Kansas City

Missouri Valley
LIFE AND HEALTH
INSURANCE COMPANY

PLANS UNDERWRITTEN BY MISSOURI VALLEY LIFE AND HEALTH INSURANCE COMPANY, ADMINISTERED BY BLUE KC.

2025 MEDICARE SUPPLEMENT

Outline of Coverage for Kansas Residents

A, F, G, High Deductible G, K, L and N
Rates valid through December 31, 2025

REV 12/24

MSUPP_KS_MVLH_24

WHAT IS MEDICARE SUPPLEMENT

MEDICARE SUPPLEMENT INSURANCE - MEDIGAP

Medicare Supplement insurance helps pay for some out-of-pocket costs not covered by Original Medicare Part A and Part B.

If you are enrolled in Medicare Part A and Part B, a Medicare Supplement plan (Medigap) can help fill the gaps. Medicare Supplement plans are designed to assist you with out-of-pocket costs from deductibles, copays and coinsurance which are not covered by Part A or Part B. A Medicare Supplement policy covers only one person so spouses must buy separate policies. Medigap plans are sold in 10 standard plans plus two high-deductible plans, each with their own set of unique benefits. Of these 10, we currently offer seven that best suit the needs of the members we serve.

All Medicare Supplement plans require you to continue to pay your Part B premium and a separate premium for the Medigap coverage. Once you enroll and continue to pay your premium, your plan will renew each year.

We're here to help you find the plan that best fits your needs! Let's get started!

BASIC BENEFITS

Hospitalization

Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. Plans K and L require insureds to pay a portion of the Part A deductible.

Medical Expenses

Part B coinsurance (generally 20 percent of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood

First three pints of blood each year. Plans K and L may require members to pay a portion of blood costs.

Hospice

Part A hospice care coinsurance or copayment. Plans K and L may require members to pay a portion of Part A hospice care coinsurance or copayments.

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS

FOR PLANS EFFECTIVE JAN. 1, 2025 - DEC. 31, 2025

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

Every company must make Plan A available. We offer the plans highlighted in blue.

Benefits	A	B	D	G[1]	K[2]	L[2]	M	N[3]	MEDICARE FIRST ELIGIBLE BEFORE JAN 1, 2020 ONLY C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	50%	75%	100%	100%[3]	100%	100%
Blood (first three pints)	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
Skilled nursing facility coinsurance			100%	100%	50%	75%	100%	100%	100%	100%
Medicare Part A deductible[4]		100%	100%	100%	50%	75%	50%	100%	100%	100%
Medicare Part B deductible[4]									100%	100%
Medicare Part B excess charges				100%						100%
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit[4]					$7,220	$3,610				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,870 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. High deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

[4] Based on 2024 numbers. 2025 numbers subject to change with updates from CMS Cost Share.

Plan A

For basic coverage at the lowest premium, choose Plan A. You'll be responsible for paying your Part A deductible and Part B deductible. The plan will pay the coinsurance thereafter, including hospitalization for 365 days after Medicare coverage ceases. After Medicare pays 80%, this plan pays the remaining 20% of the Part B coinsurance.

Plan G

You'll be entitled to all the coverage of Plan F, except you will be responsible for paying your Part B deductible.

High Deductible Plan G

You'll be entitled to all the coverage of Plan G, once you satisfy the up-front deductible amount.

Plan K and L

Plans cover a portion of the covered Medicare benefits until you reach your yearly out-of-pocket limit, after which the plan pays 100% of approved costs.

Plan N

You'll be entitled to all the coverage of Plan D, except you will be subject to up to a $20 copayment for office visits and up to a $50 copayment for emergency services.

Plan F

If you were eligible for Medicare on or before January 1, 2020, you may select Plan F. You'll be entitled to all the coverage of Plan C, plus 100 percent of Medicare Part B excess charges.

Who is Missouri Valley Life and Health Insurance Company?

Missouri Valley Life and Health Insurance Company (MVLH) is a subidiary of Blue Cross and Blue Shield of Kansas City (Blue KC). These plans are offered and underwritten by MVLH and administered by Blue KC. This means when you have questions about your plan and claims, you'll speak with the people you know and trust at Blue KC.

