

Overview of Available Plans

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Medicare Supplement Plans A, B, C, F, K, L, N are currently being offered by UnitedHealthcare Insurance Company.

Basic Benefits:

- **Hospitalization:** Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B co-insurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance

Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to \$20 co-payment for office visit, and up to \$50 copayment for ER
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible					
				Part B excess (100%)	Part B excess (100%)				
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
						Out-of-pocket limit \$4940; paid at 100% after limit reached	Out-of-pocket limit \$2470; paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This option is not currently offered by UnitedHealthcare Insurance Company. This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.**

Your Guide to AARP Medicare Supplement Insurance Portfolio of Plans

How to Use Your Guide

This Guide contains detailed information about the AARP Medicare Supplement Insurance Plans.

The AARP Medicare Supplement Insurance Portfolio of Plans, insured by UnitedHealthcare Insurance Company, provides a choice of benefits to AARP members, so you can choose the plan that best fits your individual supplemental health insurance needs.

To help you choose the AARP Medicare Supplement Plan to meet your needs and budget:

- Look at the Cover Page which shows the benefits of each Medicare supplement plan and indicates any specific provisions that may apply in your state. Also be sure to review the Monthly Premium information. Benefits and cost vary depending upon the plan selected.
- For more information on a specific plan, look at the chart(s) which outline(s) the benefits of that plan. The detailed chart(s) show(s) the expenses Medicare pays, the benefits the plan pays and the specific costs you would have to pay yourself.

If you have any questions, call toll free, 1-800-523-5800, any weekday from 7 a.m. to 11 p.m. or Saturday from 9 a.m. to 5 p.m., Eastern Time. For members with speech or hearing impairments who have access to TTY, call 711 weekdays from 9 a.m. to 5 p.m., Eastern Time. Hablamos español — llame al 1-800-822-0246, de lunes a viernes, de las 8 a.m. a las 5 p.m. y sábado de las 9 a.m. a las 5 p.m., hora del este.

Eligibility to Apply

To be eligible to apply, you must be an AARP member or spouse of a member, age 50 or older, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare supplement coverage. (Note: If you are not yet age 65, you may only enroll if you are enrolling within the 6 months after either 1) enrolling in Medicare Part B; or 2) your termination from the Maryland Health Insurance Plan as a result of your enrollment in Medicare Part B and you must include evidence of termination from the Maryland Health Insurance Plan along with your enrollment form. If you meet either of these requirements, you may only enroll in Plan A or C. Please note that you may be eligible to enroll in Plans other than A and C and/or enroll outside of the 6 month time frame if you are an “Eligible Person” entitled to guaranteed acceptance as shown in the following “Guaranteed Acceptance” section.)

Guaranteed Acceptance

- Your acceptance in any plan is guaranteed during your Medicare supplement open enrollment period which lasts for 6 months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.
- If you are an AARP member, age 55 or over, and enrolled in Medicare Parts A and B solely due to disability, you are entitled to guaranteed acceptance into all available AARP Medicare Supplement Plans if all of the following is true:

Your employee welfare benefit plan terminates;

You are receiving pension benefits paid by the federal Pension Benefit Guaranty Corporation; and

You apply for Medicare supplement coverage no later than 63 days after your employee welfare benefit plan terminates.

If you meet this criteria and are interested in an AARP Medicare Supplement Plan other than Plan C, please include along with your enrollment application: 1) evidence of loss of your employee welfare benefit plan, and 2) proof that you are receiving pension benefits paid by the federal Pension Benefit Guaranty Corporation.

- If you lose health insurance coverage and are an eligible AARP member, you may be considered an “Eligible Person” entitled to guaranteed acceptance and you may have a guaranteed right to enroll in certain AARP Medicare Supplement Plans under specific circumstances. You are required to:
 1. Apply within the required time period following the termination of your prior health insurance plan.
 2. Provide a copy of the termination notice you received from your prior insurer with your application. This notice must verify the circumstances of your prior plan’s termination and describe your right to guaranteed issue of Medicare supplement insurance.

If you have any questions on your guaranteed right to insurance, you may wish to contact the administrator of your prior health insurance plan or your local state department on aging.

Glossary of Terms

Medicare Eligible Expenses are the health care expenses of the kinds covered under Medicare Parts A and B that Medicare recognizes as reasonable and medically necessary. Physicians under Medicare can agree to accept Medicare's eligible expense as their fee amount. Your physician or surgeon may charge you more.

