BlueCross BlueShield Minnesota

2024

MEDICARE SUPPLEMENT PLANS

You can trust your Blue Cross and Blue Shield of Minnesota plan has everything you need including access to quality providers, excellent coverage and benefits that meet your needs.

THE VALUE OF BLUE℠

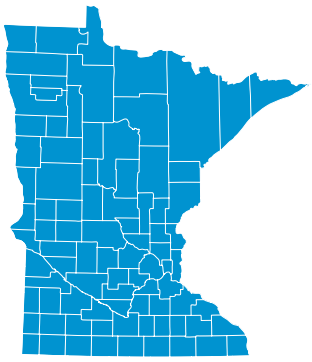
97% of members keep their Blue Cross Medicare Supplement plan[1]

Exceptional support and service from Medicare experts

Blue Cross has been **supporting** Medicare since it began[2]

Serving Minnesota as a nonprofit for more than 90 years[2]

MEDICARE SUPPLEMENT PLANS AT A GLANCE



Blue Cross Medicare Supplement plans provide medical-only coverage that is guaranteed renewable as long as you pay your premium.

Plus, see any provider who accepts Medicare assignment.

Plan availability area listed on page 2.

To learn more, speak with a Blue Cross Medicare Advisor or schedule an appointment
1-855-252-9164, TTY **711**, 8 a.m. to 8 p.m. daily, Central Time
bluecrossmn.com/PlanAdvisor

[1]Highmark monthly Medicare enrollments on January 31, 2023, compared to December 31, 2022. [2]The Blue Cross and Blue Shield of Minnesota Story, A Sixty-Year History, published 1993, Blue Cross and Blue Shield of Minnesota; bluecrossmn.com/about.

This plan is a good choice if you want:

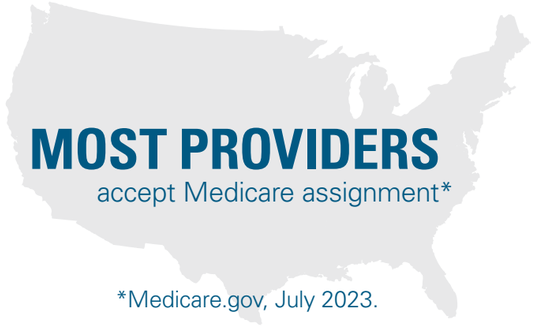
- Medical-only coverage
- Coverage that you can keep if you move to another state
- Guaranteed renewable benefits, as long as you pay your premiums
- Coverage while traveling within the U.S. and emergency foreign travel

Eligibility requirements: Have Medicare Part A and Part B • Live in Minnesota at the time you enroll

With a Medicare Supplement plan you can choose your doctor without any network restrictions.* See any provider that accepts Medicare assignment.

PROVIDERS

Medicare assignment is accepted nationwide by most providers. You may see any provider who accepts Medicare assignment for in-network benefits with our Basic Medicare Supplement Plan, Medicare Supplement Plan with Copayments (Plan N) and Medicare Supplement Plan with High Deductible Coverage (High Deductible Plan F).



*Medicare.gov, July 2023.

ADDITIONAL THINGS TO **CONSIDER**

- A Medicare Supplement plan is a medical-only plan and does not include prescription drug coverage. You can pair a Medicare Supplement plan with any stand-alone prescription drug plan. To see the Blue Cross MedicareBlue Rx plan, go to page 8.
- A Medicare Supplement plan can help pay for some of the costs Original Medicare doesn't, like copays, deductibles and coinsurance. A Medicare Supplement plan works with your Original Medicare coverage. Original Medicare is your primary coverage and the Medicare Supplement plan is your secondary coverage.
- If you apply for a Medicare Supplement plan more than six months after the month your Part B coverage begins, you may be required to submit a health history with your application and you may not get the plan you want

*Our Senior Gold℠ plan uses the Aware® Network — the largest Blue Cross network.

Each healthcare provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

LET'S COMPARE **COSTS AND COVERAGE**

Blue Cross Medicare Supplement plans offer different levels of coverage and cost sharing. Each plan pays a different amount toward your medical coverage. The right plan for you depends on how often you visit the doctor and how much you want to pay monthly versus paying when you get care.

Choose a plan:

HIGH DEDUCTIBLE PLAN F

Good option if you don't go to the doctor very often

- **Lower** monthly premium
- **No copays or coinsurance** after deductible is met

PLAN N

Good option if you aren't sure how often you'll go to the doctor

- **Lower** monthly premium
- **Copays** for Part B services

BASIC

Good option if you need more coverage and go to the doctor often

- **Higher** monthly premium
- **No copays or coinsurance** when all riders are selected

ADDITIONAL SUPPLEMENT PLANS AVAILABLE

Blue Cross offers additional Medicare Supplement plans, including Senior Gold℠. Visit **bluecrossmn.com/MedicareSupplementPlan** for more information or contact us or your agent to discuss options.