PLAN A

PLAN A BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:	All but $838 a day	$838 a day	$0
• While using 60 lifetime reserve days			
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	Three pints	$0
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive 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.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
– First $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
Blood			
– First three pints	$0	All costs	$0
– Next $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

SERVICES	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 $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

†Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN F

PLAN F BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	Three pints	$0
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive 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.

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

Plan F is available if beneficiary is eligible for Medicare prior to January 1, 2020.

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostictests, durable medical equipment.			
– First $257 of Medicare-approved amounts†	$0	$257 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
Blood			
– First three pints	$0	All costs	$0
– Next $257 of Medicare-approved amounts†	$0	$257 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

SERVICES	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 $257 of Medicare-approved amounts†	$0	$257 (Part B deductible)	$0
• Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Foreign Travel Not covered by Medicare - medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
– First $250 each calendar year	$0	$0	$250
– Remainder of charges	$0	80% to a lifetime max benefit of $50,000	20% and amounts over the $50,000 lifetime max

†Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN G

PLAN G BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	Three pints	$0
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive 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.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
– First $257 of Medicare-approved amounts†	$0	$0	$257 (Unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
Blood			
– First three pints	$0	All costs	$0
– Next $257 of Medicare-approved amounts†	$0	$0	$257 (Unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

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 $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Foreign Travel Not covered by Medicare - medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
– First $250 each calendar year	$0	$0	$250
– Remainder of charges	$0	80% to a lifetime max benefit of $50,000	20% and amounts over the $50,000 lifetime max

†Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

HIGH DEDUCTIBLE PLAN G

HIGH DEDUCTIBLE PLAN G BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS**	YOU PAY**
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$1,676 (Part A deductible**)	$0
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	Three pints	$0
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive 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.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,870 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS**	YOU PAY**
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
– First $257 of Medicare-approved amounts†	$0	$0	$257 (Unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
Blood			
– First three pints	$0	All costs	$0
– Next $257 of Medicare-approved amounts†	$0	$0	$257 (Unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

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 $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS**	YOU PAY**
Foreign Travel Not covered by Medicare - medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
– First $250 each calendar year	$0	$0	$250
– Remainder of charges	$0	80% to a lifetime max benefit of $50,000	20% and amounts over the $50,000 lifetime max

†Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN K

PLAN K BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$838 (50% of Part A deductible)	$838 (50% of Part A deductible) ♦
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $104.75 a day (50% of Part A Coinsurance)	Up to $104.75 a day (50% of Part A Coinsurance) ♦
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	50%	50% ♦
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/ coinsurance ♦

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7,220 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period 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.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
– First $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible) ♦****
– Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
– Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	0%	All costs (and they do not count toward annual out-of-pocket limit of $7,220)**
Blood			
– First three pints	$0	50%	50%
– Next $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible) ♦****
– Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ♦
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

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 $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible) ♦
• Remainder of Medicare-approved amounts	80%	10%	10% ♦

† Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $7,220 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

PLAN L BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$1,257 (75% of Part A deductible)	$419 (25% of Part A deductible) ♦
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $157 a day (75% of Part A Coinsurance)	Up to $52.50 a day (25% of Part A Coinsurance) ♦
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	75%	25% ♦
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of Medicare co-payment/ coinsurance ♦

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,610 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** A benefit period 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.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
– First $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible) ♦****
– Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
– Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	0%	All costs (and they do not count toward annual out-of-pocket limit of $3,610**
Blood			
– First three pints	$0	75%	25% ♦
– Next $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

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 $257 of Medicare-approved amounts†****	$0	$0	$257 (Part B deductible) ♦
• Remainder of Medicare-approved amounts	80%	15%	5% ♦

† Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $3,610 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN N

PLAN N BENEFITS

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
– First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
– 61st thru 90th day	All but $419 a day	$419 a day	$0
– 91st day and after:			
• While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
• Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
– 101st day and after	$0	$0	All costs
Blood			
– First three pints	$0	Three pints	$0
– Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*A benefit period begins on the first day you receive 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.

