Benefits & Enrollment Guide

November 2026 – March 2027



MEDICARE SUPPLEMENT

Senior Preferred
Senior Security
Senior Saver

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

D50119 10/26

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



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

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

- Help pay Original Medicare deductibles, copayments, and coinsurance
- No specialist referrals needed
- No waiting period for preexisting conditions
- Includes SilverSneakers LIVE online classes and workshops, and On-Demand training videos
- Covers hearing aid services, plus free upgrades to rechargeable hearing aids[1]
- See any doctor in the U.S. who accepts Medicare with our Senior Security and Senior Saver plans.
- Access to an Arizona network with over 42,000 providers (Senior Preferred℠ plan)[2]
- Save with the Early Enrollment Discount[3] and Household Discount[4]

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

1-888-264-1733, TTY: 711
8 a.m. to 8 p.m.

Daily: October 1 – March 31
Monday – Friday: April 1 – September 30
Or, contact your broker

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

Medicare Supplement Plans **THAT WORK FOR YOU**

You've earned your Medicare benefits. At AZ Blue, you'll find Medicare Supplement plans that work hard to help you be your healthiest.

Extras for Your Best Health

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

Easy Access to Quality Care

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

Caring for Your Happiness

For over 85 years, our local Member Services team has consistently delivered personalized service with health insurance expertise to make our members feel good.

What You'll Find Inside

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What Is a Medicare Supplement Plan?

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

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

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

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

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



Find the Right Plan for You

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

Senior Security and Senior Saver Plans

Coverage that travels with you.



Life on the go and a plan to match.
If you travel often or spend a lot of time out of state, the Senior Security or Senior Saver plan could be right for you.

At a glance:

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

Senior Preferred Plan

Affordable coverage close to home.



Peace of mind and savings.
This plan gives you a choice. If you stay closer to home, the Senior Preferred Medicare Select plan may be better for you.

At a glance:

- No preexisting condition waiting periods
- Choice of over 42,000 in-network doctors and hospitals in Arizona*
- No referrals required to see doctors or specialists within the plan's network

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

Savings and Wellness Extras

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

Fitness Programs[2]

(not applicable to Senior Saver plan)
SilverSneakers® is more than a fitness program. It's an opportunity to improve your health, gain confidence, and connect with your community at no additional cost with an AZ Blue Medicare Supplement plan. Whether you play tennis, swim laps, lift weights, visit the gym, or take live classes from home, SilverSneakers has you covered. Movement and exercise are essential to your health, and SilverSneakers supports you in any way you decide to move. Questions? Visit **SilverSneakers.com** or call **1-888-423-4632, TTY: 711,** Monday through Friday, 8 a.m. to 8 p.m. ET.

Hearing Services

(not applicable to Senior Saver plan)
Get a comprehensive hearing care solution with high-quality hearing aids and local, professional care at a fraction of the cost through TruHearing®.[3] In addition to offering an online hearing assessment tool, TruHearing acts as a concierge service that guides you through the full process, from scheduling the exam, to selecting the product, and obtaining the hearing aids. Members get two TruHearing-branded hearing aids (one per ear per year) starting at $699-$999 copay per aid. To learn more or schedule an appointment, call **1-855-205-6360** or visit our website at **TruHearing.com/bcbsazms.**

Prescription Savings Program

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

24/7 Nurse On Call

(not applicable to Senior Saver plan)
Getting answers to your health questions is easy with Nurse On Call.[5] For no additional cost, you can talk to a registered nurse any time you need—days, nights, weekends, and holidays—from wherever you are. Contact a Nurse On Call 24/7 at **1-866-422-2729, TTY: 711.**

Health & Wellness Discounts[6]

Enjoy discounts on a wide range of health, wellness, and lifestyle products and services from brands you know with Blue365.®
Visit **blue365deals.com/BCBSAZ** or call **1-855-511-2583, TTY: 711** to learn more.

Additional Coverage Options

Do You Like to Travel? AZ Blue offers travel insurance to ensure you are covered no matter where you are.

International Health Plans from GeoBlue®

The name you trust at home can go with you anywhere in the world.
Not all medical insurance covers you when you leave the U.S. If you're traveling or living abroad, you'll want to make sure you have access to the same quality care you're used to, from a partner that can ensure you get the treatment you need when you need it. Part of the AZ Blue family, GeoBlue[7] offers a variety of international health plans when you go on vacation or live and work abroad. Visit **azblue.com/geobluetravel** to learn more.

We've got you covered!



Getting Started

HERE'S WHAT YOU CAN EXPECT AFTER YOU ENROLL.

Check your mail for these important communications:



Confirmation of Enrollment

Once your enrollment is approved, you'll receive a confirmation letter which can be used as proof of insurance until you receive your ID card.



New Member Kit

You will also receive a New Member Kit which includes a Quick Start Guide, your ID card, and your Plan Benefit Book. The guide contains important information you need to know about your plan and how to easily navigate your healthcare coverage. Be sure to save this guide for helpful information at your fingertips.



Member ID Card

Please present your member ID card every time you receive healthcare services. Take a moment and review it for accuracy. Remember to keep your card where you can easily find it, and do not let anyone else use it.



Find a Doctor

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

Important steps to take once you're enrolled



Schedule Your Annual Physical Exam

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



Questions? Call Us.

602-864-4122 (Arizona)
Toll Free: **1-800-232-2345, ext. 4122**
We're here from 8 a.m. to 5 p.m. (Arizona time), Monday through Friday.

OUTLINE OF COVERAGE

Benefit Chart of Medicare Supplement Plans sold on or after January 1, 2026

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

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

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G***	**K**	**L**	**M**	**N**	**C**	**F***
Medicare Part A coinsurance and hospital coverage (Up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply***	✓	✓
Blood (First 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled Nursing Facility Care coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A Deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B Deductible									✓	✓
Medicare Part B Excess Charges				✓						✓
Foreign Travel Emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-Of-Pocket Limit in 2026**					$8,000	$4,000				

*Plans F and G also have a high-deductible option which requires 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 towards meeting the plan deductible.

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

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

Blue Cross Blue Shield of Arizona Premium Rate Information — **Non-Tobacco Use** and **Tobacco Use**

Rates are effective November 1, 2026, through March 31, 2027, for the Senior Saver plan and April 1, 2026, through March 31, 2027, for Senior Security and Senior Preferred plans. Blue Cross Blue Shield of Arizona can only raise your premium if we raise the premium for all policies like yours in Arizona. Should this occur, you will receive a 30-day notice.

Early-enrollment discount

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

2026 Medicare Supplement Plan Monthly Rates at a Glance

SENIOR SAVER℠ • NON-TOBACCO USE

Early Enrollment Discount – ages 65–72

BLUEVALUE℠ RATES												
AGE	Plan G						Plan N					
	Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)		Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$210.30	$181.06	$175.79	$151.35	$180.65	$155.53	$190.54	$164.04	$159.27	$137.12	$163.67	$140.91
66	$210.30	$181.06	$175.79	$151.35	$180.65	$155.53	$190.54	$164.04	$159.27	$137.12	$163.67	$140.91
67	$210.30	$181.06	$175.79	$151.35	$180.65	$155.53	$190.54	$164.04	$159.27	$137.12	$163.67	$140.91
68	$224.68	$193.43	$187.81	$161.69	$193.00	$166.16	$203.56	$175.25	$170.16	$146.49	$174.86	$150.54
69	$240.29	$206.87	$200.86	$172.92	$206.41	$177.70	$217.70	$187.43	$181.98	$156.67	$187.01	$161.00
70	$257.13	$221.37	$214.93	$185.04	$220.87	$190.16	$232.96	$200.56	$194.73	$167.65	$200.11	$172.28
71	$274.79	$236.58	$229.70	$197.75	$236.05	$203.22	$248.96	$214.34	$208.11	$179.16	$213.86	$184.12
72	$294.10	$253.20	$245.84	$211.65	$252.63	$217.50	$266.45	$229.40	$222.73	$191.75	$228.88	$197.05
73+	$410.75	$353.63	$343.35	$295.60	$352.83	$303.76	$372.14	$320.39	$311.07	$267.81	$319.67	$275.21

STANDARD RATES												
AGE	Plan G						Plan N					
	Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)		Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$458.44	$394.69	$383.21	$329.92	$393.80	$339.04	$415.35	$357.59	$347.19	$298.91	$356.78	$307.17
66	$458.44	$394.69	$383.21	$329.92	$393.80	$339.04	$415.35	$357.59	$347.19	$298.91	$356.78	$307.17
67	$458.44	$394.69	$383.21	$329.92	$393.80	$339.04	$415.35	$357.59	$347.19	$298.91	$356.78	$307.17
68	$489.78	$421.67	$409.41	$352.47	$420.72	$362.21	$443.74	$382.03	$370.92	$319.34	$381.17	$328.16
69	$523.81	$450.96	$437.85	$376.96	$449.95	$387.37	$474.57	$408.57	$396.69	$341.52	$407.65	$350.96
70	$560.52	$482.57	$468.54	$403.38	$481.48	$414.52	$507.83	$437.20	$424.49	$365.46	$436.22	$375.56
71	$599.02	$515.71	$500.72	$431.08	$514.56	$443.00	$542.71	$467.24	$453.65	$390.56	$466.19	$401.36
72	$641.10	$551.94	$535.90	$461.37	$550.71	$474.12	$580.84	$500.06	$485.52	$418.00	$498.94	$429.55
73+	$895.40	$770.87	$748.46	$644.37	$769.14	$662.18	$811.23	$698.41	$678.11	$583.80	$696.85	$599.93

*The early-enrollment discount is reduced annually through the age of 76. For 2026, your renewal premium includes your current early-enrollment discount. For 2027 and beyond, the reduction in the early-enrollment discount will occur on our annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security, Senior Preferred, or Senior Saver plan.

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

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

2026 Medicare Supplement Plan Monthly Rates at a Glance



SENIOR SAVER • TOBACCO USE
Early Enrollment Discount – ages 65–72

BLUEVALUE℠ RATES												
AGE	Plan G						Plan N					
	Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)		Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$268.55	$231.21	$224.48	$193.72	$230.69	$198.61	$243.32	$209.48	$203.39	$175.10	$209.01	$179.94
66	$268.55	$231.21	$224.48	$193.72	$230.69	$198.61	$243.32	$209.48	$203.39	$175.10	$209.01	$179.94
67	$268.55	$231.21	$224.48	$193.72	$230.69	$198.61	$243.32	$209.48	$203.39	$175.10	$209.01	$179.94
68	$286.92	$247.01	$239.83	$206.48	$246.46	$212.19	$259.95	$223.79	$217.29	$187.07	$223.30	$192.24
69	$306.85	$264.17	$256.50	$220.82	$263.59	$226.92	$278.00	$239.35	$232.39	$200.07	$238.81	$205.60
70	$328.36	$282.69	$274.47	$236.30	$282.05	$242.83	$297.49	$256.12	$248.67	$214.09	$255.54	$220.00
71	$350.91	$302.11	$293.33	$252.53	$301.44	$259.51	$317.92	$273.71	$265.76	$228.79	$273.10	$235.12
72	$375.57	$323.34	$313.94	$270.28	$322.61	$277.75	$340.26	$292.94	$284.43	$244.86	$292.28	$251.63
73+	$524.53	$451.58	$438.45	$377.48	$450.57	$387.91	$475.22	$409.13	$397.24	$341.99	$408.21	$351.44

STANDARD RATES												
AGE	Plan G						Plan N					
	Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)		Region 1 (Maricopa and Pinal counties)		Region 2 (Pima and Santa Cruz counties)		Region 3 (All other counties)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$585.43	$504.02	$489.36	$421.31	$502.88	$432.95	$530.40	$456.64	$443.36	$381.71	$455.61	$392.26
66	$585.43	$504.02	$489.36	$421.31	$502.88	$432.95	$530.40	$456.64	$443.36	$381.71	$455.61	$392.26
67	$585.43	$504.02	$489.36	$421.31	$502.88	$432.95	$530.40	$456.64	$443.36	$381.71	$455.61	$392.26
68	$625.45	$538.47	$522.82	$450.10	$537.26	$462.54	$566.66	$487.85	$473.66	$407.80	$486.75	$419.06
69	$668.91	$575.88	$559.13	$481.38	$574.59	$494.67	$606.03	$521.74	$506.57	$436.12	$520.57	$448.18
70	$715.78	$616.24	$598.33	$515.12	$614.85	$529.34	$648.50	$558.30	$542.07	$466.69	$557.05	$479.59
71	$764.95	$658.56	$639.42	$550.49	$657.09	$565.71	$693.04	$596.67	$579.31	$498.75	$595.32	$512.54
72	$818.68	$704.83	$684.34	$589.17	$703.26	$605.45	$741.73	$638.58	$620.01	$533.79	$637.15	$548.54
73+	$1,143.42	$984.40	$955.78	$822.86	$982.20	$845.60	$1,035.94	$891.87	$865.94	$745.51	$889.87	$766.12

2026 Medicare Supplement Plan Monthly Rates at a Glance

SENIOR SECURITY℠ • NON-TOBACCO USE
Early Enrollment Discount – ages 65–72

BLUEVALUE℠ RATES						
AGE	**Plan A**	**Plan C***	**Plan D**	**Plan F***	**Plan G**	**Plan N**
65	$202.43	$162.42	$239.28	$263.24	$226.12	$188.74
66	$215.83	$173.16	$255.12	$280.66	$241.09	$201.23
67	$232.95	$186.90	$275.35	$302.92	$260.21	$217.19
68	$244.48	$196.15	$288.99	$317.92	$273.10	$227.95
69	$259.37	$208.10	$306.58	$337.28	$289.72	$241.82
70	$273.14	$219.14	$322.86	$355.18	$305.10	$254.66
71	$293.97	$235.86	$347.49	$382.28	$328.38	$274.09
72	$308.86	$247.80	$365.08	$401.64	$345.01	$287.97
73+	$372.12	$298.56	$439.86	$483.90	$415.67	$346.95

STANDARD RATES						
AGE	**Plan A**	**Plan C***	**Plan D**	**Plan F***	**Plan G**	**Plan N**
65	$326.94	$263.68	$382.74	$421.19	$365.43	$304.68
66	$348.57	$281.13	$408.06	$449.06	$389.61	$324.84
67	$376.22	$303.42	$440.43	$484.67	$420.51	$350.60
68	$394.85	$318.45	$462.24	$508.68	$441.33	$367.97
69	$418.89	$337.84	$490.38	$539.65	$468.20	$390.37
70	$441.13	$355.77	$516.41	$568.29	$493.06	$411.09
71	$474.78	$382.91	$555.81	$611.65	$530.67	$442.46
72	$498.82	$402.30	$583.95	$642.62	$557.54	$464.86
73+	$600.99	$484.70	$703.56	$774.24	$671.74	$560.07

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

*The early-enrollment discount is reduced annually through the age of 76. For 2026, your renewal premium includes your current early-enrollment discount. For 2027 and beyond, the reduction in the early-enrollment discount will occur on our annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security or Senior Preferred plan.

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

2026 Medicare Supplement Plan Monthly Rates at a Glance



SENIOR SECURITY • TOBACCO USE
Early Enrollment Discount – ages 65 – 72

BLUEVALUE℠ RATES						
AGE	**Plan A**	**Plan C***	**Plan D**	**Plan F***	**Plan G**	**Plan N**
65	$222.67	$178.66	$263.21	$289.56	$248.73	$207.61
66	$237.41	$190.48	$280.63	$308.73	$265.20	$221.35
67	$256.25	$205.59	$302.89	$333.21	$286.23	$238.91
68	$268.93	$215.77	$317.89	$349.71	$300.41	$250.75
69	$285.31	$228.91	$337.24	$371.01	$318.69	$266.00
70	$300.45	$241.05	$355.15	$390.70	$335.61	$280.13
71	$323.37	$259.45	$382.24	$420.51	$361.22	$301.50
72	$339.75	$272.58	$401.59	$441.80	$379.51	$316.77
73+	$409.33	$328.42	$483.85	$532.29	$457.24	$381.65

STANDARD RATES						
AGE	**Plan A**	**Plan C***	**Plan D**	**Plan F***	**Plan G**	**Plan N**
65	$359.63	$290.05	$421.01	$463.31	$401.97	$335.15
66	$383.43	$309.24	$448.87	$493.97	$428.57	$357.32
67	$413.84	$333.76	$484.47	$533.14	$462.56	$385.66
68	$434.34	$350.30	$508.46	$559.55	$485.46	$404.77
69	$460.78	$371.62	$539.42	$593.62	$515.02	$429.41
70	$485.24	$391.35	$568.05	$625.12	$542.37	$452.20
71	$522.26	$421.20	$611.39	$672.82	$583.74	$486.71
72	$548.70	$442.53	$642.35	$706.88	$613.29	$511.35
73+	$661.09	$533.17	$773.92	$851.66	$738.91	$616.08

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

*The early-enrollment discount is reduced annually through the age of 76. For 2026, your renewal premium includes your current early-enrollment discount. For 2027 and beyond, the reduction in the early-enrollment discount will occur on our annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security or Senior Preferred plan.

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

2026 Medicare Supplement Plan Monthly Rates at a Glance

SENIOR PREFERRED℠ • NON-TOBACCO USE
Early Enrollment Discount – ages 65–72

BLUEVALUE℠ RATES				
AGE	**Plan C***	**Plan D**	**Plan G**	**Plan N**
65	$230.07	$209.54	$226.12	$158.99
66	$245.30	$223.40	$241.09	$169.52
67	$264.75	$241.12	$260.21	$182.96
68	$277.87	$253.06	$273.10	$192.02
69	$294.78	$268.47	$289.72	$203.71
70	$310.43	$282.72	$305.10	$214.53
71	$334.11	$304.29	$328.38	$230.89
72	$351.03	$319.70	$345.01	$242.58
73+	$422.93	$385.18	$415.67	$292.27

STANDARD RATES				
AGE	**Plan C***	**Plan D**	**Plan G**	**Plan N**
65	$368.25	$335.19	$362.34	$257.14
66	$392.62	$357.37	$386.32	$274.16
67	$423.76	$385.71	$416.96	$295.90
68	$444.74	$404.81	$437.61	$310.56
69	$471.82	$429.46	$464.25	$329.46
70	$496.87	$452.25	$488.90	$346.95
71	$534.77	$486.76	$526.20	$373.43
72	$561.85	$511.40	$552.84	$392.33
73+	$676.93	$616.15	$666.07	$472.69

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

*The early-enrollment discount is reduced annually through the age of 76. For 2026, your renewal premium includes your current early-enrollment discount. For 2027 and beyond, the reduction in the early-enrollment discount will occur on our annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security or Senior Preferred plan.

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

2026 Medicare Supplement Plan Monthly Rates at a Glance

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

SENIOR PREFERRED • TOBACCO USE
Early Enrollment Discount – ages 65–72

BLUEVALUE℠ RATES				
AGE	**Plan C***	**Plan D**	**Plan G**	**Plan N**
65	$253.08	$230.49	$248.73	$174.89
66	$269.83	$245.74	$265.20	$186.47
67	$291.23	$265.23	$286.23	$201.26
68	$305.66	$278.37	$300.41	$211.22
69	$324.26	$295.32	$318.69	$224.08
70	$341.47	$310.99	$335.61	$235.98
71	$367.52	$334.72	$361.22	$253.98
72	$386.13	$351.67	$379.51	$266.84
73+	$465.22	$423.70	$457.24	$321.50

STANDARD RATES				
AGE	**Plan C***	**Plan D**	**Plan G**	**Plan N**
65	$405.08	$368.71	$398.57	$282.85
66	$431.88	$393.11	$424.95	$301.58
67	$466.14	$424.28	$458.66	$325.49
68	$489.21	$445.29	$481.37	$341.62
69	$519.00	$472.41	$510.68	$362.41
70	$546.56	$497.48	$537.79	$381.65
71	$588.25	$535.44	$578.82	$410.77
72	$618.04	$562.54	$608.12	$431.56
73+	$744.62	$677.77	$732.68	$519.96

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

*The early-enrollment discount is reduced annually through the age of 76. For 2026, your renewal premium includes your current early-enrollment discount. For 2027 and beyond, the reduction in the early-enrollment discount will occur on our annual renewal. When your discount no longer applies, you will be charged the BlueValue or Standard rate assigned to your Senior Security or Senior Preferred plan.

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

Senior Saver

Medicare (Part A) Hospital Services — Per Benefit Period

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

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

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

Please consult the latest "Choosing a Medigap Policy."

Senior Saver

Medicare (Part B) Medical Services — Per Calendar Year

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

Services	Medicare Pays	Plan G		Plan N	
		Plan Pays	You Pay	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment					
First $283 of Medicare-approved amounts*	$0	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0	$0	All costs
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
First $283 of Medicare-approved amounts*	$0	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Saver

Medicare Parts A & B

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

Services	Medicare Pays	Plan G		Plan N	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Healthcare MEDICARE-APPROVED SERVICES					
• Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
• Durable medical equipment – First $283 of Medicare-approved amounts*	$0	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2026.

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part A) Hospital Services — Per Benefit Period

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

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

Please consult the latest "Choosing a Medigap Policy."

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

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

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$1,736 (Part A deductible)	$0	$1,736 (Part A deductible)	$0
$434 a day	$0	$434 a day	$0
$868 a day	$0	$868 a day	$0
100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
$0	All costs	$0	All costs
$0	$0	$0	$0
Up to $217 a day	$0	Up to $217 a day	$0
$0	All costs	$0	All costs
3 pints	$0	3 pints	$0
$0	$0	$0	$0
Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part A) Hospital Services — Per Benefit Period

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

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

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

Please consult the latest "Choosing a Medigap Policy."

Medicare (Part B) Medical Services — Per Calendar Year

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

Services	Medicare Pays	Plan A		Plan C†	
		Plan Pays	You Pay	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment					
First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

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

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
Generally 20%	$0	Generally 20%	$0
$0	All costs	100%	$0
All costs	$0	All costs	$0
$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
20%	$0	20%	$0
$0	$0	$0	$0

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

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare (Part B) Medical Services — Per Calendar Year

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

	Plan G		Plan N	
Services	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment				
First $283 of Medicare-approved amounts*	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	100%	$0	$0	All costs
Blood				
First 3 pints	All costs	$0	All costs	$0
First $283 of Medicare-approved amounts*	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	20%	$0	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	$0	$0	$0	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare Parts A & B

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

Services	Medicare Pays	Plan A		Plan C†	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Healthcare MEDICARE-APPROVED SERVICES					
• Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
• Durable medical equipment – First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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

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

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2026.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan F†	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**
$0	$0	$0	$0
$0	$283 (Part B deductible)	$283 (Part B deductible)	$0
20%	$0	20%	$0

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

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

Please consult the latest "Choosing a Medigap Policy."

Senior Security

Medicare Parts A & B

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

	Plan G		Plan N	
Services	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Home Healthcare MEDICARE-APPROVED SERVICES				
• Medically necessary skilled care services and medical supplies	$0	$0	$0	$0
• Durable medical equipment – First $283 of Medicare-approved amounts*	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
– Remainder of Medicare-approved amounts	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2026.

Please consult the latest "Choosing a Medigap Policy."

Senior Preferred

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

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

Medicare (Part A) Hospital Services — Per Benefit Period

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

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$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 Once lifetime reserve days are used:	All but $868 a day	$868 a day	$0
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $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 having a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

Please consult the latest "Choosing a Medigap Policy."

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

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$1,736 (Part A deductible)	$0	$1,736 (Part A deductible)	$0	$1,736 (Part A deductible)	$0
$434 a day	$0	$434 a day	$0	$434 a day	$0
$868 a day	$0	$868 a day	$0	$868 a day	$0
100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
$0	All costs	$0	All costs	$0	All costs
$0	$0	$0	$0	$0	$0
Up to $217 a day	$0	Up to $217 a day	$0	Up to $217 a day	$0
$0	All costs	$0	All costs	$0	All costs
3 pints	$0	3 pints	$0	3 pints	$0
$0	$0	$0	$0	$0	$0
Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Please consult the latest "Choosing a Medigap Policy."

Senior Preferred

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

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

Medicare (Part B) Medical Services — Per Calendar Year

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

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $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	$0	All costs
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

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

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$0	$283 (Part B deductible)	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
Generally 20%	$0	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
$0	All costs	100%	$0	$0	All costs
All costs	$0	All costs	$0	All costs	$0
$0	$283 (Part B deductible)	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
20%	$0	20%	$0	20%	$0
$0	$0	$0	$0	$0	$0

Senior Preferred

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

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

Medicare Parts A & B

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

		Plan C†	
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Healthcare MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment – First $283 of Medicare-approved amounts*	$0	$283 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits Not Covered By Medicare

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

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

Medicare benefits are subject to change. The Medicare deductible and copayment amounts in this outline are effective through December 31, 2026.

Please consult the latest "Choosing a Medigap Policy."

Plan D		Plan G		Plan N	
Plan Pays	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
$0	$0	$0	$0	$0	$0
$0	$283 (Part B deductible)	$0	$283 (Unless Part B deductible has been met)	$0	$283 (Part B deductible)
20%	$0	20%	$0	20%	$0

Other Benefits Not Covered By Medicare

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

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

Please consult the latest "Choosing a Medigap Policy."

