AARP® | Medicare Supplement from UnitedHealthcare®

Enrollment Kit

California

Enrollment is for June 1, 2021 – May 1, 2022 plan effective dates.

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

IMPORTANT MESSAGE

ABOUT PLAN C & PLAN F

For 1/1/2020 new plan start 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 start date if:

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

OR

You will be age 50 or older **ON or AFTER** 1/1/2020

AND

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

Please note that if you are age 50-64 and eligible for Medicare by reason of disability and do not have End-Stage Renal Disease and are not in your Birthday Open Enrollment Period and replacing a Medicare supplement plan, you must apply within 6 months after enrolling in Medicare Part B or receiving notification of retroactive eligibility for Medicare Part B, unless you're entitled to Guaranteed Issue shown in the "Your Guide." If you were **eligible for Medicare Part A before 1/1/2020**, you may only apply for Plan A, B, C, F or K. If you are **eligible for Medicare Part A on or after 1/1/2020**, you may only apply for Plan A, B, G or K.

If you do not meet either situation above, please refer to the enclosed materials for plans **other than** C and F that you may apply for.

Questions?

Contact your licensed insurance agent/producer.

Gym Membership, Discounts, and More

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

Gym Membership

Renew Active™ by UnitedHealthcare:

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

Brain Health

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

Dental Discount

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

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

The Dentegra dental discount is not insurance.

Vision Discount

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

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

Hearing Discount

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

The Hearing Care Program by HearUSA includes:

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

24/7 Nurse line

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

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

Driver Safety

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

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

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

AARP® | Medicare Supplement from UnitedHealthcare®

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Renew Active by UnitedHealthcare

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

The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan. Renew Active premium gym and fitness location network only available with certain plans.

AARP Staying Sharp

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

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

Participation in the brain health assessment is voluntary.

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

Dentegra Dental Discount

†Dentegra Fee Schedules vs. Fair Health Mean Data

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

AARP Vision Discounts provided by EyeMed

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

*Offer valid at participating providers. Eye exam discount applies only to comprehensive eye exams and does not include contact lens exams or fitting. Contact lens purchase requires valid contact lens prescription.

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

Hearing program by HearUSA

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

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

Nurse line

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

AARP Driver Safety

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

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

This offer is non-transferrable and void where prohibited.

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

AARP Medicare Supplement Insurance Plans

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company.

UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers. You must be an AARP member to enroll in an AARP Medicare Supplement Plan.

AARP Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company, Horsham, PA. Policy Form No. GRP 79171 GPS-1 (G-36000-4).

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

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

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

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

Discover the Real Possibilities of AARP Membership

Membership with AARP means:

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

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

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

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

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

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

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

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

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

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

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

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Bright Ways To Save

These discounts can add up to valuable savings on an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare).

SAVE up to 36% with the Enrollment Discount

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

SAVE 7% with the Multi-Insured Discount starting 6/1/21

You can take 7% off your monthly premiums if two or more members are enrolled under the same AARP membership number and each is insured under an eligible AARP-branded supplemental insurance policy insured by UnitedHealthcare Insurance Company.

TAKE $24 OFF with Electronic Funds Transfer

You'll save $2.00 off your total monthly household premium, or $24 per year, when you use the convenient and easy payment option, Electronic Funds Transfer (EFT). Your monthly payments are automatically forwarded by your bank, which means no checks to write and no postage to pay. Simply complete the EFT form located in this booklet.

SAVE $24 per year with the Annual Payer Discount

Take $24 off your total household premium when you pay your entire annual premium at one time.

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

LOCK In Your Premium with the Rate Guarantee

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

AARP® | Medicare Supplement from UnitedHealthcare®

Contact your licensed insurance agent/producer to get your personalized rate quote.

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

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

Plans may be available to persons under age 65 who are eligible for Medicare by reason of disability.

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

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

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

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Outline of Coverage | UnitedHealthcare Insurance Company

Overview of Available Plans

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

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G [1]	K	L	M	N	C	F [1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ 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 2021[2]					$6220[2]	$3110[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2370 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.

AARP® | Medicare Supplement from UnitedHealthcare®

Your Plans and Rates

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

1 Review plan

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

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

2 Find your rate

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

For Applicants Age 65 and Older:

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

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

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

If you are in Group 1 and under age 77, you may be eligible for the Standard rates with Enrollment Discount. You can find information about the Enrollment Discount on the next page. If you are in Group 2, your rate is shown on the rate page.

Applicants Age 50-64

If you are age 50-64 and eligible for Medicare due to disability, you are in Group 3.

3 Enroll

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

*Note: Do not choose the rate for tobacco users if you are eligible for guaranteed acceptance based on the information shown on your Application Form.

Enrollment Discount

Who is eligible?

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

- 65 to 74, or
- 75 to 76 and your plan effective date is within 10 years of your Medicare Part B effective date

How it works

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

Example 1: Meet JANE*...

- Jane's Plan Effective Date is: June 1st
- Jane's Age When Her Plan Becomes Effective: 67
- Time since Jane enrolled in Medicare Part B: 1 year

Jane is eligible for the enrollment discount

- Jane's discount will begin at age 67
- Starting discount: 30%
- Discount will change to 27% beginning on Jane's anniversary date (June 1st of the next year)

Example 2: Meet JOE*...

- Joe's Plan Effective Date is: June 1st
- Joe's Age When His Plan Becomes Effective: 71
- Time since Joe enrolled in Medicare Part B: 3 years
- Joe does not have any of the medical conditions listed on the application

Joe is eligible for the enrollment discount

- Joe's discount will begin at age 71
- Starting discount: 18%
- Discount will change to 15% beginning on Joe's anniversary date (June 1st of the next year)

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

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

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.

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

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

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

Not connected with or endorsed by the U.S. Government or the federal Medicare program.
This is a solicitation of insurance. A licensed agent/producer may contact you.

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

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Attention Applicants with Birthdays on 1/1/2020 and After

This information modifies the information shown in **Question 3A** on the enclosed Application Form.

Your acceptance is guaranteed in any Plan you're eligible to enroll in, as long as you are enrolling:

- During your 60-day Birthday Open Enrollment Period that begins on your birthday **AND**;
- You are replacing a Medicare supplement plan with equal or lesser benefits.

If you meet this criteria, please answer "yes" to **Question 3A** on the enclosed Application Form.

Please note that your Application Form must be received during the 60-day period that begins on your birthday.

Cover Page - Rates
Non-Tobacco Monthly Plan Rates for California - Area 1

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$122.72	$171.36	$162.40	$64.48	$114.08	$137.44	$202.88	$203.68
66	$128.47	$179.39	$170.01	$67.50	$119.42	$143.88	$212.39	$213.22
67	$134.22	$187.42	$177.62	$70.52	$124.77	$150.32	$221.90	$222.77
68	$139.97	$195.45	$185.23	$73.54	$130.12	$156.76	$231.41	$232.32
69	$145.73	$203.49	$192.85	$76.57	$135.47	$163.21	$240.92	$241.87
70	$151.48	$211.52	$200.46	$79.59	$140.81	$169.65	$250.43	$251.41
71	$157.23	$219.55	$208.07	$82.61	$146.16	$176.09	$259.94	$260.96
72	$162.98	$227.58	$215.68	$85.63	$151.51	$182.53	$269.45	$270.51
73	$168.74	$235.62	$223.30	$88.66	$156.86	$188.98	$278.96	$280.06
74	$174.49	$243.65	$230.91	$91.68	$162.20	$195.42	$288.47	$289.60
75	$180.24	$251.68	$238.52	$94.70	$167.55	$201.86	$297.98	$299.15
76	$185.99	$259.71	$246.13	$97.72	$172.90	$208.30	$307.49	$308.70
	Standard Rates for individuals ages 77 and older							
77+	$191.75	$267.75	$253.75	$100.75	$178.25	$214.75	$317.00	$318.25

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$239.68	$334.68	$317.18	$125.93	$222.81	$268.43	$396.25	$397.81

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Tobacco Monthly Plan Rates
for California - Area 1

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$134.98	$188.49	$178.63	$70.92	$125.48	$151.18	$223.16	$224.04
66	$141.31	$197.32	$187.01	$74.24	$131.36	$158.26	$233.62	$234.54
67	$147.64	$206.16	$195.38	$77.57	$137.24	$165.35	$244.09	$245.04
68	$153.97	$214.99	$203.75	$80.89	$143.13	$172.44	$254.55	$255.55
69	$160.29	$223.83	$212.13	$84.22	$149.01	$179.52	$265.01	$266.05
70	$166.62	$232.67	$220.50	$87.54	$154.89	$186.61	$275.47	$276.55
71	$172.95	$241.50	$228.87	$90.87	$160.77	$193.70	$285.93	$287.05
72	$179.28	$250.34	$237.25	$94.19	$166.65	$200.78	$296.39	$297.55
73	$185.60	$259.17	$245.62	$97.52	$172.54	$207.87	$306.85	$308.06
74	$191.93	$268.01	$253.99	$100.84	$178.42	$214.96	$317.31	$318.56
75	$198.26	$276.84	$262.37	$104.17	$184.30	$222.04	$327.77	$329.06
76	$204.59	$285.68	$270.74	$107.49	$190.18	$229.13	$338.23	$339.56
	Standard Rates for individuals ages 77 and older							
77+	$210.92	$294.52	$279.12	$110.82	$196.07	$236.22	$348.70	$350.07

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$263.65	$368.15	$348.90	$138.52	$245.08	$295.27	$435.87	$437.58

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Under 65 Monthly Plan Rates
for California - Area 1

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 3	Applies to individuals age 50-64 who are eligible for Medicare.							
Age[1]	**Plan A**	**Plan B**	**Plan G[4]**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Non-Tobacco Rates							
50-64	$239.67	$334.67	$317.17	$125.92	N/A	N/A	$396.24	$397.80
	Tobacco Rates							
50-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 76. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible
You are eligible for the enrollment discount if you are between the ages of 65 and 76 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date.

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

3 **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.

4 **NOTE (for individuals age 50-64 who are eligible for Medicare): Plan G is only available to eligible Applicants with a Medicare Part A effective date on or after 1/1/2020.**

CALIFORNIA Area 1 ZIP Codes

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

90001	90046	90093	90275	90602	90720	91001	91129	91331	91406	91617	91791
90002	90047	90094	90277	90603	90721	91003	91182	91333	91407	91618	91792
90003	90048	90095	90278	90604	90723	91006	91184	91334	91408	91702	91793
90004	90049	90096	90280	90605	90731	91007	91185	91335	91409	91706	91801
90005	90050	90099	90290	90606	90732	91008	91188	91337	91410	91711	91802
90006	90051	90189	90291	90607	90733	91009	91189	91340	91411	91714	91803
90007	90052	90201	90292	90608	90734	91010	91199	91341	91412	91715	91804
90008	90053	90202	90293	90609	90740	91011	91201	91342	91413	91716	91896
90009	90054	90209	90294	90610	90742	91012	91202	91343	91416	91722	91899
90010	90055	90210	90295	90620	90743	91016	91203	91344	91423	91723	92602
90011	90056	90211	90296	90621	90744	91017	91204	91345	91426	91724	92603
90012	90057	90212	90301	90622	90745	91020	91205	91346	91436	91731	92604
90013	90058	90213	90302	90623	90746	91021	91206	91350	91470	91732	92605
90014	90059	90220	90303	90624	90747	91023	91207	91351	91482	91733	92606
90015	90060	90221	90304	90630	90748	91024	91208	91352	91495	91734	92607
90016	90061	90222	90305	90631	90749	91025	91209	91353	91496	91735	92609
90017	90062	90223	90306	90632	90755	91030	91210	91354	91499	91740	92610
90018	90063	90224	90307	90633	90801	91031	91214	91355	91501	91741	92612
90019	90064	90230	90308	90637	90802	91040	91221	91356	91502	91744	92614
90020	90065	90231	90309	90638	90803	91041	91222	91357	91503	91745	92615
90021	90066	90232	90310	90639	90804	91042	91224	91364	91504	91746	92616
90022	90067	90233	90311	90640	90805	91043	91225	91365	91505	91747	92617
90023	90068	90239	90312	90650	90806	91046	91226	91367	91506	91748	92618
90024	90069	90240	90401	90651	90807	91066	91301	91371	91507	91749	92619
90025	90070	90241	90402	90652	90808	91077	91302	91372	91508	91750	92620
90026	90071	90242	90403	90660	90809	91101	91303	91376	91510	91754	92623
90027	90072	90245	90404	90661	90810	91102	91304	91380	91521	91755	92624
90028	90073	90247	90405	90662	90813	91103	91305	91381	91522	91756	92625
90029	90074	90248	90406	90670	90814	91104	91306	91382	91523	91759	92626
90030	90075	90249	90407	90671	90815	91105	91307	91383	91526	91765	92627
90031	90076	90250	90408	90680	90822	91106	91308	91384	91601	91766	92628
90032	90077	90251	90409	90701	90831	91107	91309	91385	91602	91767	92629
90033	90078	90254	90410	90702	90832	91108	91310	91386	91603	91768	92630
90034	90079	90255	90411	90703	90833	91109	91311	91387	91604	91769	92637
90035	90080	90260	90501	90704	90834	91110	91313	91390	91605	91770	92646
90036	90081	90261	90502	90706	90835	91114	91316	91392	91606	91771	92647
90037	90082	90262	90503	90707	90840	91115	91321	91393	91607	91772	92648
90038	90083	90263	90504	90710	90842	91116	91322	91394	91608	91773	92649
90039	90084	90264	90505	90711	90844	91117	91324	91395	91609	91775	92650
90040	90086	90265	90506	90712	90846	91118	91325	91396	91610	91776	92651
90041	90087	90266	90507	90713	90847	91121	91326	91401	91611	91778	92652
90042	90088	90267	90508	90714	90848	91123	91327	91402	91612	91780	92653
90043	90089	90270	90509	90715	90853	91124	91328	91403	91614	91788	92654
90044	90090	90272	90510	90716	90895	91125	91329	91404	91615	91789	92655
90045	90091	90274	90601	90717	90899	91126	91330	91405	91616	91790	92656

CALIFORNIA Area 1 ZIP Codes CONTINUED

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The following ZIP codes are no longer recognized by the U.S. Post Office: 89034 and 89035

Cover Page - Rates
Non-Tobacco Monthly Plan Rates for California - Area 2

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$110.56	$154.40	$146.24	$58.08	$102.72	$123.84	$182.72	$183.52
66	$115.74	$161.63	$153.09	$60.80	$107.53	$129.64	$191.28	$192.12
67	$120.92	$168.87	$159.95	$63.52	$112.35	$135.45	$199.85	$200.72
68	$126.10	$176.11	$166.80	$66.24	$117.16	$141.25	$208.41	$209.32
69	$131.29	$183.35	$173.66	$68.97	$121.98	$147.06	$216.98	$217.93
70	$136.47	$190.58	$180.51	$71.69	$126.79	$152.86	$225.54	$226.53
71	$141.65	$197.82	$187.37	$74.41	$131.61	$158.67	$234.11	$235.13
72	$146.83	$205.06	$194.22	$77.13	$136.42	$164.47	$242.67	$243.73
73	$152.02	$212.30	$201.08	$79.86	$141.24	$170.28	$251.24	$252.34
74	$157.20	$219.53	$207.93	$82.58	$146.05	$176.08	$259.80	$260.94
75	$162.38	$226.77	$214.79	$85.30	$150.87	$181.89	$268.37	$269.54
76	$167.56	$234.01	$221.64	$88.02	$155.68	$187.69	$276.93	$278.14
	Standard Rates for individuals ages 77 and older							
77+	$172.75	$241.25	$228.50	$90.75	$160.50	$193.50	$285.50	$286.75

