

## Instructions Page

### Please Read Before Printing

This file contains an electronic version of the AARP® Medicare Supplement Insurance Plans pre-enrollment kit booklet. It may be substituted for the AARP Medicare Supplement Enrollment Material booklet, which is in the printed pre-enrollment kit. This file may be e-mailed to prospects.<sup>1</sup> It includes:

- Rates – Cover Page(s)
- Overview of Available Plans
- Your Guide to AARP's Medicare Supplement Insurance Portfolio of Plans*
- Plan Benefit Tables
- Enrollment Checklist
- Enrollment Application
- AARP Membership Application
- Automatic Payments Authorization Form<sup>2</sup> (see below)
- Replacement Notice<sup>3</sup> (see below)
- Conditional Receipt<sup>4</sup> (see below)
- New York Agent Required Disclosure<sup>5</sup>
- “Thank You” - an opportunity to note the plan and premium the applicant requested and a description of “What to Expect”

The *2010 Choosing a Medigap Policy* booklet is published by the federal government as an aid for people with Medicare. **Agents can get these documents electronically (including the supplement with the 2011 Medicare deductibles and co-pays) through the agent portal by clicking Product Information and Materials>Materials>Sales Materials>Year>State>Any County>Medicare Supplement.**

<sup>1</sup>A copy of the booklet, with the supplement, must be delivered to the prospect at the time of application.

<sup>2</sup>Two copies of the Automatic Payments Authorization Form are also included in this file. If the applicant is requesting the automatic payment option, the applicant must fill out and sign both copies of the form. The applicant keeps one completed signed copy; the other completed signed copy must be submitted with the enrollment application.

<sup>3</sup>Two copies of the Replacement Notice are included in this file. If the applicant is replacing coverage, both copies are to be filled out and signed. The applicant keeps one completed signed copy and the other completed signed copy must be submitted with the enrollment application.

<sup>4</sup>Two copies of the Conditional Receipt are also included in this file. If an amount is being collected as a premium deposit, please complete both copies. The applicant must keep one completed/signed copy for his or her records. The other completed/signed copy must be retained in your records.

<sup>5</sup>New York Agent Required Disclosure must be presented to the applicant on or before time of sale.

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#### Please mail completed applications to:

Regular Mail:  
UnitedHealthcare Ins. Co.  
PO Box 105331  
Atlanta, GA 30348-5331

Overnight Mail:  
Attn: Application Processing Dept.  
UnitedHealthcare  
4868 GA Hwy 85, Ste 100  
Forest Park, GA 30297  
Phone: 404-751-9906

Dear Prospective Member,

Thank you for taking the time to learn more about the AARP<sup>®</sup> Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company.

Hopefully, you now have a good idea of how the plans work and have had your questions answered. As you take some more time to review this material, you may want to pay special attention to the following:

- **Outline of Medicare Supplement Coverage** – This includes an overview of the plans and the benefits covered under each plan. It will also help you identify the benefits most important to you and help you choose the plan that best fits your individual needs. For a more detailed description of the benefits, look for the plan of your choice toward the end of the booklet.
- **Cover Page – Rates** – This page shows the rates for each of the plans described on the Outline of Medicare Supplement Coverage.
- **Your Guide** – This contains detailed information about the Medicare supplement plans available to you.

If you haven't already applied to enroll, your Sales Representative can help you complete and submit the Application Form. Remember to include the first month's premium and, if you are not already an AARP member, please remember to include your completed AARP Membership form and a check or money order for your annual Membership dues.

If you have any questions, call toll-free: 1-866-387-7550 any weekday from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

We look forward to answering your questions. Please feel free to call.

Sincerely,



Susan Morisato,  
President, Insurance Solutions  
UnitedHealthcare Insurance Company

Important disclosure on back



(10-10)

The AARP Medicare Supplement Insurance Plans carry the AARP name and UnitedHealthcare Insurance Company pays a royalty fee to AARP for use of the AARP intellectual property. Amounts paid are used for the general purposes of AARP and its members. Neither AARP nor its affiliate is the insurer.

AARP doesn't make individual recommendations for health-related products, services, insurance or programs. You are strongly encouraged to evaluate your needs and compare products.

Insured by UnitedHealthcare Insurance Company, Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy Form No. GRP 79171 GPS-I (G-36000-4). In some states, plans may be available to persons eligible for Medicare by reason of disability. All plans may not be available in your state/area.

**Not connected with or endorsed by the U.S. Government or the Federal Medicare Program.**

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

AARP and its affiliate are not insurance agencies or carriers and do not employ or endorse insurance agents, brokers, producers, representatives or advisors.

See enclosed materials for complete information including benefits, costs, eligibility requirements, exclusions and limitations.



Rates shown are valid for Plan effective dates through December 1, 2012.

# Cover Page - Rates for New York - Area 1

## Monthly Plan Rates

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company of New York

| Plan A                | Plan B   | Plan C   | Plan F   | Plan K   | Plan L   | Plan N   |
|-----------------------|----------|----------|----------|----------|----------|----------|
| <b>Standard Rates</b> |          |          |          |          |          |          |
| \$156.50              | \$213.75 | \$249.50 | \$250.75 | \$102.00 | \$145.50 | \$161.00 |

These rates are for plan effective dates from January - December 2011.

# NEW YORK Area 1 ZIP Codes, Effective August 1, 2010

The ZIP Codes Below Apply to Rates Included on the Page Headed "Cover Page – Rates"

|       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 00501 | 10044 | 10125 | 10199 | 10313 | 10523 | 10603 | 10986 | 11210 | 11357 | 11427 | 11568 |
| 00544 | 10045 | 10126 | 10203 | 10314 | 10526 | 10604 | 10989 | 11211 | 11358 | 11428 | 11569 |
| 06390 | 10046 | 10128 | 10211 | 10451 | 10527 | 10605 | 10993 | 11212 | 11359 | 11429 | 11570 |
| 10001 | 10055 | 10129 | 10212 | 10452 | 10528 | 10606 | 10994 | 11213 | 11360 | 11430 | 11571 |
| 10002 | 10060 | 10130 | 10213 | 10453 | 10530 | 10607 | 11001 | 11214 | 11361 | 11431 | 11572 |
| 10003 | 10065 | 10131 | 10242 | 10454 | 10532 | 10610 | 11002 | 11215 | 11362 | 11432 | 11575 |
| 10004 | 10069 | 10132 | 10249 | 10455 | 10533 | 10701 | 11003 | 11216 | 11363 | 11433 | 11576 |
| 10005 | 10072 | 10133 | 10256 | 10456 | 10535 | 10702 | 11004 | 11217 | 11364 | 11434 | 11577 |
| 10006 | 10075 | 10138 | 10257 | 10457 | 10536 | 10703 | 11005 | 11218 | 11365 | 11435 | 11579 |
| 10007 | 10079 | 10149 | 10258 | 10458 | 10538 | 10704 | 11010 | 11219 | 11366 | 11436 | 11580 |
| 10008 | 10080 | 10150 | 10259 | 10459 | 10540 | 10705 | 11020 | 11220 | 11367 | 11439 | 11581 |
| 10009 | 10081 | 10151 | 10260 | 10460 | 10543 | 10706 | 11021 | 11221 | 11368 | 11451 | 11582 |
| 10010 | 10082 | 10152 | 10261 | 10461 | 10545 | 10707 | 11022 | 11222 | 11369 | 11499 | 11590 |
| 10011 | 10087 | 10153 | 10265 | 10462 | 10546 | 10708 | 11023 | 11223 | 11370 | 11501 | 11596 |
| 10012 | 10090 | 10154 | 10268 | 10463 | 10547 | 10709 | 11024 | 11224 | 11371 | 11507 | 11598 |
| 10013 | 10094 | 10155 | 10269 | 10464 | 10548 | 10710 | 11026 | 11225 | 11372 | 11509 | 11599 |
| 10014 | 10095 | 10156 | 10270 | 10465 | 10549 | 10801 | 11027 | 11226 | 11373 | 11510 | 11690 |
| 10016 | 10096 | 10157 | 10271 | 10466 | 10550 | 10802 | 11030 | 11228 | 11374 | 11514 | 11691 |
| 10017 | 10098 | 10158 | 10272 | 10467 | 10551 | 10803 | 11040 | 11229 | 11375 | 11516 | 11692 |
| 10018 | 10099 | 10159 | 10273 | 10468 | 10552 | 10804 | 11042 | 11230 | 11377 | 11518 | 11693 |
| 10019 | 10101 | 10160 | 10274 | 10469 | 10553 | 10805 | 11050 | 11231 | 11378 | 11520 | 11694 |
| 10020 | 10102 | 10161 | 10275 | 10470 | 10560 | 10901 | 11051 | 11232 | 11379 | 11530 | 11695 |
| 10021 | 10103 | 10162 | 10276 | 10471 | 10562 | 10911 | 11052 | 11233 | 11380 | 11531 | 11697 |
| 10022 | 10104 | 10163 | 10277 | 10472 | 10566 | 10913 | 11053 | 11234 | 11381 | 11535 | 11701 |
| 10023 | 10105 | 10164 | 10278 | 10473 | 10567 | 10920 | 11054 | 11235 | 11385 | 11542 | 11702 |
| 10024 | 10106 | 10165 | 10279 | 10474 | 10570 | 10923 | 11055 | 11236 | 11386 | 11545 | 11703 |
| 10025 | 10107 | 10166 | 10280 | 10475 | 10573 | 10927 | 11096 | 11237 | 11390 | 11547 | 11704 |
| 10026 | 10108 | 10167 | 10281 | 10499 | 10576 | 10931 | 11101 | 11238 | 11405 | 11548 | 11705 |
| 10027 | 10109 | 10168 | 10282 | 10501 | 10577 | 10952 | 11102 | 11239 | 11411 | 11549 | 11706 |
| 10028 | 10110 | 10169 | 10285 | 10502 | 10578 | 10954 | 11103 | 11240 | 11412 | 11550 | 11707 |
| 10029 | 10111 | 10170 | 10286 | 10503 | 10580 | 10956 | 11104 | 11241 | 11413 | 11551 | 11709 |
| 10030 | 10112 | 10171 | 10292 | 10504 | 10583 | 10960 | 11105 | 11242 | 11414 | 11552 | 11710 |
| 10031 | 10113 | 10172 | 10301 | 10505 | 10587 | 10962 | 11106 | 11243 | 11415 | 11553 | 11713 |
| 10032 | 10114 | 10173 | 10302 | 10506 | 10588 | 10964 | 11109 | 11245 | 11416 | 11554 | 11714 |
| 10033 | 10115 | 10174 | 10303 | 10507 | 10589 | 10965 | 11120 | 11247 | 11417 | 11555 | 11715 |
| 10034 | 10116 | 10175 | 10304 | 10510 | 10590 | 10968 | 11201 | 11249 | 11418 | 11556 | 11716 |
| 10035 | 10117 | 10176 | 10305 | 10511 | 10591 | 10970 | 11202 | 11251 | 11419 | 11557 | 11717 |
| 10036 | 10118 | 10177 | 10306 | 10514 | 10594 | 10974 | 11203 | 11252 | 11420 | 11558 | 11718 |
| 10037 | 10119 | 10178 | 10307 | 10517 | 10595 | 10976 | 11204 | 11256 | 11421 | 11559 | 11719 |
| 10038 | 10120 | 10179 | 10308 | 10518 | 10596 | 10977 | 11205 | 11351 | 11422 | 11560 | 11720 |
| 10039 | 10121 | 10184 | 10309 | 10519 | 10597 | 10980 | 11206 | 11352 | 11423 | 11561 | 11721 |
| 10040 | 10122 | 10185 | 10310 | 10520 | 10598 | 10982 | 11207 | 11354 | 11424 | 11563 | 11722 |
| 10041 | 10123 | 10196 | 10311 | 10521 | 10601 | 10983 | 11208 | 11355 | 11425 | 11565 | 11724 |
| 10043 | 10124 | 10197 | 10312 | 10522 | 10602 | 10984 | 11209 | 11356 | 11426 | 11566 | 11725 |

