Area 2

Cover Page - Monthly Rates for Florida

AARP® Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company

Non-Tobacco Rates [1]							
Age[2]	Plan A	Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
50-64	$387.75	$456.50	$529.00	$532.00	$190.25	$317.25	$384.00
65	$134.00	$157.50	$182.75	$183.75	$ 65.75	$109.75	$132.75
66-69	$145.00	$170.75	$197.75	$199.00	$ 71.25	$118.75	$143.75
70-74	$161.75	$190.25	$220.50	$221.75	$ 79.25	$132.25	$160.25
75-79	$176.00	$207.00	$240.00	$241.50	$ 86.25	$144.00	$174.25
80+	$192.50	$226.25	$262.25	$264.00	$ 94.50	$157.50	$190.50

Tobacco Rates [1]							
Age[2]	Plan A	Plan B	Plan C	Plan F	Plan K	Plan L	Plan N
50-64	$426.52	$502.15	$581.90	$585.20	$209.27	$348.97	$422.40
65	$147.40	$173.25	$201.02	$202.12	$ 72.32	$120.72	$146.02
66-69	$159.50	$187.82	$217.52	$218.90	$ 78.37	$130.62	$158.12
70-74	$177.92	$209.27	$242.55	$243.92	$ 87.17	$145.47	$176.27
75-79	$193.60	$227.70	$264.00	$265.65	$ 94.87	$158.40	$191.67
80+	$211.75	$248.87	$288.47	$290.40	$103.95	$173.25	$209.55

The rates above are for plan effective dates from January 2015 - December 2015.

1 The rates on this page are for the person whose name is on the enclosed application.
These rates are for plan effective dates from January 2015 - December 2015 and may change.

2 Your age as of your plan effective date. Your rate will always be based on your age on your effective date.

UnitedHealthcare Insurance Company
Outline of Coverage
Benefit Plans A, B, C, F, K, L, N
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization:** Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B co-insurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance

Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible					
				Part B excess (100%)	Part B excess (100%)				
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
						Out-of-pocket limit $4940; paid at 100% after limit reached	Out-of-pocket limit $2470; paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

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

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AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

Your Guide to AARP Medicare Supplement Insurance Portfolio of Plans

How to Use Your Guide

This Guide contains detailed information about the AARP Medicare Supplement Insurance Plans.

The AARP Medicare Supplement Insurance Portfolio of Plans, insured by UnitedHealthcare Insurance Company, provides a choice of benefits to AARP members, so you may choose the plan that best fits your individual supplemental health insurance needs.

To help you choose the AARP Medicare Supplement Plan to meet your needs and budget:

- Look at the Cover Page which shows the benefits of each Medicare supplement plan and indicates any specific provisions that may apply in your state. Also be sure to review the Monthly Premium information. Benefits and cost vary depending upon the plan selected.
- For more information on a specific plan, look at the chart(s) which outline(s) the benefits of that plan. The detailed chart(s) show(s) the expenses Medicare pays, the benefits the plan pays and the specific costs you would have to pay yourself.

If you have any questions, call toll free, 1-800-523-5800, any weekday from 7 a.m. to 11 p.m. or Saturday from 9 a.m. to 5 p.m., Eastern Time. For members with speech or hearing impairments who have access to TTY, call 711 weekdays from 9 a.m. to 5 p.m., Eastern Time. Hablamos español — llame al 1-800-822-0246, de lunes a viernes, de las 8 a.m. a las 5 p.m. y sábado de las 9 a.m. a las 5 p.m., hora del este.

Eligibility to Apply

To be eligible to apply, you must be an AARP member or spouse of a member, age 50 or over, covered by both Part A and Part B of original Medicare, and not duplicating any Medicare supplement coverage. (If you are not yet age 65 you must enroll within 6 months of enrolling in Medicare Part B, unless you are an "Eligible Person" entitled to Guaranteed Acceptance as shown under the following "Guaranteed Acceptance" Section.)

Guaranteed Acceptance

- Your acceptance in any plan 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 you lose health insurance coverage and are an eligible AARP member, you may be considered an "Eligible Person" entitled to guaranteed acceptance and you may have a guaranteed right to enroll in certain AARP Medicare Supplement Plans under specific circumstances. You are required to:
  1. Apply within the required time period following the termination of your prior health insurance plan.
  2. Provide a copy of the termination notice you received from your prior insurer with your application. This notice must verify the circumstances of your prior plan's termination and describe your right to guaranteed issue of Medicare supplement insurance.

If you have any questions on your guaranteed right to insurance, you may wish to contact the administrator of your prior health insurance plan or your local state department on aging.

Glossary of Terms

Medicare Eligible Expenses are the health care expenses of the kinds covered under Medicare Parts A and B that Medicare recognizes as reasonable and medically necessary. Physicians under Medicare may agree to accept Medicare's eligible expense as their fee amount. Your physician or surgeon may charge you more.

