Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: GROUP MEDICARE SUPPLEMENT PLANS	SERFF Tr Num: UHLC-126263862	State: Arkansas
TOI: MS08G Group Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 43459
Sub-TOI: MS08G.001 Plan A 2010	Co Tr Num: MDA0001	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Wanda Augustus, Karyn Feeney, Stephen Kane, Gerry McCadden, Mike Mann, Nancy Cuozzo, Bonnie Fluck, Marie Schwartz	Disposition Date: 11/05/2009
	Date Submitted: 09/04/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date: 06/01/2010
State Filing Description:		

General Information

Project Name: MIPPA (MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT	Status of Filing in Domicile: Not Filed
Project Number: MDA0001	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 11/05/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/05/2009
Deemer Date:	Created By: Wanda Augustus
Submitted By: Mike Mann	Corresponding Filing Tracking Number:

Filing Description:

UnitedHealthcare Insurance Company

NAIC No. 0707–79413

Group Accident and Health Insurance
Standardized Medicare Supplement Certificates: MDA 0001 – MDN 0007 (Non-Agent Sales Only)
Standardized Medicare Supplement Certificates: MAA 0010 – MAN 0016 (Agent Sales only)
Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Non-Agent Sales Only)
Standardized Medicare Select Certificate: MASC 0017, MASF 0018 (Agent Sales only)

Plan Benefit Tables: BT25 – BT33
BT002 ST AB, CF, KLN
BT002 ST CCSelect,
BT002 ST FFSelect
Plan Overviews: POV3, POV4
Rules & Disclosures: RD4, RD5
Premium Rate Pages: MRP0001 (Med Supp), MRP0002 (Med Select) - - (All Non-Agent Marketing Channels)
MRP0003 (Med Supp), MRP0004 (Med Select) - - (All Marketing Channels)
Medicare Select Plan of Operation: PO3

Company and Contact

Filing Contact Information

Karyn A. Feeney, Director, Contract and Compliance
680 Blair Mill Rd.
Horsham, PA 19044
Karyn_A_Feeney@uhc.com
215-902-8468 [Phone]
215-902-8813 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $1,900.00

SERFF Tracking Number:	*UHLC-126263862*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*43459*
Company Tracking Number:	*MDA0001*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*GROUP MEDICARE SUPPLEMENT PLANS*		
Project Name/Number:	*MIPPA (MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT/MDA0001*		
Retaliatory?	No		
Fee Explanation:	$50.00 X 38 FORMS = 1,900		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$1,900.00	09/04/2009	30358859

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	11/05/2009	11/05/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	10/16/2009	10/16/2009	Marie Schwartz	10/19/2009	10/19/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	ACTUARIAL MEMORANDUM, RATE SCHEDULES AND RATE ATTACHMENTS	Wanda Augustus	10/28/2009	10/28/2009
Supporting Document	RATE COVER LETTER	Wanda Augustus	10/28/2009	10/28/2009
Form	Plan of Operation	Mike Mann	09/04/2009	09/04/2009

Disposition

Disposition Date: 11/05/2009

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment: We respect the confidentiality of the trade secrets contained within this filing. The rate schedules are subject to public access.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126263862*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*43459*
Company Tracking Number:	*MDA0001*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*GROUP MEDICARE SUPPLEMENT PLANS*		
Project Name/Number:	*MIPPA (MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT/MDA0001*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Filing Cover Letter	Accepted for Informational Purposes	Yes
Supporting Document	RATE COVER LETTER	Accepted for Informational Purposes	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
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Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	PLAN BENEFIT TABLE	Approved	Yes
Form	PLAN BENEFIT TABLE	Approved	Yes
Form	PLAN BENEFIT TABLE	Approved	Yes
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Form	PLAN BENEFIT TABLE	Approved	Yes
Form	PLAN BENEFIT TABLE	Approved	Yes

SERFF Tracking Number:	*UHLC-126263862*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*43459*
Company Tracking Number:	*MDA0001*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*GROUP MEDICARE SUPPLEMENT PLANS*		
Project Name/Number:	*MIPPA (MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT/MDA0001*		

Form	PLAN BENEFIT TABLE	Approved	Yes
Form	PLAN OVERVIEW	Approved	Yes
Form	PLAN OVERVIEW	Approved	Yes
Form	RULES AND DISCLOSURES	Approved	Yes
Form	RULES AND DISCLOSURES	Approved	Yes
Form	PREMIUM RATE PAGE	Approved	Yes
Form	PREMIUM RATE PAGE	Approved	Yes
Form	PREMIUM RATE PAGE	Approved	Yes
Form	PREMIUM RATE PAGE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	CERTIFICATE	Approved	Yes
Form	Plan of Operation	Approved	Yes
Rate	ACTUARIAL MEMORANDUM, RATE SCHEDULES AND RATE ATTACHMENTS	Approved	No

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/16/2009
Submitted Date	10/16/2009
Respond By Date	11/16/2009

Dear Karyn A. Feeney,

This will acknowledge receipt of the captioned filing.

Please either direct me to the rates for these plans or attach the rates to the rate schedule.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/19/2009
Submitted Date	10/19/2009

Dear Stephanie Fowler,

Comments:
Thank you for your inquiry regarding the above-referenced submission. Your question has been referred to me for handling. Please see our response below.

Response 1

Comments: Our actuarial area is working on the actuarial memoranda for our MIPPA plans. We will submit this information to you for your review as soon as it is completed. In the meantime, we hope that you can continue with your review of the forms and pend any final approval for submission and approval of the rates. Your consideration of this request is greatly appreciated.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your review of this submission and consideration of our request. If you have any further concerns, please let us know.

Sincerely,
Bonnie Fluck, Gerry McCadden, Karyn Feeney, Marie Schwartz, Mike Mann, Nancy Cuozzo, Stephen Kane, Wanda Augustus

Amendment Letter

Submitted Date: 10/28/2009

Comments:

SEE ATTACHED RATE INFORMATION.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
ACTUARIAL MEMORANDUM, RATE SCHEDULES AND RATE ATTACHMENTS	MDA 0001, MDB 0002, MDC 0003, MDF 0004, MDK 0005, MDL 0006, MDSC 0008, MDSF 0009, MAA 0010, MAB 0011, MAC 0012, MAF 0013, MAL 0015, MAN 0016, MASC 0017, MASF 0018, MDN 0007, MAK 0014	New		AR_MIPPA _memo_.pdf
AR MIPPA Rate Schedules.pdf	AR MIPPA Attachments.pdf	AR_MIPPA _memo_.pdf AR MIPPA Rate Schedules.pdf AR MIPPA Attachments.pdf		

Supporting Document Schedule Item Changes:

User Added -Name: RATE COVER LETTER

Comment: SEE ATTACHED RATE COVER LETTER.

AR cover letter - MIPPA Initial Filing (2).pdf

Amendment Letter

Submitted Date: 09/04/2009

Comments:

Please see attached Med Select Plan of Operation

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
PO3	Other	Plan of Operation	Initial				50.000	PO3 (AR).pdf

Form Schedule

Lead Form Number: MDA0001

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/05/2009	MDA0001	Certificate	CERTIFICATE	Initial		52.000	MDA 0001.pdf
Approved 11/05/2009	MDB0002	Certificate	CERTIFICATE	Initial		52.100	MDB 0002.pdf
Approved 11/05/2009	MDC0003	Certificate	CERTIFICATE	Initial		55.000	MDC 0003.pdf
Approved 11/05/2009	MDF0004	Certificate	CERTIFICATE	Initial		54.900	MDF 0004.pdf
Approved 11/05/2009	MDK0005	Certificate	CERTIFICATE	Initial		52.000	MDK 0005.pdf
Approved 11/05/2009	MDL0006	Certificate	CERTIFICATE	Initial		52.100	MDL 0006.pdf
Approved 11/05/2009	MDN0007	Certificate	CERTIFICATE	Initial		52.200	MDN 0007.pdf
Approved 11/05/2009	MAA0010	Certificate	CERTIFICATE	Initial		55.100	MAA 0010.pdf
Approved 11/05/2009	MAB0011	Certificate	CERTIFICATE	Initial		55.200	MAB 0011.pdf
Approved 11/05/2009	MAC0012	Certificate	CERTIFICATE	Initial		55.000	MAC 0012.pdf
Approved 11/05/2009	MAF0013	Certificate	CERTIFICATE	Initial		54.900	MAF 0013.pdf
Approved 11/05/2009	MAK0014	Certificate	CERTIFICATE	Initial		55.100	MAK 0014.pdf
Approved 11/05/2009	MAL0015	Certificate	CERTIFICATE	Initial		55.100	MAL 0015.pdf
Approved 11/05/2009	MAN0016	Certificate	CERTIFICATE	Initial		55.200	MAN 0016.pdf
Approved 11/05/2009	BT25	Outline of Coverage	PLAN BENEFIT TABLE	Initial		50.000	BT25 STD A.pdf

Approved 11/05/2009	BT26	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT26 STD B.pdf
Approved 11/05/2009	BT27	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT27 STD C.pdf
Approved 11/05/2009	BT28	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT28 STD F.pdf
Approved 11/05/2009	BT29	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT29 STD K.pdf
Approved 11/05/2009	BT30	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT30 STD L.pdf
Approved 11/05/2009	BT31	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT31 STD N.pdf
Approved 11/05/2009	BT32	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT32 STD Select C.pdf
Approved 11/05/2009	BT33	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT33 STD Select F.pdf
Approved 11/05/2009	BT002 ST	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT002 ST Combo AB,CF,KLN (w brackets).pdf
Approved 11/05/2009	BT002 ST CCSELECT	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT002 ST CCSelect (w brackets).pdf
Approved 11/05/2009	BT002 ST FFSELECT	Outline of Coverage	PLAN BENEFIT TABLE	Initial	50.000	BT002 ST FFSelect (w brackets).pdf
Approved 11/05/2009	POV3	Other	PLAN OVERVIEW	Initial	50.000	POV3 STD.pdf
Approved 11/05/2009	POV4	Other	PLAN OVERVIEW	Initial	50.000	POV4 STD Select.pdf
Approved 11/05/2009	RD4	Other	RULES AND DISCLOSURES	Initial	50.000	RD4 STD.pdf
Approved 11/05/2009	RD5	Other	RULES AND DISCLOSURES	Initial	50.000	RD5 STD Select.pdf
Approved 11/05/2009	MRP0001	Other	PREMIUM RATE PAGE	Initial	50.000	MRP0001 (6-10) AR

Approved 11/05/2009	MRP0002	Other	PREMIUM RATE PAGE	Initial	50.000	Filing.pdf MRP0002 (6-10) AR
Approved 11/05/2009	MRP0003	Other	PREMIUM RATE PAGE	Initial	50.000	Filing.pdf MRP0003 (6-10) AR
Approved 11/05/2009	MRP0004	Other	PREMIUM RATE PAGE	Initial	50.000	Filing.pdf MRP0004 (6-10) AR
Approved 11/05/2009	MDSC0008	Certificate	CERTIFICATE	Initial	50.000	Filing.pdf MDSC 0008.pdf
Approved 11/05/2009	MDSF0009	Certificate	CERTIFICATE	Initial	50.000	MDSF 0009.pdf
Approved 11/05/2009	MASC0017	Certificate	CERTIFICATE	Initial	50.000	MASC 0017.pdf
Approved 11/05/2009	MASF0018	Certificate	CERTIFICATE	Initial	50.000	MASF 0018.pdf
Approved 11/05/2009	PO3	Other	Plan of Operation	Initial	50.000	PO3 (AR).pdf

AARP Medicare Supplement Plan A Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, and *Part B Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Hospice Care*
3. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
4. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will **not** pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

3. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

4. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date.*

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan A Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan A Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan B Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, and *Part B Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Hospice Care*
3. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
4. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

3. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

4. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan B Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan B Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan C Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible***,** *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible***,** *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan C Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan C Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Supplement Plan F
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.
3. If your provider does not accept *Medicare Assignment*, the provider may charge you *Part B Excess Charges* for *Medicare*-approved services. *Part B Excess Charges* are the difference between the *Medicare-approved Amount* and any charge limitation established by *Medicare* or state law.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.
3. This *Plan* will pay your *Part B Excess Charges*. No benefits are payable for services which are not covered by *Medicare*.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*, except as stated for *Part B Excess Charges* in "Medical Services - Medicare Part B."

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan F Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Part B Excess Charges means the amount a provider who does not accept *Medicare Assignment* is legally permitted to charge you above the *Medicare-approved Amount.*

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan F Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Supplement Plan K Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

ANNUAL OUT-OF-POCKET LIMIT

The benefits of this *Plan* are subject to an annual out-of-pocket limit. After your out-of-pocket expenses under Part A and Part B of *Medicare* equal [$4620], this *Plan* will pay 100% of the Part A and Part B co-insurance and co-payments for the rest of the calendar year. This annual out-of-pocket limit is set by the Secretary of the U.S. Department of Health and Human Services and may change each year due to inflation.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay 50% of your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay 50% of your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay 50% of all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. Except for Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 50% of your *Part B Co-insurance* and your Part B co-payments.

   For Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 100% of your *Part B Co-insurance* and your

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you

Medicare requires you to share the cost of blood

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay 50% of the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay 50% of the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan K Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan K Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan L
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

ANNUAL OUT-OF-POCKET LIMIT

The benefits of this *Plan* are subject to an annual out-of-pocket limit. After your out-of-pocket expenses under Part A and Part B of *Medicare* equal [$2310], this *Plan* will pay 100% of the Part A and Part B co-insurance and co-payments for the rest of the calendar year. This annual out-of-pocket limit is set by the Secretary of the U.S. Department of Health and Human Services and may change each year due to inflation.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay 75% of your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay 75% of your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay 75% of all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. Except for Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 75% of your *Part B Co-insurance* and your Part B co-payments.

   For Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 100% of your *Part B Co-insurance* and your

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you

Medicare requires you to share the cost of blood

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay 75% of the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay 75% of the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan L Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan L Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan N Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments, except you are required to pay the following amounts:
   - Up to $20 per office visit.
   - Up to $50 per emergency room visit. This amount will be waived if you are admitted to the *Hospital* and your emergency room visit is covered as a *Medicare Eligible Expense* under Part A.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan N Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan N Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Supplement Plan A Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, and *Part B Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Hospice Care*
3. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
4. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will **not** pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

3. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

4. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan A Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan A Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan B Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, and *Part B Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Hospice Care*
3. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
4. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

3. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

4. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan B Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan B Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan C Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible***,** *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible***,** *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan C Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan C Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Supplement Plan F Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.
3. If your provider does not accept *Medicare Assignment*, the provider may charge you *Part B Excess Charges* for *Medicare*-approved services. *Part B Excess Charges* are the difference between the *Medicare-approved Amount* and any charge limitation established by *Medicare* or state law.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.
3. This *Plan* will pay your *Part B Excess Charges*. No benefits are payable for services which are not covered by *Medicare*.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*, except as stated for *Part B Excess Charges* in "Medical Services - Medicare Part B."