LET'S TALK **TRAVEL**

- Live or travel anywhere in the U.S. and get in-network benefits when you see a provider that accepts Medicare assignment
- No matter where you are, emergency services, including emergency foreign travel, are always covered. Some cost sharing may apply.

BENEFITS OVERVIEW

Amounts shown are what you pay for Medicare-eligible services and supplies. You must continue to pay your Medicare Part B premium.

MONTHLY PLAN PREMIUMS	HIGH DEDUCTIBLE PLAN F		PLAN N		BASIC		SENIOR GOLD[1]	
	Tobacco-free	**Standard**	**Tobacco-free**	**Standard**	**Tobacco-free**	**Standard**	**Tobacco-free**	**Standard**
Monthly plan premium	$59.35	$75.25	$178.05	$213.65	$226.85	$264.10	$253.10	$303.65
					OPTIONAL		*OPTIONAL*	
• Part A: Inpatient hospital deductible	100% covered after high deductible is met		100% covered		*Add plan riders:* + $ 36.00 for 100% coverage	*Add plan riders:* + $ 36.00 for 100% coverage	*Add plan riders:* + $ 36.00 for 100% coverage	*Add plan riders:* + $ 36.00 for 100% coverage
• Part B: Annual deductible*	No coverage		No coverage		No coverage	No coverage	No coverage	No coverage
• Medical expenses and supplies that exceed Medicare-approved charges and are not covered by Medicare Part B	100% coverage		100% coverage		+ $ 1.00 for 100% coverage	+ $ 1.00 for 100% coverage	+ $ 1.00 for 100% coverage	+ $ 1.00 for 100% coverage
• Supplemental preventive benefits not covered by Medicare (vision, hearing, annual physical exams and other routine screenings; up to $120 maximum per calendar year)	No coverage		No coverage		+ $ 4.00	+ $ 4.00	+ $ 4.00	+ $ 4.00
Total including all optional plan riders					= $267.85	= $305.10	= $294.10	= $344.65
ORIGINAL MEDICARE-COVERED BENEFITS								
Annual deductible	$2,700** (in 2023)		You will be responsible for meeting the Medicare Part B deductible		$0 when all plan riders are selected. You will be responsible for meeting the Medicare Part B deductible.*		$0 when all plan riders are selected. You will be responsible for meeting the Medicare Part B deductible.*	
Annual out-of-pocket maximum	After meeting the annual deductibles, there is minimal to no cost sharing for eligible services and supplies		There is no limit to out-of-pocket expenses		When all plan riders are selected, there are minimal to no out-of-pocket expenses		When all plan riders are selected, there are minimal to no out-of-pocket expenses	
Medicare-covered preventive services	$0		$0		$0		$0	
Immunizations (Flu, pneumonia and hepatitis B)	$0		$0		$0		$0	
Cancer screenings[2] (Plan provides broader coverage for cancer screenings than Original Medicare)	$0		$0		$0		$0	
Office visits (Primary care, specialists, chiropractic and podiatry)	$0		$20 copay		$0		$0	
Diagnostic tests, X-rays, lab and radiology services	$0		$0		$0		$0	
Durable medical equipment, prosthetics	$0		$0		$0		$0	
Diabetes programs and supplies	$0		$0		$0		$0	
Outpatient care (Therapy/outpatient visits, some lab services, outpatient or ambulatory surgical center visits)	$0		$0		$0		$0	
Urgent care (within U.S.)	$0		$0		$0		$0	
Emergency care	$0		$50 copay in U.S.; 20% coins. worldwide		$0 in U.S.; 20% coins. worldwide		$0 in U.S.; 20% coins. worldwide	
Inpatient hospital stay Per benefit period	$0; limit of 365 days per benefit period		$0; limit of 365 days per benefit period		$0 when all plan riders are selected; no day limit		$0 when all plan riders are selected; no day limit	
Skilled nursing facility care (Up to 100 days each benefit period)	$0		$0		$0		$0	
Prescription drugs (Part B-covered drugs only; Part D drugs not covered)	$0		$0		$0		$0	

*The federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits coverage of the Medicare Part B deductible for individuals who are newly eligible for Medicare on or after January 1, 2020. Contact us or your agent to find out how/if this applies to you.

