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

AARP | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AARP® Medicare Supplement Insurance Plans

insured by UnitedHealthcare Insurance Company

Keep cruising. Don’t slow down.

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

BA25435ST

Discover the healthcare coverage that goes the distance with you: A Medicare Supplement Insurance Plan

Hello...

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

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

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

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

All of us at UnitedHealthcare look forward to serving your health insurance needs now and for many years to come | **GO LONG®**

Sincerely,

Susan Morisato
President, Insurance Solutions
UnitedHealthcare Insurance Company

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

Questions? Contact your licensed insurance agent or call toll-free: **1-866-387-7550**
Mon.-Fri. 7 a.m. to 11 p.m. and Sat. 9 a.m. to 5 p.m., Eastern Time.

* From a report prepared for UnitedHealthcare Insurance Company by GFK Custom Research NA, "Medicare Supplement Plan Satisfaction Posted Questionnaire," 6/17/2013, www.uhcmedsupstats.com or call 1-800-523-5800 to request a copy of the full report.

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

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

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

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

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

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

Plans & Rates

SA25578ST

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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).

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SA25578ST

Overview of Available Plans

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

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

Basic Benefits:

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

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

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

Cover Page - Rates

Monthly Plan Rates for New York - Area 1

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company of New York

Plan A	Plan B	Plan C	Plan F	Plan G	Plan K	Plan L	Plan N
Standard Rates							
$164.25	$238.00	$293.50	$294.50	$264.50	$76.50	$159.50	$187.25

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

NEW YORK Area 1 ZIP Codes

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

00501	10026	10090	10128	10171	10272	10451	10503	10546	10597	10913	11003
00544	10027	10101	10129	10172	10273	10452	10504	10547	10598	10920	11004
06390	10028	10102	10130	10173	10274	10453	10505	10548	10601	10923	11005
10001	10029	10103	10131	10174	10275	10454	10506	10549	10602	10927	11010
10002	10030	10104	10132	10175	10276	10455	10507	10550	10603	10931	11020
10003	10031	10105	10133	10176	10277	10456	10510	10551	10604	10952	11021
10004	10032	10106	10138	10177	10278	10457	10511	10552	10605	10954	11022
10005	10033	10107	10150	10178	10279	10458	10514	10553	10606	10956	11023
10006	10034	10108	10151	10179	10280	10459	10517	10560	10607	10960	11024
10007	10035	10109	10152	10185	10281	10460	10518	10562	10610	10962	11026
10008	10036	10110	10153	10199	10282	10461	10519	10566	10701	10964	11027
10009	10037	10111	10154	10203	10285	10462	10520	10567	10702	10965	11030
10010	10038	10112	10155	10211	10286	10463	10521	10570	10703	10968	11040
10011	10039	10113	10156	10212	10301	10464	10522	10573	10704	10970	11042
10012	10040	10114	10157	10213	10302	10465	10523	10576	10705	10974	11050
10013	10041	10115	10158	10242	10303	10466	10526	10577	10706	10976	11051
10014	10043	10116	10159	10249	10304	10467	10527	10578	10707	10977	11052
10016	10044	10117	10160	10256	10305	10468	10528	10580	10708	10980	11053
10017	10045	10118	10162	10258	10306	10469	10530	10583	10709	10982	11054
10018	10055	10119	10163	10259	10307	10470	10532	10587	10710	10983	11055
10019	10060	10120	10164	10260	10308	10471	10533	10588	10801	10984	11096
10020	10065	10121	10165	10261	10309	10472	10535	10589	10802	10986	11101
10021	10069	10122	10166	10265	10310	10473	10536	10590	10803	10989	11102
10022	10075	10123	10167	10268	10311	10474	10538	10591	10804	10993	11103
10023	10080	10124	10168	10269	10312	10475	10540	10594	10805	10994	11104
10024	10081	10125	10169	10270	10313	10501	10543	10595	10901	11001	11105
10025	10087	10126	10170	10271	10314	10502	10545	10596	10911	11002	11106

NEW YORK Area 1 ZIP Codes CONTINUED

11109	11226	11357	11411	11451	11560	11697	11732	11767	11797	11952
11120	11228	11358	11412	11499	11561	11701	11733	11768	11798	11953
11201	11229	11359	11413	11501	11563	11702	11735	11769	11801	11954
11202	11230	11360	11414	11507	11565	11703	11737	11770	11802	11955
11203	11231	11361	11415	11509	11566	11704	11738	11771	11803	11956
11204	11232	11362	11416	11510	11568	11705	11739	11772	11804	11957
11205	11233	11363	11417	11514	11569	11706	11740	11773	11815	11958
11206	11234	11364	11418	11516	11570	11707	11741	11775	11853	11959
11207	11235	11365	11419	11518	11571	11709	11742	11776	11901	11960
11208	11236	11366	11420	11520	11572	11710	11743	11777	11930	11961
11209	11237	11367	11421	11530	11575	11713	11746	11778	11931	11962
11210	11238	11368	11422	11531	11576	11714	11747	11779	11932	11963
11211	11239	11369	11423	11542	11577	11715	11749	11780	11933	11964
11212	11241	11370	11424	11545	11579	11716	11751	11782	11934	11965
11213	11242	11371	11425	11547	11580	11717	11752	11783	11935	11967
11214	11243	11372	11426	11548	11581	11718	11753	11784	11937	11968
11215	11245	11373	11427	11549	11582	11719	11754	11786	11939	11969
11216	11247	11374	11428	11550	11590	11720	11755	11787	11940	11970
11217	11249	11375	11429	11551	11596	11721	11756	11788	11941	11971
11218	11251	11377	11430	11552	11598	11722	11757	11789	11942	11972
11219	11252	11378	11431	11553	11599	11724	11758	11790	11944	11973
11220	11256	11379	11432	11554	11690	11725	11760	11791	11946	11975
11221	11351	11380	11433	11555	11691	11726	11762	11792	11947	11976
11222	11352	11381	11434	11556	11692	11727	11763	11793	11948	11977
11223	11354	11385	11435	11557	11693	11729	11764	11794	11949	11978
11224	11355	11386	11436	11558	11694	11730	11765	11795	11950	11980
11225	11356	11405	11439	11559	11695	11731	11766	11796	11951	

The following zip codes are no longer recognized by the U.S. Post Office: 10161 and 11819

Cover Page - Rates

Monthly Plan Rates for New York - Area 2

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company of New York

Plan A	Plan B	Plan C	Plan F	Plan G	Plan K	Plan L	Plan N
Standard Rates							
$132.00	$191.25	$235.75	$236.75	$212.75	$61.50	$128.25	$150.50

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

NEW YORK Area 2 ZIP Codes

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

10509	10941	12017	12052	12082	12131	12167	12201	12234	12305	12423	12454
10512	10949	12018	12053	12083	12132	12168	12202	12235	12306	12424	12455
10516	10950	12019	12054	12084	12133	12169	12203	12236	12307	12427	12456
10524	10953	12020	12055	12085	12134	12170	12204	12237	12308	12428	12457
10537	10958	12022	12056	12086	12136	12172	12205	12238	12309	12429	12458
10541	10959	12023	12057	12087	12137	12173	12206	12239	12325	12430	12459
10542	10963	12024	12058	12089	12138	12174	12207	12240	12345	12431	12460
10579	10969	12025	12059	12090	12140	12175	12208	12241	12401	12432	12461
10910	10973	12027	12060	12092	12141	12176	12209	12242	12402	12433	12463
10912	10975	12028	12061	12093	12143	12177	12210	12243	12404	12434	12464
10914	10979	12029	12062	12094	12144	12180	12211	12244	12405	12435	12465
10915	10981	12031	12063	12095	12147	12181	12212	12245	12406	12436	12466
10916	10985	12032	12065	12106	12148	12182	12214	12246	12407	12438	12468
10917	10987	12033	12066	12107	12149	12183	12220	12247	12409	12439	12469
10918	10988	12035	12067	12110	12150	12184	12222	12248	12410	12440	12470
10919	10990	12036	12068	12115	12151	12185	12223	12249	12411	12441	12471
10921	10992	12037	12069	12117	12153	12186	12224	12250	12412	12442	12472
10922	10996	12040	12070	12118	12154	12187	12225	12255	12413	12443	12473
10924	10997	12041	12071	12120	12156	12188	12226	12257	12414	12444	12474
10925	10998	12042	12072	12121	12157	12189	12227	12260	12416	12446	12475
10926	12007	12043	12073	12122	12158	12192	12228	12261	12417	12448	12477
10928	12008	12045	12074	12123	12159	12193	12229	12288	12418	12449	12480
10930	12009	12046	12075	12124	12160	12194	12230	12301	12419	12450	12481
10932	12010	12047	12076	12125	12161	12195	12231	12302	12420	12451	12482
10933	12015	12050	12077	12128	12165	12196	12232	12303	12421	12452	12483
10940	12016	12051	12078	12130	12166	12198	12233	12304	12422	12453	12484

NEW YORK Area 2 ZIP Codes CONTINUED

12485	12517	12548	12584	12736	12769	12811	12846	12883	12944	13317	13839
12486	12518	12549	12585	12737	12770	12814	12848	12884	12946	13339	13842
12487	12520	12550	12586	12738	12771	12815	12849	12885	12950	13410	13846
12489	12521	12551	12588	12740	12775	12816	12850	12886	12952	13428	13847
12490	12522	12552	12589	12741	12776	12817	12851	12887	12955	13452	13856
12491	12523	12553	12590	12742	12777	12819	12852	12901	12956	13459	13860
12492	12524	12555	12592	12743	12778	12820	12853	12903	12958	13470	
12493	12525	12561	12594	12745	12779	12821	12854	12910	12959	13731	
12494	12526	12563	12601	12746	12780	12822	12855	12911	12960	13739	
12495	12527	12564	12602	12747	12781	12823	12856	12912	12961	13740	
12496	12528	12565	12603	12748	12783	12824	12857	12913	12962	13750	
12498	12529	12566	12604	12749	12784	12827	12858	12918	12964	13751	
12501	12530	12567	12701	12750	12785	12828	12859	12919	12972	13752	
12502	12531	12568	12719	12751	12786	12831	12860	12921	12974	13753	
12503	12533	12569	12720	12752	12787	12832	12861	12923	12975	13755	
12504	12534	12570	12721	12754	12788	12833	12862	12924	12977	13756	
12506	12537	12571	12722	12758	12789	12834	12863	12928	12978	13757	
12507	12538	12572	12723	12759	12790	12835	12865	12929	12979	13774	
12508	12540	12574	12724	12760	12791	12836	12866	12932	12981	13775	
12510	12541	12575	12725	12762	12792	12837	12870	12933	12985	13782	
12511	12542	12577	12726	12763	12801	12838	12871	12934	12987	13783	
12512	12543	12578	12727	12764	12803	12839	12872	12935	12992	13786	
12513	12544	12580	12729	12765	12804	12841	12873	12936	12993	13788	
12514	12545	12581	12732	12766	12808	12843	12874	12941	12996	13804	
12515	12546	12582	12733	12767	12809	12844	12878	12942	12997	13806	
12516	12547	12583	12734	12768	12810	12845	12879	12943	12998	13838	

The following zip codes are no longer recognized by the U.S. Post Office: 12252 and 12256

Cover Page - Rates

Monthly Plan Rates for New York - Area 3

AARP® Medicare Supplement Insurance Plans
insured by UnitedHealthcare Insurance Company of New York

Plan A	Plan B	Plan C	Plan F	Plan G	Plan K	Plan L	Plan N
Standard Rates							
$113.50	$164.75	$203.00	$203.75	$183.00	$53.00	$110.25	$129.50

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

NEW YORK Area 3 ZIP Codes

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

12064	13020	13072	13131	13208	13323	13406	13473	13617	13659	13734	13815
12108	13021	13073	13132	13209	13324	13407	13475	13618	13660	13736	13820
12116	13022	13074	13134	13210	13325	13408	13476	13619	13661	13737	13825
12139	13024	13076	13135	13211	13326	13409	13477	13620	13662	13738	13826
12155	13026	13077	13136	13212	13327	13411	13478	13621	13664	13743	13827
12164	13027	13078	13137	13214	13328	13413	13479	13622	13665	13744	13830
12190	13028	13080	13138	13215	13329	13415	13480	13623	13666	13745	13832
12197	13029	13081	13139	13217	13331	13416	13482	13624	13667	13746	13833
12812	13030	13082	13140	13218	13332	13417	13483	13625	13668	13747	13834
12842	13031	13083	13141	13219	13333	13418	13484	13626	13669	13748	13835
12847	13032	13084	13142	13220	13334	13420	13485	13627	13670	13749	13840
12864	13033	13087	13143	13221	13335	13421	13486	13628	13671	13754	13841
12914	13034	13088	13144	13224	13337	13424	13488	13630	13672	13758	13843
12915	13035	13089	13145	13225	13338	13425	13489	13631	13673	13760	13844
12916	13036	13090	13146	13235	13340	13426	13490	13632	13674	13761	13845
12917	13037	13092	13147	13244	13341	13431	13491	13633	13675	13762	13848
12920	13039	13093	13148	13250	13342	13433	13492	13634	13676	13763	13849
12922	13040	13101	13152	13251	13343	13435	13493	13635	13677	13776	13850
12926	13041	13102	13153	13252	13345	13436	13494	13636	13678	13777	13851
12927	13042	13103	13154	13261	13346	13437	13495	13637	13679	13778	13859
12930	13043	13104	13155	13290	13348	13438	13501	13638	13680	13780	13861
12937	13044	13107	13156	13301	13350	13439	13502	13639	13681	13784	13862
12939	13045	13108	13157	13302	13352	13440	13503	13640	13682	13787	13863
12945	13051	13110	13158	13303	13353	13441	13504	13641	13683	13790	13864
12949	13052	13111	13159	13304	13354	13442	13505	13642	13684	13794	13865
12953	13053	13112	13160	13305	13355	13449	13599	13643	13685	13795	13901
12957	13054	13113	13162	13308	13357	13450	13601	13645	13687	13796	13902
12965	13056	13114	13163	13309	13360	13454	13602	13646	13690	13797	13903
12966	13057	13115	13164	13310	13361	13455	13603	13647	13691	13801	13904
12967	13060	13116	13165	13312	13362	13456	13605	13648	13692	13802	13905
12969	13061	13117	13166	13313	13363	13457	13606	13649	13693	13803	14001
12970	13062	13118	13167	13314	13364	13460	13607	13650	13694	13807	14004
12973	13063	13119	13201	13315	13365	13461	13608	13651	13695	13808	14005
12976	13064	13120	13202	13316	13367	13464	13611	13652	13696	13809	14006
12980	13065	13121	13203	13318	13368	13465	13612	13654	13697	13810	14008
12983	13066	13122	13204	13319	13401	13468	13613	13655	13699	13811	14009
12986	13068	13123	13205	13320	13402	13469	13614	13656	13730	13812	14010
12989	13069	13124	13206	13321	13403	13471	13615	13657	13732	13813	14011
12995	13071	13126	13207	13322	13404	13472	13616	13658	13733	13814	14012

NEW YORK Area 3 ZIP Codes CONTINUED

14013	14068	14139	14224	14429	14504	14551	14620	14723	14777	14837	14884
14020	14069	14140	14225	14430	14505	14555	14621	14724	14778	14838	14885
14021	14070	14141	14226	14432	14506	14556	14622	14726	14779	14839	14886
14024	14072	14143	14227	14433	14507	14557	14623	14727	14781	14840	14887
14025	14075	14144	14228	14435	14508	14558	14624	14728	14782	14841	14889
14026	14080	14145	14231	14437	14510	14559	14625	14729	14783	14842	14891
14027	14081	14150	14233	14441	14511	14560	14626	14730	14784	14843	14892
14028	14082	14151	14240	14443	14512	14561	14627	14731	14785	14845	14893
14029	14083	14166	14241	14445	14513	14563	14638	14732	14786	14846	14894
14030	14085	14167	14260	14449	14514	14564	14639	14733	14787	14847	14895
14031	14086	14168	14261	14450	14515	14568	14642	14735	14788	14850	14897
14032	14091	14169	14263	14452	14516	14569	14643	14736	14801	14851	14898
14033	14092	14170	14264	14453	14517	14571	14644	14737	14802	14852	14901
14034	14094	14171	14265	14454	14518	14572	14646	14738	14803	14853	14902
14035	14095	14172	14267	14456	14519	14580	14647	14739	14804	14854	14903
14036	14098	14173	14269	14461	14520	14585	14649	14740	14805	14855	14904
14037	14101	14174	14270	14462	14521	14586	14650	14741	14806	14856	14905
14038	14102	14201	14272	14463	14522	14588	14651	14742	14807	14857	
14039	14103	14202	14273	14464	14525	14589	14652	14743	14808	14858	
14040	14105	14203	14276	14466	14526	14590	14653	14744	14809	14859	
14041	14107	14204	14280	14467	14527	14591	14692	14745	14810	14860	
14042	14108	14205	14301	14468	14529	14592	14694	14747	14812	14861	
14043	14109	14206	14302	14469	14530	14602	14701	14748	14813	14863	
14047	14110	14207	14303	14470	14532	14603	14702	14750	14814	14864	
14048	14111	14208	14304	14471	14533	14604	14706	14751	14815	14865	
14051	14112	14209	14305	14472	14534	14605	14707	14752	14816	14867	
14052	14113	14210	14410	14475	14536	14606	14708	14753	14817	14869	
14054	14120	14211	14411	14476	14537	14607	14709	14754	14818	14870	
14055	14125	14212	14413	14477	14538	14608	14710	14755	14819	14871	
14056	14126	14213	14414	14478	14539	14609	14711	14756	14820	14872	
14057	14127	14214	14415	14479	14541	14610	14712	14757	14821	14873	
14058	14129	14215	14416	14480	14542	14611	14714	14758	14822	14874	
14059	14130	14216	14418	14481	14543	14612	14715	14760	14823	14876	
14060	14131	14217	14420	14482	14544	14613	14716	14766	14824	14877	
14061	14132	14218	14422	14485	14545	14614	14717	14767	14825	14878	
14062	14133	14219	14423	14486	14546	14615	14718	14769	14826	14879	
14063	14134	14220	14424	14487	14547	14616	14719	14770	14827	14880	
14065	14135	14221	14425	14488	14548	14617	14720	14772	14830	14881	
14066	14136	14222	14427	14489	14549	14618	14721	14774	14831	14882	
14067	14138	14223	14428	14502	14550	14619	14722	14775	14836	14883	

Eligibility & Benefits

SA25579ST

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

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

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

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

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

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

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

SA25579ST

Your Guide to AARP Medicare 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 of New York, 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 older, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage.

In New York, there is ongoing Guaranteed Acceptance so Medicare supplement plans are guaranteed available.

Glossary of Terms

Medicare Eligible Expenses are the health care expenses of the kinds covered under Medicare Parts A and B that Medicare recognizes as reasonable and medically necessary. Physicians under Medicare may agree to accept Medicare's eligible expense as their fee amount. Your physician or surgeon may charge you more. Excess charges may not exceed 5% in New York State.

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.
- Stays which occur or care or supplies received before your plan's effective date.
- In no event will medical payments under your Plan duplicate any benefits provided under Workers' Compensation.
- 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.
- Stays occurring and/or care or supplies received during the first 6 months of coverage will not be covered, if they are caused by or result from a pre-existing condition. A pre-existing condition is any sickness or injury for which you receive medical advice or treatment during the 6 months prior to your insurance effective date.

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

1. 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
2. Individuals who, within the last 63 days, have been covered under other health insurance coverage or are replacing current health insurance coverage.

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 cannot be canceled because of your age, your health, or the number of claims you make. Your Medicare supplement plan may be canceled due to nonpayment of premium or material misrepresentation. If 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 New York. 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 of New York, not by AARP or its affiliates. Please contact UnitedHealthcare Insurance Company of New York 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 of New York, 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 Company of New York 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.

This policy meets the minimum standards for MEDICARE SUPPLEMENT INSURANCE as defined by the New York State Department of Financial Services. The expected benefit ratio for this policy is 75%. This ratio is the portion of future premiums which the Company expects to return as benefits, when averaged over all people with this policy.

IMPORTANT NOTICE: A CONSUMER'S GUIDE TO HEALTH INSURANCE FOR PEOPLE ELIGIBLE FOR MEDICARE MAY BE OBTAINED FROM YOUR LOCAL SOCIAL SECURITY OFFICE OR FROM THIS INSURER.

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 Benefit Tables: Plan A

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

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

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Notes

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

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

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

Plan Benefit Tables: Plan B

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

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

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Notes

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

Plan Benefit Tables: Plan B (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan B Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

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

Plan Benefit Tables: Plan C

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

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

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Notes

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

Plan Benefit Tables: Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan C Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

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

Notes

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

Plan Benefit Tables: Plan F

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

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

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Notes

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

Plan Benefit Tables: Plan F (continued)

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

Parts A and B				
Service		**Medicare Pays**	**Plan F Pays**	**You Pay**
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$183 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

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

Notes

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

Plan Benefit Tables: Plan G

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

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

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Notes

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

Plan Benefit Tables: Plan G (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B Deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

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

Notes

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

Plan Benefit Tables: Plan K

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

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

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Notes

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

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

Plan Benefit Tables: Plan K (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay[3]
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

Continued on next page ▶

Notes

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

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

Plan Benefit Tables: Plan K (continued)

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay[3]
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deduct-ible)♦
	Remainder of Medicare-approved amounts	80%	10%	10%♦

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

Plan Benefit Tables: Plan L

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

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

Continued on next page ▶

Notes

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

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

Plan Benefit Tables: Plan L (continued)

Medicare Part B: Medical Services per Calendar Year

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

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay[3]
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

Continued on next page ▶

Notes

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

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

Plan Benefit Tables: Plan L (continued)

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay[3]
Durable medical equipment Medicare-approved services	First $183 of Medicare-approved amounts[5]	$0	$0	$183 (Part B deductible)♦
	Remainder of Medicare-approved amounts	80%	15%	5%♦

Notes

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

Plan Benefit Tables: Plan N

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

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

Continued on next page

Notes

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

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

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

Continued on next page

Notes

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

Plan Benefit Tables: Plan N (continued)

Parts A and B, continued

Service		Medicare Pays	Plan N Pays	You Pay
Durable Medical Equipment Medicare-approved services	First $183 of Medicare-approved amounts[2]	$0	$0	$183 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits not covered by Medicare				
Foreign Travel NOT COVERED BY MEDICARE - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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. Your premium can only be changed with the approval of AARP and/or your state insurance department.

Disclosures

Use the *Overview of Available Plans*, the *Plan Benefit Tables* and *Cover Page - Rates* to compare benefits and premiums among plans. **This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.**

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.

Enrollment Forms

SA25580ST

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

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

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

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

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

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

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

SA25580ST

Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Enrollment Checklist

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

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

✔ **Application Form**

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

✔ **AARP Membership Form**

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

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

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

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

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

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

✔ **Conditional Receipt for New York Residents**

If you are submitting premium, be sure to review and sign both copies of the form. Keep one copy for your records. The licensed insurance agent keeps the other copy in his or her records.

✔ **New York Agent Required Disclosure**

Be sure to review the Disclosure which describes your rights to request certain information from your licensed insurance agent.

✔ **If Reply Envelope Is Missing**

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

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

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

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

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

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

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

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Application Form

AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company of New York, Islandia, NY 11749

Plans and rates described are good only for residents of New York.

Instructions

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

AARP Membership Number
(If you are already a member)

____

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

Applicant First Name ________ MI ____ Last Name ________

Permanent Home Address ________ City ____ State ____ Zip ____

Mailing Address (if different from above) ________ City ____ State ____ Zip ____

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1 Tell us about yourself

Please provide your Medicare insurance information.

NAME OF BENEFICIARY
1A. ____________________

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

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

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

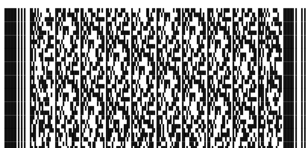
1G. Birthdate ____ / ____ / ____
Month Day Year

1H. Phone Number (___) ___ - ____

1I. email address (optional)

____

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



2460720307

First Name Last Name

2 Choose your plan and start date

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

You are eligible to apply if all of these are true:
- you are an AARP member or the spouse of a member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A and B,
- you are not enrolled in more than one Medicare supplement plan at the same time.

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

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

/01/
Month Day Year

3 Tell us about your past and current coverage

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

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy must be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of timely notice, the issuer must either return to the certificate holder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.
- If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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

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First Name Last Name

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

PLEASE ANSWER ALL QUESTIONS.	
To the best of your knowledge, **3A.** Did you turn age 65 in the last 6 months?	☐Yes ☐No
3B. Did you enroll in Medicare Part B in the last 6 months?	☐Yes ☐No
3C. If YES, what is the effective date?	/01/ Month Day Year
Answer these questions about Medicaid	
3D. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 3E and 3F.**	☐Yes ☐No
3E. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
3F. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Answer these questions about Medicare Advantage plans (sometimes called Medicare Part C)	
3G. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 3H through 3K.**	☐Yes ☐No
3H. Fill in the start and end dates of your Medicare plan. If you are still covered under this plan, leave the end date blank.	**Start Date** /01/ Month Day Year **End Date** / / Month Day Year
3I. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare Supplement plan has been issued, you will need to cancel your Medicare Advantage Plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.) **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
3J. Was this your first time in this type of Medicare plan?	☐Yes ☐No
3K. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐Yes ☐No

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First Name Last Name

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

Answer these questions about Medicare supplement plans	
3L. Do you have another Medicare supplement policy in force? If so, what company and what plan do you have? Company:______________ Policy: ______________ **If YES, you must answer Question 3M.**	☐Yes ☐No
3M. Do you intend to replace your current Medicare supplement policy with this policy? **If YES, please enclose a copy of the Replacement Notice.**	☐Yes ☐No
Answer these questions about any other type of health insurance coverage	
3N. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? **If YES, you must answer Questions 3O through 3Q.**	☐Yes ☐No
3O. If so, with what company and what kind of policy? **Company:**______________	**Policy:** ☐ HMO/PPO ☐ Major Medical ☐ Employer Plan ☐ Union Plan ☐ Other______
3P. What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.	**Start Date** ___/___/___ Month Day Year **End Date** ___/___/___ Month Day Year
3Q. Are you replacing this health insurance?	☐Yes ☐No

______________ **Your Signature – 1** (required)

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

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4 Authorization and Verification of Application Form Information

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

- My signature indicates I have read and understand the contents of this application.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- **The sale of a Medicare supplement policy or certificate is prohibited where an individual has a Medicare supplement policy or certificate in force and does not desire to replace the existing policy or certificate or where the Medicare supplement policy or certificate would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.**

First Name Last Name

4 Authorization and Verification of Application Form Information (continued)

If application is being made through an agent:

- I understand that the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company of New York, and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I understand the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company of New York. This person may be compensated based on my enrollment in a plan.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.

If you are replacing your current health insurance coverage, or if your application is received within 6 months after you are first enrolled in Medicare Part B at age 65 or older, the following exclusion will not apply to you. Please see "Your Guide" for more information.

I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 6 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 6 months prior to the insurance effective date. I also understand that stays which start before the insurance effective date will not be covered until 6 months after the effective date.

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

✗ ______________________________ ____/____/____

Your Signature – 2 (required) **Today's Date** (required)

Month Day Year

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

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

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company of New York and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to apply for the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. This authorization is valid for 24 months from the date of my signature.

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

✗ ______________________________ ____/____/____

Your Signature – 3 (required) **Today's Date** (required)

Month Day Year

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

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First Name Last Name

5 For Agent Use Only

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

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

2. List policies issued which are still in force:

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

I have reviewed the current health insurance coverage for the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Agent Name (PLEASE PRINT) First Name MI Last Name

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

Agent Email Address Agent Phone Number

✗ Broker Broker ID

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Application Form Checklist

Did you remember to…

- ❑ Fill in all requested information in all sections?
- ❑ Sign in all three signature boxes?
- ❑ Enclose a check or money order with your first month's insurance payment, payable to UnitedHealthcare Insurance Company of New York? Refer to the enclosed "Cover Page – Rates" for the monthly cost of the plan you have selected.
- ❑ If you are not already an AARP member, did you complete the AARP membership form and enclose a check or money order with your membership dues?
- ❑ Staple or clip your check and any other documents to this application?
- ❑ Include the appropriate legal documentation, if you are signing as a Legal Representative?

Mail the completed form(s) in the enclosed envelope. If the return envelope is missing, please mail to: UnitedHealthcare Insurance Company, P.O. Box 105331, Atlanta, GA 30348-5331.

You can also apply online at: www.aarpmedicareplans.com or fax this form to 1-888-836-3985.

Once your application is processed, you will be notified. If accepted, you will receive your monthly insurance rate and a Certificate of Insurance with your start date. *Thank you!*

TEAR HERE

TEAR HERE

New York Agent Required Disclosure

As of January 1, 2011, New York regulations assure that you have the right to discuss compensation with your agent.

Agents who are licensed and appointed by UnitedHealthcare Insurance Company of New York for the solicitation of, negotiation for, or the sale of Medicare supplement insurance plans will receive compensation from UnitedHealthcare for helping you purchase one of the plans.

Your agent's compensation may vary depending on the plan you enroll in, how much business they provide to UnitedHealthcare, or the profitability of the insurance coverage that they provide to UnitedHealthcare.

You may request information about the expected compensation based on the sale, and the compensation expected to be received on any alternative quotes presented.

You may request information about the agent's expected compensation anytime up until 30 days following your plan effective date.

TEAR HERE

TEAR HERE

CONDITIONAL RECEIPT

UnitedHealthcare Insurance Company of New York
Islandia, NY 11749

(To be completed and retained by the Agent with a copy given to the Applicant.)

$____________________ Received from: ________________________________
Name of Applicant

This amount is tendered with the application for the referenced insurance plan as a deposit for the premium due, subject to the following:

It is mutually agreed that the insurance plan applied for will become effective on the first day of the month following approval of the application but will not be in force unless UnitedHealthcare Insurance Company of New York has determined that the person(s) proposed for insurance have provided satisfactory evidence of insurability and the full first month's premium has been paid as required.

If the application is accepted, the Applicant will be advised in writing by UnitedHealthcare Insurance Company of New York. If the application is not accepted, UnitedHealthcare Insurance Company of New York will advise the Applicant, promptly refund the premium deposit paid; and the refund of such deposit will fully discharge any and all obligations of UnitedHealthcare Insurance Company of New York to the Applicant.

Agent acknowledges receipt of deposit for the premium due and delivery of a copy of Conditional Receipt to Applicant.

AGENT SIGNATURE (REQUIRED)____

AGENT ID (REQUIRED)____

TODAY'S DATE (REQUIRED) ____

TEAR HERE

TEAR HERE

CONDITIONAL RECEIPT

UnitedHealthcare Insurance Company of New York
Islandia, NY 11749

(To be completed and retained by the Agent with a copy given to the Applicant.)

$____________________ Received from: ______________________________
Name of Applicant

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Agent acknowledges receipt of deposit for the premium due and delivery of a copy of Conditional Receipt to Applicant.

AGENT SIGNATURE (REQUIRED)____

AGENT ID (REQUIRED)____

TODAY'S DATE (REQUIRED) ____

TEAR HERE

AARP membership offers so much for so little.

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

BA25233 (07-14)

TEAR HERE

Yes, I'd like to join AARP today!

It's simple ... just follow these instructions.

If you're already a member, give this to someone you know or complete it to renew your membership.

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

____
Address Apt.

____
City State Zip

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

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

Choose from 3 easy ways to join:

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

I agree to pay for the term I select:

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

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

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

____
E-mail Address V7FYUHG

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

AA25001 (07-14) AGT

Explore the possibilities of AARP membership with:

Travel Discounts
Using AARP's exclusive travel savings just once could pay for your membership several times over!
- Savings on hotels, motels and resorts worldwide
- Discounted rates on airfares, cruises and auto rentals
- Special pricing on vacation packages

Health-Related Benefits
With today's high health care costs, AARP membership is more valuable than ever.
- Supplemental health plans and dental insurance for AARP members
- Vision, hearing and prescription discounts nationwide

Local Opportunities
AARP offers many ways to get active in your community.
- Over 2,200 local AARP chapters
- Social activities
- Volunteer opportunities
- Safe driving courses
- Classes and workshops

Protection of Your Rights
Your job. Your health. Your future. AARP will stand up for you by ...
- Representing your interests in Washington and your state
- Confronting age discrimination by employers
- Strengthening Social Security
- Protecting pension and retirement benefits
- Fighting predatory home loan lending

Dependable Financial Programs
Designed specifically for AARP members. With the high level of service you expect.
- Earn rewards with a no-annual-fee credit card
- Auto, homeowners and life insurance

Valuable Information
Accurate and authoritative, direct from your reliable source – AARP.
- *AARP The Magazine*
- *AARP Bulletin*
- FREE financial and health guides
- Our web site, www.aarp.org

Specially Priced Products & Services
AARP helps you save in ways and places you never imagined.
- Discounts on groceries, home security, restaurants and more!
- Reduced-fee legal services*
- Roadside assistance and emergency towing

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

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

Value our members appreciate.

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

TEAR HERE

TEAR HERE

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

The Easiest Way to Pay

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

In addition to saving up to $24 a year:

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

Signing Up is Easy

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

Your EFT Effective Date

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

Complete Form on Reverse ▶

This side for your information only, return not required.

AUTOMATIC PAYMENT AUTHORIZATION FORM

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

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

Member Name ________________________ AARP Member Number ________________

Member Address ____
Street Addresss

Member Address ____
City State Zip Code

Bank Name ________________________

Bank Routing No. ________________________
(9 digit number)

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

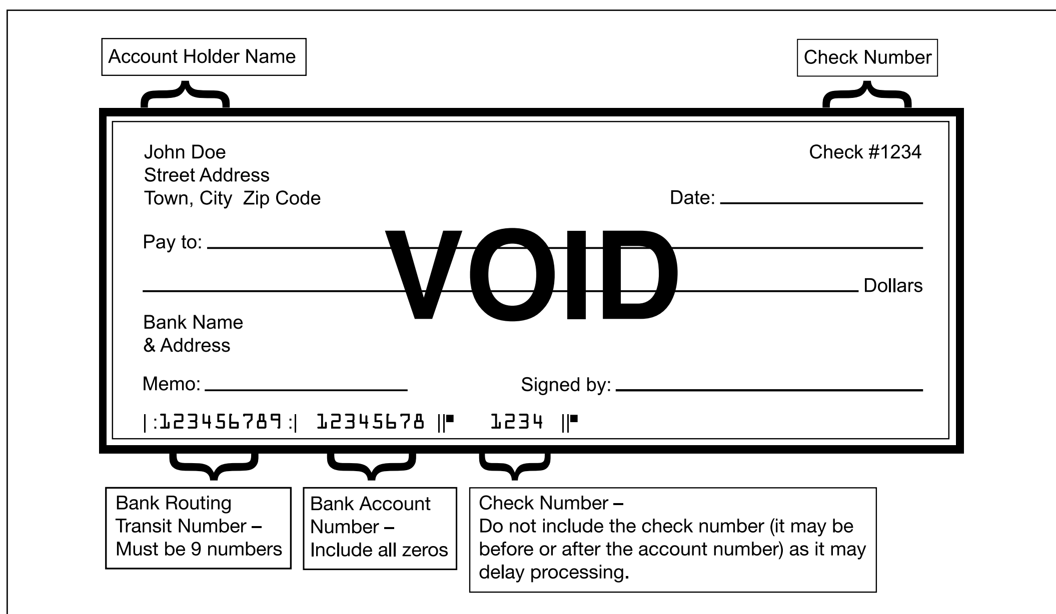
Bank Account No. ________________________

Bank Account Holder's Name if other than Member ________________________

Bank Account Holder's Signature ________________________

IMPORTANT

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



We look forward to continuing to serve you.

