2024

READY TO HELP

Confidence comes with every card.®

Blue Cross Medicare Supplement℠

Enrollment Kit

It’s easy!

This enrollment kit includes the following information to assist you in becoming a member.

1. Agent scope of sales appointment confirmation form
2. Enrollment application form
3. Outline of coverage
4. Choosing a Medigap policy

Have questions?
We’re ready to help you enroll.

Call **1-888-563-3307**, Monday through Friday, from 8 a.m. to 9 p.m. Eastern time, with weekend hours Oct. 1 through March 31. TTY users, call **711**.

Go to **www.bcbsm.com/medicare-supplement**.

Contact your Blue Cross-authorized, independent agent.

Complete **the enclosed enrollment application form and mail it in.**

Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephone sales meeting to ensure understanding of what will be discussed between the agent and the Medicare member (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his or her authorized representative.

Please initial beside the products you want the agent to discuss.
(Refer to the following page for product descriptions.)

- ☐ Stand-alone Medicare prescription drug plans (Part D)
- ☐ Medicare Advantage plans (Part C)
- ☐ Dental/vision/hearing products
- ☐ Ancillary products (not Medicare-affiliated)
- ☐ Medicare supplement (Medigap) products

By signing the form, you agree to meet with a sales agent to discuss the products you initialed above. The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work for the federal government. This individual may also be paid based on your enrollment in a plan. **Signing this form doesn't obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.**

Member or authorized representative signature and signature date	
Signature	Signature date
If you are the authorized representative, please sign above and print below	
Representative name	Your relationship to the member
To be completed by agent	
Agent name	Agent phone
Member name	Member phone
Member address	
Initial method of contact (indicate here if member was a walk-in)	
Agent signature	
Plans represented by agent during meeting	Date appointment completed

Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-alone Medicare prescription drug plans (Part D)
Medicare Prescription Drug Plan (PDP) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare cost plans, some Medicare private fee-for-service plans and Medicare medical savings account plans.
Medicare Advantage plans (Part C)
Medicare health maintenance organization (HMO) – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare preferred provider organization (PPO) plan – A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare private fee-for-service (PFFS) plan – A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare special needs plan (SNP) – A Medicare Advantage plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who live in nursing homes, and people who have certain chronic medical conditions.
Dental/vision/hearing products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.
Ancillary products
Critical illness and accident insurance – Plans offering coverage for consumers who have been diagnosed with a specific illness on a predetermined list. These plans are not affiliated or connected to Medicare. **Hospital indemnity insurance** – Plans that offer coverage each day you are hospitalized, up to a designated number of days. These plans are not affiliated with or connected to Medicare. **Travel insurance** – Plans offering additional benefits for consumers who travel outside the United States. These plans are not affiliated or connected to Medicare.
Medicare supplement (Medigap) products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

2024

READY TO HELP

Confidence comes with every card.®

Blue Cross Medicare Supplement℠

Plans A, C, D, F, High-Deductible F, G, High-Deductible G and N

Enrollment Application

2024 Medicare supplement application

1 Applicant information

Please print in black or blue ink. All sections must be completed unless otherwise indicated. All information provided will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be found at **www.bcbsm.com**. We only use your information for understanding and processing your application. All information you provide is confidential.

First name	Middle initial	Last name	Social Security number

Residential street address (cannot be a P.O. Box)	City	State	ZIP code

Mailing street address (if different from above)	City	State	ZIP code

County	Phone number	☐ Home ☐ Cell	Alternate number (optional)	☐ Home ☐ Cell

Email	☐ Male ☐ Female	Date of birth

Number of months you live in MI each year	Have you used nicotine in any form (including, but not limited to, cigarettes, e-cigarettes, vaping and nicotine patches or gum) in the past year? ☐ **Yes** ☐ **No** You don't have to answer this question if you're in your Medigap open enrollment period or have a guaranteed issue right (refer to Sections 5 and 6 of this application for details).

Did you have a Blue Cross Medicare Supplement or Legacy Medigap plan that ended in the past six months? ☐ **Yes** ☐ **No**	If **yes**, enrollee ID number:

Household discount eligibility

You may be eligible for a lower premium if another person in your household currently has a Blue Cross Medicare Supplement or Legacy Medigap plan. Household is defined as a single-family home, a condominium unit or an apartment unit within an apartment complex.

Please check the box below that applies to you:

☐ I live with a person who's currently covered under a Blue Cross Medicare Supplement plan or Legacy Medigap plan.

Name of that person (answer required) _____

Enrollee ID number[1] of that person (answer required) _____

☐ I live with a person who is in the process of applying for a Blue Cross Medicare Supplement plan.

Name of that person (answer required) _____

Social Security number of that person (answer required) _____

☐ I don't currently live with another person who has a Blue Cross Medicare Supplement plan or Legacy Medigap plan, and I'm not eligible for the household discount.

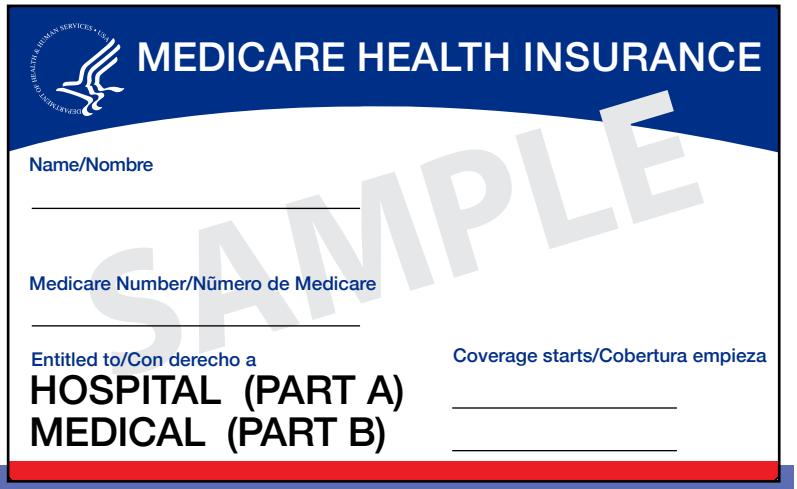
Only members with a Blue Cross Medicare Supplement or a Legacy Medigap plan are eligible for a household discount and must live with another eligible person.

Members with Medicare Advantage plans from Blue Cross or Blue Care Network, or Blue Care Network's MyBlue℠ Medigap plans aren't eligible for this discount.

[1]Enrollee ID number is on the Blue Cross member ID card.

Please refer to your red, white and blue Medicare health insurance card to complete this section.

Please fill in the blanks on this card so they match the information on your Medicare card.



2 Plan selection

Please check the appropriate box for the plan you want:

☐ Plan A ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan HD-F ☐ Plan G ☐ Plan HD-G ☐ Plan N

Please note that HD means high-deductible plan.

If any of the below information applies to you, we consider you eligible as a **conversion member**. This means that if you apply for one of the Medicare supplement plans for which you're eligible within 180 days after you lost coverage under a group policy, you're entitled to the plan without restriction.

- *If you turned 65 years old, or became Medicare eligible on or after January 1, 2020, you can't enroll in a plan that covers the Part B deductible (plans C, F and High-Deductible F).*
- *You're eligible for **Plan C** if you turned 65 or became eligible for Medicare prior to January 1, 2020. You can enroll in Plan C if you've lost coverage under a group policy after becoming eligible for Medicare. You're also eligible if you had Plan C, then enrolled in a Medicare Advantage plan, and now would like to return to Plan C. You can do this as long as it's within the first 12 months of your Medicare Advantage plan.*
- *You're eligible for **Plan D** if you turned 65 or became eligible for Medicare due to disability or end stage renal disease, on or after January 1, 2020. You can enroll in Plan D if you've lost coverage under a group policy after becoming eligible for Medicare. You're also eligible if you had Plan D, then enrolled in a Medicare Advantage plan, and now would like to return to Plan D. You can do this as long as it's within the first 12 months of your Medicare Advantage plan.*
- *You're automatically eligible for **Plan A** or **Plan D**. If you're younger than 65, you're eligible only for Plan A or Plan D if you've lost coverage under a group policy after becoming eligible for Medicare. You're also eligible if you had Plan A, then enrolled in a Medicare Advantage plan, and now would like to return to Plan A. You can do this as long as it's within the first 12 months of your Medicare Advantage plan.*

Requested start date: ___ /_01_ /_____ **(***must be a future date and must not be more than six months past today's date***)**

When choosing a plan, it's important to know the following:

- You must be enrolled in Medicare parts A and B.
- You can't have more than one Medicare supplement plan.
- You can't be enrolled in a Medicare supplement plan and a Medicare Advantage plan at the same time.
- At the time of enrollment, you must be a permanent resident of Michigan and physically live in Michigan for at least six months of the year.
- Once enrolled, if you permanently move outside Michigan or live in Michigan for fewer than six months of every year, your premium may change.
- Coverage will only continue if all other eligibility requirements continue to be satisfied. Refer to the *Outline of Coverage* at What will a Medicare supplement plan cost me? | BCBSM for the monthly costs and descriptions of each plan.
- If you're younger than 65, you're eligible to enroll in plans A and D only.

3 Blue Cross Medicare Supplement's Dental Vision Hearing Package

The Dental Vision Hearing Package is additional coverage that gives you:

- In-network dental exams, cleanings, X-rays and fluoride treatment at no additional cost
- In-network vision coverage that includes standard lenses every 12 months
- One hearing exam every 12 months and savings of up to 60% off average retail hearing aid prices at a TruHearing® provider

The monthly premium for the Dental Vision Hearing Package is $29.50 in addition to your Blue Cross Medicare Supplement premium.

New Blue Cross Medicare Supplement members can add the Dental Vision Hearing Package at the time of their initial enrollment or within the first 30 days following their policy start date.

For new members who sign up for a Blue Cross Medicare Supplement plan and the Dental Vision Hearing Package at the same time, **coverage will begin on the same day**.

For new members who sign up for the Dental Vision Hearing Package within the first 30 days following their Blue Cross Medicare Supplement policy start date, **coverage will start the first of the month after the application is accepted. Please note:** applications must be received within the first 30 days of a member's policy start date.

Conditions of enrollment

By choosing to add the Dental Vision Hearing Package, I confirm that I will have an active Blue Cross Medicare Supplement plan and will not have dental, vision or hearing coverage through another individual plan. I agree to add the Dental Vision Hearing Package, which is in addition to my monthly Medicare supplement plan premium. I understand that the premium of $29.50 for the Dental Vision Hearing Package is subject to change each year, and I'll be provided with written notice 30 days prior to any change. I understand that the additional coverage is subject to the terms and conditions stated in my plan certificate. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state of Michigan) on this application means that I've read and understand its contents. If signed by an authorized individual, this signature certifies that this person is authorized under state law to complete this enrollment, and documentation of this authority is available upon request by Blue Cross Blue Shield of Michigan.

☐ I'm choosing to add the Dental Vision Hearing Package to my Blue Cross Medicare Supplement plan for an additional monthly cost.

☐ I decline to add the Dental Vision Hearing Package to my Blue Cross Medicare Supplement plan.

The Dental Vision Hearing Package is only available in conjunction with a Blue Cross Medicare Supplement plan. You can't have dental, vision or hearing coverage through another individual plan.

Paying your plan premium

The premium for the Dental Vision Hearing Package will be added to your monthly Medicare supplement plan premium and paid through the method you choose in Section 9 of this application.

