information

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

SECTION 2

Medigap Basics

What's a Medigap policy?

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

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

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

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

Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies.

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 effective on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- Plans E, H, I, and J are **no longer sold**, but, if you already have one, you can generally keep it.
- Starting January 1, 2020, Medigap plans sold to 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 will be able to keep your plan. If you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy one of these plans.
  - People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.

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

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

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Medicare Part B coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%** ***
Blood (first 3 pints)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A hospice care coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Skilled nursing facility care coinsurance			**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A deductible		**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	50%	**100%**
Part B deductible			**100%**		**100%**					
Part B excess charges					**100%**	**100%**				
Foreign travel emergency (up to plan limits)			**80%**	**80%**	**80%**	**80%**			**80%**	**80%**
							Out-of-pocket limit in 2019**			
							$5,560	$2,780		

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,300 in 2019 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($185 in 2019), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

What Medigap policies don't cover

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

Types of coverage that are NOT Medigap policies

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

What types of Medigap policies can insurance companies sell?

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

Words in blue are defined on pages 49–50.

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

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

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

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

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

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to buy a Medigap policy.
- If you have a Medicare Advantage Plan (like an HMO or PPO) but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the Plan. Ask that the new Medigap policy start when your Medicare Advantage Plan enrollment ends, so you'll have continuous coverage.
- You pay the private insurance company a premium for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, **you each will have to buy separate Medigap policies**.
- When you have your Medigap Open Enrollment Period, you can buy a Medigap policy from any insurance company that's licensed in your state.
- If you want to buy a Medigap policy, see page 11 for an overview of the basic benefits covered by different Medigap policies. Then, follow the "**Steps to Buying a Medigap Policy**" on pages 25–30.
- If you want to drop your Medigap policy, write your insurance company to cancel the policy and confirm it's cancelled. Your agent can't cancel the policy for you.
- Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you stay enrolled and pay the premium.
- Different insurance companies may charge different premiums for the same exact policy. As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).
- Some states may have laws that may give you additional protections.
- Although some Medigap policies sold in the past covered prescription drugs, Medigap policies sold after January 1, 2006, aren't allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D) offered by private companies approved by Medicare. See pages 6–7.

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

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

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

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

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

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

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

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

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

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

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

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

Employer coverage

Words in blue are defined on pages 49–50.

If you have group health coverage through an employer or union, because either you or your spouse is currently working, you may want to wait to enroll in Part B. Benefits based on current employment often provide coverage similar to Part B, so you wouldn't want to pay for Part B before you need it, and your Medigap Open Enrollment Period might expire before a Medigap policy would be useful. When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty which means your Medigap Open Enrollment Period will start when you're ready to take advantage of it. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare. See page 24 for more information.

How do insurance companies set prices for Medigap policies?

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

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

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

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

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

Comparing Medigap costs

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

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

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

- Offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses medical underwriting, or applies a different premium when you don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. See page 20.
- Offers a "high-deductible option" for Plan F. If you buy Plan F with a high-deductible option, you must pay the first $2,300 of deductibles, copayments, and coinsurance (in 2019) 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 $2,300 deductible (in 2019) before the policy pays anything for medical benefits.

What's Medicare SELECT?

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

How does Medigap help pay my Medicare Part B bills?

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

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

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

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

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

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

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

When do I have guaranteed issue rights?

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

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

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

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

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

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

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

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

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

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

For more information about Medigap rights

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

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

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

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

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

SECTION 4

Steps to Buying a Medigap Policy

Step-by-step guide to buying a Medigap policy

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

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

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

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

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

STEP 4: Buy the Medigap policy.

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

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

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

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

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

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

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

  ✔ What each Medigap policy covers.

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

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

Words in blue are defined on pages 49–50.

STEP 2: (continued)

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

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

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

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

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

STEP 3: (continued)

Watch out for illegal practices.

It's illegal for anyone to:

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

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

STEP 4: Buy the Medigap policy.

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

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

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

SECTION 5

If You Already Have a Medigap Policy

Read this section 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.

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

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

Words in blue are defined on pages 49–50.

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

Losing Medigap coverage

Can my Medigap insurance company drop me?

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

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

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

Medigap policies and Medicare prescription drug coverage

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

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

Medigap policies and Medicare prescription drug coverage (continued)

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

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

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

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

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

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

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

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

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

In general, you can only join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) during the Medicare Open Enrollment Period between October 15 –December 7. If you join during Medicare Open Enrollment Period, your coverage will begin on January 1. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you won't be able to get it back so pay careful attention to the timing.

SECTION 6

Medigap Policies for People with a Disability or ESRD

Information for people under 65

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

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

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

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

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

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

SECTION

7

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

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

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

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

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

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

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

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

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

Mandatory riders

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

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

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

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

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

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

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

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

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

Optional riders

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

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

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

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan ($2,300 deductible for 2019) is also available.

SECTION

8

For More Information

Where to get more information

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

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

How to get help with Medicare and Medigap questions

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

Visit Medicare.gov:

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

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

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

State Health Insurance Assistance Program and State Insurance Department

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

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

SECTION 9

Definitions

Where words in BLUE are defined

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice of Accessible Communications

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

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

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

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

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

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

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

Send a letter to:

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

You can also contact the Customer Accessibility Resource staff:

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

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

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

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

Nondiscrimination Notice

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

How to file a complaint

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

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

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

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

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

Official Business
Penalty for Private Use, $300

CMS Product No. 02110
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To get this publication in Braille, Spanish, or large print (English), visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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

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

For Your Records:

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

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

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

What's Next:

Once your application is approved, you 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**.

AARP® | Medicare Supplement Plans insured by UnitedHealthcare Insurance Company

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

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

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

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

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

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

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

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