Anthem

Choose a Medicare Supplement insurance plan that covers you and your needs

California 2026
A, F, Innovative F, G & N
Booklet includes: 2026 Premium Rates (Effective March 1, 2026)
2026 Medicare Cost-Sharing Amounts (Deductibles, Copays)
26CAMSABC (Rev. 05/2026)

Medicare Supplement plan

Anthem Blue Cross

California 2026

Anthem

26CAMSABC

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Upgrade your health plan with Medicare Supplement coverage from Anthem

Medicare doesn't cover everything. Our Medicare Supplement plan can help cover what Medicare doesn't.

Our Supplement plan gives you:

- **More coverage:** Medicare does not cover everything. A Medicare Supplement plan helps cover deductibles, coinsurance, and copayments.
- **Freedom:** You can see any doctor who's accepting new Medicare patients. You don't need a referral and you won't have to fill out claim forms. Some plans even offer coverage when you're traveling out of the country.
- **Consistency:** Once you enroll, you have guaranteed benefits for life.‡ Your coverage cannot be canceled and you don't need to worry about re-enrolling.
- **Portability:** If you move, your Medicare Supplement plan moves with you.
- **Flexibility:** We offer additional benefits with our individual dental and vision plans.

‡ Your coverage cannot be terminated for any reason other than non-payment of premium or material misrepresentation in the application for coverage.

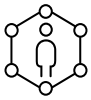
With Anthem, you'll have:

Competitive rates: Our size and commitment to innovation allows us to offer you competitive rates.

Premium Rate Guarantee: Concerned your Medicare Supplement premium will increase within the first six months of membership? Not with us. Anthem will hold any premium rate increase for six months, making it easier for you to budget your premium costs. After the initial six month rate guarantee period ends, premiums are subject to change in accordance with the terms of your plan.

Service: We believe your coverage shouldn't be hard to figure out. We deliver clear, easy-to-read communications and a dedicated customer service team that will help answer all your health plan questions.

Dependability: We're here with a focus on stability – of your coverage, and your rates – so you can plan for the future.



Overall health: We offer special member-only programs, discounts, and offers that can help you get and stay your healthiest.

SilverSneakers® fitness program

Stay active, healthy and connected, at no extra charge to you.

SilverSneakers is more than a traditional fitness program. It's a way to improve your health, gain confidence and connect with your community. Whether you prefer staying active at home, or enjoy group fitness classes, sports or using strength and cardio equipment, SilverSneakers has you covered.

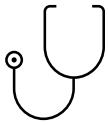
SilverSneakers gives you access to:

- A nationwide network of participating locations, with group fitness classes at select locations – enroll in as many as you like, at any time
- SilverSneakers LIVE online classes and workshops
- SilverSneakers On-Demand library with 200+ online workout videos
- SilverSneakers GO mobile app with digital workout programs
- SilverSneakers Community classes offered in neighborhood locations outside of the gym

With SilverSneakers, you have more options than ever.

Once enrolled in your Medicare Supplement plan, you can create your free online account and explore your full SilverSneakers membership.

To join the program, visit **silversneakers.com/check** or call **888-423-4632 (TTY: 711)**.



Always check with your doctor before you start an exercise program.

How to choose a plan that's right for you

Medicare Supplement plans vary in benefits and cost, it all comes down to choosing one that best fits your health needs and budget.

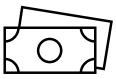
The enclosed Outline of Coverage shows the plans we offer and how much they cost. Things to consider:

Plan G is our most popular plan. Plan G covers all out-of-pocket costs not covered by Medicare for Medicare-approved services, except for the Medicare Part B deductible ($283 for 2026).

Plan N is a good option if you want to save on monthly premiums in exchange for sharing the cost. With Plan N, you have a set copay for covered doctor and emergency room visits.

Plan F or Innovative F is only available if you first became eligible for Medicare before January 1, 2020.

How to choose a plan that's right for you *(Continued)*



How to save on your monthly premium

Pay yearly or with automatic bank draft:

- Save up to $48 when you pay your premium for the year.
- Save $2 a month when you pay by automatic bank draft or electronic funds transfer.

Household Discount Program

Save 10% when more than one member in your household is enrolled in one of our Medicare Supplement plans.‡

New to Medicare Discount Program◊

If you're new to Medicare, these two plans offer an enrollment discount for the first 12 months:

- Enroll in Plan G and save $25 per month.
- Enroll in Plan F or Innovative F and save $20 per month.

◊ To qualify you must be 65 or older and within six months of your Medicare Part B effective date. Plan G is for coverage effective as of 3/1/2021.

‡ If you live with someone that has a Medicare Supplement plan with us, that individual's discount is based on their original coverage effective date. Members with an original coverage effective date on or after March 1, 2023 will receive a 10 percent Household Discount. Members with an original coverage effective date between June 1, 2010, and February 28, 2023, will receive a 5 percent Household Discount. To be eligible, individuals must occupy the same household. A household does not include assisted living facilities, retirement communities, group homes, senior-only apartment complexes, nursing home or any other health residential facilities. You may be required to provide additional documentation to verify eligibility.

Ways to save with a Medicare Supplement Plan

See the potential savings through this plan comparison of a Medicare Supplement plan and Medicare only.

Medical care	Costs with Medicare only	Costs with Medicare Supplement Innovative F◊	Costs with Medicare Supplement Plan G◊	Costs with Medicare Supplement Plan N◊
$4,000 in physician costs and tests (such as an MRI)[1]	$1,083	$0	$283	$303
15 days in the hospital, 22 days in a skilled nursing facility, and $12,000 for doctors, surgeons, and tests[2]	$4,853	$0	$283	$303
75 days in the hospital, 60 days in a skilled nursing facility, $100,000 for doctors, surgeons and tests,[3] and $600 for a provider that does not accept Medicare's payment in full (excess charges)	$36,558	$0	$283	$903
Preventative hearing and vision services not covered by Medicare	All costs	Covers routine hearing and vision exam every 12 months + frame/lens and hearing aid benefits (see Outline of Coverage for more information)	All costs	All costs

◊ These estimates are based on 2026 Medicare cost-sharing amounts. Your cost will vary with other Medicare Supplement plans.

1 Cost represents $283 Part B Deductible and 20% of the Medicare covered services (Plan N = lessor of 20% or $20 copay)

2 Cost represents $1,736 Part A Deductible, $283 Part B Deductible, 2-days of Skilled Nursing at $217 per day and 20% of the Medicare covered services (Plan N = lessor of 20% or $20 copay)

3 Cost represents $1,736 Part A Deductible, $283 Part B Deductible, 14-days of hospitalization over covered days $434 per day, 39-days of Skilled Nursing over covered days at $217 per day and 20% of the Medicare covered services (Plan N = lessor of 20% or $20 copay)

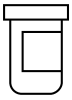
Additional programs◊ from Anthem

ScriptSave® WellRx Premier prescription savings and medication management:

We have partnered with ScriptSave to bring you instant savings on brand-name and generic prescriptions. In addition, ScriptSave can also help you manage your medication. ScriptSave WellRx Premier features include:

Prescription savings:

- Accepted at over 60,000 pharmacies nationwide
- Save up to 80%* or more on brand-name and generic prescription medications
- No enrollment fee and no limits on usage
- Savings for your entire household, pets too!
- Text, print, email, or download your prescription savings card



Medication management tools:

- Take your pill and refill reminders
- Medication information with images
- Pill identifier
- Drug and lifestyle interaction alerts
- Keep track of medications in *My Medicine Chest*
- Be alerted of medications with similar ingredients

◊ Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information offered by the vendors or providers. We negotiated the arrangements and discounts with each independent vendor or provider in order to assist our members. These discounts are not insurance and are not part of the Medicare Supplement plans.

DISCOUNT ONLY – NOT INSURANCE. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Members are required to pay for all prescription purchases. Members may cancel their registration at any time or file a complaint by contacting Customer Care. This program is administered by Medical Security Card Company, LLC of Tucson, AZ.

* Based on 2022 national program savings data.

Additional programs from Anthem *(Continued)*

Grocery guidance:

- Identify foods aligned with health goals
- Personalized food recommendations
- Bar code scanner
- Be alerted when foods are not aligned with dietary preferences and allergen settings
- Better-for-You food recommendations
- Nutrition facts and ingredient information

ScriptSave WellRx Premier works for everyone:

- Seniors with Medicare Part D save on prescriptions that are excluded from coverage.
- Those with limited, high-deductible, or no prescription coverage reduce out-of-pocket prescription costs.
- Those with prescription coverage reduce the cost of prescriptions not covered by insurance.

As an Anthem member, additional discounts on products and services are available to you. These discounts are available through SpecialOffers and can help save money while taking care of your health.

Learn more about SpecialOffers
Log in to **anthem.com/ca**, choose *Care*, and select *Discounts*.

Vendors and offers are subject to change without prior notice. Anthem Blue Cross does not endorse and is not responsible for the products, services or information offered by the vendors or providers. We negotiated the arrangements and discounts with each independent vendor or provider in order to assist our members. **These discounts are not insurance and are not part of the Medicare Supplement plans.**

Individual Dental and Vision

Dental and vision benefits to enhance your Medicare Supplement plan
Benefits that support your whole health experience

Dental and vision benefits

The confidence of care

We understand every member's needs are unique. That's why we offer a variety of dental and vision options to fit your preferences for coverage.

Dental coverage with Essential Choice

A healthy mouth can be key to your overall health, so it's important to have dental benefits that cover preventive services. With individual dental plans, you receive:

- Diagnostic and preventive care, including exams, cleanings, and X-rays. Deductible waived for diagnostic and preventive services when visiting a participating provider.
- Short waiting periods of 3 months for basic services and 6 months for major services, which can be waived for members with prior dental coverage. Incentive plans have no waiting periods.
- A third cleaning or other enhanced preventive services if you have diabetes, heart disease, or another qualifying medical condition.
- Dental coverage while you're traveling outside the U.S., through the International Emergency Dental Program.
- Higher Annual Benefit Maximums up to $2,500 with the potential to double the annual maximum after 5 years with Annual Maximum Carryover.
- Coverage on popular procedures including posterior composite filings (all Essential Choice plans), cosmetic teeth whitening, and dental implants.

Individual Dental and Vision *(Continued)*

Vision coverage with Blue View Vision

Routine eye exams are a preventive measure to help ensure health and wellness. For example, eye doctors can see the early signs of many serious illnesses, including diabetes, cancer, and high blood pressure, during routine exams.* That's why vision coverage is key to your overall health. With individual vision plans, you can:

- Choose from over 42,000 eye doctors and other eye care providers at more than 32,000 locations nationwide.
- Visit eye doctors, online at **glasses.com**, ContactsDirect or 1-800 CONTACTS® and at retail locations like LensCrafters®, Target Optical®, and most Pearle Vision® locations.
- See any eye doctor you select but pay less when you use a doctor in your plan.
- Save 40% off unlimited additional pairs of glasses and 20% off nonprescription sunglasses, and accessories, when visiting a provider in your plan.

For more information

You can call our toll-free Member Services line at **877-391-3897** (TTY: **711**), 8 a.m. - 5 p.m., local time, seven days a week.

* Your Sight Matters: 7 Health Problems Eye Exams Can Detect (accessed March 2022): yoursightmatters.com.

When you can enroll

- **You are turning 65 and have Medicare Parts A and B:** You can apply for a Medicare Supplement plan during the six months after you enroll in Medicare Part B. In some states, plan(s) may be available to persons younger than 65 who are eligible for Medicare.
- **If you're already 65:** You are welcome to apply at any time.◊
- **Pre-existing conditions:** If you had at least six months of prior creditable coverage or are in a guaranteed issue situation, you don't have to wait for coverage to start. You can use this prior coverage to remove or shorten waiting periods for pre-existing conditions. A pre-existing condition means you were treated or diagnosed six months before the start date of your plan. Remember, for Medicare-covered services, Original Medicare will cover the condition, even if you are responsible for out-of-pocket costs during the pre-existing condition waiting period.

If you want to learn more about Medicare Supplement (Medigap) plans, please see the *Choosing a Medigap Policy* guide included with your kit.

Ready to enroll?

Go to the Application section of this booklet.

◊ Medical underwriting for current health status and tobacco usage may apply.

How to reach us

Sales Department‡

888-211-9813 (TTY: 711)
8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30

Customer Service

800-333-3883 (TTY: 711)
8 a.m. to 6 p.m. PT, Monday - Friday

Online benefits, discounts and health resources

- **anthem.com/ca**

General Medicare information

- **medicare.gov**
- **anthem.com/ca/medicare**

TTY lines are available for those with hearing or speech loss.

‡ By calling this number, you will reach an authorized licensed insurance agent who can answer questions about our plans and enrollment.