4 Medicaid information

If you're 65 or older, you may be eligible for benefits under Medicaid, and may not need a Medicare supplement plan.

Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**

Note: If you're participating in a spend-down program and haven't met your out-of-pocket cost maximum, please answer "No" to this question.

If "**Yes,"** Will Medicaid pay your premiums for this Medicare supplement plan? ☐ **Yes** ☐ **No**

Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

If, after purchasing a Medicare supplement plan, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement plan may be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you're no longer entitled to Medicaid, your suspended Medicare supplement plan may be available. If it's no longer available, a substantially equivalent plan will be reinstated if requested within 90 days of losing Medicaid eligibility.

If the Medicare supplement policy provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy won't have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5 Open enrollment period

The Medigap open enrollment period is the six month period that begins when you're age 65 or older and enrolled in Medicare Part B.

A. Will you be 65 or older by (or on) the **first** day of the month following your start date?

☐ **Yes** ☐ **No,** I'm younger than 65 and eligible for Medicare due to disability or end stage renal disease.

If you answered no and are younger than 65, you're only eligible for plans A and D.

B. Are you turning 65 the same month or **no more than six months prior** to the first day of your requested start month?

☐ **Yes** ☐ **No,** I turned 65 more than six months ago.

C. Is your Medicare Part B effective date the same month or **no more than six months prior** to the first day of the month you requested to start?

☐ **Yes** ☐ **No,** I enrolled in Part B more than six months ago.

6 Guaranteed issue rights

Guaranteed issue, or GI, rights means you can't be turned down for Medicare supplement coverage or pay a higher premium for preexisting health conditions when you enroll within your Medigap Open Enrollment Period (OEP) or have a guaranteed issue right, all of which are listed below (A through F).

A. Do you have another active Medicare supplement policy? ☐ **Yes** ☐ **No**

If so, name the company and the plan.

_____

If so, do you intend to replace your current Medicare supplement policy with this policy?

☐ **Yes** ☐ **No** (If no, you aren't eligible for this Medicare supplement plan.)

If the Medicare supplement plan has ended or will have ended when this plan starts, why did it end?

☐ Through no fault of my own

☐ Company misled me or failed to follow the rules

☐ Other

B. Have you lost or are you losing other health coverage, or have you received a notice from your previous health plan saying you're eligible for guaranteed issue of a Medicare supplement plan or that you had certain rights to buy a guaranteed issue plan?

☐ **Yes** Start date _____

End date (if you're still covered under this plan, leave the end date blank): _____

Reason for disenrollment: _____

☐ **No**

C. Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?

☐ **Yes** Start date: _____ ☐ **No**

End date (if you're still covered under this plan, leave the end date blank): _____

If "Yes," name of the carrier:_____

If "Yes," select the reason you disenrolled or will be disenrolled when this plan becomes effective.

☐ Plan is leaving Medicare.

☐ Plan is no longer offered in my area.

☐ I'm moving out of the plan's service area.

☐ I replaced a Medicare supplement policy (or switched to a Medicare SELECT policy) for the first time, have been in the plan less than a year and now wish to return to my previous Medicare supplement policy. This is considered a "trial right."

☐ Voluntary disenrollment.

☐ I joined a Medicare Advantage plan (or PACE) when I was first eligible for Medicare Part A at 65, and within the first year of joining I decided to switch to Original Medicare and join a Medicare supplement plan. This is also considered a "trial right."

☐ Company misled me or failed to follow the rules.

☐ Other _____

D. Do you have Original Medicare and a Medicare SELECT policy, and have moved out of the Medicare SELECT policy service area?

☐ **Yes** ☐ **No**

E. Did you have coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare Advantage HMO or PPO plan)?

☐ **Yes** ☐ **No**

If "Yes", indicate your start and end dates below. If you're still covered under this plan, leave the end date blank. **Start date** _____ **End date** _____

Was this your first time in this type of Medicare plan?

☐ **Yes** ☐ **No**

Did you cancel a Medicare supplement policy to enroll in the Medicare Advantage plan?

☐ **Yes** ☐ **No**

F. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?

☐ **Yes** ☐ **No** If so, with what company and what kind of policy?

_____

What are your dates of coverage under the other policy? (If you're still covered under the other policy, leave end date blank.)

Start date _____ **End date** _____

If the plan has ended or will end by the effective date of this plan, what is the reason?

☐ My coverage ended for one of these reasons:

- ☐ Death of the policyholder
- ☐ Divorce from the policyholder
- ☐ I became eligible for Medicare and am no longer eligible for the plan
- ☐ My employer no longer offers group coverage

☐ I voluntarily canceled my coverage due to cost, benefits or another reason.

Important note: If you're currently enrolled in a Medicare Advantage plan and want to enroll in Medicare supplement, you must separately disenroll in writing from Medicare Advantage. Submission of this application doesn't automatically disenroll you from your current Medicare Advantage insurance carrier. Call your Medicare Advantage customer service department for information on how to disenroll from that plan and prevent duplication of coverage or a lapse in coverage. Medicare Advantage plans only allow disenrollment certain times of the year.

If you indicated your employer or group health plan coverage is ending (through no action of your own), or that you received a notice from a prior heath plan that you have a right to buy a GI plan, scan and email a copy of the termination or GI notice to **MedSuppUnderwriting@bcbsm.com** or fax it to **1-877-205-6651**. Be sure your first and last name are clearly legible on the email or fax.

7 Conversion rights (for plans A, C and D)

Have you lost, or will you lose, coverage under a group policy after becoming eligible for Medicare?

☐ **Yes** ☐ **No**

If yes, what is the date you lost, or will lose, coverage? _____

Note: You aren't eligible to enroll in Plan C if you became 65 or qualified for Medicare due to age, disability or end stage renal disease on or after January 1, 2020.

If you're applying for plans A, C or D, you must submit proof that you've lost coverage under a group policy after becoming eligible for Medicare.

8 Health information (for nonguaranteed issue only)

Complete this section only if you aren't applying during your Medigap open enrollment period or don't have a guaranteed issue right.

The information you provide is confidential and will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at **www.bcbsm.com**.

Height: _____ ft. _____ in. Weight: _____ lbs.

A. Do any of these apply to you? Please check all that apply.

- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cardiomyopathy
- ☐ End stage renal disease (ESRD), chronic kidney disease, currently receiving or may require dialysis
- ☐ Leukemia, lymphoma, malignant melanoma
- ☐ Organ, bone marrow or stem cell transplant
- ☐ Stroke or TIA (mini stroke)
- ☐ Cirrhosis of liver
- ☐ Hemophilia
- ☐ **None of these apply**

Within the past two years, has a medical professional discussed any of the following treatment options that haven't yet been addressed? Please check all that apply.

- ☐ Hospital admittance as an inpatient
- ☐ Organ transplant
- ☐ Back or spine surgery
- ☐ Joint replacement
- ☐ Surgery, radiation or chemotherapy for cancer
- ☐ Heart or vascular surgery
- ☐ **None of these apply**

B. Have you been diagnosed or treated (including taking medication) for any of the following conditions in the past five years? Please check all that apply.

- ☐ Angina, coronary artery disease, heart attack, congestive heart failure, artery/vein blockage, implantation of pacemaker, peripheral vascular disease
- ☐ Chronic obstructive pulmonary disease (COPD), emphysema, any lung or respiratory disorder requiring oxygen
- ☐ Cancer
- ☐ Alzheimer's disease, dementia or any other cognitive disorder
- ☐ Parkinson's disease, multiple sclerosis, systemic lupus erythematosus, rheumatoid arthritis
- ☐ Diabetes with circulatory or kidney problems or retinopathy
- ☐ Crohn's disease, ulcerative colitis
- ☐ Major depression
- ☐ **None of these apply**

C. Do you have any of the following health conditions? Please check all that apply.

- ☐ Atrial fibrillation, cardiac arrhythmia
- ☐ Asthma, sleep apnea
- ☐ Diabetes (well controlled with no complications)
- ☐ Glaucoma, macular degeneration
- ☐ Hypertension (high blood pressure)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Osteoporosis with fractures, arthritis that restricts mobility or activities of daily living
- ☐ **None of these apply**

List medications you've taken in the last 12 months (if more room is needed, please list on a separate page and attach to your application):

Authorization for protected health information, also called PHI, use and disclosure (required if applying outside your open enrollment or Medigap open enrollment period or don't have a guaranteed issue right).

I understand that the following parties may need to collect information about me in regard to the proposed coverage: Blue Cross Blue Shield of Michigan and its reinsurers, any insurance support organization, any consumer reporting agency and all persons authorized to represent these organizations for this purpose.

Any and all individually identifiable health information, including, but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results may be disclosed to or by Blue Cross Blue Shield of Michigan. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol and drug use. This also may include information on the diagnosis, treatment and testing results related to HIV, AIDS and sexually transmitted diseases, unless otherwise restricted by state law.

Those parties that need to collect information may disclose information to the following: other insurers to whom I've applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearinghouses; or persons who perform business, professional or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 30 months after the date signed.

I understand I can revoke this authorization any time by giving written notice on a standard form available online at **www.bcbsm.com**, or by contacting my agent. I also understand that my revocation won't affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but if I refuse, I may not be eligible for enrollment. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. Failure to sign this authorization, or subsequent revocation of this authorization may impair the ability of Blue Cross Blue Shield of Michigan to process my application or evaluate claims, and may be a basis for denying a claim for benefits; however my ability to receive health care services will not be changed if I do not sign this authorization.

Applicant printed name (must match the name as entered in Section 1 of this application)	
Applicant signature	Date

9 Payment information

Choose one:

☐ Receive a monthly bill and pay by mail ☐ Electronic funds transfer from your bank account each month

If you selected electronic funds transfer, on the due date for each bill, the checking or savings account you designate will be debited for the amount of your premium.

Once enrolled, you can request a monthly statement or get more information about your automatic bill payment plan by calling Customer Service at **1-888-216-4858**, from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call **711**.

Name of financial institution		Account type ☐ Checking ☐ Savings
ABA/routing number and attach copy of a voided check		Account number
Printed name of the account holder	Signature of the account holder	Date
Email address		

Additional information

You don't need more than one Medicare supplement plan.

- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you're eligible for, and have enrolled in, a Medicare supplement plan because of a disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you have coverage under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy), will be re-instituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy won't have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Your coverage will automatically be renewed each year as long as you pay your premiums.
- To terminate your Blue Cross Medicare Supplement plan, please notify Blue Cross Blue Shield of Michigan in writing or call Customer Service at **1-888-216-4858**, from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call **711**.
- Counseling services may be available in your state to provide advice about your purchase of Medicare supplement insurance and Medicaid.

10 Confirm and sign

Please read, sign and date where indicated.

My signature indicates that I've read and understand the contents of this application. I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, Blue Cross Blue Shield of Michigan may have the right to rescind my Blue Cross Medicare Supplement coverage or adjust my premium. I understand that I may not be eligible for all offered plans, and confirm that I haven't applied for any plan for which I'm not eligible.

If I cancel within the first 30 days of the effective date of this coverage, I'll be entitled to a refund of my previous premium payment. Please note that the reasonable costs for any health services paid by Blue Cross during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received. If I choose to cancel my coverage after the first 30 days, I understand I must write or call Blue Cross' Customer Service department.

Any person who knowingly, and with intent to defraud any health plan company or other person, files an application or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand the coverage under the plan I'm applying for won't take effect until issued by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan requires proper handling of personal health information for its members. Details of Blue Cross Blue Shield of Michigan's confidentiality policies and procedures are available at **www.bcbsm.com**.

☐ **Yes** ☐ **No** I have received a copy of the Blue Cross Medicare Supplement plan *Outline of Coverage*.

☐ **Yes** ☐ **No** I have received a copy of *Choosing a Medigap Policy*.

Applicant's printed name (must match name as entered in Section 1 of this application)	Applicant's signature	Date

You will receive an ID card with a letter confirming your start date and premium. A *Certificate of Coverage* will be made available to you.

If you're the authorized personal representative, or have an authorized representative currently on file with Blue Cross, you must provide the following information:

Personal representative's printed name			
Personal representative's signature		Date	
Street address	City	State	ZIP code
Phone	Relationship to applicant		

Applications can be submitted in the following ways:

Online: For Members: Medicare Enrollment Forms | BCBSM

Fax: 1-866-392-7528

Mail: Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407

Agents must submit applications online at **www.bcbsm.com/agents**.

11 For agent use only

Enrolling an individual in a Medicare supplement plan requires that you provide the following information:

1. Have you sold any other health plan policies to this individual that are still in force?
   - ☐ **Yes** Policy descriptions (name of policy, policy number, start date):

     _____

   - ☐ **No**
2. Have you sold any health plan policies to this individual in the last five years that aren't still in force?
   - ☐ **Yes** Policy descriptions (name of policy, policy number, start and end dates):

     _____

     _____

   - ☐ **No**
3. Did you ask the applicant all the questions in this application and record the answers as given to you?
   - ☐ **Yes**
   - ☐ **No**

Managing agent / general agency name (if applicable)		MA/GA two-digit code
Email address	Primary phone	Fax
Agent's first and last name		Agent five-digit code
Agent's signature		Date agent accepted application
Name of person who entered application online	Blue Cross badge ID E_____ or C_____	Blue Cross source code

Applications must be submitted online at **www.bcbsm.com/agents** or submitted to the managing agent or general agent within 24 hours of accepting the applicant's paper application.

Notice to applicant about replacement of Medicare supplement coverage

Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
Detroit, Michigan 48226

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

According to your application or the information you furnished, you intend to drop or otherwise terminate existing Medicare supplement coverage or a Medicare Advantage plan and replace it with a new certificate to be issued by Blue Cross Blue Shield of Michigan. Your new certificate provides 30 days within which you may decide, without cost, whether you want to keep the certificate.

You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by Blue Cross' Medicare supplement agent, broker or other representative:

I've reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction doesn't duplicate your existing Medicare supplement, or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan, to the best of my knowledge. The replacement plan is being purchased for the following reason (check one):

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ Enrolling in Part D and current plan has drug coverage

☐ Disenrollment from a Medicare Advantage plan

Reason for disenrollment _____

☐ Other (please specify) _____

☐ **Didn't replace existing Medicare supplement coverage**

If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all important medical information on an application may provide a basis for the insurer to deny any future claims and refund your premium as though your policy or certificate had never been in force. Before you sign your completed application, review it carefully to be certain that all information has been properly recorded.

Don't cancel your present policy until you've received your new certificate and are sure you want to keep it.

Please select the option below that applies to you:

☐ The *Notice to Applicant* was delivered to me on (date): _____

☐ I delivered this *Notice to Applicant* to the applicant on (date): _____

Signature of agent, broker or other representative (signature not required for direct response sales)		Date	
Printed name of agent		Agent number	
Agent's street address	City	State	ZIP code

Applicant's signature		Date	
Printed name of applicant			
Applicant's street address	City	State	ZIP code
Policy, certificate or contract number being replaced			

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

For Members: Selecting Medicare Supplement Plans | BCBSM

This is a solicitation of insurance. We may contact you about buying insurance.
Blue Cross Medicare Supplement plans aren't connected with or endorsed by the
U.S. government or the federal Medicare program.

2024

READY TO HELP

Confidence comes with every card.®

Blue Cross Medicare Supplement℠

Outline of Medicare supplement coverage — Plans A, C, D, F, High-Deductible F, G, High-Deductible G and N

Medicare supplement coverage offered by Blue Cross Blue Shield of Michigan

www.bcbsm.com/medicare-supplement

Table of contents

Medicare supplement made easy.....3

Plans across the country.....4-5

Eligibility and premiums.....6

Choose a plan option.....7

Plans A, C and D.....8-9

2024 Outline of coverage benefit charts.....10-13

Dental Vision Hearing Package.....14-17

Well-Being Program.....18-19

Household discount..... 20-21

Guaranteed issue right.....22-23

Find your estimated premium.....24

2024 Premium charts.....25-39

Enrollment.....40

Payment options.....41

Change/cancel plan.....42

Terms defined.....43

Medicare Supplement
made easy

Becoming eligible for Medicare means you have new options for health care.

Medicare supplement, also called Medigap, is a health care policy purchased through a private insurance company that works with Original Medicare.

To purchase a Medicare supplement plan, you need to have Part A (hospital) and Part B (medical) coverage through Original Medicare.

Supplement plans can be sold in 10 standard plans and two high-deductible plans. The Medicare supplement standard plans are A, B, C, D, F, G, K, L, M and N.*

Private insurers may offer a variation of these plans, but every supplement insurer must make Plan A available.

Plan A includes these basic benefits:

- **Hospitalization:** Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
- **Medical expenses:** Medicare Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services
- **Blood:** First three pints of blood per calendar year

Blue Cross Medicare Supplement offers plans A, C, D, F, G and N plus High-Deductible F and High-Deductible G.

Other Michigan insurance carriers may offer other plans in addition to Plan A.

**Plans E, H, I and J are no longer available for sale and Plans B, K, L and M aren't offered by Blue Cross.*

Medicare supplement
plans across the country

Benefits	A
Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✔
Medicare Part B coinsurance or copay	✔
Blood (first three pints)	✔
Part A hospice care coinsurance or copay	✔
Skilled nursing facility care coinsurance	
Medicare Part A deductible	
Medicare Part B deductible	
Medicare Part B excess charges	
Foreign travel emergency (up to plan limits)	

If a row is blank, the benefit isn't a part of that policy. Note: The supplement policy pays for coinsurance only after you've paid the deductible unless the supplement policy also pays the deductible. Some policies pay for a portion of the deductible.

[1]*There are also two high-deductible plans, HD-F and HD-G. If you are eligible for either plan and decide to enroll, this means you must pay for Medicare-covered costs up to the deductible amount of $2,800 for 2024 before your supplement plan pays anything.*

[2]*For plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($240 for 2024), the Medicare supplement plan pays 100% of included services for the rest of the calendar year.*

All nationwide plans								
B	C	D	F[1]	G[1]	K	L	M	N
✔	✔	✔	✔	✔	✔	✔	✔	✔
✔	✔	✔	✔	✔	50%	75%	✔	✔[3]
✔	✔	✔	✔	✔	50%	75%	✔	✔
✔	✔	✔	✔	✔	50%	75%	✔	✔
	✔	✔	✔	✔	50%	75%	✔	✔
✔	✔	✔	✔	✔	50%	75%	50%	✔
	✔		✔					
			✔	✔				
	80%	80%	80%	80%			80%	80%
					Out-of-pocket limit[2]			
					$7,060 in 2024	$3,530 in 2024		

Currently Blue Cross does not offer Plans B, K, L and M.

Plans C, F and HD-F are only available to those who have Medicare start dates before January 1, 2020.

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

Blue Cross Medicare Supplement
eligibility and premiums

Anyone who has Medicare Part A and Part B and lives in Michigan at least six months of the year at the time of enrollment is eligible to enroll in a Blue Cross Medicare Supplement plan. Once enrolled, the premium may change if a member moves out of Michigan or lives in Michigan less than six months of the year.

The monthly premium for Blue Cross Medicare Supplement Plans is based on where you live, your age and gender. There are also certain situations when medical underwriting is necessary, which means your health status and use of nicotine in any form* are used to determine your premium amount.

The deductibles, coinsurance and copay amount of all Medicare supplement plans are set each year by the Centers for Medicare & Medicaid Services. These amounts are subject to change each plan year.

Your premium **won't** be affected by your nicotine use, health status (including body mass index value), claims experience, receipt of health care or medical condition, if you:

- Apply during your Medigap Open Enrollment Period
- Have a situation that **qualifies as a guaranteed issue right**

* Nicotine products include but are not limited to, cigarettes, e-cigarettes, vaping, and nicotine patches or gum.

READY TO HELP

MICHIGAN

Choose a plan option that meets your needs.

The charts on pages 10 through 13 outline the coverage options offered by Blue Cross plans A, C, D, F, G and N as well as High-Deductible F and High-Deductible G. This *Outline of Coverage* doesn't give all the details of Medicare coverage. For information about your Medicare Part A and Part B coverage, contact your local Social Security office or consult *Medicare & You* (online at **www.medicare.gov**). Medicare benefits are subject to change. Please consult the latest *Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*, which can be found online at **www.medicare.gov**.

Once enrolled in Blue Cross Medicare Supplement, we'll send you a member ID card and plan handbook that provides comprehensive details about your coverage. We'll also provide a *Certificate of Coverage* in your member portal. It's your legal contract with Blue Cross. We encourage you to read the certificate to understand all of the rights and duties of both you and Blue Cross. For more information about Blue Cross Medicare Supplement coverage, call **1-888-563-3307** or contact an insurance agent authorized to sell Blue Cross policies. TTY users should call **711**.

Important information about Plans A, C and D

If you're interested in enrolling in Plan A, you're eligible if ...

- You're eligible for Medicare **and one of the following:**
  - You've lost coverage under a group policy after becoming eligible for Medicare
  - You were enrolled in Plan A, subsequently enrolled in a Medicare Advantage plan and now would like to return to Plan A (but only if you're returning within the first 12 months of enrolling in the Medicare Advantage plan)

If you're interested in enrolling in Plan C, you're eligible if ...

- You turned 65 years old, or became eligible for Medicare due to disability or end stage renal disease, before Jan. 1, 2020, **and one of the following:**
  - You've lost coverage under a group policy after becoming eligible for Medicare
  - You were enrolled in Plan C, subsequently enrolled in a Medicare Advantage plan and now would like to return to Plan C (but only if you're returning within the first 12 months of enrolling in the Medicare Advantage plan)

If you're interested in enrolling in Plan D, you're eligible if ...

- You turned 65 years old, or became eligible for Medicare due to disability or end stage renal disease, on or after Jan. 1, 2020, **and one of the following:**
  - You've lost coverage under a group policy after becoming eligible for Medicare
  - You were enrolled in Plan D, subsequently enrolled in a Medicare Advantage plan and now would like to return to Plan D (but only if you're returning within the first 12 months of enrolling in the Medicare Advantage plan)

If you're younger than 65, you're only eligible for Plans A and D.

	Became eligible for Medicare or turned 65 before Jan. 1, 2020	Became eligible for Medicare or turned 65 on or after Jan. 1, 2020
Plan A	Available	Available
Plan C	Available	
Plan D	Available	Available

Blue Cross Medicare Supplement Outline of Coverage

The Medicare deductibles, coinsurance and copay amounts listed are based upon the 2024 CMS-approved values and could change for 2025.