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

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	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.
– First $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	Generally 80%		
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
Blood			
– First three pints	$0	All costs	$0
– Next $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

PARTS A&B

SERVICES	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 $257 of Medicare-approved amounts†	$0	$0	$257 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Foreign Travel Not covered by Medicare - medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
– First $250 each calendar year	$0	$0	$250
– Remainder of charges	$0	80% to a lifetime max benefit of $50,000	20% and amounts over the $50,000 lifetime max

†Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

MEDICARE SUPPLEMENT BENEFITS FOR KANSAS RESIDENTS

DISCLOSURES
This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2025. Policies sold for effective dates prior to January 1, 2025 may have different benefits and/or premiums.

READ YOUR POLICY VERY CAREFULLY
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to MVLH, P.O. Box 419071, Kansas City, Missouri 64141-6071. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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

RENEWAL CONDITIONS
You may renew this policy as long as you live by paying the premium on time. We cannot cancel or refuse to renew your policy, or place any restrictions on it, other than for non-payment or for fraudulent misstatements made by you in your application for the policy. The ability to move from one product to another may be restricted.

CANCELLATION BY INSURED
You may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the insured, the insurer will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

RIGHT TO CHANGE PREMIUM
Your benefits are designed to cover cost-sharing amounts under Medicare. These benefits will be changed automatically to coincide with any changes in the applicable Medicare deductible and coinsurance amounts. In addition, premiums may be modified annually by providing you with at least 30 days notice. The notice may be provided via contract rider or some other appropriate means and will be mailed to you at the address which appears on our records. If you continue payment of premium after notice has been provided, it is agreed that such change is acceptable to you.

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

MVLH IS NOT CONNECTED WITH MEDICARE
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office at 1-800-772-1213 or consult The Medicare Handbook, available online at www.Medicare.gov for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT
When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

EXCLUSIONS FOR KANSAS RESIDENTS

We will not make payment for:

1. Services to the extent that Medicare will pay for them.
2. Any service or item for which benefit payment is not available under the provisions of Part A or Part B of Medicare, except for skilled nursing facility benefits, unless specifically covered as a benefit of this contract.
3. Any service or item excluded by Part A or Part B of Medicare.
4. Any charge which exceeds an amount recognized as reasonable by Medicare.
5. Services to the extent they are obtained without cost to you from any federal, state, municipal or other governmental body or agency.
6. Services for injuries or diseases related to your job to the extent you are covered or are required to be covered by a workers' compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a workers' compensation law, we will not pay for those medical services that would have been payable except for that settlement.
7. For services or supplies received from any provider in a country where the terms of any sanction, embargo, boycott, executive order or other legislative or regulatory action taken by the Congress, President or an administrative agency of the United States would prohibit payment or reimbursement by MVLH for such services.

MY PLAN INFORMATION

I have purchased Medicare Supplement plan _____ with a premium of $_____ paid on a(n)

_____ basis. This amount does not include any optional riders.

(premium mode)

Name and address of agent/broker: _____

_____

_____

_____

NOTES

2025 MEDICARE SUPPLEMENT

INSURANCE PREMIUM RATES FOR KANSAS RESIDENTS
PLANS A, F, G, AND HIGH DEDUCTIBLE G.

	PLAN A Underwritten/ First Eligible		PLAN F Underwritten/ First Eligible		PLAN G Underwritten/ First Eligible		HIGH DED. PLAN G Underwritten/ First Eligible	
ATTAINED AGE [1]	MONTHLY PREMIUM		MONTHLY PREMIUM		MONTHLY PREMIUM		MONTHLY PREMIUM	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Disabled	$162	$145	$242	$220	$193	$174	$56	$51
65	$162	$145	$242	$220	$193	$174	$56	$51
66	$165	$148	$247	$225	$196	$177	$57	$52
67	$168	$151	$252	$229	$200	$180	$58	$52
68	$171	$156	$258	$235	$209.50	$186	$59	$54
69	$175	$160	$264	$257	$209	$191	$61	$56
70	$177	$162	$268	$243	$212	$194	$62	$57
71	$183	$167	$277	$251	$219	$199	$64	$58
72	$189	$171	$283	$258	$225	$209.50	$66	$59
73	$194	$175	$292	$265	$231	$210	$67	$61
74	$199	$179	$299	$271	$237	$216	$69	$63
75	$203	$186	$307	$279	$243	$222	$71	$65
76	$209	$191	$315	$288	$250	$227	$73	$66
77	$216	$196	$324	$295	$257	$234	$75	$68
78	$222	$201	$332	$302	$264	$257	$77	$70
79	$227	$206	$343	$310	$271	$247	$79	$72
80	$234	$212	$352	$320	$279	$254	$82	$74
81	$257	$218	$361	$328	$288	$261	$84	$76
82	$247	$225	$372	$336	$295	$268	$86	$78
83	$254	$230	$382	$346	$302	$274	$88	$80
84	$261	$237	$392	$356	$310	$282	$91	$82
85+	$261	$236	$392	$356	$310	$281	$91	$82