Excess Charge is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Hospital or Skilled Nursing Facility — A hospital is an institution that provides care for which Medicare pays hospital benefits. A skilled nursing facility is a facility that provides skilled nursing care and is approved for payment by Medicare. The skilled nursing facility stay must begin within 30 days after a hospital stay of 3 or more days in a row or a prior covered skilled nursing facility stay. Both the hospital stay and the skilled nursing facility stay must start while you are covered under this plan. Custodial care does not qualify as an eligible expense.

Lifetime Reserve Days are limited by Medicare to 60 days during your lifetime. Once these are used, Medicare provides no hospital coverage after 90 days of a benefit period.

Hospice Care means care for those who are terminally ill. Hospice Care typically focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

General Information

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company 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.

This package describes the AARP Medicare Supplement Plans available in your state, but is not a contract, policy, or insurance certificate. Please read your Certificate of Insurance, upon receipt, for plan benefits, definitions, exclusions, and limitations. AARP Medicare Supplement Plans have been developed in line with federal standards. **However, these plans are not connected with, or endorsed by, the U.S. Government or the federal Medicare program.** The Policy Form No. GRP79171 GPS-1 (G-36000-4) is issued in the District of Columbia to the Trustees of the AARP Insurance Plan. By enrolling, you are agreeing to the release of Medicare claim information to UnitedHealthcare Insurance Company so your AARP Medicare Supplement Plan claims may be processed automatically.

AARP does not employ or endorse agents, brokers or producers.

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

Exclusions

- Benefits provided under Medicare.
- Care not meeting Medicare's standards.
- Stays beginning, or care or supplies received, before your plan's effective date.
- 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.
- 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 "Eligible Persons" entitled to Guaranteed Acceptance, 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.

You Cannot Be Singled Out for Cancellation

Your Medicare supplement plan cannot be canceled because of your age, your health, or the number of claims you make. Your Medicare supplement plan may be canceled due to nonpayment of premium or material misrepresentation. If the group policy terminates and is not replaced by another group policy providing the same type of coverage, you may convert your AARP Medicare Supplement Plan to an individual Medicare supplement policy issued by UnitedHealthcare Insurance Company. Of course, you may cancel your AARP Medicare Supplement Plan any time you wish. All transactions go into effect on the first of the month following receipt of the request.

The AARP Insurance Trust

AARP established the AARP Insurance Plan, a trust, to hold the master group insurance policies. The AARP Medicare Supplement Insurance Plan is insured by UnitedHealthcare Insurance Company, not by AARP or its affiliates. Please contact UnitedHealthcare Insurance Company 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 Insurance Company, 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 Insurance Company 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.

AARP® | Medicare Supplement Plans
insured by UnitedHealthcare Insurance Company

AARP Medicare Supplement Plans insured by: UnitedHealthcare Insurance Company
1-800-523-5800
For information about the family of health products and services
www.aarphealthcare.com

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* 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.

Services	Medicare Pays	Plan A		Plan B	
		Plan Pays	You Pay	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but $1,260	$0	$1,260 (Part A deductible)	$1,260 (Part A deductible)	$0
61st thru 90th day	All but $315 per day	$315 per day	$0	$315 per day	$0
91st day and after: While using 60 lifetime reserve days	All but $630 per day	$630 per day	$0	$630 per day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare- eligible expenses	$0**	100% of Medicare- eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
21st thru 100th day	All but $157.50 per day	$0	Up to $157.50 per day	$0	Up to $157.50 per day
101st day and after	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE					
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

** **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.

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MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $147 of Medicare Approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A		Plan B	
		Plan Pays	You Pay	Plan Pays	You Pay
MEDICAL EXPENSES INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
PART B EXCESS CHARGES					
Above Medicare Approved amounts	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	All costs	$0	All costs	$0
Next $147 of Medicare Approved amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES					
Tests for diagnostic services	100%	$0	$0	$0	$0

PARTS A & B

HOME HEALTH CARE					
MEDICARE APPROVED SERVICES					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment					
First $147 of Medicare Approved amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	$0	20%	$0

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* 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.

