



# Enrollment Kit

AARP® Medicare Supplement Insurance Plans, insured by  
UnitedHealthcare Insurance Company

## Oregon

Enrollment is for January 1, 2026 - December 1, 2026 plan effective dates.





# Bright Ways To Save



**Contact your  
licensed insurance  
agent to get your  
personalized  
rate quote.**

These discounts can add up to valuable savings on an AARP® Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare).

## **SAVE 12% with the Multi-Insured Discount**

You can take 12% off your monthly premiums if two insureds on one account are enrolled under the same AARP membership number and each is insured under an eligible AARP-branded supplemental insurance policy insured by UnitedHealthcare Insurance Company.

## **TAKE \$24 OFF with Electronic Funds Transfer**

You'll save \$2.00 off your total monthly premium, or \$24 per year, when you use the convenient and easy payment option, Electronic Funds Transfer (EFT). Your monthly payments are automatically forwarded by your bank, which means no checks to write and no postage to pay.

**AARP** | Medicare Supplement  
from  **UnitedHealthcare**

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare. UnitedHealthcare pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

**You must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan. If you are not a member, you can join AARP for just \$20 a year.**

Insured by UnitedHealthcare Insurance Company, Hartford, CT. Policy Form No. GRP 79171 GPS-1 (G-36000-4).

**Plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.**

**Not connected with or endorsed by the U.S. government or the federal Medicare program.**

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

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

## Overview of Available Plans

Medicare Supplement Plans A, B, C, F, G, K, L, N and Medicare Select Plans G and N are currently being offered by UnitedHealthcare Insurance Company.

◆ Medicare Select Plans G and N contain the same benefits as standardized Medicare Supplement Plans G and N, except for restrictions on your use of hospitals.

### Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of this benefit is paid.

| Benefits                                                                                                             | Plans Available to All Applicants |   |   |                  |                     |                     |     |                                | Medicare first eligible before 2020 only |                |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|---|------------------|---------------------|---------------------|-----|--------------------------------|------------------------------------------|----------------|
|                                                                                                                      | A                                 | B | D | G <sup>1</sup> ◆ | K                   | L                   | M   | N◆                             | C                                        | F <sup>1</sup> |
|                                                                                                                      |                                   |   |   |                  |                     |                     |     |                                |                                          |                |
| Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✓                                 | ✓ | ✓ | ✓                | ✓                   | ✓                   | ✓   | ✓                              | ✓                                        | ✓              |
| Medicare Part B coinsurance or Copayment                                                                             | ✓                                 | ✓ | ✓ | ✓                | 50%                 | 75%                 | ✓   | ✓<br>copays apply <sup>3</sup> | ✓                                        | ✓              |
| Blood (first three pints)                                                                                            | ✓                                 | ✓ | ✓ | ✓                | 50%                 | 75%                 | ✓   | ✓                              | ✓                                        | ✓              |
| Part A hospice care coinsurance or copayment                                                                         | ✓                                 | ✓ | ✓ | ✓                | 50%                 | 75%                 | ✓   | ✓                              | ✓                                        | ✓              |
| Skilled nursing facility coinsurance                                                                                 |                                   |   | ✓ | ✓                | 50%                 | 75%                 | ✓   | ✓                              | ✓                                        | ✓              |
| Medicare Part A deductible                                                                                           |                                   | ✓ | ✓ | ✓                | 50%                 | 75%                 | 50% | ✓                              | ✓                                        | ✓              |
| Medicare Part B deductible                                                                                           |                                   |   |   |                  |                     |                     |     |                                | ✓                                        | ✓              |
| Medicare Part B excess charges                                                                                       |                                   |   |   | ✓                |                     |                     |     |                                |                                          | ✓              |
| Foreign travel emergency (up to plan limits)                                                                         |                                   |   | ✓ | ✓                |                     |                     | ✓   | ✓                              | ✓                                        | ✓              |
| Out-of-pocket limit in 2025 <sup>2</sup>                                                                             |                                   |   |   |                  | \$7220 <sup>2</sup> | \$3610 <sup>2</sup> |     |                                |                                          |                |

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of \$2870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.





## **Important Note about the Plan Information in This Package**

The deductibles and co-payments shown in this package are the 2025 amounts.

If Medicare decides to make a change for 2026, your AARP® Medicare Supplement Plan benefits will automatically change to match any increase in the deductibles and co-payments.

If you have any questions, please contact your licensed insurance agent/producer.



**Female Non-Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$150.49              | \$226.51 | \$232.81 | \$209.71              | \$77.00  | \$155.95 | \$183.11 | \$170.93              | \$239.25            | \$262.21            |
| <b>65</b>        | \$150.49              | \$226.51 | \$232.81 | \$209.71              | \$77.00  | \$155.95 | \$183.11 | \$170.93              | \$239.25            | \$262.21            |
| <b>66</b>        | \$150.49              | \$226.51 | \$232.81 | \$209.71              | \$77.00  | \$155.95 | \$183.11 | \$170.93              | \$239.25            | \$262.21            |
| <b>67</b>        | \$150.49              | \$226.51 | \$232.81 | \$209.71              | \$77.00  | \$155.95 | \$183.11 | \$170.93              | \$239.25            | \$262.21            |
| <b>68</b>        | \$158.59              | \$238.70 | \$245.34 | \$221.00              | \$81.14  | \$164.35 | \$192.97 | \$180.13              | \$252.12            | \$276.32            |
| <b>69</b>        | \$166.67              | \$250.85 | \$257.83 | \$232.25              | \$85.27  | \$172.71 | \$202.79 | \$189.30              | \$264.96            | \$290.39            |
| <b>70</b>        | \$174.77              | \$263.04 | \$270.36 | \$243.53              | \$89.42  | \$181.11 | \$212.65 | \$198.50              | \$277.84            | \$304.50            |
| <b>71</b>        | \$182.87              | \$275.24 | \$282.89 | \$254.82              | \$93.56  | \$189.50 | \$222.50 | \$207.70              | \$290.72            | \$318.61            |
| <b>72</b>        | \$190.94              | \$287.39 | \$295.38 | \$266.07              | \$97.69  | \$197.87 | \$232.33 | \$216.87              | \$303.55            | \$332.68            |
| <b>73</b>        | \$199.04              | \$299.58 | \$307.91 | \$277.36              | \$101.83 | \$206.26 | \$242.18 | \$226.07              | \$316.43            | \$346.79            |
| <b>74</b>        | \$207.14              | \$311.77 | \$320.44 | \$288.65              | \$105.98 | \$214.66 | \$252.04 | \$235.27              | \$329.31            | \$360.91            |
| <b>75</b>        | \$216.83              | \$326.35 | \$335.43 | \$302.15              | \$110.94 | \$224.70 | \$263.83 | \$246.28              | \$344.71            | \$377.79            |
| <b>76</b>        | \$226.54              | \$340.98 | \$350.46 | \$315.69              | \$115.91 | \$234.76 | \$275.65 | \$257.31              | \$360.15            | \$394.72            |
| <b>77</b>        | \$236.26              | \$355.60 | \$365.49 | \$329.23              | \$120.88 | \$244.83 | \$287.47 | \$268.35              | \$375.60            | \$411.64            |
| <b>78</b>        | \$245.98              | \$370.22 | \$380.52 | \$342.76              | \$125.85 | \$254.90 | \$299.29 | \$279.38              | \$391.04            | \$428.57            |
| <b>79</b>        | \$255.69              | \$384.84 | \$395.55 | \$356.30              | \$130.82 | \$264.97 | \$311.11 | \$290.42              | \$406.49            | \$445.50            |
| <b>80</b>        | \$265.38              | \$399.43 | \$410.54 | \$369.80              | \$135.78 | \$275.01 | \$322.90 | \$301.42              | \$421.89            | \$462.38            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Non-Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$275.09 | \$414.05 | \$425.56 | \$383.34              | \$140.75 | \$285.07 | \$334.72 | \$312.46              | \$437.34            | \$479.30            |
| 82               | \$284.81 | \$428.67 | \$440.59 | \$396.88              | \$145.72 | \$295.14 | \$346.54 | \$323.49              | \$452.78            | \$496.23            |
| 83               | \$294.52 | \$443.29 | \$455.62 | \$410.42              | \$150.69 | \$305.21 | \$358.36 | \$334.52              | \$468.22            | \$513.16            |
| 84               | \$304.21 | \$457.88 | \$470.61 | \$423.92              | \$155.64 | \$315.25 | \$370.15 | \$345.53              | \$483.63            | \$530.04            |
| 85               | \$313.93 | \$472.50 | \$485.64 | \$437.46              | \$160.61 | \$325.32 | \$381.97 | \$356.56              | \$499.07            | \$546.96            |
| 86               | \$323.64 | \$487.12 | \$500.67 | \$450.99              | \$165.58 | \$335.38 | \$393.79 | \$367.60              | \$514.52            | \$563.89            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$165.53              | \$249.16 | \$256.09 | \$230.68              | \$84.70  | \$171.54 | \$201.42 | \$188.02              | \$263.17            | \$288.43            |
| <b>65</b>        | \$165.53              | \$249.16 | \$256.09 | \$230.68              | \$84.70  | \$171.54 | \$201.42 | \$188.02              | \$263.17            | \$288.43            |
| <b>66</b>        | \$165.53              | \$249.16 | \$256.09 | \$230.68              | \$84.70  | \$171.54 | \$201.42 | \$188.02              | \$263.17            | \$288.43            |
| <b>67</b>        | \$165.53              | \$249.16 | \$256.09 | \$230.68              | \$84.70  | \$171.54 | \$201.42 | \$188.02              | \$263.17            | \$288.43            |
| <b>68</b>        | \$174.44              | \$262.57 | \$269.87 | \$243.10              | \$89.25  | \$180.78 | \$212.26 | \$198.14              | \$277.33            | \$303.95            |
| <b>69</b>        | \$183.33              | \$275.93 | \$283.61 | \$255.47              | \$93.79  | \$189.98 | \$223.06 | \$208.23              | \$291.45            | \$319.42            |
| <b>70</b>        | \$192.24              | \$289.34 | \$297.39 | \$267.88              | \$98.36  | \$199.22 | \$233.91 | \$218.35              | \$305.62            | \$334.95            |
| <b>71</b>        | \$201.15              | \$302.76 | \$311.17 | \$280.30              | \$102.91 | \$208.45 | \$244.75 | \$228.47              | \$319.79            | \$350.47            |
| <b>72</b>        | \$210.03              | \$316.12 | \$324.91 | \$292.67              | \$107.45 | \$217.65 | \$255.56 | \$238.55              | \$333.90            | \$365.94            |
| <b>73</b>        | \$218.94              | \$329.53 | \$338.70 | \$305.09              | \$112.01 | \$226.88 | \$266.39 | \$248.67              | \$348.07            | \$381.46            |
| <b>74</b>        | \$227.85              | \$342.94 | \$352.48 | \$317.51              | \$116.57 | \$236.12 | \$277.24 | \$258.79              | \$362.24            | \$397.00            |
| <b>75</b>        | \$238.51              | \$358.98 | \$368.97 | \$332.36              | \$122.03 | \$247.17 | \$290.21 | \$270.90              | \$379.18            | \$415.56            |
| <b>76</b>        | \$249.19              | \$375.07 | \$385.50 | \$347.25              | \$127.50 | \$258.23 | \$303.21 | \$283.04              | \$396.16            | \$434.19            |
| <b>77</b>        | \$259.88              | \$391.16 | \$402.03 | \$362.15              | \$132.96 | \$269.31 | \$316.21 | \$295.18              | \$413.16            | \$452.80            |
| <b>78</b>        | \$270.57              | \$407.24 | \$418.57 | \$377.03              | \$138.43 | \$280.39 | \$329.21 | \$307.31              | \$430.14            | \$471.42            |
| <b>79</b>        | \$281.25              | \$423.32 | \$435.10 | \$391.93              | \$143.90 | \$291.46 | \$342.22 | \$319.46              | \$447.13            | \$490.05            |
| <b>80</b>        | \$291.91              | \$439.37 | \$451.59 | \$406.78              | \$149.35 | \$302.51 | \$355.19 | \$331.56              | \$464.07            | \$508.61            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$302.59 | \$455.45 | \$468.11 | \$421.67              | \$154.82 | \$313.57 | \$368.19 | \$343.70              | \$481.07            | \$527.23            |
| 82               | \$313.29 | \$471.53 | \$484.64 | \$436.56              | \$160.29 | \$324.65 | \$381.19 | \$355.83              | \$498.05            | \$545.85            |
| 83               | \$323.97 | \$487.61 | \$501.18 | \$451.46              | \$165.75 | \$335.73 | \$394.19 | \$367.97              | \$515.04            | \$564.47            |
| 84               | \$334.63 | \$503.66 | \$517.67 | \$466.31              | \$171.20 | \$346.77 | \$407.16 | \$380.08              | \$531.99            | \$583.04            |
| 85               | \$345.32 | \$519.75 | \$534.20 | \$481.20              | \$176.67 | \$357.85 | \$420.16 | \$392.21              | \$548.97            | \$601.65            |
| 86               | \$356.00 | \$535.83 | \$550.73 | \$496.08              | \$182.13 | \$368.91 | \$433.16 | \$404.36              | \$565.97            | \$620.27            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Non-Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$169.70              | \$255.42 | \$262.53 | \$236.48              | \$86.82  | \$175.86 | \$206.49 | \$192.75              | \$269.79            | \$295.68            |
| <b>65</b>        | \$169.70              | \$255.42 | \$262.53 | \$236.48              | \$86.82  | \$175.86 | \$206.49 | \$192.75              | \$269.79            | \$295.68            |
| <b>66</b>        | \$169.70              | \$255.42 | \$262.53 | \$236.48              | \$86.82  | \$175.86 | \$206.49 | \$192.75              | \$269.79            | \$295.68            |
| <b>67</b>        | \$169.70              | \$255.42 | \$262.53 | \$236.48              | \$86.82  | \$175.86 | \$206.49 | \$192.75              | \$269.79            | \$295.68            |
| <b>68</b>        | \$178.84              | \$269.17 | \$276.66 | \$249.21              | \$91.50  | \$185.33 | \$217.60 | \$203.13              | \$284.31            | \$311.59            |
| <b>69</b>        | \$187.94              | \$282.88 | \$290.74 | \$261.90              | \$96.16  | \$194.76 | \$228.68 | \$213.47              | \$298.78            | \$327.46            |
| <b>70</b>        | \$197.08              | \$296.62 | \$304.87 | \$274.62              | \$100.83 | \$204.23 | \$239.79 | \$223.84              | \$313.31            | \$343.37            |
| <b>71</b>        | \$206.21              | \$310.37 | \$319.00 | \$287.35              | \$105.50 | \$213.69 | \$250.91 | \$234.22              | \$327.83            | \$359.29            |
| <b>72</b>        | \$215.32              | \$324.08 | \$333.09 | \$300.04              | \$110.16 | \$223.13 | \$261.98 | \$244.56              | \$342.30            | \$375.15            |
| <b>73</b>        | \$224.45              | \$337.82 | \$347.22 | \$312.77              | \$114.83 | \$232.59 | \$273.10 | \$254.93              | \$356.82            | \$391.07            |
| <b>74</b>        | \$233.58              | \$351.57 | \$361.35 | \$325.50              | \$119.51 | \$242.06 | \$284.21 | \$265.31              | \$371.35            | \$406.98            |
| <b>75</b>        | \$244.51              | \$368.02 | \$378.25 | \$340.72              | \$125.10 | \$253.38 | \$297.51 | \$277.72              | \$388.71            | \$426.02            |
| <b>76</b>        | \$255.47              | \$384.51 | \$395.20 | \$355.99              | \$130.70 | \$264.73 | \$310.84 | \$290.16              | \$406.13            | \$445.10            |
| <b>77</b>        | \$266.42              | \$400.99 | \$412.15 | \$371.25              | \$136.31 | \$276.09 | \$324.17 | \$302.60              | \$423.55            | \$464.19            |
| <b>78</b>        | \$277.38              | \$417.48 | \$429.09 | \$386.52              | \$141.91 | \$287.44 | \$337.50 | \$315.05              | \$440.96            | \$483.28            |
| <b>79</b>        | \$288.33              | \$433.97 | \$446.04 | \$401.79              | \$147.52 | \$298.79 | \$350.83 | \$327.49              | \$458.38            | \$502.37            |
| <b>80</b>        | \$299.26              | \$450.42 | \$462.94 | \$417.01              | \$153.11 | \$310.11 | \$364.12 | \$339.90              | \$475.75            | \$521.40            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Non-Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$310.21 | \$466.91 | \$479.89 | \$432.28              | \$158.71 | \$321.47 | \$377.45 | \$352.34              | \$493.17            | \$540.49            |
| 82               | \$321.17 | \$483.39 | \$496.84 | \$447.54              | \$164.32 | \$332.82 | \$390.78 | \$364.79              | \$510.58            | \$559.58            |
| 83               | \$332.12 | \$499.88 | \$513.79 | \$462.81              | \$169.92 | \$344.17 | \$404.11 | \$377.23              | \$528.00            | \$578.67            |
| 84               | \$343.05 | \$516.33 | \$530.69 | \$478.03              | \$175.51 | \$355.49 | \$417.40 | \$389.64              | \$545.37            | \$597.70            |
| 85               | \$354.00 | \$532.82 | \$547.64 | \$493.30              | \$181.12 | \$366.85 | \$430.73 | \$402.08              | \$562.78            | \$616.79            |
| 86               | \$364.96 | \$549.31 | \$564.58 | \$508.57              | \$186.72 | \$378.20 | \$444.06 | \$414.53              | \$580.20            | \$635.88            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Tobacco Monthly Plan Rates for Oregon - Area 1**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$186.67              | \$280.96 | \$288.78 | \$260.12              | \$95.50  | \$193.44 | \$227.13 | \$212.02              | \$296.76            | \$325.24            |
| <b>65</b>        | \$186.67              | \$280.96 | \$288.78 | \$260.12              | \$95.50  | \$193.44 | \$227.13 | \$212.02              | \$296.76            | \$325.24            |
| <b>66</b>        | \$186.67              | \$280.96 | \$288.78 | \$260.12              | \$95.50  | \$193.44 | \$227.13 | \$212.02              | \$296.76            | \$325.24            |
| <b>67</b>        | \$186.67              | \$280.96 | \$288.78 | \$260.12              | \$95.50  | \$193.44 | \$227.13 | \$212.02              | \$296.76            | \$325.24            |
| <b>68</b>        | \$196.72              | \$296.08 | \$304.32 | \$274.13              | \$100.65 | \$203.86 | \$239.36 | \$223.44              | \$312.74            | \$342.74            |
| <b>69</b>        | \$206.73              | \$311.16 | \$319.81 | \$288.09              | \$105.77 | \$214.23 | \$251.54 | \$234.81              | \$328.65            | \$360.20            |
| <b>70</b>        | \$216.78              | \$326.28 | \$335.35 | \$302.08              | \$110.91 | \$224.65 | \$263.76 | \$246.22              | \$344.64            | \$377.70            |
| <b>71</b>        | \$226.83              | \$341.40 | \$350.90 | \$316.08              | \$116.05 | \$235.05 | \$276.00 | \$257.64              | \$360.61            | \$395.21            |
| <b>72</b>        | \$236.85              | \$356.48 | \$366.39 | \$330.04              | \$121.17 | \$245.44 | \$288.17 | \$269.01              | \$376.53            | \$412.66            |
| <b>73</b>        | \$246.89              | \$371.60 | \$381.94 | \$344.04              | \$126.31 | \$255.84 | \$300.41 | \$280.42              | \$392.50            | \$430.17            |
| <b>74</b>        | \$256.93              | \$386.72 | \$397.48 | \$358.05              | \$131.46 | \$266.26 | \$312.63 | \$291.84              | \$408.48            | \$447.67            |
| <b>75</b>        | \$268.96              | \$404.82 | \$416.07 | \$374.79              | \$137.61 | \$278.71 | \$327.26 | \$305.49              | \$427.58            | \$468.62            |
| <b>76</b>        | \$281.01              | \$422.96 | \$434.72 | \$391.58              | \$143.77 | \$291.20 | \$341.92 | \$319.17              | \$446.74            | \$489.61            |
| <b>77</b>        | \$293.06              | \$441.08 | \$453.36 | \$408.37              | \$149.94 | \$303.69 | \$356.58 | \$332.86              | \$465.90            | \$510.60            |
| <b>78</b>        | \$305.11              | \$459.22 | \$471.99 | \$425.17              | \$156.10 | \$316.18 | \$371.25 | \$346.55              | \$485.05            | \$531.60            |
| <b>79</b>        | \$317.16              | \$477.36 | \$490.64 | \$441.96              | \$162.27 | \$328.66 | \$385.91 | \$360.23              | \$504.21            | \$552.60            |
| <b>80</b>        | \$329.18              | \$495.46 | \$509.23 | \$458.71              | \$168.42 | \$341.12 | \$400.53 | \$373.89              | \$523.32            | \$573.54            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