Covered service	Plan option	Plan A[1]	
	Medicare pays	Plan pays	You pay
Medicare Part A hospital coverage — Semi-private room, general nursing care, miscellaneous services and supplies[2]			
Deductible	$0	$0	$1,632
First 60 days of care	100%	$0	$0
Days 61 to 90	All but the $408 daily copay	$408 daily copay	$0
Days 91 to 150 (lifetime reserve days)	All but the $816 daily copay	$816 daily copay	$0
Day 151 and beyond (additional 365 days after lifetime reserve days used)	$0	100% of Medicare-eligible expenses	$0
Blood benefit	All but the first three pints	Your first three pints	$0
Skilled nursing facility care — including having been in a hospital for at least three days			
First 20 days of care	100%	$0 (Medicare covers in full)	
Days 21 to 100	All but $204 daily skilled nursing facility copay	$0	$204 daily copay
Hospice care			
	All but very limited copay/coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0
Emergency care outside the U.S.			
	No benefits for care outside U.S.	No benefits for care outside U.S.	All costs[2] for services
Medicare Part B physician and outpatient services — In- or out-of-the-hospital and outpatient hospital physician's services (such as tests), and durable medical equipment, per calendar year			
Deductible (annual)[3]	$0	$0	$240
Coinsurance	80% of the approved amount after $240 deductible is met	20% coinsurance after the $240 deductible is met	$0
Blood benefit	All but the first three pints	Your first three pints	$0
Clinical laboratory services — tests for diagnostic services	All charges	$0 (Medicare covers in full)	
Home health care services — Medicare-approved services			
Medically necessary skilled care services and medical supplies	All charges	$0 (Medicare covers in full)	
Durable medical equipment	80% of the approved amount after the $240 deductible is met	20% coinsurance after the $240 deductible is met	$0
Excess charges	$0	$0	All costs

[1]See Important Information about Plans A, C and D on pages 8 and 9.

[2]Per benefit period. A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you've been out of the hospital and haven't received skilled nursing care in any other facility for 60 consecutive days.

[3]The Part B deductible needs to be met only once each calendar year (Jan. 1 through Dec. 31). After, Medicare makes payments up to the limiting charge established by law and shown on your Medicare explanation of benefits.

Plan C[1]	
Plan pays	**You pay**
$1,632	$0
$0	$0
$408 daily copay	$0
$816 daily copay	$0
100% of Medicare-eligible expenses	$0
Your first three pints	$0
$0 (Medicare covers in full)	
$204 daily copay	$0
Medicare copay/ coinsurance	$0
80% of approved amount for covered services after $250 deductible is met. Lifetime maximum of $50,000	$250 deductible, plus 20% coinsurance
$240	$0
20% coinsurance after the $240 deductible is met	$0
Your first three pints	$0
$0 (Medicare covers in full)	
$0 (Medicare covers in full)	
20% coinsurance after the $240 deductible is met	$0
$0	All costs

Plan D[1]	
Plan pays	**You pay**
$1,632	$0
$0	$0
$408 daily copay	$0
$816 daily copay	$0
100% of Medicare-eligible expenses	$0
Your first three pints	$0
$0 (Medicare covers in full)	
$204 daily copay	$0
Medicare copay/ coinsurance	$0
80% of approved amount for covered services after $250 deductible is met. Lifetime maximum of $50,000	$250 deductible, plus 20% coinsurance
$0	$240
20% coinsurance after the $240 deductible is met	$0
Your first three pints	$0
$0 (Medicare covers in full)	
$0 (Medicare covers in full)	
20% coinsurance after the $240 deductible is met	$0
$0	All costs

Covered service	Plan option	Plans F and HD-F[4]	
	Medicare pays	Plan pays	You pay
Medicare Part A hospital coverage — Semi-private room, general nursing care, miscellaneous services and supplies[2]			
Deductible	$0	$1,632	$0
First 60 days of care	100%	$0	$0
Days 61 to 90	All but the $408 daily copay	$408 daily copay	$0
Days 91 to 150 (lifetime reserve days)	All but the $816 daily copay	$816 daily copay	$0
Day 151 and beyond (additional 365 days after lifetime reserve days used)	$0	100% of Medicare-eligible expenses	$0
Blood benefit	All but the first three pints	Your first three pints	$0
Skilled nursing facility care — You must meet Medicare's requirements, including having been in a hospital for at least three days			
First 20 days of care	100%	$0 (Medicare covers in full)	
Days 21 to 100	All but $204 daily skilled nursing facility copay	$204 daily copay	$0
Hospice care			
	All but very limited copay/coinsurance for outpatient drugs and inpatient respite care	Medicare copay/ coinsurance	$0
Emergency care outside the U.S.			
	No benefits for care outside U.S.	80% of approved amount for covered services, after $250 deductible is met. Lifetime maximum of $50,000	$250 deductible, plus 20% coinsurance
Medicare Part B physician and outpatient services — In- or out-of-the-hospital and outpatient hospital physician's services, (such as tests) and durable medical equipment, per calendar year			
Deductible (annual)[3]	$0	$240	$0
Coinsurance	80% of the approved amount after the $240 deductible is met	20% coinsurance after the $240 deductible is met	$0
Blood benefit	All but the first three pints	Your first three pints	$0
Clinical laboratory services — tests for diagnostic services	All charges	$0 (Medicare covers in full)	
Home health care services — Medicare-approved services			
Medically necessary skilled care services and medical supplies	All charges	$0 (Medicare covers in full)	
Durable medical equipment	80% of the approved amount after the $240 deductible is met	20% coinsurance after the $240 deductible is met	$0
Excess charges	$0	All remaining charges	$0

[2]Per benefit period. A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you've been out of the hospital and haven't received skilled nursing care in any other facility for 60 consecutive days.
[3]The Part B deductible needs to be met only once each calendar year (Jan. 1 through Dec. 31). After, Medicare makes payments up to the limiting charge established by law and shown on your Medicare explanation of benefits.
[4]See Pages 4 and 5 for information about Plans HD-F and HD-G.

Plans G and HD-G[4]		Plan N	
Plan pays	**You pay**	**Plan pays**	**You pay**
$1,632	$0	$1,632	$0
$0	$0	$0	$0
$408 daily copay	$0	$408 daily copay	$0
$816 daily copay	$0	$816 daily copay	$0
100% of Medicare-eligible expenses	$0	100% of Medicare-eligible expenses	$0
Your first three pints	$0	Your first three pints	$0
$0 (Medicare covers in full)		$0 (Medicare covers in full)	
$204 daily copay	$0	$204 daily copay	$0
Medicare copay/ coinsurance	$0	Medicare copay/ coinsurance	$0
80% of approved amount for covered services, after $250 deductible is met. Lifetime maximum of $50,000	$250 deductible, plus 20% coinsurance	80% of approved amount for covered services, after $250 deductible is met. Lifetime maximum of $50,000	$250 deductible, plus 20% coinsurance
$0	$240	$0	$240
20% coinsurance after the $240 deductible is met	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit, after the $240 deductible is met	Up to $20 per office visit and up to $50 per emergency room visit
Your first three pints	$0	Your first three pints	$0
$0 (Medicare covers in full)		$0 (Medicare covers in full)	
$0 (Medicare covers in full)		$0 (Medicare covers in full)	
20% coinsurance after the $240 deductible is met	$0	20% coinsurance after the $240 deductible is met	$0
All remaining charges	$0	$0	All remaining charges

Dental Vision Hearing Package

Our Dental Vision Hearing Package is essential to your best health.

Get three for one price

- Add dental, vision and hearing coverage for an additional $29.50 per month.*
- The Dental Vision Hearing Package is sold as one package. Dental, vision or hearing benefits cannot be purchased separately.
- You must have an active Blue Cross Medicare Supplement or Legacy Medigap plan to enroll in the Dental Vision Hearing Package.
- You may not have dental, vision or hearing coverage through another individual plan.

Available for new and existing members

- The Dental Vision Hearing Package is available to new Blue Cross Medicare Supplement members and existing Blue Cross Medicare Supplement and Legacy Medigap members.
- If you're new to Blue Cross Supplement, you have the option to add the Dental Vision Hearing Package at enrollment or within the first 30 days following the policy start date.
- As an existing Blue Cross Medicare Supplement and Legacy Medigap member, you can add the Dental Vision Hearing Package between Feb. 1 and April 30 each year. Contact an agent or apply electronically at www.bcbsm.com/medicare/help/forms-documents/enrollment.html.

**The premium for the Dental Vision Hearing Package will be reevaluated each year and is subject to change.*

Dental services

	In-network	Out-of-network
Deductible	$0	$0
Exams: Two per calendar year **Cleanings:** Two per calendar year **Fluoride:** Once per calendar year **Brush biopsy:** Once per calendar year **X-rays:** Once every two calendar years EITHER -One set of up to four bitewings OR -Six periapical films	0% coinsurance	50% coinsurance
Annual maximum Combined in- and out-of-network. Applies to services below.	$1,500	
Amalgam and resin fillings: Once per tooth every 48 months **Root canals:** Once per tooth, per lifetime **Simple extractions** **Crown:** for permanent teeth, once per tooth every 84 months **Crown repairs**	50% coinsurance	50% coinsurance

Finding an in-network dentist

Visit **www.MIBlueDentist.com** and choose *Medicare Supplement* to search for in-network dentists or call Customer Service at **1-888-826-8152**.

Check out the Blue Dental℠ resource center for additional dental health information.

The Blue Dental resource center allows you to:

- Get dental procedure cost estimates by ZIP code
- Take an oral assessment to identify dental risk factors
- Ask a dentist a question

To access the Blue Dental resource center, go to **www.bcbsm.com** and log in to your member account. Click *My Coverage* at the top, and select *Dental*.

Vision services

	In-network	Out-of-network
Frames or elective contact lenses	$300 allowance for frames or elective contact lenses every 12 months	Frames reimbursed up to $70 or elective contact lenses reimbursed up to $105 every 12 months
Lenses	Standard lenses[4] are covered in full every 12 months	Reimbursement, every 12 months, up to: • Single-vision lenses: $30 • Bifocal lenses: $50 • Trifocal lenses: $65 • Lenticular lenses: $100
Exams	$20 copayment; offered every 12 months	Reimbursed up to $45 every 12 months

[4]Standard lenses include single vision lenses, bifocal lenses and trifocal lenses

Finding an in-network eye doctor

Visit **www.vsp.com** to find a VSP network eye care provider or to find out if your eye care provider participates. You can also call **1-800-877-7195** to speak to a VSP Customer Service representative.

Hearing services

Hearing exam	Included			
Frequency	One hearing aid per ear every 12 months			
Network	TruHearing			
Hearing aids				
	Basic	**Standard**	**Advanced**	**Premium**
You pay	$495 per ear	$895 per ear	$1,295 per ear	$1,695 per ear
Preferred listening environment	• Best for quiet or mild environments, such as 1-on-1 conversations	• Best for predictable environments, such as home	• Best for more challenging environments, such as offices or when in motion	• Best for challenging environments, such as restaurants or when in large groups of people
Features	• Limited noise reduction • Basic feedback cancellation	• Noise reduction • Adjustable speech enhancement	• Noise reduction • Adjustable speech enhancement • Artificial intelligence technology	• Automatic noise reduction • Adjustable speech enhancement • Adaptive directional microphone • Impulse sound management

Finding a TruHearing hearing specialist

Call TruHearing at **1-844-825-0033** to speak to a hearing consultant who can answer any questions and assist you in scheduling an appointment with a provider near you. **You must use a TruHearing provider to receive benefits**.