Services	Medicare Pays	Plan C		Plan F	
		Plan Pays	You Pay	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.					
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0	$1,260 (Part A deductible)	$0
61st thru 90th day	All but $315 per day	$315 per day	$0	$315 per day	$0
91st day and after: While using 60 lifetime reserve days	All but $630 per day	$630 per day	$0	$630 per day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare- eligible expenses	$0**	100% of Medicare- eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
21st thru 100th day	All but $157.50 per day	Up to $157.50 per day	$0	Up to $157.50 per day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE					
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

** **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.

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MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $147 of Medicare Approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan C		Plan F	
		Plan Pays	You Pay	Plan Pays	You Pay
MEDICAL EXPENSES INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.					
First $147 of Medicare Approved amounts*	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
PART B EXCESS CHARGES					
Above Medicare Approved amounts	$0	$0	All costs	100%	$0
BLOOD					
First 3 pints	$0	All costs	$0	All costs	$0
Next $147 of Medicare Approved amounts*	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES					
Tests for diagnostic services	100%	$0	$0	$0	$0

PARTS A & B

HOME HEALTH CARE					
MEDICARE APPROVED SERVICES					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment					
First $147 of Medicare Approved amounts*	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan C•		Plan F	
		Plan Pays	You Pay	Plan Pays	You Pay
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.					
First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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* You will pay half (one-fourth for Plan L) of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4940 ($2470 for Plan L) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦). Once you reach the annual limit, the plan pays 100% of the Medicare co-payment and co-insurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** 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.

Services	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies.							
First 60 days	All but $1,260	$630 (50% of Part A deductible)	$630 (50% of Part A deductible)♦	$945 (75% of Part A deductible)	$315 (25% of Part A Deductible)♦	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 per day	$315 per day	$0	$315 per day	$0	$315 per day	$0
91st day and after: While using 60 lifetime reserve days	All but $630 per day	$630 per day	$0	$630 per day	$0	$630 per day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible costs	$0***	100% of Medicare-eligible costs	$0***	100% of Medicare-eligible costs	$0***
Beyond the additional 365 days	$0	$0	All costs	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved facility within 30 days after leaving the hospital.							
First 20 days	All approved amounts	$0	$0	$0	$0	$0	$0
21st thru 100th day	All but $157.50 per day	Up to $78.75 per day	Up to $78.75 per day♦	Up to $118.13 per day	Up to $39.37 per day♦	Up to $157.50 per day	$0
101st day and after	$0	$0	All costs	$0	All costs	$0	All costs
BLOOD							
First 3 pints	$0	50%	50%♦	75%	25%♦	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0	$0	$0

*** **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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD, CONTINUED

**** Once you have been billed $147 of Medicare Approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay
HOSPICE CARE							
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance ♦	75% of copayment/ coinsurance	25% of Medicare copayment/ coinsurance♦	Medicare copayment/ coinsurance	$0

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

MEDICAL EXPENSES INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.							
First $147 of Medicare Approved amounts****	$0	$0	$147 (Part B deduct-ible)****♦	$0	$147 (Part B deduct-ible)****♦	$0	$147 (Part B deductible)
Preventive Benefits for Medicare Covered Services	Generally 80% or more of Medicare Approved amounts	Remainder of Medicare Approved amounts	All costs above Medicare Approved amounts	Remainder of Medicare Approved amounts	All costs above Medicare Approved amounts	Balance, other than up to $20 per office visit	Up to $20 per office visit
Remainder of Medicare Approved amounts	Generally 80%	Generally 10%	Generally 10%♦	Generally 15%	Generally 5%♦	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

* This plan limits your annual out-of-pocket payments for Medicare Approved amount to $4940 per calendar year ($2470 for Plan L). However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR, CONTINUED

**** Once you have been billed $147 of Medicare Approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay*	Plan Pays	You Pay*	Plan Pays	You Pay
PART B EXCESS CHARGES							
Above Medicare Approved amounts	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4940)*	$0	All costs (and they do not count toward annual out-of-pocket limit of $2470)*	$0	All costs
BLOOD							
First 3 pints	$0	50%	50%♦	75%	25%♦	All costs	$0
Next $147 of Medicare Approved amounts****	$0	$0	$147 (Part B deduct-ible)****♦	$0	$147 (Part B deduct-ible)****♦	$0	$147 (Part B deductible)
Remainder of Medicare Approved amounts	Generally 80%	Generally 10%	Generally 10%♦	Generally 15%	Generally 5%♦	20%	$0
CLINICAL LABORATORY SERVICES							
Tests for diagnostic services	100%	$0	$0	$0	$0	$0	$0

PARTS A & B

HOME HEALTH CARE							
MEDICARE APPROVED SERVICES							
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0	$0	$0
Durable medical equipment							
First $147 of Medicare Approved amounts*****	$0	$0	$147 (Part B deductible)♦	$0	$147 (Part B deductible)♦	$0	$147 (Part B deductible)
Remainder of Medicare Approved amounts	80%	10%	10%♦	15%	5%♦	20%	$0

* This plan limits your annual out-of-pocket payments for Medicare Approved amount to $4940 per calendar year ($2470 for Plan L). However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan K		Plan L		Plan N	
		Plan Pays	You Pay	Plan Pays	You Pay	Plan Pays	You Pay
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.							
First $250 each calendar year	$0	$0	All costs	$0	All costs	$0	$250
Remainder of charges	$0	$0	All costs	$0	All costs	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum