2024 Benefits & Enrollment Guide

MEDICARE SUPPLEMENT

BlueCross BlueShield Arizona

Medicare Supplement Plans to Fit Your **LIFE, HEALTH, AND BUDGET**

Medicare Supplement works for your life now and what's next with the freedom and flexibility of a Medicare Supplement plan from Blue Cross Blue Shield of Arizona (AZ Blue). We make it easy to find plans with a wide choice of doctors, out-of-state coverage options, and competitive pricing—delivered with local service and support.

Here are more reasons to choose a Medicare Supplement plan from Blue:

- Help pay Original Medicare deductibles, copayments, and coinsurance
- No specialist referrals needed
- No waiting period for preexisting conditions
- Includes no-cost fitness offerings and home exercise kits
- Covers hearing aid services, plus free upgrades to rechargeable hearing aids*
- See any doctor in the U.S. who accepts Medicare with our Senior Security℠ plan
- Access to an Arizona network with over 35,000 providers (Senior Preferred℠ plan)****
- Save with the Early Enrollment Discount** and Household Discount***

9 out of 10 members are highly satisfied with our plans and the access to doctors and hospitals of their choice.†

LET US HELP YOU FIND THE PLAN THAT WORKS FOR YOU!

†2022 Medicare Supplement Member Relationship Survey administered by Sparks Research.

*Routine hearing exam and hearing aid services available through participating providers.
**If you enroll in a Senior Security or Senior Preferred plan at age 65 through 72, you will receive an early enrollment discount on your rate. The early enrollment discount is reduced annually, upon plan renewal, through the age of 76. When your discount no longer applies, you will be charged the BlueValue℠ or Standard rate assigned to your Senior Security or Senior Preferred plan.
***Medicare Supplement 5% discount available to households with two or more Medicare Supplement members. Certain terms and conditions apply.
****Approximate list of providers as of 3/1/24 and is subject to change. For the most current information, please visit azblue.com/FindMedicareDoc.

Medicare Supplement Plans **THAT WORK FOR YOU**

You've earned your Medicare benefits. At Blue Cross® Blue Shield® of Arizona (AZ Blue), you'll find Medicare Supplement plans that work hard to help you be your healthiest.

Extras for Your Best Health

Wherever you are on your health journey, AZ Blue has you covered. From hearing and fitness extras, your plan empowers you to take charge of your health and embrace your best life.

Easy Access to Quality Care

You deserve to get the care you need—when you need it. AZ Blue offers a choice of plans and a large network of providers and hospitals for easy access to quality care.

Caring for Your Happiness

Built on AZ Blue's 80-plus-year legacy of excellent service, our local Member Services team consistently delivers personalized service and a health insurance experience members feel good about.

What You'll Find Inside

What Is a Medicare Supplement Plan?

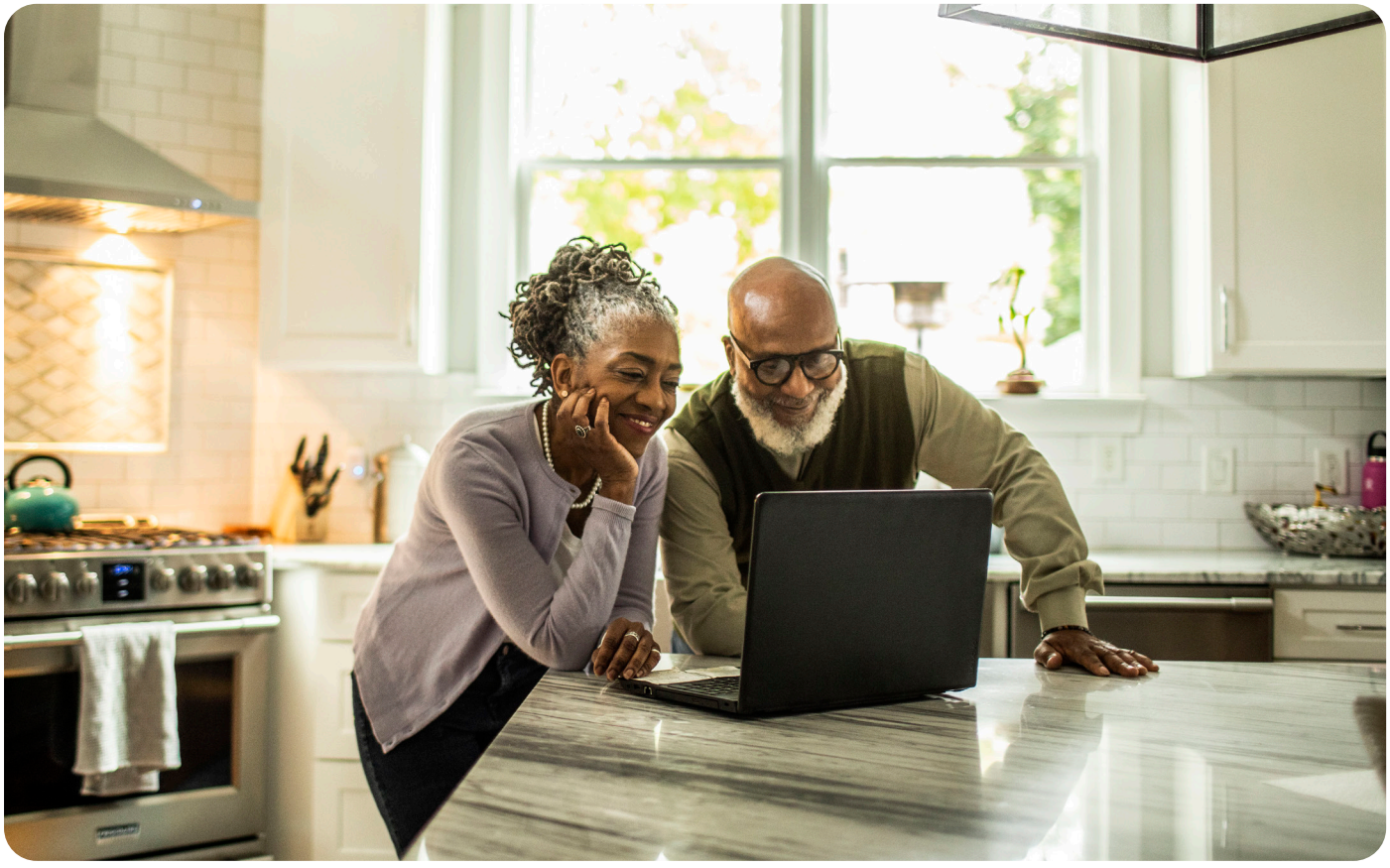
Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) and pays for much, but not all, of the cost for covered healthcare services and supplies.

A Medicare Supplement plan (also known as Medigap) helps fill the "gaps" and pays for some of the approved expenses and costs that Original Medicare doesn't, like copayments, coinsurance, and deductibles. If you have Original Medicare and a Medicare Supplement plan, Medicare first pays its share of the Medicare-approved expenses for covered healthcare costs. Then, your Medicare Supplement plan pays its share.

A Medicare Supplement plan is different from a Medicare Advantage (MA) Plan

MA plans are another way to get your Part A and Part B benefits and often include prescription drug coverage. You can only have a Medicare Supplement plan if you do not have coverage through a Medicare Advantage plan or Medicaid.

Refer to the CMS *Guide to Choosing a Medigap Policy* to learn more about coverage options through a Medicare Supplement (Medigap) plan.



Find the Right Plan for You

Blue offers a choice of Medicare Supplement plans to fit your health, life, and budget. See below for a quick look at the Medicare Supplement plan options from AZ Blue.

Senior Security Plan

Coverage that travels with you.

Life on the go and a plan to match.

If you travel often or spend a lot of time out of state, the Senior Security℠ plan could be right for you—it provides coverage in all 50 states. It also gives you the freedom to see any Medicare-participating doctor, even specialists, without a referral.

At a glance:

- Full Medicare Supplement insurance coverage throughout the U.S.
- No waiting periods for preexisting conditions
- Freedom to see any Medicare-participating doctor or specialist without a referral

Senior Preferred Plan

Affordable coverage close to home.

Peace of mind and savings.

If you stay closer to home, the Senior Preferred℠ Medicare Select plan may be better for you. With a lower monthly premium than the Senior Security plan, this plan gives you a choice of over 35,000 in-network doctors and hospitals in Arizona*.

At a glance:

- Lower monthly premiums
- No preexisting condition waiting periods
- Freedom to see an in-network specialist without a referral

*For Senior Preferred plans, non-emergency services are only covered if you use a network provider. Senior Preferred plans available only for applicants residing in Apache, Cochise, Coconino, Maricopa, Mohave, Pima, Pinal, or Santa Cruz counties. List of providers is subject to change. For the most current information, please visit **azblue.com/FindMedicareDoc.**

Savings and Wellness Extras

These exclusive member savings and services complement your AZ Blue Medicare Supplement[1] health plan, so you can live healthier every day.