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan F Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Part B Excess Charges means the amount a provider who does not accept *Medicare Assignment* is legally permitted to charge you above the *Medicare-approved Amount.*

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan F Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Supplement Plan K Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

ANNUAL OUT-OF-POCKET LIMIT

The benefits of this *Plan* are subject to an annual out-of-pocket limit. After your out-of-pocket expenses under Part A and Part B of *Medicare* equal [$4620], this *Plan* will pay 100% of the Part A and Part B co-insurance and co-payments for the rest of the calendar year. This annual out-of-pocket limit is set by the Secretary of the U.S. Department of Health and Human Services and may change each year due to inflation.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay 50% of your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay 50% of your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay 50% of all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. Except for Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 50% of your *Part B Co-insurance* and your Part B co-payments.

   For Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 100% of your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay 50% of the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay 50% of the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan K Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan K Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan L
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do <u>one</u> of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

<u>Caution</u>: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

ANNUAL OUT-OF-POCKET LIMIT

The benefits of this *Plan* are subject to an annual out-of-pocket limit. After your out-of-pocket expenses under Part A and Part B of *Medicare* equal [$2310], this *Plan* will pay 100% of the Part A and Part B co-insurance and co-payments for the rest of the calendar year. This annual out-of-pocket limit is set by the Secretary of the U.S. Department of Health and Human Services and may change each year due to inflation.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay 75% of your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay 75% of your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay 75% of all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. Except for Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 75% of your *Part B Co-insurance* and your Part B co-payments.

   For Part B *Medicare Eligible Expenses* for preventive health services, this *Plan* will pay 100% of your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay 75% of the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay 75% of the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense*.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan L Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan L Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

AARP Medicare Supplement Plan N Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[John Q Member
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition*.

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these three statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will **not** pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments, except you are required to pay the following amounts:
   - Up to $20 per office visit.
   - Up to $50 per emergency room visit. This amount will be waived if you are admitted to the *Hospital* and your emergency room visit is covered as a *Medicare Eligible Expense* under Part A.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*. Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date*.

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare*, but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months (18 months in Hawaii) from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date*, conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan*, you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Supplement Plan N Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Supplement Plan N Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	$0	Up to [$133.50] 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.

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

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan A Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan B

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	$0	Up to [$133.50] 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.

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

Plan Benefit Tables: Plan B (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan B Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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.

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

Plan Benefit Tables: Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[3]	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

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

Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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.

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

Plan Benefit Tables: Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[3]	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

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

Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan K Pays	You Pay[3]
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$534] (50% of Part A deductible)	[$534] (50% of Part A deductible)♦
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$66.75] per day	Up to [$66.75] 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 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

3 You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan Benefit Tables: Plan K (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay[4]
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[5]	$0	$0	[$135] (Part B deductible)[5]♦
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of [$4620])[4]
Blood	First 3 pints	$0	50%	50%♦
	Next [$135] of Medicare-approved amounts[5]	$0	$0	[$135] (Part B deductible)[5]♦
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

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

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Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [$4620] per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

5 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K (continued)

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay[4]
Durable medical equipment Medicare-approved services	First [$135] of Medicare-approved amounts[6]	$0	$0	[$135] (Part B deductible)♦
	Remainder of Medicare-approved amounts	80%	10%	10%♦

Notes

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

Plan Benefit Tables: Plan L

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan L Pays	You Pay[3]
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$801] (75% of Part A deductible)	[$267] (25% of Part A deductible)♦
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$100.13] per day	Up to [$33.37] 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♦

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Notes

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

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

3 You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan Benefit Tables: Plan L (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan L Pays	You Pay[4]
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[5]	$0	$0	[$135] (Part B deductible)[5]♦
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of [$2310])[4]
Blood	First 3 pints	$0	75%	25%♦
	Next [$135] of Medicare-approved amounts[5]	$0	$0	[$135] (Part B deductible)[5]♦
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

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

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Notes

4 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [$2310] per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

5 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan L (continued)

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay[4]
Durable medical equipment Medicare-approved services	First [$135] of Medicare-approved amounts[6]	$0	$0	[$135] (Part B deductible)♦
	Remainder of Medicare-approved amounts	80%	15%	5%♦

Notes

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

Plan Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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.

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

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan N Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

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

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Notes

3 Once you have been billed [$135] 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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (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

Plan Benefit Tables: Medicare Select – Plan C

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

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

2 You must use a network hospital.

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

Plan Benefit Tables: Medicare Select – Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

		Medicare Pays	Medicare Select Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[4]	$0	[$135] (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 [$135] of Medicare-approved amounts[4]	$0	[$135] (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	Medicare Select 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 [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select 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 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Medicare Select – Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

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

2 You must use a network hospital.

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

Plan Benefit Tables: Medicare Select – Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[4]	$0	[$135] (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 [$135] of Medicare-approved amounts[4]	$0	[$135] (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	Medicare Select 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 [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select 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 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan A and Plan B

Medicare Part A: Hospital Services per Benefit Period[1]

Service	Medicare Pays	Plan A		Plan B	
		Plan Pays	You Pay	Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)	[$1,068] (Part A deductible)	$0
Days 61–90	All but [$267] per day	[$267] per day	$0	[$267] per day	$0
Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0	[$534] per day	$0
After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]	100% of Medicare-eligible expenses	$0[2]
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
Days 21–100	All but [$133.50] per day	$0	Up to [$133.50] per day	$0	Up to [$133.50] per day
Days 101 and later	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
Hospice Care					
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	Medicare co-payment/ co-insurance	$0

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Notes

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

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

Plan Benefit Tables: Plan A and Plan B, continued

Medicare Part B: Medical Services per Calendar Year

Service	Medicare Pays	Plan A		Plan B	
		Plan Pays	You Pay	Plan 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 [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges					
Above Medicare-approved amounts	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services					
Tests for diagnostic services	100%	$0	$0	$0	$0

Parts A and B

Service	Medicare Pays	Plan A		Plan B	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Health Care Medicare-approved services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment Medicare-approved services					
First [$135] of Medicare-approved amounts[3]	$0	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C and Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service	Medicare Pays	Plan C		Plan F	
		Plan Pays	You Pay	Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0	[$1,068] (Part A deductible)	$0
Days 61–90	All but [$267] per day	[$267] per day	$0	[$267] per day	$0
Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0	[$534] per day	$0
After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]	100% of Medicare-eligible expenses	$0[2]
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
Days 21–100	All but [$133.50] per day	Up to [$133.50] per day	$0	Up to [$133.50] per day	$0
Days 101 and later	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
Hospice Care					
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	Medicare co-payment/ co-insurance	$0

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Notes

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

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

Plan Benefit Tables: Plan C and Plan F, continued

Medicare Part B: Medical Services per Calendar Year

Service	Medicare Pays	Plan C		Plan F	
		Plan Pays	You Pay	Plan 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 [$135] of Medicare-approved amounts[3]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges					
Above Medicare-approved amounts	$0	$0	All costs	100%	$0
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next [$135] of Medicare-approved amounts[3]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services					
Tests for diagnostic services	100%	$0	$0	$0	$0

Parts A and B

Service	Medicare Pays	Plan C		Plan F	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Health Care Medicare-approved services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment Medicare-approved services					
First [$135] of Medicare-approved amounts[3]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

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Notes

3 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C and Plan F, continued

Medicare Part B: Medical Services per Calendar Year

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

Plan Benefit Tables: Plan K, Plan L and Plan N

Medicare Part A: Hospital Services per Benefit Period[1]							
Service	**Medicare Pays**	Plan K		Plan L		Plan N	
		Plan Pays	You Pay[3]	**Plan Pays**	You Pay[3]	**Plan Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.							
First 60 days	All but [$1,068]	[$534] (50% of Part A deductible)	[$534] (50% of Part A deductible)♦	[$801] (75% of Part A deductible)	[$267] (25% of Part A Deductible)♦	[$1,068] (Part A deductible)	$0
Days 61–90	All but [$267] per day	[$267] per day	$0	[$267] per day	$0	[$267] per day	$0
Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0	[$534] per day	$0	[$534] per day	$0
After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible costs	$0[2]	100% of Medicare-eligible costs	$0[2]	100% of Medicare-eligible costs	$0[2]
Beyond the additional 365 days	$0	$0	All costs	$0	All costs	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.							
First 20 days	All approved amounts	$0	$0	$0	$0	$0	$0
Days 21–100	All but [$133.50] per day	Up to [$66.75] per day	Up to [$66.75] per day♦	Up to [$100.13] per day	Up to [$33.37] per day♦	Up to [$133.50] per day	$0
Days 101 and later	$0	$0	All costs	$0	All costs	$0	All costs
Blood							
First 3 pints	$0	50%	50%♦	75%	25%♦	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0	$0	$0

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Notes

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

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

3 You will pay half (one-fourth for Plan L) of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$4620 ($2310 for Plan L)] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦). Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and co-insurance 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, Plan L and Plan N, continued

Medicare Part A: Hospital Services per Benefit Period[1], continued

Service	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay[3]	Plan Pays	You Pay[3]	Plan Pays	You Pay
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♦	75% of co-payment/ co-insurance	25% of Medicare co-payment/ co-insurance♦	Medicare co-payment/ co-insurance	$0

Medicare Part B: Medical Services per Calendar Year

Service	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay[3]	Plan Pays	You Pay[3]	Plan 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 [$135] of Medicare-approved amounts[4]	$0	$0	[$135] (Part B deductible)♦	$0	[$135] (Part B deductible)♦	$0	[$135] (Part B deductible)
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	All costs above Medicare-approved amounts	Balance, other than up to [$20] per office visit	Up to [$20] per office visit
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦	Generally 15%	Generally 5%♦	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.

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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.

3 This plan limits your annual out-of-pocket payments for Medicare-approved amount to [$4620 per calendar year ($2310 for Plan L)]. 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 [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K, Plan L and Plan N, continued

Medicare Part B: Medical Services per Calendar Year, continued

Service	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
Part B Excess Charges							
Above Medicare-approved amounts	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])[3]	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])[3]	$0	All costs
Blood							
First 3 pints	$0	50%	50%♦	75%	25%♦	All costs	$0
Next [$135] of Medicare-approved amounts[4]	$0	$0	[$135] (Part B deductible)[4]♦	$0	[$135] (Part B deductible)[4]♦	$0	[$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	Generally 10%	Generally 10%♦	Generally 15%	Generally 5%♦	20%	$0
Clinical Laboratory Services							
Tests for diagnostic services	100%	$0	$0	$0	$0	$0	$0

Parts A and B

Service	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay[3]	Plan Pays	You Pay[3]	Plan Pays	You Pay
Home Health Care Medicare-approved services							
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0	$0	$0
Durable medical equipment Medicare-approved services							
First [$135] of Medicare-approved amounts[4]	$0	$0	[$135] (Part B deductible)♦	$0	[$135] (Part B deductible)♦	$0	[$135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	10%	10%♦	15%	5%♦	20%	$0

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Notes

3 This plan limits your annual out-of-pocket payments for Medicare-approved amount to [$4620 per calendar year ($2310 for Plan L)]. 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 [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K, Plan L and Plan N, continued

Benefits not covered by Medicare							
Service	**Medicare Pays**	Plan K		Plan L		Plan N	
		Plan Pays	You Pay[3]	Plan Pays	You Pay[3]	Plan Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.							
First [$250] each calendar year	$0	$0	All costs	$0	All costs	$0	[$250]
Remainder of charges	$0	$0	All costs	$0	All costs	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 This plan limits your annual out-of-pocket payments for Medicare-approved amount to [$4620 per calendar year ($2310 for Plan L)]. 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 C and Medicare Select Plan C

Medicare Part A: Hospital Services per Benefit Period[1]					
Service	**Medicare Pays**	Plan C		Select Plan C[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Hospitalization[1] (in a Participating Hospital for Medicare Select Plan C)[3] Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0	[$1,068] (Part A deductible)	$0
Days 61–90	All but [$267] per day	[$267] per day	$0	[$267] per day	$0
Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0	[$534] per day	$0
After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]	100% of Medicare eligible expenses	$0[2]
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
Days 21–100	All but [$133.50] per day	Up to [$133.50] per day	$0	Up to [$133.50] per day	$0
Days 101 and later	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
Hospice Care					
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	Medicare co-payment/ co-insurance	$0

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Notes

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

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

3 You must use a network hospital.

Plan Benefit Tables: Plan C and Medicare Select Plan C, continued

Medicare Part B: Medical Services per Calendar Year					
Service	**Medicare Pays**	Plan C		Select Plan C[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT[3], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges					
Above Medicare-approved amounts	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services					
Tests for diagnostic services	100%	$0	$0	$0	$0

Parts A and B					
Service	**Medicare Pays**	Plan C		Select Plan C[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Health Care Medicare-approved services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment Medicare-approved services					
First [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Continued on next page ▶

Notes

3 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan C and Medicare Select Plan C, continued

Medicare Part B: Medical Services per Calendar Year					
Service	**Medicare Pays**	Plan C		Select Plan C[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.					
First [$250] each calendar year	$0	$0	[$250]	$0	[$250]
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 You must use a network hospital.

Plan Benefit Tables: Plan F and Medicare Select Plan F

Medicare Part A: Hospital Services per Benefit Period[1]					
Service	**Medicare Pays**	Plan F		Select Plan F[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Hospitalization[1] (in a Participating Hospital for Medicare Select Plan F)[3] Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0	[$1,068] (Part A deductible)	$0
Days 61–90	All but [$267] per day	[$267] per day	$0	[$267] per day	$0
Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0	[$534] per day	$0
After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]	100% of Medicare eligible expenses	$0[2]
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
Days 21–100	All but [$133.50] per day	Up to [$133.50] per day	$0	Up to [$133.50] per day	$0
Days 101 and later	$0	$0	All costs	$0	All costs
Blood					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
Hospice Care					
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	Medicare co-payment/ co-insurance	$0

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

3 You must use a network hospital.

Plan Benefit Tables: Plan F and Medicare Select Plan F, continued

Medicare Part B: Medical Services per Calendar Year					
Service	**Medicare Pays**	Plan F		Select Plan F[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT[3], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges					
Above Medicare-approved amounts	$0	100%	$0	100%	$0
Blood					
First 3 pints	$0	All costs	$0	All costs	$0
Next [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
Clinical Laboratory Services					
Tests for diagnostic services	100%	$0	$0	$0	$0

Parts A and B					
Service	**Medicare Pays**	Plan F		Select Plan F[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Home Health Care Medicare-approved services					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment Medicare-approved services					
First [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

Continued on next page ▶

Notes

3 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F and Medicare Select Plan F, continued

Medicare Part B: Medical Services per Calendar Year					
Service	**Medicare Pays**	Plan F		Select Plan F[3]	
		Plan Pays	You Pay	Plan Pays	You Pay
Foreign Travel NOT COVERED BY MEDICARE—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.					
First [$250] each calendar year	$0	$0	[$250]	$0	[$250]
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 You must use a network hospital.