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$215.93	$301.56	$285.62	$113.43	$200.62	$241.87	$356.87	$358.43

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Tobacco Monthly Plan Rates
for California - Area 2

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$121.61	$169.83	$160.86	$63.88	$112.99	$136.22	$200.99	$201.86
66	$127.31	$177.79	$168.40	$66.87	$118.28	$142.60	$210.41	$211.33
67	$133.01	$185.75	$175.94	$69.87	$123.58	$148.99	$219.83	$220.79
68	$138.71	$193.72	$183.48	$72.86	$128.88	$155.38	$229.25	$230.25
69	$144.41	$201.68	$191.02	$75.86	$134.17	$161.76	$238.67	$239.71
70	$150.11	$209.64	$198.56	$78.85	$139.47	$168.15	$248.09	$249.18
71	$155.81	$217.60	$206.10	$81.85	$144.77	$174.53	$257.52	$258.64
72	$161.51	$225.56	$213.64	$84.84	$150.06	$180.92	$266.94	$268.10
73	$167.21	$233.52	$221.18	$87.84	$155.36	$187.30	$276.36	$277.56
74	$172.91	$241.48	$228.72	$90.83	$160.66	$193.69	$285.78	$287.03
75	$178.61	$249.44	$236.26	$93.83	$165.95	$200.07	$295.20	$296.49
76	$184.31	$257.40	$243.80	$96.82	$171.25	$206.46	$304.62	$305.95
	Standard Rates for individuals ages 77 and older							
77+	$190.02	$265.37	$251.35	$99.82	$176.55	$212.85	$314.05	$315.42

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$237.52	$331.71	$314.18	$124.77	$220.68	$266.06	$392.56	$394.27

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Under 65 Monthly Plan Rates
for California - Area 2

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 3	Applies to individuals age 50-64 who are eligible for Medicare.							
Age[1]	**Plan A**	**Plan B**	**Plan G[4]**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Non-Tobacco Rates							
50-64	$215.92	$301.55	$285.61	$113.42	N/A	N/A	$356.86	$358.42
	Tobacco Rates							
50-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 76. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible
You are eligible for the enrollment discount if you are between the ages of 65 and 76 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date.

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

3 **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.

4 **NOTE (for individuals age 50-64 who are eligible for Medicare): Plan G is only available to eligible Applicants with a Medicare Part A effective date on or after 1/1/2020.**

CALIFORNIA Area 2 ZIP Codes

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

91319	91980	92067	92126	92186	92261	92554	93012
91320	91987	92068	92127	92187	92262	92555	93015
91358	92003	92069	92128	92191	92263	92556	93016
91359	92004	92070	92129	92192	92264	92557	93020
91360	92007	92071	92130	92193	92266	92561	93021
91361	92008	92072	92131	92195	92270	92562	93022
91362	92009	92074	92132	92196	92273	92563	93023
91377	92010	92075	92134	92197	92274	92564	93024
91752	92011	92078	92135	92198	92275	92567	93030
91901	92013	92079	92136	92199	92276	92570	93031
91902	92014	92081	92137	92201	92281	92571	93032
91903	92018	92082	92138	92202	92282	92572	93033
91905	92019	92083	92139	92203	92283	92581	93034
91906	92020	92084	92140	92210	92320	92582	93035
91908	92021	92085	92142	92211	92501	92583	93036
91909	92022	92086	92143	92220	92502	92584	93040
91910	92023	92088	92145	92222	92503	92585	93041
91911	92024	92091	92147	92223	92504	92586	93042
91912	92025	92092	92149	92225	92505	92587	93043
91913	92026	92093	92150	92226	92506	92589	93044
91914	92027	92096	92152	92227	92507	92590	93060
91915	92028	92101	92153	92230	92508	92591	93061
91916	92029	92102	92154	92231	92509	92592	93062
91917	92030	92103	92155	92232	92513	92593	93063
91921	92033	92104	92158	92233	92514	92595	93064
91931	92036	92105	92159	92234	92516	92596	93065
91932	92037	92106	92160	92235	92517	92599	93066
91933	92038	92107	92161	92236	92518	92860	93094
91934	92039	92108	92163	92239	92519	92877	93099
91935	92040	92109	92165	92240	92521	92878	
91941	92046	92110	92166	92241	92522	92879	
91942	92049	92111	92167	92243	92530	92880	
91943	92051	92112	92168	92244	92531	92881	
91944	92052	92113	92169	92247	92532	92882	
91945	92054	92114	92170	92248	92536	92883	
91946	92055	92115	92171	92249	92539	93001	
91948	92056	92116	92172	92250	92543	93002	
91950	92057	92117	92173	92251	92544	93003	
91951	92058	92118	92174	92253	92545	93004	
91962	92059	92119	92175	92254	92546	93005	
91963	92060	92120	92176	92255	92548	93006	
91976	92061	92121	92177	92257	92549	93007	
91977	92064	92122	92178	92258	92551	93009	
91978	92065	92123	92179	92259	92552	93010	
91979	92066	92124	92182	92260	92553	93011	

Cover Page - Rates
Non-Tobacco Monthly Plan Rates
for California - Area 3

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$101.76	$142.08	$134.56	$53.44	$94.56	$113.92	$168.16	$168.80
66	$106.53	$148.74	$140.86	$55.94	$98.99	$119.26	$176.04	$176.71
67	$111.30	$155.40	$147.17	$58.45	$103.42	$124.60	$183.92	$184.62
68	$116.07	$162.06	$153.48	$60.95	$107.85	$129.94	$191.80	$192.53
69	$120.84	$168.72	$159.79	$63.46	$112.29	$135.28	$199.69	$200.45
70	$125.61	$175.38	$166.09	$65.96	$116.72	$140.62	$207.57	$208.36
71	$130.38	$182.04	$172.40	$68.47	$121.15	$145.96	$215.45	$216.27
72	$135.15	$188.70	$178.71	$70.97	$125.58	$151.30	$223.33	$224.18
73	$139.92	$195.36	$185.02	$73.48	$130.02	$156.64	$231.22	$232.10
74	$144.69	$202.02	$191.32	$75.98	$134.45	$161.98	$239.10	$240.01
75	$149.46	$208.68	$197.63	$78.49	$138.88	$167.32	$246.98	$247.92
76	$154.23	$215.34	$203.94	$80.99	$143.31	$172.66	$254.86	$255.83
	Standard Rates for individuals ages 77 and older							
77+	$159.00	$222.00	$210.25	$83.50	$147.75	$178.00	$262.75	$263.75

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$198.75	$277.50	$262.81	$104.37	$184.68	$222.50	$328.43	$329.68

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Tobacco Monthly Plan Rates
for California - Area 3

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$111.93	$156.28	$148.01	$58.78	$104.01	$125.31	$184.97	$185.67
66	$117.18	$163.61	$154.95	$61.53	$108.88	$131.18	$193.64	$194.38
67	$122.43	$170.94	$161.88	$64.29	$113.76	$137.06	$202.31	$203.08
68	$127.67	$178.26	$168.82	$67.05	$118.63	$142.93	$210.98	$211.78
69	$132.92	$185.59	$175.76	$69.80	$123.51	$148.80	$219.65	$220.49
70	$138.17	$192.91	$182.70	$72.56	$128.39	$154.68	$228.32	$229.19
71	$143.41	$200.24	$189.64	$75.31	$133.26	$160.55	$236.99	$237.89
72	$148.66	$207.57	$196.57	$78.07	$138.14	$166.43	$245.66	$246.60
73	$153.91	$214.89	$203.51	$80.82	$143.01	$172.30	$254.33	$255.30
74	$159.15	$222.22	$210.45	$83.58	$147.89	$178.17	$263.00	$264.00
75	$164.40	$229.54	$217.39	$86.33	$152.76	$184.05	$271.67	$272.71
76	$169.65	$236.87	$224.33	$89.09	$157.64	$189.92	$280.34	$281.41
	Standard Rates for individuals ages 77 and older							
77+	$174.90	$244.20	$231.27	$91.85	$162.52	$195.80	$289.02	$290.12

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$218.62	$305.25	$289.08	$114.81	$203.15	$244.75	$361.27	$362.65

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Under 65 Monthly Plan Rates
for California - Area 3

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 3	Applies to individuals age 50-64 who are eligible for Medicare.							
Age[1]	**Plan A**	**Plan B**	**Plan G[4]**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Non-Tobacco Rates							
50-64	$198.74	$277.49	$262.80	$104.36	N/A	N/A	$328.42	$329.67
	Tobacco Rates							
50-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 76. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible
You are eligible for the enrollment discount if you are between the ages of 65 and 76 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date.