Think you might have hearing loss? In the comfort of your home, you can try TruHearing's free, fast, online screening. Accessible from your tablet, computer or smartphone. Visit **www.TruHearing.com/BCBSMI** to find the five-minute hearing assessment located on their home page.

Medicare Supplement Well-Being Program

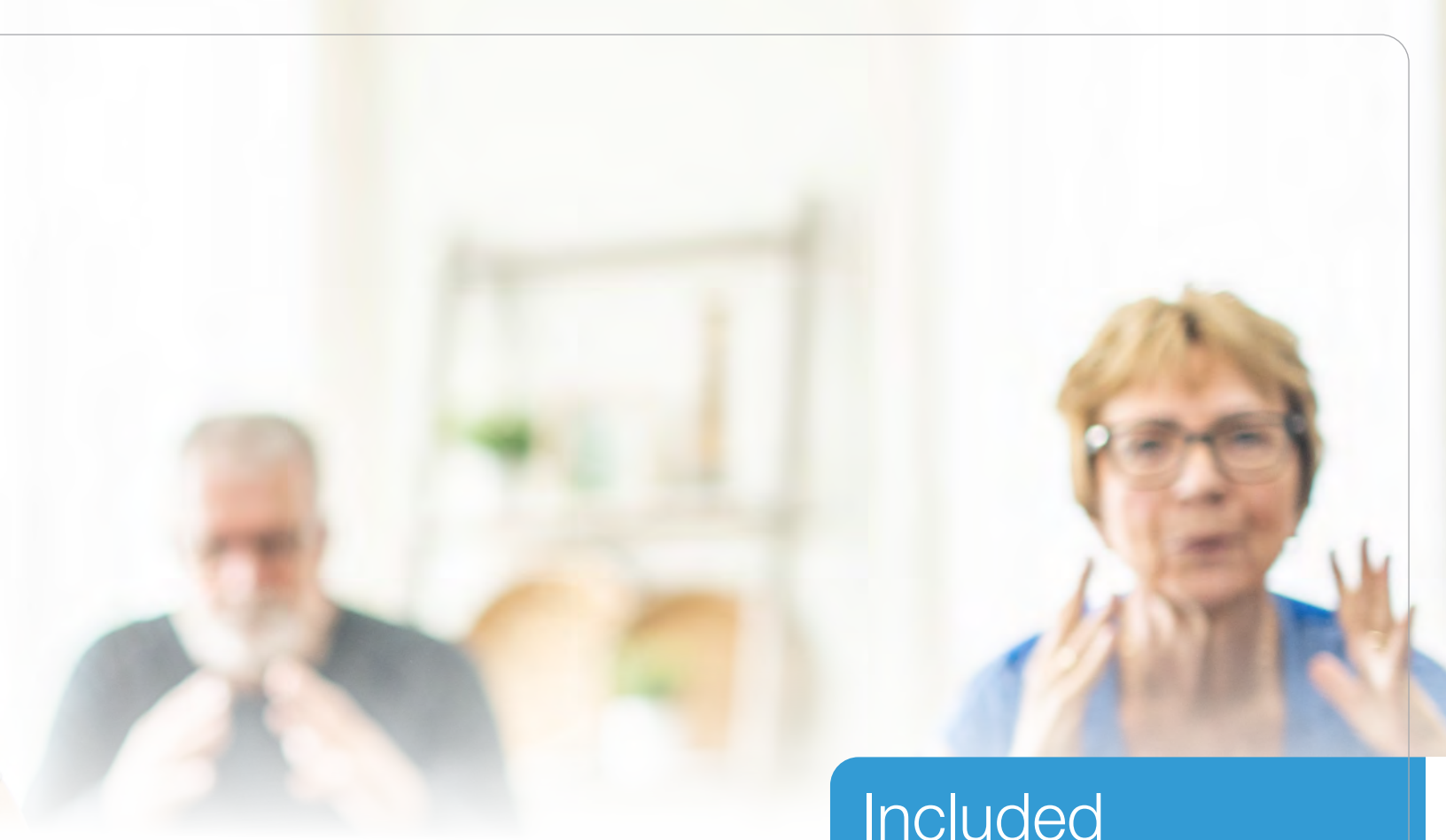
Real support for real life

Our Blue Cross Medicare Supplement℠ Well-Being Program helps you live your best life. As a member, you have advantages that will let you experience life's adventures with Blue Cross confidence. You choose the Medicare supplement plan you want, and we'll supply the well-being support you need to fulfill your personal health goals.

We're ready to help you live a healthier, happier life

READY TO HELP

MICHIGAN



Included
in your membership ...

24-Hour Nurse Line

Talk to a registered nurse about a minor illness or injury. Call the nurse line to discuss a procedure, symptoms or your health status.

Blue Cross® Virtual Well-Being

Begin a personal journey by attending our virtual well-being webinars. Each week you can access a new high-energy presentation from your computer, tablet or mobile phone. Topics include home fitness, social isolation, healthy cooking and gardening. Plus, you can download session materials to save and share with your family and caregivers.

Blue365® discounts

Show your Blue Cross member ID card to get nationwide savings for health magazines, cooking classes, weight-loss programs and retail stores. Plus save on healthy food and vitamin deliveries, travel accommodations, fitness programs and wearable fitness trackers. Get a list of current savings at **www.blue365deals.com**.

Do you qualify for a household discount?

You may be eligible to save 10% on your monthly Blue Cross Medicare Supplement plan premium.

If you're a new member

Save when you and another Medicare-eligible individual in your household apply for Blue Cross Medicare Supplement plans at the same time. Or get the discount if a household member is currently covered by a Blue Cross Medicare Supplement or Legacy Medigap plan when you apply.

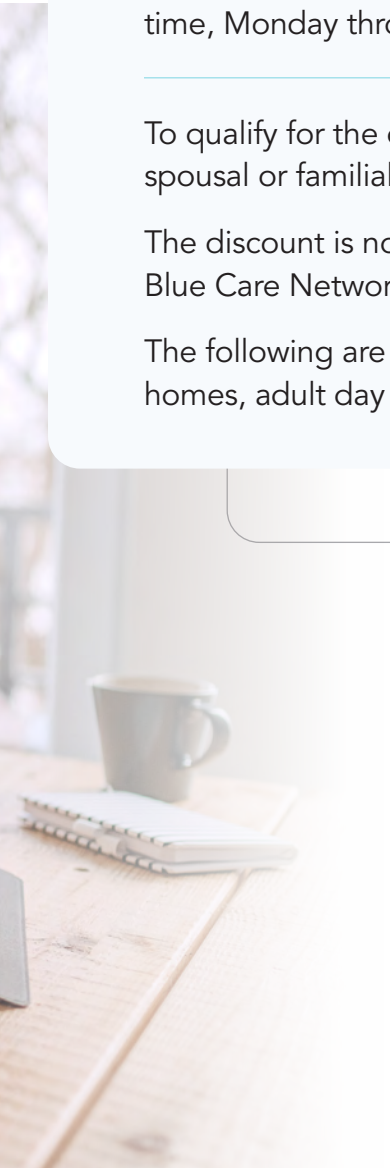
If you're an existing member

Apply for the discount if you and any other household members are currently enrolled in a Blue Cross Medicare Supplement or Legacy Medigap plan. Two or more existing Blue Cross Medicare Supplement or Legacy Medigap members in the same household must complete an *Application for Medicare Supplement Household Discount*. Access the form online at **www.bcbsm.com/medicare/help/understanding-plans/supplement/household-discounts.html**. You can also call Customer Service to apply at **1-888-216-4858** from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call **711**.

To qualify for the discount, the policy holders only need to reside in the same household, a spousal or familial relationship isn't necessary.

The discount is not available to members with Medicare Advantage plans from Blue Cross or Blue Care Network or MyBlue℠ Medigap plans from Blue Care Network.

The following are not included in the definition of household: Assisted living facilities, group homes, adult day care facilities, nursing homes or any other health residential facilities.



Do you qualify for a guaranteed issue right?

Insurance companies are required by law to offer a Medicare supplement policy without conditions or constraints on coverage to individuals who meet certain requirements. If you're applying during your **Medigap Open Enrollment Period** (known as OEP), which lasts for six months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B (for example, you elect Part B upon retirement at age 70), you already have a guaranteed issue right and do not need any of the following to apply to you.

If you are not within your Medigap Open Enrollment Period, any of the following scenarios qualify you for a guaranteed issue right:

1. You were enrolled in an employer group health care plan (including retiree or COBRA coverage) that pays after Medicare pays and that plan has ended within the past 63 days.
2. You were enrolled in a Medicare Advantage plan, Program of All-Inclusive Care for the Elderly, Health Care Pre-Payment Plan, other Medicare demonstration project or Medicare Select plan and within the past 63 days:
    - The certification of the organization or plan was terminated.
    - The plan terminated or discontinued providing coverage in the area in which you reside.
    - You moved out of the plan's service area and are no longer eligible to participate in the plan.
    - You voluntarily disenrolled because the plan substantially violated a material provision of the organization's contract with you. This includes:
        - Failing to provide an enrollee, on a timely basis, medically necessary care for which benefits are available under the plan
        - Failing to provide covered care in accordance with applicable standards
        - The organization, agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to you

3. You voluntarily disenrolled from a Medicare Advantage plan within 12 months after the effective date of enrollment, upon first becoming eligible for benefits under Medicare Part A at age 65.
4. You were enrolled in a supplement policy within the past 63 days and one of the following:
    - You involuntarily lost coverage due to insolvency of the insurer or bankruptcy of the organization offering the coverage.
    - You voluntarily disenrolled because the plan violated a material provision of the policy or the insurer materially misrepresented the policy's provisions in marketing the policy to you.
5. You terminated enrollment and subsequently enrolled, for the first time, in a Medicare Advantage plan, Medicare Select Plan, Medicare Cost Plan or Program of All-Inclusive Care for the Elderly, and the subsequent enrollment was terminated by you within the first 12 months.

Find your estimated monthly premium cost

1. Select a plan option: Plan A, C, D, F, High-Deductible F, G, High-Deductible G or N.

2. Using the following tables:

- If you're in your Medigap Open Enrollment Period or have a guaranteed issue right, use the tables on pages 25 through 28 to find your monthly premium.
- If you're not in your Medigap Open Enrollment Period and don't have a guaranteed issue right, use the tables on pages 29 through 35.
- If you're younger than 65, use the tables on pages 36 and 37.
- If you qualify for Conversion Plans A, C or D, use the table on pages 38 and 39.

3. If you turned 65 or became eligible for Medicare after Dec. 31, 2019, you're not eligible to enroll in a plan that covers the Part B deductible (Plans C, F or High-Deductible F).

4. Find your area:

- If you live in a ZIP code that begins with 480 through 485, you're in Area 1.
- If you live in any other ZIP code in Michigan, you're in Area 2.

5. Once you find the correct table, scroll down the first column to find your age.

6. Your premium will be shown at the right, based on:

  – Your gender

  – Whether you use nicotine in any form including, but not limited to, cigarettes, e-cigarettes, vaping, nicotine patches or gum

  – If you're applying outside of your Medigap OEP

  – If you have a guaranteed issue right

7. Note: The rates in the following tables are valid for new members and members that were new as of 4/1/2024.

Monthly premiums for individuals applying

during their Medigap open enrollment period or have a guaranteed issue right

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan **A** guaranteed issue rates				
	Area 1 (Southeast Michigan)		**Area 2** (Rest of Michigan)	
Age	**Male**	**Female**	**Male**	**Female**
65	$120.57	$114.83	$116.47	$110.92
66	$127.75	$121.09	$123.40	$116.97
67	$135.00	$127.35	$130.40	$123.02
68	$141.19	$132.57	$136.39	$128.06
69	$147.44	$137.79	$142.42	$133.10
70	$153.33	$141.97	$148.11	$137.14
71	$159.30	$146.14	$153.88	$141.17
72	$165.35	$150.32	$159.73	$145.20
73	$171.49	$154.50	$165.65	$149.24
74	$177.71	$158.67	$171.66	$153.27
75	$181.66	$160.76	$175.48	$155.29
76	$185.64	$162.85	$179.33	$157.31
77	$189.67	$164.93	$183.22	$159.32
78	$193.75	$167.02	$187.15	$161.34
79	$197.86	$169.11	$191.13	$163.36
80 and older	$202.01	$171.20	$195.14	$165.37

These rates don't include the premium for the optional Dental Vision Hearing Package.
Rates are subject to change each year.

Monthly premiums for individuals applying ***during their Medigap OEP or have a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan G guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$146.12	$139.16	$141.15	$134.43
66	$157.72	$149.50	$152.35	$144.41
67	$169.42	$159.83	$163.65	$154.39
68	$179.39	$168.44	$173.28	$162.71
69	$189.44	$177.05	$183.00	$171.03
70	$198.65	$183.94	$191.89	$177.68
71	$208.00	$190.83	$200.92	$184.33
72	$217.49	$197.72	$210.09	$190.99
73	$227.11	$204.61	$219.38	$197.64
74	$236.87	$211.49	$228.81	$204.30
75	$242.88	$214.94	$234.62	$207.62
76	$248.96	$218.38	$240.49	$210.95
77	$255.10	$221.83	$246.42	$214.28
78	$261.31	$225.27	$252.42	$217.61
79	$267.60	$228.72	$258.49	$220.93
80 and older	$273.95	$232.16	$264.63	$224.26

Blue Cross Medicare Supplement Plan HD-G* guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$76.89	$73.23	$74.27	$70.73
66	$82.99	$78.66	$80.17	$75.99
67	$89.15	$84.10	$86.11	$81.24
68	$94.39	$88.63	$91.18	$85.62
69	$99.68	$93.16	$96.29	$89.99
70	$104.53	$96.79	$100.97	$93.49
71	$109.45	$100.41	$105.73	$97.00
72	$114.44	$104.04	$110.55	$100.50
73	$119.50	$107.66	$115.44	$104.00
74	$124.64	$111.29	$120.40	$107.50
75	$127.80	$113.10	$123.45	$109.25
76	$131.00	$114.91	$126.54	$111.00
77	$134.23	$116.72	$129.67	$112.75
78	$137.50	$118.54	$132.82	$114.50
79	$140.81	$120.35	$136.02	$116.25
80 and older	$144.15	$122.16	$139.25	$118.00

**HD means high deductible*
Rates are subject to change each year.

Monthly premiums for individuals applying ***during their Medigap OEP or have a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan N guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$146.17	$139.21	$141.19	$134.47
66	$157.77	$149.54	$152.40	$144.46
67	$169.47	$159.88	$163.71	$154.44
68	$179.45	$168.49	$173.34	$162.76
69	$189.50	$177.11	$183.06	$171.08
70	$198.72	$184.00	$191.96	$177.74
71	$208.07	$190.89	$200.99	$184.39
72	$217.56	$197.78	$210.16	$191.05
73	$227.19	$204.67	$219.45	$197.71
74	$236.95	$211.56	$228.89	$204.36
75	$242.96	$215.01	$234.69	$207.69
76	$249.04	$218.45	$240.56	$211.02
77	$255.18	$221.90	$246.50	$214.35
78	$261.40	$225.34	$252.50	$217.68
79	$267.68	$228.79	$258.58	$221.00
80 and older	$274.04	$232.24	$264.71	$224.33

Blue Cross Medicare Supplement Plan D guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$170.13	$162.03	$164.34	$156.51
66	$183.63	$174.06	$177.38	$168.14
67	$197.25	$186.09	$190.54	$179.76
68	$208.86	$196.11	$201.76	$189.44
69	$220.57	$206.14	$213.06	$199.13
70	$231.29	$214.16	$223.42	$206.87
71	$242.18	$222.18	$233.94	$214.62
72	$253.22	$230.20	$244.61	$222.37
73	$264.43	$238.22	$255.43	$230.12
74	$275.79	$246.24	$266.41	$237.86
75	$282.79	$250.25	$273.16	$241.74
76	$289.86	$254.26	$280.00	$245.61
77	$297.02	$258.27	$286.91	$249.49
78	$304.25	$262.28	$293.90	$253.36
79	$311.56	$266.29	$300.96	$257.23
80 and older	$318.96	$270.31	$308.11	$261.11

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.

Monthly premiums for individuals applying ***during their Medigap OEP or have a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan F guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$208.25	$198.33	$201.16	$191.58
66	$224.77	$213.06	$217.13	$205.81
67	$241.45	$227.78	$233.23	$220.03
68	$255.66	$240.06	$246.96	$231.89
69	$269.99	$252.33	$260.80	$243.74
70	$283.12	$262.14	$273.48	$253.22
71	$296.44	$271.96	$286.35	$262.71
72	$309.96	$281.78	$299.41	$272.19
73	$323.67	$291.60	$312.66	$281.68
74	$337.59	$301.42	$326.10	$291.16
75	$346.15	$306.32	$334.37	$295.90
76	$354.81	$311.23	$342.73	$300.64
77	$363.56	$316.14	$351.19	$305.38
78	$372.42	$321.05	$359.75	$310.13
79	$381.37	$325.96	$368.40	$314.87
80 and older	$390.42	$330.87	$377.14	$319.61

Blue Cross Medicare Supplement Plan HD-F* guaranteed issue rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
65	$79.49	$75.71	$76.79	$73.13
66	$85.80	$81.33	$82.88	$78.56
67	$92.17	$86.95	$89.03	$83.99
68	$97.59	$91.63	$94.27	$88.51
69	$103.06	$96.32	$99.55	$93.04
70	$108.07	$100.06	$104.39	$96.66
71	$113.16	$103.81	$109.30	$100.28
72	$118.32	$107.56	$114.29	$103.90
73	$123.55	$111.31	$119.35	$107.52
74	$128.86	$115.05	$124.48	$111.14
75	$132.13	$116.93	$127.63	$112.95
76	$135.43	$118.80	$130.83	$114.76
77	$138.78	$120.68	$134.06	$116.57
78	$142.16	$122.55	$137.32	$118.38
79	$145.58	$124.42	$140.62	$120.19
80 and older	$149.03	$126.30	$143.96	$122.00

**HD means high deductible*

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.
If you were eligible for Medicare on or after January 1, 2020, you are not eligible for Plan F or High-Deductible Plan F.

Monthly premiums for individuals applying
outside of a Medigap OEP or without a guaranteed issue right

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan A nonguaranteed issue rates

Age	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
	Male	Female	Male	Female	Male	Female	Male	Female
65	$120.57	$114.83	$132.63	$126.31	$116.47	$110.92	$128.11	$122.01
66	$127.75	$121.09	$140.53	$133.20	$123.40	$116.97	$135.74	$128.67
67	$135.00	$127.35	$148.49	$140.09	$130.40	$123.02	$143.44	$135.32
68	$141.19	$132.57	$155.31	$145.83	$136.39	$128.06	$150.03	$140.87
69	$147.44	$137.79	$162.18	$151.57	$142.42	$133.10	$156.66	$146.41
70	$153.33	$141.97	$168.66	$156.17	$148.11	$137.14	$162.92	$150.85
71	$159.30	$146.14	$175.23	$160.76	$153.88	$141.17	$169.26	$155.29
72	$165.35	$150.32	$181.89	$165.35	$159.73	$145.20	$175.70	$159.73
73	$171.49	$154.50	$188.64	$169.94	$165.65	$149.24	$182.22	$164.16
74	$177.71	$158.67	$195.48	$174.54	$171.66	$153.27	$188.83	$168.60
75	$181.66	$160.76	$199.82	$176.83	$175.48	$155.29	$193.02	$170.82
76	$185.64	$162.85	$204.21	$179.13	$179.33	$157.31	$197.26	$173.04
77	$189.67	$164.93	$208.64	$181.43	$183.22	$159.32	$201.54	$175.25
78	$193.75	$167.02	$213.12	$183.72	$187.15	$161.34	$205.87	$177.47
79	$197.86	$169.11	$217.64	$186.02	$191.13	$163.36	$210.24	$179.69
80 and older	$202.01	$171.20	$222.21	$188.32	$195.14	$165.37	$214.65	$181.91

Individuals applying outside of their Medigap OEP or without a guaranteed issue right may be subject to higher rates than what's shown above due to claims experience or health status.

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan G nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$146.12	$139.16	$160.73	$153.08	$141.15	$134.43	$155.26	$147.87
66	$157.72	$149.50	$173.49	$164.44	$152.35	$144.41	$167.59	$158.85
67	$169.42	$159.83	$186.36	$175.81	$163.65	$154.39	$180.02	$169.83
68	$179.39	$168.44	$197.33	$185.28	$173.28	$162.71	$190.61	$178.98
69	$189.44	$177.05	$208.39	$194.76	$183.00	$171.03	$201.30	$188.13
70	$198.65	$183.94	$218.52	$202.33	$191.89	$177.68	$211.08	$195.45
71	$208.00	$190.83	$228.80	$209.91	$200.92	$184.33	$221.02	$202.77
72	$217.49	$197.72	$239.24	$217.49	$210.09	$190.99	$231.10	$210.09
73	$227.11	$204.61	$249.82	$225.07	$219.38	$197.64	$241.32	$217.41
74	$236.87	$211.41	$260.56	$232.64	$228.81	$204.30	$251.69	$224.73
75	$242.88	$214.94	$267.17	$236.43	$234.62	$207.62	$258.08	$228.39
76	$248.96	$218.38	$273.85	$240.22	$240.49	$210.95	$264.53	$232.05
77	$255.10	$221.83	$280.61	$244.01	$246.42	$214.28	$271.06	$235.71
78	$261.31	$225.27	$287.45	$247.80	$252.42	$217.61	$277.67	$239.37
79	$267.60	$228.72	$294.36	$251.59	$258.49	$220.93	$284.34	$243.03
80 and older	$273.95	$232.16	$301.34	$255.38	$264.63	$224.26	$291.09	$246.69

Individuals applying outside of their Medigap OEP or without a guaranteed issue right may be subject to higher rates than what's shown above due to claims experience or health status.