**Subject to change based on state and federal regulations.

[1]Our Senior Gold℠ plan uses the Aware® Network — the largest Blue Cross network.

[2]Annual service and/or coverage limits may apply.

Resources and extras

Blue Cross Medicare Supplement plans include these extras:

CARE OPTIONS	
Nurse line Registered nurses are available 24 hours a day, seven days a week to answer your questions	1-800-622-9524; TTY 711
Online care See a doctor right on your smartphone, tablet or computer from providers that offer telehealth and online care, including services like Doctor On Demand®	doctorondemand.com/bluecrossmn
SUPPORT RESOURCES	
Quitting tobacco and vaping support Personalized guidance for developing a quit plan and ongoing support from a wellness coach	1-888-662-BLUE (2583), TTY 711 or log in at bluecrossmn.com

Doctor On Demand® by Included Health is an independent company providing telehealth services.

SilverSneakers by Tivity Health®

Stay active with SilverSneakers®

- Thousands of fitness locations nationwide
- 50+ fitness classes
- On-demand workout videos
- Live-streaming classes and workshops
- Online classes covering more than 1,800 topics that help you sharpen your brain and connect with other people
- No additional cost to you

Visit **silversneakers.com**

SilverSneakers® is a registered trademark of Tivity Health, Inc., an independent company that provides health and fitness programs.

How to enroll

It's easy to enroll in a Medicare Supplement plan. Choose one of the following ways:

Speak with a Blue Cross Medicare Advisor or schedule an appointment
1-855-252-9164, TTY **711**
8 a.m. to 8 p.m. daily, Central Time
bluecrossmn.com/PlanAdvisor

Compare plans, find resources and submit your application online
bluecrossmn.com/PlanCompare

Mail your enrollment form to the address listed on the bottom of the form

Check the status of your application at
bluecrossmn.com/MedicareAppStatus

STILL HAVE QUESTIONS?

Attend a Medicare workshop

Join us for a free, no obligation Prepare for Medicare workshop to learn more about Original Medicare and Medicare plans available from Blue Cross. Visit **bluecrossmn.com/Meeting** to learn more.

Medicare help line

1-800-MEDICARE (1-800-633-4227)
TTY **1-877-486-2048**
24 hours a day, seven days a week
medicare.gov

AFTER YOU ENROLL

After we process your enrollment forms, we will mail your member ID card to you. When you receive your member ID card, register on our member website at **bluecrossmn.com** so you can make the most of your plan.

Your Medicare Supplement plan cancels within 31 days if the plan premiums are not paid. Rules only allow you to reactivate twice during the lifetime of your policy without filing an appeal.

MedicareBlue℠ Rx (PDP)

This plan is a good choice if you want:

- Prescription drug coverage only
- Coverage of generic, brand-name and specialty drugs
- Access to thousands of pharmacies nationwide

Eligibility requirements: Have Medicare Part A, Part B or both • Live in the plan availability area

Save money at thousands of network pharmacies nationwide. Plus get extra savings at preferred pharmacies within your network.

PLAN **AVAILABILITY AREA**

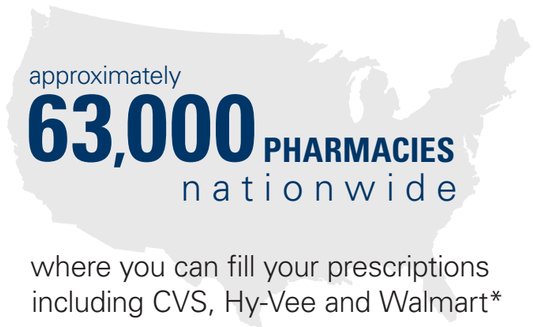
You're eligible to enroll in MedicareBlue Rx if you live in: Minnesota, Iowa, Montana, Nebraska, North Dakota, South Dakota or Wyoming

IN-NETWORK **PHARMACIES**

When you use a preferred pharmacy, you may save even more since these pharmacies may have lower copays and coinsurance on prescription drugs.

Check to see if your pharmacy is in network and your drugs (Rx) are covered

YourMedicareSolutions.com/PlanTools



where you can fill your prescriptions including CVS, Hy-Vee and Walmart*

*As of July 2023.

MEDICARE PART D **EXTRA HELP**

If you have limited income and financial resources, you might qualify for the Low-Income Subsidy (LIS) program from Social Security. Ask us for more information or visit **ssa.gov**.

Each pharmacy is an independent provider and not our agent.

LET'S COMPARE **COSTS AND COVERAGE**

MedicareBlue Rx (PDP) plans offer three levels of coverage and cost sharing. Each plan pays a different amount toward prescription drugs. The right plan for you depends on how many drugs you take and the cost of those drugs.