## Male Tobacco Monthly Plan Rates for Oregon - Area 1

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

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$341.23 | \$513.60 | \$527.87 | \$475.50              | \$174.58 | \$353.61 | \$415.19 | \$387.57              | \$542.48            | \$594.53            |
| 82               | \$353.28 | \$531.72 | \$546.52 | \$492.29              | \$180.75 | \$366.10 | \$429.85 | \$401.26              | \$561.63            | \$615.53            |
| 83               | \$365.33 | \$549.86 | \$565.16 | \$509.09              | \$186.91 | \$378.58 | \$444.52 | \$414.95              | \$580.80            | \$636.53            |
| 84               | \$377.35 | \$567.96 | \$583.75 | \$525.83              | \$193.06 | \$391.03 | \$459.14 | \$428.60              | \$599.90            | \$657.47            |
| 85               | \$389.40 | \$586.10 | \$602.40 | \$542.63              | \$199.23 | \$403.53 | \$473.80 | \$442.28              | \$619.05            | \$678.46            |
| 86               | \$401.45 | \$604.24 | \$621.03 | \$559.42              | \$205.39 | \$416.02 | \$488.46 | \$455.98              | \$638.22            | \$699.46            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

1 Your age as of your plan effective date. All rates are subject to an annual change, based on changes in health care costs and the claims experience of the plan. Additionally, rates will change each year on the anniversary date of your plan from age 68 until age 86. After the anniversary date of your plan following age 86, your rate will become level, and never change just because you get older.

2 **IMPORTANT:** Plans C and F are available only to applicants eligible for Medicare prior to 1/1/2020.

3 You must use a network hospital with Select Plans G and N.

## Oregon Area 1 ZIP Codes

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

|       |       |       |       |       |
|-------|-------|-------|-------|-------|
| 97001 | 97053 | 97124 | 97221 | 97810 |
| 97003 | 97054 | 97125 | 97222 | 97812 |
| 97004 | 97055 | 97127 | 97223 | 97813 |
| 97005 | 97056 | 97128 | 97224 | 97818 |
| 97006 | 97057 | 97129 | 97225 | 97823 |
| 97007 | 97058 | 97130 | 97227 | 97824 |
| 97008 | 97060 | 97131 | 97228 | 97826 |
| 97009 | 97062 | 97132 | 97229 | 97827 |
| 97010 | 97063 | 97133 | 97230 | 97828 |
| 97011 | 97064 | 97134 | 97231 | 97835 |
| 97013 | 97065 | 97135 | 97232 | 97836 |
| 97014 | 97067 | 97136 | 97233 | 97838 |
| 97015 | 97068 | 97138 | 97236 | 97839 |
| 97016 | 97070 | 97140 | 97238 | 97841 |
| 97017 | 97075 | 97141 | 97239 | 97842 |
| 97018 | 97076 | 97143 | 97240 | 97843 |
| 97019 | 97077 | 97144 | 97242 | 97844 |
| 97021 | 97078 | 97145 | 97250 | 97846 |
| 97022 | 97079 | 97146 | 97251 | 97850 |
| 97023 | 97080 | 97147 | 97252 | 97857 |
| 97024 | 97086 | 97148 | 97253 | 97859 |
| 97027 | 97089 | 97149 | 97254 | 97861 |
| 97028 | 97101 | 97201 | 97256 | 97862 |
| 97029 | 97102 | 97202 | 97266 | 97867 |
| 97030 | 97103 | 97203 | 97267 | 97868 |
| 97031 | 97106 | 97204 | 97268 | 97875 |
| 97033 | 97107 | 97205 | 97269 | 97876 |
| 97034 | 97108 | 97206 | 97280 | 97880 |
| 97035 | 97109 | 97207 | 97281 | 97882 |
| 97036 | 97110 | 97208 | 97282 | 97883 |
| 97037 | 97111 | 97209 | 97283 | 97885 |
| 97038 | 97112 | 97210 | 97286 | 97886 |
| 97039 | 97113 | 97211 | 97290 |       |
| 97040 | 97114 | 97212 | 97291 |       |
| 97041 | 97115 | 97213 | 97292 |       |
| 97042 | 97116 | 97214 | 97293 |       |
| 97044 | 97117 | 97215 | 97294 |       |
| 97045 | 97118 | 97216 | 97296 |       |
| 97048 | 97119 | 97217 | 97298 |       |
| 97049 | 97121 | 97218 | 97378 |       |
| 97050 | 97122 | 97219 | 97396 |       |
| 97051 | 97123 | 97220 | 97801 |       |



**Female Non-Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$142.17              | \$213.98 | \$219.94 | \$198.11              | \$72.74  | \$147.33 | \$172.99 | \$161.48              | \$226.02            | \$247.71            |
| <b>65</b>        | \$142.17              | \$213.98 | \$219.94 | \$198.11              | \$72.74  | \$147.33 | \$172.99 | \$161.48              | \$226.02            | \$247.71            |
| <b>66</b>        | \$142.17              | \$213.98 | \$219.94 | \$198.11              | \$72.74  | \$147.33 | \$172.99 | \$161.48              | \$226.02            | \$247.71            |
| <b>67</b>        | \$142.17              | \$213.98 | \$219.94 | \$198.11              | \$72.74  | \$147.33 | \$172.99 | \$161.48              | \$226.02            | \$247.71            |
| <b>68</b>        | \$149.82              | \$225.50 | \$231.77 | \$208.78              | \$76.65  | \$155.26 | \$182.30 | \$170.17              | \$238.19            | \$261.04            |
| <b>69</b>        | \$157.45              | \$236.98 | \$243.57 | \$219.41              | \$80.56  | \$163.16 | \$191.58 | \$178.84              | \$250.31            | \$274.33            |
| <b>70</b>        | \$165.10              | \$248.50 | \$255.41 | \$230.07              | \$84.47  | \$171.09 | \$200.89 | \$187.53              | \$262.48            | \$287.67            |
| <b>71</b>        | \$172.76              | \$260.02 | \$267.25 | \$240.73              | \$88.39  | \$179.02 | \$210.20 | \$196.22              | \$274.64            | \$301.00            |
| <b>72</b>        | \$180.38              | \$271.50 | \$279.05 | \$251.36              | \$92.29  | \$186.93 | \$219.48 | \$204.88              | \$286.77            | \$314.29            |
| <b>73</b>        | \$188.04              | \$283.02 | \$290.89 | \$262.03              | \$96.20  | \$194.86 | \$228.79 | \$213.57              | \$298.93            | \$327.62            |
| <b>74</b>        | \$195.69              | \$294.53 | \$302.73 | \$272.69              | \$100.12 | \$202.79 | \$238.10 | \$222.27              | \$311.10            | \$340.95            |
| <b>75</b>        | \$204.84              | \$308.31 | \$316.89 | \$285.45              | \$104.80 | \$212.27 | \$249.24 | \$232.66              | \$325.65            | \$356.90            |
| <b>76</b>        | \$214.02              | \$322.13 | \$331.08 | \$298.23              | \$109.50 | \$221.78 | \$260.41 | \$243.09              | \$340.24            | \$372.89            |
| <b>77</b>        | \$223.20              | \$335.94 | \$345.28 | \$311.02              | \$114.19 | \$231.30 | \$271.57 | \$253.51              | \$354.83            | \$388.88            |
| <b>78</b>        | \$232.38              | \$349.75 | \$359.48 | \$323.81              | \$118.89 | \$240.81 | \$282.74 | \$263.94              | \$369.42            | \$404.87            |
| <b>79</b>        | \$241.55              | \$363.57 | \$373.68 | \$336.60              | \$123.59 | \$250.32 | \$293.91 | \$274.36              | \$384.01            | \$420.87            |
| <b>80</b>        | \$250.71              | \$377.34 | \$387.84 | \$349.36              | \$128.27 | \$259.80 | \$305.05 | \$284.76              | \$398.57            | \$436.81            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Non-Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$259.89 | \$391.16 | \$402.04 | \$362.15              | \$132.96 | \$269.31 | \$316.21 | \$295.18              | \$413.16            | \$452.80            |
| 82               | \$269.06 | \$404.97 | \$416.23 | \$374.94              | \$137.66 | \$278.82 | \$327.38 | \$305.61              | \$427.75            | \$468.80            |
| 83               | \$278.24 | \$418.79 | \$430.43 | \$387.73              | \$142.36 | \$288.34 | \$338.55 | \$316.03              | \$442.34            | \$484.79            |
| 84               | \$287.39 | \$432.56 | \$444.59 | \$400.48              | \$147.04 | \$297.82 | \$349.69 | \$326.43              | \$456.89            | \$500.73            |
| 85               | \$296.57 | \$446.38 | \$458.79 | \$413.27              | \$151.73 | \$307.33 | \$360.85 | \$336.85              | \$471.48            | \$516.73            |
| 86               | \$305.75 | \$460.19 | \$472.99 | \$426.06              | \$156.43 | \$316.84 | \$372.02 | \$347.28              | \$486.07            | \$532.72            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$156.38              | \$235.37 | \$241.93 | \$217.92              | \$80.01  | \$162.06 | \$190.28 | \$177.62              | \$248.62            | \$272.48            |
| <b>65</b>        | \$156.38              | \$235.37 | \$241.93 | \$217.92              | \$80.01  | \$162.06 | \$190.28 | \$177.62              | \$248.62            | \$272.48            |
| <b>66</b>        | \$156.38              | \$235.37 | \$241.93 | \$217.92              | \$80.01  | \$162.06 | \$190.28 | \$177.62              | \$248.62            | \$272.48            |
| <b>67</b>        | \$156.38              | \$235.37 | \$241.93 | \$217.92              | \$80.01  | \$162.06 | \$190.28 | \$177.62              | \$248.62            | \$272.48            |
| <b>68</b>        | \$164.80              | \$248.05 | \$254.94 | \$229.65              | \$84.31  | \$170.78 | \$200.53 | \$187.18              | \$262.00            | \$287.14            |
| <b>69</b>        | \$173.19              | \$260.67 | \$267.92 | \$241.35              | \$88.61  | \$179.47 | \$210.73 | \$196.72              | \$275.34            | \$301.76            |
| <b>70</b>        | \$181.61              | \$273.35 | \$280.95 | \$253.07              | \$92.91  | \$188.19 | \$220.97 | \$206.28              | \$288.72            | \$316.43            |
| <b>71</b>        | \$190.03              | \$286.02 | \$293.97 | \$264.80              | \$97.22  | \$196.92 | \$231.22 | \$215.84              | \$302.10            | \$331.10            |
| <b>72</b>        | \$198.41              | \$298.65 | \$306.95 | \$276.49              | \$101.51 | \$205.62 | \$241.42 | \$225.36              | \$315.44            | \$345.71            |
| <b>73</b>        | \$206.84              | \$311.32 | \$319.97 | \$288.23              | \$105.82 | \$214.34 | \$251.66 | \$234.92              | \$328.82            | \$360.38            |
| <b>74</b>        | \$215.25              | \$323.98 | \$333.00 | \$299.95              | \$110.13 | \$223.06 | \$261.91 | \$244.49              | \$342.21            | \$375.04            |
| <b>75</b>        | \$225.32              | \$339.14 | \$348.57 | \$313.99              | \$115.28 | \$233.49 | \$274.16 | \$255.92              | \$358.21            | \$392.59            |
| <b>76</b>        | \$235.42              | \$354.34 | \$364.18 | \$328.05              | \$120.45 | \$243.95 | \$286.45 | \$267.39              | \$374.26            | \$410.17            |
| <b>77</b>        | \$245.52              | \$369.53 | \$379.80 | \$342.12              | \$125.60 | \$254.43 | \$298.72 | \$278.86              | \$390.31            | \$427.76            |
| <b>78</b>        | \$255.61              | \$384.72 | \$395.42 | \$356.19              | \$130.77 | \$264.89 | \$311.01 | \$290.33              | \$406.36            | \$445.35            |
| <b>79</b>        | \$265.70              | \$399.92 | \$411.04 | \$370.26              | \$135.94 | \$275.35 | \$323.30 | \$301.79              | \$422.41            | \$462.95            |
| <b>80</b>        | \$275.78              | \$415.07 | \$426.62 | \$384.29              | \$141.09 | \$285.78 | \$335.55 | \$313.23              | \$438.42            | \$480.49            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Female Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$285.87 | \$430.27 | \$442.24 | \$398.36              | \$146.25 | \$296.24 | \$347.83 | \$324.69              | \$454.47            | \$498.08            |
| 82               | \$295.96 | \$445.46 | \$457.85 | \$412.43              | \$151.42 | \$306.70 | \$360.11 | \$336.17              | \$470.52            | \$515.68            |
| 83               | \$306.06 | \$460.66 | \$473.47 | \$426.50              | \$156.59 | \$317.17 | \$372.40 | \$347.63              | \$486.57            | \$533.26            |
| 84               | \$316.12 | \$475.81 | \$489.04 | \$440.52              | \$161.74 | \$327.60 | \$384.65 | \$359.07              | \$502.57            | \$550.80            |
| 85               | \$326.22 | \$491.01 | \$504.66 | \$454.59              | \$166.90 | \$338.06 | \$396.93 | \$370.53              | \$518.62            | \$568.40            |
| 86               | \$336.32 | \$506.20 | \$520.28 | \$468.66              | \$172.07 | \$348.52 | \$409.22 | \$382.00              | \$534.67            | \$585.99            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Non-Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A         | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | Standard Rates |          |          |                       |          |          |          |                       |                     |                     |
| under 65         | \$160.32       | \$241.30 | \$248.01 | \$223.41              | \$82.02  | \$166.14 | \$195.07 | \$182.10              | \$254.87            | \$279.33            |
| 65               | \$160.32       | \$241.30 | \$248.01 | \$223.41              | \$82.02  | \$166.14 | \$195.07 | \$182.10              | \$254.87            | \$279.33            |
| 66               | \$160.32       | \$241.30 | \$248.01 | \$223.41              | \$82.02  | \$166.14 | \$195.07 | \$182.10              | \$254.87            | \$279.33            |
| 67               | \$160.32       | \$241.30 | \$248.01 | \$223.41              | \$82.02  | \$166.14 | \$195.07 | \$182.10              | \$254.87            | \$279.33            |
| 68               | \$168.95       | \$254.29 | \$261.36 | \$235.43              | \$86.44  | \$175.08 | \$205.57 | \$191.90              | \$268.59            | \$294.37            |
| 69               | \$177.55       | \$267.24 | \$274.67 | \$247.42              | \$90.84  | \$183.99 | \$216.04 | \$201.67              | \$282.27            | \$309.35            |
| 70               | \$186.18       | \$280.22 | \$288.02 | \$259.44              | \$95.26  | \$192.94 | \$226.53 | \$211.47              | \$295.98            | \$324.39            |
| 71               | \$194.81       | \$293.21 | \$301.37 | \$271.47              | \$99.67  | \$201.88 | \$237.03 | \$221.27              | \$309.70            | \$339.42            |
| 72               | \$203.41       | \$306.16 | \$314.67 | \$283.45              | \$104.07 | \$210.79 | \$247.50 | \$231.04              | \$323.38            | \$354.41            |
| 73               | \$212.04       | \$319.15 | \$328.02 | \$295.48              | \$108.49 | \$219.73 | \$258.00 | \$240.84              | \$337.10            | \$369.44            |
| 74               | \$220.67       | \$332.13 | \$341.37 | \$307.50              | \$112.90 | \$228.68 | \$268.50 | \$250.64              | \$350.81            | \$384.48            |
| 75               | \$230.99       | \$347.67 | \$357.34 | \$321.89              | \$118.18 | \$239.37 | \$281.06 | \$262.36              | \$367.22            | \$402.46            |
| 76               | \$241.34       | \$363.25 | \$373.35 | \$336.31              | \$123.48 | \$250.10 | \$293.65 | \$274.12              | \$383.68            | \$420.50            |
| 77               | \$251.69       | \$378.82 | \$389.36 | \$350.73              | \$128.77 | \$260.82 | \$306.24 | \$285.87              | \$400.13            | \$438.53            |
| 78               | \$262.04       | \$394.40 | \$405.37 | \$365.15              | \$134.07 | \$271.55 | \$318.84 | \$297.63              | \$416.58            | \$456.56            |
| 79               | \$272.39       | \$409.98 | \$421.38 | \$379.57              | \$139.36 | \$282.27 | \$331.43 | \$309.39              | \$433.04            | \$474.59            |
| 80               | \$282.71       | \$425.52 | \$437.35 | \$393.96              | \$144.64 | \$292.97 | \$343.99 | \$321.11              | \$449.45            | \$492.58            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Non-Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$293.06 | \$441.09 | \$453.36 | \$408.38              | \$149.94 | \$303.69 | \$356.58 | \$332.86              | \$465.90            | \$510.61            |
| 82               | \$303.41 | \$456.67 | \$469.37 | \$422.80              | \$155.23 | \$314.42 | \$369.17 | \$344.62              | \$482.35            | \$528.64            |
| 83               | \$313.76 | \$472.25 | \$485.38 | \$437.22              | \$160.53 | \$325.14 | \$381.77 | \$356.37              | \$498.81            | \$546.67            |
| 84               | \$324.08 | \$487.78 | \$501.35 | \$451.61              | \$165.81 | \$335.84 | \$394.33 | \$368.10              | \$515.22            | \$564.66            |
| 85               | \$334.43 | \$503.36 | \$517.36 | \$466.03              | \$171.10 | \$346.57 | \$406.92 | \$379.85              | \$531.67            | \$582.69            |
| 86               | \$344.78 | \$518.94 | \$533.37 | \$480.45              | \$176.40 | \$357.29 | \$419.51 | \$391.61              | \$548.12            | \$600.72            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