## NEW YORK Area 1 ZIP Codes CONTINUED

|       |       |       |
|-------|-------|-------|
| 11726 | 11779 | 11952 |
| 11727 | 11780 | 11953 |
| 11729 | 11782 | 11954 |
| 11730 | 11783 | 11955 |
| 11731 | 11784 | 11956 |
| 11732 | 11786 | 11957 |
| 11733 | 11787 | 11958 |
| 11735 | 11788 | 11959 |
| 11736 | 11789 | 11960 |
| 11737 | 11790 | 11961 |
| 11738 | 11791 | 11962 |
| 11739 | 11792 | 11963 |
| 11740 | 11793 | 11964 |
| 11741 | 11794 | 11965 |
| 11742 | 11795 | 11967 |
| 11743 | 11796 | 11968 |
| 11746 | 11797 | 11969 |
| 11747 | 11798 | 11970 |
| 11749 | 11801 | 11971 |
| 11751 | 11802 | 11972 |
| 11752 | 11803 | 11973 |
| 11753 | 11804 | 11975 |
| 11754 | 11815 | 11976 |
| 11755 | 11819 | 11977 |
| 11756 | 11853 | 11978 |
| 11757 | 11854 | 11980 |
| 11758 | 11901 |       |
| 11760 | 11930 |       |
| 11762 | 11931 |       |
| 11763 | 11932 |       |
| 11764 | 11933 |       |
| 11765 | 11934 |       |
| 11766 | 11935 |       |
| 11767 | 11937 |       |
| 11768 | 11939 |       |
| 11769 | 11940 |       |
| 11770 | 11941 |       |
| 11771 | 11942 |       |
| 11772 | 11944 |       |
| 11773 | 11946 |       |
| 11774 | 11947 |       |
| 11775 | 11948 |       |
| 11776 | 11949 |       |
| 11777 | 11950 |       |
| 11778 | 11951 |       |

# Cover Page - Rates for New York - Area 2

## Monthly Plan Rates

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company of New York

| Plan A                | Plan B   | Plan C   | Plan F   | Plan K  | Plan L   | Plan N   |
|-----------------------|----------|----------|----------|---------|----------|----------|
| <b>Standard Rates</b> |          |          |          |         |          |          |
| \$125.75              | \$171.75 | \$200.50 | \$201.50 | \$82.00 | \$117.00 | \$129.50 |

These rates are for plan effective dates from January - December 2011.

# NEW YORK Area 2 ZIP Codes, Effective August 1, 2010

The ZIP Codes Below Apply to Rates Included on the Page Headed "Cover Page – Rates"

|       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 10509 | 10997 | 12062 | 12133 | 12192 | 12246 | 12427 | 12477 | 12530 | 12589 | 12764 | 12831 |
| 10512 | 10998 | 12063 | 12134 | 12193 | 12247 | 12428 | 12480 | 12531 | 12590 | 12765 | 12832 |
| 10516 | 12007 | 12065 | 12136 | 12194 | 12248 | 12429 | 12481 | 12533 | 12592 | 12766 | 12833 |
| 10524 | 12008 | 12066 | 12137 | 12195 | 12249 | 12430 | 12482 | 12534 | 12593 | 12767 | 12834 |
| 10537 | 12009 | 12067 | 12138 | 12196 | 12250 | 12431 | 12483 | 12537 | 12594 | 12768 | 12835 |
| 10541 | 12010 | 12068 | 12140 | 12198 | 12252 | 12432 | 12484 | 12538 | 12601 | 12769 | 12836 |
| 10542 | 12015 | 12069 | 12141 | 12201 | 12255 | 12433 | 12485 | 12540 | 12602 | 12770 | 12837 |
| 10579 | 12016 | 12070 | 12143 | 12202 | 12256 | 12434 | 12486 | 12541 | 12603 | 12771 | 12838 |
| 10910 | 12017 | 12071 | 12144 | 12203 | 12257 | 12435 | 12487 | 12542 | 12604 | 12775 | 12839 |
| 10912 | 12018 | 12072 | 12147 | 12204 | 12260 | 12436 | 12489 | 12543 | 12701 | 12776 | 12841 |
| 10914 | 12019 | 12073 | 12148 | 12205 | 12261 | 12438 | 12490 | 12544 | 12719 | 12777 | 12843 |
| 10915 | 12020 | 12074 | 12149 | 12206 | 12288 | 12439 | 12491 | 12545 | 12720 | 12778 | 12844 |
| 10916 | 12022 | 12075 | 12150 | 12207 | 12301 | 12440 | 12492 | 12546 | 12721 | 12779 | 12845 |
| 10917 | 12023 | 12076 | 12151 | 12208 | 12302 | 12441 | 12493 | 12547 | 12722 | 12780 | 12846 |
| 10918 | 12024 | 12077 | 12153 | 12209 | 12303 | 12442 | 12494 | 12548 | 12723 | 12781 | 12848 |
| 10919 | 12025 | 12078 | 12154 | 12210 | 12304 | 12443 | 12495 | 12549 | 12724 | 12783 | 12849 |
| 10921 | 12027 | 12082 | 12156 | 12211 | 12305 | 12444 | 12496 | 12550 | 12725 | 12784 | 12850 |
| 10922 | 12028 | 12083 | 12157 | 12212 | 12306 | 12446 | 12498 | 12551 | 12726 | 12785 | 12851 |
| 10924 | 12029 | 12084 | 12158 | 12214 | 12307 | 12448 | 12501 | 12552 | 12727 | 12786 | 12852 |
| 10925 | 12031 | 12085 | 12159 | 12220 | 12308 | 12449 | 12502 | 12553 | 12729 | 12787 | 12853 |
| 10926 | 12032 | 12086 | 12160 | 12222 | 12309 | 12450 | 12503 | 12555 | 12732 | 12788 | 12854 |
| 10928 | 12033 | 12087 | 12161 | 12223 | 12325 | 12451 | 12504 | 12561 | 12733 | 12789 | 12855 |
| 10930 | 12035 | 12089 | 12165 | 12224 | 12345 | 12452 | 12506 | 12563 | 12734 | 12790 | 12856 |
| 10932 | 12036 | 12090 | 12166 | 12225 | 12401 | 12453 | 12507 | 12564 | 12736 | 12791 | 12857 |
| 10933 | 12037 | 12092 | 12167 | 12226 | 12402 | 12454 | 12508 | 12565 | 12737 | 12792 | 12858 |
| 10940 | 12040 | 12093 | 12168 | 12227 | 12404 | 12455 | 12510 | 12566 | 12738 | 12801 | 12859 |
| 10941 | 12041 | 12094 | 12169 | 12228 | 12405 | 12456 | 12511 | 12567 | 12740 | 12803 | 12860 |
| 10949 | 12042 | 12095 | 12170 | 12229 | 12406 | 12457 | 12512 | 12568 | 12741 | 12804 | 12861 |
| 10950 | 12043 | 12106 | 12172 | 12230 | 12407 | 12458 | 12513 | 12569 | 12742 | 12808 | 12862 |
| 10953 | 12045 | 12107 | 12173 | 12231 | 12409 | 12459 | 12514 | 12570 | 12743 | 12809 | 12863 |
| 10958 | 12046 | 12110 | 12174 | 12232 | 12410 | 12460 | 12515 | 12571 | 12745 | 12810 | 12865 |
| 10959 | 12047 | 12115 | 12175 | 12233 | 12411 | 12461 | 12516 | 12572 | 12746 | 12811 | 12866 |
| 10963 | 12050 | 12117 | 12176 | 12234 | 12412 | 12463 | 12517 | 12574 | 12747 | 12814 | 12870 |
| 10969 | 12051 | 12118 | 12177 | 12235 | 12413 | 12464 | 12518 | 12575 | 12748 | 12815 | 12871 |
| 10973 | 12052 | 12120 | 12180 | 12236 | 12414 | 12465 | 12520 | 12577 | 12749 | 12816 | 12872 |
| 10975 | 12053 | 12121 | 12181 | 12237 | 12416 | 12466 | 12521 | 12578 | 12750 | 12817 | 12873 |
| 10979 | 12054 | 12122 | 12182 | 12238 | 12417 | 12468 | 12522 | 12580 | 12751 | 12819 | 12874 |
| 10981 | 12055 | 12123 | 12183 | 12239 | 12418 | 12469 | 12523 | 12581 | 12752 | 12820 | 12878 |
| 10985 | 12056 | 12124 | 12184 | 12240 | 12419 | 12470 | 12524 | 12582 | 12754 | 12821 | 12879 |
| 10987 | 12057 | 12125 | 12185 | 12241 | 12420 | 12471 | 12525 | 12583 | 12758 | 12822 | 12883 |
| 10988 | 12058 | 12128 | 12186 | 12242 | 12421 | 12472 | 12526 | 12584 | 12759 | 12823 | 12884 |
| 10990 | 12059 | 12130 | 12187 | 12243 | 12422 | 12473 | 12527 | 12585 | 12760 | 12824 | 12885 |
| 10992 | 12060 | 12131 | 12188 | 12244 | 12423 | 12474 | 12528 | 12586 | 12762 | 12827 | 12886 |
| 10996 | 12061 | 12132 | 12189 | 12245 | 12424 | 12475 | 12529 | 12588 | 12763 | 12828 | 12887 |