TEAR HERE

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Member Name ______________________ AARP Member Number______________

Member Address ____
Street Addresss

Member Address ____
City State Zip Code

Bank Name ______________________

Bank Routing No. ____________________
(9 digit number)

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

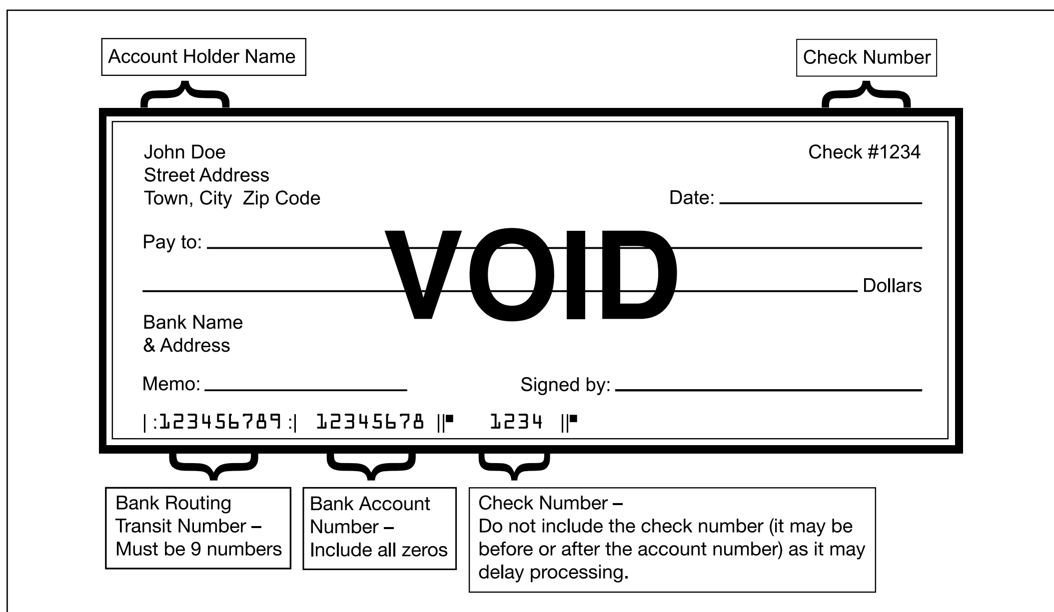
Bank Account No. ____________________

Bank Account Holder's Name if other than Member ______________________

Bank Account Holder's Signature ______________________________

IMPORTANT

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



We look forward to continuing to serve you.

TEAR HERE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Islandia, New York

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

According to the information you furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a certificate to be issued by UnitedHealthcare Insurance Company of New York. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction (does)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

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

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

_____ Other (Please Specify) ____________________

____

____

1. Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present coverage.

2. State regulation provides that in applying a pre-existing condition limitation, a Medicare Supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare Supplement insurance, Medicare Select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.

3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

TEAR HERE

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

____

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

____

(Applicant's Signature) (Date)

____

(Applicant's Printed Name & Address)

TEAR HERE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Islandia, New York

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

According to the information you furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a certificate to be issued by UnitedHealthcare Insurance Company of New York. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

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I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction (does)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

_____ Additional benefits.

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

_____ Other (Please Specify) ____________________

____

____

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3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

TEAR HERE

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

____

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

____

(Applicant's Signature) (Date)

____

(Applicant's Printed Name & Address)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE COVERAGE, MEDICARE SELECT COVERAGE, MEDICARE ADVANTAGE PLAN OR HMO RISK OR COST CONTRACT

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK

Your application for the Medicare supplement insurance certificate issued by this company indicates that you intended to terminate existing Medicare supplement insurance coverage, Medicare Select coverage, Medicare Advantage plan or health maintenance organization (HMO) issued Medicare cost contract and replace it with the coverage applied for with this company. Duplicate coverage is unnecessary and you should terminate one of your existing coverages if more than one such plan is still in force.

RN055 7/09

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

For your records:

- You selected Plan__________
- The effective date you requested is (1st day of a future month): _____ / _____
  Month Year
- Based on the information you provided, your monthly premium for the plan you selected is $__________
- You will be notified when review of your application has been completed

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

What's Next

Once Your Application Is Approved, You Will Receive:

- Your insured member identification card
- A Welcome Kit, including your certificate of insurance and coverage details
- Ongoing educational materials about how to make the most of your health plan benefits
- Help and answers to any questions you may have from courteous Customer Service Representatives
- A friendly customer service call to review the items listed above

A continuing relationship with your agent/producer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT 2018 MEDICARE BENEFIT INFORMATION

Beginning January 1, 2018, the Medicare Part A inpatient Hospital Deductible will be $1,340.

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 61st - 90th day 91st - 150th day❖ Beyond 150 days	All but $1,340 All but $335 a day All but $670 a day 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 Additional 80 days Beyond 100 days	100% of approved amount All but $167.50 a day Nothing

For 2018, the Medicare Part B Deductible will be $183.

2018 Out of Pocket Limits for Medigap Plans K & L - The 2018 out of pocket limits for Medigap Plans K & L are $5,240 and $2,620, respectively.

2018 Deductible Amount for Medigap High Deductible Options F & J - The 2018 annual deductible amount for these two plans is $2,240.

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

❖❖ These figures are for 2018 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

2017

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

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

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

Who should read this guide?

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

Important information about this guide

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

The "2017 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.

Section 1: Medicare Basics 5

A brief look at Medicare . . . 5
What's Medicare? . . . 6
The different parts of Medicare . . . 6
Your Medicare coverage choices at a glance . . . 7
Medicare and the Health Insurance Marketplace . . . 8

Section 2: Medigap Basics 9

What's a Medigap policy? . . . 9
What Medigap policies cover . . . 10
What Medigap policies don't cover . . . 12
Types of coverage that are NOT Medigap policies . . . 12
What types of Medigap policies can insurance companies sell? . . . 12
What do I need to know if I want to buy a Medigap policy? . . . 13
When's the best time to buy a Medigap policy? . . . 14
Why is it important to buy a Medigap policy when I'm first eligible? . . . 16
How do insurance companies set prices for Medigap policies? . . . 17
What this pricing may mean for you . . . 18
Comparing Medigap costs . . . 19
What's Medicare SELECT? . . . 20
How does Medigap help pay my Medicare Part B bills? . . . 20

Section 3: Your Right to Buy a Medigap Policy 21

What are guaranteed issue rights? . . . 21
When do I have guaranteed issue rights? . . . 21
Can I buy a Medigap policy if I lose my health care coverage? . . . 24

Section 4: Steps to Buying a Medigap Policy 25

Step-by-step guide to buying a Medigap policy . . . 25

Section 5: If You Already Have a Medigap Policy 31

Switching Medigap policies . . . 32
Losing Medigap coverage . . . 36
Medigap policies and Medicare prescription drug coverage . . . 36

Section 6: Medigap Policies for People with a Disability or ESRD **39**

Information for people under 65 39

Section 7: Medigap Coverage in Massachusetts, Minnesota, and Wisconsin **41**

Massachusetts benefits 42

Minnesota benefits 43

Wisconsin benefits 44

Section 8: For More Information **45**

Where to get more information 45

How to get help with Medicare and Medigap questions 46

State Health Insurance Assistance Program and State Insurance Department. . 47

Section 9: Definitions **49**

Where words in BLUE are defined 49

SECTION 1

Medicare Basics

A brief look at Medicare

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

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

Words in blue are defined on pages 49–50.

What's Medicare?

Medicare is health insurance for:

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

The different parts of Medicare

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance) helps cover

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

Medicare Part B (Medical Insurance) helps cover

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

Medicare Part C (Medicare Advantage)

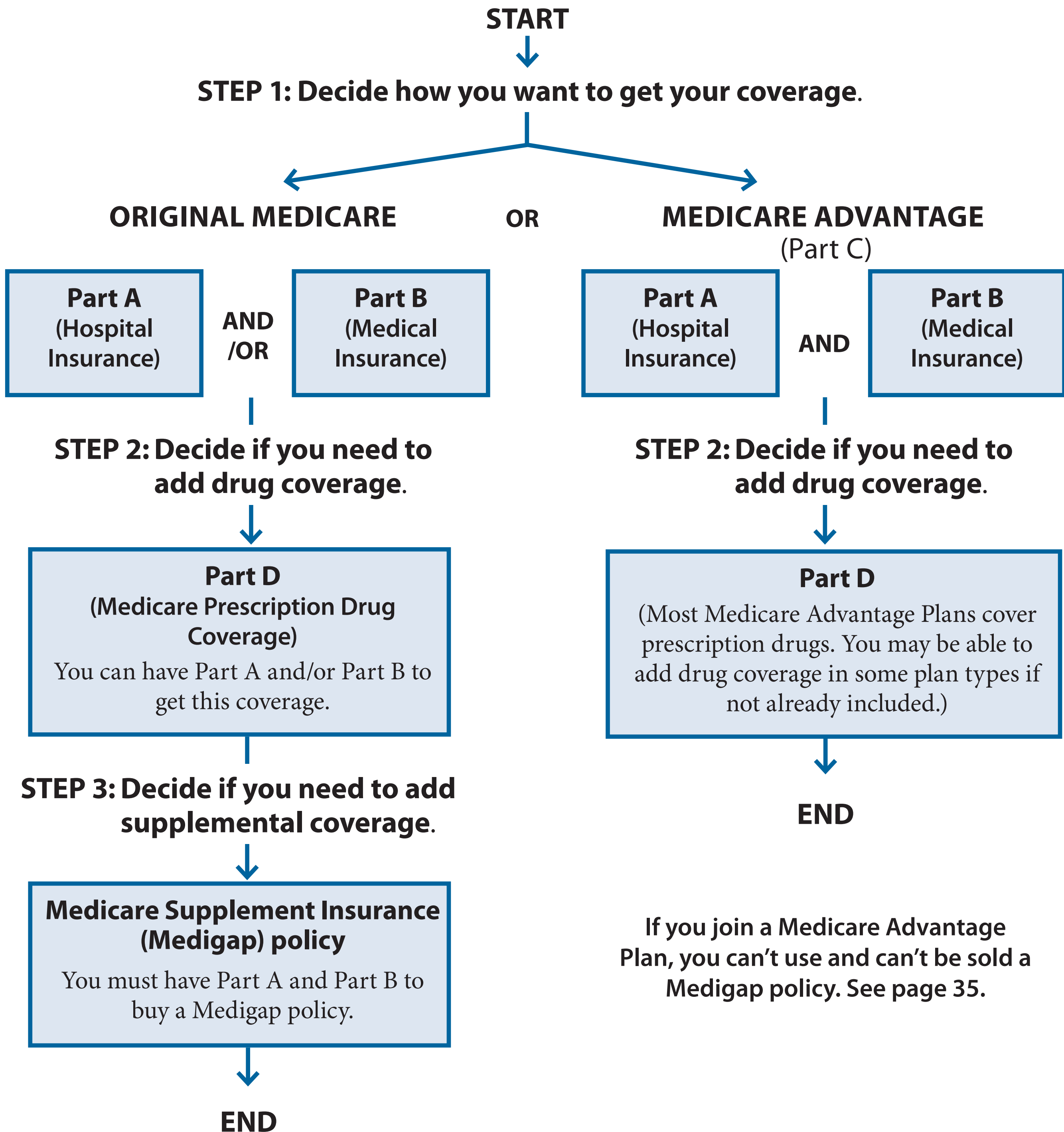
- Includes all benefits and services covered under Part A and Part B
- Run by Medicare-approved private insurance companies
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost

Medicare Part D (Medicare Prescription Drug Coverage)

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

Your Medicare coverage choices at a glance

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



Medicare and the Health Insurance Marketplace

The Health Insurance Marketplace is a way for qualified individuals, families, and employees of small businesses to get health coverage. **Medicare isn't part of the Marketplace.**

Is Medicare coverage "minimum essential coverage?"

Minimum essential coverage is coverage that you need to have to meet the individual responsibility requirement under the Affordable Care Act.

As long as you have Medicare Part A (Hospital Insurance) coverage or are enrolled in a Medicare Advantage Plan, you have minimum essential coverage and you don't have to get any additional coverage.

If you only have Medicare Part B (Medical Insurance), you aren't considered to have minimum essential coverage. This means you may have to pay a fee for not having minimum essential coverage. You'd pay this fee when you file your federal income tax return.

Can I get a Marketplace plan instead of Medicare, or can I get a Marketplace plan in addition to Medicare?

Generally, no. In most cases, it's against the law for someone who knows you have Medicare to sell you a Marketplace plan, because that would duplicate your coverage. However, if you're employed and your employer offers employer-based coverage through the Marketplace, you may be eligible to get that type of coverage. Visit HealthCare.gov for more information.

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

For more information

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

SECTION 2

Medigap Basics

What's a Medigap policy?

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

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

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

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

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

What Medigap policies cover

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

Notes:

- Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Plan C or Plan F. Not all types of Medigap policies may be available in your state. See pages 42– 44 if you live in **Massachusetts**, **Minnesota**, or **Wisconsin**.
- Plans D and G effective on or **after** June 1, 2010, **have different benefits** than Plans D or G bought **before** June 1, 2010.
- Plans E, H, I, and J are **no longer sold**, but, if you already have one, you can generally keep it.
- Medigap plans that cover the Medicare Part B deductible (Plans C and F in most states) will no longer be sold to most people who turn 65 or who first become eligible for Medicare after January 1, 2020. If you buy a Medigap Plan C or F before January 1, 2020, you can keep that plan and your benefits won't change.