Fitness Programs

SilverSneakers® is more than a fitness program. It's an opportunity to improve your health, gain confidence and connect with your community, at no additional cost with many Medicare plans. Whether you play tennis, swim laps, lift weights, visit the gym or take live classes from home, SilverSneakers has you covered. Movement and exercise are essential to your health, and SilverSneakers supports you in any way you decide to move.

Questions? Visit **SilverSneakers.com** or call **1-888-423-4632 (TTY: 711)** Monday through Friday, 8 a.m. to 8 p.m. ET.

Hearing Services

Get a comprehensive hearing care solution with high-quality hearing aids and local, professional care at a fraction of the cost through TruHearing®.[3] In addition to offering an online hearing assessment tool, TruHearing acts as a concierge service that guides you through the full process, from scheduling the exam, to selecting the product, and obtaining the hearing aids. Members get two TruHearing-branded hearing aids per year starting at $699-$999 copay per aid. To learn more or schedule an appointment, call **1-855-205-6360.**

Prescription Savings Program

Save up to 80% on prescription medications with the ScriptSave® Prescription Savings Card.[4] Get instant savings on brand-name and generic drugs for the whole household, including pets. The card is provided at no cost to you and is accepted at over 65,000 pharmacies nationwide. ScriptSave is not a replacement for prescription drug plan (PDP) coverage. Visit **WellRxPremier.com/AZ BlueMedSupp** or download the app and get started by logging in with group number 361R.

24/7 Nurse On Call

Getting answers to your health questions is easy with Nurse On Call.[5] For no additional cost, you can talk to a registered nurse any time you need—days, nights, weekends, and holidays—from wherever you are. Contact a Nurse On Call 24/7 at **1-866-422-2729, TTY: 711.**

Health & Wellness Discounts

Enjoy discounts on a wide range of health, wellness, and lifestyle products and services from brands you know with Blue365.®

Visit **blue365deals.com/AZ Blue** or call **1-855-511-2583, TTY: 711** to learn more.

Additional Coverage Options

Need extra coverage? Blue offers dental, prescription, and travel plans at an additional cost to help you take charge of your health.

BlueDental℠ Plans

Your oral health can affect your overall health, that's why taking good care of your teeth is so important. To help make it easier for you to find the right coverage for your needs and budget, we've got eight BlueDental plans that offer cost-effective choices to meet your needs, many starting at less than $1 per day[7]. Choose from more than 2,500 PPO providers in one of Arizona's largest networks[8]. Most plans offer 100% in-network coverage for routine dental cleanings and exams[9]. Visit **azblue.com/medicare/bluedental** or call **1-844-613-9200, TTY: 711,** to learn more.

Blue MedicareRx℠ (PDP)

Medications can be expensive without coverage. AZ Blue offers Part D prescription drug plans to help you manage drug costs. Even if you don't have drug costs now, enrolling can protect you from unexpected costs in the future. All plans offer access to a nationwide pharmacy network and savings on 90-day supplies of medications, including many generic and brand-name drugs[10]. To learn more, call **1-888-264-1568, TTY: 711.**

GeoBlue

International Health Plans from GeoBlue®

The name you trust at home can go with you anywhere in the world.
Not all medical insurance covers you when you leave the U.S. If you're traveling or living abroad, you'll want to make sure you have access to the same quality care you're used to, from a partner that can ensure you get the treatment you need when you need it. Part of the Blue Cross Blue Shield family, GeoBlue offers a variety of international health plans when you go on vacation or live and work abroad. Visit **azblue.com/geobluetravel** to learn more.

Getting Started

HERE'S WHAT YOU CAN EXPECT AFTER YOU ENROLL.

Check your mail for these important communications:

Confirmation of Receipt Letter
You'll receive this letter to confirm that we have received your enrollment form

Confirmation of Enrollment Letter and New Member Kit
Along with your New Member Kit, you will receive a letter confirming that your enrollment has been approved. On the date your plan becomes effective, you can register for your online member account at **azblue.com/medicare.**

Member ID Card
Your new member ID card will be sent in a separate mailing. Please present your member ID card every time you receive healthcare services. Take a moment and review it for accuracy. Remember to keep your card where you can easily find it, and do not let anyone else use it.

Find a Doctor
If you're a Senior Security℠ plan member, you have the freedom to see any Medicare-participating doctor in the U.S.—even a specialist, without a referral. If you're a Senior Preferred℠ plan member, you are required to use doctors and hospitals in your plan's network. To locate a doctor in your network, visit the online Provider Directory at **azblue.com/FindMedicareDoc** or call Member Services at the phone number below.

Important steps to take once you're enrolled

Schedule Your Annual Physical Exam
The annual physical exam with your primary care provider (PCP) is a great opportunity to review your medical history, medications, and make sure you are up to date on vaccinations and preventive screenings.

Questions? Call Us.
(602) 864-4122 (Maricopa County)
Toll Free: **1-800-232-2345, ext. 4122 (TTY: 711)**
We're here from 8 a.m. to 4:30 p.m. (Arizona time), Monday through Friday.

PLANS AND RATES

BlueCross BlueShield Arizona

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BlueCross BlueShield Arizona

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2023 Medicare Supplement Plan Monthly Rates at-a-Glance

SENIOR SECURITY • NON-TOBACCO USE

Early Enrollment Discount – ages 65-72

BLUEVALUE RATES						
AGE	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N
65	$139.98	$150.99	$169.34	$195.77	$139.13	$124.57
66	$147.10	$158.66	$177.95	$205.72	$146.20	$130.91
67	$156.59	$168.90	$189.43	$218.99	$155.63	$139.35
68	$163.70	$176.58	$198.04	$228.95	$162.71	$145.69
69	$173.19	$186.81	$209.52	$242.22	$172.14	$154.13
70	$180.31	$194.49	$218.14	$252.18	$179.22	$160.47
71	$187.43	$202.17	$226.75	$262.13	$186.29	$166.80
72	$196.92	$212.41	$238.23	$275.40	$195.72	$175.25
73+	$237.25	$255.91	$287.02	$331.81	$235.81	$211.14

STANDARD RATES						
AGE	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N
65	$226.07	$245.07	$273.50	$316.17	$224.77	$201.18
66	$237.57	$257.53	$287.41	$332.25	$236.20	$211.41
67	$252.89	$274.14	$305.95	$353.68	$251.43	$225.05
68	$264.39	$286.61	$319.86	$369.76	$262.86	$235.28
69	$279.71	$303.22	$338.40	$391.19	$278.10	$248.92
70	$291.21	$315.68	$352.31	$407.27	$289.53	$259.14
71	$302.70	$328.14	$366.21	$423.35	$300.96	$269.37
72	$318.03	$344.76	$384.75	$444.78	$316.20	$283.01
73+	$383.17	$415.37	$463.56	$535.88	$380.96	$340.98

This is an advertisement. A sales representative may contact you after receiving your inquiry.
This is only a summary of rates. For plan details, refer to the Outline of Coverage. BlueValue Rate: Premium is discounted for individuals with guaranteed issue rights, in a Medigap Open Enrollment Period, or who qualify for a discount based on medical underwriting criteria. Standard Rate: Premium is based on medical underwriting criteria for individuals who don't have a guaranteed issue right or aren't in a Medigap Open Enrollment Period. BCBSAZ offers a 5% Household Discount to households with two or more Medicare Supplement members. Certain terms and conditions apply.

*Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

BlueCross BlueShield Arizona

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2023 Medicare Supplement Plan Monthly Rates at-a-Glance

SENIOR SECURITY • TOBACCO USE

Early Enrollment Discount – ages 65-72

BLUEVALUE RATES						
AGE	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N
65	$153.98	$166.09	$186.27	$215.35	$153.04	$137.03
66	$161.81	$174.53	$195.75	$226.29	$160.82	$144.00
67	$172.25	$185.79	$208.37	$240.89	$171.19	$153.29
68	$180.07	$194.24	$217.84	$251.85	$178.98	$160.26
69	$190.51	$205.49	$230.47	$266.44	$189.35	$169.54
70	$198.34	$213.94	$239.95	$277.40	$197.14	$176.52
71	$206.71	$222.39	$249.43	$288.34	$204.92	$183.48
72	$216.61	$233.65	$262.05	$302.94	$215.29	$192.78
73+	$260.98	$281.50	$315.72	$364.99	$259.39	$232.25

STANDARD RATES						
AGE	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N
65	$248.68	$269.58	$300.85	$347.79	$247.25	$221.30
66	$261.33	$283.28	$316.15	$365.48	$259.82	$232.55
67	$278.18	$301.55	$336.55	$389.05	$276.57	$247.56
68	$290.83	$315.27	$351.85	$406.74	$289.15	$258.81
69	$307.68	$333.54	$372.24	$430.31	$305.91	$273.81
70	$320.33	$347.25	$387.54	$448.00	$318.48	$285.05
71	$332.97	$360.95	$402.83	$465.69	$331.06	$296.31
72	$349.83	$379.24	$423.23	$489.26	$347.82	$311.31
73+	$421.49	$456.91	$509.92	$589.47	$419.06	$375.08

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BlueCross BlueShield Arizona

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2023 Medicare Supplement Plan Monthly Rates at-a-Glance

SENIOR PREFERRED • NON-TOBACCO USE

Early Enrollment Discount – ages 65-72

BLUEVALUE RATES				
AGE	Plan C*	Plan D	Plan G	Plan N
65	$164.84	$150.75	$158.57	$112.96
66	$173.22	$158.41	$166.64	$118.71
67	$184.40	$168.63	$177.39	$126.36
68	$192.78	$176.30	$185.45	$132.11
69	$203.95	$186.52	$196.20	$139.77
70	$212.34	$194.18	$204.27	$145.51
71	$220.72	$201.85	$212.33	$151.25
72	$231.89	$212.07	$223.08	$158.91
73+	$279.39	$255.50	$268.77	$191.46

STANDARD RATES				
AGE	Plan C*	Plan D	Plan G	Plan N
65	$278.22	$243.51	$256.17	$182.59
66	$292.37	$255.89	$269.20	$191.87
67	$311.23	$272.40	$286.57	$204.25
68	$325.38	$284.78	$299.59	$213.53
69	$344.24	$301.29	$316.96	$225.91
70	$358.39	$313.67	$329.98	$235.20
71	$372.53	$326.06	$343.01	$244.48
72	$391.39	$342.57	$360.38	$256.86
73+	$471.56	$412.73	$434.19	$309.47

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*Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

BlueCross BlueShield Arizona

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2023 Medicare Supplement Plan Monthly Rates at-a-Glance

SENIOR PREFERRED • TOBACCO USE

Early Enrollment Discount – ages 65-72

BLUEVALUE RATES				
AGE	Plan C*	Plan D	Plan G	Plan N
65	$181.32	$165.83	$174.43	$124.26
66	$190.54	$174.25	$183.30	$130.58
67	$202.84	$185.49	$195.13	$139.00
68	$212.06	$193.93	$204.00	$145.32
69	$224.35	$205.17	$215.82	$153.75
70	$233.57	$213.60	$224.70	$160.06
71	$242.79	$222.04	$233.56	$166.38
72	$255.08	$233.28	$245.39	$174.80
73+	$307.33	$281.05	$295.65	$210.61

STANDARD RATES				
AGE	Plan C*	Plan D	Plan G	Plan N
65	$306.04	$267.86	$281.79	$200.85
66	$321.61	$281.48	$296.12	$211.06
67	$342.35	$299.64	$315.23	$224.68
68	$357.92	$313.26	$329.55	$234.88
69	$378.66	$331.42	$348.66	$248.50
70	$394.23	$345.04	$362.98	$258.72
71	$409.78	$358.67	$377.31	$268.93
72	$430.53	$376.83	$396.42	$282.55
73+	$518.72	$454.00	$477.61	$340.42

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*Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

OUTLINE OF COVERAGE

An Independent Licensee of the Blue Cross Blue Shield Association

Benefit Chart of Medicare Supplement Plans sold on or after January 1, 2023

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

Blue Cross Blue Shield of Arizona offers Medicare Supplement plans A, C, D, F, G, and N (shown in blue in the chart). Note: A ✓ means 100% of the benefit is paid.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G***	**K**	**L**	**M**	**N**	**C**	**F***
Medicare Part A coinsurance and hospital coverage (Up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply***	✓	✓
Blood (First 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled Nursing Facility Care coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A Deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B Deductible									✓	✓
Medicare Part B Excess Charges				✓						✓
Foreign Travel Emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-Of-Pocket Limit in 2023**					$6,940	$3,470				

*Plans F and G also have a high-deductible option which requires first paying a plan deductible of $2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High-deductible plan G does not cover the Medicare Part B deductible. However, high-deductible plans F and G count your payment of the Medicare Part B deductible towards meeting the plan deductible.

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

***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.

Blue Cross Blue Shield of Arizona Premium Rate Information — **Non-Tobacco Use** and **Tobacco Use** Rates are effective April 1, 2023, through March 31, 2024

Blue Cross Blue Shield of Arizona can only raise your premium if we raise the premium for all policies like yours in Arizona. Should this occur, you will receive a 30-day notice.

Early-enrollment discount
If you enroll in a Senior Security or Senior Preferred plan at age 65 through 72, you receive an early-enrollment discount* on your rate. When you are Medicare eligible at age 65 to 65½, you are **automatically eligible** for the lower BlueValue℠ rate and an early-enrollment discount. Even if you are past age 65½, you may still qualify for the lower premium BlueValue rate. The BCBSAZ Medicare Supplement application contains questions about your medical history and tobacco use, which helps determine your rate.

Non-Tobacco Use

BlueValue Monthly Rate									
	Age 65	**Age 66**	**Age 67**	**Age 68**	**Age 69**	**Age 70**	**Age 71**	**Age 72**	**Age 73[f]**
Senior Security									
Plan A	$139.98	$147.10	$156.59	$163.70	$173.19	$180.31	$187.43	$196.92	$237.25
Plan C[†]	$150.99	$158.66	$168.90	$176.58	$186.81	$194.49	$202.17	$212.41	$255.91
Plan D	$169.34	$177.95	$189.43	$198.04	$209.52	$218.14	$226.75	$238.23	$287.02
Plan F[†]	$195.77	$205.72	$218.99	$228.95	$242.22	$252.18	$262.13	$275.40	$331.81
Plan G	$139.13	$146.20	$155.63	$162.71	$172.14	$179.22	$186.29	$195.72	$235.81
Plan N	$124.57	$130.91	$139.35	$145.69	$154.13	$160.47	$166.80	$175.25	$211.14
Senior Preferred									
Plan C[†]	$164.84	$173.22	$184.40	$192.78	$203.95	$212.34	$220.72	$231.89	$279.39
Plan D	$150.75	$158.41	$168.63	$176.30	$186.52	$194.18	$201.85	$212.07	$255.50
Plan G	$158.57	$166.64	$177.39	$185.45	$196.20	$204.27	$212.33	$223.08	$268.77
Plan N	$112.96	$118.71	$126.36	$132.11	$139.77	$145.51	$151.25	$158.91	$191.46

Non-Tobacco Use

Standard Monthly Rate									
	Age 65	**Age 66**	**Age 67**	**Age 68**	**Age 69**	**Age 70**	**Age 71**	**Age 72**	**Age 73[f]**
Senior Security									
Plan A	$226.07	$237.57	$252.89	$264.39	$279.71	$291.21	$302.70	$318.03	$383.17
Plan C[†]	$245.07	$257.53	$274.14	$286.61	$303.22	$315.68	$328.14	$344.76	$415.37
Plan D	$273.50	$287.41	$305.95	$319.86	$338.40	$352.31	$366.21	$384.75	$463.56
Plan F[†]	$316.17	$332.25	$353.68	$369.76	$391.19	$407.27	$423.35	$444.78	$535.88
Plan G	$224.77	$236.20	$251.43	$262.86	$278.10	$289.53	$300.96	$316.20	$380.96
Plan N	$201.18	$211.41	$225.05	$235.28	$248.92	$259.14	$269.37	$283.01	$340.98
Senior Preferred									
Plan C[†]	$278.22	$292.37	$311.23	$325.38	$344.24	$358.39	$372.53	$391.39	$471.56
Plan D	$243.51	$255.89	$272.40	$284.78	$301.29	$313.67	$326.06	$342.57	$412.73
Plan G	$256.17	$269.20	$286.57	$299.59	$316.96	$329.98	$343.01	$360.38	$434.19
Plan N	$182.59	$191.87	$204.25	$213.53	$225.91	$235.20	$244.48	$256.86	$309.47

*The early-enrollment discount is reduced annually through the age of 76. For 2023, your renewal premium includes your current early-enrollment discount. For 2024 and beyond, the reduction in the early-enrollment discount will occur on your annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security or Senior Preferred plan.

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

f(Ages 73 and older) You may be eligible to receive a lower premium BlueValue rate. In certain situations, you may be automatically eligible to receive the BlueValue rate, regardless of your medical history. If you don't qualify for the BlueValue rate, you will receive a standard rate.

Tobacco Use

BlueValue Monthly Rate									
	Age 65	Age 66	Age 67	Age 68	Age 69	Age 70	Age 71	Age 72	Age 73*f*
Senior Security									
Plan A	$153.98	$161.81	$172.25	$180.07	$190.51	$198.34	$206.71	$216.61	$260.98
Plan C†	$166.09	$174.53	$185.79	$194.24	$205.49	$213.94	$222.39	$233.65	$281.50
Plan D	$186.27	$195.75	$208.37	$217.84	$230.47	$239.95	$249.43	$262.05	$315.72
Plan F†	$215.35	$226.29	$240.89	$251.85	$266.44	$277.40	$288.34	$302.94	$364.99
Plan G	$153.04	$160.82	$171.19	$178.98	$189.35	$197.14	$204.92	$215.29	$259.39
Plan N	$137.03	$144.00	$153.29	$160.26	$169.54	$176.52	$183.48	$192.78	$232.25
Senior Preferred									
Plan C†	$181.32	$190.54	$202.84	$212.06	$224.35	$233.57	$242.79	$255.08	$307.33
Plan D	$165.83	$174.25	$185.49	$193.93	$205.17	$213.60	$222.04	$233.28	$281.05
Plan G	$174.43	$183.30	$195.13	$204.00	$215.82	$224.70	$233.56	$245.39	$295.65
Plan N	$124.26	$130.58	$139.00	$145.32	$153.75	$160.06	$166.38	$174.80	$210.61

Tobacco Use

Standard Monthly Rate									
	Age 65	Age 66	Age 67	Age 68	Age 69	Age 70	Age 71	Age 72	Age 73*f*
Senior Security									
Plan A	$248.68	$261.33	$278.18	$290.83	$307.68	$320.33	$332.97	$349.83	$421.49
Plan C†	$269.58	$283.28	$301.55	$315.27	$333.54	$347.25	$360.95	$379.24	$456.91
Plan D	$300.85	$316.15	$336.55	$351.85	$372.24	$387.54	$402.83	$423.23	$509.92
Plan F†	$347.79	$365.48	$389.05	$406.74	$430.31	$448.00	$465.69	$489.26	$589.47
Plan G	$247.25	$259.82	$276.57	$289.15	$305.91	$318.48	$331.06	$347.82	$419.06
Plan N	$221.30	$232.55	$247.56	$258.81	$273.81	$285.05	$296.31	$311.31	$375.08
Senior Preferred									
Plan C†	$306.04	$321.61	$342.35	$357.92	$378.66	$394.23	$409.78	$430.53	$518.72
Plan D	$267.86	$281.48	$299.64	$313.26	$331.42	$345.04	$358.67	$376.83	$454.00
Plan G	$281.79	$296.12	$315.23	$329.55	$348.66	$362.98	$377.31	$396.42	$477.61
Plan N	$200.85	$211.06	$224.68	$234.88	$248.50	$258.72	$268.93	$282.55	$340.42

Senior Security

Medicare (Part A) Hospital Services — Per Benefit Period

*The benefit period, as it applies to Medicare Part A services described below, begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A		Plan C†	
		Plan Pays	You Pay	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies					
First 60 days	All but $1,600	$0	$1,600 (Part A deductible)	$1,600 (Part A deductible)	$0
61st through 90th day	All but $400 a day	$400 a day	$0	$400 a day	$0
91st day and after While using 60 lifetime reserve days. Once lifetime reserve days are used:	All but $800 a day	$800 a day	$0	$800 a day	$0
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital					
First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $200 a day	$0	Up to $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
Hospice Care You must meet Medicare's requirements, including having a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Please consult the latest "Choosing a Medigap Policy."

****Notice:** When your Medicare Part A hospital benefits are exhausted, BCBSAZ stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$1,600 (Part A deductible)	$0	$1,600 (Part A deductible)	$0
$400 a day	$0	$400 a day	$0
$800 a day	$0	$800 a day	$0
100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
$0	All costs	$0	All costs
$0	$0	$0	$0
Up to $200 a day	$0	Up to $200 a day	$0
$0	All costs	$0	All costs
3 pints	$0	3 pints	$0
$0	$0	$0	$0
Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part A) Hospital Services — Per Benefit Period

*The benefit period, as it applies to Medicare Part A services described below, begins on the first day you receive services 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 G		Plan N	
Services	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies				
First 60 days	$1,600 (Part A deductible)	$0	$1,600 (Part A deductible)	$0
61st thru 90th day	$400 a day	$0	$400 a day	$0
91st day and after While using 60 lifetime reserve days. Once lifetime reserve days are used:	$800 a day	$0	$800 a day	$0
– Additional 365 days	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
– Beyond the additional 365 days	$0	All costs	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital				
First 20 days	$0	$0	$0	$0
21st thru 100th day	Up to $200 a day	$0	Up to $200 a day	$0
101st day and after	$0	All costs	$0	All costs
Blood				
First 3 pints	3 pints	$0	3 pints	$0
Additional amounts	$0	$0	$0	$0
Hospice Care You must meet Medicare's requirements, including having a doctor's certification of terminal illness	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

****Notice:** When your Medicare Part A hospital benefits are exhausted, BCBSAZ stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part B) Medical Services — Per Calendar Year

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A		Plan C†	
		Plan Pays	You Pay	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment					
First $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
Generally 20%	$0	Generally 20%	$0
$0	All costs	100%	$0
All costs	$0	All costs	$0
$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
20%	$0	20%	$0
$0	$0	$0	$0

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part B) Medical Services — Per Calendar Year

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

	Plan G		Plan N	
Services	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment				
First $226 of Medicare-approved amounts*	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	100%	$0	$0	All costs
Blood				
First 3 pints	All costs	$0	All costs	$0
First $226 of Medicare-approved amounts*	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
Remainder of Medicare-approved amounts	20%	$0	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	$0	$0	$0	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare Parts A & B

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A		Plan C†	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Healthcare MEDICARE-APPROVED SERVICES					
• Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
• Durable medical equipment – First $226 of Medicare-approved amounts*	$0	$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2023.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$0	$0	$0	$0
$0	$226 (Part B deductible)	$226 (Part B deductible)	$0
20%	$0	20%	$0

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$0	$250	$0	$250
80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum benefit	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum benefit

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare Parts A & B

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

	Plan G		Plan N	
Services	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Home Healthcare MEDICARE-APPROVED SERVICES				
• Medically necessary skilled care services and medical supplies	$0	$0	$0	$0
• Durable medical equipment – First $226 of Medicare-approved amounts*	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
– Remainder of Medicare-approved amounts	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2023.

Please consult the latest "Choosing a Medigap Policy."

Senior Preferred

(Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties only.)

Important: Generally, you must use doctors and hospitals in the Senior Preferred provider network except for emergencies. Benefits will be provided at the Senior Preferred level for Medicare-eligible expenses for treatment of a medical emergency regardless of whether or not a Senior Preferred hospital or physician is used.

Medicare (Part A) Hospital Services — Per Benefit Period

*The benefit period, as it applies to Medicare Part A services described below, begins on the first day you receive services as an inpatient and ends after you have been out of hospital and have not received skilled care in any other facility for 60 days in a row.

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days Once lifetime reserve days are used:	All but $800 a day	$800 a day	$0
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including having a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Please consult the latest "Choosing a Medigap Policy."

Notice: When your Medicare Part A hospital benefits are exhausted, BCBSAZ stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$1,600 (Part A deductible)	$0	$1,600 (Part A deductible)	$0	$1,600 (Part A deductible)	$0
$400 a day	$0	$400 a day	$0	$400 a day	$0
$800 a day	$0	$800 a day	$0	$800 a day	$0
100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
$0	All costs	$0	All costs	$0	All costs
$0	$0	$0	$0	$0	$0
Up to $200 a day	$0	Up to $200 a day	$0	Up to $200 a day	$0
$0	All costs	$0	All costs	$0	All costs
3 pints	$0	3 pints	$0	3 pints	$0
$0	$0	$0	$0	$0	$0
Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Preferred

(Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties only.)

Important: Generally, you must use doctors and hospitals in the Senior Preferred provider network except for emergencies. Benefits will be provided at the Senior Preferred level for Medicare-eligible expenses for treatment of a medical emergency regardless of whether or not a Senior Preferred hospital or physician is used.

Medicare (Part B) Medical Services — Per Calendar Year

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare-approved amounts*	$0	$226 (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 $226 of Medicare-approved amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$0	$226 (Part B deductible)	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
Generally 20%	$0	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
$0	All costs	100%	$0	$0	All costs
All costs	$0	All costs	$0	All costs	$0
$0	$226 (Part B deductible)	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
20%	$0	20%	$0	20%	$0
$0	$0	$0	$0	$0	$0

Senior Preferred

(Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties only.)

Important: Generally, you must use doctors and hospitals in the Senior Preferred provider network except for emergencies. Benefits will be provided at the Senior Preferred level for Medicare-eligible expenses for treatment of a medical emergency regardless of whether or not a Senior Preferred hospital or physician is used.

Medicare Parts A & B

*Once you have been billed $226 of Medicare-approved amounts for covered services (which are noted with an *), your Part B deductible will have been met for the calendar year.

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Healthcare MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment – First $226 of Medicare-approved amounts*	$0	$226 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits Not Covered By Medicare

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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 $50,000 lifetime maximum

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2023.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$0	$0	$0	$0	$0	$0
$0	$226 (Part B deductible)	$0	$226 (Unless Part B deductible has been met)	$0	$226 (Part B deductible)
20%	$0	20%	$0	20%	$0

Other Benefits Not Covered By Medicare

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$0	$250	$0	$250	$0	$250
80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amounts over $50,000 lifetime maximum

You have the right to purchase a Senior Security plan, which has comparable or lesser benefits and does not contain a network restriction. Your new coverage will be effective the first day of the month after we receive your written request.

Please consult the latest "Choosing a Medigap Policy."

QUALITY ASSURANCE PROGRAM

BCBSAZ uses various processes and tools to monitor the quality of service and care, including:

- Credentialing and recredentialing of physicians and institutional providers in accordance with nationally recognized credentialing requirements and standards
- Annual member, broker, and provider surveys to determine levels of satisfaction
- Medical coverage guidelines available to providers
- Focused provider reviews
- Complaint investigation, tracking, trending, and resolution. Care and service issues are addressed according to severity of the issue, with corrective action as deemed necessary. Provider-related complaints (practitioner or institutional) are linked to the recredentialing process.
- Grievance tracking and trending

GRIEVANCE PROCEDURE/REQUEST FOR RECONSIDERATION

If you cannot resolve an issue or you disagree with an action or decision made by BCBSAZ*, you may submit a written grievance to BCBSAZ. You must send BCBSAZ your grievance request within one (1) year of the notice of the adverse benefit determination or date of occurrence if not related to a benefit determination.

First-Level Review: After receiving your grievance, BCBSAZ will review the situation, including any new information brought to BCBSAZ's attention. BCBSAZ will notify you of its decision within sixty (60) days of receiving your grievance.

Second-Level Review: If you disagree with BCBSAZ's first-level decision, you may send BCBSAZ a request for a second-level review. You must file your request for second-level review within sixty (60) days of receiving BCBSAZ's first-level decision. BCBSAZ will notify you of its second-level decision within sixty (60) days of the date BCBSAZ receives your second-level grievance. See the Senior Preferred Policy for additional information on the BCBSAZ grievance procedures.

*If your claim has been denied by Medicare, please contact the Centers for Medicare & Medicaid Services at **1-800-MEDICARE** or **www.Medicare.gov.**

EXCLUSIONS AND LIMITATIONS

Benefits are provided only for services that are eligible for Medicare reimbursement, except for those additional benefits specifically listed in the policy. A copy of the policy will be sent to you when you enroll, or upon request prior to enrollment. Additionally, no benefits will be paid under the policy for expenses associated with:

- Charges incurred before the policy becomes effective or after the policy terminates
- Cosmetic surgery
- Dental care and dentures
- Intermediate and custodial nursing facility care
- Personal comfort items such as guest trays, television, phone, etc.
- Prescription drugs not administered in a hospital or skilled nursing facility
- Private duty nursing
- Routine foot care
- Services covered by Workers' Compensation
- Services covered by any other governmental health program or provided by a governmental facility unless required by law
- Services delivered for which you are eligible as a member of a Medicare Advantage plan
- Services which are free or for which you have no legal obligation to pay
- Skilled nursing facility care beyond what is covered by Medicare

ADDITIONAL EXCLUSION FOR SENIOR PREFERRED MEDICARE SELECT

Except for a Medicare-eligible hospital stay as the result of a medical emergency or accident, or as specifically listed in the policy, services delivered by non-Senior Preferred Providers are not covered.

Note: This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the policy for detailed information about benefits, limitations, and exclusions.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your Medicare Supplement insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Blue Cross Blue Shield of Arizona.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

Blue Cross Blue Shield of Arizona
Enrollment Services Department
P.O. Box 13466
Phoenix, Arizona 85002-3466

If you send the policy back to BCBSAZ within 30 days after you receive it, BCBSAZ will treat the policy as if it had never been issued and return all of your payments.

Policy replacement

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

Notice

- This policy may not fully cover all of your medical costs.
- Neither Blue Cross Blue Shield of Arizona nor its contracted brokers are connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete answers are very important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Blue Cross Blue Shield of Arizona may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

QUALITY ASSURANCE PROGRAM

AZ Blue uses various processes and tools to monitor the quality of service and care, including:

- Credentialing and recredentialing of physicians and institutional providers in accordance with nationally recognized credentialing requirements and standards
- Annual member, broker, and provider surveys to determine levels of satisfaction
- Medical coverage guidelines available to providers
- Focused provider reviews
- Complaint investigation, tracking, trending, and resolution. Care and service issues are addressed according to severity of the issue, with corrective action as deemed necessary. Provider-related complaints (practitioner or institutional) are linked to the recredentialing process.
- Grievance tracking and trending

GRIEVANCE PROCEDURE/REQUEST FOR RECONSIDERATION

If you cannot resolve an issue or you disagree with an action or decision made by AZ Blue*, you may submit a written grievance to AZ Blue. You must send AZ Blue your grievance request within one (1) year of the notice of the adverse benefit determination or date of occurrence if not related to a benefit determination.

First-Level Review: After receiving your grievance, AZ Blue will review the situation, including any new information brought to AZ Blue's attention. AZ Blue will notify you of its decision within sixty (60) days of receiving your grievance.

Second-Level Review: If you disagree with AZ Blue's first-level decision, you may send AZ Blue a request for a second-level review. You must file your request for second-level review within sixty (60) days of receiving AZ Blue's first-level decision. AZ Blue will notify you of its second-level decision within sixty (60) days of the date AZ Blue receives your second-level grievance. See the Senior Preferred Policy for additional information on the AZ Blue grievance procedures.

*If your claim has been denied by Medicare, please contact the Centers for Medicare & Medicaid Services at **1-800-MEDICARE** or **www.Medicare.gov.**

EXCLUSIONS AND LIMITATIONS

Benefits are provided only for services that are eligible for Medicare reimbursement, except for those additional benefits specifically listed in the policy. A copy of the policy will be sent to you when you enroll, or upon request prior to enrollment. Additionally, no benefits will be paid under the policy for expenses associated with:

- Charges incurred before the policy becomes effective or after the policy terminates
- Cosmetic surgery
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- Intermediate and custodial nursing facility care
- Personal comfort items such as guest trays, television, phone, etc.
- Prescription drugs not administered in a hospital or skilled nursing facility
- Private duty nursing
- Routine foot care
- Services covered by Workers' Compensation
- Services covered by any other governmental health program or provided by a governmental facility unless required by law
- Services delivered for which you are eligible as a member of a Medicare Advantage plan
- Services which are free or for which you have no legal obligation to pay
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Note: This is only a brief summary of benefits and exclusions. Please refer to the specific provisions found within the policy for detailed information about benefits, limitations, and exclusions.

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Read your policy very carefully

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- This policy may not fully cover all of your medical costs.
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Complete answers are very important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Blue Cross Blue Shield of Arizona may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Blue Cross Blue Shield of Arizona (AZ Blue) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print and accessible electronic formats. We also provide free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages. If you need these services call **480-566-2868** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **480-566-2868** (TTY: **711**).

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **480-566-2868** (TTY: **711**).

MEDIGAP POLICY

An Independent Licensee of the Blue Cross Blue Shield Association

CENTERS FOR MEDICARE & MEDICAID SERVICES

2023

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)
- 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?

If you're thinking about buying a Medicare Supplement Insurance (Medigap) policy or you already have one, this guide can help you understand how it works.

Important information about this guide

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

"2023 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.

This product was produced at U.S. taxpayer expense.

SECTION

1 Medicare Basics

Words in blue are defined on pages 49–50.

What's Medicare?

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

The different parts of Medicare

The different parts of Medicare help cover specific services.

