

SERFF Tracking Number: UHLC-126161422 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 42439
 Company Tracking Number: BT1
 TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
 Plans
 Product Name: MEDICARE SUPPLEMENT PLANS
 Project Name/Number: PLAN LANGUAGE OUTLINE OF COVERAGE/BT1

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: MEDICARE SUPPLEMENT PLANS SERFF Tr Num: UHLC-126161422 State: ArkansasLH

TOI: MS05G Group Medicare Supplement - Standard Plans SERFF Status: Closed State Tr Num: 42439

Sub-TOI: MS05G.001 Plan A Co Tr Num: BT1 State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Stephanie Fowler

Authors: Wanda Augustus, Mike Mann Disposition Date: 06/16/2009

Date Submitted: 05/21/2009 Disposition Status: Approved

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: PLAN LANGUAGE OUTLINE OF COVERAGE

Project Number: BT1

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/16/2009

Deemer Date:

Filing Description:

Jay Bradford

Insurance Commissioner

State of Arkansas

Arkansas Department of Insurance

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 06/16/2009

Corresponding Filing Tracking Number:

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1200 West 3rd Street
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company

NAIC No. 0707-79413

Group Accident and Health Insurance

Medicare Supplement Outline of Coverage - Your Plan Choice Guide - PCG 2
- Plan Overview – POV 1
- Plan Benefit Tables - BT 1 – BT 12
- Rules & Disclosures – RD 1

Attached for your review and approval please find the above-referenced Medicare supplement Outline of Coverage components. These forms are new and, once approved by your Department, they will be used in conjunction with other marketing materials to solicit specific prospective insureds. These forms will be used in connection with the insurance program offered to AARP members.

In an effort to make our prospective and insured 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 Plain Language/Health Literacy initiative. One part of this initiative is to redesign our marketing materials to reduce complexity and confusion and to provide inquirers with clear information and direction to help them find the plan that is right for them. As a result of this marketing material redesign, we have made copy and design updates to the Medicare supplement outline of coverage forms that are currently on file with your Department. As a result of these revisions, we are filing for your review and approval the following new Medicare supplement outline of coverage forms:

- Your Plan Choice Guide
- Plan Overview
- Plan Benefit Tables
- Rules and Disclosures

These new forms will make up the entire Medicare supplement outline of coverage. It is important to note that although we have redesigned the Medicare supplement outline of coverage, the attached forms are still in compliance with your

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Department's regulations. In addition, the other marketing materials that have been redesigned and require filing prior to use will be submitted to the Department 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

Company and Contact

Filing Contact Information

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

Filing Company Information

UnitedHealthcare Insurance Company CoCode: 79413 State of Domicile: Connecticut
450 Columbus Boulevard Group Code: 707 Company Type: Life and Health
PO Box 150450
Hartford, CT 06115-0450 Group Name: State ID Number:
(860) 702-5000 ext. [Phone] FEIN Number: 36-2739571

Filing Fees

Fee Required? Yes
Fee Amount: \$750.00

SERFF Tracking Number: UHLC-126161422 State: Arkansas
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Plans
Product Name: MEDICARE SUPPLEMENT PLANS
Project Name/Number: PLAN LANGUAGE OUTLINE OF COVERAGE/BTI
Retaliatory? No
Fee Explanation: 15 FORMS X \$50.00 = \$750.00
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$750.00	05/21/2009	28038024

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	06/16/2009	06/16/2009

SERFF Tracking Number: UHLC-126161422 *State:* Arkansas
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Disposition

Disposition Date: 06/16/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	STATEMENT OF VARIABILITY	Accepted for Informational Purposes	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	BENEFIT TABLE	Approved	Yes
Form	PLAN CHOICE GUIDE	Approved	Yes
Form	PLAN OVERVIEW	Approved	Yes
Form	RULES AND DISCLOSURES	Approved	Yes

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Form Schedule

Lead Form Number: BT1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	BT1	Outline of Coverage	BENEFIT TABLE	Initial			BT1 STD A.pdf
Approved	BT2	Outline of Coverage	BENEFIT TABLE	Initial			BT2 STD B.pdf
Approved	BT3	Outline of Coverage	BENEFIT TABLE	Initial			BT3 STD C.pdf
Approved	BT4	Outline of Coverage	BENEFIT TABLE	Initial			BT4 STD D.pdf
Approved	BT5	Outline of Coverage	BENEFIT TABLE	Initial			BT5 STD E.pdf
Approved	BT6	Outline of Coverage	BENEFIT TABLE	Initial			BT6 STD F.pdf
Approved	BT7	Outline of Coverage	BENEFIT TABLE	Initial			BT7 STD G.pdf
Approved	BT8	Outline of Coverage	BENEFIT TABLE	Initial			BT8 STD H.pdf
Approved	BT9	Outline of Coverage	BENEFIT TABLE	Initial			BT9 STD I.pdf
Approved	BT10	Outline of Coverage	BENEFIT TABLE	Initial			BT10 STD J.pdf
Approved	BT11	Outline of Coverage	BENEFIT TABLE	Initial			BT11 STD K.pdf
Approved	BT12	Outline of Coverage	BENEFIT TABLE	Initial			BT12 STD L.pdf
Approved	PCG2	Outline of Coverage	PLAN CHOICE GUIDE	Initial			PCG2 AR.pdf
Approved	POV1	Outline of Coverage	PLAN OVERVIEW	Initial			POV1 STD.pdf
Approved	RD1	Outline of Coverage	RULES AND DISCLOSURES	Initial			RD1 STD.pdf