## NEW YORK Area 2 ZIP Codes CONTINUED

12901 12996  
12903 12997  
12910 12998  
12911 13317  
12912 13339  
12913 13410  
12918 13428  
12919 13452  
12921 13459  
12923 13470  
12924 13731  
12928 13739  
12929 13740  
12932 13750  
12933 13751  
12934 13752  
12935 13753  
12936 13755  
12941 13756  
12942 13757  
12943 13774  
12944 13775  
12946 13782  
12950 13783  
12952 13786  
12955 13788  
12956 13804  
12958 13806  
12959 13837  
12960 13838  
12961 13839  
12962 13842  
12964 13846  
12972 13847  
12974 13856  
12975 13860  
12977  
12978  
12979  
12981  
12985  
12987  
12992  
12993

# Cover Page - Rates for New York - Area 3

## Monthly Plan Rates

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company of New York

| Plan A                | Plan B   | Plan C   | Plan F   | Plan K  | Plan L   | Plan N   |
|-----------------------|----------|----------|----------|---------|----------|----------|
| <b>Standard Rates</b> |          |          |          |         |          |          |
| \$108.25              | \$147.75 | \$172.50 | \$173.25 | \$70.50 | \$100.75 | \$111.25 |

These rates are for plan effective dates from January - December 2011.

# NEW YORK Area 3 ZIP Codes, Effective August 1, 2010

The ZIP Codes Below Apply to Rates Included on the Page Headed "Cover Page – Rates"

|       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 12064 | 13028 | 13088 | 13153 | 13304 | 13363 | 13469 | 13620 | 13669 | 13762 | 13862 | 14054 |
| 12108 | 13029 | 13089 | 13154 | 13305 | 13364 | 13471 | 13621 | 13670 | 13763 | 13863 | 14055 |
| 12116 | 13030 | 13090 | 13155 | 13308 | 13365 | 13472 | 13622 | 13671 | 13776 | 13864 | 14056 |
| 12139 | 13031 | 13092 | 13156 | 13309 | 13367 | 13473 | 13623 | 13672 | 13777 | 13865 | 14057 |
| 12155 | 13032 | 13093 | 13157 | 13310 | 13368 | 13475 | 13624 | 13673 | 13778 | 13901 | 14058 |
| 12164 | 13033 | 13101 | 13158 | 13312 | 13401 | 13476 | 13625 | 13674 | 13780 | 13902 | 14059 |
| 12190 | 13034 | 13102 | 13159 | 13313 | 13402 | 13477 | 13626 | 13675 | 13784 | 13903 | 14060 |
| 12197 | 13035 | 13103 | 13160 | 13314 | 13403 | 13478 | 13627 | 13676 | 13787 | 13904 | 14061 |
| 12812 | 13036 | 13104 | 13162 | 13315 | 13404 | 13479 | 13628 | 13677 | 13790 | 13905 | 14062 |
| 12842 | 13037 | 13107 | 13163 | 13316 | 13406 | 13480 | 13630 | 13678 | 13794 | 14001 | 14063 |
| 12847 | 13039 | 13108 | 13164 | 13318 | 13407 | 13482 | 13631 | 13679 | 13795 | 14004 | 14065 |
| 12864 | 13040 | 13110 | 13165 | 13319 | 13408 | 13483 | 13632 | 13680 | 13796 | 14005 | 14066 |
| 12914 | 13041 | 13111 | 13166 | 13320 | 13409 | 13484 | 13633 | 13681 | 13797 | 14006 | 14067 |
| 12915 | 13042 | 13112 | 13167 | 13321 | 13411 | 13485 | 13634 | 13682 | 13801 | 14008 | 14068 |
| 12916 | 13043 | 13113 | 13201 | 13322 | 13413 | 13486 | 13635 | 13683 | 13802 | 14009 | 14069 |
| 12917 | 13044 | 13114 | 13202 | 13323 | 13415 | 13488 | 13636 | 13684 | 13803 | 14010 | 14070 |
| 12920 | 13045 | 13115 | 13203 | 13324 | 13416 | 13489 | 13637 | 13685 | 13807 | 14011 | 14072 |
| 12922 | 13051 | 13116 | 13204 | 13325 | 13417 | 13490 | 13638 | 13687 | 13808 | 14012 | 14075 |
| 12926 | 13052 | 13117 | 13205 | 13326 | 13418 | 13491 | 13639 | 13690 | 13809 | 14013 | 14080 |
| 12927 | 13053 | 13118 | 13206 | 13327 | 13420 | 13492 | 13640 | 13691 | 13810 | 14020 | 14081 |
| 12930 | 13054 | 13119 | 13207 | 13328 | 13421 | 13493 | 13641 | 13692 | 13811 | 14021 | 14082 |
| 12937 | 13056 | 13120 | 13208 | 13329 | 13424 | 13494 | 13642 | 13693 | 13812 | 14024 | 14083 |
| 12939 | 13057 | 13121 | 13209 | 13331 | 13425 | 13495 | 13643 | 13694 | 13813 | 14025 | 14085 |
| 12945 | 13060 | 13122 | 13210 | 13332 | 13426 | 13501 | 13645 | 13695 | 13814 | 14026 | 14086 |
| 12949 | 13061 | 13123 | 13211 | 13333 | 13431 | 13502 | 13646 | 13696 | 13815 | 14027 | 14091 |
| 12953 | 13062 | 13124 | 13212 | 13334 | 13433 | 13503 | 13647 | 13697 | 13820 | 14028 | 14092 |
| 12957 | 13063 | 13126 | 13214 | 13335 | 13435 | 13504 | 13648 | 13699 | 13825 | 14029 | 14094 |
| 12965 | 13064 | 13131 | 13215 | 13337 | 13436 | 13505 | 13649 | 13730 | 13826 | 14030 | 14095 |
| 12966 | 13065 | 13132 | 13217 | 13338 | 13437 | 13599 | 13650 | 13732 | 13827 | 14031 | 14098 |
| 12967 | 13066 | 13134 | 13218 | 13340 | 13438 | 13601 | 13651 | 13733 | 13830 | 14032 | 14101 |
| 12969 | 13068 | 13135 | 13219 | 13341 | 13439 | 13602 | 13652 | 13734 | 13832 | 14033 | 14102 |
| 12970 | 13069 | 13136 | 13220 | 13342 | 13440 | 13603 | 13654 | 13736 | 13833 | 14034 | 14103 |
| 12973 | 13071 | 13137 | 13221 | 13343 | 13441 | 13605 | 13655 | 13737 | 13834 | 14035 | 14105 |
| 12976 | 13072 | 13138 | 13224 | 13345 | 13442 | 13606 | 13656 | 13738 | 13835 | 14036 | 14107 |
| 12980 | 13073 | 13139 | 13225 | 13346 | 13449 | 13607 | 13657 | 13743 | 13840 | 14037 | 14108 |
| 12983 | 13074 | 13140 | 13235 | 13348 | 13450 | 13608 | 13658 | 13744 | 13841 | 14038 | 14109 |
| 12986 | 13076 | 13141 | 13244 | 13350 | 13454 | 13611 | 13659 | 13745 | 13843 | 14039 | 14110 |
| 12989 | 13077 | 13142 | 13250 | 13352 | 13455 | 13612 | 13660 | 13746 | 13844 | 14040 | 14111 |
| 12995 | 13078 | 13143 | 13251 | 13353 | 13456 | 13613 | 13661 | 13747 | 13845 | 14041 | 14112 |
| 13020 | 13080 | 13144 | 13252 | 13354 | 13457 | 13614 | 13662 | 13748 | 13848 | 14042 | 14113 |
| 13021 | 13081 | 13145 | 13261 | 13355 | 13460 | 13615 | 13664 | 13749 | 13849 | 14043 | 14120 |
| 13022 | 13082 | 13146 | 13290 | 13357 | 13461 | 13616 | 13665 | 13754 | 13850 | 14047 | 14125 |
| 13024 | 13083 | 13147 | 13301 | 13360 | 13464 | 13617 | 13666 | 13758 | 13851 | 14048 | 14126 |
| 13026 | 13084 | 13148 | 13302 | 13361 | 13465 | 13618 | 13667 | 13760 | 13859 | 14051 | 14127 |
| 13027 | 13087 | 13152 | 13303 | 13362 | 13468 | 13619 | 13668 | 13761 | 13861 | 14052 | 14129 |

## NEW YORK Area 3 ZIP Codes CONTINUED

|       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 14130 | 14222 | 14435 | 14515 | 14586 | 14701 | 14755 | 14825 | 14884 |
| 14131 | 14223 | 14437 | 14516 | 14588 | 14702 | 14756 | 14826 | 14885 |
| 14132 | 14224 | 14441 | 14517 | 14589 | 14706 | 14757 | 14827 | 14886 |
| 14133 | 14225 | 14443 | 14518 | 14590 | 14707 | 14758 | 14830 | 14887 |
| 14134 | 14226 | 14445 | 14519 | 14591 | 14708 | 14760 | 14831 | 14889 |
| 14135 | 14227 | 14449 | 14520 | 14592 | 14709 | 14766 | 14836 | 14891 |
| 14136 | 14228 | 14450 | 14521 | 14602 | 14710 | 14767 | 14837 | 14892 |
| 14138 | 14231 | 14452 | 14522 | 14603 | 14711 | 14769 | 14838 | 14893 |
| 14139 | 14233 | 14453 | 14525 | 14604 | 14712 | 14770 | 14839 | 14894 |
| 14140 | 14240 | 14454 | 14526 | 14605 | 14714 | 14772 | 14840 | 14895 |
| 14141 | 14241 | 14456 | 14527 | 14606 | 14715 | 14774 | 14841 | 14897 |
| 14143 | 14260 | 14461 | 14529 | 14607 | 14716 | 14775 | 14842 | 14898 |
| 14144 | 14261 | 14462 | 14530 | 14608 | 14717 | 14777 | 14843 | 14901 |
| 14145 | 14263 | 14463 | 14532 | 14609 | 14718 | 14778 | 14845 | 14902 |
| 14150 | 14264 | 14464 | 14533 | 14610 | 14719 | 14779 | 14846 | 14903 |
| 14151 | 14265 | 14466 | 14534 | 14611 | 14720 | 14781 | 14847 | 14904 |
| 14166 | 14267 | 14467 | 14536 | 14612 | 14721 | 14782 | 14850 | 14905 |
| 14167 | 14269 | 14468 | 14537 | 14613 | 14722 | 14783 | 14851 | 14925 |
| 14168 | 14270 | 14469 | 14538 | 14614 | 14723 | 14784 | 14852 |       |
| 14169 | 14272 | 14470 | 14539 | 14615 | 14724 | 14785 | 14853 |       |
| 14170 | 14273 | 14471 | 14541 | 14616 | 14726 | 14786 | 14854 |       |
| 14171 | 14276 | 14472 | 14542 | 14617 | 14727 | 14787 | 14855 |       |
| 14172 | 14280 | 14475 | 14543 | 14618 | 14728 | 14788 | 14856 |       |
| 14173 | 14301 | 14476 | 14544 | 14619 | 14729 | 14801 | 14857 |       |
| 14174 | 14302 | 14477 | 14545 | 14620 | 14730 | 14802 | 14858 |       |
| 14201 | 14303 | 14478 | 14546 | 14621 | 14731 | 14803 | 14859 |       |
| 14202 | 14304 | 14479 | 14547 | 14622 | 14732 | 14804 | 14860 |       |
| 14203 | 14305 | 14480 | 14548 | 14623 | 14733 | 14805 | 14861 |       |
| 14204 | 14410 | 14481 | 14549 | 14624 | 14735 | 14806 | 14863 |       |
| 14205 | 14411 | 14482 | 14550 | 14625 | 14736 | 14807 | 14864 |       |
| 14206 | 14413 | 14485 | 14551 | 14626 | 14737 | 14808 | 14865 |       |
| 14207 | 14414 | 14486 | 14555 | 14627 | 14738 | 14809 | 14867 |       |
| 14208 | 14415 | 14487 | 14556 | 14638 | 14739 | 14810 | 14869 |       |
| 14209 | 14416 | 14488 | 14557 | 14639 | 14740 | 14812 | 14870 |       |
| 14210 | 14418 | 14489 | 14558 | 14642 | 14741 | 14813 | 14871 |       |
| 14211 | 14420 | 14502 | 14559 | 14643 | 14742 | 14814 | 14872 |       |
| 14212 | 14422 | 14504 | 14560 | 14644 | 14743 | 14815 | 14873 |       |
| 14213 | 14423 | 14505 | 14561 | 14646 | 14744 | 14816 | 14874 |       |
| 14214 | 14424 | 14506 | 14563 | 14647 | 14745 | 14817 | 14876 |       |
| 14215 | 14425 | 14507 | 14564 | 14649 | 14747 | 14818 | 14877 |       |
| 14216 | 14427 | 14508 | 14568 | 14650 | 14748 | 14819 | 14878 |       |
| 14217 | 14428 | 14510 | 14569 | 14651 | 14750 | 14820 | 14879 |       |
| 14218 | 14429 | 14511 | 14571 | 14652 | 14751 | 14821 | 14880 |       |
| 14219 | 14430 | 14512 | 14572 | 14653 | 14752 | 14822 | 14881 |       |
| 14220 | 14432 | 14513 | 14580 | 14692 | 14753 | 14823 | 14882 |       |
| 14221 | 14433 | 14514 | 14585 | 14694 | 14754 | 14824 | 14883 |       |

# 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” & “B” and either “C” or “F” 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. Plans E, H, I, and J are no longer available for sale.

### 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 co-insurance  | 75% Skilled nursing facility co-insurance  | Skilled nursing facility co-insurance     | Skilled nursing facility co-insurance   |
|   | 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 \$4640; paid at 100% after limit reached                       | Out-of-pocket limit \$2320; 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 \$2000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2000. 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 of New York, 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.

## 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.

## General Information

The AARP Medicare Supplement Insurance Plans carry the AARP name and UnitedHealthcare Insurance Company pays a royalty fee to AARP for use of the AARP intellectual property. Amounts paid are used for the general purpose of AARP and its members. Neither AARP nor its affiliate is the insurer.

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.

This policy meets the minimum standards for MEDICARE SUPPLEMENT INSURANCE as defined by the New York State Insurance Department.

**IMPORTANT NOTICE: A CONSUMER'S GUIDE TO HEALTH INSURANCE FOR PEOPLE ELIGIBLE FOR MEDICARE MAY BE OBTAINED FROM YOUR LOCAL SOCIAL SECURITY OFFICE OR FROM THIS INSURER.**

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 recommend health related products, services, insurance or programs. You are strongly encouraged to evaluate your needs.

AARP and its affiliate are not insurance agencies or carriers and do not employ or endorse insurance agents, brokers, representatives or advisors.

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

### **Exclusions**

- Benefits provided under Medicare.
- Care not meeting Medicare's standards.
- Stays which occur or care or supplies received before your plan's effective date.
- In no event will medical payments under your Plan duplicate any benefits provided under Workers' Compensation.
- 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.
- Stays occurring and/or care or supplies received during the first 6 months of coverage will not be covered, if they are caused by or result from a pre-existing condition. A pre-existing condition is any sickness or injury for which you receive medical advice or treatment during the 6 months prior to your insurance effective date.

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

1. 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
2. Individuals who, within the last 63 days, have been covered under other health insurance coverage or are replacing current health insurance coverage.

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 New York. 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**

The AARP Insurance Plan ("Trust") is a trust that holds the master group insurance policy issued by UnitedHealthcare Insurance Company (UnitedHealthcare). Participants are issued certificates of insurance by UnitedHealthcare 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 in which you participate. Neither the Trust nor AARP provide insurance or guarantee the benefits offered by the insurer.

Premiums are collected from you on behalf of the trustees of the Trust. These premiums are used to pay expenses incurred by the Trust in connection with the insurance programs and to pay the insurance company for your insurance coverage. 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 and its members.




**AARP Medicare Supplement Plans insured by:  
UnitedHealthcare Insurance Company of New York  
1-800-523-5800**

**For information about the family of health products and services  
[www.aarphealthcare.com](http://www.aarphealthcare.com)**

# Plan Benefit Tables: Plan A

## Medicare Part A: Hospital Services per Benefit Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan A Pays                        | You Pay                        |
|--|--|---|------------------------------------|--------------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$0                                | \$1,132<br>(Part A deductible) |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0                            |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0                            |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0                            |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs                      |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | \$0                                | Up to \$141.50 per day         |
|  | Days 101 and later   | \$0   | \$0                                | All costs                      |
| <b>Blood</b>   | First 3 pints  | \$0   | 3 pints                            | \$0                            |
|  | Additional amounts   | 100%  | \$0                                | \$0                            |
| <b>Hospice Care</b><br>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.

## Plan Benefit Tables: Plan A (continued)

### Medicare Part B: Medical Services per Calendar Year

| Service   |   | Medicare Pays | Plan A Pays   | You Pay                      |
|---|---|---------------|---------------|------------------------------|
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>2</sup> | \$0           | \$0           | \$162<br>(Part B deductible) |
|   | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20% | \$0                          |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |   | \$0           | \$0           | All costs                    |
| <b>Blood</b>  | First 3 pints   | \$0           | All costs     | \$0                          |
|   | Next \$162 of Medicare-approved amounts <sup>2</sup>  | \$0           | \$0           | \$162<br>(Part B deductible) |
|   | Remainder of Medicare-approved amounts                | 80%           | 20%           | \$0                          |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                         | 100%          | \$0           | \$0                          |

### Parts A and B

| Service  |  | Medicare Pays | Plan A Pays | You Pay                      |
|--|--|---------------|-------------|------------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                          |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$0         | \$162<br>(Part B deductible) |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0                          |

#### Notes

**2** Once you have been billed \$162 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan B Pays                        | You Pay                |
|--|--|---|------------------------------------|------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$1,132 (Part A deductible)        | \$0                    |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0                    |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0                    |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0                    |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs              |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | \$0                                | Up to \$141.50 per day |
|  | Days 101 and later   | \$0   | \$0                                | All costs              |
| <b>Blood</b>   | First 3 pints  | \$0   | 3 pints                            | \$0                    |
|  | Additional amounts   | 100%  | \$0                                | \$0                    |
| <b>Hospice Care</b><br>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.

## Plan Benefit Tables: Plan B (continued)

### Medicare Part B: Medical Services per Calendar Year

| Service   |   | Medicare Pays | Plan B Pays   | You Pay                      |
|---|---|---------------|---------------|------------------------------|
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>2</sup> | \$0           | \$0           | \$162<br>(Part B deductible) |
|   | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20% | \$0                          |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |   | \$0           | \$0           | All Costs                    |
| <b>Blood</b>  | First 3 pints   | \$0           | All costs     | \$0                          |
|   | Next \$162 of Medicare-approved amounts <sup>2</sup>  | \$0           | \$0           | \$162<br>(Part B deductible) |
|   | Remainder of Medicare-approved amounts                | 80%           | 20%           | \$0                          |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                         | 100%          | \$0           | \$0                          |

### Parts A and B

| Service  |  | Medicare Pays | Plan B Pays | You Pay                      |
|--|--|---------------|-------------|------------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                          |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$0         | \$162<br>(Part B deductible) |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0                          |


#### Notes

**2** Once you have been billed \$162 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan C Pays                        | You Pay   |
|--|--|---|------------------------------------|-----------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$1,132 (Part A deductible)        | \$0       |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0       |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0       |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0       |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | Up to \$141.50 per day             | \$0       |
|  | Days 101 and later   | \$0   | \$0                                | All costs |
| <b>Blood</b>   | First 3 pints  | \$0   | 3 pints                            | \$0       |
|  | Additional amounts   | 100%  | \$0                                | \$0       |
| <b>Hospice Care</b><br>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.

## Plan Benefit Tables: Plan C (continued)

| Medicare Part B: Medical Services per Calendar Year   |  |               |   |  |
|---|--|---------------|---|--|
| Service   |  | Medicare Pays | Plan C Pays                                   | You Pay  |
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$162 (Part B deductible)                     | \$0  |
|   | Remainder of Medicare-approved amounts                         | Generally 80% | Generally 20%                                 | \$0  |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |  | \$0           | \$0   | All costs  |
| <b>Blood</b>  | First 3 pints  | \$0           | All costs                                     | \$0  |
|   | Next \$162 of Medicare-approved amounts <sup>2</sup>           | \$0           | \$162 (Part B deductible)                     | \$0  |
|   | Remainder of Medicare-approved amounts                         | 80%           | 20%   | \$0  |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                                  | 100%          | \$0   | \$0  |
| Parts A and B   |  |               |   |  |
| Service   |  | Medicare Pays | Plan C Pays                                   | You Pay  |
| <b>Home Health Care</b><br>Medicare-approved services   | Medically necessary skilled care services and medical supplies | 100%          | \$0   | \$0  |
| <b>Durable medical equipment</b><br>Medicare-approved services  | First \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$162 (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  |
| <b>Foreign Travel</b><br>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

**2** Once you have been billed \$162 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan F Pays                        | You Pay   |
|--|--|---|------------------------------------|-----------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$1,132 (Part A deductible)        | \$0       |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0       |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0       |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0       |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | Up to \$141.50 per day             | \$0       |
|  | Days 101 and later   | \$0   | \$0                                | All costs |
| <b>Blood</b>   | First 3 pints  | \$0   | 3 pints                            | \$0       |
|  | Additional amounts   | 100%  | \$0                                | \$0       |
| <b>Hospice Care</b><br>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.

## Plan Benefit Tables: Plan F (continued)

| Medicare Part B: Medical Services per Calendar Year   |  |               |   |  |
|---|--|---------------|---|--|
| Service   |  | Medicare Pays | Plan F Pays                                   | You Pay  |
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$162 (Part B deductible)                     | \$0  |
|   | Remainder of Medicare-approved amounts                         | Generally 80% | Generally 20%                                 | \$0  |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |  | \$0           | 100%  | \$0  |
| <b>Blood</b>  | First 3 pints  | \$0           | All costs                                     | \$0  |
|   | Next \$162 of Medicare-approved amounts <sup>2</sup>           | \$0           | \$162 (Part B deductible)                     | \$0  |
|   | Remainder of Medicare-approved amounts                         | 80%           | 20%   | \$0  |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                                  | 100%          | \$0   | \$0  |
| Parts A and B   |  |               |   |  |
| Service   |  | Medicare Pays | Plan F Pays                                   | You Pay  |
| <b>Home Health Care</b><br>Medicare-approved services   | Medically necessary skilled care services and medical supplies | 100%          | \$0   | \$0  |
| <b>Durable medical equipment</b><br>Medicare-approved services  | First \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$162 (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  |
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE—<br>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

<sup>2</sup> Once you have been billed \$162 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan K Pays                        | You Pay <sup>2</sup>                      |
|--|--|---|------------------------------------|---|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$566 (50% of Part A deductible)   | \$566 (50% of Part A deductible)◆         |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0                                       |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0                                       |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0                                       |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs                                 |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | Up to \$70.75 per day              | Up to \$70.75 per day◆                    |
|  | Days 101 and later   | \$0   | \$0                                | All costs                                 |
| <b>Blood</b>   | First 3 pints  | \$0   | 50%                                | 50%◆                                      |
|  | Additional amounts   | 100%  | \$0                                | \$0                                       |
| <b>Hospice Care</b><br>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** You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4640 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 <sup>3</sup>   |
|---|---|--|--|--|
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>4</sup> | \$0  | \$0                                    | \$162 (Part B deductible) <sup>4</sup> ◆   |
|   | 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%◆   |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |   | \$0  | \$0                                    | All Costs (and they do not count toward annual out-of-pocket limit of \$4640) <sup>3</sup> |
| <b>Blood</b>  | First 3 pints   | \$0  | 50%                                    | 50%◆   |
|   | Next \$162 of Medicare-approved amounts <sup>4</sup>  | \$0  | \$0                                    | \$162 (Part B deductible) <sup>4</sup> ◆   |
|   | Remainder of Medicare-approved amounts                | Generally 80%                                      | Generally 10%                          | Generally 10%◆   |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                         | 100%   | \$0                                    | \$0  |

## Parts A and B

| Service   |  | Medicare Pays | Plan K Pays | You Pay <sup>3</sup> |
|---|--|---------------|-------------|----------------------|
| <b>Home Health Care</b><br>Medicare-approved services | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                  |