Part A (Hospital Insurance)

Helps cover:

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

Part B (Medical Insurance)

Helps cover:

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

Part D (Drug coverage)

Helps cover:

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

Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

Your Medicare coverage options

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

Original Medicare

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

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

- A Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover - like vision, hearing, and dental services.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

☑ **Some extra benefits**

Some plans also include:

☐ **Lower out-of-pocket-costs**

Medicare and the Health Insurance Marketplace®

Even if you have Marketplace coverage, you should generally sign up for Medicare when you're first eligible to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty. Once you're eligible for Medicare, you'll have an Initial Enrollment period to sign up for Medicare. For most people, this is the 7-month period that starts 3 months before the month they turn 65, includes the month they turn 65, and ends 3 months after the month they turn 65.

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

Visit HealthCare.gov to connect to the Marketplace in your state, or learn how to end your Marketplace plan when you become eligible for Medicare to avoid a gap in coverage. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

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

Find more information about Medicare

To learn more about Medicare:

- Visit Medicare.gov.
- Read your "Medicare & You" handbook.
- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP). (Go to pages 47– 48.)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Find and compare health and drug plans at Medicare.gov/plan-compare and compare Medigap policies, too.

SECTION 2

Medigap Basics

What's a Medigap policy?

A Medigap policy is an insurance policy that helps fill "gaps" in Original Medicare and is sold by private companies. Medigap policies can help pay for some of the costs that Original Medicare doesn't, like copayments, coinsurance, and deductibles.

Some Medigap policies also cover certain benefits Original Medicare doesn't cover, like emergency medical care when you travel outside the U.S. (foreign travel emergency services). Medigap policies don't cover your share of the costs under other types of health coverage, including Medicare Advantage Plans, stand-alone Medicare drug plans, employer/union group health coverage, Medicaid, or TRICARE.

If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then, your Medigap policy pays its share. Medicare doesn't pay any of the costs of buying a Medigap policy.

A Medigap policy is different from a Medicare Advantage Plan because those plans are another way to get your Part A and Part B benefits, while a Medigap policy only helps pay for the costs that Original Medicare doesn't cover. Insurance companies generally can't sell you a Medigap policy if you have coverage through a Medicare Advantage Plan or Medicaid.

All Medigap policies must follow federal and state laws designed to protect you, and policies must be clearly identified as "Medicare Supplement Insurance." Medigap policies are standardized, and in most states are named by letters, Plans A–N. Each standardized Medigap policy under the same plan letter 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 plan letter sold by different insurance companies.

Words in blue are defined on pages 49–50.

What Medigap policies cover

The chart on page 11 gives you a quick look at the standardized Medigap plans available. You can also find out which insurance companies sell Medigap policies in your area by visiting Medicare.gov/medigap-supplemental-insurance-plans. If you need help comparing and choosing a policy, call your State Health Insurance Assistance Program (SHIP) for help. Go to pages 47–48 for your state's phone number.

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

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

This chart shows basic information about the different benefits that Medigap plans cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest. If a box is blank, the plan doesn't cover that benefit.

	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 charge					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2023**			
							$6,940	$3,470		

* Plans F and G also offer a high-deductible plan in some states (Plan F isn't available to people new to Medicare on or after January 1, 2020.) If you get the high-deductible option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,700 in 2023 before your policy pays anything, and you must also pay a separate deductible ($250 per year) for foreign travel emergency services.

**Plans K and L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and your Part B deductible ($226 in 2023). After you meet these amounts, the plan will pay 100% of your costs for approved services for the rest of the calendar year.

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

What Medigap policies don't cover

Generally, Medigap policies don't cover:

- Long-term care (like non-skilled care you get in a nursing home)
- Vision or dental services
- Hearing aids
- Eyeglasses
- Private-duty nursing

Types of coverage that aren't Medigap policies

- Medicare Advantage Plans (also known as Part C)
- Medicare 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, go to pages 42–44.

Insurance companies that sell Medigap policies don't have to offer every Medigap plan. Each insurance company decides which Medigap plans it wants to sell, although federal and state laws might affect which ones they can offer.

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

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

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

- You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- If you have a Medicare Advantage Plan but are planning to return to Original Medicare, you can apply for a Medigap policy before your coverage ends. The Medigap insurance company can sell it to you as long as you're leaving the Medicare Advantage 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'll each have to buy separate Medigap policies**.
- When you have your Medigap Open Enrollment Period, you can buy a Medigap policy from any insurance company that's licensed in your state.
- Any new Medigap policy issued since 1992 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.
- Some states may have laws that give you additional protections.
- **Different insurance companies may charge different premiums for the same exact Medigap plan type**. As you shop for a policy, be sure you're comparing policies under the same plan type (for example, compare Plan A from one company with Plan A from another company).
- 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 drug coverage, you can join a Medicare drug plan offered by private companies approved by Medicare. (Go to pages 6–7.) To learn about Medicare 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 you're both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods including those for people who are under 65. 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. (Go to page 39 for more information.)

During the Medigap Open Enrollment Period, an insurance company can't use medical underwriting to decide whether to accept your application. This means the insurance company can't do any of these because of your health problems:

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

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

Coverage for a pre-existing condition can only be excluded if the condition was treated or diagnosed within 6 months before your Medigap policy coverage starts. 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.

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

Creditable coverage

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

- You buy a Medigap policy during your 6-month Medigap Open Enrollment Period.
- You're replacing certain kinds of health coverage that counts as "creditable coverage."

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

There are many types of health 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 (SHIP). (Go to 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. Go to pages 21–23 for more information about guaranteed issue rights.

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

During your Medigap Open Enrollment Period, you have the right to buy any Medigap policy offered in your state. In addition, you'll generally get better prices and more choices among policies. If you apply for Medigap coverage **after** your Open Enrollment Period, there's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements, **unless** you're eligible for guaranteed issue rights (Medigap protections) because of one of the situations listed on pages 22–23.

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

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

Employer coverage

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

How do insurance companies set prices for Medigap policies?

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

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

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

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

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

Comparing Medigap costs

As discussed on the previous pages, the cost of Medigap policies can vary widely. **There can be big differences in the premiums that different insurance companies charge for exactly the same coverage**. As you shop for a Medigap policy, be sure to compare Medigap plan types with the same letter, and consider the type of pricing each insurance company uses. (Go to pages 17–18.) For example, compare Plan G from one company with Plan G from another 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 (SHIP). (Go to pages 47–48.)

You can also find out which insurance companies sell Medigap policies in your area by visiting Medicare.gov/medigap-supplemental-insurance-plans.

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

- Offers discounts (like discounts for women, non-smokers, or married people; 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. (Go to page 20.)
- Offers a "high-deductible option" for Plans F or G. If you buy Plans F or G with a high-deductible option, you must pay the first $2,700 of deductibles, copayments, and coinsurance (in 2023) for covered services not paid by Medicare before the Medigap policy pays anything. You must also pay a separate deductible ($250 per year) for foreign travel emergency services.

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 offered as any of the standardized Medigap plans. (Go to 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 costs?

In most Medigap policies, you agree to have the Medigap insurance company get your Part B claim information directly from Medicare. Then, the Medigap insurance company pays 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 agreed 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 it. If your doctor doesn't participate but still accepts Medicare, you may be asked to pay the coinsurance amount at the time of service. In these cases, your Medigap insurance company may pay you directly according to policy limits. Check with your Medigap policy for more details.

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

SECTION 3

Your Right to Buy a Medigap Policy

What are guaranteed issue rights?

Guaranteed issue rights are your rights to buy certain Medigap policies in certain situations outside of your Medigap Open Enrollment Period. In these situations, an insurance company must:

- Sell you a Medigap policy.
- Cover all your pre-existing health conditions.
- Not 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. Go to 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 other health coverage that changes in some way, like when you lose the other health 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, go to page 23.

Words in blue are defined on pages 49–50.

Medigap guaranteed issue right situations

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

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

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

Medigap guaranteed issue right situations (continued)

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

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

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

You may have a guaranteed issue right to buy a Medigap policy if you lose your health coverage, so 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 but you're planning to return to Original Medicare, you can apply for a Medigap policy before your plan coverage ends. The Medigap insurance company can sell it to you as long as you're leaving the Medicare Advantage Plan. Ask that the new policy take effect when your Medicare Advantage enrollment ends, so you'll have continuous health coverage.

For more information about Medigap rights

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

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

Important: The guaranteed issue rights in this section are from federal law. These rights apply to 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 Program of All-inclusive Care for the Elderly (PACE). PACE combines medical, social, and long-term care services, and prescription drug coverage for frail older adults who need nursing home services but are capable of living in the community. 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. To find a PACE plan in your area, visit Medicare.gov/plan-compare/#/pace. 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 whether to buy a Medigap policy to supplement your Original Medicare coverage and which policy to choose. Shop carefully. Compare available Medigap policies to determine 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 plans.