Overview of Available Plans

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

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

Plan K	Plan L	Plan M	Plan N
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 coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit [$4620]; paid at 100% after limit reached	Out-of-pocket limit [$2310]; 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.**

Overview of Available Plans

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, B, C, F, K, L, N and Medicare Select Plans C and F 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

♦Medicare Select Plans C and F contain the same benefits as standardized Medicare Supplement Plans C and F, except for restrictions on your use of hospitals.

Plan A	Plan B	Plan C♦	Plan D	Plan F*♦	Plan G
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
		Skilled nursing facility co-insurance	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
		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

Plan K	Plan L	Plan M	Plan N
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 coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit [$4620]; paid at 100% after limit reached	Out-of-pocket limit [$2310]; 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.**

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.

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.

Rules and Disclosures about this Insurance

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

Premium information

You may keep your 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.

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.

Grievance Procedure

Complaint and Grievance Procedure - UnitedHealthcare has established a formal procedure to respond to customer complaints and grievances. UnitedHealthcare desires to provide a fair, accessible and responsive method of evaluating and resolving complaints and grievances. If UnitedHealthcare determines that any prior action that it has taken was incorrect, corrective action will be taken. You may, at any time, submit a written complaint to the Department of Insurance in your state.

Complaints - If you have a complaint, you may call us at1-800-523-5880 or write to us at UnitedHealthcare, [P.O. Box 1012, Montgomeryville, PA 18936-1012.] We will acknowledge all complaints within 15 days and will respond to all complaints within a reasonable period of time.

Grievances - If you are dissatisfied with our handling of a complaint or a claim denial, or are dissatisfied for any other reason, you may submit a formal grievance. Grievances must be in writing and contain the words "this is a grievance" to ensure that we understand the purpose of the communication. You must clearly state the nature of the grievance and send it to: UnitedHealthcare, [P.O. Box 1012, Montgomeryville, PA 18936-1012.] We will acknowledge in writing all grievances within 15 days and respond to all grievances within a reasonable period of time. All grievances must be filed within 60 days or as soon as reasonably possible from the date of denial of benefits or other action giving rise to the grievance.

Cover Page-Rates

Your Plans and Rates

[Arkansas]

Benefits	Plan A
Part A (Hospitalization) co-insurance plus 365 additional hospital days after Medicare benefits end	✓
Part B (Medical) co-insurance or co-payments	✓
Blood first 3 pints each year (Medicare pays costs after 3 pints)	✓
Hospice Care co-insurance	✓
Skilled Nursing Facility Care co-insurance	
Part A Deductible	
Part B Annual Deductible	
Part B Excess Charges	
Foreign Travel emergency care	
Annual Out-Of-Pocket spending limit	

Monthly Plan Rates[1]	Plan A
[Standard Rates	[$X,XXX.XX]
Standard Rates for Tobacco Users	[$X,XXX.XX]
Level 2 Rates	[$X,XXX.XX]
Level 2 Rates for Tobacco Users	[$X,XXX.XX]

1 **NOTE:** The rates on these pages are for the person whose name is on the enclosed application. These rates are for plan effective dates [from June - December 2010] [in the year 2011] and may change.

2 **EXCEPTION:** Plans K and L will pay 100% of Part B co-insurance for preventive services covered by Medicare.

Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
✓	✓	✓	✓	✓	✓
✓	✓	✓	50%[2]	75%[2]	Copay[3]
✓	✓	✓	50%	75%	✓
✓	✓	✓	50%	75%	✓
	✓	✓	50%	75%	✓
✓	✓	✓	50%	75%	✓
	✓	✓			
		✓			
	✓	✓			✓
			[$X,XXX.XX]	[$X,XXX.XX]	

Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]]

3 **NOTE:** Up to $20 copay for office visits and up to $50 copay for ER.

Cover Page-Rates

Your Plans and Rates

[Arkansas]

	Plan A	Plan B
Benefits		
Part A (Hospitalization) co-insurance plus 365 additional hospital days after Medicare benefits end	✓	✓
Part B (Medical) co-insurance or co-payments	✓	✓
Blood first 3 pints each year (Medicare pays costs after 3 pints)	✓	✓
Hospice Care co-insurance	✓	✓
Skilled Nursing Facility Care co-insurance		
Part A Deductible		✓
Part B Annual Deductible		
Part B Excess Charges		
Foreign Travel emergency care		
Annual Out-Of-Pocket spending limit		

	Plan A	Plan B
Monthly Plan Rates[1]		
[Standard Rates	[$X,XXX.XX]	[$X,XXX.XX]
Standard Rates for Tobacco Users	[$X,XXX.XX]	[$X,XXX.XX]
Level 2 Rates	[$X,XXX.XX]	[$X,XXX.XX]
Level 2 Rates for Tobacco Users	[$X,XXX.XX]	[$X,XXX.XX]

1 **NOTE:** The rates on these pages are for the person whose name is on the enclosed application. These rates are for plan effective dates [from June - December 2010] [in the year 2011] and may change.

2 **NOTE:** You must use a network hospital with Medicare Select Plans C and F.

Plan C	Plan C Select[2]	Plan F	Plan F Select[2]	Plan K	Plan L	Plan N
✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	50%[3]	75%[3]	Copay[4]
✓	✓	✓	✓	50%	75%	✓
✓	✓	✓	✓	50%	75%	✓
✓	✓	✓	✓	50%	75%	✓
✓	✓	✓	✓	50%	75%	✓
✓	✓	✓	✓			
		✓	✓			
✓	✓	✓	✓			✓
				[$X,XXX.XX]	[$X,XXX.XX]	

Plan C	Plan C Select[2]	Plan F	Plan F Select[2]	Plan K	Plan L	Plan N
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]
[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]	[$X,XXX.XX]]

3 **EXCEPTION:** Plans K and L will pay 100% of Part B co-insurance for preventive services covered by Medicare.

4 **NOTE:** Up to $20 copay for office visits and up to $50 copay for ER.

Cover Page - Rates for [Arkansas]

Monthly Plan Rates[1]

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plan A	Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
Standard Rates						
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Standard Rates for Tobacco Users						
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Level 2 Rates [for individuals who have one or more of the medical conditions on the application.][2]						
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Level 2 Rates [for tobacco users who have one or more of the medical conditions on the application.][2]						
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

[1] [The rates on this page are for the person whose name is on the enclosed application.
These rates are for plan effective dates [from June - December 2010] [in the year 2011] and may change.]

[2] Refer to Section [6] of the application.

Cover Page - Rates for [Arkansas]

Monthly Plan Rates[1]

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Plan A	Plan B	Plan C	Select C[2]	Plan F	Select F[3]	Plan K	Plan L	Plan N
Standard Rates								
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Standard Rates for Tobacco Users								
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Level 2 Rates [for individuals who have one or more of the medical conditions on the application.][3]								
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Level 2 Rates [for tobacco users who have one or more of the medical conditions on the application.][3]								
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

[1] [The rates on this page are for the person whose name is on the enclosed application. These rates are for plan effective dates [from June - December 2010] [in the year 2011] and may change.]

[2] You must use a network hospital with Select Plans C and F.

[3] Refer to Section [6] of the application.

AARP Medicare Select Plan C
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[**John Q Member**
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You are no longer eligible for a Medicare Select plan. See "Medicare Select Rules" for more information .
4. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition.*

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these four statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.
4. Your *Primary Residence* is within a *Service Area*.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

Hospital Restrictions

This *Plan* requires you to use a *Network Hospital* for covered inpatient and outpatient *Hospital* services. You do not need to use a *Network Hospital* for the reasons stated below. However, the *Hospital* must be approved for payment by *Medicare* for stays, care or services to be covered under this *Plan*.

You do not need to use a *Network Hospital* only for these reasons:

1. You need care for a *Medical Emergency*.
2. The covered services you need are not available from any *Network Hospital* in your *Service Area*.
3. You are traveling and you receive covered services from a non-*Network Hospital* more than 100 miles from your *Primary Residence*.

   In this case, this *Plan* will pay these benefits:

   - 75% of the *Part A Deductible* per *Benefit Period*;
   - 75% of the *Part A Daily Co-insurance*;
   - 75% of the *Lifetime Reserve Daily Co-insurance*; and
   - 75% of the *Part B Co-insurance* or Part B co-payment for outpatient *Hospital* services not paid by *Medicare*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay. This *Plan* requires you to use a *Network Hospital* for covered inpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Network Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses. This *Plan* requires you to use a *Network Hospital* for covered outpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date.*

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare,* but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

Care provided by a non–Network Hospital

We will not pay benefits for stays, care or services that you receive in a non-*Network Hospital,* except as stated in the section called "Hospital Restrictions."

MEDICARE SELECT RULES

1. If you have been covered under this *Plan* for at least 6 months, you can ask to have this *Plan* replaced with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can replace this *Plan* with any Medicare Supplement plan that we offer that has the same or less benefits. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.
2. You may not keep this Medicare Select Plan if any of these events occur:
   - Medicare Select plans are discontinued by state or federal law.
   - Your *Primary Residence* is no longer within a *Service Area* because you moved.
   - Your *Primary Residence* is no longer within a *Service Area* because of a change in the network.

   If any of these events occur, you can continue your coverage by replacing this *Plan* with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can choose a Medicare supplement plan from us or any other company. We will let you know which Medicare supplement plans are available for you to choose from us. You cannot be denied this replacement coverage or charged a higher premium based on your health. This replacement coverage will not have a pre-existing conditions exclusion.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

Medicare Select plans may not be available where your new *Primary Residence* is located. See “Medicare Select Rules” for more information.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date,* conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan,* you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

COMPLAINTS AND GRIEVANCES

We have a formal process to receive and respond to complaints or grievances. Our goal is to provide a fair way to evaluate, consider and settle all complaints and grievances. If we find that any action we have taken is not proper, we will correct it.

Here is what you need to do to file a complaint or a grievance.

Complaints

If you have a complaint, call our toll-free number at 1-800-523-5800. You can also write to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. We will let you know that we received your complaint within 15 days. We will respond to it within a reasonable period of time.

Grievances

If you are not satisfied with how a complaint was handled, a claim denial, or for any other reason, you may submit a formal grievance. Grievances must be in writing and must state “This is a grievance” so the purpose of your communication is understood. You must clearly state the nature of your grievance. Mail it to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. You must send us your grievance within 60 days from the date of your claim denial or other reason for your grievance. We will let you know that we received your grievance within 15 days. We will respond to it within a reasonable period of time.

If you are not satisfied with how we handled your complaint or grievance, or for any other reason, you may file a written complaint with the Department of Insurance in your state.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Select Plan C Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Network Hospital means a *Hospital* that has made an agreement with us, in writing, to provide services. The status of a *Hospital* may change.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Select Plan C Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Service Area means the geographic area where we are authorized to provide a Medicare Select plan. This area has been approved by the Commissioner of Insurance in your state.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Select Plan F
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[**John Q Member**
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You are no longer eligible for a Medicare Select plan. See "Medicare Select Rules" for more information .
4. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition.*

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these four statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.
4. Your *Primary Residence* is within a *Service Area*.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

Hospital Restrictions

This *Plan* requires you to use a *Network Hospital* for covered inpatient and outpatient *Hospital* services. You do not need to use a *Network Hospital* for the reasons stated below. However, the *Hospital* must be approved for payment by *Medicare* for stays, care or services to be covered under this *Plan*.

You do not need to use a *Network Hospital* only for these reasons:

1. You need care for a *Medical Emergency*.
2. The covered services you need are not available from any *Network Hospital* in your *Service Area*.
3. You are traveling and you receive covered services from a non-*Network Hospital* more than 100 miles from your *Primary Residence*.

   In this case, this *Plan* will pay these benefits:

   - 75% of the *Part A Deductible* per *Benefit Period*;
   - 75% of the *Part A Daily Co-insurance*;
   - 75% of the *Lifetime Reserve Daily Co-insurance*; and
   - 75% of the *Part B Co-insurance* or Part B co-payment for outpatient *Hospital* services not paid by *Medicare*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay. This *Plan* requires you to use a *Network Hospital* for covered inpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Network Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.
3. If your provider does not accept *Medicare Assignment*, the provider may charge you *Part B Excess Charges* for *Medicare*-approved services. *Part B Excess Charges* are the difference between the *Medicare-approved Amount* and any charge limitation established by *Medicare* or state law.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses. This *Plan* requires you to use a *Network Hospital* for covered outpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.
3. This *Plan* will pay your *Part B Excess Charges*. No benefits are payable for services which are not covered by *Medicare*.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date.*

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare,* but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense,* except as stated for *Part B Excess Charges* in "Medical Services - Medicare Part B."

Care provided by a non–Network Hospital

We will not pay benefits for stays, care or services that you receive in a non-*Network Hospital,* except as stated in the section called "Hospital Restrictions."

MEDICARE SELECT RULES

1. If you have been covered under this *Plan* for at least 6 months, you can ask to have this *Plan* replaced with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can replace this *Plan* with any Medicare Supplement plan that we offer that has the same or less benefits. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.
2. You may not keep this Medicare Select Plan if any of these events occur:
   - Medicare Select plans are discontinued by state or federal law.
   - Your *Primary Residence* is no longer within a *Service Area* because you moved.
   - Your *Primary Residence* is no longer within a *Service Area* because of a change in the network.

   If any of these events occur, you can continue your coverage by replacing this *Plan* with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can choose a Medicare supplement plan from us or any other company. We will let you know which Medicare supplement plans are available for you to choose from us. You cannot be denied this replacement coverage or charged a higher premium based on your health. This replacement coverage will not have a pre-existing conditions exclusion.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

Medicare Select plans may not be available where your new *Primary Residence* is located. See “Medicare Select Rules” for more information.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date,* conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan,* you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

COMPLAINTS AND GRIEVANCES

We have a formal process to receive and respond to complaints or grievances. Our goal is to provide a fair way to evaluate, consider and settle all complaints and grievances. If we find that any action we have taken is not proper, we will correct it.