**Male Tobacco Monthly Plan Rates for Oregon - Area 2**  
**AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company**

| Age <sup>1</sup> | Plan A                | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|-----------------------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
|                  | <b>Standard Rates</b> |          |          |                       |          |          |          |                       |                     |                     |
| <b>under 65</b>  | \$176.35              | \$265.43 | \$272.81 | \$245.75              | \$90.22  | \$182.75 | \$214.57 | \$200.31              | \$280.35            | \$307.26            |
| <b>65</b>        | \$176.35              | \$265.43 | \$272.81 | \$245.75              | \$90.22  | \$182.75 | \$214.57 | \$200.31              | \$280.35            | \$307.26            |
| <b>66</b>        | \$176.35              | \$265.43 | \$272.81 | \$245.75              | \$90.22  | \$182.75 | \$214.57 | \$200.31              | \$280.35            | \$307.26            |
| <b>67</b>        | \$176.35              | \$265.43 | \$272.81 | \$245.75              | \$90.22  | \$182.75 | \$214.57 | \$200.31              | \$280.35            | \$307.26            |
| <b>68</b>        | \$185.84              | \$279.71 | \$287.49 | \$258.97              | \$95.08  | \$192.58 | \$226.12 | \$211.09              | \$295.44            | \$323.80            |
| <b>69</b>        | \$195.30              | \$293.96 | \$302.13 | \$272.16              | \$99.92  | \$202.38 | \$237.64 | \$221.83              | \$310.49            | \$340.28            |
| <b>70</b>        | \$204.79              | \$308.24 | \$316.82 | \$285.38              | \$104.78 | \$212.23 | \$249.18 | \$232.61              | \$325.57            | \$356.82            |
| <b>71</b>        | \$214.29              | \$322.53 | \$331.50 | \$298.61              | \$109.63 | \$222.06 | \$260.73 | \$243.39              | \$340.67            | \$373.36            |
| <b>72</b>        | \$223.75              | \$336.77 | \$346.13 | \$311.79              | \$114.47 | \$231.86 | \$272.25 | \$254.14              | \$355.71            | \$389.85            |
| <b>73</b>        | \$233.24              | \$351.06 | \$360.82 | \$325.02              | \$119.33 | \$241.70 | \$283.80 | \$264.92              | \$370.81            | \$406.38            |
| <b>74</b>        | \$242.73              | \$365.34 | \$375.50 | \$338.25              | \$124.19 | \$251.54 | \$295.35 | \$275.70              | \$385.89            | \$422.92            |
| <b>75</b>        | \$254.08              | \$382.43 | \$393.07 | \$354.07              | \$129.99 | \$263.30 | \$309.16 | \$288.59              | \$403.94            | \$442.70            |
| <b>76</b>        | \$265.47              | \$399.57 | \$410.68 | \$369.94              | \$135.82 | \$275.11 | \$323.01 | \$301.53              | \$422.04            | \$462.55            |
| <b>77</b>        | \$276.85              | \$416.70 | \$428.29 | \$385.80              | \$141.64 | \$286.90 | \$336.86 | \$314.45              | \$440.14            | \$482.38            |
| <b>78</b>        | \$288.24              | \$433.84 | \$445.90 | \$401.66              | \$147.47 | \$298.70 | \$350.72 | \$327.39              | \$458.23            | \$502.21            |
| <b>79</b>        | \$299.62              | \$450.97 | \$463.51 | \$417.52              | \$153.29 | \$310.49 | \$364.57 | \$340.32              | \$476.34            | \$522.04            |
| <b>80</b>        | \$310.98              | \$468.07 | \$481.08 | \$433.35              | \$159.10 | \$322.26 | \$378.38 | \$353.22              | \$494.39            | \$541.83            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

## Male Tobacco Monthly Plan Rates for Oregon - Area 2

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

| Age <sup>1</sup> | Plan A   | Plan B   | Plan G   | Select G <sup>3</sup> | Plan K   | Plan L   | Plan N   | Select N <sup>3</sup> | Plan C <sup>2</sup> | Plan F <sup>2</sup> |
|------------------|----------|----------|----------|-----------------------|----------|----------|----------|-----------------------|---------------------|---------------------|
| 81               | \$322.36 | \$485.19 | \$498.69 | \$449.21              | \$164.93 | \$334.05 | \$392.23 | \$366.14              | \$512.49            | \$561.67            |
| 82               | \$333.75 | \$502.33 | \$516.30 | \$465.08              | \$170.75 | \$345.86 | \$406.08 | \$379.08              | \$530.58            | \$581.50            |
| 83               | \$345.13 | \$519.47 | \$533.91 | \$480.94              | \$176.58 | \$357.65 | \$419.94 | \$392.00              | \$548.69            | \$601.33            |
| 84               | \$356.48 | \$536.55 | \$551.48 | \$496.77              | \$182.39 | \$369.42 | \$433.76 | \$404.91              | \$566.74            | \$621.12            |
| 85               | \$367.87 | \$553.69 | \$569.09 | \$512.63              | \$188.21 | \$381.22 | \$447.61 | \$417.83              | \$584.83            | \$640.95            |
| 86               | \$379.25 | \$570.83 | \$586.70 | \$528.49              | \$194.04 | \$393.01 | \$461.46 | \$430.77              | \$602.93            | \$660.79            |

*The rates above are for plan effective dates from January 2026 through December 2026 and may change.*

1 Your age as of your plan effective date. All rates are subject to an annual change, based on changes in health care costs and the claims experience of the plan. Additionally, rates will change each year on the anniversary date of your plan from age 68 until age 86. After the anniversary date of your plan following age 86, your rate will become level, and never change just because you get older.

2 **IMPORTANT:** Plans C and F are available only to applicants eligible for Medicare prior to 1/1/2020.

3 You must use a network hospital with Select Plans G and N.

## Oregon Area 2 ZIP Codes

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

|       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|
| 97002 | 97350 | 97409 | 97459 | 97525 | 97702 | 97845 |
| 97020 | 97351 | 97410 | 97461 | 97526 | 97703 | 97848 |
| 97026 | 97352 | 97411 | 97462 | 97527 | 97707 | 97856 |
| 97032 | 97355 | 97412 | 97463 | 97528 | 97708 | 97864 |
| 97071 | 97357 | 97413 | 97464 | 97530 | 97709 | 97865 |
| 97137 | 97358 | 97414 | 97465 | 97531 | 97710 | 97869 |
| 97301 | 97360 | 97415 | 97466 | 97532 | 97711 | 97870 |
| 97302 | 97361 | 97416 | 97467 | 97533 | 97712 | 97873 |
| 97303 | 97362 | 97417 | 97469 | 97534 | 97720 | 97874 |
| 97304 | 97364 | 97419 | 97470 | 97535 | 97721 | 97877 |
| 97305 | 97365 | 97420 | 97471 | 97536 | 97722 | 97884 |
| 97306 | 97366 | 97423 | 97473 | 97537 | 97730 | 97901 |
| 97307 | 97367 | 97424 | 97475 | 97538 | 97731 | 97902 |
| 97308 | 97368 | 97426 | 97476 | 97539 | 97732 | 97903 |
| 97309 | 97369 | 97429 | 97477 | 97540 | 97733 | 97904 |
| 97310 | 97370 | 97430 | 97478 | 97541 | 97734 | 97905 |
| 97311 | 97371 | 97431 | 97479 | 97543 | 97735 | 97906 |
| 97312 | 97373 | 97432 | 97480 | 97544 | 97736 | 97907 |
| 97314 | 97374 | 97434 | 97481 | 97601 | 97737 | 97908 |
| 97317 | 97375 | 97435 | 97484 | 97602 | 97738 | 97909 |
| 97321 | 97376 | 97436 | 97486 | 97603 | 97739 | 97910 |
| 97322 | 97377 | 97437 | 97487 | 97604 | 97741 | 97911 |
| 97324 | 97380 | 97438 | 97488 | 97620 | 97750 | 97913 |
| 97325 | 97381 | 97439 | 97489 | 97621 | 97751 | 97914 |
| 97326 | 97383 | 97440 | 97490 | 97622 | 97752 | 97917 |
| 97327 | 97384 | 97441 | 97491 | 97623 | 97753 | 97918 |
| 97329 | 97385 | 97442 | 97492 | 97624 | 97754 | 97920 |
| 97330 | 97386 | 97443 | 97493 | 97625 | 97756 |       |
| 97331 | 97388 | 97444 | 97494 | 97626 | 97758 |       |
| 97333 | 97389 | 97446 | 97495 | 97627 | 97759 |       |
| 97335 | 97390 | 97447 | 97496 | 97630 | 97760 |       |
| 97336 | 97391 | 97448 | 97497 | 97632 | 97761 |       |
| 97338 | 97392 | 97449 | 97498 | 97633 | 97814 |       |
| 97339 | 97394 | 97450 | 97499 | 97634 | 97817 |       |
| 97341 | 97401 | 97451 | 97501 | 97635 | 97819 |       |
| 97342 | 97402 | 97452 | 97502 | 97636 | 97820 |       |
| 97343 | 97403 | 97453 | 97503 | 97637 | 97825 |       |
| 97344 | 97404 | 97454 | 97504 | 97638 | 97830 |       |
| 97345 | 97405 | 97455 | 97520 | 97639 | 97833 |       |
| 97346 | 97406 | 97456 | 97522 | 97640 | 97834 |       |
| 97347 | 97407 | 97457 | 97523 | 97641 | 97837 |       |
| 97348 | 97408 | 97458 | 97524 | 97701 | 97840 |       |



## Your Guide

# To AARP Medicare Supplement and Medicare Select Insurance Plans

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To help you choose the AARP Medicare Supplement or Medicare Select Plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), to best meet your needs and budget, be sure to look at the information shown in this Guide and the other documents that show the expenses that Medicare pays, the benefits each Plan pays and the costs you will have to pay yourself. Also, be sure to review the Monthly Premium information. **Benefits and cost vary depending upon the Plan selected.**

## Eligibility to Apply

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**Please note that you must be an AARP member in order to purchase and continue to be enrolled in an AARP Medicare Supplement Plan. AARP membership is available for \$20.00 a year.** You are eligible to apply if you are an AARP member age 50 or older or an AARP member's spouse or Domestic Partner of any age, enrolled in both Part A and Part B of Medicare, and not duplicating any Medicare Supplement coverage. (If you are age 50-64 or an AARP member's spouse or Domestic Partner under the age of 65 and are eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD), you must either apply within 6 months after enrolling in Medicare Part B, unless you are entitled to guaranteed issue of a Medicare Supplement plan as shown under the following "Guaranteed Acceptance" section, or during your annual Birthday Enrollment Period and be replacing a Medicare Supplement plan with a Medicare Supplement plan that has equal or lesser benefits.)

## Guaranteed Acceptance

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- Your acceptance in any plan for which you're eligible to enroll is guaranteed during your **Medicare Supplement Open Enrollment Period** which lasts for 6 months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B. (If your initial enrollment in Part B is before age 65, you have a second 6 month Open Enrollment period beginning the month you turn 65.)
- Your acceptance in any plan for which you're eligible to enroll is guaranteed if you are eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD), you are not currently enrolled in a Medicare Supplement Plan, and you are applying for an AARP Medicare Supplement Plan within 63 days after establishing residency in Oregon when moving from a state where Medicare Supplement Plans were not available to persons under age 65. For this situation, you must submit proof of your new Oregon address and proof of your old address (P.O. Box/PMB is not allowed).
- **There is also an annual Birthday Enrollment Period** that runs during the 30 days prior to and the 30 days after your birthday when you can replace a Medicare Supplement plan with a Medicare Supplement plan that has equal or lesser benefits as follows:
  - If you **enrolled in Medicare Part A before 1/1/2020** and the previous Plan you had was an AARP Medicare Supplement Plan, you may apply for Plan A, B, C, F, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N that has equal or lesser benefits than your current Plan without having to answer health questions. If the previous Plan you had was with another carrier, you may apply for Plan A, B, C, F, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N which has equal or lesser benefits than your prior Medicare Supplement plan without having to answer health questions. If you choose to apply for a Plan that has more benefits than your previous Plan, you may have to answer health questions. **If you are replacing a Medicare Supplement plan from another Insurer, please provide proof of the plan being replaced.**
  - If you **enrolled in Medicare Part A on or after 1/1/2020** and the previous Plan you had was an AARP Medicare Supplement Plan, you may apply for Plan A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N that has equal or lesser benefits than your current Plan without having to answer health questions. If the previous Plan you had was with another carrier, you may apply for Plan A, B, G, K, L, N or, if available in your area, Medicare Select G or Medicare Select N which has equal or lesser benefits than your prior Medicare Supplement plan without having to answer health questions. If you choose to apply for a Plan that has more benefits than your previous Plan, you may have to answer health questions. **If you are replacing a Medicare Supplement plan from another Insurer, please provide proof of the plan being replaced.**

- Also, you may have a guaranteed issue right to enroll in a Medicare Supplement plan in certain situations. Some examples:
  - you have a specific type of health insurance coverage that changes in some way, such as a loss of the health insurance coverage, or
  - you enrolled with a “trial right” to try a Medicare Advantage Plan but change your mind and want to switch back to a Medicare Supplement plan during the trial period.

**If you have a guaranteed issue right, you must provide proof of your prior plan if you are replacing coverage, or provide a copy of the notice, disenrollment letter or other documentation you received if you lost or are losing coverage. Your Application Form must be received no more than 63 days after the termination date of your prior coverage. The documentation should include the type of coverage being lost or replaced, the termination reason, the termination date and the name of the person(s) who lost, is losing, or is replacing coverage.**

If you have questions about guaranteed issue rights, please see *The Guide to Health Insurance for People with Medicare*, which can be found at [www.Medicare.gov/publications](http://www.Medicare.gov/publications). You may also want to contact the administrator of your prior health insurance plan or your local state department on aging.

## Additional Information

### Exclusions

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- Benefits provided under Medicare.
- Care not meeting Medicare’s standards.
- Injury or sickness payable by Workers’ Compensation or similar laws.
- Stays or treatment provided by a government-owned or -operated hospital or facility unless payment of charges is required by law.
- Stays, care, or visits for which no charge would be made to you in the absence of insurance.
- For AARP Medicare Select Plans – Stays, care or services provided by a non-network hospital, except for the situations outlined in numbers 1 through 3 under the following Medicare Select Provider Restrictions Section.
- Any stay which begins, or medical expenses you incur, during the first 3 months after your effective date will not be considered if due to a pre-existing condition. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within 3 months prior to your plan’s effective date.

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

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

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

## Medicare Select Disclosure Statement – If You Are Applying for an AARP Medicare Select Plan

Please read this information carefully. The following information is provided in order to make a full and fair disclosure to you of the provisions, restrictions, and limitations of the AARP Medicare Select Plan.

### Medicare Select Provider Restrictions

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**In order for benefits to be payable under this insurance plan, you must use one of the select hospitals located throughout the United States, unless:**

- (1) there is a Medical Emergency;
- (2) covered services are not available from any select hospital in the Service Area; or
- (3) covered services are received from a Medicare-approved non-select hospital more than 100 miles from your Primary Residence.

In the case of (3) above, the following benefits may be payable subject to the terms and conditions of this plan:

- 75% of the Part A Medicare Inpatient Hospital Deductible amount per Benefit Period; and
- 75% of the Part A Medicare Eligible Expenses not paid by Medicare.

**Only certain hospitals are network providers under this policy. 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 the time of hospitalization or you will be required to pay for all expenses.**

## Right to Replace Your Medicare Select Plan

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You have the right to replace your AARP Medicare Select Plan with any other AARP Medicare Supplement Plan, insured by UnitedHealthcare, that has the same or lesser benefits as your current insurance and which does not require the use of participating providers, without providing evidence of insurability.

## Quality Assurance

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Participating providers are required to maintain a quality assurance program conforming with nationally recognized quality of care standards.

# For Your Protection, Please Be Aware of the Following:

## You Cannot Be Singled Out for Cancellation

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

## The AARP Insurance Trust

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

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

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

## General Information

By enrolling, you are agreeing to the release of Medicare claim information to UnitedHealthcare so your AARP Medicare Supplement or Medicare Select Plan claims may be processed automatically.

UnitedHealthcare accepts insurance premium payments made by the insured or a relative or legal guardian on behalf of the insured. UnitedHealthcare reserves the right to decline insurance premium payments from third parties other than a relative or legal guardian of the insured.