Choose from three levels of coverage:

SELECT

Good option if you don't take daily medications but may need drug coverage occasionally

- **Lower** monthly premium
- **Limited** preferred pharmacies
- **Deductibles:** No deductible on Tiers 1 and 2 generic drugs, so coverage starts right away with a copay. You will have a deductible on Tiers 3 – 5 drugs. After you pay your deductible, you will pay a set copay or coinsurance on covered drugs.
- **Preferred pharmacies** include Hy-Vee, Walgreens and Walmart

STANDARD

Good option if you take daily medications to manage conditions

- **Midrange** monthly premium
- **Deductibles:** No deductible on Tiers 1 and 2 generic drugs, so coverage starts right away with a copay. You will have a deductible on Tiers 3 – 5 drugs. After you pay your deductible, you will pay a set copay or coinsurance on covered drugs.
- **Preferred pharmacies** include CVS, Hy-Vee and Walmart

PREMIER

Good option if you take multiple generic and/or brand-name drugs or need extra coverage in the coverage gap stage

- **Higher** monthly premium
- **Deductibles:** No deductible on all five tiers, so coverage starts right away with copays or coinsurance
- **$0 copay** on Tier 1 and Tier 2 prescriptions when you use a preferred pharmacy. Plus, get extra coverage during the coverage gap stage on Tier 1 and Tier 2 prescriptions.
- **Preferred pharmacies** include CVS, Hy-Vee and Walmart

TIP TO AVOID A PENALTY

Enroll in a Part D plan when you're first eligible so you don't have to pay a late enrollment penalty from Medicare. Learn more at **bluecrossmn.com/Penalty**.

MEDICAREBLUE RX BENEFITS SNAPSHOT

This chart is an overview of the prescription drug benefits

- The premiums shown are for drug coverage only
- You can pair MedicareBlue Rx with a Medicare Supplement plan, a Medicare Cost plan or Original Medicare
- If your drug is not on the formulary, talk to your doctor. Your doctor may be able to prescribe a drug that the plan will cover or request to have your drug covered.

PART D PLAN OPTIONS	SELECT		STANDARD		PREMIER	
Monthly plan premium	$20.20		$76.40		$123.50	
Annual deductible	$0 on Tiers 1 – 2 drugs; $545 on Tiers 3 – 5		$0 on Tiers 1 – 2 drugs; $545 on Tiers 3 – 5		$0 all Tiers	
Initial coverage Amount you pay for a 30-day supply from a network pharmacy	**Preferred pharmacy**	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**	**Preferred pharmacy**	**Standard pharmacy**
Tier 1: Preferred generic drugs	$2 copay	$12 copay	$7 copay	$15 copay	$0 copay	$15 copay
Tier 2: Generic drugs	$6 copay	$15 copay	$13 copay	$20 copay	$0 copay	$20 copay
Tier 3: Preferred brand drugs	$42 copay	$47 copay	$43 copay	$47 copay	20% coins.	25% coins.
Tier 4: Non-preferred drugs	46% coins.	50% coins.	45% coins.	50% coins.	40% coins.	45% coins.
Tier 5: Specialty drugs	25% coins.	25% coins.	25% coins.	25% coins.	33% coins.	33% coins.
Coverage gap Begins once your total drug costs for the year reach $5,030[1]	• Generic drugs: 25% of the plan cost • Brand-name drugs: 25% of the plan cost		• Generic drugs: 25% of the plan cost • Brand-name drugs: 25% of the plan cost		Tiers 1 and 2 drug costs are the same as those listed above. For drugs in Tiers 3 – 5: • Generic drugs: 25% of the plan cost • Brand-name drugs: 25% of the plan cost	
Catastrophic coverage Begins once your total out-of-pocket costs for the year reach $8,000[2]	$0 for all plans					

[1] Total yearly drug costs include the amount you have paid for covered drugs plus what the plan has paid for the calendar year. This does not include plan premiums you pay. The brand-name drug coverage in the coverage gap is subject to agreements between the Centers for Medicare & Medicaid Services (CMS) and drug manufacturers. Not all brand drugs may be discounted. Call Blue Cross customer service if you have questions.

[2] Your out-of-pocket costs include the amount you have paid for covered drugs for the calendar year. This does not include the amount the plan has paid or the plan premiums you pay.