Here is what you need to do to file a complaint or a grievance.

Complaints

If you have a complaint, call our toll-free number at 1-800-523-5800. You can also write to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. We will let you know that we received your complaint within 15 days. We will respond to it within a reasonable period of time.

Grievances

If you are not satisfied with how a complaint was handled, a claim denial, or for any other reason, you may submit a formal grievance. Grievances must be in writing and must state “This is a grievance” so the purpose of your communication is understood. You must clearly state the nature of your grievance. Mail it to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. You must send us your grievance within 60 days from the date of your claim denial or other reason for your grievance. We will let you know that we received your grievance within 15 days. We will respond to it within a reasonable period of time.

If you are not satisfied with how we handled your complaint or grievance, or for any other reason, you may file a written complaint with the Department of Insurance in your state.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Select Plan F Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Network Hospital means a *Hospital* that has made an agreement with us, in writing, to provide services. The status of a *Hospital* may change.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Part B Excess Charges means the amount a provider who does not accept *Medicare Assignment* is legally permitted to charge you above the *Medicare-approved Amount.*

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Select Plan F Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Service Area means the geographic area where we are authorized to provide a Medicare Select plan. This area has been approved by the Commissioner of Insurance in your state.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Select Plan C
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[**John Q Member**
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You are no longer eligible for a Medicare Select plan. See "Medicare Select Rules" for more information .
4. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition.*

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these four statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.
4. Your *Primary Residence* is within a *Service Area*.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

Hospital Restrictions

This *Plan* requires you to use a *Network Hospital* for covered inpatient and outpatient *Hospital* services. You do not need to use a *Network Hospital* for the reasons stated below. However, the *Hospital* must be approved for payment by *Medicare* for stays, care or services to be covered under this *Plan*.

You do not need to use a *Network Hospital* only for these reasons:

1. You need care for a *Medical Emergency*.
2. The covered services you need are not available from any *Network Hospital* in your *Service Area*.
3. You are traveling and you receive covered services from a non-*Network Hospital* more than 100 miles from your *Primary Residence*.

   In this case, this *Plan* will pay these benefits:

   - 75% of the *Part A Deductible* per *Benefit Period*;
   - 75% of the *Part A Daily Co-insurance*;
   - 75% of the *Lifetime Reserve Daily Co-insurance*; and
   - 75% of the *Part B Co-insurance* or Part B co-payment for outpatient *Hospital* services not paid by *Medicare*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay. This *Plan* requires you to use a *Network Hospital* for covered inpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Network Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses. This *Plan* requires you to use a *Network Hospital* for covered outpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date.*

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare,* but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense.*

Care provided by a non–Network Hospital

We will not pay benefits for stays, care or services that you receive in a non-*Network Hospital,* except as stated in the section called "Hospital Restrictions."

MEDICARE SELECT RULES

1. If you have been covered under this *Plan* for at least 6 months, you can ask to have this *Plan* replaced with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can replace this *Plan* with any Medicare Supplement plan that we offer that has the same or less benefits. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.
2. You may not keep this Medicare Select Plan if any of these events occur:
   - Medicare Select plans are discontinued by state or federal law.
   - Your *Primary Residence* is no longer within a *Service Area* because you moved.
   - Your *Primary Residence* is no longer within a *Service Area* because of a change in the network.

   If any of these events occur, you can continue your coverage by replacing this *Plan* with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can choose a Medicare supplement plan from us or any other company. We will let you know which Medicare supplement plans are available for you to choose from us. You cannot be denied this replacement coverage or charged a higher premium based on your health. This replacement coverage will not have a pre-existing conditions exclusion.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

Medicare Select plans may not be available where your new *Primary Residence* is located. See “Medicare Select Rules” for more information.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date,* conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan,* you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

COMPLAINTS AND GRIEVANCES

We have a formal process to receive and respond to complaints or grievances. Our goal is to provide a fair way to evaluate, consider and settle all complaints and grievances. If we find that any action we have taken is not proper, we will correct it.

Here is what you need to do to file a complaint or a grievance.

Complaints

If you have a complaint, call our toll-free number at 1-800-523-5800. You can also write to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. We will let you know that we received your complaint within 15 days. We will respond to it within a reasonable period of time.

Grievances

If you are not satisfied with how a complaint was handled, a claim denial, or for any other reason, you may submit a formal grievance. Grievances must be in writing and must state “This is a grievance” so the purpose of your communication is understood. You must clearly state the nature of your grievance. Mail it to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. You must send us your grievance within 60 days from the date of your claim denial or other reason for your grievance. We will let you know that we received your grievance within 15 days. We will respond to it within a reasonable period of time.

If you are not satisfied with how we handled your complaint or grievance, or for any other reason, you may file a written complaint with the Department of Insurance in your state.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Select Plan C Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Network Hospital means a *Hospital* that has made an agreement with us, in writing, to provide services. The status of a *Hospital* may change.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Select Plan C Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Service Area means the geographic area where we are authorized to provide a Medicare Select plan. This area has been approved by the Commissioner of Insurance in your state.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP Medicare Select Plan F
Certificate of Insurance

About this document

We call this document your *Certificate*. A *Group Policy* has been issued to the [Trustees of the AARP Insurance Plan] and your *Certificate* is proof of your coverage under the *Group Policy*. This *Certificate* is effective on the *Effective Date* shown on this page. This *Certificate* is an important document and should be kept in a safe place. **Please read this *Certificate* carefully.**

In this document, "you" means the person whose name appears on this page and who this *Certificate* has been issued to. "We" and "us" means UnitedHealthcare Insurance Company.

Many of the terms we use in this *Certificate* have special meanings. To help you find these terms, each of them begins with a capital letter and appears in *italics*. *Certificate* is one of these terms. You can find our definitions for each of these terms in the section at the end of this *Certificate* called "Terms we use."

You have 30 days to decide if you want this Plan

If you decide you do not want this *Plan*, within 30 days after you receive this *Certificate*, you must do one of these two things:

1. Call us at the phone number shown on your ID card and ask us to void your *Plan*, or
2. Ask us in writing to void your *Plan*. You can send your request to the Administrative office shown above.

When we receive your request, we will treat the *Certificate* as if no coverage under this *Plan* was in force from the *Effective Date*. We will also refund any *Premium* you paid.

If we pay any claims for you before we process your request, we have the right to recover what we paid. We will reduce the *Premium* returned to you by the amount of the claims we paid.

If the amount we paid for your claims is more than the *Premium* you paid, you will not receive a *Premium* refund.

Notice to buyer

This *Plan* may not pay all of your medical expenses. See "What's included in your Plan."

Underwritten by:

UnitedHealthcare Insurance Company

Administrative office: [680 Blair Mill Road
Horsham, Pennsylvania 19044]

Home office: Hartford, Connecticut

Claim mailing address: see your ID card

Issued to:

[**John Q Member**
123 Any Street
Richmond IN 47374]
Membership # [999999999-1]

Effective Date: [06/01/2010]

Keeping your coverage under this Plan

To keep your coverage in force, pay the *Premium* when it is due.

This coverage is guaranteed renewable which means that we can cancel it only if certain events happen. Any of these events gives us the right to cancel your coverage under this *Plan*:

1. You have not paid your *Premium* on time.
2. The *Group Policy* has ended. See "About this Plan" for more information about the *Group Policy*.
3. You are no longer eligible for a Medicare Select plan. See "Medicare Select Rules" for more information .
4. You misstated one or more *Material Facts* when you applied for this *Plan*. See "Effects of statements you made to us" for more information.

Caution: Please review the copy of your application that we returned to you. You made statements in your application that we relied upon when we issued this *Plan*. If any statement is incorrect or untrue, we have the right to void this coverage, adjust your *Premiums* or reduce benefits. If you think you have given us incorrect or incomplete information, you should contact us now, before you have a claim.

Limit on benefits for Pre-existing Conditions

We will not pay benefits for any stay that starts or medical care you receive for a *Pre-existing Condition* during the first [3 - 6] months after your *Effective Date*. See "Terms we use" for the definition of *Pre-existing Condition.*

This limit does not apply if mandated by state law, or if we receive your application before or during your open enrollment period. Your open enrollment period lasts 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

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ABOUT THIS PLAN

Your coverage under this *Plan* is provided by UnitedHealthcare Insurance Company.

This *Plan's* coverage is in addition to your *Medicare* benefits. It does not replace those benefits and will not duplicate those benefits. To learn more about your benefits, see "What's included in your Plan" and "What's not included in your Plan."

We have issued this *Certificate* under *Group Policy* number [G-36000-4]. We issued the *Group Policy* in the District of Columbia to the [Trustees of the AARP Insurance Plan]. It provides insurance for AARP members and is governed by the laws of the District of Columbia.

All benefits are subject to the *Group Policy*. The *Group Policy* refers to this *Certificate*. This *Certificate* is included and made a part of the *Group Policy* by this reference. You may review the *Group Policy* at the office of the [Trustees of the AARP Insurance Plan]. You must visit during normal business hours. This is the office's address:

[601 E Street N.W.
Washington, DC 20049.]

Who is eligible for this Plan

You are eligible to enroll in this *Plan* if these four statements are true.

1. You are an eligible member of AARP, or you are an eligible spouse of a member of AARP.
2. You are enrolled under both Part A and Part B of original *Medicare*.
3. Either:
   a. You are enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan, and you will replace that plan with this *Plan*, or
   b. You are not enrolled in another Medicare supplement plan or in a Medicare Advantage plan or other Medicare Part C plan.
4. Your *Primary Residence* is within a *Service Area*.

When your Plan's coverage begins

If the required *Premium* is paid when it is due, your coverage under this *Plan* begins on the *Effective Date* shown on the first page of this *Certificate*.

Medicare Eligible Expenses must be incurred on or after your *Effective Date* in order to be paid under this *Plan*. Benefits will not be paid for any service or care that is received before your *Effective Date*.

See "What's included in your Plan" for additional requirements related to your *Plan* benefits.

Your Medicare coverage and this Plan

Because this *Plan* works with your *Medicare* benefits, we use the standards set by *Medicare* when we provide coverage under this *Plan*.

For example, *Medicare* sets certain standards for the kinds of expenses it will pay. In particular, *Medicare* requires your care to be "reasonable and medically necessary." In this *Certificate*, we call expenses that meet all of *Medicare's* standards for payment *Medicare Eligible Expenses.*

Medicare also sets standards for:

1. How much it will pay.
2. The deductibles, co-insurance, and co-payments that you will have to pay.
3. The amounts a health care provider can bill you above the deductibles, co-insurance, and co-payments you are required to pay.

From time to time, *Medicare* changes the amount you are required to pay for deductibles, co-payments and co-insurance. When that happens, the benefits paid by this *Plan* will change. Your benefits will be based on the new amount *Medicare* requires you to pay for the *Part A Deductible*, *Part A Daily Co-insurance*, *Lifetime Reserve Daily Co-insurance*, *Part B Deductible*, *Part B Co-insurance*, and *Skilled Nursing Facility Daily Co-insurance*.

Benefits after your Plan's coverage ends

You may be entitled to have benefits continue under this *Plan* after your coverage ends. We will continue to pay benefits for any continuous loss which began while your coverage was in force if your coverage under this *Plan* ends during that continuous loss. You must be continuously *Totally Disabled* for a loss to be considered continuous.

Receiving Medicare Part D prescription drug benefits will not be considered in determining a continuous loss.

These extended benefits will be limited to either payment for the duration of this *Plan's* benefit period or payment of maximum benefits under this *Plan*, whichever is less. These benefits are subject to all other provisions set forth in this *Certificate*.

Hospital Restrictions

This *Plan* requires you to use a *Network Hospital* for covered inpatient and outpatient *Hospital* services. You do not need to use a *Network Hospital* for the reasons stated below. However, the *Hospital* must be approved for payment by *Medicare* for stays, care or services to be covered under this *Plan*.

You do not need to use a *Network Hospital* only for these reasons:

1. You need care for a *Medical Emergency*.
2. The covered services you need are not available from any *Network Hospital* in your *Service Area*.
3. You are traveling and you receive covered services from a non-*Network Hospital* more than 100 miles from your *Primary Residence*.

   In this case, this *Plan* will pay these benefits:

   - 75% of the *Part A Deductible* per *Benefit Period*;
   - 75% of the *Part A Daily Co-insurance*;
   - 75% of the *Lifetime Reserve Daily Co-insurance*; and
   - 75% of the *Part B Co-insurance* or Part B co-payment for outpatient *Hospital* services not paid by *Medicare*.

WHAT'S INCLUDED IN YOUR PLAN

We will only pay benefits as described in this *Certificate* for the following services:

1. *Hospital* stays
2. *Skilled Nursing Facility* stays
3. *Hospice Care*
4. Medicare Part B expenses (such as *Physician*'s office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, durable medical equipment)
5. Blood
6. Emergency care outside the United States

On the following pages, under each service, you will see a column on the left called "What Medicare requires you to pay." This column explains the share of your health care costs that *Medicare* requires you to pay.

Things to remember about the information in this column:

- *Medicare* can change what it pays and what it asks you to pay, so this information could change.
- There may be costs that you incur, other than those listed, that *Medicare* does not cover.

On the following pages, under each service, you will see a column on the right called "What this Plan pays." This column tells you what benefit you will receive from your *Plan* so that you know which costs this *Plan* will pay for you.

Benefits are subject to these requirements

Things to remember about the information in the "What this Plan pays" column:

- Payment of any benefit under this *Plan* is subject to all of the terms and conditions of this *Certificate*.
- For some services, more requirements must be met in order for benefits to be paid. If there are additional requirements for a service, they are explained in "This benefit has these added requirements" that follows the benefit description.
- We will pay only one type of benefit for any covered stay or service.

Please continue to the next page to see what's included in your *Plan*.

1. Hospital Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover inpatient care received in a *Hospital*.

Each *Benefit Period*, *Medicare* requires you to share the cost of Part A *Medicare Eligible Expenses* for your inpatient *Hospital* stay in these ways:

1. You are responsible for a *Part A Deductible* the first time you are admitted to a *Hospital* in a *Benefit Period*.
2. You are responsible for a *Part A Daily Co-insurance* from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period*.
3. You are responsible for a *Lifetime Reserve Daily Co-insurance* when you use your 60 *Lifetime Reserve Days*.
4. You are responsible for the cost of your inpatient *Hospital* care if you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. You are responsible for the cost of your inpatient *Hospital* care if you have used up all of your *Lifetime Reserve Days*.