QUALITY ASSURANCE PROGRAM

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

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

GRIEVANCE PROCEDURE/REQUEST FOR RECONSIDERATION

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

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

ADDITIONAL EXCLUSION FOR SENIOR PREFERRED MEDICARE SELECT

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

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

Disclosures

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

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

Right to return policy

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

AZ Blue
Enrollment Services Department
P.O. Box 13466
Phoenix, Arizona 85002-3466

If you send the policy back to AZ Blue within 30 days after you receive it, AZ Blue 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 AZ Blue nor its contracted brokers are connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete answers are very important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. AZ Blue 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.

CHOOSING A MEDIGAP POLICY

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

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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 39 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

- 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 Original Medicare doesn't. 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)

- A Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These plans bundle together your Part A, Part B, and usually Part D.
- You may need to use doctors in its network and get approval for certain drugs or services.
- Usually have different out-of-pocket costs than Original Medicare, including a limit on out-of-pocket costs so you don't need to buy supplemental coverage like Medigap.
- Most plans offer extra benefits that Original Medicare doesn't cover—like vision, hearing, dental and more.

☑ **Part A** 

☑ **Part B** 

Most plans include:

☑ **Part D** 

☑ **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 savings on your Marketplace plan premiums or other medical costs. If you keep using the premium tax credit to lower 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 health insurance 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.

Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health and Human Services.



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 need to 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).

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.

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.

Note: Go to page 39 for definitions of **blue** words

Medigap policies are standardized

Medigap policies 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.**

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. (Go to pages 35–37.) Also, in some states, you may be able to buy another type of Medigap policy called Medicare SELECT. These are standardized policies 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.)

What Medigap policies cover

The information on page 7 gives you a snapshot of the standardized Medigap plans available in most states. 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 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 give 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.

The chart below shows basic information about the different benefits Medigap plans cover in 2026

✓ = 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 2026**			
							$,8000	$4,000		

* 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 $2,950 in 2026 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 ($202.90 in 2026), 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 15–18)

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 else 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 plan to return to Original Medicare, you can apply for a Medigap policy before your Medicare Advantage 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 separate 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 of the Medigap policies they offer. 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 15–18 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 17–18).

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 1 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 for women, non-smokers, or married people; for paying yearly or for paying your premiums using electronic funds transfer; or for multiple policies).
- Uses medical underwriting or charges 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 $2,950 (in 2026) 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 the 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.





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 39 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 17–18.

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 your state's laws. Visit **content.naic.org/state-insurance-departments** to check with your State Insurance Department and find out.



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 • Your plan's network has a significant change 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 (if you are choosing to leave the plan). OR • By the date in your plan's termination notice. • No more than 63 days after your Medicare Advantage Plan coverage ends. **Note:** Medigap policies 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: • Date your current coverage ends. • Date on the notice you get telling you that your coverage is ending (if you get one). • 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 policy ends. OR • No more than 63 days after your Medicare SELECT policy 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 signed up, 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.

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. OR • 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 repurchase the Medigap policy. (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. OR • 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 policy 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 signed up, 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 17–18 applies to you. When this happens, you can choose the guaranteed issue right that works best for your situation.

One of the situations listed includes 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**. For more information about PACE, visit **Medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Some people may have additional rights under their state's 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 39 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 34–36.

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. Visit content.naic.org/state-insurance-departments to find your local State Insurance Department information. 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 companies for quotes

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 to find out how to apply.

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 & 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 make you take a genetic test.

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

STEP 4: Apply for the plan

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 proof you have a guaranteed issue right (page 19), 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.

After you buy a policy

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 premium 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).

Get your Medigap policy materials

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 materials (like your Medigap card or proof of insurance), call your insurance company. If it's been 60 days, call your **State Insurance Department**.



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 39 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 (page 17).

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-existing 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 34–36.

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** (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, or G 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**. Go to page 18. 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 15–18 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 if you join a Part D plan 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 gives information on the minimum federal standards for Medigap policies for people under 65. 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 39 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 End-Stage Renal Disease (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 20–23.) 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 34)

Minnesota benefits (page 35)

Wisconsin benefits (page 36)

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 39 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 ($2,950 in 2026) 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 give you 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 39 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, other health care provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service as payment in full, 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.

Creditable coverage (Medigap)—Previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy.

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
- Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services 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. 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 Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format, 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 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.

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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 and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

Notes

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 es.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.

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

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

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

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

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

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

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

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

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

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Blue Cross Blue Shield of Arizona

Not a member yet?
Contact our licensed Medicare consultants.

1-888-264-1733, TTY: 711
Or, contact your broker.

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

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

azblue.com/medicare

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