This brochure is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Plan. In the event of a conflict between the Plan and this description, the terms of the Plan will prevail.

SilverSneakers participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer Members additional classes. Classes vary by location. **SilverSneakers is a value-added program. It is not insurance and not part of the Medicare Supplement plans.** It can be changed or withdrawn at any time.

Not connected with or endorsed by the U.S. Government or the federal Medicare program. The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

This plan has exclusions, limitations, and terms under which the plan may be continued in force or discontinued. For costs and complete details of the coverage, please contact your agent or the health plan.

Anthem

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-800-333-3883. (TTY: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-800-333-3883. (TTY: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك.
للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-800-333-3883 (TTY:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-800-333-3883 հեռախոսահամարով: (TTY: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-800-333-3883。(TTY: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-800-333-3883 تماس بگیرید.(TTY:711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-800-333-3883 पर तुरंत कॉल करें। (TTY: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-800-333-3883. (TTY: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-800-333-3883 (TTY: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ

យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។
ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-800-333-3883។
(TTY: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-800-333-3883로 전화하십시오. (TTY: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀ ਇਹ ਪੱਤਰ ਪੜਹ੍ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀ, ਤਾਂ ਅਸੀ ਇਸ ਨੂੰ ਪੜਹ੍ਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-800-333-3883 ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-800-333-3883. (TTY: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-800-333-3883. (TTY: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้
ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-800-333-3883 (TTY: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-800-333-3883. (TTY: 711)

It's important we treat you fairly
That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Explore our plan options in the Outline of Coverage

Outline of Coverage

Medicare Supplement plan benefits

Plans A, F, Innovative F, G & N

Anthem Blue Cross
California 2026

This booklet includes:

- 2026 Premium Rates
- 2026 Medicare deductibles, copays, and maximum out-of-pocket costs

Call toll-free **888-211-9813** with questions.
Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116

Anthem

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

This chart shows the benefits included in each of the standard Medicare Supplement plans.

Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Plans shown in gray are available for purchase. These same plans are available to those who are under 65 and qualify for Medicare due to disability (except those that qualify due to ESRD).

Note: A "✓" means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1,4]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓[1,4]
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026[2]					$8,000[2]	$4,000[2]				

1 Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. We do not offer **High Deductible Plans F** or **G**.

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

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

4 **Innovative F** includes additional benefits not contained in other standardized Medicare Supplement Plans as outlined in the following pages.

Finding the right plan for you

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change.

Next steps

- Compare the individual plan pages
- Choose the plan that meets your needs

Find your premium

Premiums for the plan you choose are determined by several factors, including age, county you live in, and tobacco use. Premium may adjust in the future as a result of the cost of medical services and supplies.

New to Medicare — Enroll in Plan G and save $300

If you are age 65 or older, and within six months of your Part B effective date you will receive $25 off your monthly premium for the first 12 months of your policy. This discount is applicable to Plan G policies with an effective date of March 1, 2021 or after. Those eligible to enroll into Plan F or Innovative F that meet the requirements will receive $20 off.

How to find your premium

Step 1: Find your county and/or zip code

Step 2: Use the premium table that applies to you (non-tobacco/tobacco)

Start comparing premiums

Ready to enroll?

Go to the application section of this booklet.

How to save on your monthly premium

Pay yearly or with automatic bank draft

- Save up to $48 when you pay your premium for the year.
- Save $2 a month when you pay by automatic bank draft.

Household Discount Program

- Save 10% when more than one member in your household is enrolled in one of our Medicare Supplement insurance plans.‡

‡ If you live with someone that has a Medicare Supplement plan with us, that individual's discount is based on their original coverage effective date. Members with an original coverage effective date on or after March 1, 2023 will receive a 10 percent Household Discount. Members with an original coverage effective date between June 1, 2010, and February 28, 2023, will receive a 5 percent Household Discount. To be eligible, individuals must occupy the same household. A household does not include assisted living facilities, retirement communities, group homes, senior-only apartment complexes, nursing home or any other health residential facilities. You may be required to provide additional documentation to verify eligibility.

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change.

Step 1: Determine your Rating Area | County Area Guide

Find the county you live in from the list below.

Got your Rating Area? Now you are ready to go to **Step 2**.

County	Area
Alpine	1
Amador	1
Butte	1
Calaveras	1
Colusa	1
Del Notre	1
El Dorado	1
Glenn	1
Humboldt	1
Inyo	1
Kings	1
Lake	1
Lassen	1
Mendocino	1
Modoc	1
Mono	1
Monterey	1
Nevada	1
Placer	1
Plumas	1
San Benito	1
Shasta	1
Sierra	1
Siskiyou	1
Sutter	1
Tehama	1
Trinity	1
Tulare	1
Tuolumne	1
Yolo	1
Yuba	1
Fresno	2
Imperial	2
Kern	2
Madera	2
Mariposa	2
Merced	2
Napa	2
Sacramento	2
San Joaquin	2
San Luis Obispo	2
Santa Barbara◊	2
(For this county, use your ZIP code to find your area) ZIP codes STARTING with 932XX or 934XX.	
Santa Cruz	2
Solano	2
Sonoma	2
Stanislaus	2
Alameda	3
Contra Costa	3
Marin	3
San Francisco	3
San Mateo	3
Santa Clara	3
Santa Barbara◊	3
(For this county, use your ZIP code to find your area) EXCEPT ZIP codes starting with 932XX or 934XX.	
Orange	4
Los Angeles◊	5
(For this county, use your ZIP code to find your area) ALL ZIP codes EXCEPT those listed in Area 6	
Los Angeles◊	6
(For this county, use your ZIP code to find your area)	
91702-91703	
91706	
91714-91716	
91721-91724	
91731-91735	
91740	
91744-91749	
91754-91756	
91765	
91770-91772	
91774-91776	
91778	
91780	
91788-91793	
91795	
91798-91799	
93510	
93532	
93534-93536	
93539	
93543-93544	
93550-93553	
93563	
93584	
93586	
93590-93591	
Riverside	6
San Bernardino	6
San Diego	6
Ventura	6

◊ This county spans multiple rating areas.

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium

Table 1 | Non-tobacco users and/or Open Enrollment or Guaranteed Issue

Use this table if: *you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

Areas 1, 2 and 3

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$357.56	$766.34	$612.12	$654.24	$518.90
65	127.25	257.00	245.65	197.21	207.82
66	132.43	267.47	256.62	205.21	216.24
67	137.76	278.27	267.94	213.51	224.97
68	143.29	289.43	279.69	222.07	234.02
69	149.04	301.04	291.86	231.00	243.42
70	154.99	313.11	304.52	240.24	253.13
71	161.18	325.56	317.60	249.82	263.23
72	167.57	338.50	331.20	259.71	273.67
73	174.23	351.93	345.28	270.04	284.54
74	181.12	365.84	359.89	280.72	295.79
75	188.26	380.25	375.01	291.77	307.44
76	195.67	395.23	390.70	303.25	319.55
77	203.34	410.70	406.97	315.15	332.07
78	211.30	426.80	423.88	327.49	345.10
79	219.56	443.48	441.38	340.28	358.57
80	228.11	460.76	459.50	353.54	372.52
81+	237.24	479.20	478.86	367.69	387.43

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

(see next page for more areas) ⊖

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium *(continued)*

Table 1 | Non-tobacco users and/or Open Enrollment or Guaranteed Issue

Use this table if: *you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

Areas 4 and 5

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$496.95	$1,000.15	$798.89	$790.53	$721.19
65	160.93	302.75	296.49	229.13	251.11
66	167.48	315.08	309.80	238.42	261.28
67	174.22	327.80	323.55	248.06	271.83
68	181.22	340.95	337.81	258.01	282.77
69	188.49	354.63	352.59	268.39	294.13
70	196.02	368.84	367.93	279.12	305.86
71	203.84	383.51	383.85	290.25	318.06
72	211.93	398.75	400.34	301.74	330.68
73	220.35	414.57	417.43	313.74	343.81
74	229.06	430.96	435.16	326.15	357.41
75	238.09	447.93	453.53	338.99	371.48
76	247.47	465.58	472.59	352.33	386.12
77	257.17	483.80	492.33	366.15	401.24
78	267.23	502.77	512.87	380.49	416.99
79	277.68	522.42	534.12	395.35	433.27
80	288.49	542.78	556.11	410.76	450.12
81+	300.04	564.50	579.61	427.20	468.14

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

(see next page for more areas) ⊖

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium *(continued)*

Table 1 | Non-tobacco users and/or Open Enrollment or Guaranteed Issue

Use this table if: *you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

Area 6

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$469.67	$844.28	$674.39	$698.75	$554.16
65	152.09	276.56	266.17	206.58	221.96
66	158.29	287.82	277.97	214.96	230.95
67	164.66	299.45	290.17	223.65	240.27
68	171.27	311.46	302.82	232.62	249.94
69	178.14	323.95	315.91	241.98	259.98
70	185.26	336.94	329.52	251.65	270.35
71	192.65	350.34	343.62	261.69	281.13
72	200.30	364.26	358.24	272.05	292.29
73	208.25	378.71	373.39	282.87	303.89
74	216.48	393.68	389.12	294.06	315.91
75	225.02	409.19	405.38	305.63	328.35
76	233.88	425.31	422.29	317.66	341.29
77	243.05	441.95	439.78	330.12	354.66
78	252.56	459.28	457.96	343.05	368.58
79	262.44	477.23	476.82	356.45	382.97
80	272.65	495.82	496.32	370.34	397.86
81+	283.57	515.67	517.13	385.16	413.79

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

(see next page for table 2) ⊖

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium

Table 2 | For tobacco users

Use this table if: *you have used tobacco products in the past 12 months. (If you are not a tobacco user, are in your Open Enrollment Period, or are eligible for Guaranteed Issue, see Table 1.)*

Areas 1, 2 and 3

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$400.46	$858.30	$685.57	$732.75	$581.16
65	142.52	287.84	275.13	220.88	232.76
66	148.32	299.57	287.41	229.83	242.18
67	154.29	311.66	300.09	239.13	251.96
68	160.49	324.16	313.25	248.72	262.10
69	166.92	337.16	326.88	258.72	272.63
70	173.59	350.68	341.06	269.07	283.51
71	180.52	364.63	355.71	279.80	294.81
72	187.68	379.12	370.94	290.87	306.51
73	195.14	394.16	386.71	302.44	318.68
74	202.85	409.74	403.08	314.40	331.29
75	210.85	425.88	420.01	326.78	344.33
76	219.16	442.66	437.58	339.64	357.90
77	227.75	459.98	455.81	352.96	371.91
78	236.65	478.02	474.75	366.79	386.51
79	245.91	496.70	494.35	381.11	401.60
80	255.48	516.05	514.64	395.97	417.22
81+	265.71	536.70	536.32	411.81	433.92

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

(see next page for more areas) ⊖

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium *(continued)*

Table 2 | For tobacco users

Use this table if: *you have used tobacco products in the past 12 months. (If you are not a tobacco user, are in your Open Enrollment Period, or are eligible for Guaranteed Issue, see Table 1.)*

Areas 4 and 5

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$556.58	$1,120.17	$894.76	$885.39	$807.73
65	180.24	339.08	332.07	256.63	281.24
66	187.58	352.89	346.98	267.03	292.63
67	195.13	367.14	362.38	277.83	304.45
68	202.97	381.86	378.35	288.97	316.70
69	211.11	397.18	394.90	300.60	329.43
70	219.54	413.10	412.08	312.61	342.56
71	228.30	429.53	429.91	325.08	356.23
72	237.36	446.60	448.38	337.95	370.36
73	246.79	464.32	467.52	351.39	385.07
74	256.55	482.67	487.38	365.29	400.30
75	266.66	501.69	507.95	379.67	416.06
76	277.17	521.45	529.30	394.61	432.45
77	288.03	541.86	551.41	410.09	449.39
78	299.30	563.10	574.41	426.15	467.03
79	311.00	585.11	598.21	442.79	485.26
80	323.11	607.91	622.84	460.05	504.13
81+	336.04	632.24	649.16	478.46	524.32

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

(see next page for more areas) ⊖

Finding your monthly premium

Plans A, F, Innovative F, G & N | Effective March 1, 2026

Premiums can change. Premium is based upon your tobacco usage, age, area and plan.