What this Plan pays

This *Plan* helps you pay your share of the cost of an inpatient *Hospital* stay. This *Plan* requires you to use a *Network Hospital* for covered inpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your inpatient *Network Hospital* stay:

1. This *Plan* will pay your *Part A Deductible* for each *Benefit Period*.
2. This *Plan* will pay your *Part A Daily Co-insurance* from the 61st day through the 90th day of each *Benefit Period*.
3. This *Plan* will pay your *Lifetime Reserve Daily Co-insurance* while you are using your 60 *Lifetime Reserve Days*.
4. This *Plan* will **not** pay any benefits when you are eligible to use your *Lifetime Reserve Days* and you choose not to use them.
5. This *Plan* will pay your Part A *Medicare Eligible Expenses* for *Hospital* care if you use all your *Hospital* benefits under Part A, including all of your *Lifetime Reserve Days*. This benefit has a lifetime maximum of an additional 365 days. This benefit will be paid at the applicable *Medicare* prospective payment system rate, or another appropriate *Medicare* standard of payment. Your *Hospital* must accept our payment as payment in full. Your *Hospital* may not bill you for any balance.

This benefit has these added requirements

To receive these *Plan* benefits, your inpatient *Hospital* stay must start on or after your *Effective Date*. This requirement does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare*; however, we will not pay any benefits for any period of a *Hospital* stay that occurs prior to your *Effective Date*.

2. Skilled Nursing Facility Stays – Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover skilled nursing care received in a *Skilled Nursing Facility* following a *Hospital* stay.

Each *Benefit Period*, *Medicare* requires you to share the cost of your *Skilled Nursing Facility* stay in these ways:

1. You are responsible for a *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period.*
2. You are responsible for the cost of your *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

What this Plan pays

This *Plan* helps you pay your share of the cost of a *Skilled Nursing Facility* stay.

Here is what this *Plan* pays for Part A *Medicare Eligible Expenses* for your *Skilled Nursing Facility* stay that follows a *Hospital* stay:

1. This *Plan* will pay the billed amount up to your *Skilled Nursing Facility Daily Co-insurance* from the 21st day through the 100th day of each *Benefit Period*.
2. This *Plan* will **not** pay any benefits for *Skilled Nursing Facility* care beyond the 100th day in a *Benefit Period*.

This benefit has these added requirements

To receive these *Plan* benefits, your *Skilled Nursing Facility* stay must follow a *Hospital* stay. Both the *Hospital* stay and the *Skilled Nursing Facility* stay must start on or after your *Effective Date*. The requirement that your *Hospital* stay must start on or after your *Effective Date* does not apply to you if your *Effective Date* is 6 months or less after the date you first enrolled in Part B of *Medicare.*

3. Hospice Care - Medicare Part A

What Medicare requires you to pay

Part A of *Medicare* helps cover *Hospice Care*, including support services for both the patient and caregivers. Part A of *Medicare* covers *Hospice Care* received at home and care received in a hospice outside the home.

Medicare requires you to share the cost of your *Hospice Care* in this way:

1. You are responsible for co-payments and co-insurance for certain Part A *Medicare* eligible *Hospice Care* and *Respite Care*.

What this Plan pays

This *Plan* helps you pay your share of the cost of *Hospice Care*.

Here is what this *Plan* pays for *Hospice Care*:

1. This *Plan* will pay all your *Medicare* co-payments and co-insurance for *Hospice Care* and *Respite Care*.

This benefit has these added requirements

To receive these *Plan* benefits, your care must be eligible for payment under Part A of *Medicare* and must be received on or after your *Effective Date*. Your *Physician* must certify that you are terminally ill.

4. Medical Services - Medicare Part B

What Medicare requires you to pay

Part B of *Medicare* helps cover medical services and care. This includes services like *Physician's* office visits, emergency room care, diagnostic tests, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, and durable medical equipment. These are called Part B *Medicare Eligible Expenses*.

Medicare requires you to share the cost of your Part B *Medicare Eligible Expenses* in these ways:

1. You are responsible for a *Part B Deductible each* calendar year.
2. After the *Part B Deductible* has been met, you are responsible for a *Part B Co-insurance* for each covered service you receive. For *Hospital* outpatient department services paid under a prospective payment system, this amount is called a Part B co-payment amount.
3. If your provider does not accept *Medicare Assignment*, the provider may charge you *Part B Excess Charges* for *Medicare*-approved services. *Part B Excess Charges* are the difference between the *Medicare-approved Amount* and any charge limitation established by *Medicare* or state law.

What this Plan pays

This *Plan* helps you pay your share of the cost of Part B expenses. This *Plan* requires you to use a *Network Hospital* for covered outpatient *Hospital* services. See "Hospital Restrictions" for more information.

Here is what this *Plan* pays for your Part B *Medicare Eligible Expenses:*

1. This *Plan* will pay your *Part B Deductible* each calendar year.
2. This *Plan* will pay your *Part B Co-insurance* and your Part B co-payments.
3. This *Plan* will pay your *Part B Excess Charges*. No benefits are payable for services which are not covered by *Medicare*.

This benefit has these added requirements

Benefits will only be paid for charges that *Medicare* determines to be *Medicare Eligible Expenses*. To receive these *Plan* benefits, services must be received on or after your *Effective Date*.

5. Blood – Medicare Parts A and B

What Medicare requires you to pay

If you receive blood, *Medicare* does not cover the cost of the first three pints of blood you receive each calendar year.

Medicare requires you to share the cost of blood in this way:

1. You are responsible for the cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare*.

What this Plan pays

This *Plan* helps you pay your share of the cost of blood.

Here is what this *Plan* pays for blood:

1. This *Plan* will pay the reasonable cost of the first three pints of blood you receive each calendar year under Part A and Part B of *Medicare.* Or instead, we will pay the reasonable cost of equivalent quantities of packed red blood cells, as defined under federal laws.

This benefit has these added requirements

This *Plan* benefit will not be paid if the blood is replaced according to federal laws. To receive these *Plan* benefits, blood must be received on or after your *Effective Date.*

6. Emergency care outside the United States – Not covered by Medicare

What Medicare requires you to pay

Medicare usually does not cover care you receive outside the United States.

1. In most cases, you are responsible for the full cost of emergency care you receive outside the United States.

What this Plan pays

This *Plan* covers certain care if you have a *Medical Emergency* while you are on a *Trip* outside the United States.

Here is what this *Plan* pays for emergency care outside the United States:

1. You are responsible for a $250 deductible each calendar year. After the deductible is met, this *Plan* will pay 80% of the billed charges for hospital, physician and medical care that would have qualified as *Medicare Eligible Expenses* if they had been received in the United States.

This benefit has these added requirements

Benefits will be paid only if the care is due to a *Medical Emergency*. Also, benefits will be paid only if the care is not covered by *Medicare,* but would have been covered by *Medicare* if it had been received in the United States. You are responsible for a deductible of $250 each calendar year. This means you must pay the first $250 of your expenses each calendar year for care received in a foreign country due to a *Medical Emergency*. Benefits will be paid up to a lifetime maximum benefit of $50,000 for *Medical Emergency* care received outside of the United States. Benefits will be paid only if the *Medical Emergency* care is received on or after your *Effective Date*.

To receive these *Plan* benefits, your care must begin within the first 60 consecutive days of your *Trip* outside the United States. You must provide us with an itemized bill for your care. You must also provide us with any necessary and relevant medical records that we request. We will pay these benefits in United States currency. We will calculate the amount of our payment using the bank transfer exchange rate in effect on the day we process your claim for payment.

WHAT'S NOT INCLUDED IN YOUR PLAN

This *Plan* does not cover all medical expenses. The following exclusions apply to your coverage under this *Plan*.

Benefits provided under Medicare

We will not pay benefits under this *Plan* that duplicate benefits provided by *Medicare*. We will not pay benefits for stays, care or services for which *Medicare* would have paid benefits if a claim had been submitted.

Benefits provided under a Medicare Advantage Plan

This *Plan* does not pay benefits to supplement a Medicare Advantage Plan or other Medicare Part C plan. This means your *Plan* does not pay benefits for deductibles, co-payments, or other cost-sharing under a Medicare Advantage Plan or other Medicare Part C plan.

Care not meeting Medicare's standards

We will not pay benefits for stays, care or services that do not meet *Medicare*'s standards, unless otherwise stated in this *Certificate.*

Care for which you have no obligation to pay

We will not pay benefits for any stays, care or services for which you are not legally obligated to pay. We will not pay benefits for stays, care or services for which you would not be charged if you did not have insurance.

Care you receive at a government Hospital

We will not pay benefits for any stays, care or services provided by a hospital or other institution which is owned or operated by any government unless payment is required by law.

Injury or sickness for which you are entitled to workers' compensation benefits

We will not pay benefits for any *Injury* or *Sickness* for which you are entitled to receive benefits under workers' compensation or any similar law.

Benefits provided under another policy

If you are replacing another Medicare supplement policy with this *Plan*, you may still be eligible for benefits under the prior policy in certain cases. We will not pay benefits for any stay or care which is covered under the prior policy.

Charges in excess of Medicare Eligible Expenses

We will not pay benefits for that part of an expense that is greater than the *Medicare Eligible Expense,* except as stated for *Part B Excess Charges* in "Medical Services - Medicare Part B."

Care provided by a non–Network Hospital

We will not pay benefits for stays, care or services that you receive in a non-*Network Hospital,* except as stated in the section called "Hospital Restrictions."

MEDICARE SELECT RULES

1. If you have been covered under this *Plan* for at least 6 months, you can ask to have this *Plan* replaced with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can replace this *Plan* with any Medicare Supplement plan that we offer that has the same or less benefits. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.
2. You may not keep this Medicare Select Plan if any of these events occur:
   - Medicare Select plans are discontinued by state or federal law.
   - Your *Primary Residence* is no longer within a *Service Area* because you moved.
   - Your *Primary Residence* is no longer within a *Service Area* because of a change in the network.

   If any of these events occur, you can continue your coverage by replacing this *Plan* with a Medicare Supplement plan that does not require you to use a *Network Hospital*. You can choose a Medicare supplement plan from us or any other company. We will let you know which Medicare supplement plans are available for you to choose from us. You cannot be denied this replacement coverage or charged a higher premium based on your health. This replacement coverage will not have a pre-existing conditions exclusion.

YOUR PREMIUMS

To be covered under this *Plan*, you must pay your first *Premium*. To maintain your coverage under this *Plan*, you must pay your *Premium* when it is due. If you do not pay your *Premium* when due, we have the right to cancel your coverage under this *Plan*.

Grace Period for paying Premiums

After you pay your first *Premium*, you have a 31-day *Grace Period* to pay each following *Premium*.

Your coverage under this *Plan* will stay in force until the end of the applicable *Grace Period*. You are responsible for paying the *Premium* for your *Plan* during the *Grace Period*.

This *Grace Period* will not apply if we issue another AARP Medicare supplement plan to replace this *Plan*. In that case, coverage under this *Plan* will stop on the *Effective Date* of your new coverage.

Changes in your Premium

We have the right to change the amount of your *Premium*. However, we will not make any change that affects only you. We will apply any change we make to everyone with this *Plan* who resides in your state at that time and who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

What happens if you move?

If you change your *Primary Residence*, we may adjust your *Premium*. Your new *Premium* will be the *Premium* we are then charging for this *Plan* in the state where your new *Primary Residence* is located. Your new *Premium* will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine *Premiums*.

Medicare Select plans may not be available where your new *Primary Residence* is located. See “Medicare Select Rules” for more information.

HOW YOUR PLAN WORKS

How to file a claim

Please show your insurance card to your health care provider when you receive services. We sent you information about how to file claims after you enrolled. Please follow those instructions when you file claims.

Evidence of claims

We pay benefits on a covered claim when we have received *Proof of Loss.*

Time limit for submitting claims

You must provide *Proof of Loss* not later than 15 months from the date of the stay, service or care that is the basis for your claim. If you do not meet this time limit, we will not pay benefits on that claim. This time limit for furnishing *Proof of Loss* does not apply if you are not legally capable of providing the *Proof of Loss*.

Who we pay benefits to

We will pay benefits directly to the provider who provided the care for which benefits are payable when your *Medicare* or your *Plan* benefits are assigned. If benefits are not assigned they will be paid to you, unless the law requires us to do otherwise.

Benefits after your death or incapacity

We may pay your benefits as described below when they are payable under this *Plan* and one of the following things has happened:

1. You have died.
2. You are not able to give a valid release.

In this situation, we may pay a benefit up to $3,000 ($1,000 in Tennessee) to any relative of yours that we decide is justly entitled to it. If we pay this benefit, our payment to your relative in good faith will fully release us of our responsibility to the extent of the payment.

Physical Examinations

We have the right to examine you physically, at our expense, while your claim is pending.

Your duty to cooperate

We expect you to cooperate with us when we are determining your coverage or handling your claims. Your failure to help us may result in this *Plan* being made void or your claims being denied.

Here are some examples of what we may need your help with:

- We may need you to provide information or documents to us to determine if benefits should be paid.
- We may need you to provide information or documents to us to determine if this *Plan* has been appropriately issued to you.
- We may need your help in getting information we need from your provider.

Changes in your benefits when Medicare is secondary

If you have other health insurance, it may be considered your primary coverage, which means it will pay benefits first. In such case, *Medicare* would be your secondary coverage.

If *Medicare* is your secondary coverage, *Medicare* benefits will be paid after your primary coverage pays. In that case, we will pay benefits under this *Plan* based on *Medicare's* reduced benefits.

Your combined benefits from your primary and secondary coverage plus benefits paid under this *Plan* will not exceed the total *Medicare Eligible Expense* for the service or item.

More than one certificate

You can only be covered under one Medicare supplement plan at any one time. This *Certificate* replaces any certificate that we issued to you before under the *Group Policy*.

Entire contract

This *Certificate*, any riders which may be issued or attached, your application, and the *Group Policy* make up the entire contract.

CHANGES TO YOUR PLAN

You have the right to request changes that affect this *Plan*. We have the right to approve or reject your request for changes.

If we do approve your request, the change will be effective on the first day of the month following the date we receive your request.

Converting this Plan to an individual policy

If the *Group Policy* ends, your coverage under this *Plan* will stop. In that case you will be offered other Medicare supplement coverage which will be either coverage from an insurance carrier named by the [Trustees of the AARP Insurance Plan], or an individual policy issued by us.

If the *Group Policy* ends and an insurance carrier is not named, we will notify you that you have the right to convert to an individual policy. You must apply for this individual policy, and pay the first premium, within 31 days after the later of these two dates:

1. The date you receive our notice of your conversion rights.
2. The date your coverage under this *Plan* stops.

Changing AARP coverage

If, on your *Effective Date*, you have changed to this *Plan* from any other AARP health coverage issued by us (the prior coverage), no benefits will be paid under this *Plan* to the extent that benefits are payable under your prior coverage.

Suspending and reinstating your Plan

At certain times, you have the right to suspend your coverage and *Premium* under this *Plan* for certain periods of time. This section describes those rights and how they work.

Disabled persons covered under group health plans

If you are under age 65, and you are entitled to benefits under *Medicare* Part A because you are disabled, you have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are covered by a group health plan. We will suspend your coverage and *Premium* for no longer than the period of time provided by federal law.

If this *Plan* is suspended and you later lose your coverage under the group health plan, we will reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Persons entitled to Medicaid

You have the right to ask us to suspend your coverage and *Premium* under this *Plan* while you are entitled to benefits under *Medicaid*. We will suspend your coverage and *Premium* for up to 24 months.

You must ask us to suspend your coverage and *Premium* within 90 days after you become eligible for *Medicaid*.

If this *Plan* is suspended and you later lose your entitlement to *Medicaid*, you have the right to ask us to reinstate this *Plan*, if it is available. If it is not available, we will offer other Medicare supplement coverage which provides substantially equivalent benefits.

Reinstating your Plan

If your *Plan* is suspended as stated above, and you lose your group health plan coverage or your *Medicaid* entitlement during the suspension, you may reinstate your *Plan*. Your *Plan* will be reinstated as of the date you lose your group health plan coverage or your *Medicaid* entitlement. To be reinstated, you must notify us within 90 days after the date you have lost your group health plan coverage or your *Medicaid* entitlement and pay all *Premiums* for the 90-day period.

If your *Plan* is reinstated, we will not require any new waiting period for *Pre-existing Conditions*. For rate purposes, we will keep you grouped in the same rating class.

DISPUTES AND LEGAL ACTIONS

Legal actions

You cannot bring any action at law or in equity for any benefits under the *Group Policy* until 60 days after you have filed written *Proof of Loss*.

You cannot bring any action at law or in equity once three years have passed from the date you were required to provide *Proof of Loss*. (In Florida, you cannot bring any action at law or in equity after the expiration of the applicable statute of limitations from the date you were required to provide *Proof of Loss*.)

Our right to recover claim payments

If we make a payment that is not required under this *Plan*, we have the right to recover the amount of that payment.

We can recover the payment from any of the following:

1. Any person to whom the payment was made.
2. You, or any other person for whom the payment was made.
3. Any insurance company.
4. Any other organization or person.

Conformity with state statutes

If any provision in this *Certificate*, on its *Effective Date,* conflicts with the laws of the state in which it is delivered, this *Certificate* is amended to meet the minimum requirements of such laws.

Subrogation

If you are injured, and we pay benefits relating to your *Injury*, we have certain rights to recover the benefits we paid from any person or entity who may be responsible for your *Injury*. These rights are called rights to subrogation. These rights are subject to your having been made whole.

When we pay benefits, we will be subrogated, to the extent of the payments we made, to all of your rights of recovery against any person or entity who may be responsible for your injuries. These rights apply even if you settle a claim. They apply whether or not a lawsuit has begun.

You agree to do these things if we pursue our rights under this section:

1. You will cooperate with us or anyone we designate.
2. You will provide all information we need to help protect our legal rights under this section.
3. You will promptly notify us before you sign any settlement agreement, waiver, release of liability or other documents. If you do not notify us as required, these documents will not be binding against us.

EFFECTS OF STATEMENTS YOU MADE TO US

On your application for this *Plan,* you have stated certain *Material Facts* to us. We have relied on your statements to issue this *Plan* and to decide what *Premium* to charge you. We deem these statements to be representations and not warranties.

Our rights to take certain actions

If you misstated any *Material Fact*, we have certain rights:

1. We have the right to void this *Plan* if you misstated any *Material Fact* and we would not have issued this coverage if the *Material Fact* had been correctly stated. This means your *Plan* will be treated as if it had never been issued.

   If we void this *Plan* for this reason, we will refund all *Premiums* you paid, less the amount we have paid for your claims under this *Plan*.

2. We have the right to adjust your *Premium* if you have misstated any *Material Fact* and we would have charged you a different *Premium* if the *Material Fact* had been correctly stated.

   If we adjust your *Premium* for this reason, you are responsible for the payment of corrected *Premiums* from your *Effective Date.* In addition to our other rights, we have the right to offset against any claim payments otherwise payable under this *Plan* to recover the amount of *Premiums* owed by you but not paid as the result of your misstatement.

Limit on our rights

Your statements will not be used as a basis to void your insurance, adjust your *Premiums* or reduce your benefits unless all of the following are true:

1. Your statement is in writing and signed by you.
2. We have furnished a copy of the statement to you or your legal representative.
3. Your insurance has been in force, prior to the contest, less than two years. This two-year limitation does not apply if your statements were fraudulent misstatements.

COMPLAINTS AND GRIEVANCES

We have a formal process to receive and respond to complaints or grievances. Our goal is to provide a fair way to evaluate, consider and settle all complaints and grievances. If we find that any action we have taken is not proper, we will correct it.

Here is what you need to do to file a complaint or a grievance.

Complaints

If you have a complaint, call our toll-free number at 1-800-523-5800. You can also write to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. We will let you know that we received your complaint within 15 days. We will respond to it within a reasonable period of time.

Grievances

If you are not satisfied with how a complaint was handled, a claim denial, or for any other reason, you may submit a formal grievance. Grievances must be in writing and must state “This is a grievance” so the purpose of your communication is understood. You must clearly state the nature of your grievance. Mail it to us at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. You must send us your grievance within 60 days from the date of your claim denial or other reason for your grievance. We will let you know that we received your grievance within 15 days. We will respond to it within a reasonable period of time.

If you are not satisfied with how we handled your complaint or grievance, or for any other reason, you may file a written complaint with the Department of Insurance in your state.

TERMS WE USE

Benefit Period means a period of time that is used to determine *Medicare* Part A benefits. It begins the day you enter a *Hospital* for inpatient care and ends when you have been out of the *Hospital* and have not received skilled care in any other facility for 60 days in a row.

Certificate means this document. It represents AARP Medicare Select Plan F Certificate of Insurance issued under Group Policy No. [G-36000-4] to the person who is named on the first page of this *Certificate*.

Effective Date means the date your *Plan* takes effect. It is shown on the first page of this *Certificate*.

Grace Period means the 31 days following the monthly due date for your *Premium*.

Group Policy means the group policy issued by us to the [Trustees of the AARP Insurance Plan] in the District of Columbia. It is identified by policy number [G-36000-4].

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.

Hospital means an institution that provides hospital care and is approved for payment by *Medicare* as a hospital.

Injury means an accidental bodily injury which is the direct result of an accident, independent of disease or illness or any other cause.

Lifetime Reserve Daily Co-insurance means the cost-sharing amount Medicare requires you to pay each day while you are using your *Lifetime Reserve Days*.

Lifetime Reserve Days means the lifetime reserve of 60 days you have for *Medicare* Part A inpatient *Hospital* care. You can use these days whenever you need more than 90 days of inpatient *Hospital* care in a *Benefit Period*. These 60 days can only be used once during your lifetime.

Material Facts are certain facts about your age, eligibility, health conditions, tobacco use and other information that you give us when you apply. We use these facts to decide whether to issue your coverage and how much *Premium* you will be charged.

Medicaid means a program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Act.

Medical Emergency means both of the following are true:

1. You experience the sudden and unexpected onset of symptoms, a condition, a *Sickness*, or an *Injury*.
2. Your symptoms, condition, *Sickness* or *Injury* could carry substantial risk of serious medical complication or permanent damage to you if you do not receive care or services.

We will use appropriate United States medical standards in deciding whether your situation meets this definition.

Medicare means the health insurance program established by Title XVIII, United States, Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq., and as later amended. *Medicare* is administered by the Centers for Medicare and Medicaid Services. Part A helps with *Hospital* costs and skilled nursing care. Part B helps with *Physician's* care and outpatient services.

Medicare-approved Amount means the amount *Medicare* determines is reasonable for a covered medical service.

Medicare Assignment means the provider agrees to accept the *Medicare-approved Amount* as full payment.

Medicare Eligible Expenses mean expenses of the kinds covered by *Medicare* Parts A and B. The expenses must be reasonable and medically necessary according to *Medicare's* standards for payment.

Network Hospital means a *Hospital* that has made an agreement with us, in writing, to provide services. The status of a *Hospital* may change.

Part A Daily Co-insurance means the cost-sharing amount *Medicare* requires you to pay each day from the 61st day through the 90th day of inpatient *Hospital* care in each *Benefit Period.*

Part A Deductible means the amount you are responsible to pay the first time you are admitted to a *Hospital* in each *Benefit Period*.

Part B Co-insurance means the amount you are responsible to pay for each covered service you receive under *Medicare* Part B after the *Part B Deductible* has been met. For *Hospital* outpatient department services paid under the prospective payment system, this amount is called a Part B co-payment amount.

Part B Deductible means the amount you are responsible for each calendar year toward Part B *Medicare Eligible Expenses*.

Part B Excess Charges means the amount a provider who does not accept *Medicare Assignment* is legally permitted to charge you above the *Medicare-approved Amount.*

Physician means a licensed practitioner of the healing arts who is acting within the scope of his or her license.

Plan means your coverage provided under this AARP Medicare Select Plan F Certificate of Insurance.

Pre-existing Condition means a condition for which one of these things happened within [3 - 6] months before your *Effective Date*:

1. A *Physician* gave you medical advice for the condition.
2. A *Physician* recommended or gave you treatment for the condition.
3. A *Physician* recommended or prescribed a prescription drug for the condition.

Premium means the monthly payment you are required to make to us for coverage under this *Plan*.

Primary Residence means the mailing address for your dwelling in the state where you reside for federal income tax purposes.

Proof of Loss means information we need to document and process your claim. For *Medicare Eligible Expenses, Proof of Loss* includes a statement from the *Medicare* carrier that shows us the *Medicare Eligible Expenses*.

Respite Care means short-term inpatient care to relieve family members caring for you.

Service Area means the geographic area where we are authorized to provide a Medicare Select plan. This area has been approved by the Commissioner of Insurance in your state.

Sickness means an illness or disease.

Skilled Nursing Facility means a facility that provides skilled nursing care and is approved for payment by *Medicare* as a skilled nursing facility.

Skilled Nursing Facility Daily Co-insurance means the amount you are responsible to pay each day from the 21st day through the 100th day of *Skilled Nursing Facility* care in each *Benefit Period*.

Totally Disabled means you are confined under a *Physician's* orders in an institution or at home for medical care or treatment and you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health.

Trip means a period of time beginning the day you leave the United States and ending the day you return.

AARP MEDICARE SELECT PLANS

Plan Of Operations

UnitedHealthcare Insurance Company

Administrative office: 680 Blair Mill Road
Horsham, Pennsylvania 19044
Home office: Hartford, Connecticut

I. SUMMARY

UnitedHealthcare Insurance Company (UnitedHealthcare), underwriter of the AARP Medicare Supplement plans, proposes to offer eligible AARP members with the opportunity to enroll in AARP Medicare Select Plans C and F. The AARP Medicare Select Plans are designed to reimburse the Medicare deductibles and coinsurance amounts and provide benefits for care received in a foreign country as a result of a Medical Emergency. These plans require the use of a Network Hospital for covered inpatient and outpatient hospital services, as defined by Medicare.

UnitedHealthcare desires to participate in the Medicare Select Program authorized under Section 4358 of Omnibus Budget Reconciliation Act (OBRA) of 1990 (Section 1182(t) of the Social Security Act).

II. DEFINITIONS

For the purposes of this Plan of Operations, the following definitions will apply:

> "Complaint" means any dissatisfaction expressed by a member insured under a Medicare Select plan concerning UnitedHealthcare or a Network Hospital.
>
> "Grievance" means dissatisfaction expressed in writing by a member insured under a Medicare Select plan with the administration, claim practices, or provision of services concerning UnitedHealthcare or a Network Hospital. Such written dissatisfaction shall state "This is a grievance".
>
> "Medical Emergency" means both of the following are true: (1) An insured experiences the sudden and unexpected onset of symptoms, a condition, a sickness, or an injury. (2) The insured's symptoms, condition, sickness or injury could carry substantial risk of serious medical complication or permanent damage if care or services are not received. UnitedHealthcare will use appropriate United States medical standards in deciding whether a situation meets this definition.
>
> "Medicare Select Plan" means a Medicare Supplement plan which contains restricted network provisions.
>
> "Network Hospital" means a hospital that has made an agreement with UnitedHealthcare, in writing, to provide services. The status of a hospital may change.
>
> "Primary Residence" means the insured's mailing address for the dwelling in the state where they reside for federal income tax purposes.
>
> "Restricted Network Provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of a Network Hospital.
>
> "Service Area" means the geographic area where UnitedHealthcare is authorized to provide a Medicare Select plan as approved by the Commissioner of Insurance.

III. STATEMENT OF COMPLIANCE

This Plan of Operations includes all of the requirements included in the Medicare Select regulations.

IV. REQUEST FOR APPROVAL

We hereby request the approval of this Plan of Operations.

V. PLAN OF OPERATION COMPONENTS

Services Subject to Use of Network Hospitals

Medicare Select Plans require the use of a Network Hospital in the Service Area for covered inpatient and outpatient hospital services. Use of a Network Hospital is not required for hospital services if the services are for a Medical Emergency. The use of a Network Hospital is not required if the covered inpatient or outpatient hospital services are not available from a Network Hospital in the Service Area. Payment of benefits is subject to any additional terms and conditions of the Medicare Select Plan. Additionally, when an insured is traveling within the United States, UnitedHealthcare will pay benefits for covered services received at a non-Network Hospital if that hospital is at least 100 miles from the insured's Primary Residence.

1. Access to Covered Services

UnitedHealthcare will provide reasonable access and availability of covered services that require the use of Network Hospital with respect to geographic location, hours of operations and after-hour care.

A) Geographical Location of Network Hospitals.

AARP Medicare Select Plans will be marketed only in areas which have reasonable geographic access to a Network Hospital. UnitedHealthcare will not solicit applications for Medicare Select Plans in geographic areas beyond a 30-mile radius of Network Hospitals and will not make Medicare Select Plans available to members on an inquiry basis beyond a 60-mile radius.

B) Hours of Operation and After-Hour Care

All Network Hospitals are duly licensed and operate within the scope of that license, are approved by Medicare for reimbursement and are operational 24 hours a day, seven days a week.

C) Service Area

UnitedHealthcare intends to offer Medicare Select Plans within the Service Area indicated in Appendix A. The number of Network Hospitals in the Service Area is sufficient with respect to current and expected insureds to adequately deliver all services for which a Network Hospital must be utilized.

D) Written Agreements

UnitedHealthcare maintains written agreements with Network Hospitals, which describe specific responsibilities and obligations.

E) Emergency Care

All Network Hospitals provide 24-hour emergency room service, seven days a week. AARP Medicare Select Plans provide for unrestricted access to providers when a covered service is required due to a Medical Emergency.

2. Geographical Maps

Appendix A includes geographical maps of the market areas serviced by Network Hospitals where AARP Medicare Select Plans will be offered.

3. Complaint and Grievance Procedures

UnitedHealthcare has a formal process to receive and respond to complaints or grievances, with a goal to provide a fair way to evaluate, consider and settle all complaints and grievances. If it is found that any action taken is not proper, it will be corrected.

Here is what an insured needs to do to file a complaint or a grievance.

Complaints

If the insured has a complaint, he/she should call the toll-free number at 1-800-523-5800 or write to UnitedHealthcare at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. Receipt of the complaint will be acknowledged within 15 days. It will be responded to within a reasonable period of time.

Grievances

If an insured is not satisfied with how a complaint was handled, a claim denial, or for any other reason, he/she may submit a formal grievance. Grievances must be in writing and must state “This is a grievance” so the purpose of the communication is understood. The insured must clearly state the nature of the grievance and mail it to UnitedHealthcare at [P.O. Box 1012, Montgomeryville, PA 18936-1012]. A grievance must be sent within 60 days from the date of the claim denial or other reason for the grievance. Receipt of the grievance will be acknowledged within 15 days. It will be responded to within a reasonable period of time.

If an insured is not satisfied with how a complaint or grievance was handled, or for any other reason, he/she may file a written complaint with the Department of Insurance in his/her state.

4. Quality Assurance Program

A) Formal Organizational Structure

The formal organizational structure of the quality assurance program is as follows:

Quality Assurance Program Description

Board Of Directors

Chief Executive Office

Quality Improvement Committee

Credentialing Customer Service Utilization Management Peer Review

Compliance with quality assurance and credentialing standards will be monitored as follows:

The Customer Service Department is the starting point for insured access to grievance procedures.

A UnitedHealthcare provider relations department, or a company contracted to act on its behalf, will act as liaison between UnitedHealthcare and Network Hospitals and as the evaluator of insured satisfaction with the network. Oversight of the Network Hospitals' responsibilities will also be performed by the UnitedHealthcare provider relations department, or a company contracted to act on its behalf.

B) Criteria for Selection and Retention and Removal of Network Hospitals

i) Selection Criteria:

a) Hospital is in good standing with State and Federal regulatory bodies
b) Current, applicable state license
c) Appropriate liability insurance
d) Hospitals below 50 beds must have:
   1. JCAHO accreditation or AAAHC (Accreditation Association for Ambulatory Health Care) accreditation;
   2. Rating and effective date or current Medicare Certification.
e) Hospitals above 50 beds must have:
   1. JCAHO accreditation;
   2. Rating and effective date.

ii) The Network Hospital must:

a) Maintain a quality assurance program that conforms with UnitedHealthcare's and nationally recognized quality of care standards.
b) Cooperate with UnitedHealthcare in the evaluation of and resolution of any complaint or grievance filed by an insured for services provided by the hospital.
c) Execute the Network Provider Agreement.
d) Appropriately respond to regulatory agency concerns and/or disciplinary action by implementing a corrective action plan that is approved by the UnitedHealthcare health plan.

iii) Retention and Removal

UnitedHealthcare may terminate a Network Hospital relationship for cause based upon lapse of any of the preceding criteria or material breach of the Network Provider Agreement. Consideration may be given to the Network Hospital if it provides evidence of the development and implementation of a timely corrective action plan approved by the UnitedHealthcare health plan.

Either party may also terminate the relationship without cause by providing written notice to the other party no less than 120 days prior to the termination date.

C) Evaluation of Quality of Care

UnitedHealthcare will develop a written summary of complaints, grievances and resolutions regarding quality of care and service. All written correspondence shall be retained in one central location. Provider Relations may consider this information in making retention and removal decisions.

Every three (3) years UnitedHealthcare will formally review, for the intent of credentialing the Network hospital and assuring its Quality Assurance Program, to enable the:

(1) Ongoing monitoring of quality of care provided by the Network Hospital; and
(2) Resolution of specific issues related to quality of care. As a result of this review and a finding of any substandard delivery of care as defined by appropriate industry standards and hospital standards, UnitedHealthcare may terminate a Network Provider Agreement for cause.

5. Network Hospital

Appendix B includes a detailed list of the Network Hospitals. The AARP Medicare Select Plans do not restrict an insured's choice of physician.

6. Disclosure Statement

The following information will be provided to an applicant in order to make a full and fair disclosure of the provisions, restrictions and limitations of AARP Medicare Select Plans:

Medicare Select Hospital Restrictions

This Plan requires you to use a Network Hospital for covered inpatient and outpatient Hospital services. You do not need to use a Network Hospital for the reasons stated below. But, the Hospital must be approved for payment by Medicare for stays, care or services to be covered under this Plan.

You do not need to use a Network Hospital only for these reasons:

1. You need care for a Medical Emergency.

2. The covered services you need are not available from any Network Hospital in your Service Area.
3. You are traveling and you receive covered services from a non-Network Hospital more than 100 miles from your Primary Residence.

   In this case, this Plan will pay these benefits:

   - 75% of the Part A Deductible per Benefit Period;
   - 75% of the Part A Daily Co-insurance;
   - 75% of the Lifetime Reserve Daily Co-insurance; and
   - 75% of the Part B Co-insurance or Part B co-payment for outpatient Hospital services not paid by Medicare.

Only certain hospitals are Network Hospitals under this plan. Check with your physician to determine if he or she has admitting privileges at the Network Hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses.

Medicare Select Rules

1. If you have been covered under this Plan for at least 6 months, you can ask to have this Plan replaced with a Medicare Supplement plan that does not require you to use a Network Hospital. You can replace this Plan with any Medicare Supplement plan that we offer that has the same or less benefits. Your new Premium will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine Premiums.
2. You may not keep this Medicare Select Plan if any of these events occur:
   - Medicare Select plans are discontinued by state or federal law.
   - Your Primary Residence is no longer within a Service Area because you moved.
   - Your Primary Residence is no longer within a Service Area because of a change in the network.

If any of these events occur, you can continue your coverage by replacing this Plan with a Medicare Supplement plan that does not require you to use a Network Hospital. You can choose a Medicare supplement plan from us or any other company. We will let you know which Medicare supplement plans are available for you to choose. You cannot be denied this replacement coverage or charged a higher premium based on your health. This replacement coverage will not have a pre-existing conditions exclusion.

Quality Assurance

UnitedHealthcare requires Network Hospitals to maintain a quality assurance program conforming with nationally recognized quality of care standards.

7. Other Required Information

UnitedHealthcare will provide all other information requested by the Department of Insurance to assure that the public is reasonably informed regarding a Medicare Select Plan.

VI. CHANGES IN THE PLAN OF OPERATION

UnitedHealthcare recognizes that any change in the list of Network Hospitals or Plan of Operations will require filing with the Department of Insurance. These changes will include:

1) Any proposed changes to the Plan of Operations; and
2) An updated list of Network Hospitals filed at least on a quarterly basis.

VII. NON-RESTRICTION OF PAYMENT

No benefits are provided under this plan for covered inpatient and outpatient hospital services provided by a non-Network Hospital. However, benefits may be payable for covered services received at a Non-Network Hospital if such services are:

1) for a Medical Emergency.
2) not available from a Network Hospital in the insured's Service Area.
3) provided at a non-Network Hospital if that hospital is at least 100 miles from the insured's Primary Residence.

VIII. FULL DISCLOSURE

The following disclosures will be made to the applicant of a Medicare Select Plan:

A) An outline of coverage identifying the Medicare Select Plan being offered by UnitedHealthcare. The outline of coverage is designed to compare benefits and premium contributions between other Medicare Supplement and the Medicare Select Plan. The outline of coverage is included in Appendix C;

B) A description of the Network Hospitals including address, telephone number and routine hours of operation;

C) A description of the restrictions on benefits when hospitals other than Network Hospitals are utilized;

D) A description of coverage for emergency and urgently needed care as well as other out-of-service-area coverage;

E) The AARP Medicare Select Plans only restrict benefits based on point of service, i.e., Network Hospitals. Hospitals do not make referrals; therefore, no restrictions on referrals exist.

F) A description of the insured's right to purchase any other AARP Medicare Supplement plan offered by UnitedHealthcare.

G) A description of our quality assurance program and complaint and grievance procedures.

IX. ACKNOWLEDGMENT OF RECEIPT OF DISCLOSURE INFORMATION

To demonstrate that the applicant has received the disclosure information and understands the restrictions of the Medicare Select Plans, he/she will be required to execute the following acknowledgment:

> I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.

_____

Signature Date

X. COMPLAINT AND GRIEVANCE PROCEDURES

UnitedHealthcare has established the following procedures for responding to complaints received in writing or by telephone and resolving written grievances of the insureds with the intent aimed at a mutual agreement for settlement.

A) In order to assure adequate disclosure, the complaint and grievance procedures are described in the Certificate of Insurance and the Outline of Coverage.

B) At the time that the Medicare Select Plan is issued, detailed information describing how a complaint or grievance may be submitted is described in the Certificate of Insurance.

C) The grievance procedures assure timely transmittal of grievances to appropriate decision makers who have the authority to fully investigate the issues and take appropriate corrective action if required.

D) Corrective action shall be taken promptly on grievances which are found to be valid.

E) All concerned parties shall be notified about the results of the grievance.

F) We shall report no later than each March 31 to the Commissioner of Insurance regarding the number, subject and nature of the grievances received during the past year in a format acceptable to the Commissioner.

G) All grievance files shall be retained for a minimum of five years. Records will include a copy of the original grievance, with receipt date noted; grievance form, copies of all correspondence, dates of decisions.

XI. RIGHT TO PURCHASE ANY MEDICARE SUPPLEMENT PLAN

UnitedHealthcare provides each applicant the opportunity of purchasing any AARP Medicare Supplement plan it offers. The following statement is included in the Certificate of Insurance and the Disclosure Statement:

> If you have been covered under this Plan for at least 6 months, you can ask to have this Plan replaced with a Medicare Supplement plan that does not require you to use a Network Hospital. You can replace this Plan with any Medicare Supplement plan that we offer that has the same or less benefits. Your new Premium will be the same as everyone who is in a situation similar to yours with respect to age, health conditions, tobacco use or other factors we consider when we determine Premiums.

XII. REPLACEMENT OPPORTUNITY

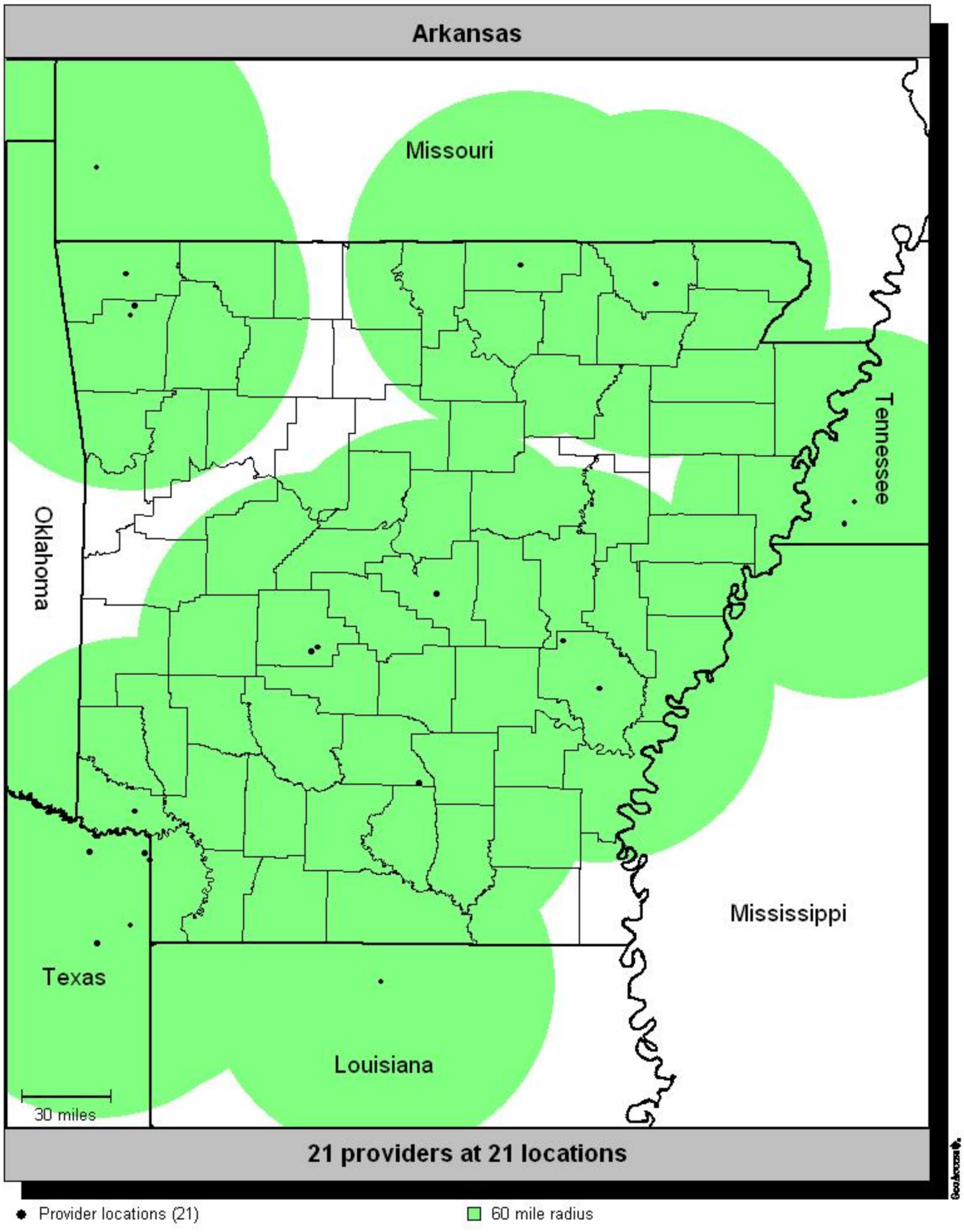
In the event that: 1) Medicare Select plans are discontinued by state or federal law; or 2) the insured's Primary Residence is no longer within a Service Area because he/she moved; or 3) the insured's Primary Residence is no longer within a Service Area because of a change in the network, the coverage under the Medicare Select plan must be replaced. To continue coverage, the insured must replace the Medicare Select plan with a Medicare Supplement Plan that does not require the use of a Network Hospital. UnitedHealthcare will let the insured know which Medicare supplement plans are available to choose. The insured can choose a Medicare supplement plan from UnitedHealthcare or any other company. This replacement coverage cannot be denied and a higher premium cannot be charged based on the insured’s health. This replacement coverage will not have a pre-existing conditions exclusion.