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

3 **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.

4 **NOTE (for individuals age 50-64 who are eligible for Medicare): Plan G is only available to eligible Applicants with a Medicare Part A effective date on or after 1/1/2020.**

CALIFORNIA Area 3 ZIP Codes

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

91701	92323	92391	93190	93385	93454	94021	94129	94247	94501	94553	94609
91708	92324	92392	93199	93386	93455	94025	94130	94248	94502	94555	94610
91709	92325	92393	93203	93387	93456	94026	94131	94249	94503	94556	94611
91710	92327	92394	93205	93388	93457	94027	94132	94250	94505	94557	94612
91729	92329	92395	93206	93389	93458	94028	94133	94252	94506	94558	94613
91730	92331	92397	93215	93390	93460	94030	94134	94254	94507	94559	94614
91737	92332	92398	93216	93401	93461	94037	94137	94256	94508	94560	94615
91739	92333	92399	93220	93402	93463	94038	94139	94257	94509	94561	94617
91743	92334	92401	93222	93403	93464	94044	94140	94258	94511	94562	94618
91758	92335	92402	93224	93405	93465	94060	94141	94259	94513	94563	94619
91761	92336	92403	93225	93406	93475	94061	94142	94261	94514	94564	94620
91762	92337	92404	93226	93407	93483	94062	94143	94262	94515	94565	94621
91763	92338	92405	93238	93408	93501	94063	94144	94263	94516	94566	94622
91764	92339	92406	93240	93409	93502	94064	94145	94267	94517	94567	94623
91784	92340	92407	93241	93410	93504	94065	94146	94268	94518	94568	94624
91785	92341	92408	93243	93412	93505	94066	94147	94269	94519	94569	94649
91786	92342	92410	93249	93420	93516	94070	94151	94271	94520	94570	94659
92242	92344	92411	93250	93421	93518	94074	94158	94273	94521	94572	94660
92252	92345	92413	93251	93422	93519	94080	94159	94274	94522	94573	94661
92256	92346	92415	93252	93423	93523	94083	94160	94277	94523	94574	94662
92267	92347	92418	93254	93424	93524	94102	94161	94278	94524	94575	94666
92268	92350	92423	93255	93427	93527	94103	94163	94279	94525	94576	94701
92277	92352	92427	93263	93428	93528	94104	94164	94280	94526	94577	94702
92278	92354	93013	93268	93429	93531	94105	94172	94282	94527	94578	94703
92280	92356	93014	93276	93430	93554	94107	94177	94283	94528	94579	94704
92284	92357	93067	93280	93432	93555	94108	94188	94284	94529	94580	94705
92285	92358	93101	93283	93433	93556	94109	94203	94285	94530	94581	94706
92286	92359	93102	93285	93434	93558	94110	94204	94287	94531	94582	94707
92301	92363	93103	93287	93435	93560	94111	94205	94288	94536	94583	94708
92304	92364	93105	93301	93436	93561	94112	94206	94289	94537	94586	94709
92305	92365	93106	93302	93437	93562	94114	94207	94290	94538	94587	94710
92307	92366	93107	93303	93438	93581	94115	94208	94291	94539	94588	94712
92308	92368	93108	93304	93440	93592	94116	94209	94293	94540	94595	94720
92309	92369	93109	93305	93441	93596	94117	94211	94294	94541	94596	94801
92310	92371	93110	93306	93442	94002	94118	94229	94295	94542	94597	94802
92311	92372	93111	93307	93443	94005	94119	94230	94296	94543	94598	94803
92312	92373	93116	93308	93444	94010	94120	94232	94297	94544	94599	94804
92313	92374	93117	93309	93445	94011	94121	94234	94298	94545	94601	94805
92314	92375	93118	93311	93446	94014	94122	94235	94299	94546	94602	94806
92315	92376	93120	93312	93447	94015	94123	94236	94303	94547	94603	94807
92316	92377	93121	93313	93448	94016	94124	94237	94401	94548	94604	94808
92317	92378	93130	93314	93449	94017	94125	94239	94402	94549	94605	94820
92318	92382	93140	93380	93451	94018	94126	94240	94403	94550	94606	94850
92321	92385	93150	93383	93452	94019	94127	94244	94404	94551	94607	95201
92322	92386	93160	93384	93453	94020	94128	94245	94497	94552	94608	95202

CALIFORNIA Area 3 ZIP Codes CONTINUED

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Cover Page - Rates
Non-Tobacco Monthly Plan Rates for California - Area 4

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$91.84	$128.16	$121.44	$48.16	$85.28	$102.72	$151.68	$152.32
66	$96.14	$134.16	$127.13	$50.41	$89.27	$107.53	$158.79	$159.46
67	$100.45	$140.17	$132.82	$52.67	$93.27	$112.35	$165.90	$166.60
68	$104.75	$146.18	$138.51	$54.93	$97.27	$117.16	$173.01	$173.74
69	$109.06	$152.19	$144.21	$57.19	$101.27	$121.98	$180.12	$180.88
70	$113.36	$158.19	$149.90	$59.44	$105.26	$126.79	$187.23	$188.02
71	$117.67	$164.20	$155.59	$61.70	$109.26	$131.61	$194.34	$195.16
72	$121.97	$170.21	$161.28	$63.96	$113.26	$136.42	$201.45	$202.30
73	$126.28	$176.22	$166.98	$66.22	$117.26	$141.24	$208.56	$209.44
74	$130.58	$182.22	$172.67	$68.47	$121.25	$146.05	$215.67	$216.58
75	$134.89	$188.23	$178.36	$70.73	$125.25	$150.87	$222.78	$223.72
76	$139.19	$194.24	$184.05	$72.99	$129.25	$155.68	$229.89	$230.86
	Standard Rates for individuals ages 77 and older							
77+	$143.50	$200.25	$189.75	$75.25	$133.25	$160.50	$237.00	$238.00

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$179.37	$250.31	$237.18	$94.06	$166.56	$200.62	$296.25	$297.50

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Tobacco Monthly Plan Rates
for California - Area 4

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 1	Applies to individuals whose plan effective date will be within ten years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Standard Rates with Enrollment Discount[2] for individuals ages 65-76							
65	$101.02	$140.97	$133.58	$52.97	$93.80	$112.99	$166.84	$167.55
66	$105.75	$147.58	$139.84	$55.45	$98.20	$118.28	$174.66	$175.40
67	$110.49	$154.18	$146.10	$57.93	$102.59	$123.58	$182.49	$183.26
68	$115.23	$160.79	$152.36	$60.42	$106.99	$128.88	$190.31	$191.11
69	$119.96	$167.40	$158.62	$62.90	$111.39	$134.17	$198.13	$198.96
70	$124.70	$174.01	$164.88	$65.38	$115.79	$139.47	$205.95	$206.82
71	$129.43	$180.62	$171.15	$67.87	$120.18	$144.77	$213.77	$214.67
72	$134.17	$187.22	$177.41	$70.35	$124.58	$150.06	$221.59	$222.53
73	$138.90	$193.83	$183.67	$72.83	$128.98	$155.36	$229.41	$230.38
74	$143.64	$200.44	$189.93	$75.32	$133.37	$160.66	$237.23	$238.23
75	$148.37	$207.05	$196.19	$77.80	$137.77	$165.95	$245.05	$246.09
76	$153.11	$213.66	$202.45	$80.28	$142.17	$171.25	$252.87	$253.94
	Standard Rates for individuals ages 77 and older							
77+	$157.85	$220.27	$208.72	$82.77	$146.57	$176.55	$260.70	$261.80