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan **HD-G*** nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$76.89	$73.23	$84.58	$80.55	$74.27	$70.73	$81.70	$77.81
66	$82.99	$78.66	$91.29	$86.53	$80.17	$75.99	$88.18	$83.59
67	$89.15	$84.10	$98.06	$92.51	$86.11	$81.24	$94.72	$89.36
68	$94.39	$88.63	$103.83	$97.49	$91.18	$85.62	$100.30	$94.18
69	$99.68	$93.16	$109.65	$102.48	$96.29	$89.99	$105.92	$98.99
70	$104.53	$96.79	$114.98	$106.47	$100.97	$93.49	$111.07	$102.84
71	$109.45	$100.41	$120.39	$110.45	$105.73	$97.00	$116.30	$106.70
72	$114.44	$104.04	$125.88	$114.44	$110.55	$100.50	$121.60	$110.55
73	$119.50	$107.66	$131.46	$118.43	$115.44	$104.00	$126.98	$114.40
74	$124.64	$111.29	$137.11	$122.42	$120.40	$107.50	$132.44	$118.25
75	$127.80	$113.10	$140.58	$124.41	$123.45	$109.25	$135.80	$120.18
76	$131.00	$114.91	$144.10	$126.40	$126.54	$111.00	$139.20	$122.10
77	$134.23	$116.72	$147.66	$128.40	$129.67	$112.75	$142.63	$124.03
78	$137.50	$118.54	$151.25	$130.39	$132.82	$114.50	$146.11	$125.95
79	$140.81	$120.35	$154.89	$132.38	$136.02	$116.25	$149.62	$127.88
80 and older	$144.15	$122.16	$158.57	$134.38	$139.25	$118.00	$153.17	$129.80

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.
**HD means high deductible*

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan **N** nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$146.17	$139.21	$160.78	$153.13	$141.19	$134.47	$155.31	$147.92
66	$157.77	$149.54	$173.55	$164.50	$152.40	$144.46	$167.64	$158.90
67	$169.47	$159.88	$186.42	$175.87	$163.71	$154.44	$180.08	$169.88
68	$179.45	$168.49	$197.39	$185.34	$173.34	$162.76	$190.67	$179.04
69	$189.50	$177.11	$208.46	$194.82	$183.06	$171.08	$201.36	$188.19
70	$198.72	$184.00	$218.59	$202.40	$191.96	$177.74	$211.15	$195.51
71	$208.07	$190.89	$228.88	$209.98	$200.99	$184.39	$221.09	$202.83
72	$217.56	$197.78	$239.31	$217.56	$210.16	$191.05	$231.17	$210.16
73	$227.19	$204.67	$249.90	$225.14	$219.45	$197.71	$241.40	$217.48
74	$236.95	$211.56	$260.64	$232.72	$228.89	$204.36	$251.78	$224.80
75	$242.96	$215.01	$267.25	$236.51	$234.69	$207.69	$258.16	$228.46
76	$249.04	$218.45	$273.94	$240.30	$240.56	$211.02	$264.62	$232.12
77	$255.18	$221.90	$280.70	$244.09	$246.50	$214.35	$271.15	$235.78
78	$261.40	$225.34	$287.54	$247.88	$252.50	$217.68	$277.76	$239.44
79	$267.68	$228.79	$294.45	$251.67	$258.58	$221.00	$284.43	$243.11
80 and older	$274.04	$232.24	$301.44	$255.46	$264.71	$224.33	$291.18	$246.77

Individuals applying outside of their Medigap OEP or without a guaranteed issue right may be subject to higher rates than what's shown above due to claims experience or health status.

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan D nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$170.13	$162.03	$187.14	$178.23	$164.34	$156.51	$180.77	$172.17
66	$183.63	$174.06	$201.99	$191.46	$177.38	$168.14	$195.12	$184.95
67	$197.25	$186.09	$216.98	$204.70	$190.54	$179.76	$209.60	$197.73
68	$208.86	$196.11	$229.75	$215.73	$201.76	$189.44	$221.93	$208.39
69	$220.57	$206.14	$242.63	$226.75	$213.06	$199.13	$234.37	$219.04
70	$231.29	$214.16	$254.42	$235.58	$223.42	$206.87	$245.77	$227.56
71	$242.18	$222.18	$266.40	$244.40	$233.94	$214.62	$257.33	$236.08
72	$253.22	$230.20	$278.54	$253.22	$244.61	$222.37	$269.07	$244.61
73	$264.43	$238.22	$290.87	$262.04	$255.43	$230.12	$280.97	$253.13
74	$275.79	$246.24	$303.37	$270.87	$266.41	$237.86	$293.05	$261.65
75	$282.79	$250.25	$311.07	$275.28	$273.16	$241.74	$300.48	$265.91
76	$289.86	$254.26	$318.85	$279.69	$280.00	$245.61	$308.00	$270.17
77	$297.02	$258.27	$326.72	$284.10	$286.91	$249.49	$315.60	$274.43
78	$304.25	$262.28	$334.68	$288.51	$293.90	$253.36	$323.29	$278.70
79	$311.56	$266.29	$342.72	$292.92	$300.96	$257.23	$331.06	$282.96
80 and older	$318.96	$270.31	$350.86	$297.34	$308.11	$261.11	$338.92	$287.22

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan F nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$208.25	$198.33	$229.07	$218.16	$201.16	$191.58	$221.28	$210.74
66	$224.77	$213.06	$247.25	$234.36	$217.13	$205.81	$238.84	$226.39
67	$241.45	$227.78	$265.59	$250.56	$233.23	$220.03	$256.56	$242.04
68	$255.66	$240.06	$281.22	$264.06	$246.96	$231.89	$271.66	$255.08
69	$269.99	$252.33	$296.99	$277.56	$260.80	$243.74	$286.88	$268.12
70	$283.12	$262.14	$311.43	$288.36	$273.48	$253.22	$300.83	$278.55
71	$296.44	$271.96	$326.08	$299.16	$286.35	$262.71	$314.99	$288.98
72	$309.96	$281.78	$340.95	$309.96	$299.41	$272.19	$329.35	$299.41
73	$323.67	$291.60	$356.04	$320.76	$312.66	$281.68	$343.93	$309.84
74	$337.59	$301.42	$371.34	$331.56	$326.10	$291.16	$358.71	$320.28
75	$346.15	$306.32	$380.76	$336.96	$334.37	$295.90	$367.81	$325.49
76	$354.81	$311.23	$390.29	$342.36	$342.73	$300.64	$377.01	$330.71
77	$363.56	$316.14	$399.92	$347.76	$351.19	$305.38	$386.31	$335.92
78	$372.42	$321.05	$409.66	$353.16	$359.75	$310.13	$395.72	$341.14
79	$381.37	$325.96	$419.51	$358.56	$368.40	$314.87	$405.24	$346.36
80 and older	$390.42	$330.87	$429.47	$363.96	$377.14	$319.61	$414.85	$351.57

Individuals applying outside of their Medigap OEP or without a guaranteed issue right may be subject to higher rates than what's shown above due to claims experience or health status. Note: If you were eligible for Medicare on or after January 1, 2020, you are not eligible for Plan F or High-Deductible Plan F.

Monthly premiums for individuals applying ***outside of a Medigap OEP or without a guaranteed issue right*** *(Continued)*

Rates shown below are valid for policies with a start date of 4/1/2023 and after. Members with plans effective prior to 4/1/23 should refer to their annual rate letter.

Blue Cross Medicare Supplement Plan **HD-F*** nonguaranteed issue rates								
	Area 1 (Southeast Michigan)				Area 2 (Rest of Michigan)			
	Non-nicotine user		Nicotine user		Non-nicotine user		Nicotine user	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$79.49	$75.71	$87.44	$83.28	$76.79	$73.13	$84.46	$80.44
66	$85.80	$81.33	$94.38	$89.46	$82.88	$78.56	$91.17	$86.42
67	$92.17	$86.95	$101.38	$95.64	$89.03	$83.99	$97.93	$92.39
68	$97.59	$91.63	$107.35	$100.80	$94.27	$88.51	$103.69	$97.37
69	$103.06	$96.32	$113.37	$105.95	$99.55	$93.04	$109.51	$102.34
70	$108.07	$100.06	$118.88	$110.07	$104.39	$96.66	$114.83	$106.33
71	$113.16	$103.81	$124.47	$114.19	$109.30	$100.28	$120.24	$110.31
72	$118.32	$107.56	$130.15	$118.32	$114.29	$103.90	$125.72	$114.29
73	$123.55	$111.31	$135.91	$122.44	$119.35	$107.52	$131.28	$118.27
74	$128.86	$115.05	$141.75	$126.56	$124.48	$111.14	$136.92	$122.25
75	$132.13	$116.93	$145.34	$128.62	$127.63	$112.95	$140.40	$124.24
76	$135.43	$118.80	$148.98	$130.68	$130.83	$114.76	$143.91	$126.24
77	$138.78	$120.68	$152.66	$132.74	$134.06	$116.57	$147.46	$128.23
78	$142.16	$122.55	$156.37	$134.80	$137.32	$118.38	$151.05	$130.22
79	$145.58	$124.42	$160.13	$136.87	$140.62	$120.19	$154.68	$132.21
80 and older	$149.03	$126.30	$163.93	$138.93	$143.96	$122.00	$158.36	$134.20

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.
**HD means high deductible*

Monthly premiums for individuals applying
who are younger than 65
(Effective April 1, 2024)

Blue Cross Medicare Supplement Plan A nonguaranteed issue rates				
	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
Age	Male	Female	Male	Female
Younger than 65	$292.73	$292.73	$292.73	$292.73

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.

READY TO HELP

MICHIGAN

Monthly premiums for individuals applying who are younger than 65 *(Continued)*

(Effective April 1, 2024)

Blue Cross Medicare Supplement Plan D nonguaranteed issue rates				
	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
Age	Male	Female	Male	Female
Younger than 65	$694.26	$694.26	$694.26	$694.26

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.

Monthly premiums for individuals, who qualify for conversion, applying

Rates shown below for Plan A and Plan D are valid for policies with a start date of 4/1/2023 and after. Members with Plan A or Plan D that were effective prior to 4/1/23 should refer to their annual rate letter.

- If you were eligible for Medicare on or after January 1, 2020, you are not eligible for Plan C.
- You're considered a conversion member if you apply for a Medicare supplement plan, for which you're eligible, within 180 days after losing coverage under a group policy. In this case, you're entitled to the plan without restriction.