To view the plan formulary, visit **YourMedicareSolutions.com/PlanTools** and click on the appropriate link under "Coverage and pricing tool"

How to enroll

It's easy to enroll in a MedicareBlue Rx plan. Choose one of the following ways:

Speak with a Blue Cross Medicare Advisor or schedule an appointment
1-844-577-7331, TTY **711**
8 a.m. to 8 p.m. daily, Central Time
bluecrossmn.com/PlanAdvisor

Compare plans, find resources and submit your application online
bluecrossmn.com/PlanCompare

Mail your enrollment form to the address listed on the bottom of the form

STILL HAVE QUESTIONS?

Attend a Medicare workshop

Join us for a free, no obligation Prepare for Medicare workshop to learn more about Original Medicare and Medicare plans available from Blue Cross. Visit **bluecrossmn.com/Meeting** to learn more.

Medicare help line

1-800-MEDICARE (1-800-633-4227)
TTY **1-877-486-2048**
24 hours a day, seven days a week
medicare.gov

AFTER YOU ENROLL

After we process your enrollment form, we will send you a letter to confirm your enrollment. We will also mail your member ID card.

Important MedicareBlue Rx plan information

Enrollment and eligibility: You are eligible to enroll in MedicareBlue Rx if you have Medicare Part A and/or Medicare Part B and live in the plan's service area. You must continue to pay your Medicare Part B premium. You may enroll in only one Part D plan at a time. Beneficiaries may enroll in MedicareBlue Rx only during specific times of the year.

You may enroll by mail, online through our website or by working with an authorized independent agent. Medicare beneficiaries may also enroll in MedicareBlue Rx through the CMS Medicare Online Enrollment Center, located at **medicare.gov**.

Extra help: You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week;
- The Social Security Office at **1-800-772-1213** between 8 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your State Medicaid Office

Formulary, pharmacy network, mail order service: Formulary drugs are subject to change within a contract year. You will be notified at least 60 days in advance when drugs are removed from the formulary. Drug coverage benefits are subject to limitations. The plan uses AllianceRx Walgreens Pharmacy®, Amazon Pharmacy or Express Scripts® Pharmacy for mail order, which allows you to have your prescriptions mailed to your home. If you use one of these services, you can also enroll in the automatic prescription refill service. For more information about mail order services, please refer to Chapter 3, Section 2.3 "Using the plan's mail order services" in your Evidence of Coverage.

Other materials available: For a pharmacy directory or information about AllianceRx Walgreens Pharmacy, Amazon Pharmacy or Express Scripts Pharmacy Mail Order Pharmacy programs, please visit **YourMedicareSolutions.com**.

Federal contract: MedicareBlue℠ Rx (PDP) is a prescription drug plan with a Medicare contract. Enrollment in MedicareBlue Rx depends on contract renewal.

Special needs: If you have special needs, alternate formats may be available. Please call for more information.

For accommodations of persons with special needs at meetings call **1-844-577-7331**, TTY **711**.

AllianceRx Walgreens Pharmacy® is an independent company that provides central specialty pharmacy and home delivery pharmacy.

Amazon Pharmacy an independent company offering pharmaceutical home delivery services.

Express Scripts® Pharmacy is an independent company that provides pharmacy services.

M07999R01 (11/23)

Summary of Coverage and Disclosure of Information

BlueCross BlueShield Minnesota

Medicare Supplement with High Deductible Coverage (Plan F)

The State of Minnesota Commissioner of Commerce, has established two categories of Medicare Supplement plans. The two categories, from most to least comprehensive, are the Extended Basic Medicare Supplement plan and the Basic Medicare Supplement plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) offers a policy that fills in the "gaps" to supplement your Medicare coverage. Our Medicare Supplement Plan with High Deductible Coverage (Plan F) for Groups is a Medicare Supplement policy where coverage is available with any provider that participates in Medicare. Contact your local Social Security office or consult the Medicare Handbook for details of Medicare coverage. This is a summary of benefits available on this Medicare Supplement plan. It is not to be read or considered as a contract.

As you read through this summary, please remember the following:

1. For some services, Medicare determines if the services available on your Medicare Supplement plan are eligible for coverage
2. If you are not satisfied with your coverage for any reason, you may return your certificate to:
   Blue Cross and Blue Shield of Minnesota
   PO Box 64560
   St. Paul, MN 55164-0560

   We will then return all payments (including any fees or charges if applicable) made for this certificate within 10 business days after we receive the returned certificate and cancellation notice. The certificate will then be considered void from the beginning. If before the end of the 30-day period you have incurred expenses and request coverage for claims in excess of the amount of your monthly premium for that period, no refund will be made for that period.
3. If you are purchasing or canceling a group Supplement plan from Blue Cross, **do not** cancel your old coverage until your new coverage is approved and you are certain that you want to keep it. This will prevent a lapse in coverage.
4. It is possible for Medicare to allow a charge but not pay for it. Whether your Blue Cross plan pays for it depends upon the certificate language. Please read your certificate language carefully to determine specific benefits and coverage.
5. **THESE CERTIFICATES DO NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THESE CERTIFICATES DO NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DO NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR CERTIFICATE CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR CERTIFICATE.**
6. **THESE CERTIFICATES DO NOT COVER ANY PORTION OF THE MEDICARE PART B DEDUCIBLE FOR NEWLY ELIGIBLE INDIVIDUALS. A NEWLY ELIGIBLE INDIVIDUAL MEANS AN INDIVIDUAL WHO IS ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020, BECAUSE THE INDIVIDUAL HAS ATTAINED AGE 65 ON OR AFTER JANUARY 2020; OR, ALTHOUGH UNDER AGE 65, IS ENTITLED TO OR DEEMED ELIGIBLE FOR BENEFITS UNDER MEDICARE PART A BY REASON OF DISABILITY OR OTHERWISE.**
7. Your certificate will not be canceled or nonrenewed because of a deterioration of your health
8. Your certificate may be allowed to lapse at your request within 90 days of your enrollment if you enroll in the Medical Assistance program. You may reinstate Supplement coverage if your Medical Assistance benefits end within 24 months from the time you first suspend your Supplement coverage.

9. If you are enrolled in Medicare because you are disabled and are covered under this group Medicare Supplement plan, you do not need an individual Medicare Supplement plan while receiving benefits from your employer. To suspend your Blue Cross and Blue Shield of Minnesota individual Medicare Supplement plan, please send a written request to Blue Cross. When your group health coverage ends, your individual Medicare Supplement policy may be reactivated if you request us to do so in writing within 90 days of your group plan coverage termination.
10. These certificates have a minimum anticipated loss ratio of 75 percent. This means that on the average, you may expect that $75 of every $100 in premium payments that you pay are returned to you as benefits over the life of that coverage.
11. You may see any provider that participates with Medicare. We will coordinate with Medicare for all Medicare-eligible services.
12. The state of Minnesota provides counseling services through Senior LinkAge to provide advice concerning the purchase of Medicare Supplement policies and enrollment under Medical Assistance. You can contact Senior LinkAge at 1-800-333-2433 and ask for a Health Insurance Counselor.
13. You can contact the Department of Commerce at any time for any reason at (651) 539-1500 or 1-800-657-3602 (Greater Minnesota only) for information about other medical insurance products currently available in Minnesota

BlueCross BlueShield Minnesota

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

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

image_0006_NDL_Portrait (09/16)

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလီတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ်, ကိး 711 တကွ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

image_0002R02_General_Portrait

I. SUMMARY OF BENEFITS Original Medicare	**Medicare Supplement Plan with High Deductible Coverage (Plan F):** This product covers 100% of all eligible charges upon satisfaction of the annual high deductible amount*.
Inpatient Hospital Services • 60 days of hospital inpatient care at 100% after your Medicare Part A deductible • Days 61– 90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount	**Inpatient Hospital Services** • Medicare Part A deductible • Medicare Part A coinsurance • Medicare-eligible services for 365 days after Medicare benefits end
Skilled Nursing Care • The first 20 days at 100% • Days 21–100 at 100% after Part A daily coinsurance amount • **No coverage** after the 100th day	**Skilled Nursing Care** • Medicare Part A coinsurance • You pay all charges after the 100th day of skilled nursing care
Hospice • Generally, most Medicare-eligible expenses for outpatient drug and inpatient respite care • You pay part of the cost for outpatient drugs and inpatient respite care • You must get care from a Medicare-certified hospice	**Hospice** • Medicare Part A coinsurance or copayments for all Medicare Part A eligible expenses and respite care
Home Health Care • 100%	**Home Health Care** • 100% of Part A and Part B home health services and medical supplies
Emergency Services • Same as hospital and medical services • 80% of Medicare-approved charges after annual Part B deductible	**Emergency Services** • Medicare Part B deductible coverage may be available dependent upon your Medicare eligibility date • Medicare Part B coinsurance • These certificates do not cover any portion of the Medicare Part B deductible for newly eligible individuals
Medical Services, Outpatient Services and Durable Medical Equipment • 80% of Medicare-approved charges after annual Part B deductible • Cancer screening services (see below) • Diabetic supplies	**Medical Services, Outpatient Services and Durable Medical Equipment** • Medicare Part B deductible coverage may be available dependent upon your Medicare Part A eligibility date • Medicare Part B coinsurance • 100% for the first three (3) pints of blood under Medicare Parts A or B • These certificates do not cover any portion of the Medicare Part B deductible for newly eligible individuals
Foreign Medical Services • **No coverage**	**Foreign Medical Services** • 100% of the hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency
Preventive Services (screening exams) • 80% to 100% of Medicare-approved charges for bone mass measurement, colorectal screening exams, immunizations, Pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam	**Preventive Services** • 100% of Medicare Part B cost sharing for Medicare Part B eligible preventive services • 100% of cost sharing for cancer screening procedures

*There is a $2,340 deductible for 2020.This amount may be adjusted annually.