Excess Charge is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Hospital or Skilled Nursing Facility — A hospital is an institution that provides care for which Medicare pays hospital benefits. A skilled nursing facility is a facility that provides skilled nursing care and is approved for payment by Medicare. The skilled nursing facility stay must begin within 30 days after a hospital stay of 3 or more days in a row or a prior covered skilled nursing facility stay. Custodial care does not qualify as an eligible expense.

Lifetime Reserve Days are limited by Medicare to 60 days during your lifetime. Once these are used, Medicare provides no hospital coverage after 90 days of a benefit period.

Hospice Care means care for those who are terminally ill. Hospice Care typically focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers.

This package describes the AARP Medicare Supplement Plans available in your state, but is not a contract, policy, or insurance certificate. Please read your Certificate of Insurance, upon receipt, for plan benefits, definitions, exclusions, and limitations. AARP Medicare Supplement Plans have been developed in line with federal standards. **However, these plans are not connected with, or endorsed by, the U.S. Government or the federal Medicare program.** The Policy Form No. GRP79171 GPS-1 (G-36000-4) is issued in the District of Columbia to the Trustees of the AARP Insurance Plan. By enrolling, you are agreeing to the release of Medicare claim information to UnitedHealthcare Insurance Company so your AARP Medicare Supplement Plan claims can be processed automatically.

AARP does not employ or endorse agents, brokers or producers.

This is a solicitation of insurance. An agent may contact you.

General Exclusions

- Benefits provided under Medicare.
- Care not meeting Medicare's standards.
- Care or supplies received before your plan's effective date.
- Any period of hospital or skilled nursing facility stay that occurs prior to the effective date.
- Injury or sickness payable by Workers' Compensation or similar laws.
- Stays or treatment provided by a government-owned or -operated hospital or facility unless payment of charges is required by law.
- Stays, care, or visits for which no charge would be made to you in the absence of insurance.
- Any expenses you incur during the first 3 months after your effective date will not be considered if due to a pre-existing condition. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within 3 months prior to your plan's effective date.

The following individuals are entitled to a waiver of this pre-existing condition exclusion:

1. Individuals who are replacing prior creditable coverage within 63 days after termination, or
2. Individuals who are turning age 65 and whose application form is received within six (6) months after they turn 65 AND are enrolled in Medicare Part B, OR
3. Individuals who are "Eligible Persons" entitled to Guaranteed Acceptance, or
4. Individuals who have been covered under other health insurance coverage within the last 63 days and have enrolled in Medicare Part B within the last 6 months.

Other exclusions may apply; however, in no event will your plan contain coverage limitations or exclusions for the Medicare Eligible Expenses that are more restrictive than those of Medicare. Benefits and exclusions paid by your plan will automatically change when Medicare's requirements change.

You Cannot Be Singled Out for Cancellation

Your Medicare supplement plan can never be canceled because of your age, your health, or the number of claims you make. Your Medicare supplement plan may be canceled due to nonpayment of premium or material misrepresentation. If the group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company. Of course, you may cancel your AARP Medicare Supplement Plan any time you wish. All transactions go into effect on the first of the month following receipt of the request.

The AARP Insurance Trust

AARP established the AARP Insurance Plan, a trust, to hold the master group insurance policies. The AARP Medicare Supplement Insurance Plan is insured by UnitedHealthcare Insurance Company, not by AARP or its affiliates. Please contact UnitedHealthcare Insurance Company if you have questions about your policy, including any limitations and exclusions.

Premiums are collected from you by the Trust. These premiums are paid to the insurance company for your insurance coverage, a percentage is used to pay expenses, benefitting the insureds, and incurred by the Trust in connection with the insurance programs. At the direction of UnitedHealthcare Insurance Company, a portion of the premium is paid as a royalty to AARP and used for the general purposes of AARP. Income earned from the investment of premiums while on deposit with the Trust is paid to AARP and used for the general purposes of AARP.

Participants are issued certificates of insurance by UnitedHealthcare Insurance Company under the master group insurance policy. The benefits of participating in an insurance program carrying the AARP name are solely the right to receive the insurance coverage and ancillary services provided by the program.



AARP Medicare Supplement Plans insured by: UnitedHealthcare Insurance Company

1-800-523-5800

For information about the family of health products and services

www.aarphealthcare.com

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$0	\$1,216 (Part A deductible)
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	\$0	Up to \$152 per day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

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

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan A Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Notes

3 Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan B

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$1,216 (Part A deductible)	\$0
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	\$0	Up to \$152 per day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

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

Plan Benefit Tables: Plan B (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan B Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All Costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan B Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Notes

3 Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$1,216 (Part A deductible)	\$0
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	Up to \$152 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

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

Plan Benefit Tables: Plan C (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ³	\$0	\$147 (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 \$147 of Medicare-approved amounts ³	\$0	\$147 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan C Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ³	\$0	\$147 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits not covered by Medicare				
Service		Medicare Pays	Plan C Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Notes

³ Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: **Plan F**

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$1,216 (Part A deductible)	\$0
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	Up to \$152 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

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

Plan Benefit Tables: Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ³	\$0	\$147 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	100%	\$0
Blood	First 3 pints	\$0	All costs	\$0
	Next \$147 of Medicare-approved amounts ³	\$0	\$147 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ³	\$0	\$147 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits not covered by Medicare

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

Notes

³ Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan K Pays	You Pay ³
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$608 (50% of Part A deductible)	\$608 (50% of Part A deductible)◆
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	Up to \$76 per day	Up to \$76 per day◆
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	50%	50%◆
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	50% of co-payment/ co-insurance	50% of Medicare co-payment/ co-insurance◆

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Notes

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

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

3 You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4940 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 the 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.

Plan Benefit Tables: Plan K (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay ⁴
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ⁵	\$0	\$0	\$147 (Part B deductible) ⁵ ◆
	Preventive Benefits for Medicare Covered Services	Generally 75% 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 \$4940) ⁴
Blood	First 3 pints	\$0	50%	50%◆
	Next \$147 of Medicare-approved amounts ⁵	\$0	\$0	\$147 (Part B deductible) ⁵ ◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay ⁴
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0

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Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4940 per 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.

5 Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K (continued)

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay ⁴
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ⁶	\$0	\$0	\$147 (Part B deduct- ible)◆
	Remainder of Medicare-approved amounts	80%	10%	10%◆


Notes

⁶ Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan Benefit Tables: Plan L

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan L Pays	You Pay ³
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$912 (75% of Part A deductible)	\$304 (25% of Part A deductible) ♦
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	Up to \$114 per day	Up to \$38 per day ♦
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	75%	25% ♦
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	75% of co-payment/ co-insurance	25% of Medicare co-payment/ co-insurance ♦

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Notes

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

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

3 You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2470 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 the 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.

Plan Benefit Tables: Plan L (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan L Pays	You Pay ⁴
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ⁵	\$0	\$0	\$147 (Part B deductible) ⁵ ◆
	Preventive Benefits for Medicare Covered Services	Generally 75% 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 \$2470) ⁴
Blood	First 3 pints	\$0	75%	25%◆
	Next \$147 of Medicare-approved amounts ⁵	\$0	\$0	\$147 (Part B deductible) ⁵ ◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay ⁴
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2470 per 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.

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5 Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan L (continued)

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay ⁴
Durable medical equipment Medicare-approved services	First \$147 of Medicare-approved amounts ⁶	\$0	\$0	\$147 (Part B deduct- ible)◆
	Remainder of Medicare-approved amounts	80%	15%	5%◆

Notes

⁶ Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan Benefit Tables: **Plan N**

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,216	\$1,216 (Part A deductible)	\$0
	Days 61–90	All but \$304 per day	\$304 per day	\$0
	Days 91 and later while using 60 lifetime reserve days	All but \$608 per day	\$608 per day	\$0
	After lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0 ²
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹ 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
	Days 21–100	All but \$152 per day	Up to \$152 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

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

Plan Benefit Tables: **Plan N** (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0

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Notes

3 Once you have been billed \$147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Parts A and B, continued

Service		Medicare Pays	Plan N Pays	You Pay
Durable Medical Equipment Medicare-approved services	First \$147 of Medicare-approved amounts ³	\$0	\$0	\$147 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits not covered by Medicare

Foreign Travel NOT COVERED BY MEDICARE - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Rules and Disclosures about this Insurance

This page explains important rules governing your Medicare supplement coverage. These rules affect you. Please read them carefully and make sure you understand them before you buy or change any Medicare supplement insurance.

Premium information

You may keep your Medicare supplement plan in force by paying the required monthly premium when due. Monthly rates shown reflect current premium levels and all rates are subject to change. Any change will apply to all members of the same class insured under your plan who reside in your state. Your premium can only be changed with the approval of AARP and/or your state insurance department.

Disclosures

Use this outline to compare benefits and premiums among plans.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

Read your certificate very carefully

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

Your right to return the certificate

If you find that you are not satisfied with your coverage, you may return the certificate to:

UnitedHealthcare
P.O. Box 1000
Montgomeryville, PA 18936-1000

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate 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 certificate and are sure you want to keep it.

Notice

The certificate may not fully cover all of your medical costs. Neither UnitedHealthcare Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Centers for Medicare & Medicaid Services (CMS) publication *Medicare & You* for more details.

Complete answers are very important

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