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### Notes

**3** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4640 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.

**4** Once you have been billed \$162 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 <sup>3</sup>          |
|--|---|---------------|-------------|-------------------------------|
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$162 of Medicare-approved amounts <sup>5</sup> | \$0           | \$0         | \$162<br>(Part B deductible)♦ |
|  | Remainder of Medicare-approved amounts                | 80%           | 10%         | 10%♦                          |

**Notes**

**5** 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan L Pays                        | You Pay <sup>2</sup>                       |
|--|--|---|------------------------------------|--|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$849 (75% of Part A deductible)   | \$283 (25% of Part A deductible) ♦         |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0  |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0  |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0  |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs                                  |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | Up to \$106.13 per day             | Up to \$35.37 per day ♦                    |
|  | Days 101 and later   | \$0   | \$0                                | All costs                                  |
| <b>Blood</b>   | First 3 pints  | \$0   | 75%                                | 25% ♦                                      |
|  | Additional amounts   | 100%  | \$0                                | \$0  |
| <b>Hospice Care</b><br>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** You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2320 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 <sup>3</sup>   |
|---|---|--|--|--|
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>4</sup> | \$0  | \$0                                    | \$162 (Part B deductible) <sup>4</sup> ◆   |
|   | 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%◆  |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |   | \$0  | \$0                                    | All Costs (and they do not count toward annual out-of-pocket limit of \$2320) <sup>3</sup> |
| <b>Blood</b>  | First 3 pints   | \$0  | 75%                                    | 25%◆   |
|   | Next \$162 of Medicare-approved amounts <sup>4</sup>  | \$0  | \$0                                    | \$162 (Part B deductible) <sup>4</sup> ◆   |
|   | Remainder of Medicare-approved amounts                | Generally 80%                                      | Generally 15%                          | Generally 5%◆  |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                         | 100%   | \$0                                    | \$0  |

## Parts A and B

| Service   |  | Medicare Pays | Plan L Pays | You Pay <sup>3</sup> |
|---|--|---------------|-------------|----------------------|
| <b>Home Health Care</b><br>Medicare-approved services | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                  |

### Notes

**3** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2320 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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**4** Once you have been billed \$162 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 <sup>3</sup>          |
|--|---|---------------|-------------|-------------------------------|
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$162 of Medicare-approved amounts <sup>5</sup> | \$0           | \$0         | \$162<br>(Part B deductible)♦ |
|  | Remainder of Medicare-approved amounts                | 80%           | 15%         | 5%♦                           |

**Notes**

**5** 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 Period<sup>1</sup>

| Service  |  | Medicare Pays   | Plan N Pays                        | You Pay   |
|--|--|---|------------------------------------|-----------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.   | First 60 days  | All but \$1,132   | \$1,132 (Part A deductible)        | \$0       |
|  | Days 61–90   | All but \$283 per day   | \$283 per day                      | \$0       |
|  | Days 91 and later while using 60 lifetime reserve days       | All but \$566 per day   | \$566 per day                      | \$0       |
|  | After lifetime reserve days are used, an additional 365 days | \$0   | 100% of Medicare eligible expenses | \$0       |
|  | Beyond the additional 365 days                               | \$0   | \$0                                | All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 \$141.50 per day  | Up to \$141.50 per day             | \$0       |
|  | Days 101 and later   | \$0   | \$0                                | All costs |
| <b>Blood</b>   | First 3 pints  | \$0   | 3 pints                            | \$0       |
|  | Additional amounts   | 100%  | \$0                                | \$0       |
| <b>Hospice Care</b><br>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.

# Plan Benefit Tables: Plan N (continued)

## Medicare Part B: Medical Services per Calendar Year

| Service   |  | Medicare Pays | Plan N Pays  | You Pay  |
|---|--|---------------|--|--|
| <b>Medical Expenses</b><br>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 \$162 of Medicare-approved amounts <sup>2</sup>          | \$0           | \$0  | \$162 (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. |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts   |  | \$0           | \$0  | All costs  |
| <b>Blood</b>  | First 3 pints  | \$0           | All costs  | \$0  |
|   | Next \$162 of Medicare-approved amounts <sup>2</sup>           | \$0           | \$0  | \$162 (Part B deductible)  |
|   | Remainder of Medicare-approved amounts                         | 80%           | 20%  | \$0  |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                                  | 100%          | \$0  | \$0  |
| <b>Parts A and B</b>  |  |               |  |  |
| Service   |  | Medicare Pays | Plan N Pays  | You Pay  |
| <b>Home Health Care</b><br>Medicare-approved services   | Medically necessary skilled care services and medical supplies | 100%          | \$0  | \$0  |

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### Notes

**2** Once you have been billed \$162 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                      |
|--|---|---------------|-------------|------------------------------|
| <b>Durable Medical Equipment</b><br>Medicare-approved services | First \$162 of Medicare-approved amounts <sup>2</sup> | \$0           | \$0         | \$162<br>(Part B deductible) |
|  | Remainder of Medicare-approved amounts                | 80%           | 20%         | \$0                          |

**Other Benefits not covered by Medicare**

|   |                                |     |   |  |
|---|--------------------------------|-----|---|--|
| <b>Foreign Travel</b><br>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.

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### 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.

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### Disclosures

Use the *Overview of Available Plans*, the *Plan Benefit Tables* and *Cover Page - Rates* 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.**

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### 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.

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### 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 premium payments. However, UnitedHealthcare has the right to recover any claims paid during that period. Any premium refund otherwise due to you will be reduced by the amount of any claims paid during this period. If you have received claims payment in excess of the amount of your premium, no refund of premium will be made.

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### 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.

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### 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.

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### 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.



## Medicare Supplement Plans

insured by **UnitedHealthcare**  
**Insurance Company**

### Enrollment Checklist

**In the following section, you will find the forms you need to complete when applying for coverage. Please be sure to complete and submit all the necessary forms to ensure your enrollment is processed quickly and accurately.**

**Here is an overview of the different forms and some helpful tips:**

✓ **Application Form**

- Be sure to review and complete each applicable section.
- Please only write comments where indicated on the application. Written comments in other areas of the form will slow down processing of the application.
- Be sure to sign and date the application in all the places indicated. The agent must also sign and date the application and include his or her agent identification number.

✓ **AARP Membership Form**

AARP membership is required to enroll in an AARP Medicare Supplement Plan. If you are not currently an AARP member, simply complete the membership form and submit with the plan application, along with a separate check for \$16.00 payable to AARP.

✓ **Automatic Payments Authorization Form**

Automatic payments are available by submitting the completed form (signed and dated) and a voided check. If requesting automatic payments, you can deduct \$2 from the first month's premium check.

✓ **Notice to Applicants Regarding Replacement of Coverage**

If you are replacing current coverage as indicated on the form, complete both copies of the form, submit one copy with the enrollment application, and keep the other copy for your records. The agent must also sign and date both copies of the form.

✓ **Conditional Receipt for New York Residents**

Be sure to review and sign both copies of the form. Keep one copy for your records. The agent keeps the other copy in his or her records.

✓ **New York Agent Required Disclosure**

Be sure to review the Disclosure which describes your rights to request certain information from your agent.

## **New York Agent Required Disclosure**

As of January 1, 2011, New York regulations assure that you have the right to discuss compensation with your agent.

Agents who are licensed and appointed by UnitedHealthcare Insurance Company of New York for the solicitation of, negotiation for, or the sale of Medicare supplement insurance plans will receive compensation from UnitedHealthcare for helping you purchase one of the plans.

Your agent's compensation may vary depending on the plan you enroll in, how much business they provide to UnitedHealthcare, or the profitability of the insurance coverage that they provide to UnitedHealthcare.

You may request information about the expected compensation based on the sale, and the compensation expected to be received on any alternative quotes presented.

You may request information about the agent's expected compensation anytime up until 30 days following your plan effective date.



## 2 Choose your plan and effective date

Please indicate your plan choice below:

- A    B    C    F    K    L    N

You are eligible to enroll if **all** of these are true:

- you are an AARP member or the spouse of a member,
- you are age 50 or older,
- you are enrolled in Medicare Parts A&B,
- you are not duplicating Medicare supplement coverage.

### Coverage Effective Date

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive a Certificate of Insurance confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below.

Requested Effective Date

M M D D Y Y Y Y

## 3 Tell us about your past and current coverage

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

- You do not need more than one Medicare Supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- 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 reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- **The sale of a Medicare supplement policy or certificate is prohibited where an individual has a Medicare supplement policy or certificate in force and does not desire to replace the existing policy or certificate or where the Medicare supplement**

**policy or certificate would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.**

- 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 reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the 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).

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### 3 Tell us about your past and current coverage – continued

**For your protection, you are required to answer all the questions below (3A through 3O) and sign in the signature box on the next page.**

**3A.** Did you turn age 65 in the last 6 months?

Y  N

**3B.** Did you enroll in Medicare Part B in the last 6 months?

Y  N

**3C.** If **YES**, what is the effective date?

M M D D Y Y Y Y

**3D.** Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

**Note to applicant:** If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer **NO** to this question.

Y  N

**If NO**, skip to question **3G**.

**If YES**, please continue to **3E** and **3F**.

**3E.** Will Medicaid pay your premiums for this Medicare supplement policy?

Y  N

**3F.** Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

Y  N

**3G.** Have you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS)?

Y  N

**If NO**, skip to question **3K**.

**If YES**, fill in your start and end dates and continue to question **3H**. If you are still covered under this plan, leave the end date blank.