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan A Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [\$1,068]	\$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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 Period¹

Service		Medicare Pays	Plan B Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [\$1,068]	[\$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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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.

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 Period¹

Service		Medicare Pays	Plan C Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [\$1,068]	[\$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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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

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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, continued

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

Plan Benefit Tables: Plan D

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan D Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 D, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan D 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 D 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

Continued on next page 

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 D, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan D Pays	You Pay
At-home Recovery Services NOT COVERED BY MEDICARE— Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan.	Benefit for each visit	\$0	Actual charges up to \$40 a visit	Balance
	Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits not to exceed 7 each week	Balance
	Calendar year maximum	\$0	\$1,600	Balance
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: Plan E

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan E Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 E, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan E 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 E 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

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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 E, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan E 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
Preventive Medical Care⁴ NOT COVERED BY MEDICARE— Some annual physical and preventive tests and services, administered or ordered by your doctor when not covered by Medicare.	First \$120 each calendar year	\$0	\$120	\$0
	Additional charges	\$0	\$0	All costs

Notes

⁴ Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but [\$1,068]	[\$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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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

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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 F, continued

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

Plan Benefit Tables: Plan G

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan G Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 G, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan G 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	80%	20%
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 G 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

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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 G, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan G Pays	You Pay
At-home Recovery Services NOT COVERED BY MEDICARE— Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan.	Benefit for each visit	\$0	Actual charges up to \$40 a visit	Balance
	Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits not to exceed 7 each week	Balance
	Calendar year maximum	\$0	\$1,600	Balance
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: Plan H

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan H Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 H, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan H 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 H 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

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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 H, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan H 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

Plan Benefit Tables: Plan I

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan I Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 I, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan I 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	100%	\$0
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 I 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

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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 I, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan I Pays	You Pay
At-home Recovery Services NOT COVERED BY MEDICARE— Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan.	Benefit for each visit	\$0	Actual charges up to \$40 a visit	Balance
	Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits not to exceed 7 each week	Balance
	Calendar year maximum	\$0	\$1,600	Balance
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: Plan J

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan J Pays	You Pay
Hospitalization¹ 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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$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 your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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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 J, continued

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan J 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 J 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

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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 J, continued

Other Benefits not covered by Medicare

Service		Medicare Pays	Plan J Pays	You Pay
At-home Recovery Services NOT COVERED BY MEDICARE— Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan.	Benefit for each visit	\$0	Actual charges up to \$40 a visit	Balance
	Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits not to exceed 7 each week	Balance
	Calendar year maximum	\$0	\$1,600	Balance
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
Preventive Medical Care⁴ NOT COVERED BY MEDICARE— Some annual physical and preventive tests and services, administered or ordered by your doctor when not covered by Medicare.	First \$120 each calendar year	\$0	\$120	\$0
	Additional charges	\$0	\$0	All costs

Notes

⁴ Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan K ³ Pays	You Pay
Hospitalization¹ 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) ³
	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 Care¹ You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$133.50] per day	Up to [\$66.75] per day	[\$66.75] per day ³
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	50%	50% ³
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or co-payments ³

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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 this footnote (³) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceeded 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
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) ⁴
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved	Generally 80%	Generally 10%	Generally 10% ³
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])
Blood	First 3 pints	\$0	50%	50% ³
	Next [\$135] of Medicare-approved amounts ⁴	\$0	\$0	[\$135] (Part B deductible) ⁴
	Remainder of Medicare-approved amounts	80%	Generally 10%	Generally 10% ³
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

Service		Medicare Pays	Plan K 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 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.

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, continued

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay
Durable medical equipment Medicare-approved services	First [\$135] of Medicare-approved amounts ⁴	\$0	\$0	[\$135] (Part B deductible) ⁴
	Remainder of Medicare-approved amounts	80%	10%	10% ³

Notes

3 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.