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

STEP 1: Decide which plan you want. Medigap policies are standardized, and in most states are named by letters, Plans A–N. Compare the benefits each plan helps pay for and choose a plan that covers what you need.

STEP 2: Pick your policy. Find policies in your area. Price is the only difference between policies with the same letter sold by different companies.

STEP 3: Contact the company. Get an official quote from the company. Prices can change at any time based on when you buy, your health conditions, and more. When you're ready to buy a policy, contact the company.

Words in blue are defined on pages 49–50.

STEP 1: Decide which plan you want.

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. Review the chart on page 11 for an overview of each Medigap plan's benefits.

STEP 2: Pick your policy.

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

- Call your State Health Insurance Assistance Program (SHIP). (Go to 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. (Go to pages 47–48.)
- Visit Medicare.gov/medigap-supplemental-insurance-plans to find out which insurance companies sell 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 find 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 coverage options, including the Medigap policies in your area. TTY users can call 1-877-486-2048.

STEP 2: (continued)

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

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

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 (SHIP). (Go to pages 47–48.)

STEP 3: Contact the company.

When you're ready to contact insurance companies, use this chart to help you keep track of the information you get.

Ask each insurance company…	Company 1	Company 2
"Are you licensed in ___?" (Say the name of your state.) **Note:** If the answer is NO, STOP here, and try another company.		
"Do you sell Medigap Plan ___?" (Say the letter of the Medigap Plan you're interested in.) **Note:** Insurance companies usually offer some, but not all, Medigap policies. Make sure the company sells the plan you want. Also, if you're interested in a Medicare SELECT or high-deductible Medigap policy, tell them.		
"Do you use medical underwriting for this Medigap policy?" **Note:** If the answer is NO, go to step 4 on page 30. If the answer is YES, but you know you're in your Medigap Open Enrollment Period or have a guaranteed issue right to buy that Medigap policy, go to step 4. Otherwise, you can ask, "Can you tell me if I'm likely to qualify for the Medigap policy?"		
"Do you have a waiting period for pre-existing conditions?" **Note:** If the answer is YES, ask how long the waiting period is and write it in the box.		
"Do you price this Medigap policy by using community-rating, issue-age-rating, or attained-age-rating?" (Go to 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?" (Go to 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, 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 (go to 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. (Go to page 7.) 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: Buying your Medigap policy

Once you decide on the insurance company and the Medigap policy you want to buy, 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. Below are some tips to keep in mind when you buy your Medigap policy:

- **Fill out your application**

  Fill out the application carefully and completely, including medical questions. The answers you give will determine your eligibility for a Medigap 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. Also, the insurance company can't ask you any questions about your family history or require you to take a genetic test.

- **Pay for your Medigap policy**

  Your insurance company will let you know your payment options for your particular policy. Many companies offer electronic funds transfer, which lets you set up a recurring payment to debit automatically from a checking account or credit card. You may also be able to pay for your Medigap policy by check, money order, or bank draft. Make it payable to the insurance company, not the agent. If you buy from an agent, get a receipt with the insurance company's name, address, and phone number for your records.

- **Start 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. (Go to 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.

  If you don't get your Medigap policy (like your Medigap card or proof of insurance) 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

This section may apply to you if:

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

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

Words in blue are defined on pages 49–50.

Switching Medigap policies

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.

Switching Medigap policies (continued)

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

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

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

No, but if you've had your current Medigap policy for less than 6 months, the insurance company offering the new Medigap policy may be able to make you wait up to 6 months before it covers a pre-existing condition.

- Your new Medigap policy must subtract the time you had your old Medigap policy from the time it makes you wait before it must cover your pre-existing condition. For example, if you had your old Medigap policy for 4 months, the new policy must subtract 4 months from how long it waits before covering your pre-existing condition. In this example, you'd wait up to 2 months before the new 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, go to pages 42–44. To help you compare benefits and decide which Medigap policy you want, follow the "**Steps to Buying a Medigap Policy**" in Section 4. If you decide to change insurance companies, you can call the new insurance company and apply for your new Medigap policy. If your application is accepted, call your current insurance company, and ask to have your coverage end. The insurance company can tell you how to submit a request to end your coverage.

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

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. (Go to pages 14–16.)

Switching Medigap policies (continued)

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 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, D, F, G, K, or L that's sold in your state by any insurance company.

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

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

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

You can't use (and can't buy) a Medigap policy while you're in a Medicare Advantage Plan. 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 end your coverage. **However, if you leave the Medicare Advantage Plan you might not be able to get back the same Medigap policy, or in some cases any Medigap policy, unless you have a "trial right."** (Go to 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 your Medigap policy, as long as it gets the state's approval to cancel your policy. However, if this does happen, you have the right to buy another Medigap policy. Review examples of guaranteed issue right situations on page 22.

Medigap policies and Medicare drug coverage (Part D)

What if I bought a Medigap policy before January 1, 2006, and it already has prescription drug coverage?

Medicare offers prescription drug coverage for everyone with Medicare. If you have a Medigap policy with prescription drug coverage, that means you chose not to join a Medicare 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 drug plan fit your needs better than the drug coverage in your Medigap policy. It's a good idea to review your coverage each fall, because you can join a Medicare drug plan between October 15–December 7. Your new coverage will begin on January 1.

Medigap policies and Medicare drug coverage (continued)

What if I change my mind and join a Medicare drug plan?

If your Medigap premium or your prescription drug needs were very low when you had your first chance to join a Medicare drug plan, your Medigap drug coverage may have met your needs. However, if your Medigap premium has gone up or you've started taking more prescription drugs recently, a Medicare drug plan might now be a better choice for you. Also consider that your prescription drug needs could increase as you get older.

In a Medicare drug plan, you may have to pay a monthly premium. There are no yearly maximum coverage amounts like with Medigap drug benefits in old Plans H, I, and J, which are no longer sold. However, a Medicare 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.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now?

If you bought a Medigap policy before January 1, 2006, that includes prescription drug coverage, you may have to pay a late enrollment penalty if the policy doesn't include "creditable prescription drug coverage." Having creditable coverage means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard drug coverage and gives the same value for your prescriptions as Medicare drug coverage (Part D).

If your Medigap policy's drug coverage **isn't** creditable coverage, and you join a Medicare 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 drug plan will make your late enrollment penalty higher. Your Medigap insurance company must send you a notice each year telling you if the drug coverage in your Medigap policy is creditable or if the drug coverage in your Medigap policy changes so that it's no longer creditable. Keep these notices in case you decide later to join a Medicare drug plan.

Will I have to pay a late enrollment penalty if I join a Medicare drug plan now? (continued)

If your Medigap policy includes creditable prescription drug coverage or if you get a notice from your Medigap insurance company that your Medigap drug coverage will no longer be creditable, and you decide to join a Medicare 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. Don't drop the drug coverage from your Medigap policy **before** you join the Medicare drug plan and the coverage starts. In general, you can only join a Medicare drug plan during the annual Medicare Open Enrollment Period between October 15–December 7. However, if you lose your Medigap policy entirely (for example, your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own), you may be able to join a Medicare drug plan.

Some people with Medicare qualify for Extra Help, a program to help people with limited income and resources pay for Medicare Part D costs, like premiums, deductibles, and coinsurance. If you qualify for Extra Help, you won't pay a late enrollment penalty when you join a Medicare drug plan.

Can I join a Medicare 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 when 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 drug coverage) and join a Medicare Advantage Plan that offers drug coverage?

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

SECTION 6

Medigap Policies for People with a Disability or ESRD

Medigap policies for people who are 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 End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

If you're under 65 and have Medicare because of a disability or ESRD, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people who are 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 Medigap policies. Your state may have different requirements. Call your State Insurance Department or State Health Insurance Assistance Program (SHIP) to get state-specific information. (Go to pages 47–48.)

Words in blue are defined on pages 49–50.

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

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

- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- 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 listed above, some insurance companies may voluntarily sell Medigap policies to people who are 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. (Go to 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 already have Medicare Part B (Medical Insurance), you'll get a Medigap Open Enrollment Period when you turn 65. You'll probably have more Medigap policy options 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 to wait through a pre-existing condition waiting period for coverage you bought during the Medigap Open Enrollment Period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, go to pages 14–15. If you have questions, call your State Health Insurance Assistance Program (SHIP). (Go to pages 47–48.)

SECTION

7

Medigap Coverage in Massachusetts, Minnesota, and Wisconsin

Words in blue are defined on pages 49–50.

Massachusetts—Chart of standardized Medigap policies

Massachusetts benefits

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

Note: Supplement 1 Plan (which includes coverage of the Part B deductible) is no longer available to people new to Medicare on or after January 1, 2020. These people can buy Supplement 1A Plan. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Supplement Plan 1.