AARP and its affiliates are not insurers. AARP does not employ or endorse agents, brokers or producers.

**Please note that you must be an AARP member in order to purchase and continue to be enrolled in an AARP Medicare Supplement Plan. AARP membership is available for \$20.00 a year.**

The Policy Form No. GRP79171 GPS-1 (G-36000-4) is issued in the District of Columbia to the Trustees of the AARP Insurance Plan.

AARP Medicare Supplement and Medicare Select Plans have been developed in line with federal standards. **However, these plans are not connected with, or endorsed by, the U.S. Government or the federal Medicare program.**

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

These materials describe the AARP Medicare Supplement and Medicare Select Plans available in your state, but is not a contract, policy, or insurance certificate. Please read your Certificate of Insurance, upon receipt, for plan benefits, definitions, exclusions, and limitations.

# Plan Benefit Tables: Plan A

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan A Pays                        | You Pay                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|--------------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$0                                | \$1,676<br>(Part A deductible) |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0                            |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0                            |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup>               |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs                      |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0                            |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | \$0                                | Up to \$209.50 per day         |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs                      |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 3 pints                            | \$0                            |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0                            |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance   | \$0                            |

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 A** (continued)**Medicare Part B: Medical Services per Calendar Year**

| Service                                                                                                                                                                                                                                                                                   |                                                       | Medicare Pays | Plan A Pays   | You Pay                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------|---------------|---------------------------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup> | \$0           | \$0           | \$257 (Part B deductible) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20% | \$0                       |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0           | \$0           | All costs                 |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0           | All costs     | \$0                       |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>  | \$0           | \$0           | \$257 (Part B deductible) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%           | 20%           | \$0                       |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%          | \$0           | \$0                       |

**Parts A and B**

| Service                                                        |                                                                | Medicare Pays | Plan A Pays | You Pay                   |
|----------------------------------------------------------------|----------------------------------------------------------------|---------------|-------------|---------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                       |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0         | \$257 (Part B deductible) |
|                                                                | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0                       |

**Notes**

<sup>3</sup> Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Plan Benefit Tables: Plan B

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan B pays                        | You Pay                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$1,676 (Part A deductible)        | \$0                    |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0                    |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0                    |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup>       |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs              |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0                    |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | \$0                                | Up to \$209.50 per day |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs              |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 3 pints                            | \$0                    |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0                    |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance   | \$0                    |

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**

| <b>Service</b>                                                                                                                                                                                                                                                                            |                                                       | <b>Medicare Pays</b> | <b>Plan B pays</b> | <b>You Pay</b>            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------|--------------------|---------------------------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup> | \$0                  | \$0                | \$257 (Part B deductible) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80%        | Generally 20%      | \$0                       |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0                  | \$0                | All costs                 |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0                  | All costs          | \$0                       |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>  | \$0                  | \$0                | \$257 (Part B deductible) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%                  | 20%                | \$0                       |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%                 | \$0                | \$0                       |

**Parts A and B**

| <b>Service</b>                                                 |                                                                | <b>Medicare Pays</b> | <b>Plan B Pays</b> | <b>You Pay</b>            |
|----------------------------------------------------------------|----------------------------------------------------------------|----------------------|--------------------|---------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%                 | \$0                | \$0                       |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0                  | \$0                | \$257 (Part B deductible) |
|                                                                | Remainder of Medicare-approved amounts                         | 80%                  | 20%                | \$0                       |

**Notes**

<sup>3</sup> Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Plan Benefit Tables: Plan C

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                 | Plan C Pays                        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                               | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                         | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                         | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                           | 100% of Medicare eligible expenses | \$0 <sup>2</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                           | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                          | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                      | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                           | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                           | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                          | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/ co-insurance  | \$0              |

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#### Notes

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

**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**

| <b>Service</b>                                                                                                                                                                                                                                                                            |                                                       | <b>Medicare Pays</b> | <b>Plan C Pays</b>        | <b>You Pay</b>   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------|---------------------------|------------------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup> | \$0                  | \$257 (Part B deductible) | <b>\$0</b>       |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80%        | Generally 20%             | <b>\$0</b>       |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0                  | \$0                       | <b>All costs</b> |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0                  | All costs                 | <b>\$0</b>       |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>  | \$0                  | \$257 (Part B deductible) | <b>\$0</b>       |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%                  | 20%                       | <b>\$0</b>       |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%                 | \$0                       | <b>\$0</b>       |

**Parts A and B**

| <b>Service</b>                                                 |                                                                | <b>Medicare Pays</b> | <b>Plan C Pays</b>        | <b>You Pay</b> |
|----------------------------------------------------------------|----------------------------------------------------------------|----------------------|---------------------------|----------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%                 | \$0                       | <b>\$0</b>     |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0                  | \$257 (Part B deductible) | <b>\$0</b>     |
|                                                                | Remainder of Medicare-approved amounts                         | 80%                  | 20%                       | <b>\$0</b>     |

**Other Benefits not covered by Medicare**

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

**Notes**

**3** Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Plan Benefit Tables: Plan F

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                 | Plan F Pays                        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                               | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                         | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                         | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                           | 100% of Medicare eligible expenses | \$0 <sup>2</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                           | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                          | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                      | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                           | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                           | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                          | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/ co-insurance  | \$0              |

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#### Notes

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

**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 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------|---------------------------|---------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup> | \$0           | \$257 (Part B deductible) | \$0     |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20%             | \$0     |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0           | 100%                      | \$0     |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0           | All costs                 | \$0     |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>  | \$0           | \$257 (Part B deductible) | \$0     |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%           | 20%                       | \$0     |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%          | \$0                       | \$0     |

**Parts A and B**

| Service                                                        |                                                                | Medicare Pays | Plan F Pays               | You Pay |
|----------------------------------------------------------------|----------------------------------------------------------------|---------------|---------------------------|---------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0                       | \$0     |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$257 (Part B deductible) | \$0     |
|                                                                | Remainder of Medicare-approved amounts                         | 80%           | 20%                       | \$0     |

**Other Benefits not covered by Medicare**

| Service                                                                                                                                                    |                                   | Medicare Pays | Plan F Pays                                   | You Pay                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the 60 days of each trip outside the USA. | First \$250 of 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 \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Plan Benefit Tables: Plan G

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan G Pays                        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance   | \$0              |

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#### Notes

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

**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                                            |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0                                           | \$257<br>(Unless Part B deductible has been met)   |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | Generally 80% | Generally 20%                                 | \$0                                                |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                                | \$0           | 100%                                          | \$0                                                |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                                  | \$0           | All costs                                     | \$0                                                |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>           | \$0           | \$0                                           | \$257<br>(Unless Part B deductible has been met)   |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | 80%           | 20%                                           | \$0                                                |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                                  | 100%          | \$0                                           | \$0                                                |
| Parts A and B                                                                                                                                                                                                                                                                             |                                                                |               |                                               |                                                    |
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays | Plan G Pays                                   | You Pay                                            |
| <b>Home Health Care</b><br>Medicare-approved services                                                                                                                                                                                                                                     | Medically necessary skilled care services and medical supplies | 100%          | \$0                                           | \$0                                                |
| <b>Durable medical equipment</b><br>Medicare-approved services                                                                                                                                                                                                                            | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0                                           | \$257<br>(Unless Part B deductible has been met)   |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | 80%           | 20%                                           | \$0                                                |
| Other Benefits not covered by Medicare                                                                                                                                                                                                                                                    |                                                                |               |                                               |                                                    |
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays | Plan G Pays                                   | You Pay                                            |
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the 60 days of each trip outside the USA.                                                                                                                                | First \$250 of each calendar year                              | \$0           | \$0                                           | \$250                                              |
|                                                                                                                                                                                                                                                                                           | Remainder of charges                                           | \$0           | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

**Notes**

<sup>3</sup> Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

# Plan Benefit Tables: Plan K

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan K Pays                        | You Pay <sup>3</sup>                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$838 (50% of Part A deductible)   | \$838 (50% of Part A deductible)♦        |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0                                      |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0                                      |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup>                         |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs                                |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0                                      |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | Up to \$104.75 per day             | Up to \$104.75 per day♦                  |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs                                |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 50%                                | 50%♦                                     |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0                                      |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | 50% of co-payment/co-insurance     | 50% of Medicare co-payment/co-insurance♦ |

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### Notes

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

**2 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 \$7220 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

| Medicare Part B: Medical Services per Calendar Year                                                                                                                                                                                                                                       |                                                                |                                                    |                                        |                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------|
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays                                      | Plan K pays                            | You Pay <sup>4</sup>                                                                       |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>5</sup>          | \$0                                                | \$0                                    | \$257 (Part B deductible) <sup>5</sup> ♦                                                   |
|                                                                                                                                                                                                                                                                                           | Preventive Benefits for Medicare covered services              | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts                                                  |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | Generally 80%                                      | Generally 10%                          | Generally 10% ♦                                                                            |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                                | \$0                                                | \$0                                    | All costs (and they do not count toward annual out-of-pocket limit of \$7220) <sup>4</sup> |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                                  | \$0                                                | 50%                                    | 50% ♦                                                                                      |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>5</sup>           | \$0                                                | \$0                                    | \$257 (Part B deductible) <sup>5</sup> ♦                                                   |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | 80%                                                | Generally 10%                          | Generally 10% ♦                                                                            |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                                  | 100%                                               | \$0                                    | \$0                                                                                        |
| Parts A and B                                                                                                                                                                                                                                                                             |                                                                |                                                    |                                        |                                                                                            |
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays                                      | Plan K Pays                            | You Pay <sup>4</sup>                                                                       |
| <b>Home Health Care</b><br>Medicare-approved services                                                                                                                                                                                                                                     | Medically necessary skilled care services and medical supplies | 100%                                               | \$0                                    | \$0                                                                                        |

Continued on next page **Notes**

**4** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$7220 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 \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

| Parts A and B                                           |                                                       |               |             |                               |
|---------------------------------------------------------|-------------------------------------------------------|---------------|-------------|-------------------------------|
| Service                                                 |                                                       | Medicare Pays | Plan K Pays | You Pay <sup>4</sup>          |
| Durable medical equipment<br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>6</sup> | \$0           | \$0         | \$257<br>(Part B deductible)♦ |
|                                                         | Remainder of Medicare-approved amounts                | 80%           | 10%         | 10%♦                          |

**Notes**

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



## Plan Benefit Tables: Plan L

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan L Pays                        | You Pay <sup>3</sup>                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$1,257 (75% of Part A deductible) | \$419 (25% of Part A deductible)♦        |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0                                      |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0                                      |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup>                         |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs                                |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0                                      |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | Up to \$157.13 per day             | Up to \$52.37 per day♦                   |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs                                |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 75%                                | 25%♦                                     |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0                                      |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | 75% of co-payment/co-insurance     | 25% of Medicare co-payment/co-insurance♦ |

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#### Notes

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

**2 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 \$3610 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

| Medicare Part B: Medical Services per Calendar Year                                                                                                                                                                                                                                       |                                                                |                                                    |                                        |                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------|
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays                                      | Plan L Pays                            | You Pay <sup>4</sup>                                                                       |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>5</sup>          | \$0                                                | \$0                                    | \$257 (Part B deductible) <sup>5</sup> ♦                                                   |
|                                                                                                                                                                                                                                                                                           | Preventive Benefits for Medicare covered services              | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts                                                  |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | Generally 80%                                      | Generally 15%                          | Generally 5% ♦                                                                             |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                                | \$0                                                | \$0                                    | All costs (and they do not count toward annual out-of-pocket limit of \$3610) <sup>4</sup> |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                                  | \$0                                                | 75%                                    | 25% ♦                                                                                      |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>5</sup>           | \$0                                                | \$0                                    | \$257 (Part B deductible) <sup>5</sup> ♦                                                   |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | 80%                                                | Generally 15%                          | Generally 5% ♦                                                                             |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                                  | 100%                                               | \$0                                    | \$0                                                                                        |
| Parts A and B                                                                                                                                                                                                                                                                             |                                                                |                                                    |                                        |                                                                                            |
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays                                      | Plan L Pays                            | You Pay <sup>4</sup>                                                                       |
| <b>Home Health Care</b><br>Medicare-approved services                                                                                                                                                                                                                                     | Medically necessary skilled care services and medical supplies | 100%                                               | \$0                                    | \$0                                                                                        |

Continued on next page **Notes**

**4** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$3610 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 \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

| Parts A and B                                           |                                                             |               |             |                                  |
|---------------------------------------------------------|-------------------------------------------------------------|---------------|-------------|----------------------------------|
| Service                                                 |                                                             | Medicare Pays | Plan L Pays | You Pay <sup>4</sup>             |
| Durable medical equipment<br>Medicare-approved services | First \$257 of<br>Medicare-approved<br>amounts <sup>6</sup> | \$0           | \$0         | \$257<br>(Part B<br>deductible)♦ |
|                                                         | Remainder of<br>Medicare-approved<br>amounts                | 80%           | 15%         | 5%♦                              |

**Notes**

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



## Plan Benefit Tables: Plan N

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Plan N Pays                        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                                                             | First 60 days                                                | All but \$1,676                                                                              | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>2</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance   | \$0              |

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#### Notes

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

**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                                                                                                                                                                                                          |
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0                                                                                                                                                                                                                                  | \$257 (Part B deductible)                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | Generally 80% | Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                                | \$0           | \$0                                                                                                                                                                                                                                  | All costs                                                                                                                                                                                                        |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                                  | \$0           | All costs                                                                                                                                                                                                                            | \$0                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>3</sup>           | \$0           | \$0                                                                                                                                                                                                                                  | \$257 (Part B deductible)                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                         | 80%           | 20%                                                                                                                                                                                                                                  | \$0                                                                                                                                                                                                              |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                                  | 100%          | \$0                                                                                                                                                                                                                                  | \$0                                                                                                                                                                                                              |
| Parts A and B                                                                                                                                                                                                                                                                             |                                                                |               |                                                                                                                                                                                                                                      |                                                                                                                                                                                                                  |
| Service                                                                                                                                                                                                                                                                                   |                                                                | Medicare Pays | Plan N Pays                                                                                                                                                                                                                          | You Pay                                                                                                                                                                                                          |
| <b>Home Health Care</b><br>Medicare-approved services                                                                                                                                                                                                                                     | Medically necessary skilled care services and medical supplies | 100%          | \$0                                                                                                                                                                                                                                  | \$0                                                                                                                                                                                                              |

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**Notes**

**3** Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

| Parts A and B, continued                                                                                                                                   |                                                       |               |                                               |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------|-----------------------------------------------|-----------------------------------------------------------|
| Service                                                                                                                                                    |                                                       | Medicare Pays | Plan N Pays                                   | You Pay                                                   |
| <b>Durable medical equipment</b><br>Medicare-approved services                                                                                             | First \$257 of Medicare-approved amounts <sup>3</sup> | \$0           | \$0                                           | <b>\$257</b><br>(Part B deductible)                       |
|                                                                                                                                                            | Remainder of Medicare-approved amounts                | 80%           | 20%                                           | <b>\$0</b>                                                |
| Other Benefits not covered by Medicare                                                                                                                     |                                                       |               |                                               |                                                           |
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the 60 days of each trip outside the USA. | First \$250 of each calendar year                     | \$0           | \$0                                           | <b>\$250</b>                                              |
|                                                                                                                                                            | Remainder of charges                                  | \$0           | 80% to a lifetime maximum benefit of \$50,000 | <b>20% and amounts over the \$50,000 lifetime maximum</b> |

**Notes**

**3** Once you have been billed \$257 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 G

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                | Medicare Select Plan G Pays        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup> in a Participating Hospital<sup>2</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                     | First 60 days                                                | All but \$1,676                                                                              | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                        | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                        | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                          | 100% of Medicare eligible expenses | \$0 <sup>3</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                          | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                         | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                     | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                          | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                          | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                         | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance   | \$0              |

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#### Notes

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

**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 G** (continued)**Medicare Part B: Medical Services per Calendar Year**

| <b>Service</b>                                                                                                                                                                                                                                                                            |                                                       | <b>Medicare Pays</b> | <b>Medicare Select Plan G Pays</b> | <b>You Pay</b>                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------|------------------------------------|--------------------------------------------------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>4</sup> | \$0                  | \$0                                | \$257<br>(Unless Part B deductible has been met) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80%        | Generally 20%                      | \$0                                              |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0                  | 100%                               | \$0                                              |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0                  | All costs                          | \$0                                              |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>4</sup>  | \$0                  | \$0                                | \$257<br>(Unless Part B deductible has been met) |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%                  | 20%                                | \$0                                              |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%                 | \$0                                | \$0                                              |

**Parts A and B**

| <b>Service</b>                                                 |                                                                | <b>Medicare Pays</b> | <b>Medicare Select Plan G Pays</b> | <b>You Pay</b>                                   |
|----------------------------------------------------------------|----------------------------------------------------------------|----------------------|------------------------------------|--------------------------------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%                 | \$0                                | \$0                                              |
| <b>Durable medical equipment</b><br>Medicare-approved services | First \$257 of Medicare-approved amounts <sup>4</sup>          | \$0                  | \$0                                | \$257<br>(Unless Part B deductible has been met) |
|                                                                | Remainder of Medicare-approved amounts                         | 80%                  | 20%                                | \$0                                              |

Continued on next page **Notes**

**4** Once you have been billed \$257 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 G (continued)

| Other Benefits not covered by Medicare                                                                                                              |                                   |               |                                               |                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| Service                                                                                                                                             |                                   | Medicare Pays | Medicare Select Plan G Pays                   | You Pay                                            |
| Foreign Travel<br>NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the 60 days of each trip outside the USA. | First \$250 of 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 N