Group 2	Applies to individuals whose plan effective date will be ten or more years following their 65th birthday or Medicare Part B effective date, if later.							
Age[1]	**Plan A**	**Plan B**	**Plan G**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Level 2 Rates							
75+	$197.31	$275.33	$260.90	$103.46	$183.21	$220.68	$325.87	$327.25

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

Cover Page - Rates
Under 65 Monthly Plan Rates
for California - Area 4

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company

Plans Available to All Applicants							Medicare first eligible before 2020 only[3]	
Group 3	Applies to individuals age 50-64 who are eligible for Medicare.							
Age[1]	**Plan A**	**Plan B**	**Plan G[4]**	**Plan K**	**Plan L**	**Plan N**	**Plan C[3]**	**Plan F[3]**
	Non-Tobacco Rates							
50-64	$179.36	$250.30	$237.17	$94.05	N/A	N/A	$296.24	$297.49
	Tobacco Rates							
50-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

The rates above are for plan effective dates from June 2021 - May 2022 and may change.

1 Your age as of your plan effective date.

2 The **Enrollment Discount** is available to applicants age 65 to 76. You may qualify for an Enrollment Discount based on your age and your Medicare Part B effective date. If you are eligible, the discounted rates will be shown.

Who is eligible
You are eligible for the enrollment discount if you are between the ages of 65 and 76 and your plan effective date is within ten years following your 65th birthday or Medicare Part B effective date.

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

3 **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.

4 **NOTE (for individuals age 50-64 who are eligible for Medicare): Plan G is only available to eligible Applicants with a Medicare Part A effective date on or after 1/1/2020.**

CALIFORNIA Area 4 ZIP Codes

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

92328	93290	93628	93707	93791	94085	94941	95014	95077	95158	95316	95374
92384	93291	93630	93708	93792	94086	94942	95015	95101	95159	95317	95375
92389	93292	93631	93709	93793	94087	94945	95017	95103	95160	95318	95379
93201	93426	93633	93710	93794	94088	94946	95018	95106	95161	95319	95380
93202	93450	93634	93711	93844	94089	94947	95019	95108	95164	95321	95381
93204	93512	93635	93712	93888	94301	94948	95020	95109	95170	95322	95382
93207	93513	93636	93714	93901	94302	94949	95021	95110	95172	95323	95383
93208	93514	93637	93715	93902	94304	94950	95023	95111	95173	95324	95386
93210	93515	93638	93716	93905	94305	94951	95024	95112	95190	95325	95387
93212	93517	93639	93717	93906	94306	94952	95026	95113	95191	95326	95388
93218	93522	93640	93718	93907	94309	94953	95030	95115	95192	95327	95389
93219	93526	93641	93720	93908	94510	94954	95031	95116	95193	95328	95397
93221	93529	93642	93721	93912	94512	94955	95032	95117	95194	95329	95401
93223	93530	93643	93722	93915	94533	94956	95033	95118	95196	95333	95402
93227	93541	93644	93723	93920	94534	94957	95035	95119	95221	95334	95403
93230	93542	93645	93724	93921	94535	94960	95036	95120	95222	95335	95404
93232	93545	93646	93725	93922	94571	94963	95037	95121	95223	95338	95405
93234	93546	93647	93726	93923	94585	94964	95038	95122	95224	95340	95406
93235	93549	93648	93727	93924	94589	94965	95039	95123	95225	95341	95407
93237	93601	93649	93728	93925	94590	94966	95041	95124	95226	95343	95409
93239	93602	93650	93729	93926	94591	94970	95042	95125	95228	95344	95410
93242	93603	93651	93730	93927	94592	94971	95043	95126	95229	95345	95412
93244	93604	93652	93737	93928	94901	94972	95044	95127	95232	95346	95415
93245	93605	93653	93740	93930	94903	94973	95045	95128	95233	95347	95416
93246	93606	93654	93741	93932	94904	94974	95046	95129	95245	95348	95417
93247	93607	93656	93744	93933	94912	94975	95050	95130	95246	95350	95418
93256	93608	93657	93745	93940	94913	94976	95051	95131	95247	95351	95419
93257	93609	93660	93747	93942	94914	94977	95052	95132	95248	95352	95420
93258	93610	93661	93750	93943	94915	94978	95053	95133	95249	95353	95421
93260	93611	93662	93755	93944	94920	94979	95054	95134	95251	95354	95425
93261	93612	93664	93760	93950	94922	94998	95055	95135	95252	95355	95427
93262	93613	93665	93761	93953	94923	94999	95056	95136	95254	95356	95428
93265	93614	93666	93764	93954	94924	95001	95060	95138	95255	95357	95429
93266	93615	93667	93765	93955	94925	95002	95061	95139	95257	95358	95430
93267	93616	93668	93771	93960	94926	95003	95062	95140	95301	95360	95431
93270	93618	93669	93772	93962	94927	95004	95063	95141	95303	95361	95432
93271	93619	93670	93773	94022	94928	95005	95064	95148	95305	95363	95433
93272	93620	93673	93774	94023	94929	95006	95065	95150	95306	95364	95436
93274	93621	93675	93775	94024	94930	95007	95066	95151	95307	95365	95437
93275	93622	93701	93776	94035	94931	95008	95067	95152	95309	95367	95439
93277	93623	93702	93777	94039	94933	95009	95070	95153	95310	95368	95441
93278	93624	93703	93778	94040	94937	95010	95071	95154	95311	95369	95442
93279	93625	93704	93779	94041	94938	95011	95073	95155	95312	95370	95444
93282	93626	93705	93786	94042	94939	95012	95075	95156	95313	95372	95445
93286	93627	93706	93790	94043	94940	95013	95076	95157	95315	95373	95446