Step 2: Find your premium *(continued)*

Table 2 | For tobacco users

Use this table if: *you have used tobacco products in the past 12 months. (If you are not a tobacco user, are in your Open Enrollment Period, or are eligible for Guaranteed Issue, see Table 1.)*

Area 6

Age*	Plan **A**	Plan **F**	Innovative **F**	Plan **G**	Plan **N**
<65 ◊	$526.03	$945.59	$755.32	$782.60	$620.66
65	170.35	309.74	298.11	231.37	248.59
66	177.28	322.36	311.33	240.75	258.66
67	184.41	335.38	324.99	250.49	269.10
68	191.82	348.83	339.16	260.54	279.93
69	199.52	362.82	353.82	271.02	291.18
70	207.49	377.37	369.06	281.85	302.79
71	215.77	392.38	384.85	293.09	314.87
72	224.33	407.97	401.23	304.69	327.36
73	233.24	424.16	418.20	316.81	340.36
74	242.46	440.92	435.81	329.34	353.82
75	252.02	458.29	454.03	342.31	367.75
76	261.95	476.34	472.96	355.78	382.25
77	272.22	494.99	492.55	369.74	397.21
78	282.87	514.39	512.92	384.22	412.81
79	293.93	534.50	534.04	399.22	428.92
80	305.37	555.32	555.88	414.78	445.60
81+	317.60	577.55	579.19	431.38	463.44

* Attained age as of the coverage effective date.

◊ Plan G is available to those under 65 and Medicare eligible for reason other than age and those newly eligible for Medicare as of January 1, 2020.

Important plan disclosures

Plans A, F, Innovative F, G & N
Retain this outline for your records.

Premium information

We, Anthem Blue Cross, can only raise your premium if we raise the premium for all plans like yours in this State. We will recalculate your age each year and adjust your premium based on the new age band in March, up to the age cap.

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2026. Medicare may change their amounts annually.

Read your policy very carefully

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

Right to return policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy replacement

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

Notice

This policy may not fully cover all of your medical costs.

Neither Anthem Blue Cross nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

Complete answers are very important

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

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

Plan A

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

Plan A

(continued)

Medicare (Part B) – Medical Services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical Expenses — in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
Above Medicare Approved Amounts	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare pays	Plan pays	You pay
Home Health Care — Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment: – First $283 of Medicare approved amounts*	$0	$0	$283 (Part B deductible)
– Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan F

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used: – Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

Plan F

(continued)

Medicare (Part B) – Medical Services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical Expenses — in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
Above Medicare Approved Amounts	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare pays	Plan pays	You pay
Home Health Care — Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment: – First $283 of Medicare approved amounts*	$0	$283 (Part B deductible)	$0
– Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan F

(continued)

Other benefits - not covered by Medicare

Services	Medicare pays	Plan pays	You pay
Foreign Travel — not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Innovative F

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used: – Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

Innovative F

(continued)

Medicare (Part B) – Medical Services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical Expenses — in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
Above Medicare Approved Amounts	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Home Health Care — Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment: – First $283 of Medicare approved amounts*	$0	$283 (Part B deductible)	$0
– Remainder of Medicare approved amounts	80%	20%	$0
Foreign Travel — not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Innovative F

(continued)

Innovative Benefits – not covered by Medicare or Standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine Vision Benefit — Through Blue View Vision Insight network you can maximize your benefits. You may receive covered benefits outside of the Blue View Vision Insight network. You will need to pay the provider at the time of service and submit a claim for reimbursement.			
A. Routine Eye Exam (with dilation as needed) once every 12 months	$0	In Network: 100% after the Copayment Out of Network: Up to $35 allowance	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
B. Eyeglass Frames – Allowance toward new frames once every 24 months	$0	In-Network: $100 allowance Out-of-Network: Up to $45 allowance	Any amounts remaining after the Plan pays
C. Lenses: Standard Plastic (CR39) – up to 55 mm in: Single Vision, Bifocal, Trifocal (FT 25-28), Lenticular (once every 12 months)	$0	In Network: 100% after the Copayment Out of Network: Single Vision: Up to $25 Bifocal: Up to $40 Trifocal or Lenticular: Up to $55	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
• Contact Lenses (in place of eyeglass lenses) – once every 12 months – Elective (conventional/ disposable)	$0	In Network: $100 allowance Out of Network: Up to $80 allowance	Any amounts remaining after the Plan pays
– Non-Elective	$0	In Network: All Costs Out of Network: Up to $210 allowance	
Routine Hearing Benefit — Through TruHearing network of providers, coverage is provided for an annual hearing exam and hearing aid(s). This is separate from diagnostic hearing examinations and related charges as covered by Medicare. Includes a 60-day evaluation period, returns subject to a $75 restocking fee per hearing aid.			
Hearing Exam – Coverage for up to (1) routine hearing exam every 12 months.	$0	100%	$0
Hearing Aid(s) – Includes fitting evaluation for a hearing aid(s).	$0	Coverage allowance up to $750 toward a hearing device(s) every year. Includes 1-year supply of batteries (up to 64 cells per hearing aid).	Amounts in excess of Allowance
Nurse Advice Telephone Line — Access to a Nurse HelpLine, which allows you to contact a registered nurse by telephone for routine support and answers to common health-related questions. This service is available 7 days a week, 24 hours a day, 365 days per year.			
	$0	100%	$0

Plan G

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used: – Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

Plan G

(continued)

Medicare (Part B) – Medical Services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical Expenses — in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
Above Medicare Approved Amounts	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Services	Medicare pays	Plan pays	You pay
Home Health Care — Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment: – First $283 of Medicare approved amounts*	$0	$0	$283 (Part B deductible)
– Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan G

(continued)

Other benefits - not covered by Medicare

Services	Medicare pays	Plan pays	You pay
Foreign Travel — not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

Plan N

(continued)

Medicare (Part B) – Medical Services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical Expenses — in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
Above Medicare Approved Amounts	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan N

(continued)

Parts A & B Services

Services	Medicare pays	Plan pays	You pay
Home Health Care — Medicare approved services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment: – First $283 of Medicare approved amounts*	$0	$0	$283 (Part B deductible)
– Remainder of Medicare approved amounts	80%	20%	$0

Other benefits – not covered by Medicare

Services	Medicare pays	Plan pays	You pay
Foreign Travel — not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

P.O. Box 659816
San Antonio, TX 78265-9116

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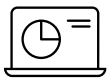
Ready to get started?

Here are our Enrollment Instructions.

Enrollment Instructions

4 ways you can enroll



Fill out your application online at **anthem.com/ca** (fastest).

Give us a call at **888-211-9813**.

Work directly with your insurance agent

Fill out the paper application and fax or mail it.

Application checklist

- ☐ Find the plan you want.
- ☐ Fill out all sections that apply to you.
- ☐ Choose how to pay your monthly premium. If you choose Automatic Bank Draft, please send the Premium Payment Form.
- ☐ Sign and date the application and submit it. (It's good idea to keep a copy for your own records.)

Please note

- You must live in California for this plan.
- You will want to submit your application within 90 days of the signature date. Your requested effective date must be within 180 days of application signature for guaranteed acceptance applicants, and 90 days for applicants subject to medical underwriting.

If you're faxing or mailing the application, please include any additional forms.

Fax (preferred)
844-236-7967

Mail
Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

We're here to help if you have questions 888-211-9813

Anthem

Application for Medicare Supplement California

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116

Do you currently have an Anthem Medicare Supplement plan? ..... ☐ **Yes** ☐ **No**

SECTION 1

1A. Applicant information (Use black ink and print your name as it appears on your Medicare ID card.)

Last name	First name	MI	Sex ☐ M ☐ F

Home street address (physical address, not a P.O. Box)	Apt #

City	County	State	Zip code

Mailing address (if different than above)	City	State	Zip code

Billing address (if different than above)	City	State	Zip code

Date of birth (MM/DD/YYYY)	Phone number
/ /	( )

Email address

Language Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

1B. Eligibility and plan choice
If applying due to a **Guaranteed Issue** situation, see the **Guaranteed Issue (GI) Guidelines,** attached to this application for your plan options. Timeframe to enroll may be limited.

Requested policy effective date: _____ / _____ / _____
MM DD YYYY

Coverage is effective as of the 1st of the month following approval of your completed application unless continuation of coverage requires you to request a date other than the 1st of the month.

Please complete the information below using your Medicare ID card (include all letters and numbers). Your Application cannot be completed without your Medicare number. If your Medicare ID card has not been received, note PENDING and your Medicare effective dates. Please provide your Medicare ID number upon receipt.

Medicare number: _____

Hospital (Part A) effective date: _____ / **01** / _____
MM DD YYYY

Medical (Part B) effective date: _____ / **01** / _____
MM DD YYYY

PLEASE MAKE A COPY FOR YOUR RECORDS.

1B. Eligibility and plan choice *(continued)*

Make your plan selection. If applicable, check (A) if you are in Open Enrollment, (B) in a Guaranteed Issue situation, or (C) are a Medicare qualified individual under the age of 65:

A. Open Enrollment: ☐ Turning age 65 **OR** ☐ Enrolling in Medicare Part B for the first time

B. ☐ **Guaranteed Issue (GI) situation #**_____ (Verify your plan options in the attached GI Guidelines. Proof of GI situation may be required.)

➔ **Plan Selection:** ☐ Plan A ☐ Plan F* ☐ Innovative F* ☐ Plan G ☐ Plan N

✔ After choosing your plan, if you **checked A or B** above you can **PROCEED TO Section 3.**

✖ If you **did not** check **A or B** above, you will need to **PROCEED TO Section 2.**

C. ☐ **Under age 65 and within six (6) months** of enrollment into Medicare Part B. If you are outside the six (6) months, you are not eligible to enroll.

➔ **Plan Selection:** ☐ Plan A ☐ Plan F* ☐ Innovative F* ☐ Plan G** ☐ Plan N

- Describe the health condition that qualified you for Medicare early:_____

_____

- Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**
  (If you answered YES to the ESRD question above, you do not qualify.)

✔ After choosing your plan **PROCEED TO Section 3**.

➔ If replacing a Medicare Supplement or Medicare Advantage plan, please be sure to complete and return the **Notice of Replacement of Coverage** form and submit with your application.

* You may enroll in Plans F or Innovative F only if you first became eligible for Medicare **before January 1, 2020**.

** You may enroll in Plan G only if you first became eligible for Medicare on or after January 1, 2020.

SECTION 2: MEDICAL QUESTIONS

2A. Health history and medical provider information

COMPLETE THIS SECTION ONLY WHEN YOU ARE NOT IN YOUR OPEN ENROLLMENT PERIOD OR WHEN YOU ARE NOT ELIGIBLE FOR GUARANTEE ISSUE. Please provide complete and accurate answers to the questions. Failure to provide complete and accurate information in any part of this application may result in future denial of benefits or rescission of coverage.

If you answer **"Yes"** to any of the following questions (in **Section 2A**), you are **NOT eligible** at this time to enroll. If your health status changes in the future allowing a "No" response to the questions, please submit a new application.

1. Are you currently bed ridden, hospitalized, in a nursing or assisted living facility and require help with activities of daily living (ADL), receiving home healthcare, or using supplemental oxygen? (ADL includes bathing, transferring, toileting, eating, dressing, or dependent on a wheelchair or other motorized mobility device.) ☐ **Yes** ☐ **No**

2. Are you currently hospitalized, in a skilled nursing facility, or rehabilitation facility or advised to have surgery, treatment or testing? (Treatment includes but is not limited to joint replacement, organ transplant, surgery for cancer, back or spine surgery, heart or vascular surgery, medical treatment that would require an inpatient admittance.) ☐ **Yes** ☐ **No**

3. At any time have you been medically diagnosed, been treated, taken medications, or had surgery or any kind of treatment recommended for any of the following:

A. Insulin dependent diabetes ☐ **Yes** ☐ **No**

B. Neuropathy ☐ **Yes** ☐ **No**

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2A. Health history and medical provider information *(continued)*

C. Chronic Kidney Disease, kidney/renal failure/insufficiency, kidney/renal dialysis, End Stage Renal Disease (ESRD), cirrhosis or necrosis of the liver, any organ transplant except cornea ☐ **Yes** ☐ **No**

D. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Fibrosis, Cystic Fibrosis ☐ **Yes** ☐ **No**

E. Congestive Heart Failure, cardiomyopathy, unoperated aneurysm, heart Pacemaker, defibrillator ☐ **Yes** ☐ **No**

F. Cerebral Palsy, Myasthenia Gravis, Muscular Dystrophy, Multiple Sclerosis, Parkinson's, Lou Gehrig's Disease (ALS), Alzheimer's Disease, Dementia, Organic Brain Disorder ☐ **Yes** ☐ **No**

G. Blood Coagulation Defect, Hemophilia ☐ **Yes** ☐ **No**

H. Any acquired immune deficiency disorder (AIDS), AIDS-Related Complex (ARC), or HIV positive? (*California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining health insurance coverage.) ☐ **Yes** ☐ **No**

4. Within the past 12 months has a medical professional advised or recommended that you have treatment, further diagnosis, therapy, diagnostic testing, or surgery (to include joint replacement surgery), that has not yet been performed, or do you have any pending test results? ☐ **Yes** ☐ **No**

If all questions are answered **"No,"** please continue to **Section 2B**.
REMINDER: If you answered **"Yes"** to any of the questions above, you are **NOT** eligible to enroll at this time.