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

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

Visit Medicare.gov/medigap-supplemental-insurance-plans or call your State Insurance Department at 1-877-563-4467 for more information on these Medigap policies.

Minnesota—Chart of standardized Medigap policies

Minnesota benefits

- **Inpatient hospital costs:** 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. Preventive care Medicare doesn't cover

Visit Medicare.gov/medigap-supplemental-insurance-plans or call your State Insurance Department at 1-800-657-3602.

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

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

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

Important: The basic and extended basic plans are available when you enroll in Part B, regardless of age or health problems. If you're under 65, return to work, and drop Part B to join 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 join Part B again.

Wisconsin — Chart of standardized Medigap policies

Wisconsin benefits

- **Inpatient hospital costs:** 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	✓

Visit Medicare.gov/medigap-supplemental-insurance-plans or call your State Insurance Department at 1-800-236-8517.

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 ($2,700 for 2023) is also available.

Optional riders

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

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

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

SECTION 8

For More Information

Where to get more information

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

- Call your SHIP for free 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
  - Questions about Medicare bills
- Call your State Insurance Department if you have questions about the Medigap policies sold in your area, rights that are specific to your state, or any insurance-related problems.

Words in blue are defined on pages 49–50.

How to get help with Medicare and Medigap questions

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

- **Visit Medicare.gov**

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

- **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 (SHIP) 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	1-800-282-9134
California	1-800-434-0222	1-800-927-4357
Colorado	1-888-696-7213	1-800-930-3745
Connecticut	1-800-994-9422	1-800-203-3447
Delaware	1-800-336-9500	1-800-282-8611
Florida	1-800-963-5337	1-877-693-5236
Georgia	1-866-552-4464	1-800-656-2298
Guam	1-671-735-7415	1-671-635-1835
Hawaii	1-888-875-9229	1-808-586-2790
Idaho	1-800-247-4422	1-800-721-3272
Illinois	1-800-252-8966	1-888-473-4858
Indiana	1-800-452-4800	1-800-622-4461
Iowa	1-800-351-4664	1-877-955-1212
Kansas	1-800-860-5260	1-800-432-2484
Kentucky	1-877-293-7447	1-800-595-6053
Louisiana	1-800-259-5300	1-800-259-5301
Maine	1-800-262-2232	1-800-300-5000
Maryland	1-800-243-3425	1-800-492-6116
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	1-844-822-4622	1-800-562-2957
Missouri	1-800-390-3330	1-800-726-7390
Montana	1-800-551-3191	1-800-332-6148
Nebraska	1-800-234-7119	1-800-234-7119

State	State Health Insurance Assistance Program	State Insurance Department
Nevada	1-800-307-4444	1-800-992-0900
New Hampshire	1-866-634-9412	1-800-852-3416
New Jersey	1-800-792-8820	1-800-446-7467
New Mexico	1-800-432-2080	1-888-427-5772
New York	1-800-701-0501	1-800-342-3736
North Carolina	1-855-408-1212	1-855-408-1212
North Dakota	1-888-575-6611	1-800-247-0560
Northern Mariana Islands	Not available	1-670-664-3064
Ohio	1-800-686-1578	1-800-686-1526
Oklahoma	1-800-763-2828	1-800-522-0071
Oregon	1-800-722-4134	1-888-877-4894
Pennsylvania	1-800-783-7067	1-877-881-6388
Puerto Rico	1-877-725-4300	1-888-722-8686
Rhode Island	1-888-884-8721	1-401-462-9520
South Carolina	1-800-868-9095	1-803-737-6160
South Dakota	1-800-536-8197	1-605-773-3563
Tennessee	1-877-801-0044	1-800-342-4029
Texas	1-800-252-9240	1-800-252-3439
Utah	1-800-541-7735	1-800-439-3805
Vermont	1-800-642-5119	1-800-964-1784
Virgin Islands	1-340-772-7368 (St. Croix) 1-340-714-4354 (St. Thomas)	1-340-773-6449 1-340-774-2991
Virginia	1-800-552-3402	1-877-310-6560
Washington	1-800-562-6900	1-800-562-6900
Washington D.C.	1-202-727-8370	1-202-727-8000
West Virginia	1-877-987-4463	1-888-879-9842
Wisconsin	1-800-242-1060	1-800-236-8517
Wyoming	1-800-856-4398	1-800-438-5768

SECTION 9

Definitions

Where words in BLUE are defined

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

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

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

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

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

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

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

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

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

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include: Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for by 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 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 drug plans.

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

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

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

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

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

CMS Accessible Communications

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

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

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048
   For Marketplace: 1-800-318-2596 TTY: 1-855-889-4325
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**

   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop DO-01-20
   Baltimore, MD 21244-1850
   Attn: Customer Accessibility Resource Staff (CARS)

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

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

Nondiscrimination Notice

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

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

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

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

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

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

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

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To get this publication in braille, Spanish, or large print (English), visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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

[1] All of these programs are considered "value-added" services or programs and are not part of your Medicare Supplement insurance coverage.

[2] Always talk to your doctor before starting an exercise program.

1. Participating locations ("PL") not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer Members additional classes. Classes vary by location.

[3] TruHearing is an independent and separate company contracted with AZ Blue to provide hearing aid services to AZ Blue members. The TruHearing program is not an insurance policy and does not provide insurance coverage.

Three follow-up visits must be used within one year after the date of initial purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant. TruHearing is a registered trademark of TruHearing, Inc.

[4] ScriptSave® is a DISCOUNT ONLY — NOT INSURANCE. Discounts are available exclusively though participating pharmacies. The range of the discount will vary depending on the pharmacy or provider chosen and services rendered. The program does not make payments directly to the pharmacies or providers. Members are required to pay for prescription purchases and any other discounted services used. You may cancel your registration at any time or file a complaint by contacting Customer Care at 1-800-700-3957. Average savings of 54%, with potential savings of up to 80%. All prescription medications are eligible for savings.

ScriptSave® WellRx Premier is a drug discount card program operated by Medical Security Card Company (MSC), LLC (dba ScriptSave) of Tucson, AZ, an independent and separate company contracted with AZ Blue to make the ScriptSave® WellRx Premier Prescription Savings program available to AZ Blue members. The ScriptSave® WellRx Premier program is not insurance coverage. MSC does not provide AZ Blue products or services and is solely responsible for ScriptSave services.

[5] Nurse On Call service and treatment options presented may not be covered under your AZ Blue benefit plan. AZ Blue contracts with a third party to administer Nurse On Call services. The Nurse On Call service should not be used in health emergencies. If you have a health emergency or need immediate help for an accident or injury, seek emergency care or call 911.

[6] The Blue365 program is brought to you by the Blue Cross Blue Shield Association. Blue365 offers access to savings on health and wellness products and services and other interesting items that members may purchase from independent vendors, which are different from covered benefits under your policies with your local Blue Company, its contracts with Medicare, or any other applicable federal healthcare program. The products and services available through Blue365 are not insurance products and are not covered under your insurance policy with your local Blue Company. To find out what is covered under your policies, contact your local Blue Company. The products and services described on the Blue365.com website are neither offered nor guaranteed under your Blue Company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding your health insurance products and services may be subject to your Blue Company's grievance process. BCBSA may receive payments from vendors providing products and services on or accessible through the site. Neither BCBSA nor any Blue Company recommends, endorses, warrants, or guarantees any specific vendor, product, or service available under or through the Blue365 program or site.

[7] Applies to BlueDental plans for a monthly premium for one adult.

[8] Source: Internal company data representing AZ Blue's statewide dental PPO network only.

[9] Benefit limitations, exclusions, and calendar-year maximums apply.

[10] Blue MedicareRx is a prescription drug plan with a Medicare contract. Enrollment in Blue MedicareRx depends on contract renewal.

[11] GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued in the District of Columbia by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. This coverage is offered to the members of the Global Citizens Association, Washington, D.C.

Blue Cross Blue Shield of Arizona (AZ Blue) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print and accessible electronic formats. We also provide free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages. If you need these services, call **480-566-2868** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **480-566-2868** (TTY: **711**).

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí' go Diné Bizaad, saad bee áká' ánída' áwo' dęę̨, t'áá jiik'eh, éí ná hóló, kojį́ hódíílnih **480-566-2868** (TTY: **711**).

Blue Cross Blue Shield of Arizona

Not a member yet?
Contact our licensed Medicare consultants.

1-888-264-1733, TTY: 711

Or, contact your broker.

October 1 – March 31:
Daily, 8 a.m. to 8 p.m.

April 1 – September 30:
Monday – Friday, 8 a.m. to 8 p.m.

azblue.com/medicare

BlueCross BlueShield Arizona

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