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 L

Medicare Part A: Hospital Services per Benefit Period¹

Service		Medicare Pays	Plan L ³ Pays	You Pay
Hospitalization¹ 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) ³
	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 Care¹ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	\$0	\$0
	Days 21–100	All but [\$133.50] per day	Up to [\$100.13] per day	[\$33.37] per day ³
	Days 101 and later	\$0	\$0	All costs
Blood	First 3 pints	\$0	75%	25% ³
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-insurance for outpatient drugs and inpatient respice care	75% of coinsurance or copayments	25% of coinsurance or co-payments ³

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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 this footnote ⁽³⁾ in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceeded 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
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) ⁴
	Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ³
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])
Blood	First 3 pints	\$0	75%	25% ³
	Next [\$135] of Medicare-approved amounts ⁴	\$0	\$0	[\$135] (Part B deductible) ⁴
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ³
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0

Parts A and B

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

Continued on next page ►

Notes

3 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.

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 L, continued

Parts A and B

Service		Medicare Pays	Plan L Pays	You Pay
Durable medical equipment Medicare-approved services	First [\$135] of Medicare-approved amounts ⁴	\$0	\$0	[\$135] (Part B deductible) ⁴
	Remainder of Medicare-approved amounts	80%	15%	5% ³

Notes

3 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.

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.

► **Personalized For:** [Sample A. Sample]¹

To help you choose a plan that fits your needs, this guide compares the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company, offered in your state.

The table below outlines each plan’s benefits as well as the rates available to you. The dollar amounts shown are monthly payments per person. These are current rates and may change. Additional discounts may be available to you—call a representative for details. For more detailed plan information, see the *Reference Materials* section in this booklet.

The plan(s) highlighted in yellow below [are the 2 most popular Medicare supplement insurance plans. More than 60% of people choose one of these plans. (Source: AHIP. *Trends in Medigap Policies*, December 2004 to December 2006. March 2008.)] Benefits marked with a check ✓ are included under the specific plan.

For the earliest plan effective date, enroll by [January 31, 2009.]

	Plan A	Plan B	Plan C	Plan D
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				
At-Home Recovery Services				✓
Foreign Travel emergency care			✓	✓
Preventive Medical Care Not covered by Medicare				
Annual Out-Of-Pocket spending limit				
Plan Rates				
[Base Rate]	[\$X,XXX.XX]	[\$X,XXX.XX]	[\$X,XXX.XX]	[\$X,XXX.XX]

1 NOTE: The rates listed on these pages are only for the person named above at the address shown on the enclosed enrollment form and for plan effective dates shown on the enrollment form.

Your rate will be the Base Rate listed at the bottom of the chart. The Base Rate applies to all applicants age 65 or older.

Need help with a word? Terms you see underlined are defined in the *Glossary* in this booklet.

► Questions? Just call **1.800.620.9037**. A helpful representative can answer your questions in easy-to-understand language and help you explore your options. Available Monday to Friday, 7 a.m. to 11 p.m., and Saturday, 9 a.m. to 5 p.m., Eastern Time. TTY users should call 1.800.232.7773.

Plan E	Plan F	Plan G	Plan H	Plan I	Plan J	Plan K	Plan L
✓	✓	✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓	50% ²	75% ²
✓	✓	✓	✓	✓	✓	50%	75%
	✓					50%	75%
✓	✓	✓	✓	✓	✓	50%	75%
✓	✓	✓	✓	✓	✓	50%	75%
	✓				✓		
	✓	80%		✓	✓		
	✓	✓		✓	✓		
✓	✓	✓	✓	✓	✓		
✓					✓	100%	100%
						[\$4,620.00]	[\$2,310.00]
[\$X,XXX.XX]	[\$X,XXX.XX]						

2 EXCEPTION: Plans K and L will pay 100% of Part B co-insurance for preventive services covered by Medicare.

Overview of Available Plans

Showing the 12 standard Medicare supplement plans, A through L

The table below and on the following page compares the benefits included in each of the 12 standard Medicare supplement plans. These standard plans are defined by law, and all insurance companies must offer the same benefits in each plan. Every company must offer “Plan A”. Some plans may not be available in your state. See the *Plan Benefit Tables* for additional plan information.

Basic Benefits for plans A through J include:

- **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.
- **Blood:** First 3 pints of blood each year (Medicare covers the blood you need after the first 3 pints).

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F ¹	Plan G	Plan H	Plan I	Plan J ¹
Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits	Basic benefits
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility 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 A deductible	Part A deductible	Part A deductible	Part A deductible
		Part B deductible			Part B deductible				Part B deductible
					Part B excess (100%)	Part B excess (80%)		Part B excess (100%)	Part B excess (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency
			At-home recovery			At-home recovery		At-home recovery	At-home recovery
				Preventive care NOT covered by Medicare					Preventive care NOT covered by Medicare

Continued on next page 

Notes

¹ Plans F and J are also offered in a high-deductible option. **This option is not currently offered by UnitedHealthcare Insurance Company.** These high deductible plans pay the same benefits as Plans F and J, but benefits will not begin until you have paid the [\$2,000] calendar year deductible.

Expenses that count toward this deductible are costs normally covered by Medicare supplement insurance, including Medicare Part A and B deductibles, but not the plan’s separate foreign travel emergency deductible.

Overview of Available Plans, continued

Showing the 12 standard Medicare supplement plans, A through L

Basic Benefits for Plans K and L include similar services as Plans A through J, but cost sharing for some benefits is at different levels. See the *Plan Benefit Tables* for additional plan information.

Plan J	Plan K ²	Plan L ²
Basic benefits	<p>100% of Part A hospitalization co-insurance plus coverage for 365 days after Medicare benefits end</p> <p>50% of hospice cost-sharing</p> <p>50% of Medicare-eligible expenses for the first three pints of blood</p> <p>50% of Part B co-insurance, except 100% of co-insurance for Part B preventive services</p>	<p>100% of Part A hospitalization co-insurance plus coverage for 365 days after Medicare benefits end</p> <p>75% of hospice cost-sharing</p> <p>75% of Medicare-eligible expenses for the first three pints of blood</p> <p>75% of Part B co-insurance, except 100% of co-insurance for Part B preventive services</p>
Skilled nursing facility co-insurance	50% of Skilled nursing facility co-insurance	75% of Skilled nursing facility co-insurance
Part A deductible	50% of Part A deductible	75% of Part A deductible
Part B deductible		
Part B excess (100%)		
Foreign travel emergency		
At-home recovery		
Preventive care NOT covered by Medicare		
	[\$4,620] out-of-pocket annual limit ³	[\$2,310] out-of-pocket annual limit ³

Notes

2 Plans K and L provide different cost-sharing for items and services than Plans A through J. When you reach your annual out-of-pocket spending limit, Plans K and L pay 100% of all Medicare co-insurance, co-payments and deductibles for the rest of the year. Your payment toward excess charges, or charges from your provider

that exceed Medicare-approved amounts, don't count toward your annual spending limit. You are responsible for paying excess charges.

3 The out-of-pocket limit will change each year due to inflation.

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 *Your Plan Choice Guide* 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.

SERFF Tracking Number: UHLC-126161422 *State:* Arkansas
Filing Company: UnitedHealthcare Insurance Company *State Tracking Number:* 42439
Company Tracking Number: BTI
TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
Plans
Product Name: MEDICARE SUPPLEMENT PLANS
Project Name/Number: PLAN LANGUAGE OUTLINE OF COVERAGE/BTI

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-126161422 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 42439
 Company Tracking Number: BTI
 TOI: MS05G Group Medicare Supplement - Standard Sub-TOI: MS05G.001 Plan A
 Plans
 Product Name: MEDICARE SUPPLEMENT PLANS
 Project Name/Number: PLAN LANGUAGE OUTLINE OF COVERAGE/BTI

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Accepted for Informational Purposes 06/16/2009

Comments:
SEE ATTACHED READABILITY CERTIFICATION.

Attachment:
READABILITY CERTIFICATION.pdf

Bypassed -Name: Application **Review Status:** 06/16/2009

Bypass Reason: NOT REQUIRED.

Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** 06/16/2009

Bypass Reason: NOT REQUIRED.

Comments:

Satisfied -Name: Outline of Coverage **Review Status:** Approved 06/16/2009

Comments:
THE OUTLINES OF COVERAGE ARE ATTACHED TO THE FORMS SCHEDULE TAB.

Satisfied -Name: STATEMENT OF VARIABILITY **Review Status:** Accepted for Informational Purposes 06/16/2009

Comments:
SEE ATTACHED STATEMENT OF VARIABILITY.

Attachment:
ThoughtForm PCG 2 - Statement of Variability.pdf

UnitedHealthcare Insurance Company

THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A FLESH READING EAST TEST SCORE OF:

FORM NUMBER	FLESH SCORE
BT1	51
BT2	51
BT3	51
BT4	51
BT5	51
BT6	51
BT7	51
BT8	51
BT9	51
BT10	51
BT11	51
BT12	51
PCG1	51
POV1	51
RD1	51



SIGNATURE

Paul D. Kallmeyer
Vice President, Compliance
TYPE NAME AND TITLE

May 21, 2009
DATE

Your Plan Choice Guide

Statement of Variability

Form Number

Variable Language

PCG2

First page - Third paragraph - - variable language options:

1. “are the 2 most popular Medicare supplement Insurance plans. More than 60% of people choose one of these plans. (Source: AHIP, *Trends in Medigap Policies*, December 2004 to December 2006. March 2008.)”
2. “are the plans you recently requested while talking with a phone representative. One of these plans may fit you best.”