CALIFORNIA Area 4 ZIP Codes CONTINUED

95448	95537	95618	95688	95923	95973	96035	96093	96146
95449	95538	95619	95689	95924	95974	96037	96094	96148
95450	95540	95620	95691	95925	95975	96038	96095	96150
95452	95542	95623	95692	95926	95976	96039	96096	96151
95454	95543	95625	95694	95927	95977	96040	96097	96154
95456	95545	95627	95695	95928	95978	96041	96099	96155
95459	95546	95629	95696	95929	95979	96044	96101	96156
95460	95547	95631	95697	95930	95980	96046	96103	96157
95462	95548	95633	95698	95932	95981	96047	96104	96158
95463	95549	95634	95699	95934	95982	96048	96105	96160
95465	95550	95635	95701	95935	95983	96049	96106	96161
95466	95551	95636	95703	95936	95984	96050	96107	96162
95468	95552	95637	95709	95937	95986	96051	96108	96152
95469	95553	95640	95712	95938	95987	96052	96109	
95470	95554	95642	95713	95939	95988	96054	96110	
95471	95555	95644	95714	95940	95991	96055	96111	
95472	95556	95645	95715	95941	95992	96056	96112	
95473	95558	95646	95717	95942	95993	96057	96113	
95476	95559	95648	95720	95943	96001	96058	96114	
95480	95560	95650	95721	95944	96002	96059	96115	
95481	95562	95651	95722	95945	96003	96061	96116	
95482	95563	95653	95724	95946	96006	96062	96117	
95486	95564	95654	95726	95947	96007	96063	96118	
95487	95565	95656	95728	95948	96008	96064	96119	
95488	95567	95658	95735	95949	96009	96065	96120	
95490	95568	95659	95736	95950	96010	96067	96121	
95492	95569	95661	95746	95951	96011	96068	96122	
95494	95570	95663	95747	95953	96013	96069	96123	
95497	95571	95664	95762	95954	96014	96070	96124	
95501	95573	95665	95765	95955	96015	96071	96125	
95502	95585	95666	95776	95956	96016	96073	96126	
95503	95587	95667	95798	95957	96017	96074	96127	
95511	95589	95668	95799	95958	96019	96075	96128	
95514	95595	95669	95901	95959	96020	96076	96129	
95518	95601	95672	95903	95960	96021	96078	96130	
95519	95602	95674	95910	95961	96022	96079	96132	
95521	95603	95675	95912	95962	96023	96080	96133	
95524	95604	95676	95913	95963	96024	96084	96134	
95525	95605	95677	95914	95965	96025	96085	96135	
95526	95606	95678	95915	95966	96027	96086	96136	
95527	95607	95679	95916	95967	96028	96087	96137	
95528	95612	95681	95917	95968	96029	96088	96140	
95531	95613	95682	95918	95969	96031	96089	96141	
95532	95614	95684	95919	95970	96032	96090	96142	
95534	95616	95685	95920	95971	96033	96091	96143	
95536	95617	95687	95922	95972	96034	96092	96145	

AARP | Medicare Supplement from UnitedHealthcare

Your Guide to AARP Medicare Supplement Insurance Portfolio of Plans

How to Use Your Guide

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

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

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

Eligibility to Apply

To be eligible to apply, you must be an AARP member or spouse of a member, age 50 or over, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage. (If you are not yet age 65, you are only eligible to apply if you do not have End Stage Renal Disease and then you may only apply for A, B, C, F or K, unless you are in your Birthday Open Enrollment Period and replacing a Medicare supplement plan. You must apply within 6 months after enrolling in Medicare Part B or receiving notification of your retroactive eligibility for Medicare Part B, unless you are entitled to Guaranteed Issue as shown under the following "Guaranteed Issue" section.)

Guaranteed Issue

• Your acceptance in any plan is guaranteed during your Medicare supplement open enrollment period which lasts for 6 months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

• **There is also an annual one-month Open Enrollment period** when you are replacing a Medicare Supplement plan (including Medicare Select) and your enrollment application is received the month prior to, during, or the month after your birthday month. And, you may also qualify for a six-month Open Enrollment period if: a) you lost an employer-sponsored health plan; b) you lost "Medi-Cal" due to an increase in your income or assets; c) you are a military retiree, or spouse of a retiree, and had your health care services cancelled due to a base closure, because the base no longer offers services, or because you relocated; or d) you had your Medicare supplement coverage cancelled because your residence changed to a location not serviced by your plan.

• A person becomes eligible for Guaranteed Issue of a Medicare Supplement plan when he or she loses or terminates health coverage under certain circumstances. Guaranteed Issue means a Medicare Supplement plan will be issued with no pre-existing condition exclusions and no underwriting. In order to become eligible for Guaranteed Issue, your application must be received no later than 123 days after the termination date of your prior health plan. You must also provide a copy of the termination notice you received from your prior plan or employer along with your application. This notice must verify the circumstances of your prior plan's termination and also describe your right to guaranteed issue of Medicare supplement insurance. Here is a summary of these situations:

1. You have lost or are replacing a plan that was provided by your current or former employer or the employer no longer covers all the Medicare Part B coinsurance.
2. You are replacing a Medicare Advantage (MA) plan (sometimes called Medicare Part C) or a Program of All-Inclusive Care for the Elderly (PACE) or a Medicare Select plan, under these circumstances:
   - This was your first time in this type of plan; and
   - You switched to this plan from a Medicare Supplement plan; and
   - You've had it for no longer than 2 years.
3. You are replacing a Medicare Advantage (MA) plan or a Program of All-Inclusive Care for the Elderly (PACE), under these circumstances:
   - You enrolled in the MA plan when you started Medicare Part A at age 65; and
   - You've had it for no longer than 2 years.
4. You are replacing a Medicare Advantage plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Medicare Select plan, Medicare Cost or a health care prepayment plan for any of the following reasons:
   - The plan stopped coverage in your area;
   - The plan notified you it will be stopping coverage in your area; or
   - You moved out of the plan's service area.
5. You are replacing a Medicare Advantage plan, a Program of All-Inclusive Care for the Elderly (PACE), a Medicare Supplement plan, a Medicare Select plan, Medicare Cost or a health care prepayment plan for any of the following reasons:
   - The plan violated the insurance contract (for example, by failing to provide necessary medical care); or
   - The plan was misrepresented in marketing to you.
6. You are replacing a Medicare Supplement or Medicare Select plan that was ended by the company (for example, due to bankruptcy).
7. You are replacing a Medicare Advantage (or PACE, Medicare Cost, health care prepayment plan, or Medicare Select) plan because the plan:
   - Reduces benefits*
   - Increases premiums by 15% or more*

- Raises co-payments for physician or hospital services or drugs by 15% or more*
- Discontinues, for other than good cause relating to the quality of care, its relationship or contract under the MA plan with a provider who is currently furnishing services to you.

* Individuals eligible for Guaranteed Issue under these criteria who are not from UnitedHealthcare/Secure Horizons Medicare Advantage plans may only enroll in an AARP Medicare Supplement Plan during the Annual Election Period (AEP).

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.

8. Your Medicare Advantage (or PACE, Medicare Cost, health care prepayment plan, or Medicare Select) plan reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the MA plan with a provider who is currently furnishing services to the individual.*

   * This Guaranteed Issue requirement only applies to individuals enrolled in a UnitedHealthcare/Secure Horizons Medicare Advantage plan.
9. While you were enrolled in a Medicare supplement plan that covers outpatient prescription drugs you enrolled in a Medicare Part D plan during the initial enrollment period and terminated your Medicare supplement plan.

Glossary of Terms

Medicare Eligible Expenses are the health care expenses of the kinds covered under Medicare Parts A and B that Medicare recognizes as reasonable and medically necessary. Physicians under Medicare can agree to accept Medicare's eligible expense as their fee amount. Your physician or surgeon may charge you more.

Excess Charge is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Hospital or Skilled Nursing Facility—A hospital is an institution that provides care for which Medicare pays hospital benefits. A skilled nursing facility is a facility that provides skilled nursing care and is approved for payment by Medicare. The skilled nursing facility stay must begin within 30 days after a hospital stay of 3 or more days in a row or a prior covered skilled nursing facility stay. Custodial care does not qualify as an eligible expense.

Lifetime Reserve Days are limited by Medicare to 60 days during your lifetime. Once these are used, Medicare provides no hospital coverage after 90 days of a benefit period.

Hospice Care means care for those who are terminally ill. Hospice Care typically focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

Exclusions

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

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

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

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

You Cannot Be Singled Out for Cancellation

Your Medicare supplement plan can never be cancelled because of your age, your health, or the number of claims you make. Your Medicare supplement plan may be cancelled due to nonpayment of premium or material misrepresentation. If the group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company. Of course, you may cancel your AARP Medicare Supplement Plan any time you wish. All transactions go into effect on the first of the month following receipt of the request.