**Start Date**

**End Date**

M M D D Y Y Y Y M M D D Y Y Y Y

**3H.** If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

Y  N

**3I.** Was this your first time in this type of Medicare Advantage plan?

Y  N

**3J.** Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan?

Y  N

Continued on next page ►



# 4 Authorization and Verification of Information

Please read carefully, and sign and date in the highlighted area below.

- My signature indicates I have read and understand the contents of this application form.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### If application is being made through an agent:

- I understand that the agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand that coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company of New York, and actual rates are not determined until coverage is issued.
- I understand that the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- I acknowledge receipt of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage.
- I understand that the person discussing plan options with me is either employed by or contracted with UnitedHealthcare Insurance Company of New York. This person may be compensated based on my enrollment in a plan.

**If you are replacing your current health insurance coverage, or if your enrollment form is received within 6 months after you are first enrolled in Medicare Part B at age 65 or older, the following exclusion will not apply to you. Please see "Your Guide" for more information.**

**I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 6 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 6 months prior to the insurance effective date. I also understand that stays which start before the insurance effective date will not be covered until 6 months after the effective date.**

*Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.*

**I have read all information and have answered all questions to the best of my ability.**



**Your Signature – 2** (required)

X \_\_\_\_\_

**Today's Date** (required)

□ □ □ □ □ □ □ □ □ □  
M M D D Y Y Y Y

**Note:** If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Continued on next page ►





# AARP membership offers so much for so little.

| What You Get                        |  | Price           |
|-------------------------------------|--|-----------------|
| <b>Membership</b>                   | - For you (12 months)  | <b>\$16</b>     |
| <b>Membership</b>                   | - For your spouse or partner (at any age)  | <b>Included</b> |
| <b>Discounts (nationwide)</b>       | - Vision: exams, frames, lenses<br>- Pharmacy: prescriptions and over-the-counter items<br>- Fitness: gym membership and personal trainers<br>- Travel: vacation packages, hotels, car rentals, airlines, cruises<br>- Plus: legal services,* home security, books & comfortable shoes | <b>Included</b> |
| <b>Trusted Information</b>          | - <i>AARP The Magazine</i> : the largest magazine circulation in the world<br>- <i>AARP Bulletin</i> Newspaper (10 issues per year)  | <b>Included</b> |
| <b>Access to Health Products</b>    | - Exclusive health insurance for you and your dependents<br>- Dental and long-term care insurance  | <b>Included</b> |
| <b>Advocacy</b>                     | - Representation of your interests in Washington and your state<br>- Confronting age discrimination by employers<br>- Strengthening Social Security<br>- Protecting pension and retirement benefits<br>- Fighting predatory home loan lending  | <b>Included</b> |
| <b>Access to Financial Programs</b> | - Auto, homeowners, life, mobile home, motorcycle insurance<br>- Cash-back credit card   | <b>Included</b> |
| <b>Local Opportunities</b>          | - Safe driving courses (also available online)<br>- Over 2,000 local AARP chapters<br>- Social activities, volunteer opportunities, classes & workshops  | <b>Included</b> |

\* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

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## Yes, I'd like to join AARP today!

Please return this form in the envelope provided. You can also join AARP online at [www.AGNTU.aarp enrollment.com](http://www.AGNTU.aarp enrollment.com) or by calling **1-866-331-1964**, and begin using your member benefits right away.

My Name (please print: First, Middle Initial, Last) \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ / Day \_\_\_\_\_ / Year \_\_\_\_\_

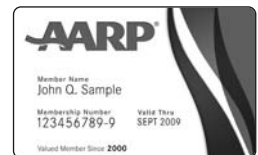
Spouse's/Partner's Name (for **FREE** membership - at any age) \_\_\_\_\_

Please keep in touch with me by e-mail about AARP activities, events and member benefits.

E-mail Address \_\_\_\_\_ V7FYUHG

- 1 year/\$16**  
 **3 years/\$43**  
 **5 years/\$63**

I agree to pay for the term I select.



- Check or money order enclosed, payable to AARP.  
**Do not send cash.**

Daytime Phone Number (in case we need to contact you) \_\_\_\_\_

Dues are not deductible for income tax purposes. One membership includes spouse/partner. Annual dues include \$4.03 for a subscription to *AARP The Magazine*, \$3.09 for the *AARP Bulletin*. Dues outside U.S. domestic mail limits: Canada and Mexico - 1 year/\$17, all other countries - 1 year/\$28. Please allow up to six weeks for delivery of Membership Kit. When you join, AARP shares your membership information with the companies we have selected to provide AARP member benefits and support AARP operations. If you do not want us to share your information with providers of AARP member benefits, please let us know by calling 1-800-516-1993 or e-mailing us at [member@aarp.org](mailto:member@aarp.org).

AA1035 (9-11) AGT



# As a member, you have access to:

## Travel Discounts

Using AARP's exclusive travel savings just once could pay for your membership several times over!

- Savings on hotels, motels and resorts worldwide
- Discounted rates on airfares, cruises and auto rentals
- Special pricing on vacation packages

## Health-Related Benefits

With today's high health care costs, AARP membership is more valuable than ever.

- Supplemental and employer-like health insurance for you and your dependents
- Vision and prescription discounts nationwide
- Dental and long-term care insurance

## Local Opportunities

AARP offers many ways to get active in your community.

- Over 2,000 local AARP chapters
- Social activities
- Volunteer opportunities
- Safe driving courses
- Classes and workshops



## Protection of Your Rights

Your job. Your health. Your future. AARP will stand up for you by ...

- Representing your interests in Washington and your state
- Confronting age discrimination by employers
- Strengthening Social Security
- Protecting pension and retirement benefits
- Fighting predatory home loan lending

## Dependable Financial Programs

Designed specifically for AARP members. With the high level of service you expect.

- Low-interest, no-fee credit card
- Online tools and calculators
- Auto, homeowners, and life insurance



## Valuable Information

Accurate and authoritative, direct from your reliable source – AARP.

- *AARP The Magazine*
- *The AARP Bulletin*
- FREE financial and health guides
- Our web site, [www.aarp.org](http://www.aarp.org)

## Specially Priced Products & Services

AARP helps you save in ways and places you never imagined.

- Discounts on home security, internet access, gifts and other products
- Reduced-fee legal services\*
- Roadside assistance and emergency towing plans

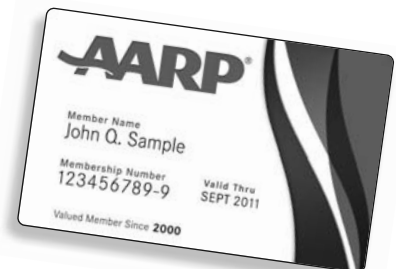
**NOTE:** The benefits listed are only a partial list. Your Membership Kit will supply you with a full list of approved service providers that offer exclusive services and discounts to AARP members only.

\* Legal Services Network reduced-fee benefits are not available in HI, NV and OH.

## Value our members appreciate.

Members often tell us their AARP membership paid for itself with the first service they use. They're surprised at how many ways and places their membership proves valuable. And it's an even better value because **your spouse/partner is included free (at any age)!**

**To become an AARP member, please return the form on the front in the envelope provided.**



## Automatic Payments

### Save \$24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save \$2.00 off the total monthly rate for your household.

#### *That's up to \$24.00 a year! In addition:*

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

#### Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

#### Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 (6-11)

Cut along the dotted line.

---

#### AUTOMATIC PAYMENT AUTHORIZATION FORM

I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Bank Name \_\_\_\_\_

Bank Routing No. \_\_\_\_\_

Bank Account No. \_\_\_\_\_

Account Type:  Checking

Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ►

## IMPORTANT

- Please refer to the diagram below to obtain your bank routing information.
- Be sure to attach a voided check from the checking account you wish to use.

The diagram shows a check with the word "VOID" in large, bold, black letters in the center. The check contains the following text: "John Doe", "Street Address", "Town, City Zip Code", "Check #1234", "Date: \_\_\_\_\_", "Pay to: \_\_\_\_\_", "\_\_\_\_\_ Dollars", "Bank Name & Address", "Memo: \_\_\_\_\_", "Signed by: \_\_\_\_\_", and a MICR line: "|:123456789:| 12345678 || 1234 ||". Brackets connect labels to specific parts of the check: "Account Holder Name" to the top left, "Check Number" to the top right, "Bank Routing/Transfer Number" to the first part of the MICR line, "Bank Account Number" to the second part of the MICR line, and "Check Number" to the third part of the MICR line. A note below the MICR line states: "Check Number Please do not include the check number (it may be before or after the account number) as it may delay processing."

We look forward to continuing to serve you.

---

**This authority remains in effect until UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) and BANK receive notification from me (or either of us) of its termination in such time and manner as to give UnitedHealthcare Insurance Company and BANK a reasonable opportunity to act on it. I (we) have the right to stop payment of a withdrawal by notification to BANK in such time as to give BANK a reasonable opportunity to act upon it, with the understanding that such action may put my (our) health care contract in late status and subject to cancellation.**

Name(s) \_\_\_\_\_ Member # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

*(if joint account is maintained)*

*Please do not write in the space below for company use only.*

---

## Automatic Payments

### Save \$24 a year with Automatic Payments

The easiest way to pay.