*Premium rates are based on the age and gender of the insured on January 1 of the current year and will automatically increase on January 1 following a birthday which places the insured into the next age classification upon which premiums are based. Premiums may also change once per 12-month period due to medical costs.

INSURANCE PREMIUM RATES FOR KANSAS RESIDENTS
PLANS K, L, & N.

ATTAINED AGE [1]	PLAN K Underwritten/ First Eligible		PLAN L Underwritten/ First Eligible		PLAN N Underwritten/ First Eligible	
	MONTHLY PREMIUM		MONTHLY PREMIUM		MONTHLY PREMIUM	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Disabled	$85	$76	$125	$113	$193	$174
65	$85	$76	$125	$113	$193	$174
66	$86	$78	$127	$115	$197	$178
67	$88	$79	$130	$117	$200	$182
68	$89	$82	$132	$121	$205	$187
69	$92	$84	$136	$124	$210	$192
70	$93	$85	$138	$126	$213	$194
71	$96	$87	$142	$129	$220	$200
72	$99	$89	$146	$132	$226	$205
73	$101	$92	$150	$136	$231	$210
74	$104	$95	$154	$140	$238	$216
75	$107	$97	$158	$144	$244	$223
76	$110	$100	$162	$147	$251	$228
77	$113	$103	$167	$152	$258	$235
78	$116	$105	$171	$156	$265	$257
79	$119	$108	$176	$160	$272	$247
80	$123	$112	$181	$165	$280	$255
81	$127	$115	$187	$169	$289	$262
82	$130	$118	$192	$174	$296	$268
83	$133	$120	$196	$178	$303	$275
84	$136	$124	$201	$183	$312	$282
85+	$136	$123	$201	$182	$312	$282

*Premium rates are based on the age and gender of the insured on January 1 of the current year and will automatically increase on January 1 following a birthday which places the insured into the next age classification upon which premiums are based. Premiums may also change once per 12-month period due to medical costs.

Missouri Valley
LIFE AND HEALTH
INSURANCE COMPANY

Blue Cross and Blue Shield of Kansas City
2301 Main, P.O. Box 419169 | Kansas City, MO 64141-6169
866-264-9930 | BlueKC.com

Medicare Supplement Application

If your spouse would like to apply, a separate application must be completed.

☐ Check if eligible for Medicare due to a disability.

Requested Effective Date _____
Note: Effective dates are on the 1st of each month.

I. Personal Details

LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX	GENDER ☐ Male ☐ Female

SOCIAL SECURITY NUMBER	DATE OF BIRTH

HOME ADDRESS (Street Number and Name, Apt. Number)			
CITY	**STATE**	**ZIP**	**COUNTY**

ALTERNATE ADDRESS (Please indicate only one): ☐ Billing Only ☐ Billing and All Correspondence			
CITY	**STATE**	**ZIP**	**COUNTY**

DAYTIME PHONE	HOME PHONE	E-MAIL ADDRESS

Home address denotes applicant's permanent legal address and must be completed. Alternate address should be selected if billing, I.D. cards, etc. should go to a different address.