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

| Service                                                                                                                                                                                                                                |                                                              | Medicare Pays                                                                                 | Medicare Select Plan N Pays        | You Pay          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>1</sup> in a Participating Hospital<sup>2</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies.                                                                     | First 60 days                                                | All but \$1,676                                                                               | \$1,676 (Part A deductible)        | \$0              |
|                                                                                                                                                                                                                                        | Days 61-90                                                   | All but \$419 per day                                                                         | \$419 per day                      | \$0              |
|                                                                                                                                                                                                                                        | Days 91 and later while using 60 lifetime reserve days       | All but \$838 per day                                                                         | \$838 per day                      | \$0              |
|                                                                                                                                                                                                                                        | After lifetime reserve days are used, an additional 365 days | \$0                                                                                           | 100% of Medicare eligible expenses | \$0 <sup>3</sup> |
|                                                                                                                                                                                                                                        | Beyond the additional 365 days                               | \$0                                                                                           | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | First 20 days                                                | All approved amounts                                                                          | \$0                                | \$0              |
|                                                                                                                                                                                                                                        | Days 21-100                                                  | All but \$209.50 per day                                                                      | Up to \$209.50 per day             | \$0              |
|                                                                                                                                                                                                                                        | Days 101 and later                                           | \$0                                                                                           | \$0                                | All costs        |
| <b>Blood</b>                                                                                                                                                                                                                           | First 3 pints                                                | \$0                                                                                           | 3 pints                            | \$0              |
|                                                                                                                                                                                                                                        | Additional amounts                                           | 100%                                                                                          | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.                                                                    |                                                              | All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/ co-insurance  | \$0              |

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#### Notes

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

**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 N** (continued)**Medicare Part B: Medical Services per Calendar Year**

| <b>Service</b>                                                                                                                                                                                                                                                                            |                                                       | <b>Medicare Pays</b> | <b>Medicare Select Plan N Pays</b>                                                                                                                                                                                                   | <b>You Pay</b>                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medical Expenses</b><br>INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | First \$257 of Medicare-approved amounts <sup>4</sup> | \$0                  | \$0                                                                                                                                                                                                                                  | <b>\$257</b><br>(Part B deductible)                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | Generally 80%        | Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| <b>Part B Excess Charges</b><br>Above Medicare-approved amounts                                                                                                                                                                                                                           |                                                       | \$0                  | \$0                                                                                                                                                                                                                                  | All costs                                                                                                                                                                                                        |
| <b>Blood</b>                                                                                                                                                                                                                                                                              | First 3 pints                                         | \$0                  | All costs                                                                                                                                                                                                                            | <b>\$0</b>                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                           | Next \$257 of Medicare-approved amounts <sup>4</sup>  | \$0                  | \$0                                                                                                                                                                                                                                  | <b>\$257</b><br>(Part B deductible)                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                           | Remainder of Medicare-approved amounts                | 80%                  | 20%                                                                                                                                                                                                                                  | <b>\$0</b>                                                                                                                                                                                                       |
| <b>Clinical Laboratory Services</b>                                                                                                                                                                                                                                                       | Tests for diagnostic services                         | 100%                 | \$0                                                                                                                                                                                                                                  | <b>\$0</b>                                                                                                                                                                                                       |

Continued on next page **Notes**

**4** Once you have been billed \$257 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 N** (continued)**Parts A and B**

| <b>Service</b>                                                                                                                                             |                                                                | <b>Medicare Pays</b> | <b>Medicare Select Plan N Pays</b>            | <b>You Pay</b>                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------|-----------------------------------------------|----------------------------------------------------|
| <b>Home Health Care</b><br>Medicare-approved services                                                                                                      | Medically necessary skilled care services and medical supplies | 100%                 | \$0                                           | \$0                                                |
| <b>Durable medical equipment</b><br>Medicare-approved services                                                                                             | First \$257 of Medicare-approved amounts <sup>4</sup>          | \$0                  | \$0                                           | \$257 (Part B deductible)                          |
|                                                                                                                                                            | Remainder of Medicare-approved amounts                         | 80%                  | 20%                                           | \$0                                                |
| <b>Other Benefits not covered by Medicare</b>                                                                                                              |                                                                |                      |                                               |                                                    |
| <b>Foreign Travel</b><br>NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the 60 days of each trip outside the USA. | First \$250 of 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**

**4** Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.



## 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.

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### 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.

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### Disclosures

Use the *Overview of Available Plans*, the *Plan Benefit Tables* and *Cover Page - Rates* to compare benefits and premiums among plans.

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### Read your certificate very carefully

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

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### Your right to return the certificate

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

UNITEDHEALTHCARE  
PO BOX 9003  
HUNTINGDON VALLEY PA 19006-9998

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your premium payments. However, UnitedHealthcare has the right to recover any claims paid during that period. Any premium refund otherwise due to you will be reduced by the amount of any claims paid during this period. If you have received claims payment in excess of the amount of your premium, no refund of premium will be made.

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### Policy replacement

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

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### Notice

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

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### Complete answers are very important

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

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### 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 at 1-800-523-5880 or write to us at:

UNITEDHEALTHCARE  
PO BOX 1891  
SOUTHAMPTON PA 18966-9998

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  
PO BOX 1891  
SOUTHAMPTON PA 18966-9998

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.



# Oregon Resident Directory

## Participating Hospitals - Effective April 2024 For AARP® Medicare Select Plans

### Oregon

#### Lane County

PeaceHealth Cottage Grove  
Community Hospital\*  
1515 Village Drive  
Cottage Grove, OR 97424  
(541) 767-5500

PeaceHealth Peace Harbor  
Hospital\*  
400 9th Street  
Florence, OR 97439  
(541) 997-8412

PeaceHealth Sacred Heart  
Medical Center at Riverbend\*  
3333 Riverbend Drive  
Springfield, OR 97477  
(541) 222-7300

#### Marion County

Santiam Hospital\*  
1401 North Tenth Avenue  
Stayton, OR 97383  
(503) 406-9451

#### Multnomah County

Legacy Emanuel Medical Center  
2801 North Gantenbein Avenue  
Portland, OR 97227  
(503) 413-2200

Legacy Good Samaritan  
Medical Center  
1015 NW 22nd Avenue  
Portland, OR 97210  
(503) 413-7711

#### Multnomah County

*(Continued)*

Legacy Mount Hood  
Medical Center  
24800 SE Stark Street  
Gresham, OR 97030  
(503) 667-1122

#### Umatilla County

Good Shepherd Medical Center  
610 NW 11th Street  
Hermiston, OR 97838  
(541) 667-3400

#### Washington County

Legacy Meridian Park Hospital  
19300 SW 65th Avenue  
Tualatin, OR 97062  
(503) 692-1212

### Washington

#### Benton County

Trios Women's and Children's  
Hospital  
900 South Auburn Street  
Kennewick, WA 99336  
(509) 221-7000

Prosser Memorial Hospital  
723 Memorial Street  
Prosser, WA 99350  
(509) 786-2222

#### Clark County

Legacy Salmon Creek Hospital  
2211 NE 139th Street  
Vancouver, WA 98686  
(360) 487-1000

PeaceHealth Southwest Medical  
Center\*  
400 NE Mother Joseph Place  
Vancouver, WA 98664  
(360) 514-2000

#### Cowlitz County

PeaceHealth Saint John Medical  
Center\*  
1615 Delaware Street  
Longview, WA 98632  
(360) 414-2000

#### Franklin County

Lourdes Medical Center\*\*  
520 North Fourth Avenue  
Pasco, WA 99301  
(509) 547-7704

\*This hospital was contracted by USA Managed Care Organization and leased by UnitedHealthcare for inclusion in the AARP Medicare Select Network.

\*\*This hospital was contracted by AmeriPlus and leased by UnitedHealthcare for inclusion in the AARP Medicare Select Network.

## Washington (Continued)

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### Klickitat County

Skyline Hospital  
211 NE Skyline Drive  
White Salmon, WA 98672  
(509) 493-1101

### Pacific County

Willapa Harbor Hospital  
800 Alder Street  
South Bend, WA 98586  
(360) 875-5526



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Participating Hospitals listed in this directory are subject to change. For health systems with multiple hospitals, all locations may not participate. Check with your doctor to make sure he or she has admitting privileges at a network hospital. Prior to scheduling any inpatient hospital service, it is recommended you call UnitedHealthcare Customer Service at 1-800-523-5800, TTY 711, weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 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.

Network changes will be communicated annually to insureds impacted by hospitals who no longer participate. Coverage will remain until insured is notified in writing.

**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.**

# For AARP® Medicare Select Plans Only

## Oregon - Effective October 2023

Medicare Select Plans are available to individuals in the following zip code areas:

|       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 97002 | 97035 | 97077 | 97129 | 97219 | 97280 | 97325 | 97371 | 97420 | 97462 | 97827 |
| 97003 | 97036 | 97078 | 97132 | 97220 | 97281 | 97326 | 97373 | 97423 | 97463 | 97835 |
| 97004 | 97037 | 97079 | 97133 | 97221 | 97282 | 97327 | 97374 | 97424 | 97467 | 97836 |
| 97005 | 97038 | 97080 | 97137 | 97222 | 97283 | 97329 | 97375 | 97426 | 97470 | 97838 |
| 97006 | 97039 | 97086 | 97138 | 97223 | 97286 | 97330 | 97376 | 97429 | 97471 | 97839 |
| 97007 | 97040 | 97089 | 97140 | 97224 | 97290 | 97331 | 97377 | 97430 | 97473 | 97841 |
| 97008 | 97041 | 97101 | 97141 | 97225 | 97291 | 97333 | 97378 | 97431 | 97475 | 97843 |
| 97009 | 97042 | 97102 | 97143 | 97227 | 97292 | 97335 | 97380 | 97432 | 97477 | 97844 |
| 97010 | 97044 | 97103 | 97144 | 97228 | 97293 | 97336 | 97381 | 97434 | 97478 | 97850 |
| 97011 | 97045 | 97106 | 97145 | 97229 | 97294 | 97338 | 97383 | 97435 | 97479 | 97859 |
| 97013 | 97048 | 97107 | 97146 | 97230 | 97296 | 97339 | 97384 | 97436 | 97480 | 97861 |
| 97014 | 97049 | 97108 | 97148 | 97231 | 97298 | 97341 | 97385 | 97437 | 97481 | 97862 |
| 97015 | 97050 | 97109 | 97201 | 97232 | 97301 | 97343 | 97386 | 97438 | 97486 | 97868 |
| 97016 | 97051 | 97110 | 97202 | 97233 | 97302 | 97344 | 97389 | 97439 | 97487 | 97875 |
| 97017 | 97053 | 97111 | 97203 | 97236 | 97303 | 97345 | 97390 | 97440 | 97488 | 97876 |
| 97018 | 97054 | 97112 | 97204 | 97238 | 97304 | 97346 | 97391 | 97441 | 97489 | 97880 |
| 97019 | 97055 | 97113 | 97205 | 97239 | 97305 | 97347 | 97392 | 97443 | 97490 | 97882 |
| 97020 | 97056 | 97114 | 97206 | 97240 | 97306 | 97348 | 97394 | 97446 | 97492 | 97885 |
| 97021 | 97058 | 97115 | 97207 | 97242 | 97307 | 97351 | 97396 | 97447 | 97493 | 97886 |
| 97022 | 97060 | 97116 | 97208 | 97250 | 97308 | 97352 | 97401 | 97448 | 97494 |       |
| 97023 | 97062 | 97117 | 97209 | 97251 | 97309 | 97355 | 97402 | 97449 | 97495 |       |
| 97024 | 97063 | 97118 | 97210 | 97252 | 97310 | 97357 | 97403 | 97451 | 97496 |       |
| 97026 | 97064 | 97119 | 97211 | 97253 | 97311 | 97358 | 97404 | 97452 | 97498 |       |
| 97027 | 97065 | 97121 | 97212 | 97254 | 97312 | 97360 | 97405 | 97453 | 97499 |       |
| 97028 | 97067 | 97122 | 97213 | 97256 | 97313 | 97361 | 97407 | 97454 | 97801 |       |
| 97029 | 97068 | 97123 | 97214 | 97258 | 97314 | 97362 | 97408 | 97455 | 97810 |       |
| 97030 | 97070 | 97124 | 97215 | 97266 | 97317 | 97365 | 97409 | 97456 | 97812 |       |
| 97031 | 97071 | 97125 | 97216 | 97267 | 97321 | 97366 | 97412 | 97457 | 97813 |       |
| 97032 | 97075 | 97127 | 97217 | 97268 | 97322 | 97369 | 97413 | 97459 | 97818 |       |
| 97034 | 97076 | 97128 | 97218 | 97269 | 97324 | 97370 | 97419 | 97461 | 97826 |       |



# Application Form

## AARP® Medicare Supplement Insurance Plans

Insured by UnitedHealthcare Insurance Company  
(UnitedHealthcare), Hartford, CT 06103

### Instructions

1. Please note that you must be an AARP member or an AARP member's spouse or Domestic Partner of any age in order to purchase and continue to be enrolled in an AARP Medicare Supplement Plan. AARP membership is available for \$20.00 a year.
2. Fill in all requested information on this Application Form and sign in all places a signature is needed.
3. Print clearly, using CAPITAL letters AND black or blue ink - not pencil. *Example:* ☒ Yes ☐ No ☐ Not Sure
4. Initial any changes or corrections you make while completing this Application Form.

**Note:** Plans and rates are only good for residents of the state of Oregon. The information you provide on this Application Form will be used to determine your acceptance and rate.

**AARP Membership Number** (If you are already a member) \_\_\_\_\_

Applicant First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Permanent Home Address Line 1 (P.O. Box/PMB is not allowed) \_\_\_\_\_

Permanent Home Address Line 2 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address Line 1 (if different from permanent address) \_\_\_\_\_

Mailing Address Line 2 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 1 Provide additional information about yourself and your Medicare Insurance.

( \_\_\_\_\_ ) - \_\_\_\_\_

**1A.** Phone Number \_\_\_\_\_

**1B.** Email address (optional). Include periods (.) and symbols (@). \_\_\_\_\_

By providing your address, phone number and/or email address, you are agreeing to receive information and be contacted by UnitedHealthcare.

**1C.** Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **1D.** Gender ☐ Male ☐ Female  
Month Day Year

**1E.** Medicare Number \_\_\_\_\_ (From your Medicare card.)

**1F.** Medicare Start: Hospital (Part A) \_\_\_\_\_ / 01 / \_\_\_\_\_ Medical (Part B) \_\_\_\_\_ / 01 / \_\_\_\_\_  
Month Year Month Year

**1G.** Will your Medicare Part A and Part B be active on your AARP Medicare Supplement Plan start date? ☐ Yes ☐ No

2460720307 \_AGT



## 2 Choose your Plan and start date.

### Plan Choice

**2A.** You are eligible to apply if all of these are true:

• **you are an AARP member age 50 or older or an AARP member's spouse or Domestic Partner of any age. (AARP membership is available for \$20.00 a year),**

- you are enrolled in Medicare Parts A and B,
- you are not enrolled in more than one Medicare supplement plan at the same time,

**Note:** If you are an AARP member age 50-64 or an AARP member's spouse or Domestic Partner under the age of 65 and you are eligible for Medicare by reason of disability or End-Stage Renal Disease (ESRD), you must apply:

- **(1)** within 6 months after enrolling in Medicare Part B, (unless you are entitled to guaranteed issue as shown in the "Guaranteed Acceptance" section in "Your Guide;") **OR;**
- **(2)** within 63 days after establishing residency in Oregon when you moved from a state where Medicare Supplement Plans were not available to persons under age 65 and you are not currently enrolled in a Medicare Supplement Plan. For this situation, you must submit proof of your new Oregon address and proof of your old address (P.O. Box/PMB is not allowed) **OR;**
- **(3)** during your annual Birthday Enrollment Period that runs during the 30 days prior to and the 30 days after your birthday. For this situation, you must replace a Medicare supplement plan with a Medicare supplement plan that has equal or lesser benefits as shown in the "Guaranteed Acceptance" section in "Your Guide."

**Please choose 1 Plan from the right-hand column. Important: Plans C and F are only available to eligible Applicants who first became eligible for Medicare before January 1, 2020 based on age, disability or End-Stage Renal Disease (ESRD). Please call if you have questions.**

- |                                                 |                                 |
|-------------------------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A                 | <input type="checkbox"/> Plan B |
| <input type="checkbox"/> Plan C                 |                                 |
| <input type="checkbox"/> Plan F                 | <input type="checkbox"/> Plan G |
| <input type="checkbox"/> Plan K                 | <input type="checkbox"/> Plan L |
|                                                 | <input type="checkbox"/> Plan N |
| <input type="checkbox"/> Medicare Select Plan G |                                 |
| <input type="checkbox"/> Medicare Select Plan N |                                 |

### Plan Start Date

**2B.** Your Plan will start on the first day of the month following receipt and approval of this Application Form and receipt of your first month's payment. If you would like your Plan to start on a later date (the first day of a future month), please indicate the date:

/ 01 /  
 \_\_\_\_\_  
 Month      Day      Year

## 3 Is your acceptance guaranteed?

**3A.** Will your AARP Medicare Supplement Plan start date be within 6 months after you turn age 65 or enroll in Medicare Part B?

☐ Yes    ☐ No

- If **YES**, your acceptance is guaranteed. Go directly to **Section 7**. You do not have to answer the questions in **Sections 4, 5 and 6**.
- If **NO**, you must answer **Question 3B**.

**3B.** Are you eligible for Medicare by reason of disability or End-Stage Renal Disease and you are not currently enrolled in a Medicare Supplement Plan and you are applying for an AARP Medicare Supplement Plan within 63 days after establishing residency in Oregon when you moved from a state where Medicare Supplement Plans were not available to persons under age 65?

☐ Yes    ☐ No

For this situation, you must submit proof of your new Oregon address and proof of your old address (P.O. Box/PMB is not allowed).

- If **YES**, your acceptance is guaranteed. Go directly to **Section 7**. You do not have to answer the questions in **Sections 4, 5 and 6**.
- If **NO**, you must answer **Question 3C**.



First Name

Last Name

### 3 Is your acceptance guaranteed? (continued)

**3C.** Are you enrolling during your annual Birthday Enrollment Period that runs during the 30 days prior to and the 30 days after your birthday **AND** are you replacing a Medicare supplement plan with a Medicare supplement plan that has equal or lesser benefits? See "Your Guide" for more information.

☐ Yes ☐ No

- If **YES**, your acceptance is guaranteed. Go directly to **Section 7**. You do not have to answer the questions in **Sections 4, 5 and 6**.
- If **NO**, you must answer **Question 3D**.

**3D.** Have you lost or are losing health insurance coverage or do you have a Medicare Advantage Plan "trial right" and, if so, have you received a notice from your employer or prior insurer saying that you are eligible for guaranteed issue of a Medicare supplement plan?