II. ADDITIONAL BENEFITS

There are some benefits on your certificate that expand the coverage Medicare allows, or provide coverage that Medicare does not give or does not allow. These vary among our products. Please read your certificate language carefully to determine specific benefits and coverage.

III. OTHER INFORMATION

A. Guarantee Issue

Notice of Medicare Supplement Insurance Portability for Persons Ending or Losing Other Health Coverage.
Should you change, lose or cancel your Medicare Supplement coverage with us, you may qualify for the following provision:

Changes in federal and state law contain rights and obligations about issuing Medicare Supplement policies. The guarantee issue provisions discussed here are in addition to the Medicare Initial Open Enrollment Period for persons age 65 or older: the seven-month period that begins three months before the month the consumer turns 65, includes the month the person turns 65, and ends three months after the person turns 65.

Our Obligation

Blue Cross must guarantee issue certain basic Medicare Supplement policies to eligible individuals in specific circumstances and may not deny them coverage. We cannot discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, medical condition or age. We cannot impose a preexisting condition exclusion.

Your Rights

If a Medicare beneficiary loses health coverage under the circumstances listed below, the beneficiary is guaranteed the right to purchase certain Medicare Supplement policies.

1. In Minnesota, an eligible individual is a person who is eligible for Medicare and who:

a) Was enrolled in an employer-provided retiree benefit plan that provided health benefits that supplement Medicare and the plan terminates or ceases to provide all supplemental benefits

b) Was enrolled in a Medicare Advantage, Medicare Select, Medicare Cost, or Health Care Prepayment plan, and the enrollment ends because:

   i) The plan's certification under Medicare has been terminated or the plan discontinues providing benefits in the area in which the person resides
   ii) The individual cannot continue with the plan because the individual changes residence or
   iii) The individual demonstrates that the plan violated a material provision of the contract for coverage or that the organization materially misrepresented the plan's provisions in marketing

c) Was enrolled in a Medicare Supplement health plan and the enrollment ends because:
   i) The insurer becomes insolvent or other involuntary termination of coverage occurs
   ii) The insurer substantially violated a material provision of the policy or materially misrepresented the contract's provisions in marketing the policy to the individual

   Eligible individuals described in sections a through c (above) are entitled to a Basic Medicare Supplement or a Basic Medicare Select policy from any Minnesota issuer.

d) Was enrolled under a Medicare Supplement policy and terminates coverage to enroll for the first time in a Medicare Advantage, Medicare Cost, Health Care Prepayment plan, or Medicare Select plan, and the individual then disenrolls from that plan within the first 12 months

Eligible individuals are entitled to the same Medicare Supplement policy in which the individual was most recently enrolled, if available, from the same issuer. If the contract is not available, the person is entitled to a Basic Medicare Supplement or Select contract offered by any issuer.

e) After first enrolling in Medicare Part B, enrolls in a Medicare Advantage plan and then disenrolls from that plan within 12 months

Eligible individuals are entitled to any Medicare Supplement or Select contract offered by any issuer.

You must apply for Blue Cross Medicare Supplement coverage within 63 calendar days of the date your coverage terminates (listed above) in order for us to determine if guarantee issue of coverage applies to you. If you apply after this 63-day period, a completed health history questionnaire must accompany your application.

If your Medicare Advantage plan is terminating, you have 63 days from the date of your plan's official Notice of Termination, as well as 63 calendar days after the plan's actual termination, to apply for Blue Cross coverage under guarantee issue. If your employer group coverage is being terminated, you have 63 days from the date of official notice or from the date that you are notified of a denied claim. Applications outside of those periods will require a completed health history application, unless you are otherwise eligible for guarantee issue of coverage.

B. Relationship to Medicare

Neither Blue Cross nor its agents are associated with Medicare.

C. Completing Your Application for Coverage

If your employer has chosen the paper enrollment process and you have any questions as you fill out your application for coverage, please call Blue Cross or contact your employer for assistance. We are happy to help.