If you would prefer information and communication in a language other than English, please contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

By including your phone number, you agree to be contacted by Us at either the primary or secondary phone number provided. If the phone number you provided is a cellular phone number any calls may subject you to charges by your cellular carrier and/or service provider as provided in your wireless rate plan (contact your carrier for pricing plans and details).

We may use your email address to provide documents, materials and other notices related to coverage.

This Medicare Supplement product is offered by Missouri Valley Life and Health Insurance Company (MVLH), a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City (Blue KC).

II. Medicare Information

Please complete the information below as it appears on your Medicare card. Or, attach a copy of your Medicare card or your Letter of Verification from the Social Security or Railroad Retirement Office. We cannot consider this form complete until we have obtained this information.	
NAME	
MEDICARE OR RAILROAD RETIREMENT BOARD NUMBER	
IS ENTITLED TO:	
HOSPITAL INSURANCE (PART A)	EFFECTIVE DATE
MEDICAL INSURANCE (PART B)	EFFECTIVE DATE

III. Coverage Selection: Medical

MEDICARE SUPPLEMENT			
☐ Plan A[2]	☐ Plan F[2]*	☐ Plan G[2]	☐ High Deductible Plan G[2]
☐ Plan K[2]	☐ Plan L[2]	☐ Plan N[2]	
*Only beneficiaries who were either entitled to Medicare due to disability/ESRD, or who turned 65, prior to January 1, 2020 are eligible to select a **Plan F** policy.			

☐ **YES** ☐ **NO**	Were you Age 65 and eligible for Medicare prior to 1/1/2020?
☐ **YES** ☐ **NO**	Were you entitled to Medicare prior to 1/1/2020 due to disability/ESRD?

V. Other Insurance Information

To the best of your knowledge, please answer the following questions:		
☐ **YES**	☐ **NO**	1. A. Did you turn age 65 in the last 6 months?
☐ **YES**	☐ **NO**	B. Will you be turning 65 in the next 6 months?
☐ **YES**	☐ **NO**	C. Did you enroll in Medicare Part B in the last 6 months? D. If yes, what is the effective date? Date: _____
☐ **YES**	☐ **NO**	E. Are you enrolling in Medicare Part B in the next 6 months? F. If yes, what is the effective date? Date: _____
☐ **YES**	☐ **NO**	2. A. Are you covered for medical assistance through the state Medicaid Program? NOTE TO APPLICANT: If you are participating in a "Spenddown Program" and have not met your "Share of Cost," please answer NO to this question.
☐ **YES**	☐ **NO**	B. If yes, will Medicaid pay your premiums for this Medicare supplement policy?
☐ **YES**	☐ **NO**	C. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

☐ **YES**	☐ **NO**	3. A. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below and provide applicable policy and company information. If you are still covered under this plan, leave "END" blank. Start: _____ End :_____ Company: _____ Plan ID#: _____ When was your policy effective: _____ Company Phone Number: _____
☐ **YES**	☐ **NO**	B. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
☐ **YES**	☐ **NO**	C. Was this your first time in this type of Medicare Plan?
☐ **YES**	☐ **NO**	D. Did you drop a Medicare supplement policy to enroll in the Medicare plan? NOTE: It is your responsibility to disenroll from your existing Medicare Advantage plan.
☐ **YES**	☐ **NO**	4. A. Do you have another Medicare supplement policy in force? B. If yes, with what company and what plan do you have? Company: _____ Plan ID#: _____ C. When was your policy effective: _____ Company Phone Number: _____
☐ **YES**	☐ **NO**	D. If so, do you intend to replace your current Medicare supplement policy with this policy?
☐ **YES**	☐ **NO**	5. A. Have you had coverage under Blue KC, MVLH or any other health insurance within the past 63 days? For example, an employer, union or individual plan. B. If so, with what company and what kind of policy? Company: _____ Plan ID#: _____ Company Phone Number: _____ C. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank? Start _____ End _____
☐ **YES**	☐ **NO**	6. If you have dependents on your current Blue KC individual policy, do you want to continue coverage for the dependents?

VI. Required Notices

You do not need more than one Medicare Supplement Policy.
If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Policy.
If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union- based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).
If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.
This Medicare Supplement product is offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City.

VII. Medical Questionnaire

Complete questions 1 and 2 below, and then complete the Medical Questions only if NOT applying during a GI or OE period.

Open Enrollment (OE) – A one-time only, 6-month period when federal law allows you to buy any Medicare Supplement policy you want that's sold in your state.		
Guaranteed Issue (GI) – Guaranteed Issue rights are your rights to buy certain Medicare Supplement policies in certain situations outside of your Medicare Supplement Open Enrollment Period.		
Guaranteed Acceptance – PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE		
☐ **YES**	☐ **NO**	1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period?
☐ **YES**	☐ **NO**	2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed issue?
If you answered Yes to either question, please proceed directly to Section VIII		
GENETIC INFORMATION NONDISCRIMINATION ACT: The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic test, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.		

Height:		Weight:
☐ **YES**	☐ **NO**	1. Within the past three years have you had or been treated for a stroke, phlebitis, heart attack, chronic heart condition or congestive heart failure?
☐ **YES**	☐ **NO**	2. Have you ever had heart valve surgery, a pacemaker or other implanted cardiac device?
☐ **YES**	☐ **NO**	3. Within the past three years have you been diagnosed with or treated for any type of cancer, excluding common skin cancer?
☐ **YES**	☐ **NO**	4. Within the past three years have you been diagnosed with or treated for Parkinson's Disease, Alzheimer's Disease, Dementia or Bipolar disorder?
☐ **YES**	☐ **NO**	5. Have you ever been diagnosed or treated for emphysema, any chronic lung condition or use oxygen?
☐ **YES**	☐ **NO**	6. Have you had an amputation due to disease or trauma?

☐ **YES**	☐ **NO**	7. Any complications from diabetes including retinopathy, neuropathy, edema or kidney disease? Have you ever been advised to have dialysis of any kind?
☐ **YES**	☐ **NO**	8. Any treatment for severe disabling arthritis, fibromyalgia, myasthenia gravis, lupus, multiple sclerosis, amyothrophic lateral sclerosis (ALS), paralysis, joint replacement or organ transplant of any kind?
☐ **YES**	☐ **NO**	9. Ever been diagnosed or treated for drug or alcohol abuse, cirrhosis of the liver, HIV, AIDS or AIDS related complex (ACR)?
☐ **YES**	☐ **NO**	10. In the past 5 years, have you been advised to have surgery or treatment not yet performed?
☐ **YES**	☐ **NO**	11. Do you walk with a cane or walker, use a wheelchair or are you bedridden?
☐ **YES**	☐ **NO**	12. Have you been hospitalized, inpatient or outpatient within the last 2 years?
☐ **YES**	☐ **NO**	13. Are you currently taking any medications?

Please complete the following information for any "yes" responses to Medical questions 1 through 13 above.

Question #	Type of Ailment or Diagnosis of Condition	Date of Condition	Date of Last Treatment	Date of Surgery	Prescription Drugs Being Taken	Name(s) and Address(es) of Physician(s)

VIII. Agreement and Acknowledgment

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Missouri Valley Life and Health has the right to reject my application and any premiums paid will be refunded. I understand and agree that any incorrect statements made by me in this application will invalidate my coverage and that all statements made by me will, in the absence of fraud, be deemed representations and not warranties. I realize that any fraudulent misrepresentation regarding the presence of preexisting impairments or disease will result in cancellation of my coverage retroactive to the effective date. This application is submitted subject to all the terms and conditions of the policy under which application is made. I hereby agree to accept all terms and conditions of the policy. I acknowledge that I have received an outline of coverage.

You agree that by checking "Yes" you consent and request that MVLH, our affiliates, and those acting on our or their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include advertisements or telemarketing messages concerning our or our affiliates' benefits and services. You understand that consent is not a condition of purchase. ☐ **Yes** ☐ **No**

If MVLH receives your application before your 65th birthday, your coverage can begin on the first day of your birthday month.

If your 65th birthday is on the first day of the month, your coverage can begin on the first day of the previous month.

Rates quoted are based upon your age at the time of your initial effective date of coverage and zip code. If requesting a future effective date results in your age changing, your quoted rate may change.

The Benefits and Premium amounts displayed are based on the selected start date and may change if a different date is chosen. If you wish to select a different start date, you will need to click cancel application and start over.

Applicant's Signature:

Printed Name:

Date:

OFFICE USE ONLY

Date Received	Effective Date	Pre-X Effective Date	Closed Date
List Bill Number	Class	Health Plan	
Area/Issue Age	Premium	Reason for Decline	

IX. Applicant Representative

This section is to be filled out when the individual filling out the application is either not the primary applicant or is below 18 years of age.

LAST NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT
HOME ADDRESS (Street Number and Name, Apt. Number)		
CITY	STATE	ZIP
PRIMARY PHONE NUMBER	COUNTY	

NONDISCRIMINATION NOTICE

DISCRIMINATION IS AGAINST THE LAW. Blue KC and MVLH comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC and MVLH do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC and MVLH:

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

If you need these services, contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC or MVLH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

BROKER REPRESENTATION **(if applicable)**

I represent that to the best of my knowledge all statements are complete and accurate.

Blue KC/MVLH Broker Number (required)	DATE
PRINTED BROKER'S NAME	BROKER SIGNATURE
TELEPHONE NUMBER	E-MAIL ADDRESS
1.List any health insurance policies you have sold to the applicant which are still in force:	
2.List any other health insurance policies you have sold to the applicant in the past five (5) years which are no longer in force:	

NOTICE REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

_____ Other. (please specify) _____

_____

Please read the required notices below. MVLH does not impose any pre-existing condition limitations, waiting periods, elimination periods or probationary periods.

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

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

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

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

Blue KC/MVLH Broker Number (Required If Applicable)	

I represent that to the best of my knowledge all statements are complete and accurate.		
PRINTED BROKER'S/AGENT'S/ OTHER REPRESENTATIVE'S NAME	SIGNATURE*	DATE
PRINTED APPLICANT'S NAME	SIGNATURE	DATE

*Signature not required for direct response sales.

Payment Options

☐ **Pay by check**. Make checks payable to **BCBS of KC**. Please remember to enclose correct premium payment.

☐ **Pay by electronic funds transfer.** I understand that my premium will be deducted from my bank account automatically each month on the **5th day** of the month (or next business day) for the full premium due.

- Your first premium will be processed immediately upon approval.
- For future payments, your account will be drafted on the 5th day of the month

NAME	SOCIAL SECURITY #
NAME OF BANK	NAME ON ACCOUNT
ROUTING NUMBER (9 digit #)	BANK ACCOUNT #
SIGNATURE	TODAY'S DATE

☐ **Pay by credit card.** I understand that my credit card will be charged automatically each month on the **5th day** of the month (or next business day) for the full premium due.

CHOOSE ONE: ☐ Visa or ☐ Master Card			
ACCOUNT NUMBER	EXPIRATION DATE		CVV CODE
BILLING ADDRESS	CITY	STATE	ZIP
ACCOUNT NAME	SIGNATURE		

CREDIT CARD AUTHORIZATION: We offer the convenience of paying by credit card. Payment by credit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit card for your full premium each month (all information must be complete for processing). To cancel your automatic credit card authorization, your request must be received **10 days prior** to your credit card withdrawal date.

For Agent Use Only

AGENT'S FULL NAME	AGENT #		
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	EMAIL ADDRESS		

NOTES

800-867-9014
www.bluekc.com/shop-plans/medicare-plan-options/medicare-supplement/

Missouri Valley
LIFE AND HEALTH
INSURANCE COMPANY

PLANS UNDERWRITTEN BY MISSOURI VALLEY LIFE AND HEALTH INSURANCE COMPANY, ADMINISTERED BY BLUE KC.

Medicare Supplement plans are offered and underwritten by MVLH, a wholly owned subsidiary of Blue Cross and Blue Shield of Kansas City, and are administered by Blue Cross and Blue Shield of Kansas City. Missouri Valley Life and Health (MVLH) and Blue Cross and Blue Shield of Kansas City are not connected with or endorsed by the U.S. government or the federal Medicare program.

P.O. Box 419169, Kansas City, MO 64141-6169
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