☐ Yes ☐ No

**If you have a guaranteed issue right, you must provide a copy of the notice, disenrollment letter or other documentation you received AND your Application Form must be received no more than 63 days after the termination date of your prior coverage. The documentation should include the type of coverage being lost, the termination reason, the termination date and the name of the person(s) who lost or is losing coverage.**

If you have questions about guaranteed issue rights, please see "Your Guide."

- If **YES**, skip directly to **Section 7**.
- If you answered **NO** to all of the questions in **Section 3** and you are:
  - **age 65 or over**, continue to **Section 4**.
  - **age 50-64 or an AARP member's spouse or Domestic Partner under age 65 and you are eligible for Medicare by reason of disability or ESRD**, you are **NOT** eligible to apply.

**Answer the health questions in Sections 4-6 ONLY if your acceptance is not guaranteed as defined in Section 3.**

### 4 Tell us about your medical providers.

**Provide the following information for all physicians that you have seen within the past 2 years. We may follow up with your physicians for additional information and verification of your health history. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it.** ☐

Primary Physician ( ) -  
Phone #

Specialist Name Specialty ( ) -  
Phone #

Diagnosis/Condition

Specialist Name Specialty ( ) -  
Phone #

Diagnosis/Condition



First Name

Last Name

**5**

**Answer this health question.** If you answer YES or NOT SURE, we may follow up for additional information.

**5A.** Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys other than kidney stones?

☐ Yes ☐ No ☐ Not Sure

**6**

**Answer these health questions.** If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information.

**6A.** Were you hospitalized as an inpatient (not including overnight Outpatient observation)

- within the past 90 days or
- 3 or more times within the past 2 years?

☐ Yes ☐ No ☐ Not Sure

**6B.** Are you confined to a bed, receiving home health care, or currently being treated or living in any type of nursing facility other than an assisted living facility?

☐ Yes ☐ No ☐ Not Sure

**6C.** Within the past 2 years, did you receive IV infusions or injections for Primary Immunodeficiency Syndrome?

☐ Yes ☐ No ☐ Not Sure

**6D.** Has a medical professional ever told you that you have End-Stage Renal (Kidney) Disease (ESRD) or that you may or will require dialysis?

☐ Yes ☐ No ☐ Not Sure

**6E.** Within the past 5 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for:

- Leukemia, Lymphoma or Multiple Myeloma?

☐ Yes ☐ No ☐ Not Sure

**6F.** Within the past 3 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for:

- Cancer (other than Leukemia, Lymphoma, or Multiple Myeloma)
- Melanoma or Metastatic Merkel Cell (but not other skin cancers)?

☐ Yes ☐ No ☐ Not Sure

**6G.** Within the past year, did a medical professional tell you that you may need any of the following that **has NOT been completed**:

- Any surgery, biopsy, further evaluation, treatment, or diagnostic testing?

☐ Yes ☐ No ☐ Not Sure

**6H.** Are you awaiting any diagnostic test results?

☐ Yes ☐ No ☐ Not Sure

**6I.** Within the past 5 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?

- Pulmonary Heart Disease, Heart Failure, Ventricular Tachycardia, or a cardiac defibrillator
- Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems
- Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD)
- Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)
- Alzheimer's Disease, Dementia, or Parkinson's Disease
- Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant

☐ Yes ☐ No ☐ Not Sure

☐ Yes ☐ No ☐ Not Sure

☐ Yes ☐ No ☐ Not Sure

☐ Yes ☐ No ☐ Not Sure

☐ Yes ☐ No ☐ Not Sure

☐ Yes ☐ No ☐ Not Sure



First Name

Last Name

**6**

**Answer these health questions.** If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information. (continued)

**6J.** Within the past 2 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?

- |                                                                                                                                                              |                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| • Artery blockage, or had bypass surgery, stents, or balloon angioplasty                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Heart Attack, Cardiomyopathy, an Enlarged Heart, or Atrial Fibrillation                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Carotid Artery Disease, Stroke, Transient Ischemic Attack (TIA), or Mini-Stroke                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Peripheral Vascular Disease (PVD) or Amputation due to disease                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Cystic Fibrosis                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Any lung or respiratory disorder:<br>- requiring the use of a nebulizer or oxygen,<br>- on 3 or more medications, or<br>- currently using tobacco products | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Hemophilia, Hepatitis (other than A) or Pancreatitis                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Osteoporosis, but only if you received injections or have had a fracture                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Spinal Stenosis, Quadriplegia, Paraplegia, or Hemiplegia                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Psoriatic Arthritis or Rheumatoid Arthritis                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Systemic Lupus Erythematosus (SLE) or Myasthenia Gravis                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Macular Degeneration, but only if you have the Wet form                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Bipolar Disorder or Schizophrenia                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Alcoholism or Drug Abuse                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |

**6K.** Within the past 2 years, did you receive any of the following:

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------|------------------------|-----------------|-------------------|-----------------------------------|------------------------|----------------------|--|------------------|--------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Skin grafts, or</li> <li>• Blood transfusions, IV infusions or injections (not including vaccinations or B12 injections) for any of the following conditions?               <table border="0"> <tbody> <tr> <td>• Asthma</td> <td>• Connective tissue disorders</td> </tr> <tr> <td>• Autoimmune disorders</td> <td>• Eye disorders</td> </tr> <tr> <td>• Blood disorders</td> <td>• Genetic or Hereditary disorders</td> </tr> <tr> <td>• Cognitive impairment</td> <td>• Migraine headaches</td> </tr> <tr> <td></td> <td>• Osteoarthritis</td> </tr> </tbody> </table> </li> </ul> | • Asthma                          | • Connective tissue disorders | • Autoimmune disorders | • Eye disorders | • Blood disorders | • Genetic or Hereditary disorders | • Cognitive impairment | • Migraine headaches |  | • Osteoarthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure |
| • Asthma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | • Connective tissue disorders     |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |
| • Autoimmune disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | • Eye disorders                   |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |
| • Blood disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | • Genetic or Hereditary disorders |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |
| • Cognitive impairment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | • Migraine headaches              |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | • Osteoarthritis                  |                               |                        |                 |                   |                                   |                        |                      |  |                  |                                                                                            |

**7**

**Tell us about your tobacco usage.** If you answer YES to this question, your rate will be the tobacco rate (see "Cover Page - Rates").

**7A.** At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product?

☐ Yes ☐ No



## 8 Your past and current coverage

### Review the statements.

- You do not need more than one Medicare supplement policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your Application Form.

### PLEASE ANSWER ALL QUESTIONS.

#### To the best of your knowledge,

**8A.** Did you turn age 65 in the last 6 months?

☐ Yes ☐ No

**8B.** Did you enroll in Medicare Part B within the last 6 months?

☐ Yes ☐ No

**8C.** If YES, what is the effective date?

\_\_\_\_/01/\_\_\_\_  
Month Day Year

### Questions about Medicaid

**8D.** Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question.

☐ Yes ☐ No

**If YES, you must answer Questions 8E and 8F.**

**8E.** Will Medicaid pay your premiums for this Medicare supplement policy?

☐ Yes ☐ No

**8F.** Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

☐ Yes ☐ No



First Name

Last Name

## 8 Your past and current coverage (continued)

### Questions about Medicare Advantage plans (sometimes called Medicare Part C)

**8G.** Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

☐ Yes ☐ No

**If YES, you must answer Questions 8H through 8K.**

**8H.** Provide the start and end dates of your Medicare plan other than original Medicare. If you are still covered under this plan, leave the end date blank.

**Start Date**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

**End Date**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

**8I.** If you are still covered under the Medicare plan other than original Medicare, do you intend to replace your current coverage with this new Medicare supplement policy? (When you receive confirmation that this Medicare Supplement plan has been issued, you will need to cancel your Medicare Advantage Plan. Please contact your Medicare Advantage insurer for instructions on how to cancel, using the customer service number on the back of your ID card.)

☐ Yes ☐ No

**If YES, please enclose a copy of the Replacement Notice.**

**8J.** Was this your first time in this type of Medicare plan?

☐ Yes ☐ No

**8K.** Did you drop a Medicare supplement policy to enroll in the Medicare plan?

☐ Yes ☐ No

### Questions about Medicare supplement plans

**8L.** Do you have another Medicare supplement policy in force?

If so, what insurance company and what plan do you have?

Insurance Company: \_\_\_\_\_

Policy: \_\_\_\_\_

**If YES, you must answer Questions 8M and 8N.**

**8M.** Do you intend to replace your current Medicare supplement policy with this policy?

☐ Yes ☐ No

**If YES, please enclose a copy of the Replacement Notice.**

**8N.** What is the plan code of your current Medicare Supplement Plan?

**Plan Code (A-N)** \_\_\_\_\_

### Questions about any other type of health insurance coverage

**8O.** Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?

☐ Yes ☐ No

**If YES, you must answer Questions 8P through 8R.**

**8P.** If so, with what insurance company and what kind of policy?

**Insurance Company:** \_\_\_\_\_

**Policy:**

☐ HMO/PPO

☐ Major Medical

☐ Employer Plan

☐ Union Plan

☐ Individual Health Insurance Plan

☐ Other \_\_\_\_\_



First Name

Last Name

## 8 Your past and current coverage (continued)

**8Q.** What are your dates of coverage under the other policy? Leave the end date blank if you are still covered under the policy.

**Start Date**/ /  
Month Day Year**End Date**/ /  
Month Day Year

**8R.** Are you replacing this health insurance?

☐ Yes ☐ No**Your Signature** (required)/ /  
**Today's Date** (required)  
Month Day Year

## 9 Authorization and Verification of Application Information

**Read carefully, and sign and date in the signature box.**

- I represent that the answers on this Application Form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this Application Form becomes a part of the insurance contract and that any incomplete, incorrect or untrue answers in this Application Form which were relied upon and materially affect either the acceptance of the risk or hazard assumed by UnitedHealthcare can result in a rescission of coverage, an adjustment of premium or a reduction in benefits, if permitted by law.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand coverage, if provided, will not take effect until issued by UnitedHealthcare, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.
- I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.
- If you are enrolling in a Medicare Select Plan: 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.

**If the Application Form is being completed through an Agent or Broker:**

- I understand an agent or broker discussing Plan options with me is appointed by UnitedHealthcare, and may be compensated based on my enrollment in a Plan.
- I understand that an agent or broker cannot change or waive any terms or requirements related to this Application Form and its contents, underwriting, premium or coverage and cannot grant approval.



**9 Authorization and Verification of Application Information (continued)****Authorization for the Release of Medical Information**

I authorize UnitedHealthcare and its affiliates ("The Company") to obtain from any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution or person, or The Company's own information, any data or records about me or my mental or physical health. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate.

I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law.

I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws.

I understand I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. If not revoked, this authorization is valid for 24 months from the date of my signature.

Please see "Your Guide" to determine if the following pre-existing condition waiting period applies to you.

**I understand the plan will not pay benefits for stays beginning or medical expenses incurred during the first 3 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 3 months prior to the insurance effective date.**

**My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.**

**X****Your Signature** (required)**Today's Date** (required)

Month Day Year

**Note:** If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐



First Name

Last Name

## 10 Authorization for Verification of Information

**Read carefully, and sign and date in the signature box below.**

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare and its affiliates ("The Company") any data or records about me or my mental or physical health. This may include information about medical advice, diagnosis, treatment and prescribed medications related to mental illness, alcoholism and drug abuse. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies.

I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law.

I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws.

I understand I may end this authorization, at any time, if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

**My signature indicates I have read and understand all contents of this Application Form and have answered all questions to the best of my ability.**

**X**

**Your Signature** (required)

**Today's Date** (required)

Month Day Year

**Note:** If you are signing as the legal representative (e.g., POA, Guardian, Conservator, etc.) for the applicant, please send a complete copy of the appropriate legal documentation and check this box. ☐



First Name

Last Name

11

## For Agent/Broker Use Only

**Agent/Broker must complete the following information and include the notice of replacement coverage, if appropriate, with this Application Form. All information must be complete or the Application Form will be returned.**

1. List any other health insurance policies issued to the applicant:

---

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2. List policies issued which are still in force:

---

---

3. List policies issued in the past 5 years which are no longer in force:

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---

Agent Name (PLEASE PRINT) \_\_\_\_\_  
First Name MI Last Name

X \_\_\_\_\_ / /  
Agent Signature (required) Agent ID (required) Today's Date (required)  
Month Day Year

\_\_\_\_\_  
Agent Email Address ( ) -  
Agent Phone Number



# AARP Member Benefits

Using just one benefit can pay for the cost of membership.

Join or renew AARP Membership and  
**SAVE 25%\***  
when you sign up for **Automatic Renewal!**



Visit [aarp.org/savetoday](http://aarp.org/savetoday) or  
call 1-866-331-1964

Plus, join today and receive a **FREE**  
second household membership



Scan now  
to join



## Explore everything AARP membership has to offer:

### Health Care Products & Discounts

Access to health care and dental insurance products,  
as well as vision, hearing and prescription discounts.

### Insurance & Financial Services

Access to life, auto and homeowners insurance,  
AARP-endorsed credit cards, plus banking and  
investment options.

### Travel Tips and Discounts

Travel tips and destination guides, insider tips,  
tools and travel advice.

### Community Involvement

Volunteer opportunities, social activities, safe driving  
courses and charitable programs.

### Advocacy That Matters

Fighting for you in your state and across the country  
to strengthen Medicare and Social Security, confront  
age discrimination and protect pension benefits.

### Award-Winning Publications

Including *AARP The Magazine*, *AARP Bulletin* and  
free guides on financial planning and health.

#### \*off AARP standard yearly price for your first year

With AARP automatic renewal, you will be charged \$15 for your first year. For any subsequent year you remain enrolled, you will be charged the full annual rate (currently \$20) on the first day of the month in which your membership expires. You may cancel at any time by calling 1-800-516-1993.

VGCDUHCM

**Or, join or renew your  
membership by mail.**

### Mail-in Membership Activation Form

Check or money order enclosed, payable to AARP.  
(Send no cash, please.)

- ☐ 1 year/\$20  
☐ 3 years/\$55  
☐ 5 years/\$79



Your Name (please print) \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

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

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

### FREE Membership for Household Member

Spouse's/Partner's Name \_\_\_\_\_

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

VGCDUHCM  
BA25608ST

AGT

# Act today and make the most of membership.



Join or renew with Automatic Renewal  
and **SAVE 25%** your first year!



Visit [aarp.org/savetoday](http://aarp.org/savetoday)



Or call 1-866-331-1964



Scan now to join.

## Here are some featured health-related benefits you'll have access to as an AARP member:

- ✓ Medicare Supplemental Insurance
- ✓ Dental Coverage
- ✓ Hearing Care Discounts
- ✓ Vision Care Discounts
- ✓ AARP Medicare Resource Center
- ✓ Personalized Nutrition Resources
- ✓ Healthy Food Delivery Service
- ✓ AARP Hearing Center
- ✓ Family Caregiving Resources
- ✓ AARP Staying Sharp



**Return this form in the  
enclosed envelope.**

**Please allow 3-4 weeks for membership kit and gift.** AARP is a nonprofit, nonpartisan organization. AARP offers member benefits, including those provided by unaffiliated third parties that pay AARP a royalty fee for use of its intellectual property. These fees are used for AARP's general purposes. Some benefits are age limited. One membership includes additional household member. Anyone 18+ can join. AARP shares member information with companies that provide member benefits and support AARP operations, as well as select nonprofits. To learn how we collect, use, and share data, or if you don't want your information shared with benefit providers or nonprofits, call 800-433-7419, email [aarpmember@aarp.org](mailto:aarpmember@aarp.org), or visit [aarp.org/privacy](http://aarp.org/privacy). Annual dues include - \$4.45 for subscriptions to **AARP The Magazine**, \$3.35 to **AARP Bulletin**. We may convert your check into an electronic deposit.

TEAR HERE

TEAR HERE

# Take advantage of the Electronic Funds Transfer (EFT) service!

---

## The Easiest Way to Pay

Enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save \$2.00 a month – or more.\*

\*Additional EFT savings may be available based on your enrollment in other eligible plans.

## Benefits of the EFT service:

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

## Signing Up is Easy

Complete the Automatic Payment Authorization Form on the reverse side. Return it with the application and be sure to keep a copy for your records. Please be sure the information is clear, as it is required for processing your request for EFT. Please do not include a check. All that is required is the EFT Authorization details noted on the back.

## Your EFT Start Date

- Recurring monthly EFT withdrawals will occur on or about the fifth of each month. EFT will usually begin the same month your plan is effective. If your enrollment application is accepted at the end of the month and your plan is effective the next month, there may be a processing delay in starting your EFT. In that case, EFT will start the month after your plan is effective, and your account statement will explain how to make a payment until your EFT starts.
- If this EFT form is received and processed after your application is accepted, the start date of EFT is based on the date your EFT form is processed and whether your plan has started or is effective in the future. EFT will usually begin the month after your EFT form is processed but could start the following month. If your coverage is effective two or more months in the future, EFT will begin the same month your plan is effective. The amount and date of the first EFT withdrawal will be shown on your account statement. If any payment is due before your EFT starts, use the coupon on the account statement which will explain how to make a payment.

**Complete Form on Reverse**



**This side for your information only, return not required.**

## AUTOMATIC PAYMENT AUTHORIZATION FORM

☐ I allow UnitedHealthcare Insurance Company or an affiliate, together known as “UnitedHealthcare,” to take monthly withdrawals, for the then-current monthly rate for the named member, from the bank account shown on this form. I also allow the named banking facility (BANK) to charge such withdrawals to this account.

Monthly withdrawal amounts will be for the individual’s payment due each month. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name \_\_\_\_\_ AARP Member Number \_\_\_\_\_

Member Address \_\_\_\_\_

Street Address

City

State

Zip Code

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

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

(9 digit number)

Account Type: ☐ Checking

☐ Savings (statement savings only)

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

Bank Account Holder’s Name if other than Member \_\_\_\_\_

Bank Account Holder’s Signature \_\_\_\_\_

### IMPORTANT

Please refer to the diagram below of a sample check to obtain your bank routing information.

The diagram shows a sample check with the following fields and labels:

- Account Holder Name:** John Doe, Street Address, Town, City Zip Code
- Check Number:** Check #1234
- Date:** \_\_\_\_\_
- Pay to:** \_\_\_\_\_ Dollars
- Bank Name & Address:** \_\_\_\_\_
- Memo:** \_\_\_\_\_
- Signed by:** \_\_\_\_\_
- MICR Line:** |:123456789:| 12345678 || 1234 ||

Labels for MICR line components:

- Bank Routing Transit Number – Must be 9 numbers** (points to |:123456789:|)
- Bank Account Number – Include all zeros** (points to 12345678 ||)
- Check Number – Do not include the check number (it may be before or after the account number) as it may delay processing.** (points to 1234 ||)

We look forward to continuing to serve you.

TEAR HERE

TEAR HERE

# Take advantage of the Electronic Funds Transfer (EFT) service!

---

## The Easiest Way to Pay

Enjoy the convenience of the EFT option. With EFT, your monthly payment will automatically be deducted from your checking or savings account. Also, you'll save \$2.00 a month – or more.\*

\*Additional EFT savings may be available based on your enrollment in other eligible plans.

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

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**Complete Form on Reverse**



**This side for your information only, return not required.**

## AUTOMATIC PAYMENT AUTHORIZATION FORM

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Monthly withdrawal amounts will be for the individual's payment due each month. This authority is active until UnitedHealthcare and the BANK receive notice from me to end withdrawals in enough time to give UnitedHealthcare and the BANK a reasonable opportunity to act on it. I have the right to stop payment of a withdrawal by giving notice to the BANK in such time as to give the BANK a reasonable opportunity to act upon it. I understand such action may make the health care insurance coverage past due and subject to cancellation.

Member Name \_\_\_\_\_ AARP Member Number \_\_\_\_\_

Member Address \_\_\_\_\_

Street Address

City

State

Zip Code

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

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

(9 digit number)

Account Type: ☐ Checking

☐ Savings (statement savings only)

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

Bank Account Holder's Name if other than Member \_\_\_\_\_

Bank Account Holder's Signature \_\_\_\_\_

### IMPORTANT

Please refer to the diagram below of a sample check to obtain your bank routing information.

The diagram shows a sample check with the following fields and labels:

- Account Holder Name**: John Doe, Street Address, Town, City Zip Code
- Check Number**: Check #1234
- Date**: Date: \_\_\_\_\_
- Pay to**: Pay to: \_\_\_\_\_ Dollars
- Bank Name & Address**: Bank Name & Address
- Memo**: Memo: \_\_\_\_\_
- Signed by**: Signed by: \_\_\_\_\_
- Bank Routing Transit Number**: :123456789: (Must be 9 numbers)
- Bank Account Number**: 12345678 (Include all zeros)
- Check Number**: 1234 (Do not include the check number (it may be before or after the account number) as it may delay processing.)

We look forward to continuing to serve you.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE  
UNITEDHEALTHCARE INSURANCE COMPANY**

Horsham, Pennsylvania

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

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.
- ☐ Other (Please Specify) \_\_\_\_\_

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to

- the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

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

\_\_\_\_\_  
(Date)

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

\_\_\_\_\_  
(Date)

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



**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE  
UNITEDHEALTHCARE INSURANCE COMPANY**

Horsham, Pennsylvania

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

According to the information you furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons (check one):

- \_\_\_\_\_ Additional benefits.
- \_\_\_\_\_ No change in benefits, but lower premiums.
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

- \_\_\_\_\_ Disenrollment from a Medicare Advantage plan. Please explain reason for Disenrollment.
- \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to

the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

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

\_\_\_\_\_  
(Date)

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

\_\_\_\_\_  
(Date)

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

TEAR HERE

TEAR HERE



**NOTICE OF AVAILABILITY AND LANGUAGE ASSISTANCE SERVICES AND  
ALTERNATE FORMATS**

**ATTENTION:** If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call toll-free 1-800-523-5800 (TTY 711).

**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame gratis al 1-800-822-0246 (TTY 711).

**ملاحظة:** إذا كنت تتحدث اللغة العربية (**Arabic**) ، ستوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل مجاناً على 1-800-523-5800 (الهاتف النصي 711).

**দেখুন:** আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। 1-800-523-5800 (TTY 711) টোল ফ্রি নম্বরে কল করুন।

**注意：**如果您說**中文 (Chinese)**，您可以獲得免費語言協助服務以及大字體等其他形式的免費通訊。請致電免付費電話 1-800-523-5800（聽力語言殘障服務專線 (TTY 711)）。

**ATTENTION:** Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Veuillez appeler le 1-800-523-5800 (numéro vert) ou le 711 (ATS).

**ATTENTION:** Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòm disponib, tankou sa ki enprime ak gwo lèt. Rele gratis 1-800-523-5800 (TTY 711).

**ACHTUNG:** Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachunterstützungsdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie gebührenfrei 1-800-523-5800 (TTY 711) an.

**ધ્યાન આપો:** જો તમે **ગુજરાતી (Gujarati)** બોલો છો , તો મફત ભાષા સહાય સેવાઓ અને અન્ય ફોર્મેટમાં મફત સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. ટોલ-ફ્રી 1-800-523-5800 (TTY 711) પર કોલ કરો.

**XIN LƯU Ý:** Nếu quý vị nói Tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi số điện thoại miễn phí 1-800-523-5800 (TTY 711).

**ध्यान दें:** यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएं और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। टोल-फ्री 1-800-523-5800 (TTY 711) पर कॉल करें।

**ATTENZIONE:** Se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami gratuitamente l'1-800-523-5800 (TTY 711).

**ご注意：**日本語 (**Japanese**) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。1-800-523-5800 (TTY 711) にお電話ください。

**알림사항:** **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사소통 매체를 이용하실 수 있습니다. 해당 서비스가 필요한 경우 무료 전화 1-800-523-5800 (TTY 711)번으로 전화해 주십시오.

**توجه:** اگر بہ زبان فارسی (**Farsi**) صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. به رایگان با شماره 1-800-523-5800 (TTY 711) تماس بگیرید.

**UWAGA:** Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej oraz bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer 1-800-523-5800 (telefon tekstowy TTY: 711).

**ATENÇÃO:** se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue gratuitamente para 1-800-523-5800 (TTY 711).

**ВНИМАНИЕ!** Если вы говорите **на русском языке (Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Позвоните бесплатно 1-800-523-5800 (телетайп TTY 711).

**PAUNAWA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag nang walang bayad sa 1-800-523-5800 (TTY 711).

**توجه:** اگر آپ اردو (**Urdu**) بولتے ہیں تو، زبان کی مدد کی مفت خدمات اور دوسرے فارمیٹس میں مفت پیغام رسانی، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ ٹول فری کال کریں 1-800-523-5800 (TTY 711)



# Glossary: Prescription Drugs

For **Agent/Producer use** to assist applicant with answering the health questions on the Application Form for AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare® Insurance Company.

Below is a partial prescription drug list which includes some prescription drugs commonly prescribed for medical conditions listed on the application.

This drug list is not all inclusive and should be used for reference only.

## Partial Prescription Drug List

| Drug Name                                      | Application Condition(s)                                     |
|------------------------------------------------|--------------------------------------------------------------|
| <b>Abemaciclib</b>                             | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Abiraterone Acetate</b>                     | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Acamprosate Calcium</b>                     | Alcoholism or drug abuse                                     |
| <b>Aclidinium &amp; Formoterol, Inhalation</b> | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Aclidinium Bromide, Inhalation</b>          | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Adasuve</b>                                 | Bipolar disorder, schizophrenia                              |
| <b>Adefovir Dipivoxil</b>                      | Hepatitis (other than A)                                     |
| <b>Afatinib</b>                                | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Afinitor</b>                                | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Alecensa</b>                                | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Alectinib</b>                               | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Alkeran</b>                                 | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Ambrisentan</b>                             | Pulmonary heart disease                                      |
| <b>Amiodarone Hydrochloride</b>                | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Ampyra</b>                                  | Multiple sclerosis                                           |
| <b>Anoro</b>                                   | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Antabuse</b>                                | Alcoholism or drug abuse                                     |
| <b>Apalutamide</b>                             | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Apixaban</b>                                | Artery blockage, atrial fibrillation                         |

| Drug Name                                               | Application Condition(s)                                   |
|---------------------------------------------------------|------------------------------------------------------------|
| <b>Apomorphine Hydrochloride</b>                        | Parkinson's disease                                        |
| <b>Arava</b>                                            | Rheumatoid arthritis                                       |
| <b>Arcapta</b>                                          | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Arformoterol Tartrate, Inhalation</b>                | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Aricept</b>                                          | Alzheimer's disease or dementia                            |
| <b>Asenapine</b>                                        | Bipolar disorder, schizophrenia                            |
| <b>Aubagio</b>                                          | Multiple sclerosis                                         |
| <b>Azilect</b>                                          | Parkinson's disease                                        |
| <b>Aztreonam Nebulizer</b>                              | Cystic fibrosis                                            |
| <b>Bafiertam</b>                                        | Multiple sclerosis                                         |
| <b>Baraclude</b>                                        | Hepatitis (other than A)                                   |
| <b>Baricitinib</b>                                      | Rheumatoid arthritis                                       |
| <b>Betapace</b>                                         | Ventricular tachycardia                                    |
| <b>Bicalutamide</b>                                     | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Breztri</b>                                          | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Brilinta</b>                                         | Artery blockage, heart attack, stroke, TIA, or mini-stroke |
| <b>Brovana</b>                                          | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Budesonide &amp; Glycopyrrolate &amp; Formoterol</b> | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Bunavail</b>                                         | Alcoholism or drug abuse                                   |
| <b>Buprenorphine &amp; Naloxone</b>                     | Alcoholism or drug abuse                                   |
| <b>Buprenorphine, for Opioid Dependence</b>             | Alcoholism or drug abuse                                   |
| <b>Cabergoline</b>                                      | Parkinson's disease                                        |

| Drug Name                            | Application Condition(s)                                                                                  |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------|
| <b>Calcium Acetate</b>               | Chronic kidney disease (CKD), end-stage renal disease (ESRD)                                              |
| <b>Campral</b>                       | Alcoholism or drug abuse                                                                                  |
| <b>Caplyta</b>                       | Bipolar disorder, schizophrenia                                                                           |
| <b>Carbidopa</b>                     | Parkinson's disease                                                                                       |
| <b>Cariprazine</b>                   | Bipolar disorder, schizophrenia                                                                           |
| <b>Casodex</b>                       | Cancer other than leukemia, lymphoma, or multiple myeloma                                                 |
| <b>Cayston Nebulizer</b>             | Cystic fibrosis                                                                                           |
| <b>Cilostazol</b>                    | Artery blockage, peripheral vascular disease (PVD)                                                        |
| <b>Cinacalcet Hydrochloride</b>      | Chronic kidney disease (CKD), end-stage renal disease (ESRD)                                              |
| <b>Cladribine (Mavenclad)</b>        | Multiple sclerosis                                                                                        |
| <b>Clopidogrel</b>                   | Artery blockage, heart attack, stroke, TIA, mini-stroke, balloon angioplasty, stenting, or bypass surgery |
| <b>Clozapine</b>                     | Bipolar disorder, schizophrenia                                                                           |
| <b>Clozaril</b>                      | Bipolar disorder, schizophrenia                                                                           |
| <b>Comtan</b>                        | Parkinson's disease                                                                                       |
| <b>Cordarone</b>                     | Ventricular tachycardia, atrial fibrillation                                                              |
| <b>Corlanor</b>                      | Cardiomyopathy, heart failure                                                                             |
| <b>Coumadin</b>                      | Artery blockage, heart attack, stroke, TIA, or mini-stroke                                                |
| <b>Crizotinib</b>                    | Cancer other than leukemia, lymphoma, or multiple myeloma                                                 |
| <b>Cyclosporine (Oral)</b>           | Bone marrow, stem cell, or organ transplant                                                               |
| <b>Dabigatran Etexilate Mesylate</b> | Artery blockage, atrial fibrillation                                                                      |
| <b>Daclatasvir</b>                   | Hepatitis (other than A)                                                                                  |
| <b>Daklinza</b>                      | Hepatitis (other than A)                                                                                  |

| Drug Name                                           | Application Condition(s)                                     |
|-----------------------------------------------------|--------------------------------------------------------------|
| <b>Dalfampridine</b>                                | Multiple sclerosis                                           |
| <b>Daliresp</b>                                     | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Dasatinib</b>                                    | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Deferoxamine Mesylate</b>                        | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Desferal</b>                                     | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Dhivy</b>                                        | Parkinson's disease                                          |
| <b>Digitek</b>                                      | Atrial fibrillation, cardiomyopathy, heart failure           |
| <b>Digox</b>                                        | Atrial fibrillation, cardiomyopathy, heart failure           |
| <b>Digoxin</b>                                      | Atrial fibrillation, cardiomyopathy, heart failure           |
| <b>Dilatrate-SR</b>                                 | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Dimethyl Fumarate</b>                            | Multiple sclerosis                                           |
| <b>Diroximel Fumarate</b>                           | Multiple sclerosis                                           |
| <b>Disulfiram</b>                                   | Alcoholism or drug abuse                                     |
| <b>Dofetilide</b>                                   | Atrial fibrillation                                          |
| <b>Donepezil &amp; Memantine</b>                    | Alzheimer's disease or dementia                              |
| <b>Donepezil Hydrochloride</b>                      | Alzheimer's disease or dementia                              |
| <b>Dornase Alpha Nebulizer</b>                      | Cystic fibrosis                                              |
| <b>Dronedarone</b>                                  | Atrial fibrillation                                          |
| <b>Duaklir</b>                                      | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Edoxaban</b>                                     | Artery blockage, atrial fibrillation                         |
| <b>Effient</b>                                      | Artery blockage, heart attack                                |
| <b>Elbasvir &amp; Grazoprevir</b>                   | Hepatitis (other than A)                                     |
| <b>Elexacaftor &amp; Tezacaftor &amp; Ivacaftor</b> | Cystic fibrosis                                              |

| Drug Name                       | Application Condition(s)                                                                                             |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>Eliphos</b>                  | Chronic kidney disease (CKD), end-stage renal disease (ESRD)                                                         |
| <b>Eliquis</b>                  | Artery blockage, atrial fibrillation                                                                                 |
| <b>Entacapone</b>               | Parkinson's disease                                                                                                  |
| <b>Entecavir</b>                | Hepatitis (other than A)                                                                                             |
| <b>Entresto</b>                 | Cardiomyopathy, heart failure                                                                                        |
| <b>Envarsus XR</b>              | Bone marrow, stem cell, or organ transplant                                                                          |
| <b>Enzalutamide</b>             | Cancer other than leukemia, lymphoma, or multiple myeloma                                                            |
| <b>Epclusa</b>                  | Hepatitis (other than A)                                                                                             |
| <b>Epivir HBV</b>               | Hepatitis (other than A)                                                                                             |
| <b>Epoetin Alfa</b>             | Cancer, leukemia, lymphoma, or multiple myeloma, chronic kidney disease (CKD), End-stage renal kidney disease (ESRD) |
| <b>Erleada</b>                  | Cancer other than leukemia, lymphoma, or multiple myeloma                                                            |
| <b>Erlotinib</b>                | Cancer other than leukemia, lymphoma, or multiple myeloma                                                            |
| <b>Esbriet</b>                  | Pulmonary heart disease                                                                                              |
| <b>Everolimus, (Afinitor)</b>   | Cancer other than leukemia, lymphoma, or multiple myeloma                                                            |
| <b>Everolimus, (Zortress)</b>   | Bone marrow, stem cell, or organ transplant                                                                          |
| <b>Exelon</b>                   | Alzheimer's disease or dementia                                                                                      |
| <b>Exservan</b>                 | Amyotrophic lateral sclerosis (ALS)                                                                                  |
| <b>Fanapt</b>                   | Schizophrenia                                                                                                        |
| <b>Fazaclo</b>                  | Bipolar disorder, schizophrenia                                                                                      |
| <b>Fingolimod</b>               | Multiple sclerosis                                                                                                   |
| <b>Flecainide Acetate</b>       | Atrial fibrillation, ventricular tachycardia                                                                         |
| <b>Galantamine Hydrobromide</b> | Alzheimer's disease or dementia                                                                                      |
| <b>Gengraf</b>                  | Bone marrow, stem cell, or organ transplant                                                                          |

| Drug Name                                           | Application Condition(s)                                     |
|-----------------------------------------------------|--------------------------------------------------------------|
| <b>Geodon</b>                                       | Bipolar disorder, schizophrenia                              |
| <b>Gilenya</b>                                      | Multiple sclerosis                                           |
| <b>Gilotrif</b>                                     | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Glecaprevir &amp; Pibrentasvir</b>               | Hepatitis (other than A)                                     |
| <b>Gleevec</b>                                      | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Glycopyrrolate &amp; Indacaterol, Inhalation</b> | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Glycopyrrolate, Inhalation</b>                   | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Gonitro</b>                                      | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Harvoni</b>                                      | Hepatitis (other than A)                                     |
| <b>Hecoria</b>                                      | Bone marrow, stem cell, or organ transplant                  |
| <b>Hepsera</b>                                      | Hepatitis (other than A)                                     |
| <b>Ibrance</b>                                      | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Ibrutinib</b>                                    | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Iloperidone</b>                                  | Schizophrenia                                                |
| <b>Iloprost</b>                                     | Pulmonary heart disease                                      |
| <b>Imatinib Mesylate</b>                            | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Imbruvica</b>                                    | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Imdur ER</b>                                     | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Inbrija</b>                                      | Parkinson's disease                                          |
| <b>Incruse</b>                                      | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Indacaterol, Capsules for Inhalation</b>         | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Invega ER</b>                                    | Schizophrenia                                                |