The AARP Insurance Trust

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

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

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

General Information

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

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

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

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

Plan 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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $6220 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 $1,484	$742 (50% of Part A Deductible)	$742 (50% of Part A Deductible)♦
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $92.75 a day	$92.75 a day♦
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 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 $203 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 $203 of Medicare Approved Amounts****	$0	$0	$203 (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 $6220)*
BLOOD			
First 3 Pints	$0	50%	50%♦
Next $203 of Medicare Approved Amounts****	$0	$0	$203 (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 $6220 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 $203 of Medicare Approved Amounts*****	$0	$0	$203 (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 $3110 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 $1,484	$1,113 (75% of Part A Deductible)	$371 (25% of Part A Deductible)♦
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $139.13 a day	$46.37 a day♦
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 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 $203 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 $203 of Medicare Approved Amounts****	$0	$0	$203 (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 $3110)*
BLOOD			
First 3 Pints	$0	75%	25%♦
Next $203 of Medicare Approved Amounts****	$0	$0	$203 (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 $3110 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 $203 of Medicare Approved Amounts*****	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 supplement coverage. These rules affect you. Please read them carefully and make sure you understand them before you buy or change any Medicare supplement insurance.

Premium information

You may keep your Medicare supplement plan in force by paying the required monthly premium when due. Monthly rates shown reflect current premium levels and all rates are subject to change. Any change will apply to all members of the same class insured under your plan who reside in your state.

Disclosures

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

Read your certificate very carefully

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

Your right to return the certificate

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

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

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

Policy replacement

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

Notice

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

Complete answers are very important

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

AARP | Medicare Supplement from UnitedHealthcare

UnitedHealthcare Insurance Company (UnitedHealthcare)

Plan Document Delivery Preferences

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

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

Electronic Delivery Terms and Conditions

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

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

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

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

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

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

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

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)

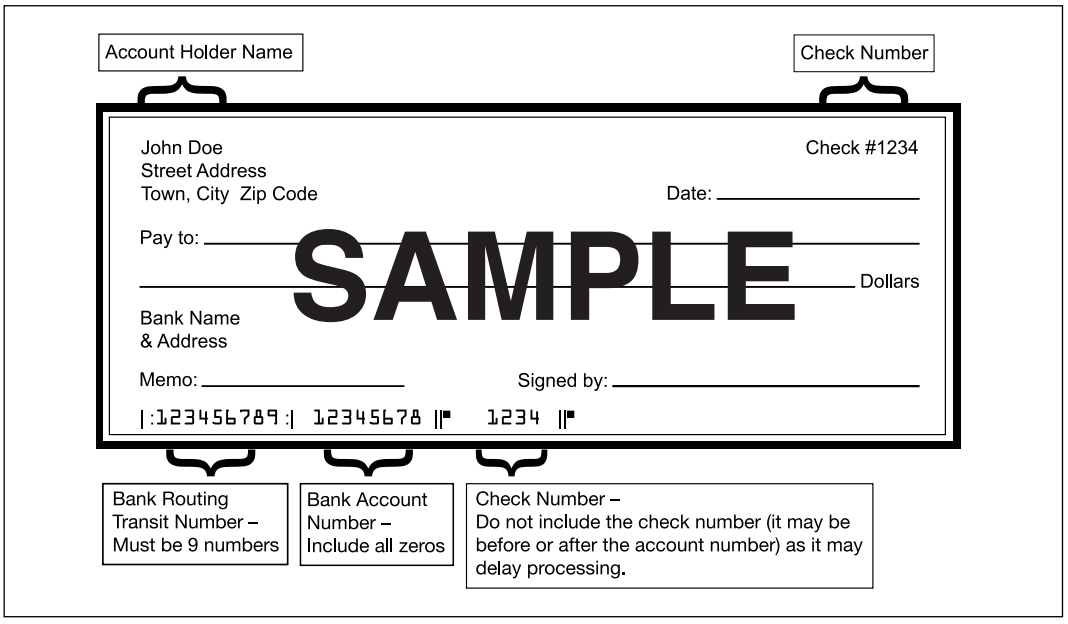
Bank Account No._____

Bank Account Holder's Name if other than Member _____

Bank Account Holder's Signature _____

IMPORTANT

Please refer to the diagram below of a sample check to obtain your bank routing information.



We look forward to continuing to serve you.

Glossary: Prescription Drugs

Partial Prescription Drug List

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

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

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

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

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

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

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

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

IMPORTANT 2021 MEDICARE BENEFIT INFORMATION

Beginning January 1, 2021, the Medicare Part A inpatient Hospital Deductible will be $1,484.

The chart below lists Medicare's updated benefits.

SERVICE	BENEFIT	MEDICARE PAYS❖❖
HOSPITALIZATION Semi-private room & board, general nursing and miscellaneous hospital services and supplies per benefit period.(1)	First 60 days	All but $1,484
	61st - 90th day	All but $371 a day
	91st - 150th day❖	All but $742 a day
	Beyond 150 days	Nothing

SERVICE	BENEFIT	MEDICARE PAYS❖❖
POST HOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.(2)	First 20 days	100% of approved amount
	Additional 80 days	All but $185.50 a day
	Beyond 100 days	Nothing

For 2021, the Medicare Part B Deductible will be $203.

2021 Out of Pocket Limits for Medigap Plans K & L - The 2021 out of pocket limits for Medigap Plans K & L are $6,220 and $3,110, respectively.

2021 Deductible Amount for Medigap High Deductible Options F, G & J - The 2021 annual deductible amount for these three plans is $2,370.

❖ 60 Reserve Days may be used only once; days used are not renewable.

❖❖ These figures are for 2021 and are subject to change each year.

(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

(2) Medicare and private insurance will not pay for most nursing home care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

2020

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

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

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

Who should read this guide?

This guide can help if you're thinking about buying a Medicare Supplement Insurance (Medigap) policy or already have one. It'll help you understand how Medigap policies work.

Important information about this guide

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

The "2020 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Paid for by the Department of Health & Human Services.

SECTION

1 Medicare Basics

A brief look at Medicare

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

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

Words in blue are defined on pages 49–50.

What's Medicare?

Medicare is health insurance for people 65 or older, certain people under 65 with disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

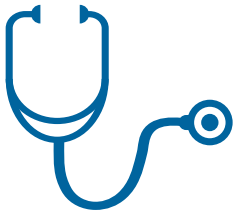
The different parts of Medicare

The different parts of Medicare help cover specific services.

Part A (Hospital Insurance)

Helps cover:

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



Part B (Medical Insurance)

Helps cover:

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

Part D (Prescription drug coverage)

Helps cover:

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

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

Your Medicare options

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

Original Medicare

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

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

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

Medicare Advantage (also known as Part C)

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

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

☑ **Extra benefits**

Some plans also include:

☐ **Lower out-of-pocket-costs**

Medicare and the Health Insurance Marketplace

If you have coverage through an individual Marketplace plan (not through an employer), you may want to end your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. For most people, their Initial Enrollment period is the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.

You can keep your Marketplace plan without penalty until your Medicare coverage starts. Once you're considered eligible for premium-free Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you may have to pay back some or all of the help you got when you file your taxes.

Visit HealthCare.gov to connect to the Marketplace in your state, or find out how to terminate your Marketplace financial help or plan to avoid a gap in coverage. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

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

For more information

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

SECTION 2

Medigap Basics

What's a Medigap policy?

A Medigap policy is an insurance policy that helps supplement Original Medicare and is sold by private companies. A Medigiap policy can help pay some of the remaining health care costs that Original Medicare doesn't pay for covered services and supplies, like copayments, coinsurance, and deductibles. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. These are "gaps" in Medicare coverage.

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

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

All Medigap policies must follow federal and state laws designed to protect you, and policies must be clearly identified as "Medicare Supplement Insurance." Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it.

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

What Medigap policies cover

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

- Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Plan C or Plan F to individuals who are not new to Medicare and either Plan D or Plan G to individuals who are new to Medicare. Not all types of Medigap policies may be available in your state.
- Plans D and G with coverage starting on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- **Plans E, H, I, and J are no longer sold**, but, if you already have one, you can generally keep it.
- Starting January 1, 2020, Medigap plans sold to people new to Medicare won't be allowed to cover the Part B deductible. Because of this, **Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020**.
  - If you already have either of these two plans (or the high deductible version of Plan F) or are covered by one of these plans prior to January 1, 2020, you'll be able to keep your plan. If you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy one of these plans.
  - People new to Medicare are those who turn 65 on or after January 1, 2020, and those who get Medicare Part A (Hospital Insurance) on or after January 1, 2020.