Almost 1.8 million AARP Medicare Supplement members nationwide enjoy the convenience of the Automatic Payments option. With automatic payments, your monthly payment will automatically be deducted from your checking or savings account. If you use automatic payments, you'll save \$2.00 off the total monthly rate for your household.

#### *That's up to \$24.00 a year! In addition:*

- You'll save on the cost of checks and rising postal rates.
- You don't have to take time to write a check each month.
- You don't have to worry about mailing a payment if you travel or become ill, because your payment is always deducted on or about the fifth day of each month.

#### Sign Up in Two Easy Steps

1. Complete both sides of the Authorization Form below. Return it with the application **and be sure to keep a copy for your records.**
2. Be sure to include a voided check from the account you want your payments withdrawn from. The information on your check is necessary for us to process your Authorization Form. Do not send a deposit slip or cancelled check.

#### Your Automatic Payments Effective Date

If you are submitting this Electronic Funds Transfer (EFT) form with your enrollment application, your automatic payments start date will be equal to your plan effective date. Please note that if your coverage is effective in the future or your account is paid in advance, automatic withdrawals will begin for the next payment due. If your account is effective in the past or is in arrears, a letter will be sent under separate cover that provides the specific information necessary to remit the payment due to bring your account up to date. A letter will be sent confirming that we processed your Automatic Payments Authorization Form form and will include the amount of your withdrawal.

BA9957 (6-11)

Cut along the dotted line.

---

#### AUTOMATIC PAYMENT AUTHORIZATION FORM

I (we) authorize UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for New York residents) to initiate monthly withdrawals, in the amount of the then-current monthly rate, from the account named on this form, and authorize the named banking facility BANK to charge such withdrawals to my (our) account.

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Bank Name \_\_\_\_\_

Bank Routing No. \_\_\_\_\_

Bank Account No. \_\_\_\_\_

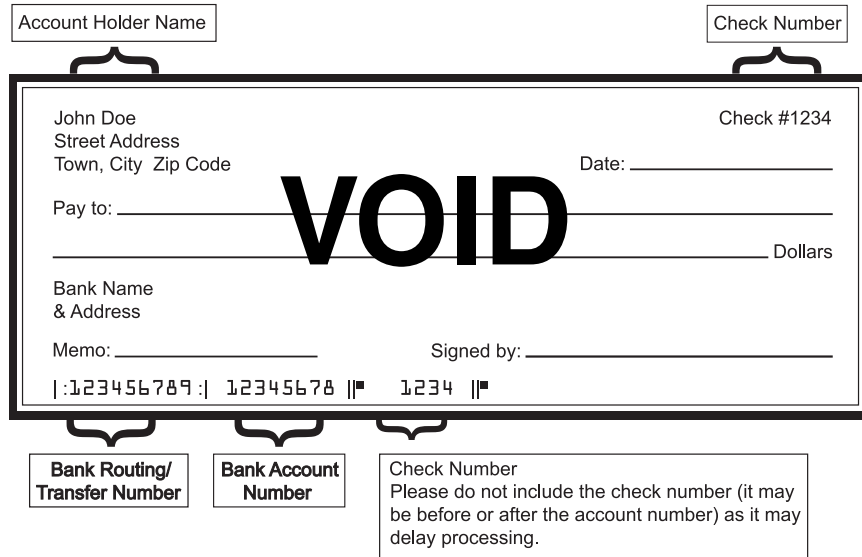
Account Type:  Checking

Savings (statement savings only)

Please complete the reverse of this form to enroll in automatic payments. ►

## IMPORTANT

- Please refer to the diagram below to obtain your bank routing information.
- Be sure to attach a voided check from the checking account you wish to use.



We look forward to continuing to serve you.

---

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Name(s) \_\_\_\_\_ Member # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

*(if joint account is maintained)*

*Please do not write in the space below for company use only.*

---

**CONDITIONAL RECEIPT**

**UnitedHealthcare Insurance Company of New York**  
Islandia, NY 11749

(To be completed and retained by the Agent with a copy given to the Applicant.)

\$ \_\_\_\_\_ Received from: \_\_\_\_\_  
Name of Applicant

This amount is tendered with the application for the referenced insurance plan as a deposit for the premium due, subject to the following:

**It is mutually agreed that the insurance plan applied for will become effective on the first day of the month following approval of the application but will not be in force unless UnitedHealthcare Insurance Company of New York has determined that the person(s) proposed for insurance have provided satisfactory evidence of insurability and the full first month's premium has been paid as required.**

If the application is accepted, the Applicant will be advised in writing by UnitedHealthcare Insurance Company of New York. If the application is not accepted, UnitedHealthcare Insurance Company of New York will advise the Applicant, promptly refund the premium deposit paid; and the refund of such deposit will fully discharge any and all obligations of UnitedHealthcare Insurance Company of New York to the Applicant.

Agent acknowledges receipt of deposit for the premium due and delivery of a copy of Conditional Receipt to Applicant.

AGENT SIGNATURE (REQUIRED) \_\_\_\_\_

AGENT ID (REQUIRED) \_\_\_\_\_

TODAY'S DATE (REQUIRED) \_\_\_\_\_

**CONDITIONAL RECEIPT**

**UnitedHealthcare Insurance Company of New York**  
Islandia, NY 11749

(To be completed and retained by the Agent with a copy given to the Applicant.)

\$ \_\_\_\_\_ Received from: \_\_\_\_\_  
Name of Applicant

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**It is mutually agreed that the insurance plan applied for will become effective on the first day of the month following approval of the application but will not be in force unless UnitedHealthcare Insurance Company of New York has determined that the person(s) proposed for insurance have provided satisfactory evidence of insurability and the full first month's premium has been paid as required.**

If the application is accepted, the Applicant will be advised in writing by UnitedHealthcare Insurance Company of New York. If the application is not accepted, UnitedHealthcare Insurance Company of New York will advise the Applicant, promptly refund the premium deposit paid; and the refund of such deposit will fully discharge any and all obligations of UnitedHealthcare Insurance Company of New York to the Applicant.

Agent acknowledges receipt of deposit for the premium due and delivery of a copy of Conditional Receipt to Applicant.

AGENT SIGNATURE (REQUIRED) \_\_\_\_\_

AGENT ID (REQUIRED) \_\_\_\_\_

TODAY'S DATE (REQUIRED) \_\_\_\_\_

**ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR  
EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT  
NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK**

Islandia, New York

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

According to the information you furnished, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a certificate to be issued by UnitedHealthcare Insurance Company of New York. Your new certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

**Statement To Applicant By Issuer, Agent, Broker Or Other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction (does)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

- |   |   |
|---|---|
| <p>_____ Additional benefits.</p> <p>_____ No change in benefits, but lower premiums.</p> <p>_____ Fewer benefits and lower premiums</p> <p>_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.</p> | <p>_____ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.</p> <p>_____ Other (Please Specify) _____</p> <p>_____</p> <p>_____</p> |
|---|---|

1. Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present coverage.
2. State regulation provides that in applying a pre-existing condition limitation, a Medicare Supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare Supplement insurance, Medicare Select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.
3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

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

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative) (Date)

\_\_\_\_\_  
(Applicant's Signature) (Date)

\_\_\_\_\_  
(Applicant's Printed Name & Address)

**ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR  
EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT  
NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK**

Islandia, New York

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

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You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this certificate. Terminate your present coverage only if after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

**Statement To Applicant By Issuer, Agent, Broker Or Other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction (does)/(does not) duplicate coverage. The replacement policy is being purchased for one of the following reasons (check one):

- |  |   |
|--|---|
| <input type="checkbox"/> Additional benefits.  | <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment. |
| <input type="checkbox"/> No change in benefits, but lower premiums.                                      | <input type="checkbox"/> Other (Please Specify) _____   |
| <input type="checkbox"/> Fewer benefits and lower premiums   | _____   |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D. | _____   |

1. Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new certificate. This could result in denial or delay of a claim for benefits under the new certificate, whereas a similar claim might have been payable under your present coverage.
2. State regulation provides that in applying a pre-existing condition limitation, a Medicare Supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare Supplement insurance, Medicare Select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate.
3. If you still wish to terminate your present policy and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

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

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative) (Date)

\_\_\_\_\_  
(Applicant's Signature) (Date)

\_\_\_\_\_  
(Applicant's Printed Name & Address)



Medicare Supplement Plans  
insured by **UnitedHealthcare**  
Insurance Company

## Thank You For Applying For An AARP® Medicare Supplement Insurance Plan.

### For your records:

- You selected Plan \_\_\_\_\_
- Based on the information you provided, your monthly premium for the plan you selected is \$ \_\_\_\_\_
- You will be notified when review of your application has been completed

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## What's Next

### Once Your Application Is Approved, You Will Receive:

- Your insured member identification card
- A Welcome Kit, including your certificate of insurance and coverage details
- Ongoing educational materials about how to make the most of your health plan benefits
- Help and answers to any questions you may have from courteous Customer Service Representatives

### A continuing relationship with your agent/producer

SA25235ST