| Drug Name                                        | Application Condition(s)                                     |
|--------------------------------------------------|--------------------------------------------------------------|
| <b>Isochron</b>                                  | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Isordil</b>                                   | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Isosorbide Dinitrate</b>                      | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Isosorbide Mononitrate</b>                    | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Istradefylline</b>                            | Parkinson's disease                                          |
| <b>Ivabradine</b>                                | Cardiomyopathy, heart failure                                |
| <b>Ivacaftor</b>                                 | Cystic fibrosis                                              |
| <b>Ivacaftor &amp; Lumacaftor</b>                | Cystic fibrosis                                              |
| <b>Jantoven</b>                                  | Artery blockage, heart attack, stroke, TIA, or mini-stroke   |
| <b>Kalydeco</b>                                  | Cystic fibrosis                                              |
| <b>Kynmobi</b>                                   | Parkinson's disease                                          |
| <b>Lamivudine HBV</b>                            | Hepatitis (other than A)                                     |
| <b>Lamivudine, for Hepatitis B Virus</b>         | Hepatitis (other than A)                                     |
| <b>Lanoxin</b>                                   | Atrial fibrillation, cardiomyopathy, heart failure           |
| <b>Latuda</b>                                    | Bipolar disorder, schizophrenia                              |
| <b>Ledipasvir-Sofosbuvir</b>                     | Hepatitis (other than A)                                     |
| <b>Leflunomide</b>                               | Rheumatoid arthritis                                         |
| <b>Lenalidomide</b>                              | Cancer, leukemia, lymphoma, or multiple myeloma              |
| <b>Letairis</b>                                  | Pulmonary heart disease                                      |
| <b>Levodopa</b>                                  | Parkinson's disease                                          |
| <b>Levodopa &amp; Carbidopa</b>                  | Parkinson's disease                                          |
| <b>Levodopa &amp; Carbidopa &amp; Entacapone</b> | Parkinson's disease                                          |

| Drug Name                                         | Application Condition(s)                                                                             |
|---------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <b>Levodopa &amp; Carbidopa, Extended-Release</b> | Parkinson's disease                                                                                  |
| <b>Lithium, Carbonate or Citrate</b>              | Bipolar disorder                                                                                     |
| <b>Lithobid</b>                                   | Bipolar disorder                                                                                     |
| <b>Lodosyn</b>                                    | Parkinson's disease                                                                                  |
| <b>Lonhala</b>                                    | Chronic obstructive pulmonary disease (COPD), emphysema                                              |
| <b>Loxapine, Succinate or Hydrochloride</b>       | Bipolar disorder, schizophrenia                                                                      |
| <b>Lumateperone</b>                               | Bipolar disorder, schizophrenia                                                                      |
| <b>Lupkynis</b>                                   | Systemic lupus erythematosus (SLE)                                                                   |
| <b>Lurasidone</b>                                 | Bipolar disorder, schizophrenia                                                                      |
| <b>Macitentan</b>                                 | Pulmonary heart disease                                                                              |
| <b>Mavenclad</b>                                  | Multiple sclerosis                                                                                   |
| <b>Mavyret</b>                                    | Hepatitis (other than A)                                                                             |
| <b>Mayzent</b>                                    | Multiple sclerosis                                                                                   |
| <b>Mekinist</b>                                   | Melanoma, cancer other than leukemia, lymphoma, or multiple myeloma                                  |
| <b>Melphalan</b>                                  | Leukemia, lymphoma, or multiple myeloma                                                              |
| <b>Memantine Hydrochloride</b>                    | Alzheimer's disease or dementia                                                                      |
| <b>Mestinon</b>                                   | Myasthenia gravis                                                                                    |
| <b>Methotrexate Sodium</b>                        | Rheumatoid arthritis, psoriatic arthritis, cancer other than leukemia, lymphoma, or multiple myeloma |
| <b>Minitran</b>                                   | Artery blockage, heart attack, cardiomyopathy, heart failure                                         |
| <b>Monoket</b>                                    | Artery blockage, heart attack, cardiomyopathy, heart failure                                         |
| <b>Monomethyl Fumarate</b>                        | Multiple sclerosis                                                                                   |

| Drug Name                                                            | Application Condition(s)                                     |
|----------------------------------------------------------------------|--------------------------------------------------------------|
| <b>Multaq</b>                                                        | Atrial fibrillation                                          |
| <b>Namenda</b>                                                       | Alzheimer's disease or dementia                              |
| <b>Namzaric</b>                                                      | Alzheimer's disease or dementia                              |
| <b>Neoral</b>                                                        | Bone marrow, stem cell, or organ transplant                  |
| <b>Neratinib</b>                                                     | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Nerlynx</b>                                                       | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Nexavar</b>                                                       | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Nilotinib</b>                                                     | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Nintedanib</b>                                                    | Pulmonary heart disease                                      |
| <b>Nitro-Dur</b>                                                     | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Nitroglycerin, Transdermal System</b>                             | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Nitrostat</b>                                                     | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Nourianz</b>                                                      | Parkinson's disease                                          |
| <b>Ofev</b>                                                          | Pulmonary heart disease                                      |
| <b>Olodaterol, Inhalation</b>                                        | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Olumiant</b>                                                      | Rheumatoid arthritis                                         |
| <b>Olysio</b>                                                        | Hepatitis (other than A)                                     |
| <b>Ombitasvir &amp; Paritaprevir &amp; Ritonavir</b>                 | Hepatitis (other than A)                                     |
| <b>Ombitasvir &amp; Paritaprevir &amp; Ritonavir &amp; Dasabuvir</b> | Hepatitis (other than A)                                     |
| <b>Ongentys</b>                                                      | Parkinson's disease                                          |
| <b>Opicapone</b>                                                     | Parkinson's disease                                          |
| <b>Opsumit</b>                                                       | Pulmonary heart disease                                      |

| Drug Name                            | Application Condition(s)                                                                                           |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Orenitram</b>                     | Pulmonary heart disease                                                                                            |
| <b>Orkambi</b>                       | Cystic fibrosis                                                                                                    |
| <b>Osimertinib</b>                   | Cancer other than leukemia, lymphoma, or multiple myeloma                                                          |
| <b>Ozanimod</b>                      | Multiple sclerosis                                                                                                 |
| <b>Pacerone</b>                      | Artery blockage, heart attack, cardiomyopathy, heart failure                                                       |
| <b>Palbociclib</b>                   | Cancer other than leukemia, lymphoma, or multiple myeloma                                                          |
| <b>Paliperidone, or as Palmitate</b> | Schizophrenia                                                                                                      |
| <b>Parcopa</b>                       | Parkinson's disease                                                                                                |
| <b>Phoslo</b>                        | Chronic kidney disease (CKD), end-stage renal disease (ESRD)                                                       |
| <b>Phoslyra</b>                      | Chronic kidney disease (CKD), end-stage renal disease (ESRD)                                                       |
| <b>Pirfenidone</b>                   | Pulmonary heart disease                                                                                            |
| <b>Plavix</b>                        | Artery blockage, heart attack, stroke, TIA, mini-stroke, balloon angioplasty, stenting, or bypass surgery          |
| <b>Pletal</b>                        | Artery blockage, peripheral vascular disease (PVD)                                                                 |
| <b>Pomalidomide</b>                  | Leukemia, lymphoma, or multiple myeloma                                                                            |
| <b>Pomalyst</b>                      | Leukemia, lymphoma, or multiple myeloma                                                                            |
| <b>Ponesimod</b>                     | Multiple sclerosis                                                                                                 |
| <b>Ponvory</b>                       | Multiple sclerosis                                                                                                 |
| <b>Pradaxa</b>                       | Artery blockage, atrial fibrillation                                                                               |
| <b>Prasugrel Hydrochloride</b>       | Artery blockage, heart attack                                                                                      |
| <b>Procrit</b>                       | Cancer, leukemia, lymphoma, or multiple myeloma, chronic kidney disease (CKD), End-stage renal kidney disease ESRD |
| <b>Prograf</b>                       | Bone marrow, stem cell, or organ transplant                                                                        |
| <b>Propafenone Hydrochloride</b>     | Ventricular tachycardia, atrial fibrillation                                                                       |

| Drug Name                         | Application Condition(s)                                     |
|-----------------------------------|--------------------------------------------------------------|
| <b>Pulmozyme</b>                  | Cystic fibrosis                                              |
| <b>Pyridostigmine Bromide</b>     | Myasthenia gravis                                            |
| <b>Ranexa ER</b>                  | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Ranolazine</b>                 | Artery blockage, heart attack, cardiomyopathy, heart failure |
| <b>Rapamune</b>                   | Bone marrow, stem cell, or organ transplant                  |
| <b>Rasagiline</b>                 | Parkinson's disease                                          |
| <b>Razadyne</b>                   | Alzheimer's disease or dementia                              |
| <b>Renagel</b>                    | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Renvela</b>                    | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Retevmo</b>                    | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Revefenacin</b>                | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Rheumatrex</b>                 | Rheumatoid arthritis, psoriatic arthritis                    |
| <b>Rilutek</b>                    | Amyotrophic lateral sclerosis (ALS)                          |
| <b>Riluzole</b>                   | Amyotrophic lateral sclerosis (ALS)                          |
| <b>Rivaroxaban</b>                | Artery blockage, atrial fibrillation                         |
| <b>Rivastigmine Tartrate</b>      | Alzheimer's disease or dementia                              |
| <b>Roflumilast</b>                | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Rytary</b>                     | Parkinson's disease                                          |
| <b>Rythmol</b>                    | Ventricular tachycardia, atrial fibrillation                 |
| <b>Sacubitril &amp; Valsartan</b> | Cardiomyopathy, heart failure                                |
| <b>Safinamide</b>                 | Parkinson's disease                                          |
| <b>Sandimmune</b>                 | Bone marrow, stem cell, or organ transplant                  |
| <b>Saphris</b>                    | Bipolar disorder, schizophrenia                              |

| Drug Name                                              | Application Condition(s)                                     |
|--------------------------------------------------------|--------------------------------------------------------------|
| <b>Savaysa</b>                                         | Artery blockage, atrial fibrillation                         |
| <b>Secuado</b>                                         | Bipolar disorder, schizophrenia                              |
| <b>Seebri</b>                                          | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Selpercatinib</b>                                   | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Sensipar</b>                                        | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Sevelamer Hydrochloride or Carbonate</b>            | Chronic kidney disease (CKD), end-stage renal disease (ESRD) |
| <b>Simeprevir</b>                                      | Hepatitis (other than A)                                     |
| <b>Sinemet</b>                                         | Parkinson's disease                                          |
| <b>Siponimod</b>                                       | Multiple sclerosis                                           |
| <b>Sirolimus</b>                                       | Bone marrow, stem cell, or organ transplant                  |
| <b>Sofosbuvir</b>                                      | Hepatitis (other than A)                                     |
| <b>Sofosbuvir &amp; Ledipasvir</b>                     | Hepatitis (other than A)                                     |
| <b>Sofosbuvir &amp; Velpatasvir</b>                    | Hepatitis (other than A)                                     |
| <b>Sofosbuvir &amp; Velpatasvir &amp; Voxilaprevir</b> | Hepatitis (other than A)                                     |
| <b>Sorafenib</b>                                       | Cancer other than leukemia, lymphoma, or multiple myeloma    |
| <b>Sorine</b>                                          | Ventricular tachycardia                                      |
| <b>Sotalol Hydrochloride</b>                           | Ventricular tachycardia                                      |
| <b>Sotylize</b>                                        | Ventricular tachycardia                                      |
| <b>Sovaldi</b>                                         | Hepatitis (other than A)                                     |
| <b>Spiriva</b>                                         | Chronic obstructive pulmonary disease (COPD), emphysema      |
| <b>Sprycel</b>                                         | Leukemia, lymphoma, or multiple myeloma                      |
| <b>Stalevo</b>                                         | Parkinson's disease                                          |

| Drug Name                                      | Application Condition(s)                                   |
|------------------------------------------------|------------------------------------------------------------|
| <b>Stiolto</b>                                 | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Striverdi</b>                               | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Suboxone</b>                                | Alcoholism or drug abuse                                   |
| <b>Subutex</b>                                 | Alcoholism or drug abuse                                   |
| <b>Sunitinib Malate</b>                        | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Sutent</b>                                  | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Symdeko</b>                                 | Cystic fibrosis                                            |
| <b>Tacrolimus</b>                              | Bone marrow, stem cell, or organ transplant                |
| <b>Tagrisso</b>                                | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Tambocor</b>                                | Atrial fibrillation, ventricular tachycardia               |
| <b>Tarceva</b>                                 | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Tasigna</b>                                 | Leukemia, lymphoma, or multiple myeloma                    |
| <b>Tasmar</b>                                  | Parkinson's disease                                        |
| <b>Tecfidera</b>                               | Multiple sclerosis                                         |
| <b>Technivie</b>                               | Hepatitis (other than A)                                   |
| <b>Telbivudine</b>                             | Hepatitis (other than A)                                   |
| <b>Tenofovir Alafenamide</b>                   | Hepatitis (other than A)                                   |
| <b>Teriflunomide</b>                           | Multiple sclerosis                                         |
| <b>Tezacaftor &amp; Ivacaftor</b>              | Cystic fibrosis                                            |
| <b>Ticagrelor</b>                              | Artery blockage, heart attack, stroke, TIA, or mini-stroke |
| <b>Tiglutik</b>                                | Amyotrophic lateral sclerosis (ALS)                        |
| <b>Tikosyn</b>                                 | Atrial fibrillation                                        |
| <b>Tiotropium &amp; Olodaterol, Inhalation</b> | Chronic obstructive pulmonary disease (COPD), emphysema    |

| Drug Name                                        | Application Condition(s)                                            |
|--------------------------------------------------|---------------------------------------------------------------------|
| <b>Tiotropium Bromide, Inhalation</b>            | Chronic obstructive pulmonary disease (COPD), emphysema             |
| <b>Tofacitinib</b>                               | Rheumatoid arthritis, psoriatic arthritis                           |
| <b>Tolcapone</b>                                 | Parkinson's disease                                                 |
| <b>Trametinib</b>                                | Melanoma, cancer other than leukemia, lymphoma, or multiple myeloma |
| <b>Treprostinil</b>                              | Pulmonary heart disease                                             |
| <b>Trexall</b>                                   | Rheumatoid arthritis, psoriatic arthritis                           |
| <b>Trikafta</b>                                  | Cystic fibrosis                                                     |
| <b>Tudorza</b>                                   | Chronic obstructive pulmonary disease (COPD), emphysema             |
| <b>Tyvaso</b>                                    | Pulmonary heart disease                                             |
| <b>Tyzeka</b>                                    | Hepatitis (other than A)                                            |
| <b>Umeclidinium &amp; Vilanterol, Inhalation</b> | Chronic obstructive pulmonary disease (COPD), emphysema             |
| <b>Umeclidinium, Inhalation</b>                  | Chronic obstructive pulmonary disease (COPD), emphysema             |
| <b>Utibron</b>                                   | Chronic obstructive pulmonary disease (COPD), emphysema             |
| <b>Vemlidy</b>                                   | Hepatitis (other than A)                                            |
| <b>Ventavis</b>                                  | Pulmonary heart disease                                             |
| <b>Versacloz</b>                                 | Bipolar disorder, schizophrenia                                     |
| <b>Verzenio</b>                                  | Cancer other than leukemia, lymphoma, or multiple myeloma           |
| <b>Viekira Pak</b>                               | Hepatitis (other than A)                                            |
| <b>Viekira XR</b>                                | Hepatitis (other than A)                                            |
| <b>Voclosporin</b>                               | Systemic lupus erythematosus (SLE)                                  |
| <b>Vosevi</b>                                    | Hepatitis (other than A)                                            |
| <b>Vraylar</b>                                   | Bipolar disorder, schizophrenia                                     |

| Drug Name                        | Application Condition(s)                                   |
|----------------------------------|------------------------------------------------------------|
| <b>Vumerity</b>                  | Multiple sclerosis                                         |
| <b>Warfarin Sodium</b>           | Artery blockage, heart attack, stroke, TIA, or mini-stroke |
| <b>Xadago</b>                    | Parkinson's disease                                        |
| <b>Xalkori</b>                   | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Xarelto</b>                   | Artery blockage, atrial fibrillation                       |
| <b>Xatmep</b>                    | Rheumatoid arthritis, psoriatic arthritis                  |
| <b>Xeljanz</b>                   | Rheumatoid arthritis, psoriatic arthritis                  |
| <b>Xeljanz XR</b>                | Rheumatoid arthritis, psoriatic arthritis                  |
| <b>Xtandi</b>                    | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Yonsa</b>                     | Cancer other than leukemia, lymphoma, or multiple myeloma  |
| <b>Yupelri</b>                   | Chronic obstructive pulmonary disease (COPD), emphysema    |
| <b>Zepatier</b>                  | Hepatitis (other than A)                                   |
| <b>Zeposia</b>                   | Multiple sclerosis                                         |
| <b>Ziprasidone Hydrochloride</b> | Bipolar disorder, schizophrenia                            |
| <b>Zortress</b>                  | Bone marrow, stem cell, or organ transplant                |
| <b>Zubsolv</b>                   | Alcoholism or drug abuse                                   |
| <b>Zytiga</b>                    | Cancer other than leukemia, lymphoma, or multiple myeloma  |



## NOTES

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## NOTES

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# Thank You for Applying for an AARP® Medicare Supplement Insurance Plan Insured by UnitedHealthcare Insurance Company

## For Your Records:

You selected Plan \_\_\_\_\_ with a requested effective date (1st day of a future month) of \_\_\_\_/\_\_\_\_/\_\_\_\_.

Based on the information you provided, your monthly premium for the plan you selected may be \$\_\_\_\_\_. **Please note that your final monthly premium will be determined once your application is approved.**

You will be notified when review of your application has been completed.

## What's Next:

Once your application is approved, you may expect your insured Member Identification (ID) Card to arrive. Using the information on the Member ID Card, you can register for a secure online account at **[www.myaarpmedicare.com](http://www.myaarpmedicare.com)** to gain access to tools and resources to help you manage both your plan and your health.

In addition to your insured Member ID Card and website access, you'll also receive:



### Welcome Kit.

The Welcome Kit will include your Certificate of Insurance and coverage details.



### Educational Materials.

UnitedHealthcare's educational materials can help you make the most of your plan benefits.



### Dedicated Customer Service.

You'll receive a friendly call from one of our courteous and caring UnitedHealthcare Customer Service Advocates, who will review your new member materials, and help answer questions you may have.



### Exclusive AARP Member Benefits.

A full listing of the benefits you receive with your AARP membership – including healthcare-related discounts, access to financial programs, driver safety courses, social activities, and more – can be found when you log into **[www.myaarpmedicare.com](http://www.myaarpmedicare.com)**.



## Let's talk about your needs.

Your licensed insurance agent/producer contracted with UnitedHealthcare Insurance Company is here to help.

Name \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_



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You must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan.

Insured by UnitedHealthcare Insurance Company, 185 Asylum Street, Hartford, CT 06103. Policy form No. GRP 79171 GPS-1 (G-36000-4).

**In some states, plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease.**

**Not connected with or endorsed by the U.S. Government or the federal Medicare program.**

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

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