XIII. STATE AND FEDERAL EVALUATION

UnitedHealthcare will comply with all reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, to enable regulators to evaluate the Medicare Select Program.

August 2009

General Acute Care Provider Locations



- For Medicare Select Plans Only* -

Arkansas Participating Hospitals

Effective August 2009

*** This directory does not apply to AARP's Standard Medicare Supplement Plans.**

Arkansas

[Arkansas County

DeWitt Hospital
1641 South Whiteland Drive
DeWitt, AR 72042
(870) 946-3571

Stuttgart Regional Medical Center
1703 North Buerkle Road
Stuttgart, AR 72160
(870) 673-3511

Benton County

Northwest Medical Center of Benton County
3000 Medical Center Parkway
Bentonville, AR 72712
(479) 553-1000

Dallas County

Dallas County Hospital
201 Clifton Street
Fordyce, AR 71742
(870) 352-6300

Fulton County

Fulton County Hospital
679 North Main Street
Salem, AR 72576
(870) 895-2691

Garland County

Health Park Hospital
1636 Higdon Ferry Road
Hot Springs, AR 71913
(501) 520-2000

National Park Medical Center
1910 Malvern Avenue
Hot Springs, AR 71901
(501) 321-1000

Little River County

Little River Memorial Hospital
451 West Locke Street
Ashdown, AR 71822
(870) 898-5011

Pulaski County

University of Arkansas for Medical Sciences
4301 West Markham Street
Little Rock, AR 72205
(501) 686-7000

Randolph County

Five Rivers Medical Center
2801 Medical Center Drive
Pocahontas, AR 72455
(870) 892-6000

Washington County

Northwest Arkansas Hospital – Willow Creek Women's Hospital
4301 Greathouse Springs Road
Johnson, AR 72741
(479) 684-3000

Northwest Medical Center of Washington County
609 West Maple Avenue
Springdale, AR 72764
(479) 751-5711

Louisiana

Union Parish

Tri-Ward General Hospital
409 First Street
Bernice, LA 71222
(318) 285-9066

Missouri

Newton County

Freeman Neosho Hospital
113 West Hickory Street
Neosho, MO 64850
(417) 455-4352

Tennessee

Shelby County

Saint Francis Hospital
5959 Park Avenue
Memphis, TN 38119
(901) 765-1000

Shelby County (continued)

Saint Francis Hospital – Bartlett
2986 Kate Bond Road
Bartlett, TN 38133
(901) 820-7000

Texas

Bowie County

Christus St. Michael Health System
2600 St. Michael Drive
Texarkana, TX 75503
(903) 614-1000

Living Hope New Boston Medical Center
520 Hospital Drive
New Boston, TX 75570
(903) 628-5531

Bowie County (continued)

Wadley Regional Medical Center
1000 Pine Street
Texarkana, TX 75501
(903) 798-8000

Cass County

Atlanta Memorial Hospital
1007 South William Street
Atlanta, TX 75551
(903) 799-3000

Cass County (continued)

Good Shepherd Medical Center – Linden
404 North Kaufman Street
Linden, TX 75563
(903) 756-5561]

Prior to scheduling any inpatient or outpatient hospital service it is recommended you contact Customer Service at 1-800-523-5800 (any weekday between 7 a.m. and 11 p.m., and on Saturdays between 9 a.m. and 5 p.m., Eastern Time) for a current listing of participating hospitals in your area. You may also call this number to obtain a directory of participating hospitals for other areas when you will be traveling

All participating hospitals are open 24 hours a day, 7 days a week.

Your Medicare Select policy will only pay full supplemental benefits if covered services are obtained through specified participating hospitals. Medicare Select policies deny payment or pay less than the full benefit if you use a non-participating hospital for non-emergency services.

Overview of Available Plans

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, B, C, F, K, L, N and Medicare Select Plans C and F 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

♦Medicare Select Plans C and F contain the same benefits as standardized Medicare Supplement Plans C and F, except for restrictions on your use of hospitals.

Plan A	Plan B	Plan C♦	Plan D	Plan F*♦	Plan G
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
		Skilled nursing facility co-insurance	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
		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

Plan K	Plan L	Plan M	Plan N
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 coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit [$4620]; paid at 100% after limit reached	Out-of-pocket limit [$2310]; 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.**

Rules and Disclosures about this Insurance

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

Premium information

You may keep your 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.

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.

Grievance Procedure

Complaint and Grievance Procedure - UnitedHealthcare has established a formal procedure to respond to customer complaints and grievances. UnitedHealthcare desires to provide a fair, accessible and responsive method of evaluating and resolving complaints and grievances. If UnitedHealthcare determines that any prior action that it has taken was incorrect, corrective action will be taken. You may, at any time, submit a written complaint to the Department of Insurance in your state.

Complaints - If you have a complaint, you may call us at1-800-523-5880 or write to us at UnitedHealthcare, [P.O. Box 1012, Montgomeryville, PA 18936-1012.] We will acknowledge all complaints within 15 days and will respond to all complaints within a reasonable period of time.

Grievances - If you are dissatisfied with our handling of a complaint or a claim denial, or are dissatisfied for any other reason, you may submit a formal grievance. Grievances must be in writing and contain the words "this is a grievance" to ensure that we understand the purpose of the communication. You must clearly state the nature of the grievance and send it to: UnitedHealthcare, [P.O. Box 1012, Montgomeryville, PA 18936-1012.] We will acknowledge in writing all grievances within 15 days and respond to all grievances within a reasonable period of time. All grievances must be filed within 60 days or as soon as reasonably possible from the date of denial of benefits or other action giving rise to the grievance.

Plan Benefit Tables: Medicare Select – Plan C

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan C Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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 must use a network hospital.

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

Plan Benefit Tables: Medicare Select – Plan C (continued)

Medicare Part B: Medical Services per Calendar Year

		Medicare Pays	Medicare Select Plan C Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[4]	$0	[$135] (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 [$135] of Medicare-approved amounts[4]	$0	[$135] (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	Medicare Select 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 [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select 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 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Medicare Select – Plan F

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Hospitalization[1] in a Participating Hospital[2] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
	Days 61–90	All but [$267] per day	[$267] per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but [$534] per day	[$534] per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 [$133.50] per day	Up to [$133.50] 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-payments/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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 must use a network hospital.

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

Plan Benefit Tables: Medicare Select – Plan F (continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Medicare Select Plan F Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT[2], such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First [$135] of Medicare-approved amounts[4]	$0	[$135] (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 [$135] of Medicare-approved amounts[4]	$0	[$135] (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	Medicare Select 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 [$135] of Medicare-approved amounts[4]	$0	[$135] (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare

Service		Medicare Pays	Medicare Select 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 You must use a network hospital.

4 Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	11/05/2009

Comments:
SEE ATTACHED READABILITY CERTIFICATION.
Attachment:
READABILITY CERTIFICATION w SELECT(SERFF).pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	11/05/2009

Comments:
The applications that will be used with the attached Medicare supplement certificate forms will be sent via SERFF under separate cover.

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	NOT REQUIRED		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	11/05/2009

Comments:
THE OUTLINES OF COVERAGE (PLAN BENEFIT TABLE) ARE ATTACHED TO THE FORM SCHEDULE TAB.

		Item Status:	Status Date:
Satisfied - Item:	Filing Cover Letter	Accepted for Informational	11/05/2009

Purposes

Comments:

See attached cover letter.

Attachment:

AR - MIPPA Form Submission letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	RATE COVER LETTER	Accepted for Informational Purposes	11/05/2009

Comments:

SEE ATTACHED RATE COVER LETTER.

Attachment:

AR cover letter - MIPPA Initial Filing (2).pdf

UnitedHealthcare Insurance Company

THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A FLESCH READING EAST TEST SCORE OF:

FORM NUMBER	FLESH SCORE
MDA0001	52
MDB0002	52.1
MDC0003	55
MDF0004	54.9
MDK0005	52
MDL0006	52.1
MDN0007	52.2
MAA0010	55.1
MAB0011	55.2
MAC0012	55
MAF0013	54.9
MAK0014	55.1
MAL0015	55.1
MAN0016	55.2
BT25	50
BT26	50
BT27	50
BT28	50
BT29	50
BT30	50
BT31	50
BT002ST	50
POV3	50
RD4	50
MRP0001	50
MRP0003	50
MDSC0008	55.1
MDSF0009	55.2
MASC0017	55
MASF0018	52.2
BT32	50
BT33	50
BT002 ST CCSELECT	50
BT002 ST FFSELECT	50
POV4	50
RD5	50
MRP0002	50

SIGNATURE

Paul D. Kallmeyer
Vice President, Compliance
TYPE NAME AND TITLE

September 3, 2009
DATE

UnitedHealth Group
P.O. Box 130 Montgomeryville, PA 18936

September 4, 2009

Jay Bradford
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company
NAIC No. 0707–79413
Group Accident and Health Insurance
Standardized Medicare Supplement Certificates: MDA 0001 – MDN 0007 (Non-Agent Sales Only)
Standardized Medicare Supplement Certificates: MAA 0010 – MAN 0016 (Agent Sales only)
Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Non-Agent Sales Only)
Standardized Medicare Select Certificate: MASC 0017, MASF 0018 (Agent Sales only)
Plan Benefit Tables: BT25 – BT33
BT002 ST AB, CF, KLN
BT002 ST CCSelect,
BT002 ST FFSelect
Plan Overviews: POV3, POV4
Rules & Disclosures: RD4, RD5
Premium Rate Pages: MRP0001 (Med Supp), MRP0002 (Med Select) - - (All Non-Agent Marketing Channels)
MRP0003 (Med Supp), MRP0004 (Med Select) - - (All Marketing Channels)
Medicare Select Plan of Operation: PO3

To Comply with the Medicare Improvements for Patients and Providers Act

Dear Commissioner Bradford:

Enclosed for your review and approval are copies of the above-referenced group Standardized Medicare Supplement Benefit Plan A – C, F, K, L, and N certificate forms, Medicare Select Benefit Plan C and F certificate forms, a Medicare Select Plan of Operation, and the various forms that comprise the Medicare supplement/Select outline of coverage: plan benefit tables, plan overview, rules and disclosures, and premium rate pages. The certificate forms for plans A – C, F, N, Select C and F are new and will not replace any form currently on file with the Department. All of the forms referenced above will be used in connection with the insurance program offered to AARP members.

These new forms have been developed in accordance with the Medicare Improvements for Patients and Providers Act (MIPPA), H.R. 6331. As a result of the MIPPA provisions and subsequent modifications to the NAIC Medicare Supplement Model #651, revisions are required for the standardized Medicare supplement plans and the related Medicare supplement outlines of coverage. MIPPA has also authorized the development of two new standardized Medicare supplement plans M and N (**we are only submitting Plan N for review and approval at this time**) and their related outlines of coverage.

In an effort to make our member communications more user friendly and to enhance our members' ability to understand all aspects of our insurance program, we are currently working on a Health Literacy/Plain Language initiative. One part of this initiative is to redesign our certificate forms to reduce complexity and to provide our insured members with clear information regarding their insurance coverage and related benefits in easy-to-read language. The enclosed certificate forms and outlines of coverage contain not only the required MIPPA benefit modifications but also modifications to the text and format based on our plain language guidelines. It is important to note that all of these forms have been developed in accordance with your Department's Medicare supplement laws and regulations.

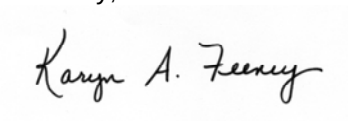
Although MIPPA did not alter the benefit structure of the Standardized Medicare Supplement Plans K and L, we have revised these certificate forms to incorporate our plain language standards and to maintain consistency with the attached Medicare supplement plans A – C, F, and N. Upon approval from your Department, we will replace the plan K and L certificate forms that are currently on file with these revised plan K and L forms for all new business effective 6/1/2010 and later.

Please be advised that we have submitted four separate premium rate pages for you review and approval. Once approved, MRP0001 (Med Supp) and MRP0002 (Med Select) will only be used in our non-agent sales marketing materials. MRP0003 (Med Supp) and MPR0004 (Med Select), on the other hand, will be used in our agent sales marketing materials and may occasionally be used in our other non-agent sales marketing. It is important to note that only one of these rate pages will be included in the outline of coverage that will be part of each marketing kit.

Once the Department has approved the enclosed forms, it is our intention to begin marketing these new plans during the first quarter of the calendar year 2010 with certificate effective dates of June 1, 2010 and later. These forms will not be used in conjunction with any in force business or new business with effective dates prior to June 1, 2010. Please make note that we will not implement these new certificate forms until the corresponding rates have been approved by your Department. Rates and supporting documentation for all of these plans will be filed under separate cover.

Thank you for the time and consideration spent in reviewing this filing. If you have any questions or concerns regarding this submission, please feel free to call, fax, or e-mail me at the numbers or address shown below.

Sincerely,



Karyn A. Feeney
Director, Contract & Compliance
e-mail: karyn_a_feeney@uhc.com
phone: (215) 902 - 8468
fax: (215) 902 - 8812

October 28, 2009

Jay Bradford
Commissioner
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-19044

Re: Initial Rate Filing
Rates for Standardized Medicare Supplement Plans and Medicare Select Plans C & F
UnitedHealthcare Insurance Company
NAIC #0707-79413

Dear Commissioner:

The attached filing is made to obtain approval for rates effective through 2010 for the modernized versions of Standardized Medicare Supplement Plans and Medicare Select Plans C and F following the plan designs required in the MIPPA legislation. These plans will be issued to members of AARP beginning June 1, 2010.

The lifetime target loss ratio for these plans is 75.0%. The enclosed actuarial memorandum provides supporting information. Certification regarding compliance with loss ratio standards for your state is also provided.

We request that the contents of this filing be treated as proprietary and confidential to the extent allowed by your state's laws, due to its nature as trade secrets.

If you need any further information regarding this matter, please contact me at (215) 902-8427, or via fax at (215) 902-8801. If you prefer to e-mail me, my address is David_M_Walker@uhc.com.

Sincerely,

David M. Walker, ASA, MAAA, FLMI
Director, Actuarial Services