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 2017**			
							$5,120	$2,560		

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,200 in 2017 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2017), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

What Medigap policies don't cover

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

Types of coverage that are NOT Medigap policies

- Medicare Advantage Plans (Part C), like an HMO, PPO, or Private Fee-for-Service Plan
- 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, even if you have health problems. Here are certain times that you're guaranteed the right to buy a Medigap policy:

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

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

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

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

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

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

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

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

Creditable coverage

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

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

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

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

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

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

When you're first eligible, you have the right to buy any Medigap policy offered in your state. In addition, you generally will get better prices and more choices among policies. It's very important to understand your Medigap Open Enrollment Period. Medigap insurance companies are generally allowed to use medical underwriting to decide whether to accept your application and how much to charge you for the Medigap policy. However, if you apply during your Medigap Open Enrollment Period, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health. If you apply for Medigap coverage **after** your Open Enrollment Period, there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements, **unless** you're eligible 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. In most cases, it makes sense to enroll in Part B and purchase a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty and you might miss your Medigap Open Enrollment Period. However, there are exceptions if you have employer coverage.

Employer coverage

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

Words in blue are defined on pages 49–50.

How do insurance companies set prices for Medigap policies?

Each insurance company decides how it'll set the price, or premium, for its Medigap policies. It's important to ask how an insurance company prices its 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 because, with this type of Medigap pricing, everyone pays the same price regardless of age.
Issue-age-rated (also called "entry age-rated")	The premium is based on the age you are when you buy (are "issued") the Medigap policy.	Premiums are lower for people who buy at a younger age and won't change as you get older. Premiums may go up because of inflation and other factors but not because of your age.	Mr. Han is 65. He buys a Medigap policy and pays a $145 monthly premium. Mrs. Wright is 72. She buys the same Medigap policy as Mr. Han. Since she is older when she buys it, her monthly premium is $175.
Attained-age-rated	The premium is based on your current age (the age you've "attained"), so your premium goes up as you get older.	Premiums are low for younger buyers but go up as you get older. They may be the least expensive at first, but they can eventually become the most expensive. Premiums may also go up because of inflation and other factors.	Mrs. Anderson is 65. She buys a Medigap policy and pays a $120 monthly premium. Her premium will go up each year: • At 66, her premium goes up to $126. • At 67, her premium goes up to $132. • At 72, her premium goes up to $165. Mr. Dodd is 72. He buys the same Medigap policy as Mrs. Anderson. He pays a $165 monthly premium. His premium is higher than Mrs. Anderson's because it's based on his current age. Mr. Dodd's premium will go up each year: • At 73, his premium goes up to $171. • At 74, his premium goes up to $177.

Comparing Medigap costs

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

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

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

- Offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Uses medical underwriting, or applies a different premium when you don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less. See page 20.
- Offers a "high-deductible option" for Plan F. If you buy Plan F with a high-deductible option, you must pay the first $2,200 of deductibles, copayments, and coinsurance (in 2017) 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 your 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 $2,200 deductible (in 2017) before the policy pays anything for medical benefits.

What's Medicare SELECT?

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

How does Medigap help pay my Medicare Part B bills?

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

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

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

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

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

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

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

When do I have guaranteed issue rights?

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

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

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

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

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

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

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

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

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

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

For more information

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

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

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

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

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

SECTION 4

Steps to Buying a Medigap Policy

Step-by-step guide to buying a Medigap policy

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

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

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

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

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

STEP 4: Buy the Medigap policy.

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

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

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

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

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

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

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

  ✔ What each Medigap policy covers.

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

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

Words in blue are defined on pages 49–50.

STEP 2: (continued)

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

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

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

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

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

STEP 3: (continued)

Watch out for illegal practices.

It's illegal for anyone to:

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

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

STEP 4: Buy the Medigap policy.

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

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

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

SECTION 5

If You Already Have a Medigap Policy

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

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

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

Switching Medigap policies

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

Can I switch to a different Medigap policy?

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

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

Words in blue are defined on pages 49–50.

Switching Medigap policies (continued)

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

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

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

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

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

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

Switching Medigap policies (continued)

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

Some reasons for switching may include:

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

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

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

Switching Medigap policies (continued)

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

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

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

Losing Medigap coverage

Can my Medigap insurance company drop me?

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

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

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

Medigap policies and Medicare prescription drug coverage

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

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

Medigap policies and Medicare prescription drug coverage (continued)

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 6

Medigap Policies for People with a Disability or ESRD

Information for people under 65

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

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

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

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

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

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

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

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

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

Words in blue are defined on pages 49–50.

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

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

SECTION

7

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Massachusetts benefits 42

Minnesota benefits 43

Wisconsin benefits. 44

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

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

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

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

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

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

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

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

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

Mandatory riders
Insurance companies can offer 4 additional riders that can be added to a basic plan. You may choose any one or all of these riders to design a Medigap policy that meets your needs: 1. Part A: inpatient hospital deductible 2. Part B: deductible 3. Usual and customary fees 4. Non-medicare preventive care

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

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

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

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

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

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

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

Optional riders
Insurance companies are allowed to offer these 7 additional riders to a Medigap policy: 1. Part A deductible 2. Additional home health care (365 visits including those paid by Medicare) 3. Part B deductible 4. Part B excess charges 5. Foreign travel emergency 6. 50% Part A deductible 7. Part B copayment or coinsurance

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

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan ($2,200 deductible for 2017) is also available.

SECTION 8

For More Information

Where to get more information

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

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

How to get help with Medicare and Medigap questions

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

Visit Medicare.gov:

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

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

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

State Health Insurance Assistance Program and State Insurance Department

State	State Health Insurance Assistance Program	State Insurance Department
Alabama	1-800-243-5463	1-800-433-3966
Alaska	1-800-478-6065	1-800-467-8725
American Samoa	Not available	1-684-633-4116
Arizona	1-800-432-4040	1-800-325-2548
Arkansas	1-800-224-6330	1-800-224-6330
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7421	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-3272
Illinois	1-217-524-6911	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	1-877-353-3771	1-800-300-5000
Maryland	1-800-243-3425	1-800-492-6116
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	1-800-948-3090	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	1-800-443-9354	1-800-546-5664
North Dakota	1-800-247-0560	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	1-401-462-0510	1-401-462-9500
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 1-340-714-4354 (St. Thomas)	1-340-774-7166
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-994-6272	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION 9

Definitions

Where words in BLUE are defined

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We'll take appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

Relay service — TTY users can call 1-877-486-2048.

Alternate formats

- To request other Medicare publications in alternate formats, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- For all other CMS publications:
  - Call 1-844-ALT-FORM (1-844-258-3676). TTY users can call 1-844-716-3676.
  - Send a fax to 1-844-530-3676.
  - Send an email to AltFormatRequest@cms.hhs.gov.
  - Send a letter to: Centers for Medicare & Medicaid Services Office of Equal Employment Opportunity & Civil Rights (OEOCR), 7500 Security Boulevard, Room N2-22-16, Baltimore, MD 21244-1850, Attn: CMS Alternate Format Team

Note: Your request for a CMS publication should include your name, phone number, mailing address where we should send the publications, and the publication title and product number, if available. Also include the format you need, like Braille, large print, compact disc (CD), audio CD, or a qualified reader.

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- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing: Office for Civil Rights

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

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CMS Product No. 02110
Revised May 2017

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

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Get answers here.

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

Name:

Email:

Phone:

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

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

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