2B. Health history and medical provider information *(continued)*

Complete this section only if you answered "No" to every question in **Section 2A.**

1. Have you used any tobacco products of any form (including e-cigs) in the past 12 months? ☐ **Yes** ☐ **No**

2. **In the past 3 years (36 months),** have you been medically diagnosed, treated or advised to have treatment for, tests, surgery or prescription medications for any of the following? Please answer "yes or no", and **if "yes",** provide details under **Question 6**.

A. Internal cancer, carcinoma, melanoma or radiation therapy ☐ **Yes** ☐ **No**

B. Alcoholism, drug abuse, or Schizophrenia ☐ **Yes** ☐ **No**

C. Heart attack, heart bypass, Ventricular Fibrillation, Atrial Fibrillation (AFib), Peripheral Vascular Disease, stroke, Transient Ischemic Attack (TIA), aneurysm repair, valve replacement, angioplasty, stent ☐ **Yes** ☐ **No**

D. Rheumatoid Arthritis, Lupus ☐ **Yes** ☐ **No**

E. Diabetes, stroke, TIA, heart attack or diabetic retinopathy ☐ **Yes** ☐ **No**

F. Treated with chemotherapy for one of the following: multiple Myeloma, Lymphoma, Leukemia, Non-Hodgkin's or Hodgkin's disease ☐ **Yes** ☐ **No**

3. Within the last 3 years have you been hospitalized, treated at an outpatient facility, or emergency room. **If yes,** provide details to include the medical diagnosis or condition, date, treatment received, including any medications prescribed and any further treatment needed, under **Question 6**. ☐ **Yes** ☐ **No**

4. Provide a list of any other medical conditions you have. Include details of treatment or surgery received, needed or recommended, any tests performed or recommended, and any medications currently taken or recommended, under **Question 6**.

5. List any physicians you've seen in the past 24 months under **Question 6**.

PLEASE MAKE A COPY FOR YOUR RECORDS.

2B. Health history and medical provider information *(continued)*

6. Please use the table below to provide additional details to any "yes" answers in **Section 2B**, **(Questions 2, 3, 4 and 5)** above.

Question #	**Medical condition #1**		
Treatment dates	From _____ / _____ / _____	To _____ / _____ / _____	
Medication(s)	1.	2.	3.
Treating physician			
Question #	**Medical condition #2**		
Treatment dates	From _____ / _____ / _____	To _____ / _____ / _____	
Medication(s)	1.	2.	3.
Treating physician			
Question #	**Medical condition #3**		
Treatment dates	From _____ / _____ / _____	To _____ / _____ / _____	
Medication(s)	1.	2.	3.
Treating physician			

Use an additional sheet of paper to provide any additional information not previously disclosed.

Primary physician_____

Phone (_____) _____ Fax (_____) _____

7. Please list any **additional medications** you have been prescribed to take, which have not been previously listed or disclosed on this application. List for what medical condition and the dates you started taking the medications, including injectables, and how often you take the medications.

Medication #1	**Frequency**	**Dosage**

Medication start date	**Reason for medication (diagnosis)**

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2B. Health history and medical provider information *(continued)*

Medication #2	Frequency	Dosage

Medication start date	Reason for medication (diagnosis)

Medication #3	Frequency	Dosage

Medication start date	Reason for medication (diagnosis)

Use an additional sheet of paper if needed.

To the best of my knowledge and belief, all information on this application, including all information provided in the Health history and medical provider information section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Anthem Blue Cross determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Anthem Blue Cross with any new information that arises after the submission of this application but before my enrollment begins.

I understand that Anthem Blue Cross may need to collect personal information about me from outside sources in order to approve my Medicare Supplement application. Personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 C.F.R. Parts 160 and 164) and state law. I also understand that under the HIPAA Privacy Regulations and state law, I have a right to see and correct personal information that Anthem Blue Cross collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Blue Cross.

I hereby authorize, at the request of Anthem Blue Cross, any medical professional, hospital, clinic or other medical or medically related facility, government agency or other medical person or firm, to disclose information, including copies of records concerning advice, care or treatment provided to me in order for Anthem Blue Cross to review and evaluate my Medicare Supplement application. This authorization does not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the provider's other medical records. This authorization will expire upon completion of the application process. I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Anthem Blue Cross, P.O. Box 659816, San Antonio, TX 78265-9116.

I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

☐ I give Anthem consent to contact me at the email address provided in **Section 1A** for questions related to my medical conditions.

Signature of applicant, or authorized representative (if applicable)*

Date

*If signed by an authorized representative, a copy of the authority to represent applicant must be attached to this application (such as a Power of Attorney).

(continued)

PLEASE MAKE A COPY FOR YOUR RECORDS.

SECTION 3

3A. How do you wish to pay your premium? (SEND NO MONEY NOW!)

Automated bank draft

☐ I would like my payment to be deducted automatically.

➔ My **Premium Payment Form** will be attached to this application.

Billing frequency (Electronic delivery is available in **Section 3D**. Paper bills will be mailed to the address in **Section 1A**.)

☐ Monthly ☐ Quarterly

☐ Annual – save $48 per year

Household discount:

When more than one member in the same household enrolls in a Medicare Supplement plan with us, both parties may qualify for our Household Discount.*

Last name _____ First name _____ MI _____

Medicare number: _____ Date of birth (MM/DD/YYYY) _____

Anthem Member ID number (or application date): _____

*Available to members with a coverage effective date on or after June 1, 2010, discount percentage may vary based on members original coverage effective date. See the Outline of Coverage for more details.

3B. Other coverage information

Important Statements

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

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy. If you are eligible for the Qualified Medicare Beneficiary (QMB) Program you cannot purchase a Medicare Supplement plan as it duplicates coverage.

4. If after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested during your entitlement to benefits under Medi-Cal, for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medi-Cal 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

3B. Other coverage information *(continued)*

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement plan and concerning medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION.

To the best of your knowledge, please answer all questions by marking "Yes" or "No" with an "X". If you recently lost, are losing or replacing other health insurance coverage and received a notice stating you were eligible for guaranteed issue of a Medicare Supplement plan policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice with your application.**

1. A. Did you turn age 65 in the last 6 months? ☐ **Yes** ☐ **No**

B. Did you enroll in Medicare Part B in the last 6 months? ☐ **Yes** ☐ **No**

If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medi-Cal program? ☐ **Yes** ☐ **No**

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer "NO" to this question.

If yes,

A. Will Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ **Yes** ☐ **No**

B. Do you receive any benefits from Medi-Cal **other than** payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

3. A. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. (If you know your upcoming coverage end date, then enter that date).

START ____ / ____ / _____ END ____ / ____ / _____

B. If ending, indicate reason why your coverage is ending: _____

C. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ **Yes** ☐ **No**

D. Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No**

E. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ **Yes** ☐ **No**

4. A. Do you currently have a Medicare Supplement policy in force? ☐ **Yes** ☐ **No**

B. If yes, Company: _____ Plan: _____

Do you intend to replace your current Medicare Supplement policy with this policy? ☐ **Yes** ☐ **No**

C. If yes, what was your "START" and expected "END" date?

START ____ / ____ / _____ END ____ / ____ / _____

PLEASE MAKE A COPY FOR YOUR RECORDS.

3B. Other coverage information *(continued)*

5. Have you had coverage under any other health insurance within the past 63 days? ☐ **Yes** ☐ **No**
(for example, an employer, union or individual plan)

A. If yes, Company: _____ Policy type: _____

B. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START ____ / ____ / _____ END ____ / ____ / _____

C. If ending, indicate reason why your coverage is ending: _____

☐ Voluntary ☐ Involuntary

3C. Authorizations and agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that any false statement or misrepresentation on the application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this application;

2. understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits;

3. understand if coverage is rescinded for fraud or intentionally misleading statements Anthem Blue Cross will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;

4. understand that I/we are responsible for notifying Anthem Blue Cross in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;

5. understand if I am applying for coverage and am not in a guaranteed issue period that there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this six-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

6. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

7. understand upon acceptance that my application will become part of the agreement between the Company and myself;

8. authorize Anthem Blue Cross to use and disclose my personal information when necessary for the operation of my health or other related activities and that Anthem Blue Cross will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

9. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

10. understand a rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number 1-888-466-2219, by calling

3C. Authorizations and agreements *(continued)*

the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's internet website (www.dmhc.ca.gov).

11. acknowledge responsibility for any overdraft fees permitted by state law;

12. acknowledge receipt of:

- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
- the *Outline of Coverage,* and a copy of this application

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature of applicant, or authorized representative (if applicable)*	Date
✕	

PLEASE MAKE A COPY FOR YOUR RECORDS.

3D. Policy issuance Email is the fastest, easiest way to get important plan information.

I agree to receive electronically the following materials based on my email address provided in Section 1A:

- ✔ **General information about my benefits, health programs and other services offered by Anthem that are available to me**
- ✔ **Important Plan documents:**
  - **Medicare's annual Notice of Change (includes upcoming changes to Medicare amounts)**
  - **Notice of Privacy Practices (annual notice required)**
  - **Renewal Notices (including upcoming premium changes)**

  ☐ No thanks, I prefer to get my important plan documents by paper mail.
- ✔ **Medicare Supplement Explanation of Benefits (EOBs) (claims information)**

  ☐ No thanks, I prefer to get my EOBs by paper mail.
- ✔ **Premium bill notification** (based on Section 3A.)

  ☐ No thanks, I prefer to get my premium billing statement by paper mail.

I understand I can change my email preference at any time by logging into my secure member profile at anthem.com/ca or calling the customer service number on the back of my Medicare Supplement plan ID card.

⚠ ***IMPORTANT: This application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in this application.***

Please do not cancel your present coverage, if any, until you receive documentation from Anthem Blue Cross, such as an ID card or written notification, showing that your application has been approved.

SEND NO MONEY NOW — PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Signature of applicant, or authorized representative (if applicable)* ✖	Date

* If signed by an authorized representative, a copy of the authority to represent applicant must be attached to application (such as a Power of Attorney).

SECTION 4: AGENT/BROKER ONLY

4A. Agent/broker information

Before this form can be processed the agent/broker must be appointed with us.

Agent/broker's printed name:

_____

Agent/broker #:

_____

Agency #:

_____

Agency name:

_____

(Any commission will be processed using these identification numbers.)

Street address: _____

City: _____ State: _____ ZIP code: _____

Phone: (_____) _____

Fax: (_____) _____

Email: _____

PLEASE MAKE A COPY FOR YOUR RECORDS.

4A. Agent/broker information *(continued)*

Attestation – please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant in the past five (5) years, either in force or not:

Company name	**Policy/certificate number**	**Type of coverage**	**Policy effective date**	**Policy term date** (if applicable)

I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section.

Signature of agent/broker | Date

If you are a current Anthem Blue Cross member and enrolling in a Medicare Supplement policy and have dependents that need to retain current coverage, please call the Customer Service number on the back of your ID Card. If you purchased your Anthem policy through the ACA Marketplace, you will need to call the ACA Marketplace to cancel your policy and to retain coverage for your dependents.

PLEASE MAKE A COPY FOR YOUR RECORDS.

Notice to Applicant Regarding Replacement of Medicare Supplement Plan or Medicare Advantage

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to applicant by issuer, agent, broker or other representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not 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. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. Note: If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy 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 material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✖ _____
(Signature of agent, broker or other representative)*
Typed name and address of issuer, agent or broker

✖ _____ _____
(Applicant's signature) (Date)
*Signature not required for direct response sales

Notice to Applicant Regarding Replacement of Medicare Supplement Plan or Medicare Advantage

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Anthem Blue Cross. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to applicant by issuer, agent, broker or other representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not 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. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy 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 material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✖ _____
(Signature of agent, broker or other representative)*
Typed name and address of issuer, agent or broker

✖ _____ _____
(Applicant's signature) (Date)
*Signature not required for direct response sales

Medicare Supplement Insurance

Guaranteed Issue Guidelines

Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

The following situations may qualify you for guaranteed-issuance. **Please find the situation number that applies to you and note the number on the Application under the section titled *Open Enrollment/Guaranteed Issue*.**

During guaranteed-issue periods, companies must sell you one of the required Medicare Supplement insurance policies at the best price for your age, without a pre-existing condition benefit waiting period or medical underwriting. Based on the **situation number**, your plan options may vary. ***If you are age 64 or younger with end-stage renal disease, you are not eligible to enroll.**

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability*...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
1. You have a Medicare Advantage Plan, (like a HMO or PPO) and your plan is being discontinued or you move out of the plan's service area.	• **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Under CA law, you have an additional 60 calendar days to apply for a Medicare Supplement plan due to the termination of your Medicare Advantage plan.
2. You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare and they are involuntarily terminating your employer group health plan (including retiree plan).	• **Prior to 1/1/2020,** Plan A, F, G or N (including Innovative F). Under 65 and eligible for Medicare due to disability, Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	The six month period beginning on the date of the receipt of notice of termination, or, if no such notice received, from the effective date of termination. You will need to provide proof of loss of coverage.
3. You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. You can keep your Medicare Supplement insurance policy, or you may want to switch to another Medicare Supplement insurance policy.	• **Prior to 1/1/2020,** Plan A, F, G or N (including Innovative F). Under 65 and eligible for Medicare due to disability, Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends.

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San Antonio, TX 78265-9116

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability*...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
4. (Trial Right) You joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	• **Prior to 1/1/2020,** Plan A, F, Innovative F, G or N. • **On or after 1/1/2020,** Plan A, G or N.	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.
5. (Trial Right) You dropped a Medicare Supplement insurance policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year, and you want to switch back.	The Medicare Supplement insurance 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 Medicare Supplement insurance policy isn't available, you can buy a Plan from any carrier based on when you became eligible for Medicare when turning age 65 or by disability: • **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	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.
6. Your Medicare Supplement insurance company goes bankrupt and you lose your coverage, or your Medicare Supplement insurance policy coverage otherwise ends through no fault of your own.	• **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	No later than 63 calendar days from the date your coverage ends.
7. You leave a Medicare Advantage Plan or drop a Medicare Supplement insurance policy because the company hasn't followed the rules, or it misled you.	• **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** you have the right to enroll into Plan A, G or N.	No later than 63 calendar days from the date your coverage ends.

Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability*...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
8. You enroll in a Medicare Part D plan during the initial enrollment period, and at the time you are enrolled in a Medicare Supplement insurance policy that covers outpatient prescription drugs. You enroll into a Medicare Supplement insurance policy without outpatient prescription drug coverage.	New enrollment is permitted into a policy without outpatient prescription drug coverage by the same issuer who issued the Medicare Supplement insurance policy with outpatient prescription drug coverage. If not available by the same insurer, we offer the following plans, if you are eligible for Medicare when turning age 65 or by disability: • **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** you have the right to enroll into Plan A, G or N.	As early as 60 calendar days immediately preceding the initial Part D enrollment period and ends on the date that is 63 calender days after the effective date of the individual's coverage under Medicare Part D.
9. Birthday Rule: Based on your date of birth, you can choose to change your existing Medicare Supplement plan. You can choose a plan with the same or fewer benefits as your existing plan from any company.	Any Medicare Supplement insurance policy that has the same or fewer benefits than the existing Medicare Supplement plan you are currently enrolled. *NOTE: For a coverage effective date of July 1, 2020 or later, Innovative F and standard Plan F are considered to have the same benefits when determining if a plan has the same or fewer benefits.*	No later than 60-days starting from your date of birth.
10. Employee Welfare Benefit Plan Terminates or Changes: You are enrolled under a employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates, stops providing supplemental benefits to Medicare or stops paying the Medicare Part B 20% coinsurance.	• **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	No later than 63 calendar days from the date the employer-sponsored plan terminates or ceases, or the date you are notified of termination or cessation of all supplemental health benefits; if no notice is received, the date of the notice denying a claim due to benefit termination.

Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability*...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
11. Medicare Advantage (MA) Plan Change: a) Your Anthem MA plan increased your premium or copayments, reduced your benefits, and you decide to voluntarily terminate your MA plan and return to Original Medicare and use your special enrollment period to enroll, or your MA plan terminated its relationship with your medical provider for reasons other than good cause relating to quality of care who was treating you. b) If the MA plan you belong to doesn't sell a Medicare Supplement insurance policy, you still have the right to buy a Medicare Supplement plan from any other company if the MA plan: (i) increased your premium or copayments by15% or more, (ii) reduced your benefits, (iii) or terminated their relationship with your medical provider for reasons other than good cause relating to quality of care who was treating you.	• **Prior to 1/1/2020,** Plan A, F or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N. Medicare Supplement enrollment is only permitted during the annual election period for Medicare Advantage.	As early as 60 days before the effective date of disenrollment and ends on the date that is 63 days after the effective date of the disenrollment. You will need to provide proof of benefit changes with your application.
12. You have Original Medicare and are notified that due to an increase in income or assets you are either: 1) no longer eligible for Medi-Cal (Medicaid) benefits; or 2) only eligible for Medi-Cal benefits with a share of cost and you certify at the time of application that you have not met the share of cost.	• **Prior to 1/1/2020,** Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	The six month period beginning on the date of the receipt of notice of loss of eligibility, or, if no such notice received, from the effective date of the loss of eligibility. You will need to provide proof of loss of eligibility.

Anthem Blue Cross
P.O. Box 659816
San Antonio, TX 78265-9116

Guaranteed issue right situation...	**Anthem offers the following Medicare Supplement insurance plans, if you are eligible for Medicare when turning age 65 or by disability*...**	**When to apply for a Medicare Supplement insurance (Medigap) policy...** (Days are Calendar Days)
13. Military: Health care services are terminated for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.	• **Prior to 1/1/2020,** Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	The six month period beginning on the date of the receipt of notice of termination, or, if no such notice received, from the effective date of termination. You will need to provide proof of loss of coverage due to base closure, stoppage or services, or change of residence.
14. Divorce or Death of Spouse: Loss of eligibility due to divorce or death of spouse from any employer-sponsored health plan (including retiree, COBRA or Cal-COBRA).	• **Prior to 1/1/2020,** Plan A, F, G or N (including Innovative F). • **On or after 1/1/2020,** Plan A, G or N.	The six month period beginning on the date of the receipt of notice of termination, or, if no such notice received, from the effective date of termination. You will need to provide proof of loss of coverage.

Anthem

Premium Payment Form for Medicare Supplement

Anthem Blue Cross
P.O. Box 659816 • San Antonio, TX 78265-9116 • Fax: 1-844-236-7967

Simplify your life. It saves you valuable time and money.

When enrolling in a Medicare Supplement plan, sign up for monthly Automatic Bank Draft (ABD) and save $2 per month. Drafts are made to your account on the 6th day of the month.

To ensure proper payment setup, this form MUST be returned with your Application.

Please print and use black ink.

Please print your name as it appears on your Medicare card.	Medicare Number:

I understand that the premium I have selected to pay through ABD is for my:

☐ Medicare Supplement plan

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your premium billing preference selection does not guarantee your premium for any specific time period.

Banking Information for ABD Withdrawals

(See next page for help locating bank routing and account numbers. To ensure proper set-up, please include the routing number from a check and not a deposit slip.)

Deduct premium: Start date: _____ / _____ / _____ ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**

Deduct premium from: **Checking:** ☐ Personal ☐ Business **– OR –** **Savings:** ☐ Personal ☐ Business

Account holder name(s)	Name of financial institution
Bank Routing/Transit Number (9 digits) ☐☐☐☐☐☐☐☐☐	Bank Account Number

Automatic Bank Draft Payment: I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium(s), and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Anthem when set up, I authorize my bank to draft both the past due premium along with current premium(s) to ensure my coverage stays in effect. I understand if changes I make to my plan impact my auto withdrawal amount and the change occurs close to the auto withdrawal date, Anthem may not be able to notify me of the new auto withdrawal amount before the withdrawal is made. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

Banking Information (continued)

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Anthem and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction.

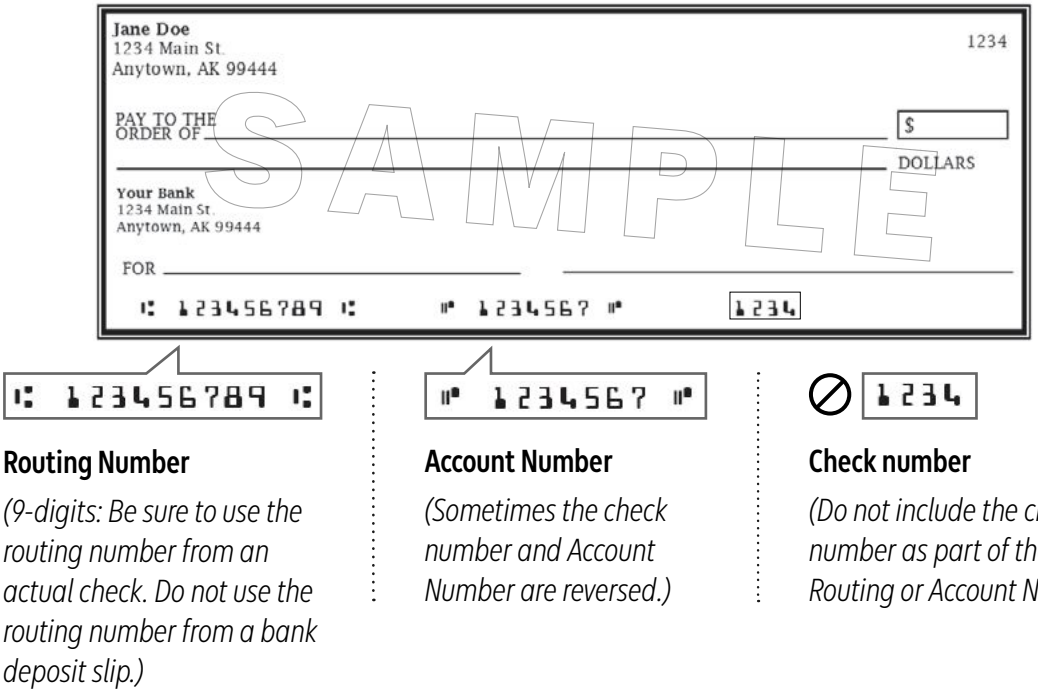
Anthem will accept premium payments made on behalf of an applicant or member from ONLY the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

Return this authorization as indicated above. **No service fees apply when paying by ABD.**

Account holder's signature (as it appears on your bank account)	Date
⊠	

To find the Bank Routing and Account Numbers:



Routing Number

(9-digits: Be sure to use the routing number from an actual check. Do not use the routing number from a bank deposit slip.)

Account Number

(Sometimes the check number and Account Number are reversed.)

Check number

(Do not include the check number as part of the Routing or Account Number.)

For more information, visit our website at **www.anthem.com/ca.**
The person who is discussing plan options with you is either employed by or contracted with Anthem Blue Cross. The person may be compensated based on your enrollment in a plan.

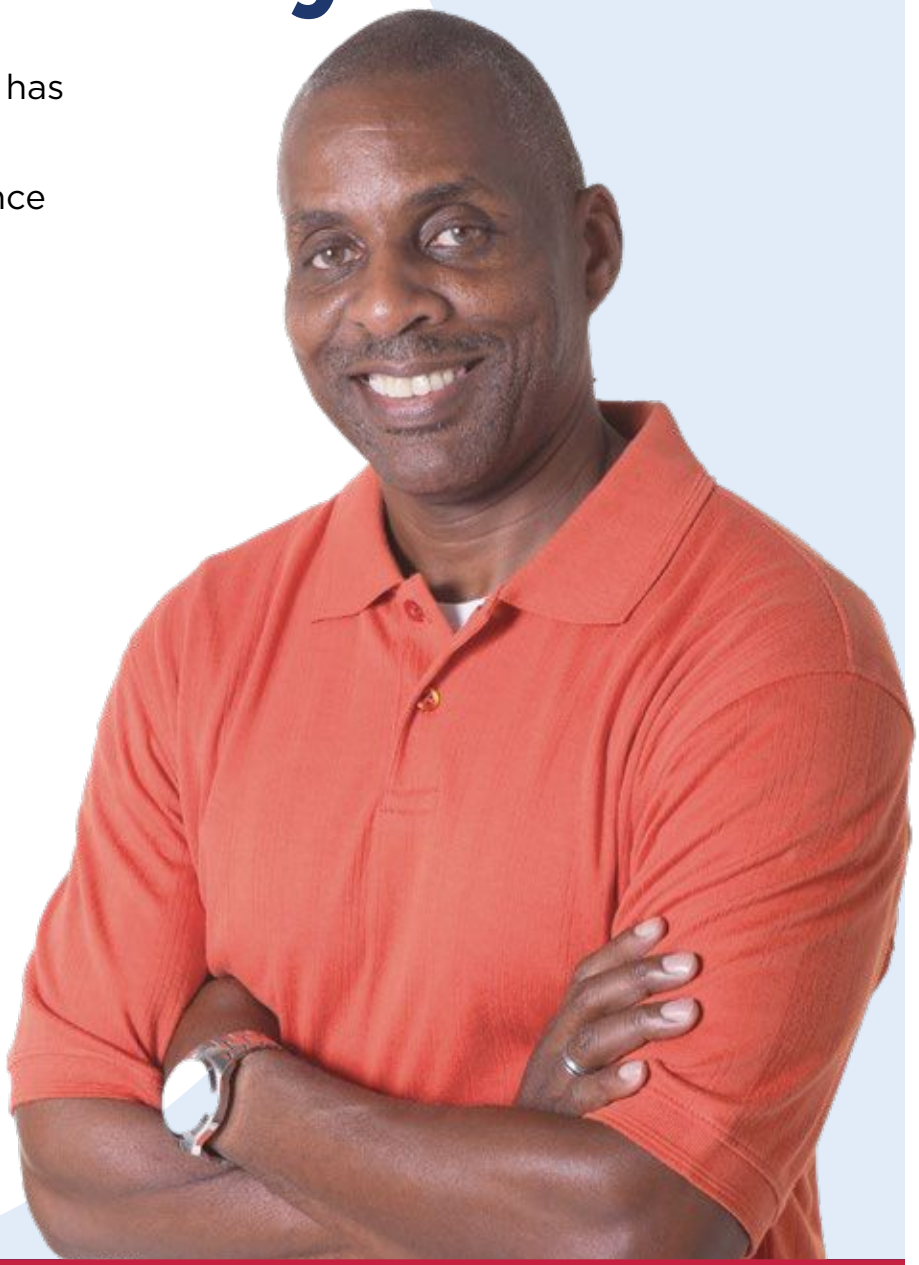
2025

Choosing a Medigap Policy

This **official government guide** has important information about:

- Medicare Supplement Insurance (Medigap) basics
- What Medigap policies cover
- Buying a Medigap policy

Medicare.gov



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

Medicare

Table of contents

Section 1:

Medicare basics

What's Medicare?

Medicare is health insurance for people 65 or older. You may be eligible to get Medicare earlier if you have a disability, End-Stage Renal Disease (ESRD), or ALS (also called Lou Gehrig's disease).

Note: Go to page 40 for definitions of **blue** words

What are the parts of Medicare?

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 the 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 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

- 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.
- You can also use or shop for and buy supplemental coverage, that helps pay your out-of-pocket costs (like your 20% coinsurance).

☑ **Part A** 

☑ **Part B** 

You can add:

☐ **Part D** 

You can also add:

☐ **Supplemental coverage**

It can help pay some costs that other parts don't cover. This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a current or former employer or union, or Medicaid (if you have it).

Medicare Advantage (also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These plans bundle your Part A, Part B, and usually Part D together.
- In many 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 often have different out-of-pocket costs than Original Medicare or supplemental coverage like Medigap. You may also have an additional premium.
- Plans may offer some extra benefits that Original Medicare doesn't cover.

☑ **Part A** 

☑ **Part B** 

Most plans include:

☑ **Part D** 

☑ **Some extra benefits**

Medicare and the Health Insurance Marketplace®

Even if you have Marketplace coverage (or other individual health coverage that isn't based on current employment), you should sign up for Medicare when you're first eligible (usually when you turn 65) to avoid a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty.

You can keep your Marketplace plan without penalty until your Medicare coverage starts. Once you're eligible for premium-free Part A, or already have 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 keep getting help to pay your Marketplace plan premiums, you may have to pay back some or all of the help you got when you file your federal income taxes.

To find out how to end your Marketplace plan when you become eligible for Medicare to avoid a gap in coverage, visit **Healthcare.gov/medicare/changing-from-marketplace-to-medicare/**. 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).

Get more information about Medicare

- Visit **Medicare.gov**.
- Read your "Medicare & You" handbook.
- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP). Visit **shiphelp.org** to get the number for your local SHIP.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Section 2:

Medigap basics

How does Medigap work?

Medicare Supplement Insurance (Medigap) is extra insurance you can buy from a private health insurance company to help pay your share of out-of-pocket costs in Original Medicare, like **copayments**, **coinsurance**, and **deductibles**. Generally, you must have Original Medicare—Part A (Hospital Insurance) and Part B (Medical Insurance)—to buy a Medigap policy.

Some Medigap policies also cover services that Original Medicare doesn't cover, like emergency medical care when you travel outside the U.S. (foreign travel emergency care). Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, glasses, or private-duty nursing.

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

Note: Go to page 40 for definitions of **blue** words

A Medigap policy is different from a **Medicare Advantage Plan (Part C)**. A Medicare Advantage Plan is another way to get your Medicare coverage besides Original Medicare, 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.

Medigap policies are standardized

Medigap must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can only sell you "standardized" plans, which are named in most states by letters A–D, F, G, and K–N. **All plans with the same letter offer the same basic benefits, no matter where you live or which insurance company you buy the policy from**. **Price is the only difference between policies with the same letter sold by different companies.** Some offer additional benefits. In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

What Medigap policies cover

The information on page 7 gives you a snapshot of 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. Visit **shiphelp.org** to get the number for your local SHIP.

Important! All insurance companies that sell Medigap policies must offer at least Medigap Plan A. Medigap plans sold to people who are new to Medicare on or after January 1, 2020, 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. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. While people new to Medicare on or after January 1, 2020, can't buy Plans C and F, they have the right to buy Plans D and G instead, which provide the same benefits (but don't cover the Part B deductible).

- In this situation, you're considered new to Medicare if you turned 65 on or after January 1, 2020, and get Medicare Part A on or after January 1, 2020.
- 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.

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. (Go to pages 35–37.) In some states, you may be able to buy another type of Medigap policy called **Medicare SELECT**. These are standardized plans that may require you to use hospitals and, in some cases, doctors within their network to be eligible for full benefits. (Go to page 13.)

The chart below shows basic information about the different benefits Medigap plans cover in 2025

✓ = The plan covers 100% of this benefit
X = The plan doesn't cover this benefit
% = The plan covers that percentage of this benefit, and you're responsible for the rest.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood benefit (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	X	X	✓	✓	✓	✓	50%	75%	✓	✓
Part A	X	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	X	X	✓	X	✓		X	X	X	X
Part B excess charge	X	X	X	X	✓	✓	X	X	X	X
Foreign travel emergency (up to plan limits)	X	X	80%	80%	80%	80%	X	X	80%	80%
Out-of-pocket limit in 2025**							$7,220	$3,610		

* Plans F and G also offer a high-deductible plan in some states. You must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,870 in 2025 before your policy pays anything. (You can't buy Plans C and F if you were new to Medicare on or after January 1, 2020.)

** For Plans K and L after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($250 in 2025), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance. You must pay 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

Medigap doesn't cover everything. Medigap policies generally don't cover:

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

Types of insurance that aren't Medigap policies

- **Medicare Advantage Plans (also known as Part C)**
- **Medicare drug plans (Part D)**
- **Medicaid**
- Employer group health plans (including the Federal Employees Health Benefits (FEHB) program, retiree, or COBRA coverage), or union plans
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans

Types of Medigap policies insurance companies can sell

In most cases, Medigap insurance companies can only sell you one of the standardized Medigap policies.

Insurance companies that sell Medigap policies don't have to offer every Medigap plan (A–D, F, G, and K–N). 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:

- When you're in your **Medigap Open Enrollment Period** (pages 10–11)
- If you have a **guaranteed issue right** (pages 16–19)

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 can only buy Medigap if you have Original Medicare. Generally, that means you have to sign up for Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) before you can buy a Medigap policy.
- 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 health coverage.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to the monthly Part B premium you pay to Medicare.
- A Medigap policy only covers one person, so if you and your spouse both want Medigap coverage, **you each have to buy your own policy**.
- When you have your Medigap Open Enrollment Period (pages 10–11), you can buy any Medigap policy sold in your state, from any insurance company that's licensed in your state to sell one.
- 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.
- You may have additional rights under state law. Visit your State Insurance Department at content.naic.org/state-insurance-departments to find out what rights you might have under state law.
- The premium amount is the only difference between policies with the same plan letter sold by different companies. **There can be big differences in the premiums that different insurance companies charge for the same coverage**, so be sure you compare Medigap plans with the same letter (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 plans sold after 2005 don't include prescription drug coverage. If you want prescription drug coverage, you can join a separate Medicare drug plan (Part D). 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?

Your best time to buy a Medigap policy is during your Medigap Open Enrollment Period. Your 6-month Medigap Open Enrollment Period starts the first month you have Medicare Part B and you're 65 or older. This is a one-time enrollment period; it doesn't repeat every year. Some states have additional Open Enrollment Periods, including those for people 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 32 for more information.)

During your Medigap Open Enrollment Period, you can:

- Enroll in any Medigap policy sold in your state. An insurance company can't refuse to sell you any Medigap policy it offers. They also can't use medical underwriting to decide whether to accept your application or deny you coverage due to pre-existing health problems.
- Generally get better prices and more choices among policies. An insurance company can't charge you more for a Medigap policy if you have health problems.
- Have your coverage start right away. An insurance company can't make you wait, except 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: Original Medicare will still cover the condition for Medicare-covered services, even if the Medigap policy won't, but you're responsible for the Medicare coinsurance or copayment.
- Avoid or shorten waiting periods for a pre-existing condition if you buy a Medigap policy to replace certain other kinds of health coverage that counts as creditable coverage.
  - 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 condition.

- Many types of health care coverage can count as creditable coverage for Medigap policies, but they'll only count if your break in coverage was no 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). Visit **shiphelp.org** to get the number for your local SHIP.
- If you buy a Medigap policy when you have a guaranteed issue right (also called "Medigap protection"), the insurance company must cover all your pre-existing health conditions without a waiting period (called the pre-existing condition waiting period). Go to pages 16–19 for more information about guaranteed issue rights.

What happens if I don't buy a Medigap policy when I'm first eligible?

Outside of your **Medigap Open Enrollment Period**:

- You may have to pay more for a policy.
- Fewer policy options may be available to you.
- There's no guarantee that an insurance company will sell you a Medigap policy if you don't meet their medical underwriting requirements. They may deny you a policy unless you have a guaranteed issue right (go to pages 18–19).

It's 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 one-time Medigap Open Enrollment Period begins when you sign up for Part B, and it can't be changed or repeated**.

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 otherwise you might have to pay a Part B late enrollment penalty or 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 20.

Note: For people with retiree coverage: Since Medicare pays first after you retire, your retiree coverage is probably similar to coverage from a Medicare Supplement Insurance (Medigap) policy. Both are likely to offer benefits that fill in some of the gaps in Medicare coverage—like coinsurance and deductibles.

How do insurance companies set prices for Medigap policies?

Each insurance company decides how it'll set the price (called a 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 in one of 3 ways:

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

Type of pricing	How it works	What this may mean for you	Examples *
Community-rated (also called "no-age-rated")	Generally the same premium is charged to everyone, 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 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, 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.

*The examples show how your age affects your premiums, and why it's important to check 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.

Comparing Medigap costs

The cost of Medigap policies can vary widely depending on the insurance company, the plan, and where you live. **The benefits in each lettered plan are the same, no matter which insurance company sells it**. The premium (an amount you pay each month) is the only difference between policies with the same plan letter sold by different companies. **There can be big differences in the premiums that different insurance companies charge for the same coverage**.

As you shop for a Medigap policy, be sure you're comparing the same lettered plan offered by different insurance companies. 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). Visit **shiphelp.org** to get the number for your local SHIP.

You can 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 or 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 lower.
- 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 $2,870 (in 2025) of **deductibles**, **copayments**, and **coinsurance** for covered services not paid by Medicare before the Medigap policy pays anything. You also pay a separate deductible ($250 per year) for foreign travel emergency care.

What's Medicare SELECT?

In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. This policy requires you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits. 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 Medigap policy doesn't cover. Medicare will pay its share of approved costs 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 will pay your doctor whatever amount you owe under your policy. Some Medigap insurance companies also provide this service for Part A claims.

If your Medigap insurance company **doesn't** get your claims information directly from Medicare, ask your doctors if they "participate" in Medicare. This means they "accept assignment" for all Medicare patients. If your doctor participates, your Medigap insurance company is required to pay the doctor directly if you ask them to. 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 that situation, your Medigap insurance company may pay you back directly (based on your 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.

Notes

Section 3:

Your right to buy a Medigap policy

What are guaranteed issue rights?

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

- Must sell you a Medigap policy.
- Must cover all your pre-existing health conditions.
- Can't charge you more for a Medigap policy because 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 35–37 for your Medigap policy choices.

Note: Go to page 40 for definitions of **blue** words

When do I have guaranteed issue rights?

In most cases, you have a **guaranteed issue right** when your other health coverage changes in some way, like if you lose your other coverage. You may also have a "trial right" to try a Medicare Advantage Plan (Part C) and still buy a Medigap policy if you change your mind. For information on trial rights, go to pages 18–19.

Medigap guaranteed issue right situations

This information describes the most common situations under federal law where you may be able to buy a Medigap or **Medicare SELECT** policy outside your **Medigap Open Enrollment Period**, the kind of policy you can buy, and when you can or must apply for it. You may have additional rights under state law. Check with your State Insurance Department about what rights you might have under state law.

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 any of the following are true: • Your plan is leaving Medicare • Your plan stops giving care in your area • You move out of the plan's service area You only have this right if you switch to Original Medicare (rather than join another Medicare Advantage Plan).	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	• 60 days before the date your Medicare Advantage Plan coverage ends. • No more than 63 days after your Medicare Advantage Plan coverage ends. **Note:** Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree, COBRA, or union coverage) that pays after Medicare pays and that plan is ending. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until your COBRA coverage ends.	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	No more than 63 days after the latest of these 3 dates: 1. Date your current coverage ends. 2. Date on the notice you get telling you that your 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*, or G* that's sold by an insurance company in your state or the state you're moving to.	• 60 days before your Medicare SELECT coverage ends. • No more than 63 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 haven't 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 Plan D or G instead of Plan C or F.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
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. (Trial right)	Any Medigap policy that's sold by an insurance company in your state.*	• 60 days before your coverage ends. • No more than 63 days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances. Check with your State Insurance Department.
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. (Trial right)	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*, or G* that's sold by an insurance company in your state.	• 60 days before the date your coverage ends. • No more than 63 days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances. Check with your State Insurance Department.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	No more than 63 days after your current Medigap 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*, or G* that's sold by an insurance company in your state.	No more than 63 after 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 haven't 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 Plan D or G instead of Plan C or 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:

- Copies of letters, notices, emails, 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 include a copy of some or all of these papers with your Medigap application to prove you have a guaranteed issue right.

More information about Medigap rights

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

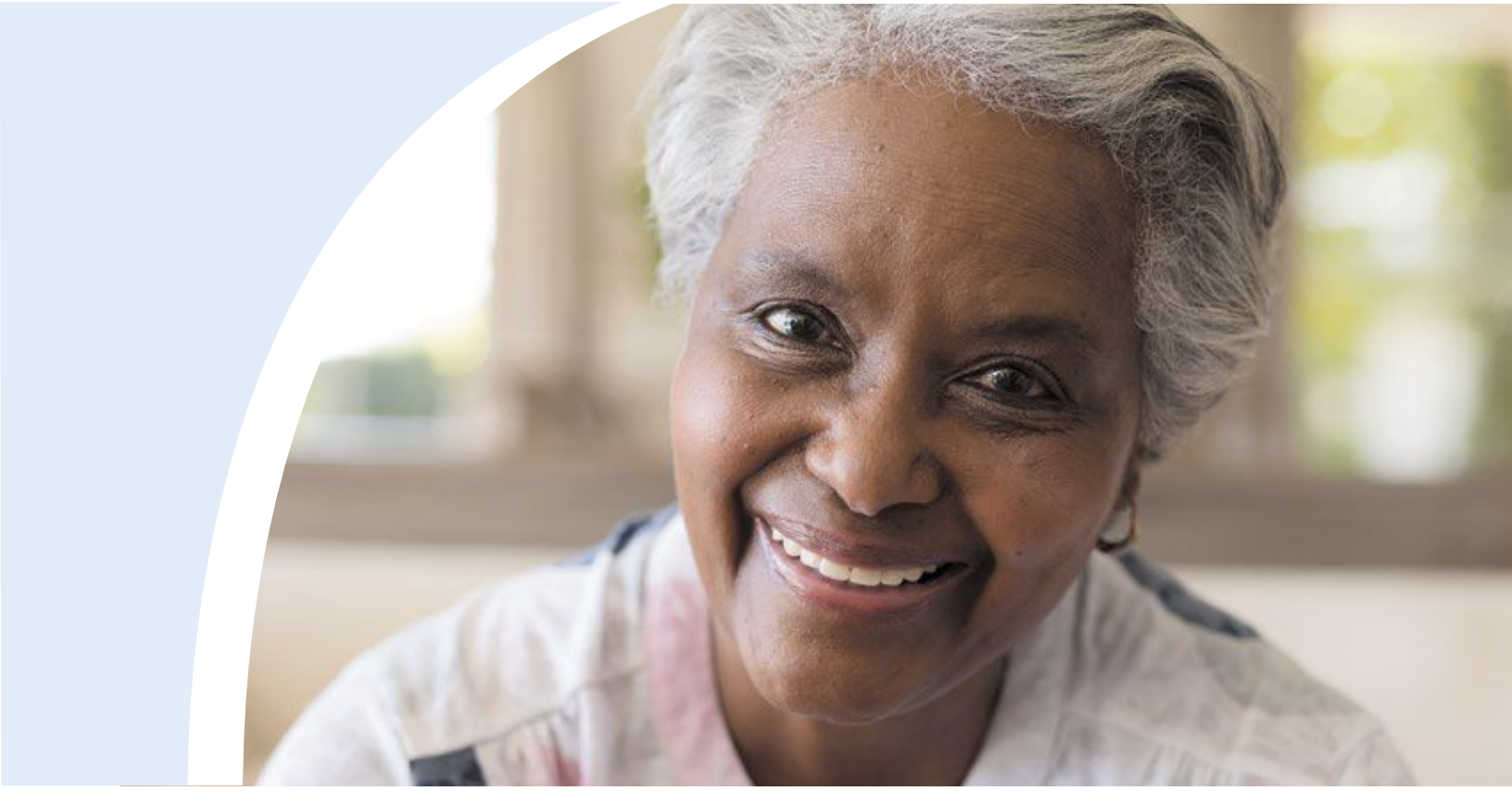
Call your State Health Insurance Assistance Program (SHIP) to make sure that you qualify for any of these guaranteed issue rights. Visit **shiphelp.org** to get the number for your local SHIP.

Call your **State Insurance Department** if you're denied Medigap coverage in any of these situations.

There may be times when more than one of the situations on pages 18–19 applies to you. When this happens, you can choose the guaranteed issue right that works best for your situation.

One 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 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 only sell you a Medigap policy 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.

Some individuals may have additional rights under their state law. Call your State Insurance Department or local SHIP to find out more information.



Section 4:

Steps to buying a Medigap policy

Buying a **Medigap policy** is an important decision. As you shop for a Medigap policy, **keep in mind there can be big differences in the premiums that different insurance companies charge for the same coverage**, and not all plans are offered in every state.

Before you contact any insurance companies, figure out if you're in your **Medigap Open Enrollment Period** or if you have a guaranteed issue right to buy a policy. If you have questions, call your State Health Insurance Assistance Program (SHIP). Visit **shiphelp.org** to get the number for your local SHIP.

Note: Go to page 40 for definitions of **blue** words

STEP 1: Decide which plan you want

Medigap plans are standardized, and in most states are named by letters, Plans A–N.

- Compare the benefits of each lettered plan.
- Think about your current and future health care needs. Decide which benefits you'll need. Remember, you might not be able to switch policies later.
- Select the plan that meets your needs.

Review the information on pages 6–7 for information about the different benefits Medigap policies cover. If you live in Massachusetts, Minnesota, or Wisconsin, go to pages 35–37.

STEP 2: Pick your policy

Find insurance companies selling the plan you want. As you shop for a policy, be sure you're comparing the same lettered plan offered by different insurance companies (for example, compare Plan A from one company with Plan A from another company).

Price is the only difference between policies with the same letter sold by different companies. Since costs can vary widely between companies, contact more than one company that sells Medigap policies in your state to get an estimate.

Remember, not all plans are offered in every state, and if a state offers a plan, not all insurance companies sell policies for it. Visit Medicare.gov/medigap-supplemental-insurance-plans to find out which insurance companies sell Medigap policies in your state.

Contact your local State Health Insurance Assistance Program (SHIP) to get free help choosing an insurance company in your area. SHIPs are state programs that give free local health insurance counseling to people with Medicare and their families. Visit shiphelp.org to get the number for your local SHIP. 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.

- Contact your State Insurance Department. Find out if they have any complaints against the insurance companies selling the plan you want.
- Talk to someone you trust, like a family member, your insurance agent, or a friend who has a Medigap policy from the same insurance company.

If you don't have a computer, your local library or senior center may be able to help you. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

STEP 3: Contact the company

Get an official quote from the insurance company. Prices can change at any time based on when you buy, your health conditions, and more.

Use this resource to help you keep track of the information you get from the insurance companies you contact.

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:** Not all plans are offered in every state, and if a state offers a plan, not all insurance companies sell policies for it. Make sure the insurance 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 you're in your Medigap Open Enrollment Period or have a guaranteed issue right to buy that Medigap policy, medical underwriting doesn't apply. 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.		
"Do you price this Medigap policy by using community-rating, issue-age-rating, or attained-age-rating?" (Go to page 12.)		
"I'm ___ years old. What would my premium be under this Medigap policy?" **Note:** If it's priced as an attained-age policy 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.		
"Do you offer any discounts or additional benefits?"		

- Once you decide on the plan you want, and what insurance company you want to buy your policy from, contact the company for an application.

  Fill out the application carefully and completely, and answer any medical questions. If you buy a Medigap policy during your Medigap Open Enrollment Period or give evidence that you're entitled to a guaranteed issue right, the insurance company can't use any medical answers you give to deny you a Medigap policy or change the price.
- The insurance company must give you a clearly worded summary of your Medigap policy. Read it carefully and keep it for your files. If you buy from an agent, get a receipt with the insurance company's name, address, and phone number for your records.

Watch out for illegal practices

Every Medigap policy must follow federal and state laws designed to protect you. It's important to watch out for illegal practices by agents and brokers or insurance companies to protect yourself when you're shopping for a Medigap policy.

It's illegal if someone tries to:

- Pressure you to buy a Medigap policy or lie to get you to switch to a new company or policy.
- Sell you a Medigap policy if they know:
  - You already have one. They can only sell you a new policy if you state, in writing, that you plan to cancel your existing policy.
  - You have Medicaid, except in limited situations.
  - You're in a **Medicare Advantage Plan**, unless you're switching back to Original Medicare. They can sell you a policy if your Medicare Advantage Plan coverage will end before the Medigap policy's start date.
  - That policy can't legally be sold in your state. Check with your State Insurance Department to make sure that the Medigap policy you're interested in can be sold in your state.
- Claim that:
  - A Medigap policy is part of the Medicare program or any other federal program. Medigap is private health insurance.
  - A Medicare Advantage Plan is a Medigap policy.
  - They're a Medicare representative if they work for a Medigap insurance company.
- Suggest the Medigap policy has been approved or recommended by the federal government, or misuse the names, letters, or symbols of the:
  - U.S. Department of Health and Human Services (HHS)
  - Social Security Administration (SSA)
  - Centers for Medicare and Medicaid Services (CMS)

- 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**. If you join a Medicare Advantage Plan, you'll be disenrolled from Original Medicare and can't buy a Medigap policy.
- Ask you questions about your family history or require you to take a genetic test.

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.

After you buy a policy

- **Start your Medigap policy**

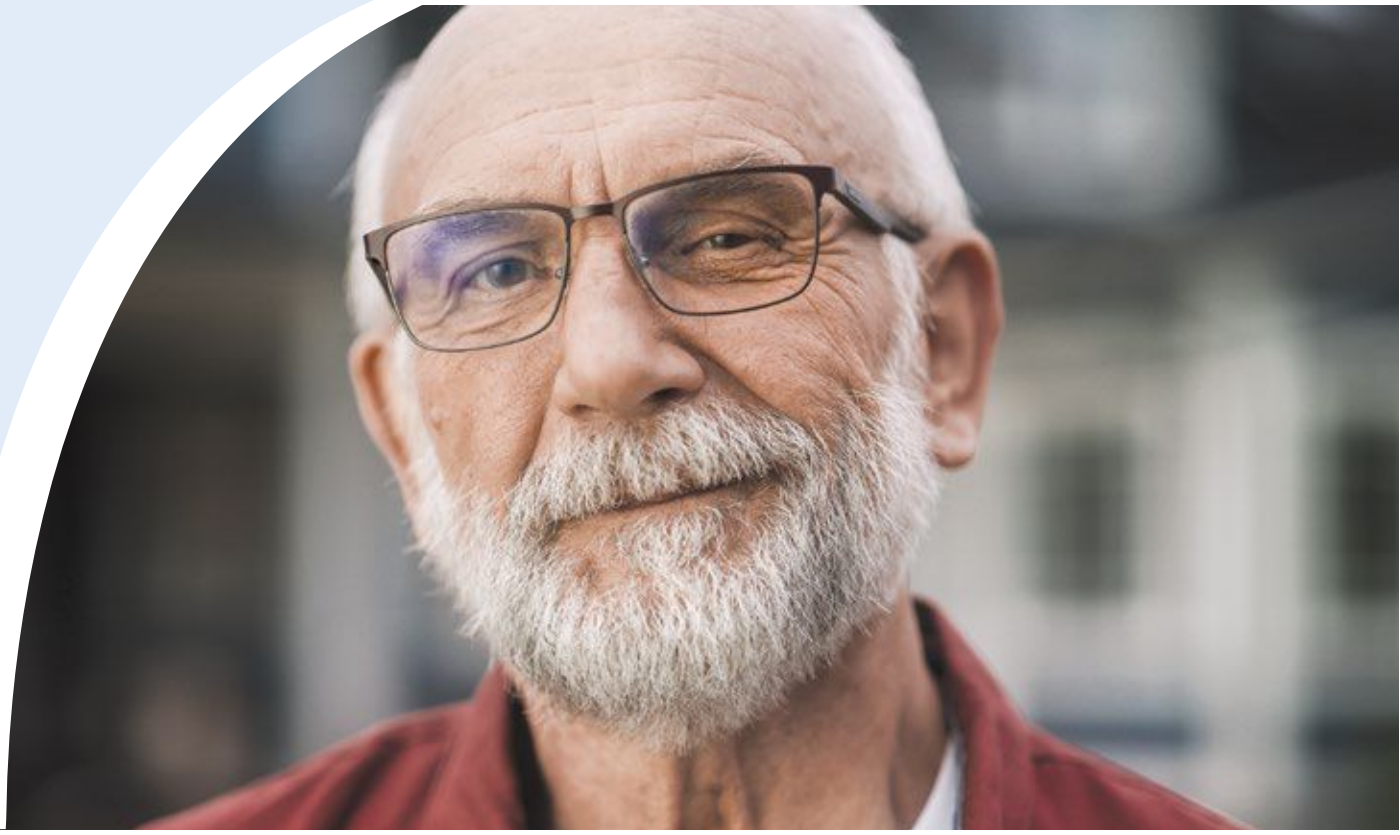
  Generally, Medigap policies begin the first day of the month after you apply.

  If it's been 30 days and you didn't get your Medigap policy (like your Medigap card or proof of insurance), call your insurance company. If it's been 60 days, call your State Insurance Department.

  Note: If you already have a Medigap policy, ask for your new Medigap policy to become effective when your old Medigap policy coverage ends.

- **Pay for your Medigap policy**

  Your insurance company will let you know what your payment options are for your particular policy. Many companies let you set up recurring automatic payments 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. Always direct your payment to the insurance company, not the agent who sold you the policy (if you used one).



Section 5:

If you already have a Medigap policy

If you already have a Medigap policy, it's important to understand when you can drop or switch your Medigap policy and the impacts that will have. It's also important to understand how Medigap works with drug coverage.

Note: Go to page 40 for definitions of **blue** words

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.
- You're eligible under a specific situation or guaranteed issue right. Go to page 16.

If your state has different rules, or the insurance company is willing to sell you a Medigap policy, make sure you compare benefits and premiums before switching. Contact your State Insurance Department to find out the rules in your state.

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," which starts when you get your new Medigap policy. **You'll need to pay both premiums the month that you have both.**

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

If you have an older Medigap policy, you don't have to switch. But if you buy a new Medigap policy, you have to cancel your old policy (except for your 30-day "free look period"). Once you cancel your old policy, you can't get it back.

If you bought your Medigap policy before June 1, 2010, it may offer coverage that isn't available in a newer Medigap policy.

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** and want to switch to a different Medigap policy, you may have to wait up to 6 months for the new policy to cover your pre-exisitng conditions.

- Your new Medigap policy must subtract the number of months you've had your current Medigap policy or prior creditable coverage (like health insurance you recently had through your employer) from the time you must wait before they'll cover your pre-existing condition.

  For example, if someone had a pre-existing condition and had creditable coverage (as described above) for 2 months and then gets a new Medigap policy, the new policy won't cover that condition for another 4 months

- If your new Medigap policy has a benefit that isn't in your current Medigap policy, you may 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 it has the same benefits as your new policy, the new insurance company can't exclude your pre-existing condition or make you wait before it covers it. If the insurance company agrees to issue you a new policy, they can't put pre-existing conditions, waiting periods, elimination periods, or probationary periods into the replacement policy.

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.
- You want to change insurance companies.
- You want a policy that costs less.

It's important to compare the benefits in your current Medigap plan to the plan you're considering switching to.

If you decide to switch 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. Make sure your old Medigap policy coverage ends after you have the new Medigap policy for 30 days (your 30 day "free look period"). The insurance company will tell you how to end your coverage.
If you live in Massachusetts, Minnesota, or Wisconsin, go to pages 35–37.

If I move out of state, can I keep my current Medigap policy (or Medicare SELECT policy) or switch to a different Medigap policy?

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 Medigap insurance company about your options.

Remember, 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 10–11.)

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 as long as it offers the same (or fewer) benefits as 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 switch to Medigap Plan A, B, C, D, F, G, K, or L that's sold by an insurance company in your state or a Medicare SELECT policy offered in the area you're moving to.

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 haven't enrolled yet, 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 Plan D or G instead of Plan C or F.

You may have additional rights under state law. Call your State Health Insurance Assistance Program (SHIP) or **State Insurance Department** for more information. Visit **shiphelp.org** to get the number for your local SHIP.

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

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.

You may want to drop your Medigap policy because you'll be paying for coverage you can't use. If you decide to keep your Medigap policy, you'll have to pay your Medigap policy premium. Your Medigap policy can't pay any Medicare Advantage Plan deductibles, copayments, **coinsurance**, or premiums.

Contact your Medigap insurance company to find out how to cancel your Medigap policy. **In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to get the same policy back (or in some cases any Medigap policy) unless you leave your Medicare Advantage Plan during your trial period** (you have a "trial right" (page 19)). Contact your State Insurance Department for more information.

Losing Medigap coverage

Can my Medigap insurance company drop me?

All standardized Medigap policies bought **after 1992** are automatically renewed every year, even if you have health problems. This means your Medigap insurance company can only drop you if:

- You stop paying your premium
- You weren't truthful on the Medigap policy application
- The insurance company goes bankrupt or goes out of business

If you bought your Medigap policy **before 1992**, the Medigap insurance company can refuse to renew your Medigap policy, as long as it gets the state's approval to cancel your policy. If that happens, you have the right to buy another Medigap policy. Go to pages 16–19 for more information about guaranteed issue rights.

Medigap policies and Medicare drug coverage (Part D)

Medigap plans sold after 2005 don't include prescription drug coverage.
If you want prescription drug coverage, you can join a separate **Medicare drug plan (Part D)**.

What if I have a Medigap policy that already has prescription drug coverage?

If you have a Medigap policy with prescription drug coverage, 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.

You can join a Medicare drug plan between October 15–December 7. Your new coverage will begin on January 1.

If your Medigap premium or your prescription drug needs were low when you had your first chance to join a Medicare drug plan, your Medigap coverage may have met your needs. However, if your Medigap premium increased or you've started taking more prescription drugs recently, a Medicare drug plan may be a better choice for you.

In a Medicare drug plan, you may have to pay a monthly premium, and a Medicare drug plan covers certain prescription drugs on its "formulary" or "drug list." It's important to check if your current drugs are on the Medicare drug plan's list of covered drugs before you join.

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

Your Medigap insurance company must send you a notice each year telling you if their prescription drug coverage 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 to join a Medicare drug plan later.

Before you decide to join a Medicare drug plan (Part D), consider:

- **If your Medigap policy includes creditable drug coverage** 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 stop the drug coverage from your Medigap policy before you join the Medicare drug plan and the coverage starts.
- **If your Medigap policy doesn't include creditable drug coverage**, you'll probably have to pay a late enrollment penalty if you join a Medicare drug plan now. The penalty amount increases for each month you wait to get Part D. In general, you'll have to pay this penalty for as long as you have Part D.

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.

If you decide to join a Medicare drug plan:

- You'll have to tell your Medigap insurance company to remove the drug coverage from your Medigap policy (and adjust your premium).
- You can't add drug coverage back to your Medigap policy.

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 may not be able to get the same policy back (or in some cases any Medigap policy), so pay careful attention to the timing**.

Section 6:

Medigap policies for people with a disability or ESRD

You may have Medicare before 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, in some states insurance companies do offer Medigap policies to people under 65.

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. Visit **content.naic.org/state-insurance-departments** to find your State Insurance Department. Visit **shiphelp.org** to get the number for your local SHIP.

Note: Go to page 40 for definitions of **blue** words

Which states offer Medigap policies to people with Medicare under 65?

At the time of printing this guide, these states require 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 have in your state.

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 more than Medigap policies sold to people over 65, and they probably use **medical underwriting**. 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. Visit **content.naic.org/state-insurance-departments** to find your State Insurance Department.

If you already have Medicare Part B (Medical Insurance), you'll still 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 (Hospital Insurance) and/or Part B (Medical Insurance) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, go to pages 10–11. If you have questions, call your State Health Insurance Assistance Program (SHIP). Visit **shiphelp.org** to get the number for your local SHIP.

Section 7:

Medigap coverage in Massachusetts, Minnesota, and Wisconsin

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way from the benefits on page 7.

Massachusetts benefits (page 35)

Minnesota benefits (page 36)

Wisconsin benefits (page 37)

Visit Medicare.gov/medigap-supplemental-insurance-plans or call your State Insurance Department for more information on these Medigap policies:

- Massachusetts: 1-877-563-4467
- Minnesota: 1-800-657-3602
- Wisconsin: 1-800-236-8517

Note: Go to page 40 for definitions of blue words

Massachusetts

In Massachusetts, Medigap policies are standardized in a different way and offer these basic benefits:

- **Inpatient hospital costs:** Covers the Medicare Part A coinsurance, and covers 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:** Covers Hospice coinsurance or copayment

Note: Supplement 1 Plan (which includes coverage of the Part B deductible) is no longer available, unless you were eligible for Medicare before January 1, 2020, but haven't yet enrolled. If you already have Supplement 1 Plan, you can keep it.

Check marks mean the benefit is covered.

Medigap benefits	Core Plan	Supplement 1 Plan	Supplement 1 A 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)	✓	✓	✓

Minnesota

In Minnesota, Medigap policies are standardized in a different way and offer these basic 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:** Covers Hospice and respite cost sharing
- **Parts A and B:** Covers Home health services and supplies cost sharing

Check marks 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 100 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 add more coverage to a Basic Plan. You may choose any or all of these options to design a Medigap policy that meets your needs:

- Part A inpatient hospital deductible
- Part B deductible**
- Usual and customary fees
- Preventive care Medicare doesn't cover

* 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 haven't 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 7 for details.).

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

There's only 1 Medigap plan available if you live in Wisconsin, which is standardized in a different way and offers these basic 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 3 pints of blood each year
- **Part A:** Covers Hospice coinsurance or copayment

Check marks 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 what Medicare covers
Home health care	40 visits per year in addition to what Medicare covers
Benefits that Wisconsin must offer (known as state-mandated benefits)	✓

Plans known as "50% and 25% cost-sharing plans" are available. These plans are similar to standardized Plans K (50%) and L (25%) on page 7. A high-deductible plan ($2,870 for 2025) is also available.

Optional riders

Insurance companies can add more coverage to the Medigap policy. You may choose any or all of these coverage options to design a Medigap policy that meets your needs:

- Part A deductible
- Additional home health care (365 visits including those paid by Medicare)
- Part B deductible*
- Part B excess charge
- Foreign travel emergency
- 50% Part A deductible
- Part B copayment or coinsurance

*Coverage of the Part B deductible is no longer available. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to get this benefit.

Section 8:

More Information

Where to get more information

- **Visit shiphelp.org to get the number for your local State Health Insurance Assistance Program (SHIP)**. Your SHIP can provide 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. Visit content.naic.org/state-insurance-departments to find your State Insurance Department.

Note: Go to page 40 for definitions of blue words

How to get help with Medicare and Medigap questions

- **Visit Medicare.gov**

  To find 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.

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 benefits 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 benefits after you pay any deductibles. A copayment is a fixed amount, like $30.

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—The payment amount that Original Medicare sets for a covered service or item. When your provider accepts assignment, Medicare pays its share and you pay your share of that amount.

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 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, 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 Medical Assistance (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 3 ways to file a complaint with the U.S. Department of Health & 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 & 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 Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, $300

Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en español. Para obtener una copia gratis, visite Medicare.gov o llame al 1-800-MEDICARE.

Medicare

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

"Choosing a Medigap Policy" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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