D. Grievance Procedures

In compliance with state statutes, Blue Cross and Blue Shield of Minnesota has established the following procedures for resolution of complaints concerning either the administration of your certificate terms or specific aspects of your health care.

1. If you orally notify Blue Cross that you wish to register a complaint, Blue Cross shall promptly provide a complaint form that includes:

a) The telephone number for service or other departments, or persons equipped to advise complaints
b) The address to which the form must be sent
c) A description of the Blue Cross internal complaint system and the time limits applicable to the grievance procedure
d) The telephone number of the State of Minnesota Commissioner of Commerce

2. Blue Cross shall provide for informal discussions, consultations, conferences, or correspondence between you and a person with the authority to resolve or recommend the resolution of the complaint. Within 30 calendar days after receiving the written complaint, Blue Cross must notify you in writing of its decision and the reasons for it. If the decision is partially or wholly adverse to you, the notification must advise you of the right to appeal according to item 3, including your option for a written reconsideration or a hearing, the right to arbitrate according to item 4, and the right to notify the Commissioner of Commerce. If Blue Cross cannot make a decision within 30 calendar days due to circumstances outside the control of Blue Cross, Blue Cross may take up to an additional 14 calendar days to notify you, provided Blue Cross informs you in advance of the extension and the reasons for the delay.

3. If you notify Blue Cross in writing of your desire to appeal the Blue Cross initial decision, Blue Cross shall provide you the option of a hearing or a written reconsideration:

a) If you choose a hearing, a person or persons with authority to resolve or recommend the resolution of the complaint shall preside, but the person or persons presiding must not be solely the same person or persons who made the decision under item 2

b) If you choose a written reconsideration, those with authority to resolve the complaint shall investigate the complaint, but the person or persons investigating must not be solely the same person or persons who made the decision under item 2
c) Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from you, staff persons, administrators, providers, or other persons, as is deemed necessary by the person or persons investigating the complaint in the case of a reconsideration or presiding person or persons in the case of a hearing for a fair appraisal and resolution of the complaint
d) In the case of a written reconsideration, a written notice of all key findings shall be given to you within 30 days of Blue Cross receiving your written notice of appeal
e) In the case of a hearing, concise written notice of all key findings shall be given to you within 45 days after Blue Cross receives your written notice of appeal

4. You may request, or Blue Cross shall provide the opportunity for, binding arbitration of any complaint which is unresolved by the mechanisms set forth in the appeal process noted in item 2 above. Arbitration must be conducted according to the American Arbitration Association and Minnesota Health Maintenance Organization Arbitration Rules.

5. If the subject of the complaint relates to a malpractice claim, the complaint shall not be subject to arbitration.

6. If a complaint involves a dispute about an immediately and urgently needed service that Blue Cross claims is experimental or investigative, not medically necessary, or otherwise not generally accepted by the medical profession, the procedures in items 1 to 4 do not apply. Blue Cross must use an expedited dispute resolution process appropriate to the particular situation:
a) By the end of the next business day after the complaint is registered, Blue Cross shall notify the Commissioner of Commerce of the nature of the complaint, the decision of Blue Cross, if any, and a description of the review process used or being used
b) If a decision is not made by the end of the next business day following the registration of the complaint, Blue Cross shall notify the Commissioner of Commerce of its decision by the end of the next business day following its decision

F. Suspension Based on Entitlement to Medical Assistance

If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Upon reinstatement there will be no additional waiting periods with respect to preexisting conditions and coverage provided will be substantially equivalent to coverage in effect before the date of the suspension. Premiums will be classified on terms that are at least as favorable to the policyholder as the premium classification that would have been applied had coverage not been suspended.

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)

M01515R02 (3/23)

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 5

What's Medicare? 6
The different parts of Medicare 6
Your Medicare coverage options 7
Medicare and the Health Insurance Marketplace® 8
Find more information about Medicare 8

Section 2: Medigap Basics 9

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

Section 3: Your Right to Buy a Medigap Policy 21

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

Section 4: Steps to Buying a Medigap Policy 25

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

Section 5: If You Already Have a Medigap Policy 31

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

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

Information for people who are under 65 39

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

Massachusetts benefits 42

Minnesota benefits 43

Wisconsin benefits 44

Section 8: For More Information 45

Where to get more information 45

How to get help with Medicare and Medigap questions 46

State Health Insurance Assistance Program (SHIP) and State Insurance Department 47

Section 9: Definitions 49

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

Massachusetts benefits 42

Minnesota benefits 43

Wisconsin benefits 44

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

CMS Product No. 02110
March 2023

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.