Blue Cross Medicare Supplement Plan A conversion rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
Younger than 65	$292.73	$292.73	$292.73	$292.73
65	$120.57	$114.83	$116.47	$110.92
66	$127.75	$121.09	$123.40	$116.97
67	$135.00	$127.35	$130.40	$123.02
68	$141.19	$132.57	$136.39	$128.06
69	$147.44	$137.79	$142.42	$133.10
70	$153.33	$141.97	$148.11	$137.14
71	$159.30	$146.14	$153.88	$141.17
72	$165.35	$150.32	$159.73	$145.20
73	$171.49	$154.50	$165.65	$149.24
74	$177.71	$158.67	$171.66	$153.27
75	$181.66	$160.76	$175.48	$155.29
76	$185.64	$162.85	$179.33	$157.31
77	$189.67	$164.93	$183.22	$159.32
78	$193.75	$167.02	$187.15	$161.34
79	$197.86	$169.11	$191.13	$163.36
80 and older	$202.01	$171.20	$195.14	$165.37

Blue Cross Medicare Supplement

Age	Area 1 (Southeast Michigan)	
	Male	Female
Younger than 65	$694.26	$694.26
65	$170.13	$162.03
66	$183.63	$174.06
67	$197.25	$186.09
68	$208.86	$196.11
69	$220.57	$206.14
70	$231.29	$214.16
71	$242.18	$222.18
72	$253.22	$230.20
73	$264.43	$238.22
74	$275.79	$246.24
75	$282.79	$250.25
76	$289.86	$254.26
77	$297.02	$258.27
78	$304.25	$262.28
79	$311.56	$266.29
80 and older	$318.96	$270.31

See important information about Plans A, C and D on Page 12.

for Plans A, D and C

Plan **D** conversion rates

Area 2 (Rest of Michigan)	
Male	Female
$694.26	$694.26
$164.34	$156.51
$177.38	$168.14
$190.54	$179.76
$201.76	$189.44
$213.06	$199.13
$223.42	$206.87
$233.94	$214.62
$244.61	$222.37
$255.43	$230.12
$266.41	$237.86
$273.16	$241.74
$280.00	$245.61
$286.91	$249.49
$293.90	$253.36
$300.96	$257.23
$308.11	$261.11

Blue Cross Medicare Supplement Plan **C** conversion rates

Age	Area 1 (Southeast Michigan)		Area 2 (Rest of Michigan)	
	Male	Female	Male	Female
Younger than 65	$465.72	$465.72	$465.72	$465.72
65	$221.22	$210.69	$213.69	$203.52
66	$234.40	$222.18	$226.42	$214.62
67	$247.69	$233.67	$239.26	$225.72
68	$259.06	$243.25	$250.24	$234.97
69	$270.52	$252.82	$261.32	$244.22
70	$281.32	$260.49	$271.75	$251.62
71	$292.28	$268.15	$282.34	$259.02
72	$303.39	$275.81	$293.07	$266.42
73	$314.65	$283.47	$303.95	$273.82
74	$326.07	$291.13	$314.97	$281.23
75	$333.31	$294.96	$321.97	$284.93
76	$340.62	$298.79	$329.03	$288.63
77	$348.02	$302.62	$336.18	$292.33
78	$355.49	$306.45	$343.39	$296.03
79	$363.03	$310.28	$350.68	$299.73
80 and older	$370.66	$314.12	$358.04	$303.43

These rates don't include the premium for the optional Dental Vision Hearing Package monthly premium.

Enrolling is easy

You can apply for coverage for a Blue Cross Medicare Supplement plan online at **www.bcbsm.com/medicare-supplement**, by contacting a Blue Cross Blue Shield of Michigan agent or by calling **1-888-563-3307**. TTY users, call **711**.

You can also complete a paper application and send it to one of the following:

Mail:
Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407

Fax: 1-866-392-7528

Use one application for each person. Be sure to answer truthfully and completely all questions about your medical and health history (if you are outside of your Medigap open enrollment period or you don't have a guaranteed issue right). Blue Cross may increase your rates, cancel your policy or refuse to pay any claims if you leave out or falsify important medical information or information about your permanent residence, date of birth, health status or nicotine product use*. If applicable, indicate you're switching to a supplement plan from your current coverage. We'll help you enroll and ensure that you have no lapse in coverage.

If you're covered under a health policy from any other insurer, don't cancel that coverage until you receive your *Welcome Guide* from Blue Cross Medicare Supplement and are sure you want to keep your plan. We'll mail a booklet when we enroll you in the plan. If you have questions, please call the number on the back of your Blue Cross member ID card or contact your agent. TTY users, call **711**.

Whether you're applying for coverage online or through an authorized insurance agent, it's important to know that neither Blue Cross nor its authorized agents are connected with Medicare.

**Nicotine products include but are not limited to, cigarettes, e-cigarettes, vaping, and nicotine patches or gum.*

About your premium

Your Blue Cross Medicare Supplement plan premium may change if you relocate to a different rating area. Other than premium adjustments due to age or relocation, we can only change your premium if we change the premium for all policies like yours. All premiums in this booklet are subject to change annually.

The Blue Cross Medicare Supplement plan may not fully cover all of your medical costs. When you receive covered services from a provider who doesn't accept Medicare assignment, you're responsible for the difference between the provider's charge and the Medicare-approved amount, plus any deductible or coinsurance amounts required by the Blue Cross Medicare Supplement plan you select.

Disenrollment may occur if premium payments aren't received by the due date. In such cases, there will be a six-month waiting period before you're eligible to reapply.

Your payment options

You may make payments through authorized automatic deductions from your bank account or by personal check, money order, cashier's check, credit card or text-to-pay. See the enrollment application for details on payment methods. Premium payments are due the 25th of each month.

Changing your coverage

You may switch to a different Blue Cross Medicare Supplement policy at any time, but **you may be subject to medical underwriting**[1]. If you're switching to a Medicare Advantage plan, you can enroll only during certain times of the year.

Important: If you're currently enrolled in a Medicare Advantage plan and wish to enroll in Medicare supplement, you must separately disenroll in writing from Medicare Advantage. Call your Medicare Advantage Customer Service department for information on how to disenroll from that plan and prevent duplication of coverage or a lapse in coverage. Medicare Advantage plans only allow disenrollment at certain times of the year.

Do you also need prescription drug coverage?

You may purchase Medicare Part D drug coverage with Blue Cross Blue Shield of Michigan's Prescription Blue℠ PDP plan. Call **1-888-563-3307**. (TTY users, call **711**).

You may cancel this coverage if it's not right for you

If you find that you aren't satisfied with Blue Cross Medicare Supplement coverage, notify us by phone, fax or write to us at the address below within the first 30 days of your coverage. You'll be responsible for any deductibles or coinsurance for Medicare Part A and Part B claims, or any services not paid for by Original Medicare incurred during that 30-day period.

If you choose to cancel your Blue Cross Medicare Supplement coverage after the first 30 days, the signature of the policy holder or legal representative is required.

Do one of the following:

Call the Customer Service number on the back of your Blue Cross member ID card. TTY users, call **711**.

Mail: **Blue Cross Blue Shield of Michigan**
P.O. Box 44407
Detroit, MI 48244-0407

Fax: 1-866-392-7528

Terms defined

Coinsurance – A fixed percentage of the costs you may pay for health care services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, such as a doctor's visit or hospital outpatient visit.

Deductible – This is a fixed dollar amount you may pay for health care services before we begin to pay.

MACRA – The Medicare Access and CHIP Reauthorization Act of 2015 affects Medicare supplement plans nationwide that cover the Medicare Part B deductible. Medicare supplement plans that cover the Part B deductible (Plans C, F and High-Deductible F) are no longer available for individuals who turned 65 or became eligible for Medicare on or after Jan. 1, 2020. Blue Cross offers Plan G, which is very comparable in benefits and available at a less expensive price than Plan F. If you turned 65 or became eligible for Medicare before Jan. 1, 2020, you may be eligible for Plans C, F and High-Deductible F, depending upon your enrollment criteria.

Medical underwriting is a process that an insurance company uses to decide, based on your medical history, how much to charge you for your plan.

Medicare supplement or Medigap – Medicare supplement plans help bridge the gap between what Original Medicare covers and the total cost of medical services. They cover all or a portion of Medicare deductibles and coinsurances and are accepted nationwide.

Open enrollment period (OEP) – A period of six months that begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B, when you can enroll for a Medicare supplement plan without being denied or charged more due to past or present health conditions.

Out-of-pocket costs – This is the portion of the cost that you pay for health care services or supplies — including your plan copay, coinsurance and deductibles, which can change every year.

Premium – Your monthly payment for health, prescription drug or add-on Dental Vision Hearing Package coverage.

To enroll in a Blue Cross Medicare Supplement plan:

- Contact your Blue Cross Blue Shield of Michigan agent.
- Enroll online at **www.bcbsm.com/medicare-supplement**.
- Call **1-888-563-3307** (TTY: **711**)
  8 a.m. to 9 p.m. Eastern time, Monday through Friday,
  with weekend hours from Oct. 1 through March 31.

This document is the Blue Cross Medicare Supplement outline of coverage, and the details and exceptions of Blue Cross Medicare Supplement follow. The deductible, coinsurance and copay amounts listed in this brochure are based on the 2024 CMS-approved values and could change for 2025. Like Medicare, Blue Cross Medicare Supplement coverage is accepted nationwide and the plan is easy to use. There are no provider networks or referrals — just use any health care provider who accepts Medicare. Simply present your Blue Cross Medicare Supplement member ID card along with your red, white and blue Medicare health insurance card whenever you receive health care services. We'll coordinate payment with Medicare and your health care providers. In most cases, you'll never have to bother with claim filing or paperwork.

This outline of Medicare supplement coverage is a summary only. Specific provisions for coverage, limitations and exclusions are contained in certificates and, if applicable, riders to those certificates. Although every effort has been made to accurately describe the benefits, if there is a discrepancy between this outline and applicable certificates and riders, the certificates and riders will govern.

This request for information is insurance related and if you respond you may be contacted in an attempt to sell you insurance. Blue Cross Medicare Supplement is not connected with or endorsed by the U.S. government or the federal Medicare program.

Blue Cross does not control the third-party websites referred to in this publication and is not responsible for their content.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

www.bcbsm.com/medicare-supplement

CENTERS FOR MEDICARE & MEDICAID SERVICES

2023

Choosing a Medigap Policy:

A Guide to Health Insurance for People with Medicare

This official government guide has important information about:

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

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

Who should read this guide?

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

Important information about this guide

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

"2023 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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

Section 1: Medicare Basics 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.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office of Civil Rights Coordinator.

If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd.
MC 1302
Detroit, MI 48226
1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
civilrights@bcbsm.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

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, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, call the number on the back of your member ID card. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para hablar con un intérprete, por favor llame al número que figura en el reverso de su tarjeta de identificación de miembro. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 会员ID卡后的电话号码。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電會員ID卡後的電話號碼。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan ang numero sa likod ng iyong ID kard ng miyembro. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, appelez le numéro au dos de votre carte d'identité de membre. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch viên miễn phí để trả lời mọi thắc mắc về chương trình sức khỏe và thuốc điều trị của chúng tôi. Nếu quý vị cần dịch vụ thông dịch viên, vui lòng gọi đến số điện thoại ở mặt sau thẻ ID hội viên của quý vị. Sẽ có nhân viên nói Tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Um einen Dolmetscherdienst zu erhalten, rufen Sie die Nummer auf der Rückseite Ihres Mitgliedsausweises an. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 회원 ID 카드 뒷면의 숫자로 전화를 걸어 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните по номеру, указанному на обратной стороне вашей идентификационной карты участника. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، اتصل بالرقم المكتوب على ظهر بطاقة هوية العضو الخاصة بك. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, chiama il numero sul retro della tua carta d'identità. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, ligue para o número no verso do seu cartão de identificação de membro. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, rele nimero ki nan do kat ID manm ou a. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski,zadzwoń pod numer podany na odwrocie legitymacji członkowskiej. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがございます。通訳をご用命になるには、会員IDカードの後部に記載されている電話番号にお電話ください。日本語を話す者が対応いたします。これは無料のサービスです。

Enroll today
and relax

Call **1-888-563-3307**, Monday through Friday, from 8 a.m. to 9 p.m. Eastern time, with weekend hours Oct. 1 through March 31. TTY users, call **711**.

Go to **www.bcbsm.com/medicare-supplement**.

Contact your Blue Cross-authorized, independent agent.

Complete **the enclosed enrollment application form and mail it in.**

Blue Cross
Blue Shield
Blue Care Network
of Michigan

OD 19163 NOV 23
W011135