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

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

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2020**			
							$5,880	$2,940		

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

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

What Medigap policies don't cover

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

Types of coverage that are NOT Medigap policies

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

What types of Medigap policies can insurance companies sell?

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

Words in blue are defined on pages 49–50.

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

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

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

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

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

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- If you have a Medicare Advantage Plan (like an HMO or PPO) but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurer can sell it to you as long as you're leaving the Plan. Ask that the new Medigap policy start when your Medicare Advantage Plan enrollment ends, so you'll have continuous coverage.
- You pay the private insurance company a premium for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, **you each will have to buy separate Medigap policies**.
- When you have your Medigap Open Enrollment Period, you can buy a Medigap policy from any insurance company that's licensed in your state.
- Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you stay enrolled and pay the premium.
- Different insurance companies may charge different premiums for the same exact policy. As you shop for a policy, be sure you're comparing the same policy (for example, compare Plan A from one company with Plan A from another company).
- Some states may have laws that may give you additional protections.
- Although some Medigap policies sold in the past covered prescription drugs, Medigap policies sold after January 1, 2006, aren't allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D) offered by private companies approved by Medicare. (See pages 6–7.) To learn about Medicare prescription drug coverage, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

Creditable coverage

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

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

Prior creditable coverage is generally any other health coverage you recently had before applying for a Medigap policy. If you've had at least 6 months of continuous prior creditable coverage, the Medigap insurance company can't make you wait before it covers your pre-existing conditions.

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

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

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

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

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

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

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap Open Enrollment Period begins when you enroll in Part B, and it can't be changed or repeated. After your Medigap Open Enrollment Period ends, you may be denied a Medigap policy or charged more for a Medigap policy due to past or present health problems.

In most cases, it makes sense to enroll in Part B and buy a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty and might miss your 6-month Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Words in blue are defined on pages 49–50.

Employer coverage

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

How do insurance companies set prices for Medigap policies?

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

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

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

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

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

Comparing Medigap costs

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

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

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

- Offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses medical underwriting, or applies a different premium when you don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. (See page 20.)
- Offers a "high-deductible option" for Plans F or G. If you buy Plans F or G with a high-deductible option, you must pay the first $2,340 of deductibles, copayments, and coinsurance (in 2020) for covered services not paid by Medicare before the Medigap policy pays anything. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

If you bought Medigap Plan J before January 1, 2006, and it still covers prescription drugs, you would also pay a separate deductible ($250 per year) for prescription drugs covered by the Medigap policy. And, if you have a Plan J with a high deductible option, you must also pay a $2,340 deductible (in 2020) before the policy pays anything for medical benefits.

What's Medicare SELECT?

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

How does Medigap help pay my Medicare Part B bills?

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

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

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

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

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

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

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

When do I have guaranteed issue rights?

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

Medigap guaranteed issue right situations

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

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

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

Medigap guaranteed issue right situations (continued)

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

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

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

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

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

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

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

For more information about Medigap rights

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

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

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

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

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

SECTION 4

Steps to Buying a Medigap Policy

Step-by-step guide to buying a Medigap policy

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

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

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

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

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

STEP 4: Buy the Medigap policy.

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

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

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

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

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

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

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

  ✔ What each Medigap policy covers.

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

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

Words in blue are defined on pages 49–50.

STEP 2: (continued)

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

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

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

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

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

STEP 3: (continued)

Watch out for illegal practices.

It's illegal for anyone to:

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

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

STEP 4: Buy the Medigap policy.

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

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

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

SECTION 5

If You Already Have a Medigap Policy

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

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

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

Switching Medigap policies

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

Can I switch to a different Medigap policy?

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

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

Words in blue are defined on pages 49–50.

Switching Medigap policies (continued)

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

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

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

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

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

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

Switching Medigap policies (continued)

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

Some reasons for switching may include:

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

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

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

Switching Medigap policies (continued)

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

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

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

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

Losing Medigap coverage

Can my Medigap insurance company drop me?

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

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

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

Medigap policies and Medicare prescription drug coverage

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

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

Medigap policies and Medicare prescription drug coverage (continued)

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 6

Medigap Policies for People with a Disability or ESRD

Information for people under 65

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

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

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

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

Mandatory riders

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

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

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

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

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

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

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

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

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

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

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

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan ($2,340 deductible for 2020) is also available.

Optional riders

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

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

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

SECTION 8

For More Information

Where to get more information

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

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

How to get help with Medicare and Medigap questions

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

Visit Medicare.gov:

- For Medigap policies in your area, visit Medicare.gov/medigap-supplemental-insurance-plans.
- For updated phone numbers, visit Medicare.gov/contacts.

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

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

State Health Insurance Assistance Program and State Insurance Department

State	State Health Insurance Assistance Program	State Insurance Department
Alabama	1-800-243-5463	1-800-433-3966
Alaska	1-800-478-6065	1-800-467-8725
American Samoa	Not available	1-684-633-4116
Arizona	1-800-432-4040	1-800-325-2548
Arkansas	1-800-224-6330	1-800-224-6330
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7415	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-3272
Illinois	1-800-252-8966	1-888-473-4858
Indiana	1-800-452-4800	1-800-622-4461
Iowa	1-800-351-4664	1-877-955-1212
Kansas	1-800-860-5260	1-800-432-2484
Kentucky	1-877-293-7447	1-800-595-6053
Louisiana	1-800-259-5300	1-800-259-5301
Maine	1-800-262-2232	1-800-300-5000
Maryland	1-800-243-3425	1-800-735-2258
Massachusetts	1-800-243-4636	1-877-563-4467
Michigan	1-800-803-7174	1-877-999-6442
Minnesota	1-800-333-2433	1-800-657-3602
Mississippi	1-844-822-4622	1-800-562-2957
Missouri	1-800-390-3330	1-800-726-7390
Montana	1-800-551-3191	1-800-332-6148
Nebraska	1-800-234-7119	1-800-234-7119

State	State Health Insurance Assistance Program	State Insurance Department
Nevada	1-800-307-4444	1-800-992-0900
New Hampshire	1-866-634-9412	1-800-852-3416
New Jersey	1-800-792-8820	1-800-446-7467
New Mexico	1-800-432-2080	1-888-727-5772
New York	1-800-701-0501	1-800-342-3736
North Carolina	1-855-408-1212	1-800-546-5664
North Dakota	1-888-575-6611	1-800-247-0560
Northern Mariana Islands	Not available	1-670-664-3064
Ohio	1-800-686-1578	1-800-686-1526
Oklahoma	1-800-763-2828	1-800-522-0071
Oregon	1-800-722-4134	1-888-877-4894
Pennsylvania	1-800-783-7067	1-877-881-6388
Puerto Rico	1-877-725-4300	1-888-722-8686
Rhode Island	1-888-884-8721	1-401-462-9500
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 (St. Croix) 1-340-714-4354 (St. Thomas)	1-340-774-7166
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-727-8370	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION 9

Definitions

Where words in BLUE are defined

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

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

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

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

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

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

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

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

Medical underwriting—The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

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

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

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

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

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

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

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

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

CMS Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

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

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

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

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

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

Nondiscrimination Notice

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

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

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

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

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

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

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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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NOTES

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

For Your Records:

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

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

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

What's Next:

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

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

Your Welcome Kit.

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

Educational Materials.

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

Dedicated Customer Service.

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

Exclusive AARP Member Benefits.

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

AARP® | Medicare Supplement from UnitedHealthcare®

Let's talk about your needs

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

Name _____

Email _____

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

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

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

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

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

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

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