

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.¹ 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 Form² (see below)
- Replacement Notice³ (see below)
- Conditional Receipt⁴ (see below)
- New York Agent Required Disclosure⁵
- “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.**

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

²Two 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.

³Two 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.

⁴Two 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.

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

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® 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



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.

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
Standard Rates						
\$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
Standard Rates						
\$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
Standard Rates						
\$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**

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,132	\$0	\$1,132 (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
Skilled Nursing Facility Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	\$0	Up to \$141.50 per day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan A Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (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 Period¹

Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,132	\$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
Skilled Nursing Facility Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	\$0	Up to \$141.50 per day
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

Plan Benefit Tables: Plan B (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan B Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All Costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan B Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (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 Period¹

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,132	\$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
Skilled Nursing Facility Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	Up to \$141.50 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

Plan Benefit Tables: Plan C (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ²	\$0	\$162 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$162 of Medicare-approved amounts ²	\$0	\$162 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan C Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ²	\$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
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Notes

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 Period¹

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,132	\$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
Skilled Nursing Facility Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	Up to \$141.50 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

Plan Benefit Tables: Plan F (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		Medicare Pays	Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ²	\$0	\$162 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges Above Medicare-approved amounts		\$0	100%	\$0
Blood	First 3 pints	\$0	All costs	\$0
	Next \$162 of Medicare-approved amounts ²	\$0	\$162 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ²	\$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
Foreign Travel NOT COVERED BY MEDICARE— Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Notes

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 K

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan K Pays	You Pay ²
Hospitalization¹ 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
Skilled Nursing Facility Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	Up to \$70.75 per day	Up to \$70.75 per day◆
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	50%	50%◆
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	50% of co-payment/ co-insurance	50% of Medicare co-payment/ co-insurance◆

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Notes

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

2 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 ³
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ⁴	\$0	\$0	\$162 (Part B deductible) ⁴ ◆
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$4640) ³
Blood	First 3 pints	\$0	50%	50%◆
	Next \$162 of Medicare-approved amounts ⁴	\$0	\$0	\$162 (Part B deductible) ⁴ ◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay ³
Home Health Care 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 ³
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ⁵	\$0	\$0	\$162 (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 Period¹

Service		Medicare Pays	Plan L Pays	You Pay ²
Hospitalization¹ 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
Skilled Nursing Facility Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	Up to \$106.13 per day	Up to \$35.37 per day ♦
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	75%	25% ♦
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	75% of co-payment/ co-insurance	25% of Medicare co-payment/ co-insurance ♦

Continued on next page ►

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 ³
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ⁴	\$0	\$0	\$162 (Part B deductible) ⁴ ◆
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$2320) ³
Blood	First 3 pints	\$0	75%	25%◆
	Next \$162 of Medicare-approved amounts ⁴	\$0	\$0	\$162 (Part B deductible) ⁴ ◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay ³
Home Health Care 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 ³
Durable medical equipment Medicare-approved services	First \$162 of Medicare-approved amounts ⁵	\$0	\$0	\$162 (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 Period¹

Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1,132	\$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
Skilled Nursing Facility Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but \$141.50 per day	Up to \$141.50 per day	\$0
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as you meet Medicare’s requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	\$0

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Notes

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

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$162 of Medicare-approved amounts ²	\$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.
Part B Excess Charges Above Medicare-approved amounts		\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Parts A and B				
Service		Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Continued on next page 

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
Durable Medical Equipment Medicare-approved services	First \$162 of Medicare-approved amounts ²	\$0	\$0	\$162 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits not covered by Medicare

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

Rules and Disclosures about this Insurance

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

Premium information

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

Disclosures

Use 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.**

Read your certificate very carefully

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

Your right to return the certificate

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

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

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your 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.

Policy replacement

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

Notice

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

Complete answers are very important

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



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

		0	1				
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).

Continued on next page ►

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)	Today's Date (required)																
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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.																	

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AARP membership offers so much for so little.

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

* 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 aarpadvisor.aarphealthcare.com/uhg 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 _____

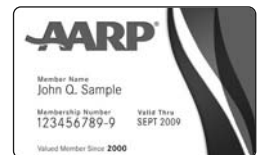
Spouse's/Partner's Name (for **FREE** membership - at any age) _____

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.

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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

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

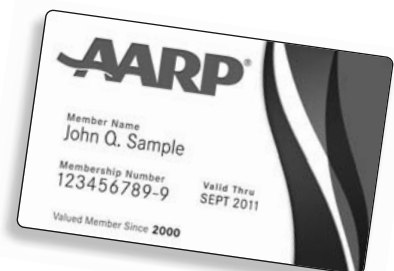
NOTE: The benefits listed are only a partial list. Your Membership Kit will supply you with a full list of approved service providers that offer exclusive services and discounts to AARP members only.

* 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 9/09

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 letters in the center. Brackets and boxes identify key areas:

- Account Holder Name:** Points to the top left of the check.
- Check Number:** Points to the top right of the check.
- Bank Routing/Transfer Number:** Points to the first 9 digits of the MICR line at the bottom.
- Bank Account Number:** Points to the next 8 digits of the MICR line.
- Check Number:** Points to the final 4 digits of the MICR line.

Below the MICR line, a note states: "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 9/09

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" printed in large, bold letters across the center. The check contains the following fields:

- Account Holder Name: John Doe
- Street Address: Street Address
- Town, City Zip Code: Town, City Zip Code
- Check Number: Check #1234
- Date: _____
- Pay to: _____
- Amount: _____ Dollars
- Bank Name & Address: Bank Name & Address
- Memo: _____
- Signed by: _____
- Routing and Account Numbers: |:123456789:| 12345678 || 1234 ||

Callouts from boxes point to the following information on the check:

- Account Holder Name** (points to John Doe)
- Check Number** (points to Check #1234)
- Bank Routing/Transfer Number** (points to |:123456789:|)
- Bank Account Number** (points to 12345678 ||)
- Check Number** (points to 1234 ||)

A note below the check states: "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.

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: _____
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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
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- | | |
|---|---|
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|---|---|

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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

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

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